

Originally Processed With FOIA(s):
2021-0094-F

FOIA Number:
2021-0094-F

FOIA MARKER

**This is not a textual record. This is used as an
administrative marker by the George Bush Presidential
Library Staff.**

Record Group/Collection: Dan Quayle Vice Presidential Records
Collection/Office of Origin: Deputy Chief of Staff's Office
Series: Porter, Richard W., Files
Subseries: Subject Files

OA/ID Number: 21805
Folder ID Number: 21805-002

Folder Title:
Health [1]

Stack:	Row:	Section:	Shelf:	Position:
G	34	6	5	7

Withdrawal/Redaction Sheet (George Bush Library)

Doc. No. / Type	Subject/Title	Date	Restriction	Classification
01. Notes	Re: Health care issues; personal information redacted. (1 pp.)	n.d.	(b)(6)	

Page 1 of 1

Collection:

Record Group: Quayle Vice Presidential Records
Office: Deputy Chief of Staff's Office
Series: Porter, Richard, Files
Subseries: Subject Files
WHORM Cat.:
File Location: Health [1]

Pinksheet Number: RML14852
OA/ID Number: 21805-002
Date Closed: 3/17/2023
FOIA/Sys Case #: 2021-0094-F
Re-review Case #:
P-2/P-5 Review Case #:

Processed by: Matt Lee
Processed by:
Processed by:

HEALTH

Withdrawal/Redaction Sheet

(George Bush Library)

Document No. and Type	Subject/Title of Document	Date	Restriction	Class.
01. Notes	Re: Health care issues; personal information redacted. (1 pp.)	n.d.	(b)(6)	

Collection:

Record Group: Quayle Vice Presidential Records
Office: Deputy Chief of Staff's Office
Series: Porter, Richard, Files
Subseries: Subject Files
WHORM Cat.:
File Location: Health [1]

Date Closed:	3/17/2023	OA/ID Number:	21805-002
FOIA/SYS Case #:	2021-0094-F	Appeal Case #:	
Re-review Case #:		Appeal Disposition:	
P-2/P-5 Review Case #:		Disposition Date:	
AR Case #:		MR Case #:	
AR Disposition:		MR Disposition:	
AR Disposition Date:		MR Disposition Date:	

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P-1 National Security Classified Information [(a)(1) of the PRA]
P-2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P-3 Release would violate a Federal statute [(a)(3) of the PRA]
P-4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P-5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
P-6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Removed as a personal record misfile.

Freedom of Information Act - [5 U.S.C. 552(b)]

(b)(1) National security classified information [(b)(1) of the FOIA]
(b)(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
(b)(3) Release would violate a Federal statute [(b)(3) of the FOIA]
(b)(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
(b)(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
(b)(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
(b)(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
(b)(9) Release would disclose geological or geophysical information

Charles Chip truck

- best health care in the world

(b)(6)

IL med.

(b)(6)

James Convent ^{security Link} - I'm going to have to
lay off a lot of people if their plan
passed. I'm always having to choose between
laying people off or cutting health benefits - I
don't like it.

- Premier of Quebec - cancer
- Ontario spent \$200 million on health in U.S. in 1991
- BC contracting for services in Seattle

**PAY OR PLAY EMPLOYER MANDATES:
EFFECTS ON INSURANCE COVERAGE
AND COSTS**

by
Sheila R. Zedlewski
Gregory P. Acs
Laura Wheaton
Colin W. Winterbottom

January 8, 1992

Funding for this paper was provided by the Pension and Welfare Benefits Administration of the U.S. Department of Labor through a contract to the Rand Corporation and a subcontract to The Urban Institute. The opinions and conclusions expressed herein are solely those of the authors and should not be construed as representing the opinions or policy of the Rand Corporation or The Urban Institute. The material presented here also does not necessarily represent the position of the U.S. Department of Labor. The authors are solely responsible for the accuracy of the statements of interpretations contained herein.



THE URBAN INSTITUTE 2100 M Street N.W. / Washington, D.C. 20037/ (202) 833-7200

Summary

Skyrocketing health care costs and the existence of increasing numbers of uninsured Americans have compelled this country to focus considerable attention on health system reform. Numerous Congressional leaders, associations, academics, and health policy analysts have suggested ways to reform the current system to provide access to health care for all Americans. Many of the prominent proposals attempt to build on our current employment-based health insurance system. These proposals call for "play or pay" employer mandates to broaden coverage to all workers and their dependents. These mandates would require employers to either provide health insurance directly ("play") or pay a payroll tax to enroll their workers into a public health insurance plan ("pay").

Most "play or pay" proposals would also provide access to a public health plan for persons who are not working. Subsidies would be provided to cover the premiums and cost sharing requirements for low-income persons. Costs for persons with incomes below poverty would be fully subsidized, and costs for persons with incomes up to 200 percent of poverty would be subsidized on a sliding scale. Thus, the play or pay proposals would ensure all Americans regular access to health care.

Despite the prominence of these proposals, we know little about their full effects. This paper presents an analysis of the direct effects of play or pay employer mandates. The Pension Welfare and Benefits Administration at the Department of Labor provided funding to develop an economic model that could evaluate these proposals. The model builds upon a microsimulation system (called TRIM2) that has been used by government agencies and private organizations to evaluate various public policies over the last 20 years. The enhanced model integrates data describing employment-based health plans and employers' average payrolls with a representative sample of nonelderly Americans from the March 1990 Current Population Survey. By comparing workers' health insurance costs to optional payroll tax payments, the model simulates employers' decisions either to provide insurance or to pay a payroll tax.

Assumptions of the Analysis

Throughout this analysis we assume that all employers would choose the less expensive insurance option. We show results for two different payroll tax rates -- 7 percent and 9 percent -- and model the requirements of the leading comprehensive play or pay proposals. These assumptions would require employers to pay 80 percent of the cost to insure persons working 18 hours a week or more (and their dependents) or pay a flat tax on their workers' wages. Employers would pay a tax on the wages of employees working less than 18 hours a week to enroll them in the public plan.

We assume that all employers could purchase a uniform benefit package with a 20 percent coinsurance requirement at the average price available to employers with similar characteristics.

Further, we assume that all workers must be insured through their own employer, and nonworking dependents are insured through the family's primary earner.

Who Would Be Covered

The most striking finding of this analysis is the large number of persons who would potentially be enrolled in the public plan. Under the 9 percent payroll tax rate nearly 40 percent of nonelderly Americans would be enrolled in the public plan (including workers, dependents of workers, and nonworkers). Under a 7 percent payroll tax rate assumption, the percentage of nonelderly Americans enrolled in the public insurance plan would increase to 52 percent.

The total number of persons insured through private, employment-based plans is likely to decline under both payroll tax options. Currently, 142.2 million Americans are insured through employment-based plans. Under a 7 percent play or pay mandate, we predict that the number would shrink to 104.7 million persons, and under the 9 percent mandate, the number would decline to 131.8 million persons. Under the 7 percent mandate, as many as 99 million Americans would switch health insurance plans, 84 million would remain in their current plans, and 33 million uninsured persons would gain health insurance. About 67 million persons would switch insurance plans under a 9 percent plan.

Some workers currently insured through employment-based plans would shift to the public plan. For example, 35.3 percent of workers currently insured through their own employer would shift into the public health plan under the 7 percent payroll tax rate. Under the 9 percent payroll tax rate, 20.8 percent of workers currently in employment-based plans would switch to the public insurance plan. In contrast, a large share of workers currently without employment-based insurance would be enrolled in the public insurance plan under a play or pay mandate. Under the 7 percent payroll tax rate assumption, 69 percent of workers currently without employment-based insurance would be enrolled in the public plan, compared to 54 percent under the 9 percent plan.

These results are not surprising given that persons without employment-based insurance typically work for very small employers and many work part time. The play or pay proposals are designed to limit costs for businesses with high health insurance costs relative to payroll compared to a straight mandate that would require all businesses to purchase insurance privately. The cost of insuring workers is high for many small employers -- they face higher insurance costs and pay lower wages than larger firms. Small employers would be much more likely to choose the payroll tax option than other employers. For example, we expect that 63.8 percent of workers in firms with fewer than 25 employees would be enrolled in the public plan under a 9 percent play or pay plan, compared to the average public plan enrollment rate of 41.5 percent.

Who Would Pay

Despite the shifts toward public plan coverage, employers would continue to finance most of the cost of insuring nonelderly Americans under play or pay mandates. Employers' insurance costs (in 1989 dollars) would increase to \$158.6 billion under the 7 percent payroll tax option and

to \$173.2 billion under the 9 percent payroll tax option, compared to current insurance costs of \$128.9 billion. The increase in costs -- \$29.7 billion (23 percent) in the 7 percent plan and \$44.3 billion (34 percent) in the 9 percent plan -- would fall most heavily on small employers. For example, insurance costs for firms with fewer than 25 workers would increase by 71 percent (\$11 billion compared to \$15.5 in the current system) under a 7 percent play or pay mandate, and would double (a \$16 billion increase) under a 9 percent play or pay plan. Under a fully phased-in play or pay system, all workers and their dependents would be enrolled in a health insurance plan by their employers -- some in a private plan and others in a public plan.

Government's costs would also increase to broaden insurance coverage for nonworking persons and to subsidize out-of-pocket costs for the working poor. The government would also subsidize some employers who enroll their workers in the public plan when their payroll taxes do not pay for the full cost of their workers' health insurance. We predict that the government's share of the costs in a 7 percent play or pay mandate would be \$64.4 billion. This represents an increase of \$36.4 billion over the 1989 Medicaid costs for the nonelderly, noninstitutionalized population. Under the 9 percent plan, government's share of the total costs would be somewhat smaller. We predict that government expenditures would be \$52.8 billion with a 9 percent play or pay employer mandate, an increase of \$25.2 billion relative to current costs. These costs represent a 17 percent increase in government spending for personal health care under a 7 percent plan and a 12 percent increase under a 9 percent plan, compared to 1989 government (federal and state and local) spending of \$215.4 billion.

We caution that these are simple estimates of government's costs under a play or pay system. If government succeeded in negotiating lower premiums because of the large size of the public plan, their costs would be lower. Uncompensated care would be eliminated, and the government and employers would realize savings as providers no longer need to shift these costs to payers. If insurance reform succeeds in reducing small employers' premiums significantly, small employers' cost increases would be less than those shown here. On the other hand, the relatively large size of the public plan and the number of low-income Americans eligible for premium and cost-sharing subsidies would result in a large administrative burden for government.

In sum, play or pay employer mandates have gained momentum as the leading health care reform proposals. They would lead to a hybrid system in which many Americans would retain private, employment-based coverage, but a large share would be covered under a public health insurance plan. Play or pay mandates would represent an expanded financial role for many employers, even though the number of persons enrolled in private, employment-based health insurance plans would diminish. However, insurance costs increases under the play or pay systems would ensure that all Americans would have access to health care on a more equal basis, and they would reduce the current burden of out-of-pocket health care spending for many families.

TABLE OF CONTENTS

	<u>Page</u>
I. INTRODUCTION.....	1
II. METHODS.....	3
III. RESULTS.....	10
Effects of Play or Pay Mandates on Insurance Coverage.....	10
Private-Sector Workers.....	15
Effects of Play or Pay Proposals on Costs by Sector.....	20
Costs by Employer Size.....	28
IV. SUMMARY.....	28
NOTES.....	32
REFERENCES.....	34

LIST OF TABLES AND FIGURES

<u>Table No.</u>	<u>Title</u>	<u>Page</u>
1	Play or Pay Employer Mandates: Simulation Assumptions.....	6
2	Shifts in Insurance Coverage: Current System Compared to Play or Pay.....	13
3	Shifts in Insurance Coverage: Current System Compared to Play or Pay.....	14
4	Effects of Play or Pay Mandate: Private Sector Workers' Health Insurance Status: 9% Employer-Paid Payroll Tax.....	21
5	Effects of a Play or Pay Mandate: Private Sector Workers' Health Insurance Status: 7% Employer-Paid Payroll Tax.....	22
6	Effects of Play or Pay Employer Mandates on Direct Spending by Payor.....	25
7	Insurance Costs by Payor: Current System Compared to Play or Pay.....	27
8	Effects of Play or Pay Mandates on Employers Costs.....	29

<u>Figure No.</u>	<u>Title</u>	
1	Predicted Annual Premium for Single Policies: Uniform Benefit Package.....	8
2	Annual Premiums for Single Coverage.....	9
3	Health Insurance Coverage of the Nonelderly: Play or Pay Employer Mandate.....	11
4	Percent of Private Sector Workers Enrolled in Public Plan: Play or Pay Employer Mandate.....	16
5	Average Payroll of Full-Time Workers.....	18
6	Differences in Payroll and Premiums by Employer Size: Difference Between Largest Employers and Smaller Employers as a Percent of Payroll and Premiums of Largest Employer.....	19
7	Insurance Costs by Major Payors.....	24

I. Introduction

The issue of health care reform has received considerable attention in the United States. Health care spending continues to absorb ever larger shares of our resources each year, yet, at any given time, about 33 million Americans do not have access to regular health care because they are uninsured. These dual problems of skyrocketing costs and lack of access have generated a number of proposals to reform the health care system.

Many of these reform proposals focus on a particular type of employer mandate, a "play or pay" system, to broaden access to care. Under these proposals employers would be required to either provide a health care plan meeting specified standards or pay a payroll tax to cover workers under a public health insurance plan. The play or pay employer mandates, thus, would cap employers' costs at some pre-specified payroll tax rate. Businesses employing large numbers of part-time or low-wage workers would be treated more favorably under these proposals compared to a straight mandate requiring them to provide health insurance because these firms face high insurance costs relative to their worker's wages. By offering an alternative to employer purchase of insurance on the private market, play or pay proposals would solve access problems and limit costs for employers who find it difficult to obtain insurance for workers with high risk jobs or unfavorable insurance ratings.

Comprehensive play or pay proposals also extend coverage under the public plan to nonworking persons, and those who can afford it would be required to pay a premium to cover the cost of the plan. Finally, these plans require new revenues to fund a variety of direct and indirect subsidies required to make the system viable. General revenues would be required to cover some

of the health costs of employers who buy into the public plan at below-market insurance rates. Direct subsidies to low-income, nonworking persons who cannot pay for the cost of the plan and low-income workers who cannot pay their premium shares and coinsurance requirements will be necessary to ensure full access to care. Of course, the elimination of acute care spending under Medicaid to some extent would offset these subsidies for government.

Despite the considerable attention focused on play or pay employer mandates, we know little about how employers would respond to this policy. The distributional consequences of such proposals are of particular interest. What types of employers would continue to provide health insurance? Will decisions differ across firm size, industry, or location? How will the subsidies work? What are the characteristics of Americans who would be enrolled in the public-sponsored plans compared to private-sponsored insurance plans?

Analysis of these proposals requires consideration of employers' insurance costs and their payroll characteristics, as well as the characteristics of workers in their employ. It also requires information about the nonworking population to fully assess the consequences of the comprehensive play or pay health care reform proposals.

This paper presents new estimates of the effects of play or pay employer mandates. Under funding from the Department of Labor's Pension Welfare and Benefit Administration, we have developed a microsimulation model of the current employment-based health insurance system. This model combines employment-based data on health plans and payrolls with data describing the characteristics of the US population. The model allows us to examine the current system and to simulate alternative employment-based systems.

We present an analysis of a play or pay employer health insurance mandate modeled after several of the comprehensive health care reform proposals introduced in the 102nd Congress. We simulate the effects of a play or pay proposal under two assumptions about employers' payroll tax rates to provide a range of estimates. This brief paper presents several basic results: the number of workers likely to be enrolled in the public plan, shifts in insurance status from the current system, employers' decisions by firm size, and the costs to the government and private sectors. A more complete and detailed analysis that examines the effects of play or pay proposals under various design assumptions is also underway and will be available in February. The discussion below briefly outlines the methods used in this analysis, the assumptions used in simulating the employer mandate, and the results.

II. Methods

We use The Urban Institute's microsimulation model, called the Transfer Income Model (TRIM2), to examine the effects of expanding the employment-based health insurance system. The model represents an enhanced version of TRIM2 used in an earlier examination of employer mandates (Zedlewski, 1991). In this analysis we integrate data from the March 1990 Current Population Survey (CPS) with data representing employment-based health insurance plans, and data describing employers' payroll characteristics. The two employment-based data sources are used to add key information about workers that is not available on the CPS. We add employment-based health insurance premiums and the average payroll for each worker's firm. Thus, we can evaluate employers' decisions to provide health insurance or to pay the tax, and we can examine

how these decisions affect workers. Insurance payments by individuals, employers, and government can be calculated and aggregated across different population characteristics.

We match insurance premiums from the 1989 Health Insurance Association of America (HIAA) and the 1989 Foster-Higgins Surveys to workers reporting health insurance coverage on the CPS using statistical matching procedures. The matching procedure uses variables common to the employer insurance plans and workers on the CPS to "match" individuals on the CPS to health plans. These variables include industry, location, firm size, and whether the worker has to pay part of the insurance premiums. For workers without health insurance we predict an insurance premium for a uniform benefit package, based on their employers' characteristics.

Similarly, we match employer payroll data from the County Business Patterns (CBP, 1988) data set to workers on the CPS. The CBP data set is a universe sample collected from payroll tax forms filed by all establishments in the US. We match these data to workers on the CPS using detailed information on their state of residence, 3-digit industry code, and establishment size.¹

The enhanced CPS, thus, provides a full socioeconomic profile of the US population, along with additional information about their employers. The enhanced file includes the employer's insurance premium and the shares paid by the worker and the employer for workers with employment-based health insurance from the health insurance plan data base. It includes the average payroll at the establishment employing each worker on the CPS from the CBP file. Using these data sources we can simulate the decisions of workers' employers to provide health insurance or pay the payroll tax by comparing their health insurance costs to the cost of paying a tax on payroll costs for workers included in the mandate.

Statistical matching techniques provide a useful vehicle through which we can explore policies that require information from multiple data sets. Obviously, we would prefer using a representative data base with information about workers and their employers obtained from direct sources, but this type of data base does not exist. However, the richness of the two employment-based donor files -- about 4,000 health plans and data summarizing the payroll characteristics of more than 160,000 establishments in the US -- ensures that reasonable imputations can be made, given the diversity of workers represented on the CPS. In addition, we have completed preliminary analyses of the employment-based data to explore their statistical properties and to guide the statistical matching procedures. Our early analysis of play or pay employer mandates using the payroll and health insurance price data alone are also very consistent with those shown here (Acs, et al., forthcoming 1992).

The assumptions used to simulate the play or pay proposals are obviously of critical importance. Table 1 outlines these assumptions. Throughout this analysis we assume that private-sector employers choose the lower-cost option between either providing health insurance or paying the optional payroll tax.² We do not assume that the government sector makes "play or pay" decisions. Instead, we assume that they provide at least a minimum health benefit package to their workers.

Employers can purchase a uniform benefit package of the type shown in table 1 at the average price currently available to employers with the same size, industry, and location characteristics. Thus, while we do not assume that insurance costs will be considerably lower than current prices, the assumption that all employers (irrespective of the experience rating of their group) can purchase insurance at current rates incorporates insurance reform provisions that

Table 1
Play or Pay Employer Mandates: Simulation Assumptions

Employer Requirements	Must <u>either</u> pay 80 % of the cost of a uniform benefit package for workers and their dependents <u>or</u> pay a payroll tax.
Benefit Package	1) All employers can purchase insurance at average rates currently-available for firms in their region in the same size/industry group. 2) The uniform benefit package includes deductibles of \$200 for singles and \$500 for families; a 20% coinsurance requirement; covers well care; preadmission certification required.
Coverage Requirements	1) Hours of work: persons working 18 hours a week or more included in play or pay mandate; employers pay a payroll tax on the wages of persons working less than 18 hours; 2) Primary payer: workers accept coverage through own employer; dependents covered through primary worker's plan; coordination of benefits for persons with dual coverage.
Workers' Premiums	Pay 20% of the cost of the employer's premium or the cost of the public plan if full time, less subsidies for low-income persons.
Public Plan	1) Government pays premiums equal to those currently available to large (1000+) firms (see Figure 2). 2) Persons not covered through employer enroll in public plan. 3) Families pay full public plan premium when not enrolled by employer, subject to premium subsidies.
Government Subsidies	1) Premiums for persons in private and public plan: reduced by 2 percentage points for each 10% that income is below 200% of poverty. 2) Premiums for families enrolled in public plan with incomes between 200-400% of poverty not to exceed 3.5%, 4%, and 5% for those with income less than 250%, 325%, and 400% of poverty, respectively. 3) Government pays cost-sharing for persons with incomes below poverty; and shares costs for persons with incomes between 100-200 percent of poverty.

