ECONOMIC BRIEFING/ PUNDITS

Insurance Market Reform

INSURANCE MARKET REFORM PRESENTATION

I. GOALS OF HEALTH REFORM

Message: It is universally accepted that the current system needs insurance market reform in order to achieve the goals of health reform.

- Make insurance more accessible/available
- Make insurance more affordable
- Increase coverage (reduce number of uninsured)

II. OVERVIEW OF CURRENT SYSTEM

Message: The current system, which has incentives for insurance companies to keep costs down by only insuring healthy people, leaves many insured people worried about losing insurance or not being able to pay for it and excludes others entirely from the insurance system.

- Preexisting condition exclusions lock people into jobs and insurance plans and keep others from being able to purchase coverage.
- Insurance companies can drop people from coverage as soon as they get sick and actually need their insurance.
  - It's not true insurance if you can be dropped from coverage when you finally need it.
- Experience rating means that insurance is often not affordable.
  - Insurance is the most expensive for the people who need it the most, and can increase when you get sick.
  - People in small groups can face high premium costs when someone <u>else</u> gets sick.
  - Charging different groups different rates can lead to high administrative costs

- Some people argue that charging people who use care higher prices serves as an incentive for them to use less care, but these costs are often beyond people's control.

III. REFORMS

Message: There are some frequently cited and accepted ways people think will address these problems of limited access and affordability.

- Eliminate pre-existing condition exclusions
  - Intended to eliminate job lock and free people from current insurance plans.
  - When people are locked into their insurance, insurance companies face fewer incentives to compete.
- Guaranteed issue and renewability
  - Means that insurance companies cannot deny anyone coverage and cannot drop people when they get sick.
- Community rating
  - Guarantees that everyone in a particular area is charged the same rate, regardless of health status.

IV. INCREMENTAL REFORMS

Message: Some people believe that health care reform can stop with incremental insurance market reform. But these reforms don't work without universal coverage.

- We can't get rid of pre-existing condition clauses.
  - In a totally voluntary system, people won't buy insurance until they're sick.
  - That's like selling homeowner's insurance when the house is already burning.

- So, for example, the reforms proposed by Senator Dole or the bill that was reported out of the Senate Finance Committee only prohibit pre-existing condition clauses for people who were previously insured. That leaves the uninsured or people who can't afford to keep their coverage in the lurch.

- We can't go very far with equalizing premiums through community rating.

  -Community rating is intended to provide real insurance for every individual -- insurance the provides a guarantee into the future that health costs will not change at the moment when someone gets sick or as soon as someone has another birthday. While young healthy people may see their insurance premiums increase initially, over time they will experience the benefits of steady, predictable costs that cannot be inflated at the will of individual insurers.

  - Community rating smooths out the variation in premiums, so that no one will have to pay really high premiums.

  - When everyone is charged the same premium, sick people who have not had access to affordable insurance flood into the system, increasing premiums for everyone.

  - When premiums go up, some healthy people choose to drop their insurance, further driving up premiums, which may lead even more healthy people to drop coverage.

- The likelihood that healthy people will drop their insurance when you move to community rating is even greater when insurance companies are forced to take all comers and pre-existing conditions are covered.

  - High-cost cases who have previously been denied coverage come flooding into the insurance system, which also drives up premiums.

- And let's not forget that people have less of an incentive to buy insurance when they know that they won't really be denied services and won't really have to pay their hospital and doctor bills in a desperate situation.

- So we're stuck in a Catch-22 situation, and in a voluntary system, there's no way out.

  - We could get some of those healthy people into insurance plans if we could lower the premiums.

- But we can't get the premiums down without them in the system.

V. CONCLUSION

Message: So in the name of increasing access and affordability, we may actually end up with a decrease in affordability and an increase in the number of uninsured in the system. At best, we only get marginal increases in the number of people who get coverage under these non-universal plans.

- Insurance companies will still have incentives to waste resources trying to attract the healthiest people.

- Individuals will still face incentives to free ride on the system.

AND STUDIES SHOW THAT THESE NON-UNIVERSAL PLANS JUST DON'T GET AS FAR AS THEY MIGHT CLAIM TO:

- CBO estimates that the Cooper plan -- considered the best of the incremental plans -- leaves 24 million people uninsured, 16 million of them in the middle class.

- Internal estimates show that the Dole plan will leave over 30 million Americans uninsured.

FACTS ABOUT INSURANCE REFORM

- **There is nothing new about community-rating, open enrollment, and other health insurance market reforms.**

  Blue Cross and Blue Shield plans used to sell health insurance on this basis, and they dominated the individual and small-group markets. However, as health care costs started to sky-rocket, healthy individuals and small groups began to demand lower, experience-rated premiums. As the healthier part of the community-rated pool dropped out, claims increased even faster than health care inflation. Now, hardly anyone sells community-rated insurance.

- **If you line up everyone in an insurance plan according to their predicted claims, the last 1 percent add about 10 percent to the premium.**

- **Typical individual premiums without insurance market reforms:**

  A recent newspaper article featured stories about uninsured families that were quoted premiums ranging from $300 to $500 per month for individual coverage with a $2500 deductible. (NYT 7/11/94).

  Employers generally spend about that amount for much more generous coverage, thanks to the efficiencies of group purchasing and the fact that adverse selection is avoided when employees are enrolled as a group.

- **Premium differences with unrestricted age-rating:**

  Without community-rating for nongroup insurance, a 64-year-old may pay 4 to 6 times as much for insurance as a 20-year-old. (Robert Pear, NYT 5/22/94)

- **Most of the uninsured have no access to insurance from an employer. Their only alternative is to buy coverage in the individual market, where premiums are inflated by adverse selection and insurance companies charge a lot more for marketing, administration, and risk.**

  Of Americans under 65 without employer-sponsored insurance or Medicaid, only a third buy individual insurance. The rest are uninsured. [EBRI, 1994]

9 out of 10 uninsured workers are not offered insurance by their employers. Only 1 out of 10 are actually offered coverage and choose not to take it. [Farley, Pam et. al, "The Employed Uninsured and the Role of Public Policy, Inquiry, Winter 1985]

- **CBO estimated that the cost of the HSA benefit package would be about $400 more per family in the voluntary system proposed by Representative Cooper than under a universal system like the HSA.** [CBO "Analysis of the Managed Competition Act" April 1994]

- **Some estimates suggest that up to 80 million Americans have preexisting conditions that could be excluded from any new coverage or would require payment of a higher premium.** [Economic Report of the President, Council of Economic Advisers, 1994]

ADDITIONAL NOTES ON HEALTH INSURANCE

Reinsurance and/or risk-adjustment systems are a necessary part of mandatory community-rating.

Without reinsurance or risk-adjustment, plans have a strong incentive to avoid selling to heavy users of health care at community rates. Even if the law requires plans to sell to everyone who wants to buy, plans can make themselves unattractive to heavy users by manipulating the nature and quality of the services that are offered to such people.

Without reinsurance or risk-adjustment, community-rating actually penalizes plans for providing good, effective services to the unhealthy people who need them most.

One of the biggest problems with controlling costs by underwriting (or screening out bad risks) is that it's only a temporary solution:

An insurer approaches a small group and offers an usually low premium. As part of the deal, the insurer excludes a couple of people from the plan and limits claims for some others with pre-existing conditions. Unfortunately, as time goes on, other people get sick--and the insurer can no longer cover the claims at the old premium. So either the premium goes up dramatically, or the group switches to another insurer and starts the process all over again.

The term, "**underwriting**," refers to the variety of practices aimed at screening out claims for identifiable risks (pre-existing clauses, denying coverage on the basis of medical conditions).

The term, "**underwriting cycle**," refers to the upward path of premiums after underwriting new enrollment. The initial premium is lowered by weeding out bad risks, but the effect inevitably wears off over time.

ROADMAP TO INSURANCE REFORM READING MATERIALS

1. **Insurance Market Reform section of the Economic Report of the President**

   - Provides an description of the current health insurance market and explains several terms, including adverse selection and community rating. Explains the need for universal coverage with insurance market reform.

2. **Edwin Chen, LA Times, "Peril Seen in Reform Limited to Insurance"**

   - Best article on the need for universal coverage with insurance market reform.

3. **Robert Pear, New York Times, "Pooling Risks and Sharing costs in Effort to Gain Stable Insurance Rates"**

   - Excellent discussion of issues surrounding the insurance reform debate. Includes a defense of the New York experience.

4. **Hillary Stout, Wall Street Journal, "Community-Rated Health Plans Prove Popular but Success May Depend on Universal Coverage"**

   - Makes the case for universal coverage with community rating, preexisting conditions, guaranteed issue and renewability. Uses New York as evidence for how things do not work without universal coverage.

5. **Leslie Scism, Wall Street Journal, "New York Finds Fewer People Have Health Insurance a Year After Reform"**

   - Good data on New York experience.

6. **Steven Pearlstein, The Washington Post, "Adjusting Insurance: Is It Health Reform?"**

   - Even more on insurance market reform and universal coverage.

7. **Neil Howe and Bill Strauss, "A Hidden Tax on Young People"**

   - FYI on intergenerational cost-shift with community rating.

Economic Report of the President, 1994

Box 4–1.—Moral Hazard and Adverse Selection

All insurance markets face two potential problems. The first, called moral hazard, involves incentives. Insurance may encourage those who are covered to use insured services more than they otherwise would, or it may discourage the insured from taking steps to lower their need for such services. Insurance against any kind of risk—including health risks—always involves some element of moral hazard. When people use health services more than they would without insurance, the total amount insurers must pay increases, and they in turn must increase their prices. Furthermore, because individuals pay less than the full social cost of the services they receive, too much of society's resources will be devoted to such services.

The second problem is adverse selection. People who know that they are more at risk than others of falling ill are more likely to purchase health insurance. Therefore, insurers who set their prices at the average cost for the population as a whole are likely to discover that their prices do not cover their costs, because their customers are on average sicker than the population at large. To address this problem, insurers have incentives both to charge prices that exceed the cost of covering the average person and to select risks as best they can. The higher prices of insurance that result from adverse selection have the perverse effect of discouraging some healthy people from purchasing insurance. Because of the adverse selection problem, all people must be required to purchase insurance if each of them is to be charged the average cost of providing insurance.

adverse selection

INSURANCE MARKET REFORM

Private insurance markets have a number of shortcomings that impede the realization of universal coverage.

INSURING MAJOR RISKS AND PREEXISTING CONDITIONS

Economic theory suggests that *at a minimum* well-functioning insurance markets should insure against the expenses that accompany large medical risks because those are precisely the ones that cause the most financial hardship to individuals and families, are the least susceptible to moral hazard, and have the lowest administrative costs as a share of benefits. In our current system, however, private insurance markets often fail even when judged against this minimal standard.

About 80 percent of conventional health insurance policies have limits—generally ranging from $250,000 to over $1 million—on the amount that the insurer will pay over the policyholder's lifetime. Many insurers also initially exclude coverage of "preexisting conditions"—health problems that exist before the policy takes effect. A typical rule, for example, is to exclude for 6 months a condition that was present in the 6 months prior to joining a plan. Some estimates suggest that up to 80 million Americans have preexisting conditions that could be excluded from any new coverage or would require payment of a higher premium.

pre-existing conditions

Both the exclusion of coverage for preexisting conditions and the limitations on maximum lifetime payments are ways that insurers respond to the adverse selection problem discussed in Box 4–1. Such practices also reflect the fact that insurers who know in advance about the likely health status of their potential policyholders can choose which risks they are willing to insure and which they are not, and can choose to charge different prices to different individuals based on this assessment.

Such common insurance practices may be privately optimal for individual insurers, but they are not socially efficient. People with preexisting conditions and people who have exhausted their lifetime insurance limits may still require care, and someone must bear the costs. If they cannot obtain private insurance and they have exhausted their own funds, either they will get insurance through public sector programs, such as medicaid, or the costs of their care will be shifted onto the premiums of those who are able to obtain insurance. By compelling all insurers to cover preexisting conditions and by eliminating limitations on lifetime payments, the government could reduce the adverse selection problem in private insurance markets and thereby improve how they function.

cost-shift

competition improves

COMMUNITY RATING

A second essential component of insurance reform is "community rating"—charging everyone in a large group the same price regardless of individual differences in demographic or health status. Currently, health insurance is often experience rated—the price for members of a particular group is based in whole or in part on that group's expected utilization of insured services. However, there are strong reasons for requiring community rating.