¹Cost-sharing estimated as average out-of-pocket spending for doctors care, drugs, and hospital care for insured families (Consumer Expenditures Survey: \$225, \$215, \$570, and \$665 for singles, adult and child, families, and two adults, respectively).

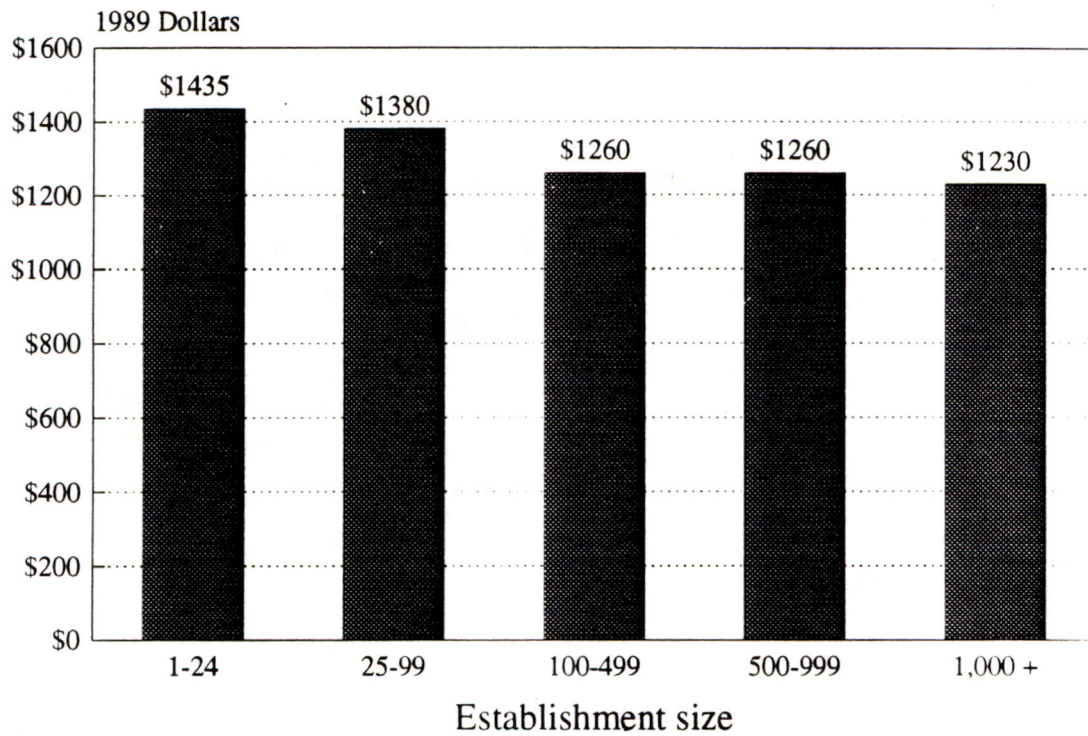
guarantee reasonable rates to all employers. Under these assumptions, however, small employers pay more than large employers for the same benefit package.³ Figure 1 shows the average premium variations by establishment size.⁴ If an employer chooses to "play" and already provides health insurance, we assume that the employer retains the current insurance package, provided that it meets the minimum standard required by the mandate.

As shown in the table outlining the simulation assumptions, employers choosing to "play" must pay 80 percent of the premium and their workers pay 20 percent. Employers must pay these costs for full-time workers (defined as 18 hours a week or more). Part-time workers can be enrolled in the public plan even when the full-time workers are insured privately, and employers pay a payroll tax based on the wages of the part-time workers.

Table 1 also outlines requirements for the public plan. We assume that the government purchases the equivalent uniform benefit package for persons enrolled in the public plan at rates currently-available to large firms. These premiums vary by location. Figure 2 shows the premium assumption for single coverage. We make a simplifying assumption that dual coverage (an adult and child) costs 1.8 times the single premium, and family coverage costs 2.5 times the single premium. These are average ratios reflected in employer and private health insurance plan data for 1989. The government covers the costs of the public plan less the taxes paid by employers, and public plan premiums paid by persons enrolled in the public plan. Workers enrolled by their employers pay 20 percent of the public plan premiums and nonworkers pay full cost, less subsidies available to low-income persons. These subsidies cover the full premium share for persons with incomes below poverty whether enrolled in the public plan or a private employer plan. This subsidy phases out for persons with incomes between 100 and 200 percent of poverty.

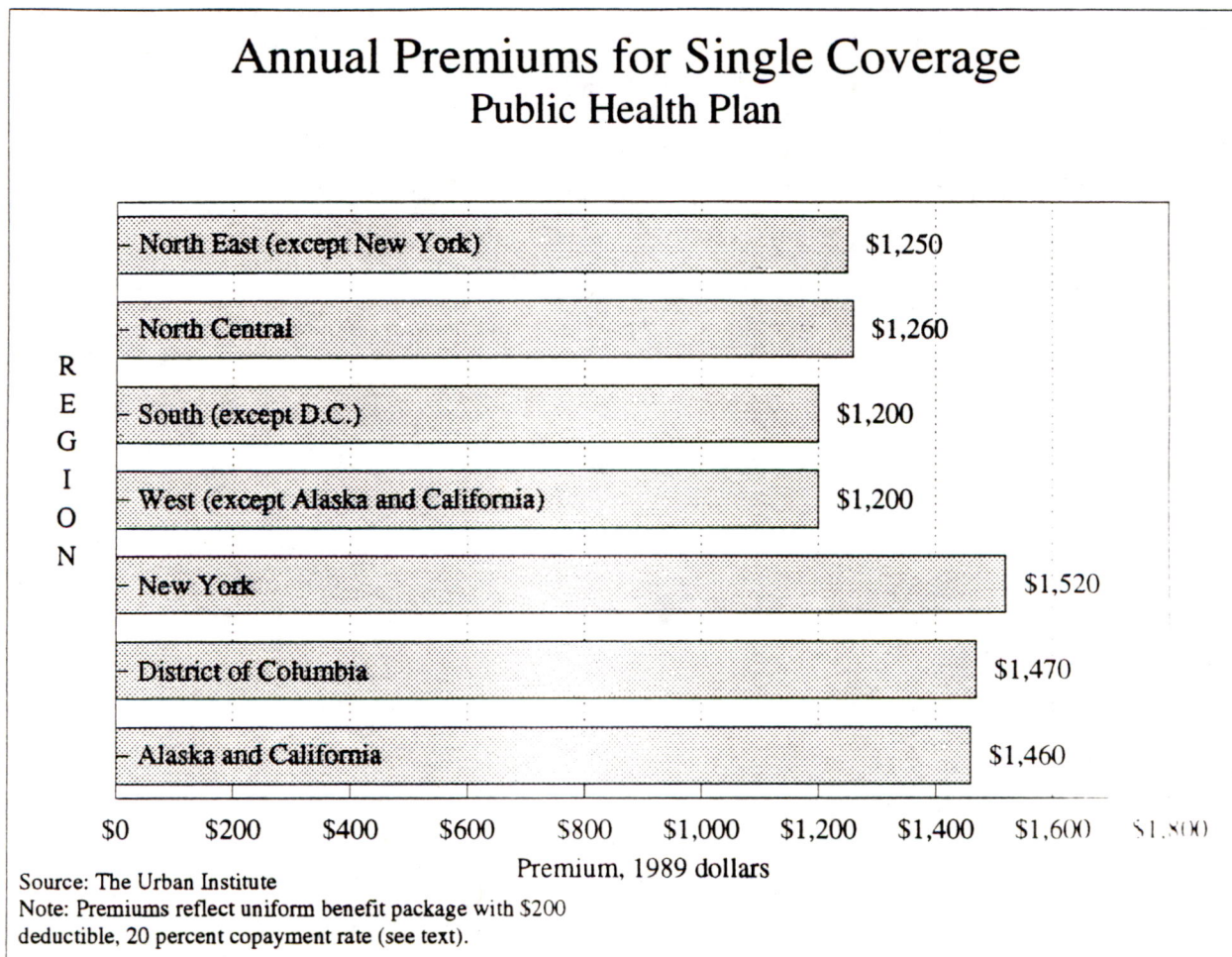
Figure 1

Predicted Annual Premium for Single Policies: Uniform Benefit Package



Source: The Urban Institute

Figure 2



The government also subsidizes cost sharing requirements under the insurance plans such that persons with incomes below poverty receive full subsidies for these costs and persons with incomes between 100 and 200 percent of poverty are subsidized on a sliding scale. Finally, public plan premiums are capped for families with incomes between 200 and 400 percent of poverty at a percentage of their family income.

III. Results

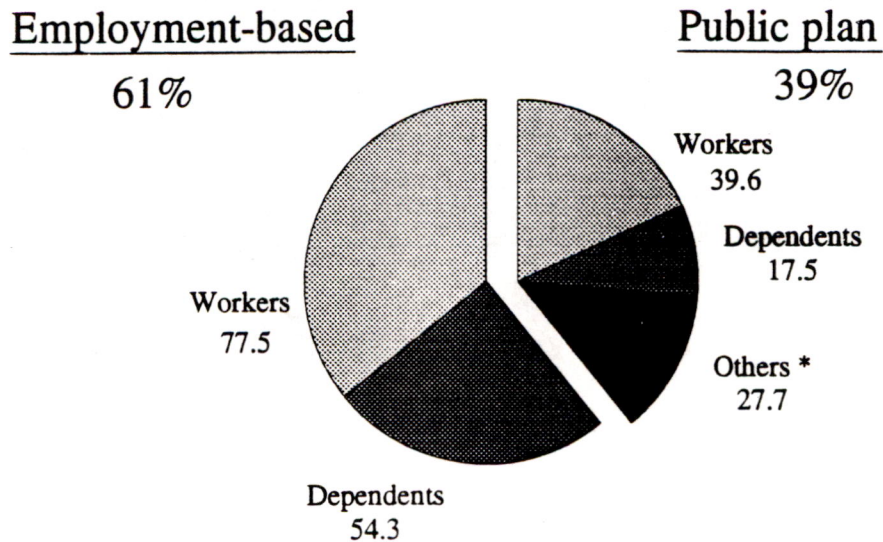
The full distributional results of play or pay employer mandates will be complex depending on the long-run cost shifts across employers, workers, and government. The results presented below focus on the simple, first-round effects of comprehensive play or pay proposals. The results represent a fully phased-in play or pay proposal affecting all employers.⁵ We show predicted changes in insurance coverage for the entire population. Then we focus on results for private-sector workers. Finally, we show basic cost effects by sector, and we provide more detail on the cost implications for employers. On the other hand, we are not able to show how employers would shift costs back to labor or consumers, nor do we show how the elimination of uncompensated care would affect payors under a play or pay employer mandate.

Effects of Play or Pay Mandates on Insurance Coverage

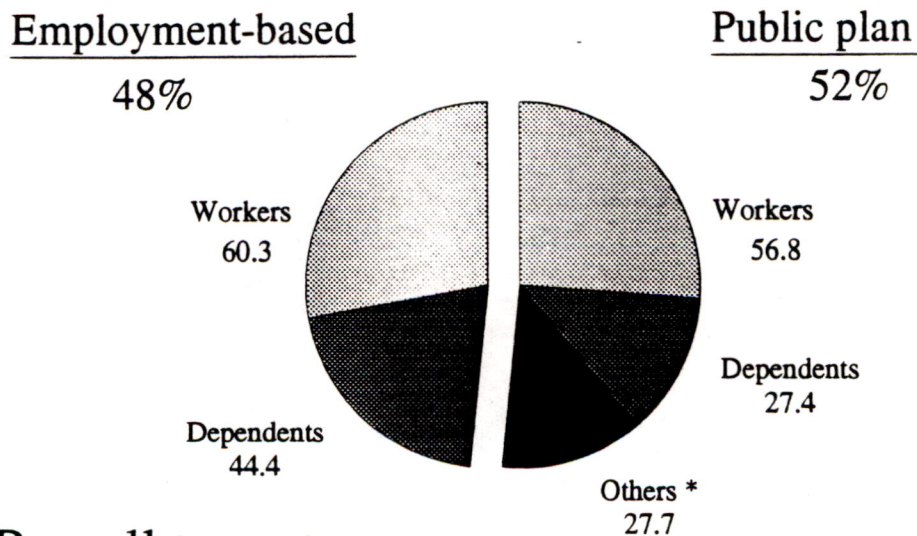
Figure 3 displays the predicted health insurance coverage of the nonelderly population under play or pay employer mandates. Under the 9 percent payroll tax rate assumption, 61 percent of the nonelderly would be enrolled in an employment-based plan, and 39 percent in the public plan. The public plan would include 39.6 million workers, 17.5 million dependents of workers, and 27.7 million nonworkers (including early retirees). Under the 7 percent tax rate assumption

Figure 3

Health Insurance Coverage of the Nonelderly: Play or Pay Employer Mandate (Millions of persons)



9% Payroll tax rate



7% Payroll tax rate

Source: TRIM2, based on the March 1990 CPS.

* Other persons include persons without an employed household member.

many more employers would enroll their workers in the public plan. As shown, more than half of the nonelderly population would be enrolled, including 56.8 million workers, 27.4 million dependents of workers, and, again, 27.7 million nonworkers.

The data in table 2 compare insurance coverage under a 9 percent pay or pay proposal to prior insurance coverage, and those in table 3 show the results for the 7 percent payroll tax assumption. Some workers and dependents currently enrolled in employment-based plans would shift to coverage under the public plan. Among the 71.3 million workers who currently have employment-based coverage through their own employer, 14.9 million would shift into the public plan (20.9 percent). Among dependents currently insured through employment-based plans, employed adults would shift to coverage through their own employer -- 8.8 million in a private plan and 8.2 million in the public plan -- and the remaining 52.9 million would remain insured as dependents -- 44.7 in private plans and 8.2 million in the public plan. Thus, the majority (63 percent) of dependents would remain in their current employment-based plan under a 9 percent payroll tax assumption.

Of the 18.2 million persons currently insured through private, individual insurance policies, two-thirds would gain coverage through an employer either as a worker or as a dependent. For example, 31.3 percent would become insured through private, employment-based plans (20.3 percent as workers, and 11.0 as dependents), and 34.6 percent would be enrolled in the public plan under employer sponsorship (24.7 percent as workers and 9.9 percent as dependents of workers). The remaining group who currently purchases private, nongroup insurance policies would be enrolled in the public plan. About 6.2 million persons who currently purchase individual insurance would enroll in the public plan.

Table 2
Shifts in Insurance Coverage:
Current System Compared to Pay or Pay
9% Employer-Paid Payroll Tax

	Total	Employment-Based		Public Plan		
	<u>(000)</u>	<u>Workers</u>	<u>Dependents</u>	<u>Workers</u>	<u>Dependents</u>	<u>Others</u>
Numbers in Millions						
Current System:						
Employment-Based Plan						
Own Employer	71.3	56.5	--	14.9	--	--
Other Employer	70.9	8.8	44.7	9.2	8.2	--
Private, Nongroup	18.2	3.7	2.0	4.5	1.8	6.2
Government ¹	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
Total	216.6	77.5	54.3	39.6	17.5	27.7
Percent by Coverage Status						
Employment-Based Plan						
Own Employer	100.0%	79.2%	----	20.8%	---	---
Other Employer	100.0	12.4	63.0%	13.0	11.6%	---
Private, Nongroup	100.0	20.3	11.0	24.7	9.9	34.0%
Government ¹	100.0	6.1	12.2	8.3	14.4	58.0
Uninsured	100.0	21.3	14.4	27.2	12.6	24.6
Total	100.0%	35.8%	25.0%	18.3%	8.1%	12.8%

SOURCE: The Urban Institute's Transfer Income Model (TRIM2) based on the March 1990 Current Population Survey.

Note: 1. Includes Medicaid, CHAMPUS, and Medicare.

Table 3
Shifts in Insurance Coverage:
Current System Compared to Pay or Pay
7% Employer-Paid Payroll Tax

	Total	Employment-Based		Public Plan		
	(000)	<u>Workers</u>	<u>Dependents</u>	<u>Workers</u>	<u>Dependents</u>	Others
Current System:						
Numbers in Millions						
Employment-Based Plan						
Own Employer	71.3	46.1	--	25.2	--	--
Other Employer	70.9	6.3	38.1	11.7	14.8	--
Private, Nongroup	18.2	2.6	1.4	5.6	2.4	6.2
Government ¹	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
Total	216.6	60.3	44.4	56.8	27.4	27.7
Percent by Coverage Status						
Employment-Based Plan						
Own Employer	100.0%	64.7%	--	35.3%	--	--
Other Employer	100.0	8.9	53.7%	16.5	20.9%	--
Private, Nongroup	100.0	14.3	7.7	30.8	13.2	34.1%
Government ¹	100.0	4.4	8.3	10.0	18.3	58.5
Uninsured	100.0	12.9	9.0	35.6	18.0	24.6
Total	100.0%	27.8%	20.5%	26.2%	12.7%	12.8%

SOURCE: The Urban Institute's Transfer Income Model (TRIM2) based on the March 1990 Current Population Survey.

Note: 1. Includes Medicaid, CHAMPUS, and Medicare.

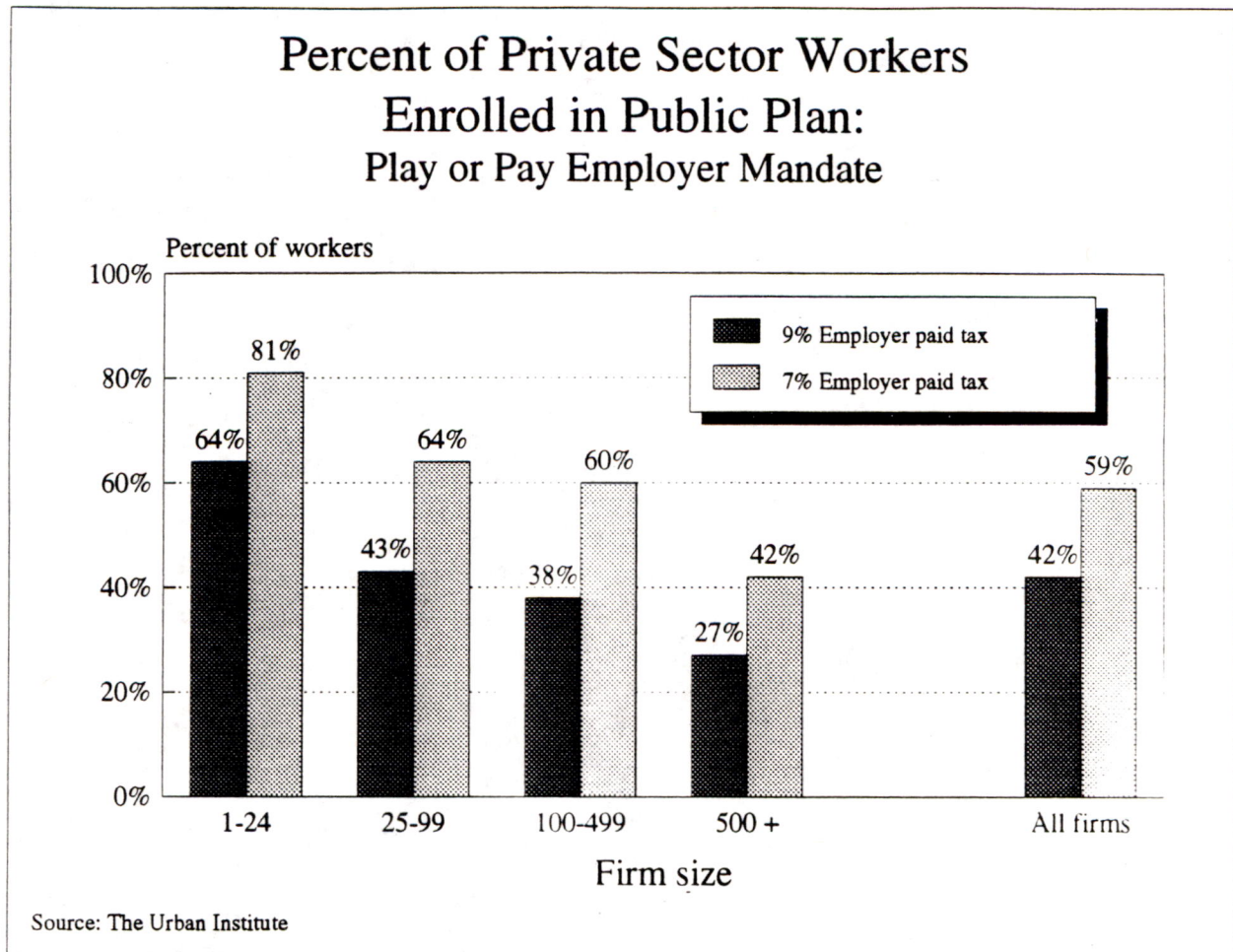
Results in table 3 show more dramatic shifts of workers into the public plan under a 7 percent employer payroll tax requirement. For example, 35.3 percent of workers who currently have employment-based health insurance would shift into the public plan. In fact, far fewer persons would be insured through private, employment-based plans in this scenario than under the current system. Currently 142.2 million Americans are in employment-based plans (71.3 million workers and 70.9 million dependents of workers). Under a 7 percent play or pay proposal, the number would shrink to 104.7 million (60.3 million workers and 44.4 million dependents of workers).

In sum, a large number of persons would change their health insurance coverage under a play or pay employer mandate. Under the 9 percent plan, 67.2 million persons would shift from their current health insurance plan to another plan (either private or public). Under the 7 percent plan, nearly 100 million persons would shift health insurance plans. Under both plans 33 million uninsured persons would gain health insurance.

Private-Sector Workers. A large share of private-sector workers employed in small firms (fewer than 25 workers) will be enrolled in the public plan. This result holds under both the 9 and 7 percent payroll tax rate assumptions. Figure 4 shows that 64 percent of workers in small firms would be enrolled in the public plan under a 9 percent play or pay plan. The proportion increases to 81 percent under the 7 percent plan. In large firms, those with more than 500 employees, 27 and 42 percent of workers would be in the public plan under the 9 and 7 percent payroll tax rate assumptions, respectively.

These differences in public plan enrollment rates are not surprising given differences in costs and average payrolls by firm size. As shown earlier, small firms would pay more than large

Figure 4



firms for the same insurance, because insurers' marketing costs are higher and insurers do not realize the same economies of scale for small firms as they do for large firms. In addition, small employers have lower than average wages (Mellow, 1982 and Acs, et al. forthcoming 1992). Figure 5 highlights average pay differences for full time workers (18 hours or more) across firm size. Full-time workers in small firms earn \$17,500 a year on average, compared to \$30,080 for workers in large firms, a difference of \$12,580 a year.⁶ Thus, workers in the smallest firms are paid about 42 percent percent less, on average, than workers in the largest firms.

Figure 6 further highlights that differences between payrolls are much larger than differences in predicted health insurance costs across firm sizes. For example, firms with fewer than 25 workers pay 41.8 percent less than firms with 1,000 workers or more, and they have to pay 16.7 percent more to purchase the same benefit package. The average predicted price for the mandated benefit package for medium size firms (100-499) is very close to the price offered large firms (a difference of only 2.4 percent), but they pay 26 percent less than large firms on average.

Of course, there is considerable variation in pay within these size categories. Nevertheless, the high cost of insurance relative to payroll prevents many small employers from offering insurance under the current system (Marquis and Long, 1991). Most small employers would require insurance prices significantly below those faced by large employers in order to equalize costs of providing health insurance relative to payroll. Capping the relative costs of health benefits would be a significant result of the play or pay employer mandates. Most small employers would choose the payroll tax over providing insurance directly, if they were required to provide this employee benefit.

Figure 5

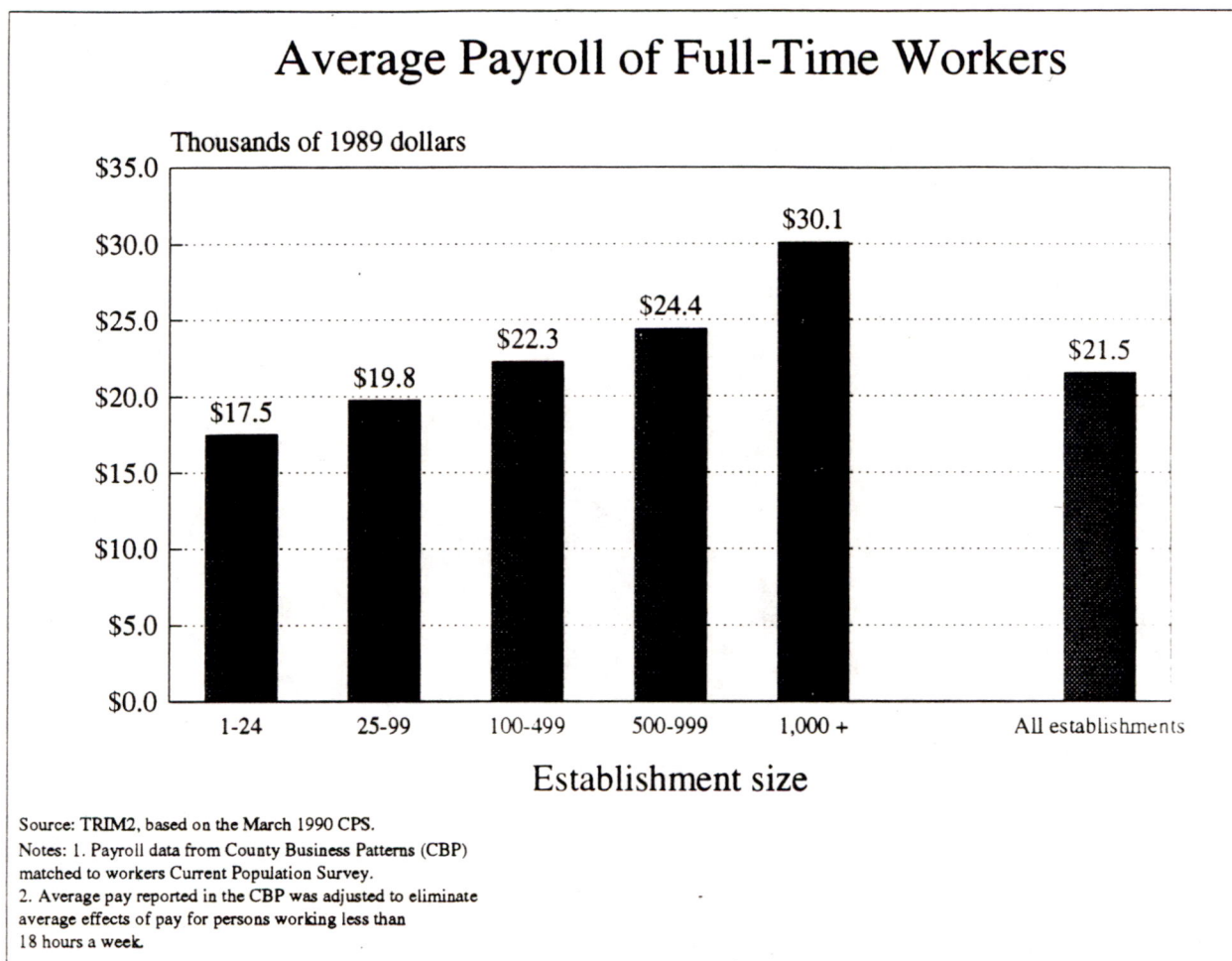
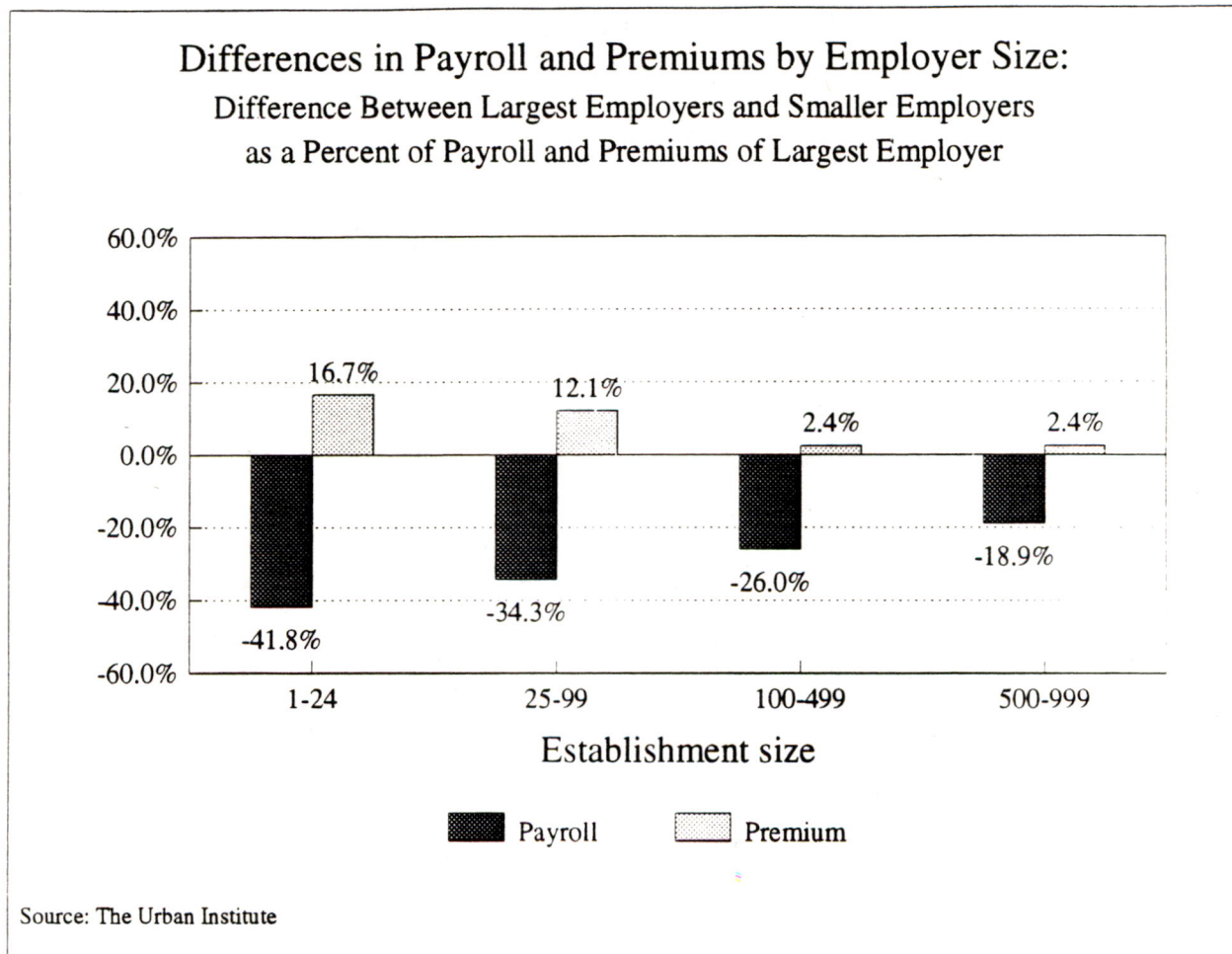


Figure 6



This effect is further highlighted in table 4 where we show results by firm size and current insurance coverage. Currently, only 8.5 million out of 26.5 million workers employed in small firms are covered under their own employers' plans. We predict that employers would shift almost half (48.2 percent) of these workers to the public plan, given the 9 percent payroll tax choice. Among workers in small firms currently insured through a family member's plan, only 2.0 million would be enrolled in a private, employment based plan under the 9 percent play or pay mandate, and 4.3 million (68.3 percent) would be enrolled in the public plan. Similarly, among workers in small firms without health insurance, 71.8 percent would be enrolled in the public plan. Most small employers who do not offer health insurance would find the 9 percent payroll tax option less expensive than purchasing health insurance privately.

Table 5 shows that 81.5 percent of workers in small firms would be enrolled in the public plan under the 7 percent payroll tax rate assumption. In addition, larger proportions of employers in larger size categories would opt for the public plan coverage. In fact, only large firms (more than 500 workers) would retain the majority of their workers in a private plan under this assumption.

Effects of Play or Pay Proposals on Costs by Sector

The proportion of the nonelderly population enrolled in the public plan will have important implications for the costs to employers, the government, and individuals. In general, the lower the tax rate (and the more persons enrolled in the public plan), the higher the cost to the government. Employers would pay less relative to the actuarial cost of insuring their workers under lower tax rates. But governments' costs would not increase linearly with the proportion of workers enrolled in the public plan. The government would pay a fixed cost for insuring the nonworking

Table 4

**Effects of a Pay or Pay Mandate:
Private Sector Workers' Health Insurance Status:
9% Employer-Paid Payroll Tax**

<u>Firm Size</u>	<u>Current System: Employment-Based Insurance</u>	<u>Total</u>	<u>Number of Workers (millions)</u>		<u>Percent:</u>	
			<u>Employer</u>	<u>Public</u>	<u>Employer</u>	<u>Public</u>
Less than 25	Own Employer Plan	8.5	4.4	4.1	51.8%	48.2%
	Other Employer Plan	6.3	2.0	4.3	31.7	68.3
	None	11.7	3.3	8.4	28.2	71.8
	Total	26.5	9.6	16.9	36.2	63.8
25-100	Own Employer Plan	8.3	5.8	2.5	69.9%	30.1%
	Other Employer Plan	2.6	1.1	1.4	42.3	53.8
	None	4.3	1.8	2.5	41.9	58.1
	Total	15.2	8.7	6.5	57.2	42.8
100-499	Own Employer Plan	9.5	6.7	2.8	70.5%	29.5%
	Other Employer Plan	2.1	1.0	1.1	47.6	52.4
	None	3.3	1.5	1.8	45.5	54.5
	Total	14.9	9.3	5.6	62.4	37.6
500+	Own Employer Plan	27.6	22.2	5.4	80.4%	19.6%
	Other Employer Plan	5.1	2.7	2.4	52.9	47.1
	None	6.2	3.4	2.8	54.8	45.2
	Total	38.9	28.3	10.6	72.8	27.2
All	Own Employer Plan	53.9	39.1	14.8	72.5%	27.5%
	Other Employer Plan	16.1	6.8	9.2	42.2	57.1
	None	25.5	10.0	15.5	39.2	60.8
	Total	95.5	55.9	39.6	58.5	41.5

Source: The Urban Institute's Transfer Income Model (TRIM2), based on the March 1990 Current Population Survey.

Table 5
Effects of a Pay or Pay Mandate:
Private Sector Workers' Health Insurance Status:
7% Employer-Paid Payroll Tax

<u>Firm Size</u>	<u>Current System</u>	<u>Total</u>	<u>Number of Workers</u> (millions)		<u>Percent:</u>	
			<u>Employer</u>	<u>Public</u>	<u>Employer</u>	<u>Public</u>
Less than 25	Employment-Based:					
	Own Employer	8.5	2.4	6.1	28.2%	71.8%
	Other Employer	6.3	1.1	5.2	17.5	82.5
	None	11.7	1.3	10.4	11.1	88.9
	Total	26.5	4.9	21.6	18.5	81.5
25-100	Employment-Based:					
	Own Employer	8.3	3.9	4.4	47.0%	53.0%
	Other Employer	2.6	.7	1.9	26.9	73.1
	None	4.3	.9	3.4	20.9	79.1
	Total	15.2	5.5	9.7	36.2	63.8
100-499	Employment-Based:					
	Own Employer	9.5	4.5	5.0	47.4%	52.6%
	Other Employer	2.1	.6	1.5	28.6	71.4
	None	3.3	.9	2.4	27.3	72.7
	Total	14.9	6.0	8.9	40.3	59.7
500+	Employment-Based:					
	Own Employer	27.6	17.9	9.7	64.9%	35.1%
	Other Employer	5.1	1.8	3.3	35.3	64.7
	None	6.2	.2	6.0	3.2	96.8
	Total	38.9	22.4	16.5	57.6	42.4
All	Employment-Based:					
	Own Employer	53.9	28.7	25.2	53.2%	46.8%
	Other Employer	16.1	4.2	11.9	26.1	73.9
	None	25.5	3.3	22.2	12.9	87.1
	Total	95.5	38.8	56.7	40.6	59.4

Source: The Urban Institute's Transfer Income Model (TRIM2), based on the March 1990 Current Population Survey.

population -- full costs for the poor and partial costs for the near poor. Workers enrolled in the public plan will pay 20 percent of the cost of the plan to the government (unless eligible for subsidies), and their employers will pay a large share of the remaining cost, depending on the payroll tax requirement. At certain tax rates some employers will pay taxes higher than the government's cost of insuring their workers (thereby partially subsidizing costs for the low-income population), because the public plan premium would be less expensive than the premium available to small employers.

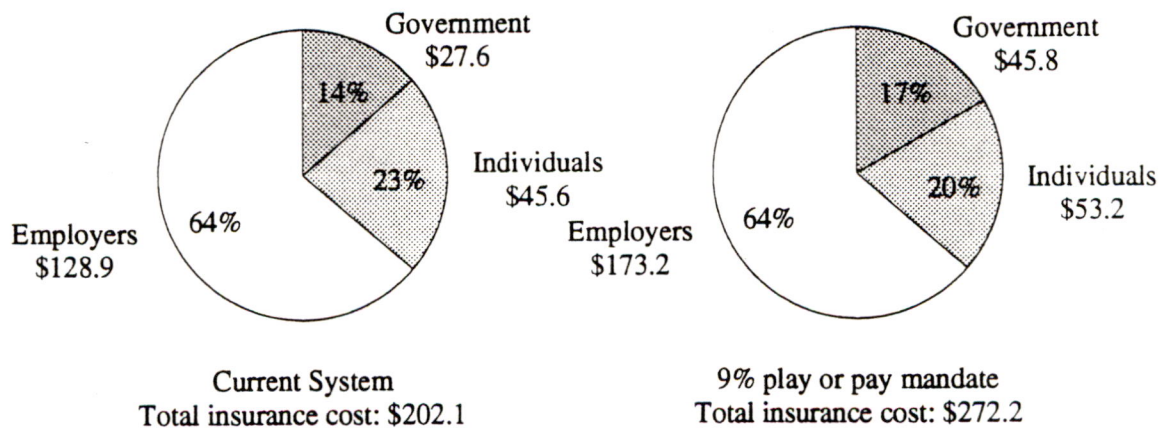
Figure 7 compares insurance costs by payor under the play or pay employer mandate with current insurance costs. Under both payroll tax options, employers would pay the majority of insurance costs. They would pay \$173.2 billion (64 percent) under the 9 percent plan, and \$158.6 billion (59 percent) under the 7 percent plan. Thus, employers' costs would be \$14.6 billion lower under the 7 percent play or pay plan than under the 9 percent plan. In contrast, government's costs would be \$11.2 billion higher under the 7 percent plan than under the 9 percent plan (\$64.4 billion compared to \$53.2 billion). Notice that individual's costs (net of premium subsidies) would be slightly higher under the 7 percent payroll tax assumption. This occurs because some workers would lose the advantage of employment-based plans that pay more than 80 percent of the premium. Instead, they would pay 20 percent of the public plan premium.⁷ Finally, total insurance costs are somewhat lower in the 7 percent payroll tax scenario compared to the 9 percent scenario -- \$269.4 billion compared to \$272.2 billion. This occurs because public plan premiums are lower than premiums for firms with fewer than 1,000 workers.⁸

Table 6 presents the components of these costs by sector. As shown, employment-based premiums would cover 51 percent of costs under the 9 percent payroll tax assumption, but only

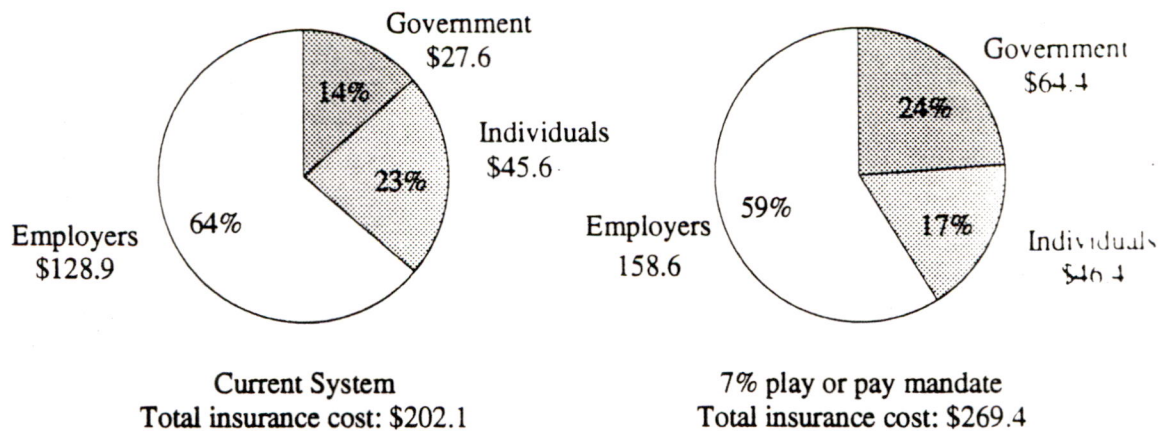
Figure 7

Insurance Costs by Major Payors¹

Current System Compared to Play or Pay Mandates (Billions of 1989 Dollars)



9% Payroll tax rate



7% Payroll tax rate

Source: The Urban Institute

1. Increased insurance costs under play or pay mandate DOES NOT imply increased health care spending. The play or pay system would insure all nonelderly persons and provide subsidies to pay for cost sharing for low-income persons.