The rationale for any kind of insurance is to spread costs throughout the insured population. Complete health insurance would spread the cost of care across everyone in the population, regardless of their health status. Similarly, complete insurance would guarantee that the price paid by each individual for coverage would be the average cost of such coverage for the population. In contrast, experience rating means that the price one pays for insurance var-

ies depending on one's health status. But at least for those health problems and their associated costs that individuals cannot influence by their behavior, experience rating is at odds with the basic function of insurance—to insure against risk.

In principle, of course, one can distinguish between those health risks that individuals can influence and those that they cannot, and apply experience rating to the former. In practice, however, this is often difficult to do, because it would require detailed monitoring of personal behavior. In addition, many major health risks, with the obvious exception of those associated with smoking, are linked quite imperfectly to individual behavior, or the medical profession's understanding of the linkage remains rudimentary. Based on these considerations, community rating of health insurance, and continued public programs to deter smoking, are appropriate elements of health insurance reform.

Community rating and universal coverage

However, community rating is difficult to enact without complementary reforms. The adverse selection issue described in Box 4–1 is one potential problem, which universal coverage could address by requiring people to have coverage. A related problem stems from the fact that insurers who are compelled to charge a community rate will have incentives to seek out the healthiest consumers, because they can be covered for the lowest cost and thus are likely to yield insurers the highest profits. This risk selection may involve high administrative costs, for example in determining the medical history of each member of a group. Resources devoted to this activity increase the overall costs of health care without providing any additional health benefits.

Several steps could be taken to minimize the possibility of such selection. First, a system of "risk adjustment payments" could be designed—monetary transfers from plans that have a healthier mix of enrollees to plans with a sicker mix of enrollees. If risk adjustment perfectly compensated for true differences in health risk, it would eliminate the incentives for selection on the part of insurers.

Second, all insurers could be required to offer the same package of benefits, thereby eliminating the opportunity to use the variations in the benefits package to attract better risks. Finally, "guaranteed issue" and "guaranteed renewability" of insurance could be required—that is, people could not be denied the right to enroll initially or renew enrollment in a health plan because of demographic or health status.

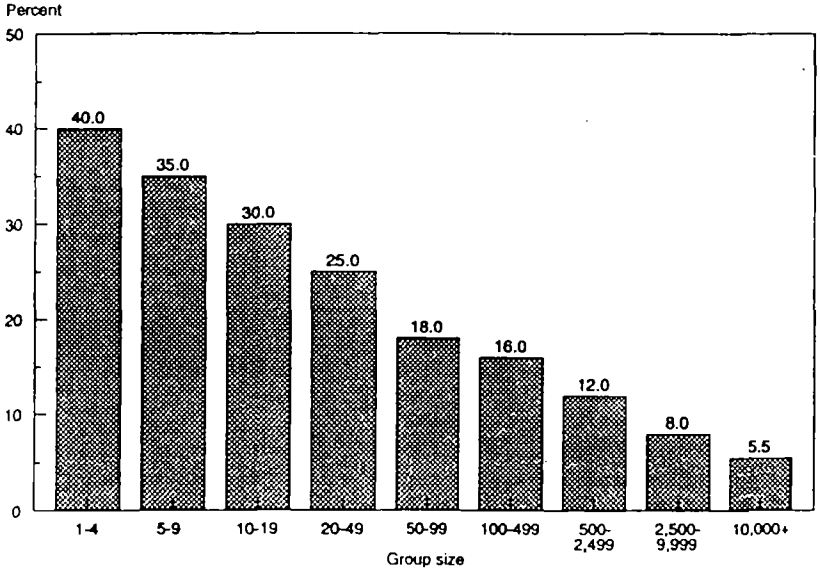
REDUCING ADMINISTRATIVE COSTS

In part because of the experience rating practices of insurance companies, there is insufficient standardization across insurers. Providers must deal with different insurers using different claim forms and covering different sets of services. Lack of standardiza-

tion results in high administrative expenses. In 1991 over 6 percent of all health care expenditures went for administrative expenses. This exceeds total spending on all public health service programs.

Standardizing benefits and billing procedures and increasing the automation of bill payment could produce substantial administrative savings. Grouping small firms and individuals into larger purchasing pools would have the same effect. As Chart 4–3 shows, the administrative load charged by commercial insurers for small groups (1 to 4 employees) averages about 40 percent of claims paid—in contrast to only about 5½ percent for large groups (over 10,000 employees).

Chart 4-3 **Administrative Expenses of Commercial Insurers as Percent of Claims Paid**
Administrative expenses are much higher in proportion to claims paid for small groups than for large groups.



Source: Hay/Huggins Company, Inc.

CREATING A MORE EFFICIENT MARKET AND CONTAINING COSTS

The third problem with the current health care system is that it appears to be far from efficient. As already noted, the United States spends a larger share of its GDP on health care than any other industrialized nation. If Americans valued medical care more

Peril Seen in Reform Limited to Insurance

■ **Health care:** Analysts warn that Congress would be shortsighted to focus only on coverage discrimination.

By EDWIN CHEN
TIMES STAFF WRITER

WASHINGTON—It sounds so simple: Ban insurers from jacking up rates on sick people and force them to accept all applicants, offering the same rates regardless of age or health status.

No single health reform proposal enjoys broader support among the public or members of Congress. And no wonder.

Ending discriminatory insurance practices would instantly allay deep-seated fears of middle-class Americans that they might lose coverage when they change jobs or be priced out of the market when they become seriously ill. In poll after poll, 60% to 80% or more of respondents favor such reforms.

But there's a big hitch.

Unless accompanied by a requirement that everyone be insured, insurance reforms would mean higher premiums for the insured and actually *increase* the ranks of the uninsured.

That's because such reforms would enable the sick and the vulnerable to buy insurance, often for the first time. Their high health costs would force insurers to increase premiums across the board.

What's more, the young and the healthy—confronted by rising rates—might drop coverage, secure in the knowledge that they could buy insurance when they needed it. That in turn would increase premiums for everyone else.

Thus would begin a vicious cycle that, experts say, would hasten the deterioration of the nation's health care financing system.

The prospect is growing that Congress will abandon comprehensive health care reform this year and instead do little more than try to remedy the apparent shortcomings of today's insurance system.

That approach could do more harm than good. Dire warnings of the unintended consequences of insurance reform are being sounded by such disparate analysts and advocates as conservative hospital lobbyist Michael Bromberg and First Lady Hillary Rodham Clinton, architect of President Clinton's agenda for change.

"Insurance reforms will solve many of the problems that the insured, voting middle class is worried about. But it won't control costs or insure the uninsured—the two biggest challenges we face," said Drew Altman, president of the Kaiser Family Foundation, a health care philanthropy based in Menlo Park, Calif.

"You buy some time, but costs will continue to escalate," added Edward F. Howard, executive vice president of the Alliance for Health Reform, a nonpartisan educational group here. "So you lay the groundwork for a bigger explosion in a few years."

Yet, as Congress prepares to begin floor debate on health reform, the appeal of insurance reforms may prove all but irresistible.

Almost every health reform bill introduced in recent years contains such measures—including all four bills reported out recently by two committees in each chamber.

Insurance reforms "solve real problems for real people. And it can happen without turning the system on its head," said Gail Wilensky, a health expert in former President George Bush's White House who now advises congressional Republicans.

Wilensky, former head of the Health Care Financing Administration, said that "it's important for Congress to say to the American people: 'We can do something, and here's one piece, signed, sealed and delivered.' "

She and other advocates of incrementalism acknowledge that insurance reforms alone will do little for the estimated 38 million uninsured Americans. But they say that such measures are a good and realistic beginning.

Opponents argue that insurance reforms alone are doomed to fail unless they are accompanied by a requirement leading to universal coverage, such as Clinton's controversial proposal to require all employers to pay at least 80% of workers' insurance premiums, with individuals picking up the rest.

Insurance reforms alone "just won't work," said Marvin B. Hall, president of the Hawaii Medical Service Assn., the largest insurance company in that state. "You'd push costs even higher."

"Insurance reforms by themselves will increase premiums substantially because you'd be allowing back into the group people who have been excluded primarily because of costs," said John Rother, legislative director of the American Assn. of Retired Persons. "And you haven't done anything at all about the cost of health care."

Among the winners of insurance market reforms, at least in the short term, would be small businesses. Most such reforms being contemplated by Congress would give them a choice of health plans by pooling them into large, voluntary purchasing groups, thus affording them lower rates enjoyed by large groups.

The biggest losers would be younger people, whose rates would rise sharply. "You'll see a bunch that's going to drop out," said Richard I. Smith, an analyst at the Assn. of Private Pension and Welfare Plans. "And what problems are we solving if we end up just producing more uninsured?"

Willis D. Gradison Jr., head of the Health Insurance Assn. of America, agreed, saying that insurance reforms "could easily have just the opposite effect of what is intended." He cited the experience of New York state as a prime example.

There, a law took effect in April of 1993 that barred insurers from setting premiums based on age, sex or health status and required them to guarantee coverage to all.

After just nine months, 40% of policyholders at Mutual of Omaha, the largest underwriter of individual policies in New York, saw their premiums drop, according to Medicine & Health, a weekly newsletter. But 60% experienced increases of as much as 60%.

Meanwhile, the number of uninsured grew by more than 25,000.

Hoping to pave the way for national insurance market reforms as a first step toward broader reforms, Reps. J. Roy Rowland (D-Ga.) and Michael Bilirakis (R-Fla.) have introduced just such a bill, saying that it is "designed to re-establish the health reform debate on a foundation of agreement rather than one of divisiveness."

"Some members have made clear that that's as far as they are willing to go," said Martin Corry, AARP's director of federal affairs. "But we think that's pretty shortsighted."

Wilensky, the Republican consultant, worries that insurance reforms could sap the will of Congress to press on with more comprehensive reforms, such as expanding coverage to the uninsured.

5/22/94

Pooling Risks and Sharing Costs in Effort to Gain Stable Insurance Rates

By ROBERT PEAR
Special to The New York Times

WASHINGTON, May 21 — Few parts of President Clinton's health plan sound so simple as the idea of charging the same insurance premiums to all people in a geographic area, whether they are young or old, sick or healthy.

The goal is to return health insurance to "what it was meant to be, a fair deal at a fair price," Mr. Clinton said last week.

But in health insurance, nothing is simple. While many Republicans agree that the Government should limit the variation in premiums, the idea of such "community rating" raises a host of political, philosophical and technical questions, like these

¶How much will rates go up for young, healthy people, whose premiums are now below the average? Are these people prepared to pay higher premiums in return for greater security?

¶Is it fair to raise premiums for young people while lowering premiums for their parents, who often have higher incomes and greater assets?

¶Is it right to charge the same premiums to smokers and nonsmokers? Should insurers be allowed to give a discount to people who take responsibility for their health, watch their diet and exercise regularly?

¶How should the Federal Government and the states divide responsibility for regulating the price of health insurance, a field long dominated by state officials?

Spreading the Risk

The move toward community rating is a reaction to the experience of the last decade, in which health insurance became prohibitively expensive for many people. Some of these people had a history of illness. Some were healthy, but were considered likely to incur high medical costs. Some were healthy, but obtained their insurance through small groups in which other people ran up high medical bills.

Insurers today charge much higher premiums to people who are old or sick. A 64-year-old may pay four to six times as much as a 20-year-old

Community rating is an attempt to stabilize health insurance premiums by pooling risks and sharing costs. "The principle of risk spreading is essential to equitable insurance," said Salvatore R. Curiale, the Superintendent of Insurance for New York State, which has gone further toward community rating than most states.

In July 1992, Gov. Mario M. Cuomo signed a bill to establish community rating of health insurance policies for individuals and small businesses in New York. Mr. Curiale said that the law, which took effect in April 1993, had been successful.

"The community rating mandate did cause premiums to increase for younger people," he said. "But about 60 percent of the people affected by the change received rate decreases or increases no greater than 20 percent. Individual and small-group health insurance is more available, and it appears that premium rates are more stable."

Marilyn W. Ogden, an owner of Fritz Helmbold Inc., a meat-processing company in Troy, N.Y., said the change probably helped level off the rates her company paid. "For a small business like us, community rating is very helpful," she said. Eight of the 18 employees are over 55 years old, and the company would have to pay higher premiums without community rating.

Gail E. Shearer, manager of policy analysis at Consumers Union, described community rating as "the fairest way to share health care costs" short of a single-payer program financed by the Government with broad-based taxes.

Arthur V. Ferrara, chairman of the Life Insurance Council of New York, a trade association for insurers, gave the experiment a mixed review. "I have to agree with the superintendent to a certain degree," he said. "Thus far, community rating appears to have worked reasonably well from the Insurance Department's vantage point.