Table 6
Effects of Play or Pay Employer Mandates on
Direct Spending by Payor
Billions of 1989 Dollars

<u>Payor:</u>	Play or Pay Mandate:			
	<u>9% Payroll Tax</u>		<u>7% Payroll Tax</u>	
	Percent		Percent	
	<u>\$</u>	<u>of Total</u>	<u>\$</u>	<u>of Total</u>
Employers				
Premiums	\$ 139.0	51.0%	\$ 110.2	40.9%
Payroll Taxes	<u>34.2</u>	<u>12.6</u>	<u>48.4</u>	<u>18.0</u>
Total	\$ 173.2	63.6%	\$ 158.6	58.9%
Individuals¹				
Workers' Private Plan Premiums	\$ 23.2	8.5%	\$ 18.2	6.8%
Workers' Public Plan Premiums	9.3	3.4	14.9	5.5
Nonworkers' Public Plan Premiums	<u>13.3</u>	<u>4.9</u>	<u>13.3</u>	<u>4.9</u>
Total	\$ 45.8	16.8%	\$ 46.4	17.2%
Government				
Workers' Coverage	\$ 16.4	6.0	\$ 27.7	10.3%
Premium Subsidies	4.4	1.6	4.3	1.6
Nonworkers' Coverage	23.8	8.7	23.8	8.8
Out-of-Pocket Subsidies	5.9	2.2	5.9	2.2
Cap for Low-Income Families	<u>2.7</u>	<u>1.0</u>	<u>2.7</u>	<u>1.0</u>
Total	\$53.2	19.5%	\$64.4	23.9%
Total Costs (gross)	\$272.2	100.0%	\$269.4	100.0%

SOURCE: The Urban Institute's Transfer Income Model (TRIM2), based on the March 1990 Current Population Survey.

Notes: 1. Individual premiums are net of subsidies provided by government to low-income persons.

40.9 percent under the 7 percent payroll tax assumption. Employers' tax payments are higher in the 7 percent scenario. Moreover, governments' share for workers' coverage is substantially higher in the 7 percent payroll tax scenario as employers enroll more workers in the public plan and pay a lower share of the cost of insuring them.

It is important to remember that these costs do not represent entirely new health care costs, nor do they represent total health care costs. The data in table 7 compare insurance costs under the play or pay mandates to current insurance costs. Current systems costs include employment-based insurance premiums, private, nongroup insurance premiums, and Medicaid spending for the nonelderly, noninstitutionalized. We also show current uncompensated hospital care charges in the current system (Propac, 1991). We cannot estimate, however, uncompensated care charges for other providers. In addition, costs under the play or pay systems include subsidies for out-of-pocket cost sharing under health care plans for low-income persons, essentially first dollar coverage policies. Many of these persons currently pay for some of these health care costs out-of-pocket, and these expenses cannot be estimated for the current system.

Nevertheless, the costs represent direct payments for insurance by government, employers, and individuals.⁹ These estimates show that total insurance costs would increase by \$54.7 billion in the 9 percent play or pay mandate and by \$52.3 billion in the 7 percent play or pay mandate. Aggregate employer cost increases are much lower under the 7 percent plan (\$29.7 billion compared to \$44.3 billion). In this plan, the government's share of the costs would be larger. Government's costs, net of current Medicaid spending for the nonelderly, would increase by \$36.4 billion in the 7 percent play or pay plan, compared to \$25.2 billion in the 9 percent plan. These

Table 7

**Insurance Costs by Payor: Current System Compared to Play or Pay
Billions of 1989 Dollars**

9 Percent Play or Pay Plan			
	<u>Current</u>	<u>Mandate</u>	<u>Difference</u>
Employers	\$128.9	\$173.2	+ \$44.3
Individuals ¹			
Group Premiums	\$31.1	\$23.2	- \$7.9
Other Premiums ²	<u>14.5</u>	<u>22.6</u>	<u>+ \$8.1</u>
Total	\$45.6	\$45.8	+ \$0.2
Government			
Public Coverage ³	<u>\$27.6</u>	<u>\$53.2</u>	<u>+ \$25.2</u>
Total	\$217.1	\$272.2	+ \$69.7
Uncompensated Hospital Care	(5)	<u>\$0.0</u>	<u>- \$15.0</u>
Total Insurance Costs	\$217.1⁶	\$272.2	+ \$55.1⁶
7 Percent Play or Pay Plan			
	<u>Current</u>	<u>Mandate</u>	<u>Difference</u>
Employers	\$128.9	\$158.6	+ \$29.7
Individuals ¹			
Group Premiums	\$31.1	\$18.2	- \$12.9
Other Premiums ²	<u>14.5</u>	<u>28.2</u>	<u>+ 13.7</u>
Total	\$45.6	\$46.4	+ \$0.8
Government			
Public Coverage ³	<u>\$27.6</u>	<u>\$64.4</u>	<u>+ \$36.4</u>
Total	\$217.1	\$269.4	+ \$67.3
Uncompensated Hospital Care	(5)	<u>\$0.0</u>	<u>- \$15.0</u>
Total Insurance Costs	\$217.1⁶	\$269.4	- \$52.3⁶

SOURCE: The Urban Institute's Transfer Income Model (TRIM2), based on the March 1990 Current Population Survey.

- Notes:**
1. Individual premiums are net of premium subsidies paid by government.
 2. Includes private, nongroup premiums under current system (Holahan and Zedlewski, 1991) and premiums in public plan under mandate.
 3. Medicaid costs for nonelderly, noninstitutionalized (Holahan and Zedlewski, 1991).
 4. Prospective Payment Commission (1991).
 5. Uncompensated care under the current system is included in insurance costs of direct payors (employers, individuals, and government).
 6. The current insurance system is far less comprehensive than the play or pay systems. Fewer persons have coverage, and out-of-pocket cost sharing is not covered for low-income persons with health insurance. Thus, many of the additional costs shown under the play or pay options would simply offset out-of-pocket health care spending under the current system.

cost increases compared to 1989 government (federal and state and local) personal health care spending of \$214.5 billion.¹⁰

We expect, however, that current uncompensated care charges would be distributed back to payors under both play or pay systems, decreasing these cost effects for government and employers. In addition, with such a large public health plan the government could potentially negotiate more favorable insurance rates than those assumed in this analysis. On the other hand, the government would pay administrative costs not reflected here to administer annual income tests for persons eligible for premium and out-of-pocket cost sharing subsidies.

Costs by Employer Size. Table 8 shows the change in employers' costs under the 9 and 7 percent play or pay mandates by firm size. As shown, small employers would experience the largest increase in cost. Under the 9 percent payroll tax rate, they would pay \$16.8 billion in premiums and \$14.4 billion in taxes to insure their workers, compared to \$15.5 billion under the current system. These cost increases include coverage of workers who currently do not have insurance, insurance upgrades for some employers who currently provide insurance. In addition, these results are net of cost savings to some employers for whom the payroll taxes or the uniform benefit package is less expensive than current costs.

IV. Summary

This paper provides estimates of some simple, first-round effects of a particular health care reform proposal, a comprehensive play or pay employer mandate with public plan coverage guaranteed to all nonelderly Americans. We show that this type of proposal would provide a

Table 8
Effects of Play or Pay Mandates on Employers Costs
Billions of 1989 Dollars

Play or Pay: 9% Tax Rate						
<u>Firm Size</u>	<u>Current</u>	<u>Employers' Costs:</u>			<u>Change:</u>	
		<u>Premiums</u>	<u>Taxes</u>	<u>Total</u>	<u>\$</u>	<u>%</u>
Less than 25	\$15.5	\$16.8	\$14.4	+\$31.2	+\$15.7	+101%
25-99	14.5	16.6	5.6	+22.2	+7.7	+53
100-499	20.8	21.4	5.1	+26.5	+5.7	+27
500-999	9.0	9.5	1.7	+11.2	+2.2	+24
1000+	69.0	74.7	7.4	+82.1	+13.1	+19
Total	\$128.9	\$139.0	\$34.2	+\$173.2	+\$44.3	+34%

Play or Pay: 7% Tax Rate						
<u>Firm Size</u>	<u>Current</u>	<u>Employers' Costs:</u>			<u>Change:</u>	
		<u>Premiums</u>	<u>Taxes</u>	<u>Total</u>	<u>\$</u>	<u>%</u>
Less than 25	\$15.5	\$9.2	\$17.3	\$26.5	+\$11.0	+71%
25-99	14.5	11.3	8.5	19.8	+5.3	+37
100-499	20.8	15.9	8.1	24.0	+3.2	+15
500-999	9.0	7.0	3.2	10.2	+1.0	+11
1000+	69.0	66.9	11.2	78.1	+9.1	+13
Total	\$128.9	\$110.2	\$48.4	\$158.6	+29.7	+23%

SOURCE: The Urban Institute's Transfer Income Model (TRIM2), based on the March 1990 Current Population Survey.

- Notes:**
1. Employers either pay 80% of the cost of covering full-time (18 hours a week or more) workers and their nonworking dependents or a tax applied to payroll.
 2. Employers who "play" must provide insurance meeting the requirements of a uniform benefit package or the actuarial equivalent.

hybrid approach to health care reform. Depending on the payroll tax rate chosen, these proposals would result in a relatively large public plan, while still retaining a relatively large role for the private insurance sector.

Some key findings are the following:

- o Comprehensive play or pay systems would guarantee all Americans regular access to health care. Nonworking persons currently in Medicaid and low-income uninsured persons would be covered under the public plan. The government would provide subsidies to help pay for the cost sharing requirements of low-income persons, whether they are insured privately or through the public health plan.
- o The number of persons with private, employment-based health insurance is likely to decline under play or pay mandates -- from 142.2 million persons currently to 131.8 million persons under a plan that requires employers to either pay a 9 percent payroll tax or provide health insurance and to 104.7 million persons under a 7 percent payroll tax requirement.
- o Because small employers' payrolls are much lower than average, and their health insurance costs are higher than average, they would find the payroll tax option more attractive than providing health insurance directly. We predict, for example, that 64 percent of private sector workers in firms with fewer than 25 workers would be enrolled in the public plan under a 9 percent payroll tax option.
- o Government's costs would increase by \$25.2 billion under a 9 percent payroll tax rate and by \$36.4 billion under a 7 percent tax rate. Employers, on the other hand would spend \$44 billion more for health insurance under the 9 percent play or pay plan, and under the 7 percent plan their costs would increase by about \$30 billion. These would offset some of the current costs that individuals pay for insurance premiums, out-of-pocket costs, and uncompensated care charges. In addition, some employers would save money under a play or pay proposal -- when the payroll tax is less expensive than their current health insurance costs and when private insurance costs are lower because working dependents will shift to their own employers' plans.

The increases in employers' health care costs may be difficult for some employers to sustain. It is possible that they would pass some of the cost increases on to workers. Consequently, some workers could experience declines in cash wages in exchange for guaranteed health insurance. Most play or pay proposals would phase-in participation of small employers so

that employers could adjust to increased cost of insuring their workers (Pepper, 1991). Nevertheless, the effect of play or pay proposals on wages needs to be examined carefully.

Further analysis will also be required to examine the full distributional effects of play or pay proposals. It will be important to understand the effects by location, industry, and population subgroup. It will also be important to show sensitivity to design options. As mentioned earlier, the 80 percent cost share required of employers for family coverage is relatively high by today's standards. Some workers could afford to pay a larger share out-of-pocket to cover dependents. This type of option would reduce the proportion of workers enrolled in the public plan, reduce the governments costs, and reduce the reliance on a proportional tax to finance health care. We also need to examine alternative definitions of part-time work. If employers did not have to cover persons working less than 35 hours a week (a traditional definition of full-time work), the effects of play or pay proposals could be substantially different than those shown here. We also need to consider the effects of these proposals over time. As mentioned above, most proposals suggest that small employers be phased into the play or pay system.

All reform proposals imply shifts in how we finance health care. Given the high and rapidly increasing costs of health care, any approach to system reform will be expensive. Different reform approaches vary considerably in choosing who will bear the burden for health care costs. Play or pay proposals place much of the burden on employers and their workers; other approaches would finance health care through the tax system. It is also important to remember that most of the health care reform proposals contain health care cost containment mechanisms. It is the long run success of these mechanisms that will be most important in determining the future burdens of different payers.

Notes

1The March CPS reports firm size, rather than establishment size, for workers. However, employers' pay or benefit decisions would be made at a lower level of aggregation. Many firms include units with separate management and legal structures. Consequently, payroll data are available at the establishment level, and sometimes, the enterprise level. Thus, we map a worker's firm size to an establishment category using data from the May 1988 Current Population Survey which provides both variables for workers before matching payroll to the workers.

2Some employers/workers, particularly those with private coverage today, may prefer private coverage to the public plan, even if the cost is a little higher than the public plan. Workers with broader coverage than provided by the uniform benefit package, for example, may prefer to retain that coverage. Future analysis will explore this possibility. However, we expect that employers will make the most financially advantageous decisions in the long run. In addition, workers and employers could purchase wrap-around insurance policies to broaden their coverage. Thus, there would be little incentive to retain private coverage that is more expensive for the same level of coverage.

3Some observers believe that costs to small firms could be reduced the levels faced by large firms. This type of assumption will be considered in the larger version of this paper.

4Note that the model also incorporates price variations by industry and location. Space does not permit full presentation of the premium matrix. See Acs et al (1992) for more details on premium assumptions.

5Most of the legislative proposals suggest a phase-in period for small employers who do not currently provide health insurance so that they can adjust to the new costs.

6The average payroll figures shown in figure 5 reflect average pay from the CBP data matched to workers on the CPS reweighted to reflect pay for full-time workers by CPS firm size categories.

7

Workers in employer plans that provide benefits better than the uniform benefit plan retain that coverage as long as the employer chooses to retain a private plan. For example, some employers currently pay more than 80 percent of the cost of insurance for their employees.

8As shown earlier, we assume that the government purchases insurance at the same price currently paid by large firms (more than 1,000 workers) in a given location, and large firms face the lowest prices for the mandated benefit package.

9 We do not show employers' cost net of taxes because we reflect payments to insurers. In addition, the full effects of financing the tax deductions for employers is beyond the scope of this project. Under pay or pay systems employers' costs (whether premiums or payroll taxes) would be deductible as business expenses. Thus, the government would finance part of the costs

shown.

¹⁰Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means, the 1991 Green Book, May 7, 1991.

References

- Acs, Gregory, Colin Winterbottom, and Sheila Zedlewski. "Employers' Health Insurance Costs and Payrolls: Implications for Play or Pay Employer Mandates," Urban Institute Report, 6117-01, Washington, D. C., forthcoming January, 1992.
- Holahan, John and Sheila Zedlewski. 1991. "The Distribution of Health Spending in the United States: Implications for Health System Reform," Urban Institute Working Paper, December 1991.
- Long, Stephen, and Susan Marquis. 1991. "Gaps in Employment-Based Health Insurance: Lack of Supply or Lack of Demand?" Washington, D.C. RAND.
- Mellow, Wesley. "Employer Size and Wages," Review of Economics and Statistics, Volume 64, Number 3, August 1982.
- Prospective Payment Assessment Commission, 1991. "The Trend and Distribution of Hospital Uncompensated Care Costs, 1980-1989." Washington, D. C.
- U. S. Bipartisan Commission on Comprehensive Health Care. 1991. A Call for Action, Final Report, U. S. Government Printing Office, Washington, D.C., (September).
- U. S. House of Representatives. 1991. Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means. U. S. Government Printing Office, Washington, D. C.

Congress of the United States
House of Representatives
OFFICE OF THE REPUBLICAN WHIP
Washington, DC 20515-6538

August 26, 1992

HL 18
Thursday in Chicago?
W

To: Bill Kristol
From: Newt Gingrich

The President should physically waive either the House Republican health care bill or the set of his bills to prove he has legislative language and should challenge Clinton to have Mitchell and Gephardt introduce the language of his health care proposal the day Congress reconvenes. We should emphasize this challenge for seven or eight days leading up to September 9th, and on the 9th, fifty House Republicans should do one minutes challenging Clinton to be honest about his 9% payroll tax.

This gives us a chance to:

- 1) prove Bush has a health care plan,
- 2) prove Clinton has a 9% payroll tax, and
- 3) remind everyone that Clinton is slippery.

FAX

BUSH
QUAYLE
921030 15th St. NW
Washington, DC 20005

Date:

9/1/92

To:

Richard Porter

Organization:

~~Porter~~ OVP

Fax Number:

456-6216

From:

D. Tell

Organization:

Number of Pages to Follow:

Part II: 17 pages

Phone Number:

336-7094

Comments:

Confidentiality Notice

The document accompanying this telecopy transmission contains information belonging to the sender which is confidential and may be legally privileged. The information is intended only for the use of the individual or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this telecopied information is strictly prohibited. If you have received this telecopy in error, please immediately notify us by telephone to arrange for return of the original document to us.

Health Care

Campaign 92: Universal Health Care

During the presidential campaign - after earlier reluctance - Clinton embraced a universal health care proposal. In 1991, Clinton's health care position was basically, we'll figure it out after I'm elected. In October he stated, "I would bring in all the players within the first 60 days and tell them to develop a national health care plan."¹ However, by January 1992, he said, "A Clinton Administration will treat affordable, quality health care as a right, not a privilege" as he announced his health care proposal.² He has attacked the President's proposal calling it "cynical."³ Even though Clinton refrains from classifying his plan as similar to the pay-or-play plans offered by Democrat leadership, the plan is of the same root substance. Compare the proposals:

Clinton plan: "employers and employees will either purchase private insurance or opt to buy into a high-quality public program."⁴

The HealthAmerica legislation sponsored by Mitchell, Kennedy, Reigle and Rockefeller stipulates that "businesses will be offered a choice of providing coverage meeting minimum standards for employees and their families or making a contribution to the public plan. The contribution will be a set percent of the payroll."⁵

Clinton's approach to cure our ailing health care system has five points: controlling costs; guaranteeing universal coverage; improve preventative and primary care; expand long-term care and intensify health education.

Cost Containment

Clinton blithely concludes that enough savings will be generated by his plan to allow every American to receive health care. As he stated, "Clearly, this program fully implemented will save far more than it costs to extend comprehensive coverage to all Americans..."⁶ And in March 1992, Clinton stated, "There's \$100 billion of inexcusable, unrelated-to-health-care costs in this system."⁷ Clinton proposes ten different cost-containment measures in his plan.

- Clinton advocates insurance reforms. Specifically, he proposes that "underwriting practices that balkanize Americans into smaller and smaller risk groups must be banned in favor of a broad-based community rating. Access, continuity, and renewability of coverage under a community rating system will be guaranteed."⁸ He relates this to grocery shopping: "... insurance companies make money the way

grocery stores to; a little bit of money on a lot of people instead of trying to insure groups of 50 25-year old women who spend four hours a day at the gym, which is what they are doing here."⁹ He has even stated that the insurance companies could be "bullied" into reform: "First of all, an election would be a referendum on that. Second of all, if they don't reform, they will end up with a Canadian system where they are knocked out all together."¹⁰

- Clinton would limit overall expenditures by creating a national board to define "a core benefit package that all insurers would provide."¹¹ The package would include ambulatory physician care, in-patient hospital care, prescription drugs, basic mental health, and preventative care programs including pre-natal care and annual mammograms. This board will also establish "annual health budget targets nationally and state by state, to guide expenditures in the public and private sectors, to develop an all-payor reimbursement system."¹²
- Clinton proposes that his plan would eliminate the unnecessary paperwork within the health care system. He claims that there are over 1,500 separate sets of rules and forms within the system and that an all-payor system would eliminate these forms and relieve the providers of the time currently needed to process these.
- Clinton plans to limit costs by reducing drug price increases. Clinton supports Senator David Pryor's proposal to eliminate existing special tax breaks for drug companies that raise their drug prices at a rate of increase greater than growth in personal income. Clinton also supports acceleration of the FDA approval process, which he believes is adding to the cost of drugs and unnecessarily delaying their impact. While Clinton would maintain the R & D tax credit on prescription drugs, he would limit the deductibility of marketing and lobbying costs. Clinton would ensure that American pharmaceutical companies don't charge buyers in their own country more than they charge those of other nations.¹³ Clinton does not specifically outline how he would accomplish this.
- Clinton believes his plan will reduce billing fraud by "moving away from the complex billing systems that invite abuse, and by vigorously prosecuting offenders."¹⁴
- Clinton plans to control the unnecessary spread of medical technology. According to Clinton, many hospitals purchase high-tech machinery, even if it duplicates neighboring institutions. To make up those costs, hospitals unnecessarily use these high-tech machines, adding to costs without improving health. Under Clinton's health care plan, the cost review board will develop recommendations and incentives for more sensible capital budgets, including the shared use of technology where appropriate.¹⁵

- The Clinton health care plan includes cost reduction through the development of a "rational" medical liability system. Clinton attributes huge increases in consumer and health care provider insurance premiums to malpractice litigation. To protect themselves from litigation, physicians practice "defensive medicine," resulting in tests that are frequently unnecessary, but ordered to insure the provider against a malpractice suit. Clinton specifically proposes to create alternative dispute resolution mechanism in every state.¹⁶
- Also to reduce malpractice litigation and cut costs, Clinton plans to provide medical practice guidelines to health care personnel. As his plan states, "Providing medical practice guidelines to health care personnel to help them make the right decisions about treatment will save money and lives, and help eliminate improper care."¹⁷
- Clinton's proposal would create a single computerized database for quick and swift exchanges of medical records between institutions of providers. He also stated that "eventually, everyone will carry a 'smart card' -- small microchips or magnetic strips coded with their personal medical information."¹⁸
- Clinton's cost reduction platform for health care reform requires that insurers, health care institutions, and individual health care providers collaborate to develop local group care models called "Health Networks." These networks would serve the private and public programs. Individual Health Networks would operate under a global budget based on the population they insure and/or provide care for. Networks would negotiate fees with participating providers and institutions, and the providers and institutions that affiliate with a given network would collectively manage care delivery with the global budget.¹⁹ This is an amazing statement, since Arkansas ranks 43rd in the United States for individuals enrolled in HMOs. (see Arkansas statistics)

Universal Coverage

Outside of employer-based coverage, Clinton maintains that the disabled and the elderly will have access to comprehensive long-term care under Medicare. The poor and unemployed will have access to his public program. However, Clinton maintains "All will be asked to share some of the costs ... Co-payments must not be burdensome but should be sufficient to discourage over-utilization and to encourage shared responsibility."²⁰ Clinton would limit this amount to a percentage of income.²¹ Clinton ends by saying, "No person will be cut off, canceled, denied, or forced to accept low quality care."²²

Clinton claims his health care plan will protect small business from rising health care costs in a number of ways. First, the insurance premiums paid by all employers will be based on a community-based rating system rather than an experience-based rating system, and small employers will be able to buy into Health Networks that serve large numbers of people. Insurance premiums will be based on the health needs of the

community, not on the health of particular employees at one firm or another. Clinton claims he would provide: (1) the opportunity to buy into the public program if it is less expensive, (2) allowing small businesses to band together to form larger groups to purchase health insurance for moderate prices, and (3) phasing in small employers' and new businesses' responsibility as costs can be reduced, during which time their employees will be covered by the public program with co-pay requirements.²³

Preventative Care

Clinton is convinced that providing preventive care will reduce medical costs and claims his plan would provide an adequate number of primary and preventive care clinics in inner city and rural areas, where health care is not readily available. He would also increase access for children to primary health care by providing school-based clinics as a supplement to universal coverage. Clinton's plan encourages medical providers to practice preventive and primary care, provides incentives for professionals to serve in primary care professions in rural and underserved areas, and increases support for training mid-level professionals, such as certified nurse-midwives and nurse practitioners.²⁴

Clinton explains in this section that Arkansas has been a leader in preventative care and cites his own Director of Health, Joycelyn Elders as a nationally renowned innovator in preventative care. It is interesting to note that Dr. Elders attacked Clinton's plan. It was reported that Elders said that "none of the major presidential candidates, including her boss, have talked enough about what it takes to reform the nation's health care system."²⁵

Long-Term Health Care

Clinton believes he can provide more services to the elderly and the disabled by expanding Medicare to include a wide range of services to be paid for through affordable and equitable cost-sharing mechanisms. Clinton plans to reduce existing restrictions, allowing Medicare payments to assist family members for in-home long-term care, private nursing, adult day care, and senior citizen transportation needs. To assist with the increased need for long-term care workers, Clinton has proposed a National Service Corps of young Americans. The government would provide funds for a college education, in exchange for which the new graduates dedicate a few years working in community based positions such as long-term health care.²⁶

Health Education

Clinton believes that billions of dollars could be saved in health care costs if the American people took responsibility for their own health. To ensure this change, Clinton proposes increased education efforts in homes, schools, workplaces, and senior centers. The national government, insists Clinton, should support these efforts with

incentives either in funds, or in manpower through his proposed National Service Corps.²⁷

Cost of Pay or Play

While the notion of insuring all is politically appealing, the cost is grave when you look the impact this plan could have on employment. Using figures from CONSAD Research Corporation on pay or play, the impact could be devastating:

- There could be over 9 million jobs which are potentially affected that are at risk, 11.37 percent of the total private sector workforce. Arkansas itself could be the hardest hit state in the country: 17.18 percent of the jobs affected.

- There could be over 23 million jobs potentially affected by this plan, 29.06 percent of the workforce. Arkansas could be the second hardest affected with 37.04 percent of the workforce potentially at risk.

Those who could be hurt the most include those most in need of help - minorities, women, elderly, and the impoverished.

- Nationally 2.8 million of the jobs affected, or 31.4 percent could come from youth, between the ages of 19-24. In Arkansas, 6.3 percent of those affected could be over the age of 65, the highest rate in the country.

- It could also affect women - nationally 5.1 million jobs or 56.6 percent could be affected.

- Minorities could also suffer - nationally 24.3 percent of those affected could be minorities, 11.8 percent black. In Arkansas, 21.9 percent of those affected could be black, the seventh highest in the country.

- An astonishing 7.7 million or 85.2 percent of those jobs-at-risk could come from individuals with incomes of under \$5,000. And 62.5 percent of those jobs could come from families earning less than \$30,000 per year. In Arkansas, 75 percent of those jobs could come from families earning less than \$30,000 per year.

This is a large difference from the Clinton in October 1991 who stated, "This [health care] is not a problem which you solve with tax and spend, with taxing more money."²⁸

'Bare Bones Legislation'

In 1991, after eleven years as Governor, Clinton provided for the issuance of insurance to provide those who are uninsured for over a year with a minimal standard of coverage. Ultimately with fewer benefits the premiums would be lower, or affordable enough for small businesses to provide coverage to the 500,000 uninsured people of Arkansas²⁹. This bill, House Bill 1117, which became enrolled Act 238 of 1991, specifically authorized "the development of new classes of hospital and medical insurance coverage for qualified groups, families and individuals; and. . . authorize[s] the Arkansas Insurance Commissioner to develop a means to assist in limiting the marketing and administrative costs of certain of such new classes of insurance coverage." A qualified family or group is made up of individuals who are "employed in or [are]. . . resident[s] of Arkansas and who [have] been without health insurance coverage. . . for the twelve (12) month period immediately preceding the effective date of " policies issued under this act."³⁰

Certain coverages would still be mandated by law, "while specific options must also be made available to the insured." The basic mandatory coverages include "primary, preventive, and hospital care, including but not limited to, the following: (1) Fifteen (15) days of inpatient hospitalization coverage per policy year. . . . A basic level of primary and preventive care, including two (2) office visits per calendar year. . . ." ³¹ is also mandated. All family policies must include "coverage for newborn infant children of the insured from the moment of birth, and for adopted minors from the date of the interlocutory decree of adoption. . . ." ³²

Options that must be offered are "prenatal care, including one prenatal office visit per month during the first two trimesters of pregnancy, two office visits per month during the seventh and eighth months of pregnancy, and one office visit per week during the ninth month until term." Also, "coverage for children's preventive health care services on a periodic basis from birth through age six. . ." must be offered as an option. Finally, obstetrical care must be offered as an option. Clinton signed this bill in February 1991. Immediately thereafter, the Insurance Commissioner began working on devising the specific regulations for the insurance policies.

By July 1991, the Commissioner and representatives of the insurance industry agreed to terms of the coverage: \$200 deductible and a 20% payment of services up to \$5,000 per year. The coverage provided for 15 days hospital care per year; 5 office visits per year, all catastrophic illnesses and injuries; and all services which are medically necessary to treat illness and injury except for in-vitro fertilization; mental illness, routine care for well babies, impairment of speech or hearing; alcohol and drug dependency treatment; mammograms; children's preventative health care or care of children 19 or older who live with their parents.³³

The regulations require a "non-cancelable and/or guaranteed renewable" provision so that no one can be dropped without evidence of nonpayment or fraud.

Interestingly, the regulations even describe the size and boldness of the type required on notices and disclosures of these provisions by the insurer.

As the commissioner is not required to file a report on this new program until 1994, it is doubtful much information exists as to its effectiveness and extent of coverage. As of December 1991, the plan had not been implemented and not one policy had been developed. This lack of action was mainly due to what an Insurance Department official said was the fear by state insurance companies that only a few people would buy the policies.³⁴

Also passed by the 1991-legislature was a "program to provide universal child health care by the year 2000. It emphasizes preventive and primary care for all children 16 and under, regardless of family income and builds on the dramatic expansion of Maternal and Child Health Care in the last two years."³⁵

AIDS

Recently, Clinton was interrupted by an ACT-UP supporter, and questioned about what a Clinton administration would do to support AIDS activists. Clinton took 10 minutes with the man, gaining warm applause from other ACT-UP supporters in the crowd. Clinton has said more attention should be paid to the national commission on AIDS, and called for more AIDS education, and money for medical research.³⁶ Said Clinton, "In a Clinton administration, we will pursue a national AIDS strategy that offers real hope for a cure of AIDS. This strategy will include commitment of increased government resources of the research, testing, and development of an AIDS vaccine; a national health care plan that controls the cost of AIDS treatment and provides health coverage to those who need it; and a national AIDS education initiative in which resources are devoted at the local, state, and federal level to improving knowledge about AIDS and encouraging our children to take personal responsibility for their own health."³⁷

In May 1992, Clinton made his strongest stand yet on AIDS and homosexuals. First, he attacked the Administration,

Over a million Americans are now HIV positive, yet the administration is still curiously silent until the famous fall. ... Then someone says something appropriate. ... But this administration ignores its own commission reports, underfunds research and treatment ... says behavior modification is the issue, then refuses to embrace the cause of sex education in our schools that would give our children a chance to save their lives.³⁸

Clinton then proposed that if he were President, he would appoint an AIDS czar and create a task force to coordinate a "Manhattan Project" to fight AIDS.³⁹ He concluded by saying, "My fellow Americans, we have too much to do to endure quaint little rules ... We can't afford to waste the hearts and minds of the gays and

lesbians."⁴⁰ However, there are supporters of AIDS research who are very displeased with Clinton. Drew Toon, president of the Arkansas Chapter of ACT-UP wrote in a press release, "George Bush has done more for people with AIDS in Arkansas than Bill Clinton. That's sickening."⁴¹ Trey Merritt, also of the group, in clarifying the statement, added further evidence of the lack of attention Clinton has shown this issue. He said, "Everything that has been done on AIDS in Arkansas has been done with federal money."⁴²

AIDS in Arkansas

As of 1988, out of 100,000 people in Arkansas only 2.2 have contracted Human Immunodeficiency Virus.⁴³ As of 1988, there are also 80 people with AIDS and 50 people who have died from AIDS.⁴⁴ While this may seem like a remarkably low number, if Clinton would have engaged this problem in 1984, when there was only 1 case and no deaths, then maybe the 80 deaths would have been only 50 by 1987.

In 1986, Clinton's budget recommendations to the State Legislative Council failed to include "some requested program increases, including one to address public health problems posed by Acquired Immune Deficiency Syndrome."⁴⁵ In March, 1987, Clinton approved an AIDS education proposal. This leading proposal would "channel \$8,000 in federal money from the state Health Department to the Arkansas AIDS foundation. The Foundation proposed to distribute brochures and hold classes for homosexual and bisexual men to educate them about AIDS."⁴⁶ Clinton said,

I don't want to leave here [legislative session] somehow with the lingering doubt that the Legislature doesn't think we ought to have AIDS education.... We need it desperately, and we need it now, and the money is a pittance. We don't want to by somehow not approving this cut off our eligibility for future funds.⁴⁷

Also in 1987, Clinton supported a proposal to mandate AIDS testing during the blood test for a marriage license.⁴⁸ The Arkansas House of Representatives approved such a bill by a vote of 68-6. This bill, HB 1615, the Premarital Examination Act of 1987, would:

require any person applying for a marriage license to have a certificate from a licensed physician that he or she has been tested for the presence of AIDS antibodies. This bill would prohibit issuance of a license if an applicant refused to take the test. If either applicant for a marriage license tested positive for the AIDS antibodies, the license would not be issued until a physician files an affidavit that he has counseled the parties concerning AIDS.⁴⁹

However, the Arkansas Senate killed this measure, 19-11.⁵⁰ Also in 1987, Clinton signed a bill which provided free testing for AIDS.⁵¹

During the summer of 1987, Dr. Yamauchi, a member of Clinton's advisory committee on AIDS, testified - at the request of Clinton - before an NGA committee on AIDS. He proposed five recommendations: A call for AIDS education programs, more AIDS research, long-term care facilities for AIDS patients, increased funding for AIDS testing and confidentiality of test results.⁵²

By late 1987, the Sheriffs Association was vehemently requesting Governor Clinton to propose a bill to protect emergency workers from exposure to AIDS. Clinton's response was to defer the issue to his advisory committee and to work within existing regulatory authority than.⁵³

During the 1990 campaign, Clinton's outlined what Arkansas should be doing to combat the AIDS crisis:

These items are essential components of an AIDS program for Arkansas: accessible HIV testing and counseling, (confidential and anonymous); diagnostic screening and testing; community-based organizations; rehabilitation services; child welfare; advocacy; HIV surveillance and seroprevalence surveys; school-based education.⁵⁴

Also in 1990, Clinton proclaimed December 1, as World AIDS Day in Arkansas.⁵⁵ However, Andre Guerrero, Regional AIDS Interfaith Network, asked that day, "Where is a strategic plan for the State?"⁵⁶

During the 1991 legislative session, Clinton signed three pieces of AIDS legislation. One of the laws, Act 289, would permit the HIV testing of health care patients without their consent and it stipulated that "health care providers or facilities may not deny appropriate care based upon the results of an HIV test."⁵⁷

Act 575 requires those individuals who are engaged in the business of collecting blood, to conduct a second HIV test if the first test proves to be positive, because the first test given is cheap and somewhat ineffective. If a donor is found to have this virus, the company is to notify the Department of Health.⁵⁸ This law became a necessity because a blood donor in Arkansas was identified as testing positive, but the lab through only threw out the blood, they did not notify the man.⁵⁹ Finally, Act 967 provides for confidentiality of state Health Department records.⁶⁰

Health Care in Arkansas

Health Statistics: Clinton has come under criticism for renegeing on his 1990 campaign pledge to not seek higher office. While he is gallivanting over the countryside running for the Presidency, his state still has some of the nation's worst health care problems:

- **Employer Uninsured Coverage:** Arkansas has the second highest rate in the country for having workers without own-employer-paid health insurance. 42.06 percent of the total private sector employment is without employer paid insurance - well above the national average at 33.68 percent.⁶¹

- **Infant Mortality:** In 1988, there were 10.7 deaths per 1,000 live births in Arkansas, ranking them 15th highest in the country.⁶²
- **Low Birth Weight:** Between 1980 and 1988, the percentage of low birth weight of live births had increased from 7.6 to 8.2 percent, an increase of over 7.8 percent. Nationally, during the same time period the low-birth weight babies increased by only 1.4 percent.⁶³
- **Hospital Use:** As of 1989, Arkansas had 430.2 hospital beds per 100,000 residents, ranking them 11th highest in the country. Yet interestingly enough, in the same year, Arkansas hospitals only had a 62.5% occupancy rate, ranking them 39th lowest in the country.⁶⁴ Another report indicates that in 1988, the numbers were even worse: Arkansas had 448 beds per 100,000 residents (14th highest) and an occupancy rate of 56.9 percent (40th lowest).⁶⁵ In 1987, Arkansas is listed as having 544 beds per 100,000 residents ranking them 19th in the country. However, the occupancy rate was 59.7 percent or 44th worst in the nation.⁶⁶ This is an interesting statistic since a major part of the increases in health care expenditures nationally are due to hospitals not being used to their full capacities.
- **Physicians:** In 1984, Arkansas had 3,202 physicians in the state, a rate of 136 physicians per 100,000 residents.⁶⁷ By 1988, this figure became 3,414 physicians, a rate of 144 per 100,000 residents (45th lowest in the country).⁶⁸ The national average in 1984 was 199 per 100,000 residents and in 1988 it was 210 per 100,000 residents. While it looks good that Clinton increased the amount of physicians in the state by 6.6 percent between 1984-1988, nationally the increase was even greater at 7.6 percent in the same time period. However, another report conducted by the American Association of Retired Persons for the year 1989 lists Arkansas at 138 physicians per 100,000 or 44th lowest in the country.⁶⁹
- **Recruitment of Doctors:** As of 1988, Arkansas only had 978 of their 3,839 physicians under the age of 35 -- only 25.47 percent.⁷⁰ Comparing Arkansas to its six neighboring states in 1986, it ranked last in this category, even lower than Mississippi:—

<u>State</u>	<u>Percent</u>
Missouri	29.54
Louisiana	28.74
Tennessee	27.52
Texas	26.84
Oklahoma	25.79
Mississippi	25.55
Arkansas	25.47

- **Nurses:** Between 1984 and 1988, registered nurses in Arkansas increased from 10,258 to 11,292, or 437 nurses per 100,000 to 473 nurses per 100,000. This was

an increase of 10.07 percent. Nationally between 1984-1988, registered nurses increased by 9.5 percent.⁷¹

- **Physician's Assistants:** In 1989, Arkansas did not have any physician assistant training programs and had only 48 physician assistants in the state in 1987, ranking them 45th worst in the country.⁷²
- **Deaths per 100,000:** One indicator of a poorly operated health care system is the amount of deaths per 100,000, especially in a state which is not prone to an abnormally high violent crime rate. In 1987, Arkansas had 1,023 deaths per 100,000 people, the fifth highest in the country.⁷³ By 1988, this figure was at 10.4 per 1,000 residents, still ranking them fifth highest in the country.⁷⁴
- **Psychiatrists:** Arkansas ranks first in the nation for population without psychiatrists. In 1990, 67.6 percent of the population was unserved by psychiatrists.⁷⁵
- **HMO Enrollment:** Only 2.3 percent of Arkansans are enrolled in a health maintenance organization, ranking the state 43rd lowest. This is an interesting statistic given the fact that one of Clinton's health care planks is the increased enrollment into HMOs.⁷⁶

Elder Choice and Medicare

As early as 1986, Clinton and some members of the Arkansas legislature expressed support for the states providing personal care at home for elderly people who otherwise might be placed in nursing homes. According to the Aging and Adult Services deputy director, many elderly Arkansans live below the poverty level, but their incomes are considered too high for them to receive Medicaid-funded personal care in their homes. Many do qualify, however, to enter nursing homes and receive a more expensive and higher level of care. Personal care includes such things as helping a medically needy elderly person dress, attend to personal hygiene or clean house. In 1986, Clinton recommended that the Division of Aging and Adult Services receive \$1.5 million during the first year of the biennium and \$2.6 million for the second year so more Arkansans whose incomes are above the \$11.05-a-day federal Medicaid limit can receive personal care.⁷⁷