"But from the public's point of view, this law has caused tremendous strain on the younger insurance-buying population," said Mr. Ferrara, who is also chairman of the Guardian Life Insurance Company of America. "If senior members of our society pay less, someone else has to pay more. That's the younger members. Many young people have opted to drop their coverage rather than pay the high costs associated with health insurance."

Under Mr. Clinton's proposal, all people would be required to carry health insurance, including the unemployed. Insurers could not reject people because of their medical problems. Employers would pay most of the cost for their workers. The Government would help buy insurance for low-income people, including many of the unemployed.

The American Academy of Actuaries, a professional organization of insurance experts, assessed the likely effects of community rating in a recent monograph.

The academy takes no position for or against community rating, but says policymakers and the public should understand the consequences. In general, it said, "the young would subsidize the old, males would subsidize females at most ages, the healthy would subsidize the sick and the poor may subsidize the wealthy, since younger people generally earn less income than older people."

President Clinton would not allow variation in premiums because of age. But many members of Congress have concluded that some adjustment for age is needed. Many insurers say they can accept a modified form of community rating and see it as inevitable.

The Method

No Incentive To Insure the Well

Simplifying one part of the premium formula immediately creates complexity in other areas.

The idea of pure community rating is that all people with the same coverage should pay the same premiums, regardless of age, sex, medical history or occupation. But obviously it costs more to care for sick people. So most proponents of community rating, including Mr. Clinton, acknowledge that health plans enrolling sicker people should receive more money.

Thus, many experts say that if the Government requires community rating of premiums, it must also have some way of redistributing money from plans with healthy customers to plans with a less healthy clientele.

"Otherwise," said Alice F. Rosenblatt, an actuary at Coopers & Lybrand, the accounting firm, "there

risk individuals. In general, 4 percent of claimants generate 50 percent of claim costs."

Or, as Mr. Curiale said: "We don't want to penalize a company because it takes older, sicker patients. It's inappropriate to have some companies benefit because they have younger, healthier people as customers."

Taking a Regional Average

The device for redistributing money among insurance companies is called a "risk adjustment mechanism." Payments to insurers and health plans are adjusted to reflect the relative risk of their customers, the likelihood that they will incur medical costs in the future.

Under the pooling arrangement in New York, the demographic characteristics of each insurer's customers are compared with a regional average. An insurer receives money from the pool if, for example, it has a disproportionately large number of people who are old or have AIDS. An insurer must contribute to the pool if its customers are younger and healthier than the average.

Ms. Rosenblatt, the actuary, said, "If you require community rating, you must have a risk adjustment mechanism at the same time." In theory, if there were a perfect method of risk adjustment, insurers would have no incentive to seek out low-cost patients. But currently there is no such perfect method.

Under Mr. Clinton's proposal, a new Federal agency, the National Health Board, would have to develop a risk adjustment method by April 1995. The bill does not say how this should be done.

The Age Issue

Should the Young Subsidize the Old?

Older people generally use more health care than young people, but whether they should pay higher premiums is an explosive question.

Representative Nancy L. Johnson, Republican of Connecticut, said insurers must be allowed to consider age as a factor in setting premiums. "Young working people already support the retirement benefits of people over 65," she said. "It would be most unfortunate if those people were also asked to subsidize health insurance premiums of their parents, who have better-paying jobs."

Representative Bill Thomas, Republican of California, said pure community rating could provoke "a generational war." Another Republican, Senator Phil Gramm of Texas, said, "A 27-year-old with three kids shouldn't subsidize a 57-year-old in his peak earning years."

But John C. Rother, chief lobbyist for the American Association of Retired Persons, strongly defended Mr. Clinton's proposal to ban the use of age as a factor in setting premiums.

"The notion that older people are better off doesn't hold when you look at individual cases," he said. "Given early 60's make less than earlier in their careers."

Moreover, Mr. Rother said: "There is pervasive age discrimination in the workplace. Many employers try to avoid hiring older workers because of the higher health costs. Community rating should encourage employers to hire older people."

While insisting that age must be a factor, many insurers are willing to limit the variation in premiums. Mary Nell Lehnhard, senior vice president of the Blue Cross and Blue Shield Association, said the Government might stipulate that the maximum premium for older people would be two or three times the premium for young people. Older people now pay as much as five or six times as much as young people.

Community rating redistributes money in other ways, too. For example, it evens out the costs of health insurance for workers and nonworkers. Nonworkers are believed to have higher medical costs; some are out of work because of health problems.

One result of community rating is that employers would pay higher premiums to subsidize health insurance for nonworkers, said John F. Sheils, a vice president of Lewin-VHI, a consulting concern that specializes in medical economics.

Mr. Sheils said that employers, taken together, would pay $44 billion a year in subsidies for nonworkers. Federal aid for small low-wage businesses would offset $11 billion of this cost under Mr. Clinton's proposal. "The net result is that employers would provide $33 billion a year in subsidies for nonworkers," said Mr. Sheils.

New York

Confident Of Coverage

New York provides the largest demonstration of how a community Clinton proposed. States do not regulate large companies that serve as their own insurers; the New York law applies only to small groups with 3 to 50 workers. If a company sells insurance to such groups, it must take all applicants and set premiums through community rating.

Data compiled by Mr. Curiale's office show that, after the law took effect, premiums increased for nearly two-thirds of all people with individual or small-group coverage from commercial insurers. Premiums doubled for 5 percent of them.

Despite the increases, Mr. Curiale said that coverage was now more secure. "What you had before was an illusion," he said. "If you were young and healthy, the insurance company would accept you. As soon as something went wrong, the rate for you or your group would go sky high. With open enrollment and community rating, you may pay more, but you have stability. You have coverage that can't be taken away."

But Cecil D. Bykerk, chief actuary for the Mutual of Omaha Companies, said: "The first year is not working very well. Since the imposition of pure community rating in New York, the average age of our policyholders has gone up 3.5 years, from 41.5 to 45. That's a very significant rise. Younger people are bailing out. If you're going to have universal access to insurance, which we support, then you need some kind of mandate for people to buy."

One lesson from New York is that the shift to community rating probably ought to be gradual.

In New York, the community rating requirement was applied to all small-group contracts on April 1, 1993. "There was some panic and a lot of uncertainty as April 1 approached," Mr. Curiale said. "Insurers sent out letters telling people, 'Your contract is terminated April 1, and we can't tell you what the cost of new coverage will be.'

"If we did it over again," he said, "we'd make it effective as the old contracts expired."

FOR AND AGAINST

Community Rating of Health Insurance

What it is Requiring insurers to charge the same premiums to all people in a geographic area, regardless of factors like age, sex, medical history or occupation.

How it would work Premiums would be set by averaging the expected cost of insuring everyone in the area. Money would be redistributed among insurance companies to reflect the relative risk of their customers, that is, the likelihood that they will incur medical costs in the future. A health plan with a large share of elderly or sick patients would receive extra money from other companies through a pooling arrangement, not by charging higher premiums.

Arguments for Community rating restores insurance to its original purpose: spreading risks among diverse groups of people. In recent years, insurers have tried to insure only the healthiest people while shunning high-risk customers who most need protection. Insurers should not be allowed to charge higher rates to sick people and older people.

Arguments against Pure community rating is unworkable and inequitable. It will raise premiums for young people while lowering premiums for older people, who often have higher incomes. Insurers also ought to be free to offer discounts to nonsmokers and others with healthy habits.

Who supports it Labor unions, consumer advocates and lobbyists for the elderly favor community rating. They say the market should not be sliced up into different demographic groups.

Who opposes it Big businesses, which generally run their own health plans, do not want to be included in the community rated pool. If their health insurance is community rated, businesses say, they will not get the benefit of savings they achieve through efficient management of their health plans and through programs promoting healthy behavior by employees.

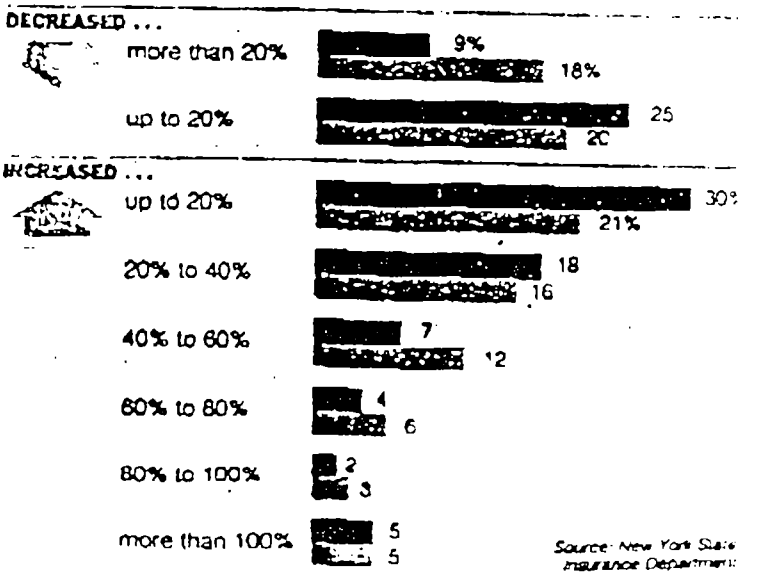
Legislative outlook Congress appears likely to limit the variation in premiums as part of any comprehensive legislation. There is wide support for a modified form of community rating, with some modest variation in premiums on account of age.

CASEBOOK

How Policyholders Fared

As part of a 1992 law regulating health insurance, New York requires community rating of premiums, so that people with the same coverage pay the same amounts without regard to age, sex, health status or occupation.

Below is the percentage of SMALL GROUP and INDIVIDUAL insurance policyholders in New York State whose rates . . .



Source: New York State Insurance Department

Community-Rated Health Plans Prove Popular, But Success May Depend on Universal Coverage

THE WALL STREET JOURNAL WEDNESDAY, JUNE 15, 199

By HILARY STOUT
Staff Reporter of THE WALL STREET JOURNAL

WASHINGTON – It's the health-care proposal everyone loves: the notion that insurance companies shouldn't be allowed to jack up rates for sick people or others at risk of piling up big medical bills.

So attractive is the concept, known as "community rating," that even many Republicans and conservative Democrats say Congress should go ahead and enact it, along with a set of other insurance-market revisions, and forget about universal health coverage for now. A new GOP television advertising campaign pushes for bipartisan insurance-market reforms to "fix health care."

There's just one problem with the idea, experts insist and real-life evidence shows. It probably won't work without universal coverage. Indeed, several of the insurance changes that reformers are clamoring for may depend for their success on bringing nearly everybody into the insurance pool.

For the past year New York state has tried community rating without a law requiring everyone to have health insurance. The result has been a rise in insurance premiums for younger, healthier people and a drop in rates for older, sicker individuals. Consequently, young people have bailed out of the system, figuring they either won't need coverage or they'll be able to get it at a reasonable price when they do.

Older, Sicker People

Now, insurers are raising prices again in order to cover the medical needs of those older, sicker people left in the pool. State insurance department figures show that as of Jan. 1, nine months after the new law took effect, 25,477 fewer people had health insurance individually or in small-employer groups. That's a 1.2% decline.

The only way to avoid this chain reaction, many experts say, is to set up a system where people can't drop out. Uwe Reinhardt, a Princeton University health economist, says that when he heard Republican calls to enact insurance market reforms alone — way to vastly improve the current system he reacted with "total disbelief." Community rating without universal coverage "will trigger the worst kind of behavior among insurers and patients," he says.

"If you can go in and out of a system at will, then the only people who will buy insurance are those who need it," says Barbara Ragle, legal counsel at Central Reserve Life Insurance Co.

Nor is community rating the only popular insurance reform that would be nearly impossible without universal coverage. The same thing is true of proposals to outlaw the common industry practice of refusing to cover people with known medical problems, so-called pre-existing conditions. Most health bills that stop short of universal coverage, such as the bipartisan Managed Competition Act championed by Democratic Rep. Jim Cooper of Tennessee, allow insurance companies to exclude coverage of a pre-existing condition for up to six months unless the prospective policy holder is switching from one policy to another. Again, the reason is that if the government requires companies to cover pre-existing conditions without requiring everyone to have insurance, people will buy policies only when they expect high medical expenses.

Seeing the Insurer's Side

Even Gail Shearer, who as manager of policy analysis for Consumers Union is usually no friend of insurance companies, says: "You can understand why the insurers want protection."

In a pure community-rated insurance system, everyone in a region would pay the same premium for the same package of health benefits, regardless of age, sex, medical history, lifestyle or place of residence, despite cancer or severe disability – or perfect health.

Some supporters of community rating are pushing to allow some adjustments, such as for age and habits that affect health, like smoking. And for all the rhetoric embracing community rating, most of the actual bills under consideration in Congress would adopt only a modified version of the concept.