It wasn't until 1991, however, that a \$14 million locally oriented and community based program called Elder Choice was funded.⁷⁸ The Elder Choice Program allows about 3,000 elderly Arkansans to use money once reserved for nursing home care for adult day-care centers or home health-care programs.⁷⁹ Proponents believe that in the long run the program will save more than it spends as it gives older citizens an opportunity to stay in their homes rather than move into nursing homes. In

a speech before a joint session of the legislature, Clinton said, "Elder Choice is not just an economic decision, it is a civil rights opportunity for the older people of the state."⁸⁰

Clinton also uses Elder Choice as an example of how to improve Medicare. In March 1992, Clinton spokesman Bruce Reed stated, "Governor Clinton believes we need to expand Medicare to provide more long-term care for the elderly."⁸¹ It was further reported that "Clinton would duplicate an Arkansas pilot program called Elder Choices, under which ailing seniors can opt for such things as home health care or going to an adult day care center rather than straight to a nursing home."⁸²

Clinton is on record as opposing the 1990 proposal to raise deductibles for Medicare participants. He said, "a lot of people in Arkansas on Medicare are a long way from being middle-class folks Before I raised deductibles on Medicare, I'd equalize the tax rate for the people making \$100,000 a year and people making a million."⁸³ In January 1992, Clinton said he would not back a proposal which asked those making over \$125,000 a year to pay a higher Medicare premiums. He stated,

If you want to say, well the wealthiest of our entitlement recipients should pay some more, then that's part of a fairness program that's going to give health care to all Americans and control costs But to throw more money down this rat hole that we've got today where \$50 billion a year is being wasted in our system of insurance finance it is to me unconscionable I don't want to make any American pay more for the same health care.⁸⁴

Clinton successfully used this as a wedge issue against Paul Tsongas in the Florida primaries. Tsongas supported means testing of entitlement programs. Clinton was opposed to this during the primaries and ran advertisements against Tsongas in Florida. However, in June 1992, Clinton stated,

I also think that in an attempt to control the cost of entitlements, people at very high income levels, who are getting back more from Medicare than they pay in, should pay more for this as part of a comprehensive long-term plan So I would raise the fees for high-income recipients as a part of national health care reform.⁸⁵

Nursing Home Violations

In 1989, over 14 percent of the residents of Arkansas were 65 years and older, ranking them 4th highest in the country with seniors.⁸⁶ Many of these residents live in nursing homes. As of 1987, there were 279 nursing homes in Arkansas.⁸⁷ A 1986 GAO report, commissioned by the Senate Aging Committee indicated severe problems with nursing home care in Arkansas. According to the report, a quarter of all the skilled nursing homes in Arkansas were "chronically deficient" in patient care, 3rd worst in the country, and nearly two thirds of Arkansas homes, (61 percent), had at least one major deficiency in 1984, also one of the highest in the country.⁸⁸ Clinton

responded to this report by insinuating that because Arkansas has strict reporting regulations, the numbers are more negative than states which do not report as vigorously. He stated, "I am relieved to learn from Mr. Scott's analysis that the statistics clearly show that we are diligent in inspecting nursing homes. In fact, our strong efforts to protect the residents could possibly be the cause of the so-called high ranking."⁸⁹ Ray Scott, then director of the state Health Department recited statistics from his internal survey as a response. The *Arkansas Gazette* reported on the review,

While Arkansas has only 1.5 percent of the skilled care nursing homes in the country, in 1985, 17 homes were found out of compliance and 'adverse actions' were initiated against them. That represented 9 per cent of the 200 homes placed out of compliance in the county.

Last year, three homes in the United States were terminated from the Medicare and Medicaid programs. Termination closes the homes. One of the three was in Arkansas.⁹⁰

The *Gazette* article also reported that the state had levied "\$19,500 in fines on seven homes between September 1985 and April 1986 for violations that led to or created the possibility of death or harm to residents."⁹¹ Also, between February 1985 and March 1986, "seven homes received notice of violations for not maintaining health and safety standards, and three homes were given notice of violation between March 1985 and April 1986 for not completing proper reports."⁹²

Medicaid in Arkansas

In 1989, Congress mandated new Medicaid programs which increased states' costs. Clinton, as well as the NGA, claimed that states should have the right to determine individual programs that best suited them. In Arkansas the Medicaid mandates for 1989 consumed nearly a third of the state's new revenues for the year. "We don't deny that we've been partners in asking for more Medicaid for maternal and child health," said Clinton.⁹³ But other mandates were imposed without consulting those being forced to foot the bill. "We didn't ask for nursing-home reform," said Clinton, "... And we didn't ask to be part of the catastrophic health plan ... nobody thought about what the practical impacts are."⁹⁴ According to the Department of Human Services Economic and Medical Services, new federal mandates making more people eligible for Medicaid, expanding the program's scope and increasing reimbursements to providers, pushed estimated Medicaid costs up to \$344 million for the budget year beginning July 1, 1990. The Medicaid program is funded with 3 federal dollars for every 1 state dollar.⁹⁵

By June 1990, Clinton was complaining about federally mandated programs. "I want to make it absolutely clear that the problem is the result of federally mandated programs, which were passed by Congress after the last legislative session"⁹⁶ And

by August 1990, Arkansas had discontinued the medically needy component of its Medicaid program for adults over age 21. The action was taken in response to the growing cost of federal mandates expanding the scope of Medicaid coverage. State officials estimate that between 1985 and 1990, the mandates have added 20,000 new clients, 80 percent of whom are children, to the program's rolls and raised the state's annual Medicaid expenditures by \$68 million.⁹⁷

To help off-set the new expenditures, in July 1991, Arkansas adopted a controversial arrangement under which states impose a tax on hospitals or solicit "voluntary donations" from them to pay part of the state's share of Medicaid. That increased the amount of federal matching funds a state receives and allows states to increase their spending as well.⁹⁸ Arkansas's 15 percent Medicaid excise tax is expected to raise \$30 million annually. The state agrees to match the \$30 million, attracting \$180 million in federal money.⁹⁹ In August 1991, the Bush administration called for a halt to federal matching funds for money donated to states by health care providers, and blamed these "sleight-of-hand" schemes for increasingly driving up federal costs.¹⁰⁰

Clinton and the NGA oppose the Bush administration decision. In an August 1991 speech to members of the American Association of Retired People, Clinton criticized Bush saying, "The same president that signed all those Medicaid mandates ... that forced states to spend billions and billions of dollars basically said, 'By the way, we're going to tell you [you] can't raise money the way you want and you have to tax all your people.'"¹⁰¹

In October 1991, Clinton said he would pay for better health coverage by moving to control health care costs, something he was unable to do in Arkansas. But he conceded there may be "some extra revenue" to be found without huge tax increases.¹⁰² By December 1991, however, Clinton had articulated his plan in which he promises affordable national health care insurance coverage for all Americans, emphasizing "a substantial increase in publicly funded -- not necessarily publicly operated -- community primary and preventive health-care clinics in rural areas and in inner city areas."¹⁰³

Rural Health Care Statistics

- Population in rural areas: As of 1988, 60.3 percent of all Arkansas residents lived in rural areas, ranking them 10th highest in the country.¹⁰⁴ In 1980, only 48.4 percent of Arkansans lived in rural areas.¹⁰⁵
- Physicians to populations in rural counties: In 1985, there were 8 small counties registered as the smallest of non-metropolitan counties (those with under 10,000 residents). In those 8 counties there was only 34.6 physicians per 100,000 residents and only 4.3 percent of those were Doctors of Osteopathy. The physicians per residents figure was the 29th worst out of 32 states in the Congressional Office of Technology Assessment report.¹⁰⁶

- **State's Effort Level:** The U.S. Department of Health and Human Services ranks states in their level of effort in Health Professions Distribution compared with their unserved and non-urban populations. They base their rankings on the number of programs, funding, and number of participants in the program. In the 1986 report, Arkansas had a 3 level of effort with 4 being the worst. This report also indicated that there were 177,000 Arkansans listed as the unserved population.¹⁰⁷

Rural Health Care Initiatives

The rural health care issue has reached crisis proportions in Arkansas. However, the state has done little to address the issue. According to the September 1990 *Health Care in Rural America* report, produced by the Congressional Office of Technology Assessment, Arkansas lacks a single certified rural health care clinic. This same table shows that 65 counties in Arkansas are designated as medically underserved and could qualify for certification.¹⁰⁸

In 1990, Clinton confronted this by providing \$800,000 in state and federal grants to 29 rural hospitals and emergency care providers. He used this opportunity to exclaim: "We can provide Medicaid health insurance for pregnant mothers and children but we've got to get people out there to rural Arkansas to give health care ... if we're ever going to get the infant mortality rate down."¹⁰⁹ Dr. Joycelyn Elders, the Director of the Health Department, also added, "The major problem is the access to basic primary care, acute care and emergency services."¹¹⁰ The remarks are true in their implication of the serious problem Arkansas faces regarding the providing of health care in the rural areas. The \$800,000 sounds good, but it amounts to only \$29,586 per hospital.

In 1991, the legislature attempted to expand rural health care assistance, by approving a bill to "create a rural health commission to develop rural health-care initiatives and recruit physicians to rural areas."¹¹¹ This bill would have also prioritized the locating of federal money to assist rural health care initiatives.¹¹² Governor Clinton vetoed this bill. He reasoned that these functions were already being performed by the Office of Primary Care in the State Health Department and that it would cost \$600,000: "In an effort to give the new acts a chance to work and not to cause the unnecessary expenditure of state money, I am disapproving the bill."¹¹³ Some legislators saw this as an attempt to protect the Health Department's turf at the expense of those in need. Senator Lewellen stated: "With all the problems faced by the Health Department, it has more than it can say grace over already The responsibility is much larger than the Health Department can handle, and the only people who will suffer will be the people in the Delta and other rural areas."¹¹⁴

- 50 Senate kills measure to require AIDS testing. April 4, 1987.
- 51 Law aimed to provide free testing for ADIS. Arkansas Gazette, July 2, 1987.
- 52 Governors group hears from second Arkansas. Arkansas Gazette, July 28, 1992.
- 53 Sheriffs want safeguards against AIDS. Arkansas Gazette, December 4, 1987.
- 54 Clinton, Nelson differ on abortion, teen-age pregnancy. Arkansas Gazette, October 4, 1990.
- 55 AIDS needs attention like to state reaction to quake. Arkansas Gazette, December 2, 1990.
- 56 AIDS needs attention like to state reaction to quake. Arkansas Gazette, December 2, 1990.
- 57 Arkansas Laws, Act 289.
- 58 Arkansas Laws, Act 575.
- 59 New AIDS laws should help assure protection. Arkansas Gazette. April 7, 1991.
- 60 New AIDS laws should help assure protection. Arkansas Gazette. April 7, 1991.
- 61 Jobs-at-risk and their demographic characteristic associated with mandated employer health insurance plan. CONSAD Research Corporation. 1992
- 62 1991 Statistical Abstract. Source: U.S. National Center for Health Statistics
- 63 Statistical Abstract 1991: Source: U.S. National Center for Health Statistics, Vital Statistics for the United States.
- 64 Reforming the Health Care System, State Profiles 1990, AARP.
- 65 1991 Statistical Abstract. American Health Association.
- 66 U.S. Bureau of the Census, Statistical Abstract of the United States: 1990.
- 67 Arkansas Statistical Abstract. UALR: Source: Health Insurance Association of America, 1986-1987 Sourcebook of Health Insurance Data.
- 68 Statistical Abstract: Physicians: American Medical Association, Chicago, Ill. Physician Characteristics and Distribution in the U.S.
- 69 Reforming the Health Care System, State Profiles 1990, AARP
- 70 Arkansas Statistical Abstract/UALR: Source American Medical Association, Physician Characteristics and Distribution in the U.S.
- 71 Statistical Abstract: Physicians: American Medical Association, Chicago, Ill. Physician Characteristics and Distribution in the U.S.
- 72 Health care in Rural America. Congress of the United States, Office of Technology Assessment. September 1990. Pg. 253. Source: U.S. Department of Health and Human Services, Sixth Report to the President and Congress on the Status of Health Personnel in the United States, June 1988-90
- 73 Reforming the Health Care System, State Profiles 1990, AARP
- 74 1991 Statistical Abstract: Source: U.S. National Center for Health Statistics, Vital Statistics of the United States, annual.
- 75 Reforming the Health Care System, State Profiles 1990, AARP
- 76 Reforming the Health Care System, State Profiles 1990, AARP
- 77 Arkansas Gazette, Legislators support home care would allow elderly to avoid institutions, 11/20/86.
- 78 Glenwood Herald, New laws to benefit older Arkansans, 7/11/91.
- 79 Arkansas Democrat, Take long-term care out of Medicaid, 7/11/91.
- 80 Glenwood Herald, New laws to benefit older Arkansans, 7/11/91.
- 81 Elderly Hit by Failing Health Care. Newday, March 6, 1992.
- 82 Elderly Hit by Failing Health Care. Newday, March 6, 1992.
- 83 Clinton opposes parts of federal budget plan. Arkansas Gazette, October 3, 1990.
- 84 Ny Democrats want Cuomo as Favorite Son. Ruter News Report. January 5, 1992
- 85 Clinton wants to make affluent elderly pay more for Social Security, Medicare. - Wall Street Journal, June 10, 1992.
- 86 Reforming the Health Care System, State Profiles 1990, AARP
- 87 Desertifying nursing homes to be sought. Arkansas Gazette, February 19, 1987.
- 88 Clinton suggest link in strong state effort, poor ranking of homes. Arkansas Gazette, May 27, 1986.
- 89 Clinton suggest link in strong state effort, poor ranking of homes. Arkansas Gazette, May 27, 1986.
- 90 Clinton suggest link in strong state effort, poor ranking of homes. Arkansas Gazette, May 27, 1986.
- 91 Clinton suggest link in strong state effort, poor ranking of homes. Arkansas Gazette, May 27, 1986.

- ⁹²Clinton suggest link in strong state effort, poor ranking of homes. Arkansas Gazette, May 27, 1986.
- ⁹³CQ Almanac, pg. 173, 1989.
- ⁹⁴Ibid
- ⁹⁵Arkansas Democrat, DHS to cut \$40 million in Medicaid services for year, 6/21/90.
- ⁹⁶Ibid
- ⁹⁷State Health Notes, October 1990, pg. 6.
- ⁹⁸AP, States say they're not to blame for soaring Medicaid costs, 7/11/91.
- ⁹⁹Arkansas Gazette, Medicaid taxes may be set aside, 8/19/91.
- ¹⁰⁰AP, States say they're not to blame for soaring Medicaid costs, 7/11/91.
- ¹⁰¹AP, New Medicaid rule may not apply to Arkansas, 9/12/91.
- ¹⁰²AP, Clinton, Harkin boost health care, disdain tax hike, 10/6/91.
- ¹⁰³Arkansas Democrat Gazette, Clinton defends health care plan, 12/20/91.
- ¹⁰⁴Reforming the Health Care System, State Profiles 1990, AARP
- ¹⁰⁵Health care in Rural America. Congress of the United States, Office of Technology Assessment. September 1990. Pg. 39
- ¹⁰⁶Health care in Rural America. Congress of the United States, Office of Technology Assessment. September 1990. Pg. 239 - Source: The Adequacy of Physician supply in small rural counties. Health Affairs, VI. 8 no. 2, 1989 pp 63-76.
- ¹⁰⁷Health care in Rural America. Congress of the United States, Office of Technology Assessment. September 1990. Pg. 364. Source: U.S. Department of Health and Human Services, Compendium of State Health Professions Distribution Programs, 1986.
- ¹⁰⁸Health care in Rural America. Congress of the United States, Office of Technology Assessment. September 1990. Pg. 127.
- ¹⁰⁹\$800,000 Ok'd for rural hospitals. Arkansas Gazette, September 20, 1990.
- ¹¹⁰\$800,000 Ok'd for rural hospitals. Arkansas Gazette, September 20, 1990.
- ¹¹¹Rural Health Commission Vetoed. Arkansas Gazette, April 12, 1991.
- ¹¹²Rural Health Commission Vetoed. Arkansas Gazette, April 12, 1991.
- ¹¹³Rural Health Commission Vetoed. Arkansas Gazette, April 12, 1991.
- ¹¹⁴Rural Health Commission Vetoed. Arkansas Gazette, April 12, 1991.

FAX

BUSH
QUAYLE
921030 15th St. NW
Washington, DC 20005

Date:

9/1/92

To:

Richard Porter

Organization:

~~Richard Porter~~ OVP

Fax Number:

456-6216

From:

D. Tell

Organization:

Number of Pages to Follow:

Part II: 17 pages

Phone Number:

336-7094

Comments:

Confidentiality Notice

The document accompanying this telecopy transmission contains information belonging to the sender which is confidential and may be legally privileged. The information is intended only for the use of the individual or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this telecopied information is strictly prohibited. If you have received this telecopy in error, please immediately notify us by telephone to arrange for return of the original document to us.

Health Care

Campaign 92: Universal Health Care

During the presidential campaign - after earlier reluctance - Clinton embraced a universal health care proposal. In 1991, Clinton's health care position was basically, we'll figure it out after I'm elected. In October he stated, "I would bring in all the players within the first 60 days and tell them to develop a national health care plan."¹ However, by January 1992, he said, "A Clinton Administration will treat affordable, quality health care as a right, not a privilege" as he announced his health care proposal.² He has attacked the President's proposal calling it "cynical."³ Even though Clinton refrains from classifying his plan as similar to the pay-or-play plans offered by Democrat leadership, the plan is of the same root substance. Compare the proposals:

Clinton plan: "employers and employees will either purchase private insurance or opt to buy into a high-quality public program."⁴

The HealthAmerica legislation sponsored by Mitchell, Kennedy, Reigle and Rockefeller stipulates that "businesses will be offered a choice of providing coverage meeting minimum standards for employees and their families or making a contribution to the public plan. The contribution will be a set percent of the payroll."⁵

Clinton's approach to cure our ailing health care system has five points: controlling costs; guaranteeing universal coverage; improve preventative and primary care; expand long-term care and intensify health education.

Cost Containment

Clinton blithely concludes that enough savings will be generated by his plan to allow every American to receive health care. As he stated, "Clearly, this program fully implemented will save far more than it costs to extend comprehensive coverage to all Americans..."⁶ And in March 1992, Clinton stated, "There's \$100 billion of inexcusable, unrelated-to-health-care costs in this system."⁷ Clinton proposes ten different cost-containment measures in his plan.