"Nobody is proposing pure community rating," says Henry Aaron, an economist at the Brookings Institution in Washington. Even the sweeping Clinton proposal would allow four different types of regional risk pools, based on family type – for individuals, for single parents with children, for couples and for two-parent families with children.

The House Ways and Means Committee, under pressure from the insurance industry, is considering a bill with five different market sectors, based largely on a person's employer. Each sector would be community rated, but insurers wouldn't have to sell policies in every sector. The leading Senate Republican bill, written by John Chafee of Rhode Island, allows insurers to adjust for age and geography in some markets.

In fact, many people argue that the only legislation that guarantees a true community-rated approach are bills establishing a "single-payer" health system, where the government pays people's medical bills with tax revenues.

Other things that make community ratings work are also opposed by supporters of the concept. A successful community-rated system requires a bureaucratic structure to oversee it. Yet many of the people calling for insurance-market reforms are the same ones decrying the large regional health alliances that President Clinton has proposed.

The alliances, which would be set up by the states, would include employees of all businesses with fewer than 5,000 workers. The White House says they were conceived to establish a large pool over which to spread insurance risks. And they are also intended to take care of a difficult but critical job known as risk adjusting.

"Community rating violates basic actuarial principles," says Princeton's Prof. Reinhardt. "A community-rated system forces a competing private insurer to look at a deathly ill patient, seeing a $100,00 bill, and cheerfully enroll that person fo $2,000. It goes against human nature. So i order to overcome normal human nature you need some coercion."

That means that while everyone pay the same amount into a community-rate system, a mechanism must be set up s insurance companies receive varyin amounts, depending on the risk levels their beneficiary pools. Otherwise, a pla that for some reason was chosen by disproportionate number of, say, HIV-pos tive people, would be in bad financi shape. Ultimately, health plans overloade with bad risks who pay low premium could collapse. Risk-adjusting basica requires plans with better risk pools subsidize those with worse risk pools.

The administration proposed health a liances to accomplish that task. However most of the people pushing insurance re forms are balking at alliances. Conse quently, large mandatory alliances ar all but dead in Congress.

Alliances aren't the only entities tha could perform such functions. "It could b done through state insurance regulation, says Mr. Aaron. The virtue of alliances Prof. Reinhardt points out, is that they als would collect the health-insurance pre miums, and could then turn around an pay money out to plans in the form of "risk-adjusted premium." He say "That's a lot different than having to go t there and fight with their lawyers."

Rating the Proposals

How the major health-reform plans deal with the issue of community rating:

- **CLINTON:** No premium variations allowed for age, medical status, geography or lifestyle. Separate pools according to family size.
- **SENATE LABOR AND HUMAN RESOURCES (approved June 9):** Same as Clinton but phased in over four years.
- **CHAFEE:** Health plans must offer a modified community rate premium for people and businesses of under 100 workers who buy insurance through a purchasing cooperative.
- **HOUSE WAYS AND MEANS (currently under consideration):** Community rating in four separate pools: individuals, employers with 2-250 employees; employers with more than 250 workers; association plans and health alliances.
- **SENATE FINANCE (currently under consideration):** Premium variations according to family size, geography and age. Highest age-adjusted premium may be no more than twice the lowest age-adjusted premium.
- **COOPER-BREAUX:** No adjustments allowed for medical status or number of past medical claims; premiums can be varied according to geography and, to some degree, age.

New York Finds Fewer People Have Health Insurance a Year After Reform

By LESLIE SCISM
Staff Reporter of THE WALL STREET JOURNAL

Almost one year after New York State adopted stiff insurance reforms, fewer people have health-care coverage than under the old system.

The surprising decline provides ammunition to supporters of nationwide mandatory insurance, and could prove troublesome for advocates pushing for incremental insurance reforms.

Under New York's system, insurers are required to offer one-size-fits-all pricing, a method that sharply decreased rates for older, sicker people but increased them for others. The law also forces insurers to take all comers, and, as a result, some insurers contend that disproportionate numbers of young, healthy people are dropping coverage on the assumption they can buy it later if needed.

With increasingly fewer healthy people counterbalancing the sick, the result, according to the insurers, is the start of an upward spiral in rates for those still in the pool. If the trend continues, insurers contend, the very people that the program was intended to help could again be priced out of the market.

Crumbling Barriers

"There should have been a substantial gain in people insured [in New York] because a number of barriers for people to be insured came down," says Robert Laszewski, a partner with Health Policy & Strategy Associates, a Washington consulting firm. But the abrupt increase in rates for young, healthy people has "affected the ability of New York to achieve a lower-cost pool. Now we may have a pool in New York skewed toward the sick, and in the long run that doesn't help the consumer."

Ronald Pollack, executive director of Washington-based Families USA Foundation, a consumer group that backs President Clinton's plan of mandated coverage, adds: "New York's experience gives very little comfort to those who just want incremental insurance reforms." Mr. Pollack insists that reforms, in isolation, "can't keep insurance affordable and available for families."

New York's effort is one of the nation's most sweeping attempts at reform and is closely watched by national policy makers. New York Insurance Department figures show that, overall, 1.2% fewer people – or 5,477 fewer people – were insured individually or in small-employer groups as of Jan. 1, nine months after the law, which covered those categories, took effect. The decline was particularly pronounced among individual policyholders – 12.4%, or 3,666 people. The figures respresents people [illegible] companies, health-maintenance organizations as well as Blue Cross/Blue Shield.

Insurance-department officials downplay the slight drop in overall enrollment, citing a "disruptive phase-in period." As for the steeper drop in individual coverage, they suggest some people previously covered individually are now in small groups, perhaps because their employers were prompted to add coverage.

'Unqualified Success'

New York Insurance Superintendent Salvatore Curiale calls the state's effort an "unqualified success" because it opened the system to those needing insurance the most. "The reason for all the effort to portray this as a failure is because the health-insurance industry is deathly afraid it will be taken up as a national policy," Mr. Curiale says. "What they're afraid of is that their profits will decrease" if they can't make money "on the backs of young, healthy people."

Many insurance companies that strongly opposed the New York law say their individual and small-group businesses have always had thin profit margins. Although they are allowed under the law to raise rates anytime they wish, the insurers contend that forcing them to take on a disproportionate number of less-healthy policyholders makes it even tougher to turn a profit, making rate increases necessary.

The insurance industry's practice of rejecting sick people, or charging them exorbitant rates, has long been one of Hillary Clinton's biggest complaints. But her calls for change have generally been in the context of sweeping reform that would bring all Americans into the health-care system, mostly by forcing employers to pay for premiums. The debate over insurance-underwriting practices has revved up recently as some leading legislators have suggested that Congress enact moderate reforms now and revisit the issue of a massive system overhaul later.

'Bailing Out'

In New York's case, the state adopted a "community rating" system, so-named because insurers must charge all people within given communities the same price regardless of such factors as age and medical condition. While considered a revolutionary effort, the state still allows insurers to refuse to cover prior medical conditions during an individual's first 12 months of coverage. The idea is that the exclusion will induce healthy people into the system before they get sick.

But Cecil Bykerk, chief actuary for Mutual of Omaha, which along with HMOs and Blue Cross/Blue Shield provides individual coverage in New York, says young, healthy people are nonetheless "bailing out." The average age of the company's New York policyholders has gone up 3.5 years under the new law, to 45 years, he says. The average New York claim more than doubled, to $7,900, while the company's claims nationally rose just $400 to $3,800.

The result at Mutual of Omaha: average 35% rate increases in New York this year, which come on top of increases for some young, healthy people of as much as 79% when the law took effect in April 1993. Before the reform, a 25-year-old male in Albany paid Mutual of Omaha $64.45 a month for coverage, and a 55-year-old paid $141.79; in the law's first year, each paid $107.33, and, with the newest rate increase, the bill is $145.10.

At New York Life Insurance Co., a small-group insurer, the average age of insured New York employees is up three years. Chubb LifeAmerica, a unit of Chubb Corp. that also sells small-group insurance, says people over 50 years old now represent 26% of New York enrollment, up from 20%.

"There's no question we have an adverse-selection cycle setting in," says Seymour Sternberg, a New York Life executive vice president, calling the situation "very unstable."

John Swope, president of Chubb LifeAmerica, meanwhile, speculates that some small employers with mostly young workers ended coverage because of the rate increases imposed when the law took effect, while employers with older workers "grabbed it because it was such a bargain."

At Chubb and New York Life, rates are jumping more than 20% this year. But Mr. Curiale says some small-group insurers with double-digit increases underpriced their policies last year and are playing catch-up. He says more representative increases are in the single-digit range.

For now, the state has no plans to reconsider the law, saying the problems are overdramatized. "The figures still don't show the system isn't working," Mr. Curiale says. "There's no doubt that there are younger, healthier people who decided not to pay the premium increases. But you can extrapolate that these are people who can get back into the system if they want to."

Adjusting Insurance: Is It Health Reform?

Steps Toward Expanding Coverage Could Involve 'Guaranteed Issue' and 'Community Rating'

By Steven Pearlstein
Washington Post Staff Writer

NEWS ANALYSIS

Most of what ails the U.S. health care system could be fixed with a few changes in insurance laws—that's the seductively simple suggestion made by Republicans in recent TV ads in an effort to derail President Clinton's health plan.

"Meaningless nonsense," says the White House, which is sticking by its prescription that only a comprehensive program of mandates, purchasing pools, subsidies and government regulations can restrain medical costs and extend coverage to uninsured Americans whose numbers are increasing at the rate of one million each year.

According to more than a dozen independent experts consulted last week, both sides in this highly partisan debate are guilty of health policy malpractice. Insurance reform by itself would be neither simple nor yield very dramatic results.

"A no-meat menu," said Thomas D. Pyle, who heads the health care business for Metropolitan Life Insurance Co.

"In terms of restraining prices, it won't do squat," said Brookings Institution health expert Henry Aaron.

But if insurance reform is somewhat thin policy gruel, experts also point out that the policy menu offers less elaborate options than the five-course banquet offered by the Clintons.

"We have to tell the truth about this," says Robert Patricelli, president of a health research and management firm in Avon, Conn., who chaired a health reform task earlier this year for the U.S. Chamber of Commerce. "Insurance market reform won't do much to bring 39 million uninsured into the system. At the same time, there are all sorts of useful things we can do, along with insurance reform, that stop short of the mandatory alliances and mandatory coverage of the Clinton plan."

One common element, known as "guaranteed issue," would require insurers to extend and renew coverage to people with chronic illnesses or preexisting conditions. Such a change likely would benefit about a million of the uninsured, according to the U.S. Census Bureau. At the same time, "guaranteed issue" would raise insurance premiums for everyone else, prompting some workers to go without.

But, middle-class voters like "guaranteed issue" because it gives them what they most want from health reform: protection against losing their insurance when they become sick or lose their jobs. "It takes care of the nightmare cases," said John Shiels, vice president of Lewin-VHI, a health research firm in Fairfax.

But "guaranteed issue" also invites generally healthy consumers to move in and out of the insurance system, going without insurance when they are young and healthy but signing up as soon as they get sick or get ready to have a baby. "Consumers are equally guilty as insurers of gaming the insurance system," said Uwe Reinhardt, an economist and health expert at Princeton University.

The other common element of insurance reform is "community rating," a requirement that insurers offer the same rates to all comers. Today, companies and health plans are able to hedge the risks of providing health care to customers more likely to get sick by adjusting rates based on age, occupation, health, lifestyle and other factors. But if forced to charge a single rate, insurers can try to increase their profits by seeking out the healthiest customers while avoiding the poor, the old, and the sick.

Such "cherry picking" can get quite clever. Health plans have been known to establish big programs in sports medicine, which tend to attract younger, healthier customers, while playing down specialties that are likely to attract customers with more expensive medical needs such as cancer treatment, obstetrics or heart surgery.

Other plans have gerrymandered their physician networks to focus on doctors with offices in suburban locations while excluding those with offices along urban subway lines where patients tend to be older, poorer, and sicker.

To minimize this "gaming" of the system, most "community rating" schemes are modified to allow premiums to vary by the age, sex or occupation of the insured. But Harvard University economist Joseph Newhouse said that such modifications can merely force insurers to become more sophisticated in their "gaming." The only way to eliminate it, he said, is to move to a system of universal coverage, such as advocated by the administration, in which everyone is required to have insurance.

The recent experience of New York State indicates what happens when "simple" market reforms are adopted. In the first nine months under a new law that included "guaranteed issue" and "community rating," people with unmet medical needs flocked into the insurance system while the young and healthy fled. The state insurance commissioner reported that 25,000 fewer people—a decline of 1.2 percent—had health insurance. Several insurers reported that their one-price-premiums increased more than 20 percent.

But even if insurance reform could overcome the glitches encountered in New York, according to health expert John Goodman, it still would not address three things most responsible for driving up the cost of health care.

David Brailer, a physician and professor at the University of Pennsylvania's Wharton School of Business, said insurance reform would have no impact on the key factors driving medical prices: the excess capacity in the health care system, the rate at which technology is developed and absorbed and the lack of financial incentive both patients and doctors have to control the amount of medical care that is used.

"Until you have comprehensive reform of the health delivery system—the doctors, the hospitals, the administrative apparatus—no one is going to solve the problem of escalating costs," said Ann Marie O'Keefe, policy director of the Washington Business Group on Health, a health lobbying group for large corporations.

Aaron also points out that while insurance reform addresses the biggest concern for middle-class Americans—the loss of coverage—it does little for low-income workers at firms that offer no health benefits.

"The root cause of why most people don't have coverage is that they don't have enough money," said Pyle of MetLife. "I don't see that insurance reform changes that."

Yet for all these complaints, nearly all of the experts contacted last week thought insurance reform could be the core of a compromise health plan that, while not quite achieving the goal of universal coverage or getting medical costs down to the general inflation rate, could get at most of the way toward both goals.

Harvard University economist David Cutler, who spent most of last year helping to craft the Clinton health plan, said that a less ambitious version of the administration proposal would still be a major accomplishment. Cutler ticked off an alternative plan that included insurance reforms, subsidies for the working poor, a limit on the tax exemption for health benefits, and mechanisms to ensure that employees can chose among several competing health plans.

Arthur Lifson, vice president for health policy with Cigna Corp., one of the country's largest health insurers, agreed. "The way to do it is to tie insurance reform to government subsidies to meet the obligation we have to the nation's poor and wrap them together in some sort of market mechanism that increases competition among health plans—and then I think you're a lot of the way there," he said.

"The answer is not something as simple as insurance reform, and the answer is probably not something with all bells and whistles of the Clinton plan," said O'Keefe at the Washington Business Group on Health. "The answer lies somewhere in between."

Neil Howe and Bill Strauss

A Hidden Tax on Young People

At the core of health insurance reform lies an enormous hidden tax on youth. It's called strict community rating. Politicians don't discuss it, the media don't cover it, but this multisyllabic catch-phrase threatens to move at least $40 billion a year out of the wallets of young adults (under age 35) and into the wallets of the middle-aged (age 45-64).

If strict community rating is enacted, you can ignore the talk about all the special "winners and losers" of health-care reform. The real issue will be generational. The big winners will be Clinton-aged Boomers now entering midlife; the big losers will be the young men and women now entering the labor force.

Community rating is a much-heralded reform that would prohibit insurers from charging different premiums for different individuals. In its "modified" form, it would simply ensure that no one can be charged higher premiums solely due to poor health or pre-existing conditions. This reform appeals to our sense of fairness and entails no systematic income transfer. But in its "stricter" form, it would require insurers to ignore all distinctions among individuals—including age—and charge a single community-wide fee.

Is this fair? Only if you think the federal government ought to enact a large new social insurance program that would tax the young to subsidize the middle-aged. Today, the typical 25-year-old consumes about $1,000 per year in health-care services while the typical 60-year-old consumes about $3,500. The premiums an individual pays out of pocket or the health costs companies take out of a worker's compensation generally reflect this differential. After strict community rating is enacted, however, people of all ages will pay the same premium—probably, around $2,000 per year for a single person. Presto! The 25-year-old pays 100 percent more and becomes a $1,000 yearly loser. The 60-year-old pays 40 percent less and becomes a $1,500 yearly winner. For family heads, the gap will be even wider.

If applied to everyone, strict community rating would mandate a total income transfer of at least $40 billion yearly—flowing away from the 55 million adults under age 35 and enriching the 49 million pre-Medicare adults over age 45. This "reform" would be equivalent to a 7 percent tax on a typical young couple's combined wages. That would make it about as large as their personal FICA tax (through which the young are already subsidizing the health costs of seniors).

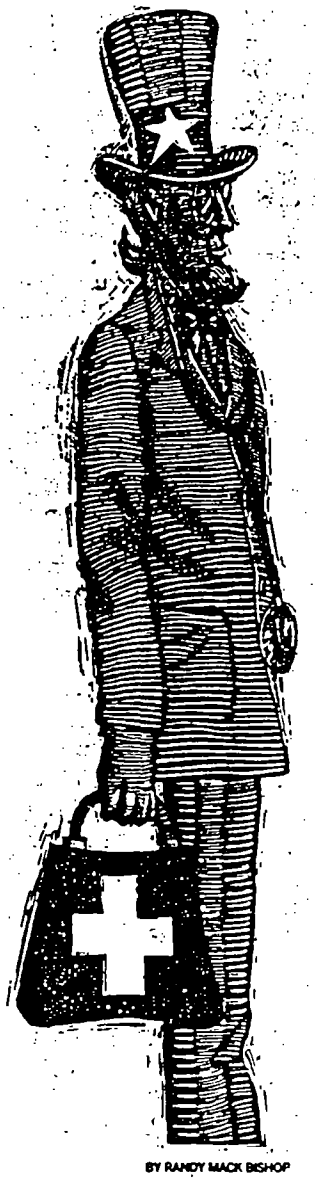
Such numbers are by no means hypothetical. Last year New York State instituted strict community rating for all small-group and individual insurers. On April 1, 1993, the price of a standard fee-for-service plan rose from $1,200 to $3,240 (a 170 percent increase) for a single 30-year-old male—while falling from $5,880 to $3,240 (a 45 percent decrease) for a single 60-year-old male.

agree on this measure, the general outlook for young people is bleak. The Clinton, Kennedy, Gibbons and McDermott plans all prohibit any age-based variation in the premium or taxes payable for all insurance policies covered by their plans. Average price tag: $1,000 per young adult. The Chafee and Michel plans allow a little variation, but would still cost young workers about $700 each. The Moynihan plan would allow an age variation up to a multiplier of two, thereby extracting roughly half as much ($500) per young worker. The Rowland plan and the Dole plan (which allows premiums to vary up to a multiplier of four, close to the actual cost variation) are the only major proposals that would hold the young harmless.

Few national leaders have bothered to bring this massive youth tax to the public's attention. President Clinton has said that premium variations are unjust. If so, why for health insurance alone? Teenage boys pay four times more than their parents for auto insurance because they're four times as reckless on the road—and nobody says that's unjust. Some politicians argue that community rating, like Social Security, won't take anything from the young that they won't get back as they grow older. But this argument assumes that such young-to-old income transfers are forever sustainable (something most twentysomethings already don't believe about Social Security). It ignores the trillion-dollar lifetime windfall that community rating will bestow on Boomers (who incurred no corresponding cost when they were young). And it implies that most 60-year-olds are economically needier than most 25-year-olds (which is patently false).

Hillary Clinton has advanced the brassiest argument for picking the pockets of the young. One of the big problems with the current system, she says, is the health costs that millions of uninsured young people shift onto insured older workers. In reality, this effect is trivial, certainly when compared with the cost shifting by seniors with Medicare discounts. It cannot justify talking about community rating as an appropriate penalty for the irresponsibility of youth.

Given the political invisibility of today's



BY RANDY MACK BISHOP

well pass Congress. If so, brace for th consequences.

First, today's young gen ation will become even po er than they are now in re tion to the old. Alrea according to the Census B reau, the real median inco of households headed by p ple under age 30 is 15 p cent lower than it was wh Boomers were their age t decades ago. With strict co munity rating, their purch ing power could fall by anc er 7 percent.

Second, the new health could defeat its own prim goal: universal covera Since adults under age 35 currently the least insu age group in America, t goal will only be achieve young people start purch ing more insurance. Hu premium hikes will have actly the opposite effe (Over the past 15 mont the New York experimen community rating has cau a 30 percent rise in po cancellations by you males.) The only pract remedy to this problem wo be to combine strict comm nity rating with unive mandated coverage—wh would seal young people i the system, force them to b vastly overpriced insuran and make them even m cynical about governm than they already are.

The final and most spec ular consequence of st community rating may be litical. Right now, few yo adults are paying attentio health care reform. But o community rating becomes law and yo wallets are emptied, that will surely char Come 1998, people born in the '60s and '7 will comprise America's largest generatio voters. Once mobilized, they will start de ing elections. That's when those who ta the young to enrich the middle-aged could run out of office by those who find themse stuck with the bills.

Everyone knows our health-care sys needs change. Costs must be controlled. F families must gain access to doctors. Insu must be barred from discriminating aga the sick. All this can be done without for all younger workers to pay far more for he care (and all older workers far less) than they actually consume.

Neil Howe and Bill Strauss are co-author

Cost Containment

"WHY UNIVERSAL COVERAGE IS ESSENTIAL FOR COST CONTAINMENT"

Table Of Contents

I. OVERVIEW OF BRIEFING

To Come from OMB

II. FACT SHEET

III. BACK-UP ARTICLES / STUDIES ETC.

- ***Annotated Bibliography***
- 1 Pager On Study By *"Center For A Responsible Budget"*
- 1 Pager On *"Family Spending: Universal Coverage Vs. Incremental Reform"*

A. Problem

1. *"The Ten-Year Budget Outlook,"* Congressional Budget Office, 1/94

B. General Cost Containment Articles

1. Stephen Zuckerman and Jack Hadley, *"Clinton's Cost Controls Can Work,"* The Washington Post, 11/7/93
2. Uwe E. Reinhardt, *"Cut Costs? Of Course,"* The New York Times, 6/12/94

C. Hawaii Example

1. Overview of the Hawaiian system
2. *"Hawaii is a Health Care Lab as Employers Buy Insurance"*, New York Times, 5/6/94
3. *"Hawaii Presents Possible Archetype for Clinton Health Plan,"* Los Angles Times, 7/8/94
4. [excerpted] *"Health Care in Hawaii: Implications for National Reform"* -- excerpts on Costs -- General Accounting Office, February 1994

D. Preventive / Emergency Room Studies

1. Emergency Room Studies
   - *"America's Health Care Safety Net: Emergency Medicine,"* American College of Emergency Physicians, 1993
   - "National Hospital Ambulatory Medical Care Survey: 1992 Emergency Department Summary," Centers for Disease Control and Prevention, HHS, 3/2/94

2. Prevention Studies
   - *"Preventive and Medical Services,"* Speech by James Mason, Assistant Secretary of Health, HHS [Under President Bush], 11/18/92
   - *"How Much Is An Ounce of Prevention Worth?"* Newhouse News Service, 12/17/94
   - *"Reducing Health Care Costs by Reducing the Need and Demand for Medical Services,"* The New England Journal of Medicine, 7/29/93

3. Counter Prevention Argument
   - *"A Costly Ounce of Prevention: Early Medical Screening May Save Lives But Not Money,"* Washington Post, 8/29/93
   - *"Prevention May Be Costlier Than a Cure,"* The Wall Street Journal, 7/6/94

E. Premiums: Universal vs. Non-Universal

1. [Excerpts] *"Coverage, Premium, and Household Spending Implications of Health Reform"*, Lewin-VHI, 7/18/94

"WHY UNIVERSAL COVERAGE IS ESSENTIAL FOR COST CONTAINMENT "
Fact Sheet

THE PROBLEM

A. National Health Expenditures:

- If we do nothing, health care spending will rise from 14% of GDP today to an astonishing 18% of GDP in the year 2000 -- meaning that **seven years from today, almost $1 out of every $5 earned by Americans will go to health spending**. [OMB]

- Although the U.S. Ranks first in world in per capita expenditures on health care, the nation falls short in basic indicators of health status. The U.S. ranks 19th in infant mortality rates, 21st in life expectancy for men and 16th in life expectancy for women. [*"Health United States"*, Department of Health and Human Services, 1992]

B. Deficit

- More than half of the expected $295 billion increase in federal revenue between 1996 and 2000 will be absorbed by health care cost increases. [*"The Economic and Budget Outlook"*, CBO, 1/94]

- For the next ten years, Medicaid and Medicare spending are predicted to increase by 10% or more each year -- growing significantly as a percentage of GDP. At the same time, other mandatory spending is expected to remain constant as a percentage of GDP and discretionary spending is expected to decrease. [*"The Economic and Budget Outlook"*, CBO, 1/94]

2. State and Local Budgets:

A. States

- In the last three years alone, state Medicaid expenditures have spiraled as a percentage of state budgets -- from just over 8 percent in 1990 to 12 percent in 1993. [HHS calculations from National Association of State Budget Officers data]