- Clinton advocates insurance reforms. Specifically, he proposes that "underwriting practices that balkanize Americans into smaller and smaller risk groups must be banned in favor of a broad-based community rating. Access, continuity, and renewability of coverage under a community rating system will be guaranteed."⁸ He relates this to grocery shopping: "... insurance companies make money the way

grocery stores to; a little bit of money on a lot of people instead of trying to insure groups of 50 25-year old women who spend four hours a day at the gym, which is what they are doing here."⁹ He has even stated that the insurance companies could be "bullied" into reform: "First of all, an election would be a referendum on that. Second of all, if they don't reform, they will end up with a Canadian system where they are knocked out all together."¹⁰

- Clinton would limit overall expenditures by creating a national board to define "a core benefit package that all insurers would provide."¹¹ The package would include ambulatory physician care, in-patient hospital care, prescription drugs, basic mental health, and preventative care programs including pre-natal care and annual mammograms. This board will also establish "annual health budget targets nationally and state by state, to guide expenditures in the public and private sectors, to develop an all-payor reimbursement system."¹²
- Clinton proposes that his plan would eliminate the unnecessary paperwork within the health care system. He claims that there are over 1,500 separate sets of rules and forms within the system and that an all-payor system would eliminate these forms and relieve the providers of the time currently needed to process these.
- Clinton plans to limit costs by reducing drug price increases. Clinton supports Senator David Pryor's proposal to eliminate existing special tax breaks for drug companies that raise their drug prices at a rate of increase greater than growth in personal income. Clinton also supports acceleration of the FDA approval process, which he believes is adding to the cost of drugs and unnecessarily delaying their impact. While Clinton would maintain the R & D tax credit on prescription drugs, he would limit the deductibility of marketing and lobbying costs. Clinton would ensure that American pharmaceutical companies don't charge buyers in their own country more than they charge those of other nations.¹³ Clinton does not specifically outline how he would accomplish this.
- Clinton believes his plan will reduce billing fraud by "moving away from the complex billing systems that invite abuse, and by vigorously prosecuting offenders."¹⁴
- Clinton plans to control the unnecessary spread of medical technology. According to Clinton, many hospitals purchase high-tech machinery, even if it duplicates neighboring institutions. To make up those costs, hospitals unnecessarily use these high-tech machines, adding to costs without improving health. Under Clinton's health care plan, the cost review board will develop recommendations and incentives for more sensible capital budgets, including the shared use of technology where appropriate.¹⁵

- The Clinton health care plan includes cost reduction through the development of a "rational" medical liability system. Clinton attributes huge increases in consumer and health care provider insurance premiums to malpractice litigation. To protect themselves from litigation, physicians practice "defensive medicine," resulting in tests that are frequently unnecessary, but ordered to insure the provider against a malpractice suit. Clinton specifically proposes to create alternative dispute resolution mechanism in every state.¹⁶
- Also to reduce malpractice litigation and cut costs, Clinton plans to provide medical practice guidelines to health care personnel. As his plan states, "Providing medical practice guidelines to health care personnel to help them make the right decisions about treatment will save money and lives, and help eliminate improper care."¹⁷
- Clinton's proposal would create a single computerized database for quick and swift exchanges of medical records between institutions of providers. He also stated that "eventually, everyone will carry a 'smart card' -- small microchips or magnetic strips coded with their personal medical information."¹⁸
- Clinton's cost reduction platform for health care reform requires that insurers, health care institutions, and individual health care providers collaborate to develop local group care models called "Health Networks." These networks would serve the private and public programs. Individual Health Networks would operate under a global budget based on the population they insure and/or provide care for. Networks would negotiate fees with participating providers and institutions, and the providers and institutions that affiliate with a given network would collectively manage care delivery with the global budget.¹⁹—This is an amazing statement, since Arkansas ranks 43rd in the United States for individuals enrolled in HMOs. (see Arkansas statistics)

Universal Coverage

Outside of employer-based coverage, Clinton maintains that the disabled and the elderly will have access to comprehensive long-term care under Medicare. The poor and unemployed will have access to his public program. However, Clinton maintains "All will be asked to share some of the costs ... Co-payments must not be burdensome but should be sufficient to discourage over-utilization and to encourage shared responsibility."²⁰ Clinton would limit this amount to a percentage of income.²¹ Clinton ends by saying, "No person will be cut off, canceled, denied, or forced to accept low quality care."²²

Clinton claims his health care plan will protect small business from rising health care costs in a number of ways. First, the insurance premiums paid by all employers will be based on a community-based rating system rather than an experience-based rating system, and small employers will be able to buy into Health Networks that serve large numbers of people. Insurance premiums will be based on the health needs of the

community, not on the health of particular employees at one firm or another. Clinton claims he would provide: (1) the opportunity to buy into the public program if it is less expensive, (2) allowing small businesses to band together to form larger groups to purchase health insurance for moderate prices, and (3) phasing in small employers' and new businesses' responsibility as costs can be reduced, during which time their employees will be covered by the public program with co-pay requirements.²³

Preventative Care

Clinton is convinced that providing preventive care will reduce medical costs and claims his plan would provide an adequate number of primary and preventive care clinics in inner city and rural areas, where health care is not readily available. He would also increase access for children to primary health care by providing school-based clinics as a supplement to universal coverage. Clinton's plan encourages medical providers to practice preventive and primary care, provides incentives for professionals to serve in primary care professions in rural and underserved areas, and increases support for training mid-level professionals, such as certified nurse-midwives and nurse practitioners.²⁴

Clinton explains in this section that Arkansas has been a leader in preventative care and cites his own Director of Health, Joycelyn Elders as a nationally renowned innovator in preventative care. It is interesting to note that Dr. Elders attacked Clinton's plan. It was reported that Elders said that "none of the major presidential candidates, including her boss, have talked enough about what it takes to reform the nation's health care system."²⁵

Long-Term Health Care

Clinton believes he can provide more services to the elderly and the disabled by expanding Medicare to include a wide range of services to be paid for through affordable and equitable cost-sharing mechanisms. Clinton plans to reduce existing restrictions, allowing Medicare payments to assist family members for in-home long-term care, private nursing, adult day care, and senior citizen transportation needs. To assist with the increased need for long-term care workers, Clinton has proposed a National Service Corps of young Americans. The government would provide funds for a college education, in exchange for which the new graduates dedicate a few years working in community based positions such as long-term health care.²⁶

Health Education

Clinton believes that billions of dollars could be saved in health care costs if the American people took responsibility for their own health. To ensure this change, Clinton proposes increased education efforts in homes, schools, workplaces, and senior centers. The national government, insists Clinton, should support these efforts with

incentives either in funds, or in manpower through his proposed National Service Corps.²⁷

Cost of Pay or Play

While the notion of insuring all is politically appealing, the cost is grave when you look the impact this plan could have on employment. Using figures from CONSAD Research Corporation on pay or play, the impact could be devastating:

- There could be over 9 million jobs which are potentially affected that are at risk, 11.37 percent of the total private sector workforce. Arkansas itself could be the hardest hit state in the country: 17.18 percent of the jobs affected.

- There could be over 23 million jobs potentially affected by this plan, 29.06 percent of the workforce. Arkansas could be the second hardest affected with 37.04 percent of the workforce potentially at risk.

Those who could be hurt the most include those most in need of help - minorities, women, elderly, and the impoverished.

- Nationally 2.8 million of the jobs affected, or 31.4 percent could come from youth, between the ages of 19-24. In Arkansas, 6.3 percent of those affected could be over the age of 65, the highest rate in the country.

- It could also affect women -- nationally 5.1 million jobs or 56.6 percent could be affected.

- Minorities could also suffer -- nationally 24.3 percent of those affected could be minorities, 11.8 percent black. In Arkansas, 21.9 percent of those affected could be black, the seventh highest in the country.

- An astonishing 7.7 million or 85.2 percent of those jobs-at-risk could come from individuals with incomes of under \$5,000. And 62.5 percent of those jobs could come from families earning less than \$30,000 per year. In Arkansas, 75 percent of those jobs could come from families earning less than \$30,000 per year.

This is a large difference from the Clinton in October 1991 who stated, "This [health care] is not a problem which you solve with tax and spend, with taxing more money."²⁸

'Bare Bones Legislation'

In 1991, after eleven years as Governor, Clinton provided for the issuance of insurance to provide those who are uninsured for over a year with a minimal standard of coverage. Ultimately with fewer benefits the premiums would be lower, or affordable enough for small businesses to provide coverage to the 500,000 uninsured people of Arkansas²⁹. This bill, House Bill 1117, which became enrolled Act 238 of 1991, specifically authorized "the development of new classes of hospital and medical insurance coverage for qualified groups, families and individuals; and. . .authorize[s] the Arkansas Insurance Commissioner to develop a means to assist in limiting the marketing and administrative costs of certain of such new classes of insurance coverage." A qualified family or group is made up of individuals who are "employed in or [are]. . .resident[s] of Arkansas and who [have] been without health insurance coverage. . .for the twelve (12) month period immediately preceding the effective date of " policies issued under this act."³⁰

Certain coverages would still be mandated by law, "while specific options must also be made available to the insured." The basic mandatory coverages include "primary, preventive, and hospital care, including but not limited to, the following: (1) Fifteen (15) days of inpatient hospitalization coverage per policy year. . . . A basic level of primary and preventive care, including two (2) office visits per calendar year. . ." ³¹ is also mandated. All family policies must include "coverage for newborn infant children of the insured from the moment of birth, and for adopted minors from the date of the interlocutory decree of adoption. . . ." ³²

Options that must be offered are "prenatal care, including one prenatal office visit per month during the first two trimesters of pregnancy, two office visits per month during the seventh and eighth months of pregnancy, and one office visit per week during the ninth month until term." Also, "coverage for children's preventive health care services on a periodic basis from birth through age six. . ." must be offered as an option. Finally, obstetrical care must be offered as an option. Clinton signed this bill in February 1991. Immediately thereafter, the Insurance Commissioner began working on devising the specific regulations for the insurance policies.

By July 1991, the Commissioner and representatives of the insurance industry agreed to terms of the coverage: \$200 deductible and a 20% payment of services up to \$5,000 per year. The coverage provided for 15 days hospital care per year; 5 office visits per year, all catastrophic illnesses and injuries; and all services which are medically necessary to treat illness and injury except for in-vitro fertilization; mental illness, routine care for well babies, impairment of speech or hearing; alcohol and drug dependency treatment; mammograms; children's preventative health care or care of children 19 or older who live with their parents.³³

The regulations require a "non-cancelable and/or guaranteed renewable" provision so that no one can be dropped without evidence of nonpayment or fraud.

Interestingly, the regulations even describe the size and boldness of the type required on notices and disclosures of these provisions by the insurer.

As the commissioner is not required to file a report on this new program until 1994, it is doubtful much information exists as to its effectiveness and extent of coverage. As of December 1991, the plan had not been implemented and not one policy had been developed. This lack of action was mainly due to what an Insurance Department official said was the fear by state insurance companies that only a few people would buy the policies.³⁴

Also passed by the 1991-legislature was a "program to provide universal child health care by the year 2000. It emphasizes preventive and primary care for all children 16 and under, regardless of family income and builds on the dramatic expansion of Maternal and Child Health Care in the last two years."³⁵

AIDS

Recently, Clinton was interrupted by an ACT-UP supporter, and questioned about what a Clinton administration would do to support AIDS activists. Clinton took 10 minutes with the man, gaining warm applause from other ACT-UP supporters in the crowd. Clinton has said more attention should be paid to the national commission on AIDS, and called for more AIDS education, and money for medical research.³⁶ Said Clinton, "In a Clinton administration, we will pursue a national AIDS strategy that offers real hope for a cure of AIDS. This strategy will include commitment of increased government resources of the research, testing, and development of an AIDS vaccine; a national health care plan that controls the cost of AIDS treatment and provides health coverage to those who need it; and a national AIDS education initiative in which resources are devoted at the local, state, and federal level to improving knowledge about AIDS and encouraging our children to take personal responsibility for their own health."³⁷

In May 1992, Clinton made his strongest stand yet on AIDS and homosexuals. First, he attacked the Administration,

Over a million Americans are now HIV positive, yet the administration is still curiously silent until the famous fall. ... Then someone says something appropriate. ... But this administration ignores its own commission reports, underfunds research and treatment ... says behavior modification is the issue, then refuses to embrace the cause of sex education in our schools that would give our children a chance to save their lives.³⁸

Clinton then proposed that if he were President, he would appoint an AIDS czar and create a task force to coordinate a "Manhattan Project" to fight AIDS.³⁹ He concluded by saying, "My fellow Americans, we have too much to do to endure quaint little rules ... We can't afford to waste the hearts and minds of the gays and

lesbians."⁴⁰ However, there are supporters of AIDS research who are very displeased with Clinton. Drew Toon, president of the Arkansas Chapter of ACT-UP wrote in a press release, "George Bush has done more for people with AIDS in Arkansas than Bill Clinton. That's sickening."⁴¹ Trey Merritt, also of the group, in clarifying the statement, added further evidence of the lack of attention Clinton has shown this issue. He said, "Everything that has been done on AIDS in Arkansas has been done with federal money."⁴²

AIDS in Arkansas

As of 1988, out of 100,000 people in Arkansas only 2.2 have contracted Human Immunodeficiency Virus.⁴³ As of 1988, there are also 80 people with AIDS and 50 people who have died from AIDS.⁴⁴ While this may seem like a remarkably low number, if Clinton would have engaged this problem in 1984, when there was only 1 case and no deaths, then maybe the 80 deaths would have been only 50 by 1987.

In 1986, Clinton's budget recommendations to the State Legislative Council failed to include "some requested program increases, including one to address public health problems posed by Acquired Immune Deficiency Syndrome."⁴⁵ In March, 1987, Clinton approved an AIDS education proposal. This leading proposal would "channel \$8,000 in federal money from the state Health Department to the Arkansas AIDS foundation. The Foundation proposed to distribute brochures and hold classes for homosexual and bisexual men to educate them about AIDS."⁴⁶ Clinton said,

I don't want to leave here [legislative session] somehow with the lingering doubt that the Legislature doesn't think we ought to have AIDS education.... We need it desperately, and we need it now, and the money is a pittance. We don't want to by somehow not approving this cut off our eligibility for future funds.⁴⁷

Also in 1987, Clinton supported a proposal to mandate AIDS testing during the blood test for a marriage license.⁴⁸ The Arkansas House of Representatives approved such a bill by a vote of 68-6. This bill, HB 1615, the Premarital Examination Act of 1987, would:

require any person applying for a marriage license to have a certificate from a licensed physician that he or she has been tested for the presence of AIDS antibodies. This bill would prohibit issuance of a license if an applicant refused to take the test. If either applicant for a marriage license tested positive for the AIDS antibodies, the license would not be issued until a physician files an affidavit that he has counseled the parties concerning AIDS.⁴⁹

However, the Arkansas Senate killed this measure, 19-11.⁵⁰ Also in 1987, Clinton signed a bill which provided free testing for AIDS.⁵¹

During the summer of 1987, Dr. Yamauchi, a member of Clinton's advisory committee on AIDS, testified - at the request of Clinton - before an NGA committee on AIDS. He proposed five recommendations: A call for AIDS education programs, more AIDS research, long-term care facilities for AIDS patients, increased funding for AIDS testing and confidentiality of test results.⁵²

By late 1987, the Sheriffs Association was vehemently requesting Governor Clinton to propose a bill to protect emergency workers from exposure to AIDS. Clinton's response was to defer the issue to his advisory committee and to work within existing regulatory authority than.⁵³

During the 1990 campaign, Clinton's outlined what Arkansas should be doing to combat the AIDS crisis:

These items are essential components of an AIDS program for Arkansas: accessible HIV testing and counseling, (confidential and anonymous); diagnostic screening and testing; community-based organizations; rehabilitation services; child welfare; advocacy; HIV surveillance and seroprevalence surveys; school-based education.⁵⁴

Also in 1990, Clinton proclaimed December 1, as World AIDS Day in Arkansas.⁵⁵ However, Andre Guerrero, Regional AIDS Interfaith Network, asked that day, "Where is a strategic plan for the State?"⁵⁶

During the 1991 legislative session, Clinton signed three pieces of AIDS legislation. One of the laws, Act 289, would permit the HIV testing of health care patients without their consent and it stipulated that "health care providers or facilities may not deny appropriate care based upon the results of an HIV test."⁵⁷

Act 575 requires those individuals who are engaged in the business of collecting blood, to conduct a second HIV test if the first test proves to be positive, because the first test given is cheap and somewhat ineffective. If a donor is found to have this virus, the company is to notify the Department of Health.⁵⁸ This law became a necessity because a blood donor in Arkansas was identified as testing positive, but the lab through only threw out the blood, they did not notify the man.⁵⁹ Finally, Act 967 provides for confidentiality of state Health Department records.⁶⁰

Health Care in Arkansas

Health Statistics: Clinton has come under criticism for renegeing on his 1990 campaign pledge to not seek higher office. While he is gallivanting over the countryside running for the Presidency, his state still has some of the nation's worst health care problems:

- **Employer Uninsured Coverage:** Arkansas has the second highest rate in the country for having workers without own-employer-paid health insurance. 42.06 percent of the total private sector employment is without employer paid insurance - well above the national average at 33.68 percent.⁶¹

- **Infant Mortality:** In 1988, there were 10.7 deaths per 1,000 live births in Arkansas, ranking them 15th highest in the country.⁶²
- **Low Birth Weight:** Between 1980 and 1988, the percentage of low birth weight of live births had increased from 7.6 to 8.2 percent, an increase of over 7.8 percent. Nationally, during the same time period the low-birth weight babies increased by only 1.4 percent.⁶³
- **Hospital Use:** As of 1989, Arkansas had 430.2 hospital beds per 100,000 residents, ranking them 11th highest in the country. Yet interestingly enough, in the same year, Arkansas hospitals only had a 62.5% occupancy rate, ranking them 39th lowest in the country.⁶⁴ Another report indicates that in 1988, the numbers were even worse: Arkansas had 448 beds per 100,000 residents (14th highest) and an occupancy rate of 56.9 percent (40th lowest).⁶⁵ In 1987, Arkansas is listed as having 544 beds per 100,000 residents ranking them 19th in the country. However, the occupancy rate was 59.7 percent or 44th worst in the nation.⁶⁶ This is an interesting statistic since a major part of the increases in health care expenditures nationally are due to hospitals not being used to their full capacities.
- **Physicians:** In 1984, Arkansas had 3,202 physicians in the state, a rate of 136 physicians per 100,000 residents.⁶⁷ By 1988, this figure became 3,414 physicians, a rate of 144 per 100,000 residents (45th lowest in the country).⁶⁸ The national average in 1984 was 199 per 100,000 residents and in 1988 it was 210 per 100,000 residents. While it looks good that Clinton increased the amount of physicians in the state by 6.6 percent between 1984-1988, nationally the increase was even greater at 7.6 percent in the same time period. However, another report conducted by the American Association of Retired Persons for the year 1989 lists Arkansas at 138 physicians per 100,000 or 44th lowest in the country.⁶⁹
- **Recruitment of Doctors:** As of 1988, Arkansas only had 978 of their 3,839 physicians under the age of 35 -- only 25.47 percent.⁷⁰ Comparing Arkansas to its six neighboring states in 1986, it ranked last in this category, even lower than Mississippi:—

<u>State</u>	<u>Percent</u>
Missouri	29.54
Louisiana	28.74
Tennessee	27.52
Texas	26.84
Oklahoma	25.79
Mississippi	25.55
Arkansas	25.47

- **Nurses:** Between 1984 and 1988, registered nurses in Arkansas increased from 10,258 to 11,292, or 437 nurses per 100,000 to 473 nurses per 100,000. This was

an increase of 10.07 percent. Nationally between 1984-1988, registered nurses increased by 9.5 percent.⁷¹

- **Physician's Assistants:** In 1989, Arkansas did not have any physician assistant training programs and had only 48 physician assistants in the state in 1987, ranking them 45th worst in the country.⁷²
- **Deaths per 100,000:** One indicator of a poorly operated health care system is the amount of deaths per 100,000, especially in a state which is not prone to an abnormally high violent crime rate. In 1987, Arkansas had 1,023 deaths per 100,000 people, the fifth highest in the country.⁷³ By 1988, this figure was at 10.4 per 1,000 residents, still ranking them fifth highest in the country.⁷⁴
- **Psychiatrists:** Arkansas ranks first in the nation for population without psychiatrists. In 1990, 67.6 percent of the population was unserved by psychiatrists.⁷⁵
- **HMO Enrollment:** Only 2.3 percent of Arkansans are enrolled in a health maintenance organization, ranking the state 43rd lowest. This is an interesting statistic given the fact that one of Clinton's health care planks is the increased enrollment into HMOs.⁷⁶

Elder Choice and Medicare

As early as 1986, Clinton and some members of the Arkansas legislature expressed support for the states providing personal care at home for elderly people who otherwise might be placed in nursing homes. According to the Aging and Adult Services deputy director, many elderly Arkansans live below the poverty level, but their incomes are considered too high for them to receive Medicaid-funded personal care in their homes. Many do qualify, however, to enter nursing homes and receive a more expensive and higher level of care. Personal care includes such things as helping a medically needy elderly person dress, attend to personal hygiene or clean house. In 1986, Clinton recommended that the Division of Aging and Adult Services receive \$1.5 million during the first year of the biennium and \$2.6 million for the second year so more Arkansans whose incomes are above the \$11.05-a-day federal Medicaid limit can receive personal care.⁷⁷

It wasn't until 1991, however, that a \$14 million locally oriented and community based program called Elder Choice was funded.⁷⁸ The Elder Choice Program allows about 3,000 elderly Arkansans to use money once reserved for nursing home care for adult day-care centers or home health-care programs.⁷⁹ Proponents believe that in the long run the program will save more than it spends as it gives older citizens an opportunity to stay in their homes rather than move into nursing homes. In

a speech before a joint session of the legislature, Clinton said, "Elder Choice is not just an economic decision, it is a civil rights opportunity for the older people of the state."⁸⁰

Clinton also uses Elder Choice as an example of how to improve Medicare. In March 1992, Clinton spokesman Bruce Reed stated, "Governor Clinton believes we need to expand Medicare to provide more long-term care for the elderly."⁸¹ It was further reported that "Clinton would duplicate an Arkansas pilot program called Elder Choices, under which ailing seniors can opt for such things as home health care or going to an adult day care center rather than straight to a nursing home."⁸²

Clinton is on record as opposing the 1990 proposal to raise deductibles for Medicare participants. He said, "a lot of people in Arkansas on Medicare are a long way from being middle-class folks Before I raised deductibles on Medicare, I'd equalize the tax rate for the people making \$100,000 a year and people making a million."⁸³ In January 1992, Clinton said he would not back a proposal which asked those making over \$125,000 a year to pay a higher Medicare premiums. He stated,

If you want to say, well the wealthiest of our entitlement recipients should pay some more, then that's part of a fairness program that's going to give health care to all Americans and control costs But to throw more money down this rat hole that we've got today where \$50 billion a year is being wasted in our system of insurance finance it is to me unconscionable I don't want to make any American pay more for the same health care.⁸⁴

Clinton successfully used this as a wedge issue against Paul Tsongas in the Florida primaries. Tsongas supported means testing of entitlement programs. Clinton was opposed to this during the primaries and ran advertisements against Tsongas in Florida. However, in June 1992, Clinton stated,

I also think that in an attempt to control the cost of entitlements, people at very high income levels, who are getting back more from Medicare than they pay in, should pay more for this as part of a comprehensive long-term plan So I would raise the fees for high-income recipients as a part of national health care reform.⁸⁵

Nursing Home Violations

In 1989, over 14 percent of the residents of Arkansas were 65 years and older, ranking them 4th highest in the country with seniors.⁸⁶ Many of these residents live in nursing homes. As of 1987, there were 279 nursing homes in Arkansas.⁸⁷ A 1986 GAO report, commissioned by the Senate Aging Committee indicated severe problems with nursing home care in Arkansas. According to the report, a quarter of all the skilled nursing homes in Arkansas were "chronically deficient" in patient care, 3rd worst in the country, and nearly two thirds of Arkansas homes, (61 percent), had at least one major deficiency in 1984, also one of the highest in the country.⁸⁸ Clinton

responded to this report by insinuating that because Arkansas has strict reporting regulations, the numbers are more negative than states which do not report as vigorously. He stated, "I am relieved to learn from Mr. Scott's analysis that the statistics clearly show that we are diligent in inspecting nursing homes. In fact, our strong efforts to protect the residents could possibly be the cause of the so-called high ranking."⁸⁹ Ray Scott, then director of the state Health Department recited statistics from his internal survey as a response. The *Arkansas Gazette* reported on the review,

While Arkansas has only 1.5 percent of the skilled care nursing homes in the country, in 1985, 17 homes were found out of compliance and 'adverse actions' were initiated against them. That represented 9 per cent of the 200 homes placed out of compliance in the county.