- State Medicaid expenditures are projected to consume nearly 18 percent of state budgets in the year 2000 -- twice as much as they had just ten years before. [HHS calculations from National Association of State Budget Officers data]

- In 1993, for the first time in history, states spent more on health care than they did on tax-financed higher education. [National Association of State Legislators]

B. Local

- In a recent study by the National League of Cities, "health care was cited as a burden by 42 percent of the cities." [AP, 7/11/94]

- For the third year in a row, health insurance costs were the biggest budget problem. Over the past three years, health insurance premiums paid by cities have increased nearly 10% in constant dollar terms. [WSJ, 7/11/94]

3. Families

- From 1988 to 1993, the average family premium for employer-based group health insurance doubled, from $2,500 to $5,200. Families wanting to buy health insurance directly from an insurer can spend as much as $10,000 a year. [HIAA (1988) and KPMG Peat Marwick (1993) in New York Times, 6/12/94]

- In 1993, families paid two-thirds (67%) of all health care payments on average or $5,190 -- three times the average family payment of $1,749 in 1980. [Lewin-VHI for Families USA, 3/94]

- Family payments for health care are consuming larger and larger portions of family incomes. In 1980, health payments consumed 9 percent of pre-tax family income, on average. By 1993, health payments by families consumed 13.1 percent of pre-tax income, on average. By 2003, without reform, this will rise to 20.1% of family income. Under the Clinton proposal in that year, it would be 18.9%. [Lewin-VHI for Families USA, 3/94]

- Cost shift to insured families:
  -- In 1991, hospitals were left with an estimated $10.8 billion in unpaid bills from uninsured patients -- up from $3.5 billion in 1981. [Lewin-ICF, Los Angeles Times, 4/12/92]

- Wage argument:
  -- If health care had been reformed in 1975, American workers would have over $1,000 in extra wages each year. [Commerce Department, Office of Management and Budget]

  -- The amount of total compensation going to health care keeps growing -- by 1993, an average of $1.10 of each worker's hourly wages went to pay for health insurance, up from 92 cents just two years before. Without reform, workers will lose another $600 per year in wages by the year 2000. [HHS, 6/94; OMB]

WHY UNIVERSAL COVERAGE WILL CONTAIN COSTS:

1. Emphasizing cost-saving preventive care and encouraging care in appropriate settings

A. Emergency Room Use:

- According to the first national survey of hospital emergency room departments, fifty-five percent of the 90 million emergency room visits in 1992 were for ailments that could have been treated elsewhere. [National Hospital Ambulatory Medical Care Survey; 1992 Emergency Department Summary; HHS, National Center for Health Statistics]

- Emergency room use increased by 19% from 1985 and 1990. Uninsured people seeking non-urgent care was the number #1 factor reported by 81% of hospitals. At the same time, there was little growth, if any, in emergency room visits by patients with private insurance. [American College of Emergency Physicians; 1993; GAO, *"Growth and Change in Emergency Room Use"*]

- Lack of primary provider was the primary reason for non-urgent emergency room use in 1990 -- far ahead of "after office hours" or "convenience". [*"Emergency Departments: Unevenly Affected by Growth and Change in Patient Use"*, GAO, 1/14/93]

- An emergency room visit costs at least three times that of a visit to a community-based physician in the same area. [Department of Health and Human Services, Inspector General Report, 1992]

B. Preventive Care:

- In 1989, only 1 in four full-time participants in health plans offered by medium and large businesses had coverage for routine physicals or immunizations. 40 to 60 percent of children under age 2 have not received the recommended immunizations. [AARP Testimony, 5/6/94]

- Immunizations work and they're highly cost effective. Every dollar spent on vaccinations for childhood diseases saves 10 to 14 dollars in long-term costs. [*"Preventive and Medical Services: Healthy People 2000"*, 11/18/92]

- A recent report indicated that one of every 10 hospital stays in Massachusetts could be avoided by better preventive medical care for conditions such as asthma, pneumonia and anemia. The study found that Massachusetts residents check in for 55,000 avoidable hospital stays each year, costing hundreds of millions of dollars. [*"1 in 10 Mass. hospital stays preventable, analysis finds,"* Boston Globe]

- At the University of California at San Diego in 1985, hospital care for babies born with no prenatal care cost an average of $2,200 more than corresponding care for babies whose mothers received adequate prenatal care. But such care cost only about $1,000 per pregnancy. [*"Opportunities for Success: Cost Effective Programs for Children,"* Report of the Select Committee on Children, Youth and Families, 1988]

2. **To enable deficit reduction:**

- **CBO:** *"And finally, as I noted earlier . . . the proposal should make ever-increasing contributions to deficit reduction after 2004."* [Reischauer Testimony, Senate Finance Committee, 2/9/94]

3. **Families Will Pay Lower Premiums**

- CBO said the premiums under the non-universal Cooper proposal would be about 20% higher than those under the Health Security Act -- explaining that half of the difference between the two *"is largely attributable to adverse selection; the Administration's proposal would require universal participation . . . "* [CBO, 4/94, p. 18]

- New Report: ***"Coverage, Premium, and Household Spending Implications of Health Reform,"*** Lewin-VHI for Catholic Health Association, 7/18/94

  - "**Premiums are lower under universal coverage** than under insurance market reform or insurance market reform linked to subsidies."

  - "**Middle income families that currently have insurance will pay more under partial reform** than under reform that includes universal coverage."

  - With non-universal coverage, the average family who has insurance today will pay an additional $182 in 1998 on premiums compared to universal coverage.

  - Under the best incremental reform package, an average household with insurance today will spend an additional $105 in 1998. Under universal coverage, that same family would ***save*** $233.

  - In 1998, a family making between $30,000 and $40,000 will spend $472 more under a non-universal system. Under universal coverage, they would save $241. *[Note: This is without wage effects -- businesses decreasing wages to reflect higher health costs. With wage effects, the average currently insured family spends more in 1998 under universal coverage.]*

With Non-Universal Approaches

- Under a Cooper-style approach, Lewin predicts that, in 1998, *"$8.1 billion of hospital uncompensated care and the $0.5 billion free physician care would ultimately be cross-subsidized by private payers through higher patient charges and insurance premiums.* ***Partial reform will perpetuate the destabilizing effects of this costs shift as much of the care provided to the uninsured would continue to be shifted to the privately insured."*** [Lewin-VHI, 7/18/94, p. 4]

HAWAII EXAMPLE

- ***Hawaii Health Director:*** *"The secret of our success. . . is prevention. We have twice as many outpatient visits -- that is, people see their doctors several times a year -- and half as many hospital stays, as the national average. People are encouraged to go to the doctor early and often, thus minimizing the chance of costly operations for maladies that could have been prevented."* [*"Hawaii: Setting an Example for the Rest of the Nation"*, New York Times, 11/14/93]

- "Hawaii has
  -- 70% of the national rate of acute hospital beds per 1000 population;
  -- 90% of the national average for acute hospital utilization;
  -- 61% of the national average for surgeries; and
  -- 48% of the national rate of emergency department utilization.
  There is no rationing and Hawaii has the same commitment to tertiary care and new technologies as other states. We believe the economies of low inpatient utilization are a major source of Hawaii's lower costs." [*"Hawaii's Employer Mandate and Its Contribution to Universal Access,"* JAMA, 5/19/93]

- "Near universal coverage can dramatically improve overall public health, further reducing spending and leading to a more productive work force. Hawaii officials cite the infant mortality rate, which is down 50 percent from its 1974 high of 16 deaths per 1,000 births and the state's life expectancy of 78, the highest in the nation." [*"Hawaii Presents Possible Archetype for Clinton Health Plan,"* Los Angles Times, 7/8/94]

"WHY UNIVERSAL COVERAGE IS ESSENTIAL FOR COST CONTAINMENT"
Annotated Bibliography

A. Problem

1. *"The Ten-Year Budget Outlook,"* Congressional Budget Office, 1/94

   Latest Congressional Budget Office Analysis of the explosion in government health care programs -- compared to projected decreases in discretionary and other mandatory spending.

B. General Cost Containment Articles

1. Stephen Zuckerman and Jack Hadley, *"Clinton's Cost Controls Can Work,"* The Washington Post, 11/7/93

   A compelling defense of both the need to control costs and the mechanisms contained in the HSA. Explores the paradox of critics on the left saying that the cost controls "won't work" and critics on the right concluding that they "will work too well and lead to massive disruption in the provider system and the rationing of care." Concludes that *"In reality, the administration's cost containment goal is modest. . . This plan does not try to shrink health spending relative to where we are now. . . The U.S. health system is fraught with inefficiencies and excess that have no measurable health benefits."*

2. Uwe E. Reinhardt, *"Cut Costs? Of Course,"* The New York Times, 6/12/94

   Highlights percentage of national product consumed by health care costs. Challenges opponents of cost control: *"[N]o other industrialized country would even contemplate spending as much as 17 percent of its G.N.P. on health care, and none spend even 10 percent today. Why then, should the Administration be made to show 17 percent is implausible? It is the critics who should demonstrate that it is unattainable."*

C. Hawaii Example

1. 2 Page Internal Overview Of The Hawaiian System

2. Articles:
   "Hawaii is a Health Care Lab as Employers Buy Insurance", Adam Clymer, New York Times, 5/6/94

   "Hawaii Presents Possible Archetype for Clinton Health Plan," Los Angles Times, 7/8/94

Two good overviews of the Hawaiian system -- touching on both its successes and shortcomings. Will likely be the most recent articles these pundits have read on Hawaii. Primarily address the employer mandate -- its effects and implications -- but also touch on some of the benefits of universal coverage and its cost containment implications.

3. [excerpted] *"Health Care in Hawaii: Implications for National Reform,"* General Accounting Office, February 1994

Good quick summary of Hawaii's cost experience. This 5 page section of the recent GAO study on Hawaii concludes that: *"The cost experience in Hawaii is seemingly anomalous because, while per capita health care costs [and health inflation] are similar in Hawaii and the nation, insurance premiums are lower in Hawaii."*

D. Preventive / Emergency Room Studies

1. Emergency Room Studies

- [excerpted] *"America's Health Care Safety Net: Emergency Medicine,"* American College of Emergency Physicians, 1993

  Excerpts address the increased demand for emergency services and the factors contributing to this demand. Also addresses the relation between the lack of insurance and emergency room use, and the increasing use of emergency facilities for primary care. *[**Note:** This was released prior to the HHS study [referred to below] which shows that over half of emergency room visits were for non-emergencies. The comparable 1990 statistic referenced in this study is 42%.]*

- *"National Hospital Ambulatory Medical Care Survey: 1992 Emergency Department Summary,"* Centers for Disease Control and Prevention, HHS, 3/2/94

  The first national survey of hospital emergency room departments, conducted by the National Center for Health Statistics in 1992. Main conclusion is that fifty-five percent of the 90 million emergency room visits in 1992 were for ailments that could have been treated elsewhere.

2. Prevention Studies

- *"Preventive and Medical Services,"* Speech by James Mason, Assistant Secretary of Health, HHS [Under President Bush], 11/18/92

  Explores the examples of waste, inefficiency, and lack of competition in our health care system. Tried to answer the question of why we do not get our money's worth in today's system: *". . . for all our technology and all our spending, we do not have the health outcomes we might expect."*

- *"How Much Is An Ounce of Prevention Worth?"* Newhouse News Service, 12/17/94

  Good balanced overview article -- describing the Clinton proposal, the need for preventive services, and referencing the analysis that prevention may not save money in the short run.

- *"Reducing Health Care Costs by Reducing the Need and Demand for Medical Services,"* The New England Journal of Medicine, 7/29/93

  Written by the Health Project -- a well respected group of prominent doctors, including C. Everett Koop -- the study advocates funding preventive medicine as a way to lower long-term health costs. *"A comprehensive health promotion program with multiple interventions can save money both in the first years and over the long-run."* In reviewing more than 200 health promotion programs in the workplace and other studies, the researchers found evidence of significant savings.

3. Counter Prevention Argument

- *"A Costly Ounce of Prevention: Early Medical Screening May Save Lives But Not Money,"* Washington Post, 8/29/93

  Widely read article from *Outlook* section explores thesis that -- with the exception of dramatic savings in a few areas, such as childhood immunization and pre-natal cares -- preventive care will not really lead to cost reductions. Prevention can, in fact, increase costs as expensive illnesses are detected much earlier than they otherwise would have been and millions of dollars are spent to screen people who would never have gotten the disease in the first place.

- *"Prevention May Be Costlier Than a Cure,"* The Wall Street Journal, 7/6/94

  Will be the last article on prevention read by these pundits, based on a very credible study. Overall theme was that prevention may not save much money. But, the study was on much more than health care -- from requiring airbags in cars to prescribing cholesterol reducing drugs to pollution control. It concluded that most effective preventive measures are in medicine -- *"Childhood immunizations, drug and alcohol treatment programs and prenatal care are among the biggest life-saving bargains, the study shows. These lower the costs of caring for sick people, thus total costs can be more than offset by health care savings. . . "*

E. Premiums: Universal vs. Non-Universal

1. [Excerpts] *"Coverage, Premium, and Household Spending Implications of Health Reform"*, Lewin-VHI, 7/18/94

   The report compares the effects on family spending of: insurance market reforms alone, insurance market reforms with premium subsides (Managed Competition Act), and universal coverage under the President's HSA (with and without premium caps). It concludes that both premiums and household spending are lower under universal coverage than under partial reform.

COMMITTEE FOR A RESPONSIBLE BUDGET

Should be prepared to respond to 7/11/94 release

- *Members include*: Edmund S. Muskie, Warren Rudman, David Stockman, Roy Ash, William Gray III, Robert Strauss, Paul Tsongas, Peter Peterson, Paul Volcker.

- AP Story, lead: "Overhauling the entire U.S. health system would be *"premature and ill-advised"* and President Clinton and Congress should settle for less, says a bipartisan group of former government officials. *"Reforming the health system cannot be achieved in one omnibus piece of legislation,"* the Committee for a Responsible Federal Budget said in a bluntly worded, 148-worded report."

- Advocates going slowly and passing incremental reform measures to start with: Increase availability of public, tax-financed health facilities and adopting measures to increase access to affordable insurance for those who want it.

    - *"Universal coverage is a means to an end -- not the end itself."*

    - Warns of expensive new entitlements and impact on future budget.

    - *"Mandates are taxes"*

- We'll need to respond to: *"Universal coverage is not a prerequisite to global cost containment. It would assure everyone pays for health care, reducing the per capita cost of coverage. But it would increase, not reduce,* ***total*** *costs, by increasing utilization of health care."*

- *"If we cannot afford the current projected trend in health spending, then we cannot afford to reallocate every dollar saved through health care reform on health care."*

Five recommendations:

1. Require transparency in the budgetary treatment of health care reform.
2. Subject the financing for health reform to as thorough a debate and analysis as any proposal affecting taxation.
3. Recognize the potential downside risks to the Federal budget and proceed with caution.
4. Reestablish deficit reduction as an essential goal of health care reform.
5. Proceed with changes upon which there is already broad agreement.

[Answer: We agree wholeheartedly with 4 out of 5 recommendations; 5 is problem]

FAMILY SPENDING:
UNIVERSAL COVERAGE VS. INCREMENTAL REFORM

SUMMARY OF REPORT

- A Lewin-VHI report -- ***"Coverage, Premium, and Household Spending Implications of Health Reform"*** -- was released July 18, 1994 by the Catholic Health Association. The report compares the effects on family spending of: insurance market reforms alone, insurance market reforms with premium subsides (Managed Competition Act), and universal coverage under the President's HSA (with and without premium caps). It also addresses the effects of adding an individual mandate to the Managed Competition Act to achieve universal coverage.

SUMMARY OF CONCLUSIONS:

1. **Premiums are lower under universal coverage** than under insurance market reform or insurance market reform linked to subsidies

2. **Middle income families that currently have insurance will pay more under partial reform** than under reform that includes universal coverage

3. **For currently insured households earning less than $100,000 annually, health spending will decline under universal coverage** with an employer mandate and cost constraints.

OTHER INTERESTING POINTS:

Household Spending Before And After Reform

- "For the 76.5 million households that currently have insurance, we estimate that health spending is generally higher under partial reform than under universal coverage with or without wage effects." [p. v]

- "Currently insured families earning less than $10,000 a year see a net decrease in health spending under all four approaches, but middle income families that already have insurance generally see an increase in spending under the Managed Competition Act with or without universal coverage." [p. v]

- Even taking into account wage effect: "Of the three universal coverage approaches, the Health Security Act as written is the only one that reduces household spending for currently insured middle income families, with or without wage effects." [p. v]

Cost Shift To Currently Insured

- In 1998, "$8.1 billion of hospital uncompensated care and the $0.5 billion free physician care would ultimately be cross-subsidized by private payers through higher patient charges and insurance premiums. **Partial reform will perpetuate the destabilizing effects of this costs shift as much of the care provided to the uninsured would continue to be shifted to the privately insured."** [p. 4]

Box 2-1.
The Ten-Year Budget Outlook

If current policies stay unchanged, the federal deficit will climb steadily after the late 1990s, according to the Congressional Budget Office's latest look at the 10-year picture. CBO projects that the federal deficit (excluding deposit insurance) will be essentially flat in 1995 through 1998. But it climbs every year after that, ultimately topping $360 billion in 2004 (see table). Of greater concern is the deficit's trend as a share of gross domestic product: from 2.2 percent in 1998, it inches up in every year, approaching 3½ percent of GDP in 2004.

What accounts for the escalating deficits after 1999? The answer lies basically in the outlook for one fast-growing and one slow-growing area of spending: health care and discretionary spending.

Outlays for the two big health care programs, Medicare and Medicaid, climb steadily by 10 percent or more every year over the 10-year period. Thus, they also climb as a percentage of GDP: from 3.7 percent in 1994 to 6.3 percent in 2004. Discretionary spending, in contrast, sinks as a share of GDP throughout the entire period. Constrained by caps through 1998, it barely grows at all in dollar terms through then and falls from 8.2 percent to 6.7 percent of GDP--more than offsetting the climb in health care spending. But the caps expire after 1998, and appropriations are assumed to rise again in step with inflation (in keeping with standard baseline methodology). Thus, although discretionary programs continue to sink as a share of GDP in 1999 through 2004, their decline (to 6 percent in 2004) is less precipitous than in the earlier period and is not sufficient to overcome the unrelenting rise of health care spending.

Most other areas of the budget change little in relation to GDP over the 1999-2004 period. Revenues slip from 19 percent to 18.8 percent of GDP. Mandatory spending other than Medicare and Medicaid is expected to stay roughly constant as a share of GDP. The biggest such program, Social Security, remains at 4.8 percent of GDP; even by 2004, the first members of the post-World War II baby boom are still four years from eligibility for retirement. Net interest outlays hover around 3 percent of GDP, and the ratio of debt to GDP--which is basically flat in 1994 through 1999--creeps up by about 3 percentage points (from 52 percent to 55 percent) in the five years thereafter.

A year ago, CBO projected that the deficit would top $650 billion in 2003; by last September, CBO had chopped its projection to $359 billion. The enormous improvement during that six-month period was almost wholly attributable to the enactment of an ambitious deficit reduction package. The newest projection for 2003, a deficit of $324 billion, is only a minor revision in comparison. Of the $35 billion revision, two-thirds stems from higher revenues as CBO has upped its estimate of potential growth, and one-third from lower interest costs as CBO has trimmed its estimate of federal debt.

Of course, these extrapolations are not as detailed as CBO's usual five-year estimates. Rather than produce a meticulous 10-year projection for every program in the budget, CBO attempts simply to judge the likely trends in broad clusters of spending and revenues. And great uncertainties surround such long-range extrapolations. The economy's performance is a big question mark; these projections are predicated on continued growth in real GDP of 2.3 percent annually in 2000 through 2004, on inflation of 3.1 percent, and on short-term and long-term interest rates (specifically, rates on three-month Treasury bills and 10-year Treasury notes) of 4.7 percent and 6.2 percent, respectively. The economy is bound to deviate from these assumptions in ways that cannot be anticipated. And other major uncertainties abound, most notably about future trends in health care spending and about other open-ended commitments, such as the pledges for deposit insurance that proved so costly in the recent past.

The Budget Outlook Through 2004 (By fiscal year)

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
					In Billions of Dollars						
Revenues	1,251	1,338	1,411	1,479	1,556	1,630	1,705	1,783	1,868	1,958	2,054
Outlays											
Discretionary	543	541	547	547	547	564	582	600	619	638	658
Mandatory											
Social Security	318	335	352	370	388	408	429	450	473	497	523
Medicare	160	177	195	215	238	264	290	320	354	392	435
Medicaid	86	96	108	121	135	151	168	186	206	227	250
Civil Service and Military Retirement	62	65	67	70	73	78	81	85	89	92	96
Other	177	171	168	184	191	199	205	211	218	225	232
Subtotal	803	844	890	960	1,026	1,099	1,173	1,253	1,339	1,433	1,536
Deposit Insurance	-5	-11	-14	-6	-4	-4	-3	-3	-2	-2	-2
Net Interest	201	212	228	239	249	261	270	283	298	315	334
Offsetting receipts	-69	-77	-74	-78	-83	-86	-90	-94	-98	-102	-106
Total	1,474	1,509	1,577	1,661	1,736	1,834	1,931	2,039	2,156	2,282	2,419
Deficit	223	171	166	182	180	204	226	256	288	324	365
Deficit Excluding Deposit Insurance	228	182	180	189	184	208	229	258	290	326	367
Debt Held by the Public	3,462	3,642	3,822	4,021	4,218	4,441	4,686	4,961	5,268	5,611	5,995
					As a Percentage of GDP						
Revenues	18.8	19.1	19.1	19.0	19.0	19.0	18.9	18.9	18.8	18.8	18.8
Outlays											
Discretionary	8.2	7.7	7.4	7.0	6.7	6.6	6.5	6.3	6.2	6.1	6.0
Mandatory											
Social Security	4.8	4.8	4.8	4.8	4.7	4.7	4.8	4.8	4.8	4.8	4.8
Medicare	2.4	2.5	2.6	2.8	2.9	3.1	3.2	3.4	3.6	3.8	4.0
Medicaid	1.3	1.4	1.5	1.6	1.7	1.8	1.9	2.0	2.1	2.2	2.3
Civil Service and Military Retirement	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9
Other	2.7	2.4	2.3	2.4	2.3	2.3	2.3	2.2	2.2	2.2	2.1
Subtotal	12.1	12.0	12.1	12.3	12.5	12.8	13.0	13.3	13.5	13.8	14.1
Deposit Insurance	-0.1	-0.2	-0.2	-0.1	a	a	a	a	a	a	a
Net Interest	3.0	3.0	3.1	3.1	3.0	3.0	3.0	3.0	3.0	3.0	3.1
Offsetting receipts	-1.0	-1.1	-1.0	-1.0	-1.0	-1.0	-1.0	-1.0	-1.0	-1.0	-1.0
Total	22.2	21.5	21.3	21.4	21.2	21.3	21.4	21.6	21.7	21.9	22.1
Deficit	3.4	2.4	2.2	2.3	2.2	2.4	2.5	2.7	2.9	3.1	3.3
Deficit Excluding Deposit Insurance	3.4	2.6	2.4	2.4	2.2	2.4	2.5	2.7	2.9	3.1	3.4
Debt Held by the Public	52.2	52.0	51.7	51.7	51.5	51.7	52.0	52.5	53.1	53.9	54.9

SOURCE: Congressional Budget Office.

a. Less than 0.05 percent of GDP.

Copyright 1993 The Washington Post
The Washington Post

November 7, 1993, Sunday, Final Edition

SECTION: EDITORIAL; PAGE C7

LENGTH: 1392 words

HEADLINE: Clinton's Cost Controls Can Work

SERIES: Occasional

BYLINE: Stephen Zuckerman, Jack Hadley

BODY:

Controlling medical care spending is "Job One" for the Clinton administration's health care reform plan. System savings from successful cost control will help pay for extending insurance to the 37 million Americans who don't have it, for making sure that those who have it can't lose it and for guaranteeing that every insurance plan includes a comprehensive benefit package.

Not surprisingly, critics from both the left and right are concentrating their firepower on the administration's cost-control plan. The criticisms can be roughly divided into two camps. One is that the plan's cost-control features won't work. The other, oddly enough, is that they will work too well and lead to massive disruption in the provider system and the rationing of care.

What is the administration's cost control plan? Although often ridiculed as being of, by and for policy wonks, the basic strategy is quite simple. It has two lines of attack. The first is to promote competition among insurance plans under a cap on the average premium in an area. The second is to limit the amount of new money flowing into the system by capping the rate at which insurance premiums are allowed to increase.

The Clinton proposal requires that all insurance plans offer a comprehensive package of benefits and charge the same premium to all comers, regardless of age, health history or employment situation. According to the theory of managed competition, with the product standardized and insurance companies less able to compete by rejecting or avoiding high risks, competition will have to take the form of price and quality competition. Insurance plans will attract customers and prosper by providing value for money.