Last year, three homes in the United States were terminated from the Medicare and Medicaid programs. Termination closes the homes. One of the three was in Arkansas.⁹⁰

The *Gazette* article also reported that the state had levied "\$19,500 in fines on seven homes between September 1985 and April 1986 for violations that led to or created the possibility of death or harm to residents."⁹¹ Also, between February 1985 and March 1986, "seven homes received notice of violations for not maintaining health and safety standards, and three homes were given notice of violation between March 1985 and April 1986 for not completing proper reports."⁹²

Medicaid in Arkansas

In 1989, Congress mandated new Medicaid programs which increased states' costs. Clinton, as well as the NGA, claimed that states should have the right to determine individual programs that best suited them. In Arkansas the Medicaid mandates for 1989 consumed nearly a third of the state's new revenues for the year. "We don't deny that we've been partners in asking for more Medicaid for maternal and child health," said Clinton.⁹³ But other mandates were imposed without consulting those being forced to foot the bill. "We didn't ask for nursing-home reform," said Clinton, "... And we didn't ask to be part of the catastrophic health plan ... nobody thought about what the practical impacts are."⁹⁴ According to the Department of Human Services Economic and Medical Services, new federal mandates making more people eligible for Medicaid, expanding the program's scope and increasing reimbursements to providers, pushed estimated Medicaid costs up to \$344 million for the budget year beginning July 1, 1990. The Medicaid program is funded with 3 federal dollars for every 1 state dollar.⁹⁵

By June 1990, Clinton was complaining about federally mandated programs. "I want to make it absolutely clear that the problem is the result of federally mandated programs, which were passed by Congress after the last legislative session"⁹⁶ And

by August 1990, Arkansas had discontinued the medically needy component of its Medicaid program for adults over age 21. The action was taken in response to the growing cost of federal mandates expanding the scope of Medicaid coverage. State officials estimate that between 1985 and 1990, the mandates have added 20,000 new clients, 80 percent of whom are children, to the program's rolls and raised the state's annual Medicaid expenditures by \$68 million.⁹⁷

To help off-set the new expenditures, in July 1991, Arkansas adopted a controversial arrangement under which states impose a tax on hospitals or solicit "voluntary donations" from them to pay part of the state's share of Medicaid. That increased the amount of federal matching funds a state receives and allows states to increase their spending as well.⁹⁸ Arkansas's 15 percent Medicaid excise tax is expected to raise \$30 million annually. The state agrees to match the \$30 million, attracting \$180 million in federal money.⁹⁹ In August 1991, the Bush administration called for a halt to federal matching funds for money donated to states by health care providers, and blamed these "sleight-of-hand" schemes for increasingly driving up federal costs.¹⁰⁰

Clinton and the NGA oppose the Bush administration decision. In an August 1991 speech to members of the American Association of Retired People, Clinton criticized Bush saying, "The same president that signed all those Medicaid mandates ... that forced states to spend billions and billions of dollars basically said, 'By the way, we're going to tell you [you] can't raise money the way you want and you have to tax all your people.'"¹⁰¹

In October 1991, Clinton said he would pay for better health coverage by moving to control health care costs, something he was unable to do in Arkansas. But he conceded there may be "some extra revenue" to be found without huge tax increases.¹⁰² By December 1991, however, Clinton had articulated his plan in which he promises affordable national health care insurance coverage for all Americans, emphasizing "a substantial increase in publicly funded -- not necessarily publicly operated -- community primary and preventive health-care clinics in rural areas and in inner city areas."¹⁰³

Rural Health Care Statistics

- Population in rural areas: As of 1988, 60.3 percent of all Arkansas residents lived in rural areas, ranking them 10th highest in the country.¹⁰⁴ In 1980, only 48.4 percent of Arkansans lived in rural areas.¹⁰⁵
- Physicians to populations in rural counties: In 1985, there were 8 small counties registered as the smallest of non-metropolitan counties (those with under 10,000 residents). In those 8 counties there was only 34.6 physicians per 100,000 residents and only 4.3 percent of those were Doctors of Osteopathy. The physicians per residents figure was the 29th worst out of 32 states in the Congressional Office of Technology Assessment report.¹⁰⁶

- **State's Effort Level:** The U.S. Department of Health and Human Services ranks states in their level of effort in Health Professions Distribution compared with their unserved and non-urban populations. They base their rankings on the number of programs, funding, and number of participants in the program. In the 1986 report, Arkansas had a 3 level of effort with 4 being the worst. This report also indicated that there were 177,000 Arkansans listed as the unserved population.¹⁰⁷

Rural Health Care Initiatives

The rural health care issue has reached crisis proportions in Arkansas. However, the state has done little to address the issue. According to the September 1990 *Health Care in Rural America* report, produced by the Congressional Office of Technology Assessment, Arkansas lacks a single certified rural health care clinic. This same table shows that 65 counties in Arkansas are designated as medically underserved and could qualify for certification.¹⁰⁸

In 1990, Clinton confronted this by providing \$800,000 in state and federal grants to 29 rural hospitals and emergency care providers. He used this opportunity to exclaim: "We can provide Medicaid health insurance for pregnant mothers and children but we've got to get people out there to rural Arkansas to give health care ... if we're ever going to get the infant mortality rate down."¹⁰⁹ Dr. Joycelyn Elders, the Director of the Health Department, also added, "The major problem is the access to basic primary care, acute care and emergency services."¹¹⁰ The remarks are true in their implication of the serious problem Arkansas faces regarding the providing of health care in the rural areas. The \$800,000 sounds good, but it amounts to only \$29,586 per hospital.

In 1991, the legislature attempted to expand rural health care assistance, by approving a bill to "create a rural health commission to develop rural health-care initiatives and recruit physicians to rural areas."¹¹¹ This bill would have also prioritized the locating of federal money to assist rural health care initiatives.¹¹² Governor Clinton vetoed this bill. He reasoned that these functions were already being performed by the Office of Primary Care in the State Health Department and that it would cost \$600,000: "In an effort to give the new acts a chance to work and not to cause the unnecessary expenditure of state money, I am disapproving the bill."¹¹³ Some legislators saw this as an attempt to protect the Health Department's turf at the expense of those in need. Senator Lewellen stated: "With all the problems faced by the Health Department, it has more than it can say grace over already The responsibility is much larger than the Health Department can handle, and the only people who will suffer will be the people in the Delta and other rural areas."¹¹⁴

- 50 Senate kills measure to require AIDS testing. April 4, 1987.
- 51 Law aimed to provide free testing for ADIS. Arkansas Gazette, July 2, 1987.
- 52 Governors group hears from second Arkansas. Arkansas Gazette, July 28, 1992.
- 53 Sheriffs want safeguards against AIDS. Arkansas Gazette, December 4, 1987.
- 54 Clinton, Nelson differ on abortion, teen-age pregnancy. Arkansas Gazette, October 4, 1990.
- 55 AIDS needs attention like to state reaction to quake. Arkansas Gazette, December 2, 1990.
- 56 AIDS needs attention like to state reaction to quake. Arkansas Gazette, December 2, 1990.
- 57 Arkansas Laws, Act 289.
- 58 Arkansas Laws, Act 575.
- 59 New AIDS laws should help assure protection. Arkansas Gazette. April 7, 1991.
- 60 New AIDS laws should help assure protection. Arkansas Gazette. April 7, 1991.
- 61 Jobs-at-risk and their demographic characteristic associated with mandated employer health insurance plan. CONSAD Research Corporation. 1992
- 62 1991 Statistical Abstract. Source: U.S. National Center for Health Statistics
- 63 Statistical Abstract 1991: Source: U.S. National Center for Health Statistics, Vital Statistics for the United States.
- 64 Reforming the Health Care System, State Profiles 1990, AARP.
- 65 1991 Statistical Abstract. American Health Association.
- 66 U.S. Bureau of the Census, Statistical Abstract of the United States: 1990.
- 67 Arkansas Statistical Abstract. UALR: Source: Health Insurance Association of America, 1986-1987 Sourcebook of Health Insurance Data.
- 68 Statistical Abstract: Physicians: American Medical Association, Chicago, Ill. Physician Characteristics and Distribution in the U.S.
- 69 Reforming the Health Care System, State Profiles 1990, AARP
- 70 Arkansas Statistical Abstract/UALR: Source American Medical Association, Physician Characteristics and Distribution in the U.S.
- 71 Statistical Abstract: Physicians: American Medical Association, Chicago, Ill. Physician Characteristics and Distribution in the U.S.
- 72 Health care in Rural America. Congress of the United States, Office of Technology Assessment. September 1990. Pg. 253. Source: U.S. Department of Health and Human Services, Sixth Report to the President and Congress on the Status of Health Personnel in the United States, June 1988-90
- 73 Reforming the Health Care System, State Profiles 1990, AARP
- 74 1991 Statistical Abstract: Source: U.S. National Center for Health Statistics, Vital Statistics of the United States, annual.
- 75 Reforming the Health Care System, State Profiles 1990, AARP
- 76 Reforming the Health Care System, State Profiles 1990, AARP
- 77 Arkansas Gazette, Legislators support home care would allow elderly to avoid institutions, 11/20/86.
- 78 Glenwood Herald, New laws to benefit older Arkansans, 7/11/91.
- 79 Arkansas Democrat, Take long-term care out of Medicaid, 7/11/91.
- 80 Glenwood Herald, New laws to benefit older Arkansans, 7/11/91.
- 81 Elderly Hit by Failing Health Care. Newday, March 6, 1992.
- 82 Elderly Hit by Failing Health Care. Newday, March 6, 1992.
- 83 Clinton opposes parts of federal budget plan. Arkansas Gazette, October 3, 1990.
- 84 Ny Democrats want Cuomo as Favorite Son. Ruter News Report. January 5, 1992
- 85 Clinton wants to make affluent elderly pay more for Social Security, Medicare. Wall Street Journal, June 10, 1992.
- 86 Reforming the Health Care System, State Profiles 1990, AARP
- 87 Desertifying nursing homes to be sought. Arkansas Gazette, February 19, 1987.
- 88 Clinton suggest link in strong state effort, poor ranking of homes. Arkansas Gazette, May 27, 1986.
- 89 Clinton suggest link in strong state effort, poor ranking of homes. Arkansas Gazette, May 27, 1986.
- 90 Clinton suggest link in strong state effort, poor ranking of homes. Arkansas Gazette, May 27, 1986.
- 91 Clinton suggest link in strong state effort, poor ranking of homes. Arkansas Gazette, May 27, 1986.

- 92 Clinton suggest link in strong state effort, poor ranking of homes. Arkansas Gazette, May 27, 1986.
- 93 CQ Almanac, pg. 173, 1989.
- 94 Ibid
- 95 Arkansas Democrat, DHS to cut \$40 million in Medicaid services for year, 6/21/90.
- 96 Ibid
- 97 State Health Notes, October 1990, pg. 6.
- 98 AP, States say they're not to blame for soaring Medicaid costs, 7/11/91.
- 99 Arkansas Gazette, Medicaid taxes may be set aside, 8/19/91.
- 100 AP, States say they're not to blame for soaring Medicaid costs, 7/11/91.
- 101 AP, New Medicaid rule may not apply to Arkansas, 9/12/91.
- 102 AP, Clinton, Harkin boost health care, disdain tax hike, 10/6/91.
- 103 Arkansas Democrat Gazette, Clinton defends health care plan, 12/20/91.
- 104 Reforming the Health Care System, State Profiles 1990, AARP
- 105 Health care in Rural America. Congress of the United States, Office of Technology Assessment, September 1990. Pg. 39
- 106 Health care in Rural America. Congress of the United States, Office of Technology Assessment, September 1990. Pg. 239 - Source: The Adequacy of Physician supply in small rural counties. Health Affairs, VI. 8 no. 2, 1989 pp 63-76.
- 107 Health care in Rural America. Congress of the United States, Office of Technology Assessment, September 1990. Pg. 364. Source: U.S. Department of Health and Human Services, Compendium of State Health Professions Distribution Programs, 1986.
- 108 Health care in Rural America. Congress of the United States, Office of Technology Assessment, September 1990. Pg. 127.
- 109 \$800,000 Ok'd for rural hospitals. Arkansas Gazette, September 20, 1990.
- 110 \$800,000 Ok'd for rural hospitals. Arkansas Gazette, September 20, 1990.
- 111 Rural Health Commission Vetoed. Arkansas Gazette, April 12, 1991.
- 112 Rural Health Commission Vetoed. Arkansas Gazette, April 12, 1991.
- 113 Rural Health Commission Vetoed. Arkansas Gazette, April 12, 1991.
- 114 Rural Health Commission Vetoed. Arkansas Gazette, April 12, 1991.

STATEMENT BY SECRETARY OF LABOR LYNN MARTIN
JANUARY 9, 1992

I am pleased to be joined here today by Secretary Louis Sullivan, my colleague at the Department of Health and Human Services. Together we will outline for you the results of a study of the "pay-or-play" health care proposals.

The Labor Department has regulatory responsibilities for employer-sponsored health care plans. Because of this, and because the Administration and the Department are concerned about access to health care, the Pension and Welfare Benefits Administration asked the Urban Institute to take an objective look at the effects various health care proposals would have on workers and on their jobs.

The research has concluded that a comprehensive pay-or-play proposal with a seven percent payroll tax on employers -- and that is the tax usually suggested -- might mean broader health care coverage. But the costs and the changes in how workers are covered would be oppressive.

Since most employers now spend more than seven percent of their payroll costs for health insurance for their workers, many of them would stop offering insurance and just pay the seven percent tax. Millions of workers who now have employer-sponsored plans would be thrown into the public plan, losing both their freedom to choose the type of coverage they want to have and their access to private health insurance coverage.

Our study found that an estimated 112 million people would be covered under the government plan. This would create a public plan approximately four times as large as Medicare -- with

all the red tape, bureaucracy, uncertainty, and delay of large government bureaucracies. In addition, almost 52 million people who now get their health care through an employer-sponsored plan would be forced into the government plan.

A pay-or-play plan of this magnitude would also cost taxpayers \$36 billion a year more than what the Federal government now spends on health care.

On top of this \$36 billion tax increase, employers would have an added bill of \$30 billion a year to pay for the costs of covering employees who now don't have insurance. Of course, we need a plan to improve the coverage for uninsured Americans. But insurance will ring hollow if it comes at the price of a job.

Pay-or-play would strike at the very sector of the economy that was the engine of job creation in the 1980's and is looked to for new jobs in the 1990's. Small employers -- those with fewer than 25 workers -- would see their health care costs increase by 71 percent. Costs on average would rise 13 percent for firms with more than 1,000 employees. To absorb these costs, companies would be forced to cut other benefits, halt wage increases, or eliminate jobs, harming the very people we are trying to help.

As Secretary of Labor, my concern is for the well-being of America's working men and women and their families, and I can't sit by and let their interests be damaged by poorly conceived proposals.

Pay-or-play is misnamed: it is pay and pay and pay ... and pay -- by the middle class. Pay-or-play is a great name. Regrettably, a great name doesn't make a great plan. A lot of good people want this to work but, it doesn't. Pay-or-play is backdoor national health insurance, it reduces choice, it is a health plan managed by politicians, and means fewer jobs. This doesn't mean today's system is perfect. But pay-or-play is no answer to our problems in health care.

I have summarized just some of the major findings of our research. The economic model that was used in our evaluation builds on a system that has been used extensively to evaluate various public policies over the past twenty years. The enhanced model integrates data describing employment-based health plans and employers' average payrolls with a representative sample of Americans from the March 1990 Current Population Survey. The model replicates employers' decisions either to provide insurance or to pay a payroll tax by comparing workers' health insurance costs to optional payroll tax payments. It can evaluate the effects of employers' decisions on the nonelderly population in the U. S.

Secretary Sullivan will now make a statement and then we will be pleased to answer your questions.

FOR RELEASE UPON DELIVERY
THURSDAY, JANUARY 9, 1992

*REMARKS BY

LOUIS W. SULLIVAN, M.D.

SECRETARY OF HEALTH AND HUMAN SERVICES

REGARDING THE STUDY ON "PAY-OR-PLAY" LEGISLATION
CONDUCTED BY THE URBAN INSTITUTE FOR
THE U.S. DEPARTMENT OF LABOR

WASHINGTON, D.C.

*THIS TEXT IS THE BASIS OF SECRETARY SULLIVAN'S ORAL REMARKS.
IT SHOULD BE USED WITH THE UNDERSTANDING THAT SOME MATERIAL MAY
BE ADDED OR OMITTED DURING PRESENTATION.

The study released today by Secretary Martin documents one thing I have been saying about health care reform since becoming Secretary of Health and Human Services: that any reform package must avoid placing overly burdensome mandates on businesses, particularly small businesses.

Without job creation -- or worse, with job destruction -- we could end up with more, rather than fewer, persons lacking health insurance. People can't get employer-sponsored health care if they don't have jobs. We need to find solutions that leave us better off than when we started, not worse.

That is why the research done by the Department of Labor is especially important. The effect of health care reform proposals on the workplace is an essential element in the debate -- one that has received far too little attention in some quarters. The information provided here today fills in some alarming gaps in our knowledge of pay-or-play. This study shows that pay-or-play proposals would result in lost jobs, higher employer costs, higher taxes, and a huge new government-run health program.

One of the most startling results of the study is the size of the public plan. As Secretary of HHS, I know how difficult it is to manage and control health care spending. The last thing we need is a new tax-subsidized government-run plan four times the size of Medicare.

Furthermore, pay-or-play would constitute a fatal step down

a slippery slope toward nationalized medicine. We need to build on our achievements by getting an even higher percentage of people covered by insurance, rather than replacing our system with something that Americans do not need and would not tolerate.

Now I acknowledge that a number of individuals, as well as some commissions and study groups, have advocated the "pay-or-play" solution. I don't question their sincerity. But I do think this study shows that they have not looked hard enough at the true ramifications of such a plan.

The fact is, "pay-or-play" is the wrong medicine, and we shouldn't take it. In fact, what this medicine really needs is a strong warning label -- and Secretary Martin's report today tells us just what that label should say.

Some people like "pay or play" because it's easy to understand -- but that does not make it a solution that will work. We can do better by the American people -- much better. It is unacceptable and unnecessary to put real jobs in jeopardy in order to address our nation's health care needs.

#