In spite of the promise of managed competition, it largely remains a theory. To put teeth into it, the Clinton plan will impose a financial penalty on any insurance plan that tries to increase its premium more than the cap allows. There is little doubt that if faced with constrained revenues, insurance plans will limit their expenses. Each plan will decide the best way to do this, including constraining the overuse of services and limiting what they pay doctors, hospitals and other health care providers. But they will have every incentive to do it in a way that doesn't drive away subscribers. One critic characterized this approach as "getting the insurance plans to do the government's dirty work." However, it seems far preferable that insurance companies that are responsible to their subscribers make these decisions than having the federal government involved in detailed price negotiations and review procedures with individual hospitals and physicians. As another critic put it, "That's like bombing from 30,000 feet. You can't see whom you kill."

In reality, the administration's cost-containment goal is modest. Its original estimate is that annual savings would be $ 136 billion in the year 2000. That's a lot of money to anyone. But let's put it into perspective. At the time this estimate was made, the Congressional Budget Office projected that health care would absorb 18.9 percent of GDP by the year 2000. The Clinton plan would bring that down to 17.3 percent. We currently spend 14.3 percent of GDP on health care, while no other industrialized country spends more than 10 percent. Thus, the Clinton plan's "draconian" cost-containment combination of more competition and caps on premium growth permits about a 3 percent increase in the share of GDP going to health. This plan does not try to shrink health spending relative to where we are now. No health care jobs will be lost, though fewer new jobs may be added in the future.

How will the system respond to these constraints? The specter of sick patients being unable to receive care is completely farfetched. The U.S. health system is fraught with inefficiencies and excesses that have no measurable health benefits. The constraints on spending growth will, for example, force more triage to reduce the estimated 15-30 percent of diagnostic tests and surgeries that may be unnecessary. Private insurers will no longer be willing to pay providers prices that are 30-40 percent above Medicare, nor should they. Providers will be able to survive with lower prices for private patients, because universal coverage will mean an end to uncompensated care and low prices for Medicaid beneficiaries.

Studies of the present system have shown that hospital costs are 10-15 percent higher than they would be if all facilities produced services more efficiently, and this excludes savings that would accrue from not producing unnecessary services. Imposing financial pressure through caps on premiums means some hospitals will scale back their investments in buildings and equipment -- which are often underutilized -- and reorganize their staffs.

Our own current research on a nationwide sample of almost 1,450 hospitals suggests that they respond to financial pressure primarily by controlling costs. The 25 percent of hospitals with the lowest profits in 1987 experienced cost increases of 13.3 percent between 1987 and 1989 compared with an average of 27.6 percent for hospitals with the highest profits. In contrast, for both groups of hospitals, total revenues grew at virtually the same rate, about 21 percent over the three years; 30-day post-admission mortality rates for Medicare patients improved slightly; and the shares of hospitals' patients covered by Medicare and Medicaid increased by about 3 percent.

Patients will also need to change. They may need to accept a less-intensive approach to diagnosis and treatment as currently practiced in the best-quality HMOs. And they may also need to consider whether a high-cost health plan is worth the extra money. If it is not, consumers will be able to choose a less costly health plan. People may not like these changes simply because change can be uncomfortable. However, Americans will no longer fear losing their coverage if they become very sick or lose their jobs.

How fast would spending growth begin to subside? If the speed with which hospitals have responded to Medicare's prospective payment system, other rate-setting systems and lowered profits is a guide, the answer is almost immediately. When providers are paid less, they move quickly to cut their expenses and organize service delivery more efficiently. When Medicare phased in its prospective payment system between 1982 and 1984, hospitals that faced the greatest potential financial loss held their expense growth to one-third that of hospitals facing prospects of financial gain, 3.2 percent compared with 10.2 percent. Hospitals in California that faced strong competitive pressures as well as prospective losses from PPS actually cut their costs by 4.3 percent between 1983 and 1985. The annual increase in the volume of so-called "overpriced procedures" provided to Medicare beneficiaries by physicians fell from 9.3 percent in 1986-87 to 2.4 percent in 1988-89 in response to a 2.4 percent cut in average fees. Given this evidence and congressional action within the next year, the system should be able to adjust by the year 2000 without major adverse consequences.

The Clinton proposal aims to alter incentives by a combination of regulatory and market forces. Some critics would rather see much greater reliance on changes in the tax treatment of health insurance premiums as the way to change incentives. Despite its intellectual appeal to some, there is little evidence to show that this approach would succeed. On the other hand, even though strict systems of regulated spending and price controls have good track records of controlling costs, they do not have widespread political support. Many people view such systems as administratively burdensome, inflexible and likely to lead to explicit rationing.

The Clinton proposal relies on competition among plans, but limits the amount of tax-subsidized dollars that can flow into the system and requires the development of a potentially regulatory framework for limiting total spending. This is a compromise. But, its acceptability and likely success may be greater than either pure alternative.

Stephen Zuckerman is a senior research associate at the Urban Institute. Jack Hadley is co-director of the Center for Health Policy Studies at Georgetown University School of Medicine.

...ut Costs? Of Course

By Uwe E. Reinhardt

PRINCETON, N.J.

The Congressional Budget Office forecast last year that spending on health care would rise from 14 percent of the gross national product to 19 percent by the year 2000.

"Impossible!" shouted America's pundits. That level of health spending, they said, would bankrupt the country.

Then President Clinton proposed to bring that projected growth down to "only" 17 percent of the G.N.P. by the year 2000.

"Impossible!" shouted America's pundits. Such a steep decline in spending would lead to rationing of care, they argued.

While Americans are thus meandering from despair over the prospect of deprivation at 17 percent to anx... over financial collapse at 19 ..., no other industrialized na... uld even contemplate spend... s much as 17 percent of its G.N.P. on health care, and none spend even 10 percent today.

Why, then, should the Administration be made to show 17 percent is an implausible goal? It is the critics who should demonstrate that it is unattainable.

Let us examine the projected cuts in spending on Medicare, the health insurance program for America's elderly. For that program, the President would allow annual spending to increase from $128.8 billion in 1993 to as much as $207.8 billion in the year 2000. That represents an average annual compound growth rate of 7.1 percent.

Can America's physicians really look the taxpayer in the eye and argue that even accounting for inflation, they could not treat the elderly properly for $207.8 billion in the year 2000?

To put that question in perspective, consider some fascinating data published in The New England Journal of Medicine in March 1993.

The authors of an article on Medicare spending in cities found that in 1989, after adjusting for differences in age and sex, Medicare payments for doctor's care, per beneficiary, varied from lows of $822 in Minneapolis, $872 in San Francisco and $954 in New York City to highs of $1,493 in Detroit, $1,637 in Fort Lauderdale and $1,874 in Miami.

Should not America's physicians, and the legislators from the high-cost states, be made to defend these differentials to the taxpaying public? Suppose Congress arbitrarily slashed Medicare reimbursements for Miami physicians by 20 percent. Even after this budget cut, Miami physicians would still be absorbing 57 percent more Medicare dollars per beneficiary than their colleagues in New York, and 82 percent more than their colleagues in Minneapolis.

Many critics argue that the 37 million uninsured Americans could not possibly be accommodated at spending levels of "only" 17 percent of the G.N.P. Oddly enough, some of the same critics also assert that these Americans merely lack health insurance, not health care, for they allegedly receive adequate treatment at the expense of paying patients to whom the cost of that charity care is shifted.

> No nation spends nearly as much on health as we do.

But if the uninsured already get the care they need, why should insuring them all of a sudden break the national bank? On this point, too, opponents of the President's health care plan should try harder to get their stories straight.

The Clinton Administration's proposal is complex enough to offer any would-be critic many targets of opportunity. It is puzzling that the spending forecast is chief among them. Sure, Mr. Clinton could explain his forecast better than he has done so far. But the burden of proof on this issue ought not to rest with the President. It rests on the shoulders of his critics, for it is they who have much explaining to do. □

Uwe E. Reinhardt is professor of political economy at Princeton.

50 Labs for Reform

By Jerry L. Mashaw and Theodore R. Marmor

NEW HAVEN

The debate over health care reform has reached a critical juncture. There is significant opposition in Congress to the Clinton plan without anything like consensus on an alternative.

How can a workable version of national reform be enacted when there's no majority for any single plan? The challenge for reformers is to find a strategy that reflects the political agreement on the goals of health reform as well as the disagreements on solutions.

The reformers are split into factions favoring managed competition, a single-payer system, expansion of Medicare and various hybrids of these approaches. But these divisions should not obscure the broad agreement among reformers on fundamental principles: universal coverage, reliable cost containment and radical reform of health insurance practices.

If a legislative proposal can be developed that brings together all those serious about health reform — no matter what option they favor — a majority can be created to overcome the resistance of reform's opponents. The trick, then, is to pursue legislation that builds on the reformers' common goals while recognizing their differences on how to achieve them administratively. One solution is the federalist option.

After all, the states have already achieved more on reform than Congress has. There is no reason to stop their progress, and every reason to encourage it. The federalist approach would set national standards for health insurance — that it be universal and portable (not based on residence or employment), cover all medical necessities and have effective cost-containment methods plus clear accountability for the quality of the overall system.

Having done that, the Government could promise to continue its current financial contributions to health care so long as the states met its conditions for acceptable plans. That would free states to experiment with any of the options the Administration has outlined — or any others, either existing or under development around the country.

In short, Mr. Clinton and Congress could acknowledge that medical organization and practices vary substantially in different geographical areas, as do demographics and political beliefs. They could develop a plan that motivated state experimentation, rather than mandating a single system for the entire country.

Mr. Clinton could insist that national legislation — Medicare, Medicaid, the Employee Retirement Income Security Act and the Internal Revenue Code — not get in the way of state innovation, but nonetheless impose sanctions on states that did not conform to broad national standards.

> Let the states experiment.

This approach recognizes that the nation does not yet know what works or will work everywhere. It would help the nation learn from successes and failures while avoiding the possible total failure of a plan imposed from Washington.

If Congress adopts an unproven and untested version of the Clinton plan and it turns out to be the health care equivalent of a train wreck, it would be sensible not to have the whole country on the same train at the same time. □

Jerry L. Mashaw and Theodore R. Marmor, co-authors of "America's Misunderstood Welfare State," are, respectively, professors of law and management at Yale.

STATE OF HAWAII

Summary: Hawaii has moved closer to universal access than any other state through its combination of employment-based coverage, Medicaid, and a state-subsidized insurance program for the "Gap Group" -- those not qualified for either employer-provided or Medicaid coverage. State officials estimate that only about 4 percent of Hawaii's population remains uninsured -- compared to estimates of 15.3 percent nationwide.

Features:

I. Shared Employer-Employee Responsibility: The foundation of Hawaii's approach is its 1974 Prepaid Health Care Act which requires that all employers provide health insurance to their employees. Employees must elect the insurance unless they have comparable coverage from another source. Employers and employees share financing of premiums.

- The law specifies that employers must provide an extensive package of medical, hospital, and laboratory services that meets minimum standards specified in the Prepaid Health Care Act. Employers have a second option of providing a state-approved benefits package more limited than one of the standard plans and then paying half the cost of dependent coverage.

- In 1990, 88 percent of Hawaii's under-65 population were covered by employer-based insurance, provided primarily by two large insurers -- a standard fee-for-service plan from Hawaii Medical Services Association (Blue Cross/Blue Shield) and an HMO plan from the Kaiser Foundation Health Plan.

II. Medicaid Insurance: In 1990, another 7 percent of Hawaii's residents were insured through Medicaid. Hawaii has a very expansive Medicaid program, accepting a greater percentage of it low-income population than most states. In addition, Hawaii ranks third among the states for the greatest number of Medicaid service options -- with a comprehensive benefit package that covers medically necessary, and some preventive, care.

III. State Health Insurance Program (SHIP) for the Gap Group: In 1989, the Hawaii government estimated that about 5 percent of the population remained uninsured, neither covered through employer-provided insurance nor eligible for Medicaid. In response to this problem, the Hawaii legislature created the State Health Insurance Program (SHIP) to provide state-subsidized private health insurance for the low-income uninsured.

- The state purchases health insurance for SHIP enrollees from HMSA and Kaiser. The state pays the entire premium for those whose income is under the poverty level; members with incomes above poverty pay a sliding scale share of the monthly premium.

- SHIP's benefits package is very different from Hawaii's employer-provided plan and the Medicaid program. Benefits are heavily weighted toward preventive and primary care, with full coverage for prenatal, well-baby, and well-child physicians' benefits as well as coverage for health appraisals. Other physician care and hospital coverage have set limits.

Small Business: Small businesses in Hawaii pay less for health insurance that their counterparts elsewhere in the U.S. There are several reasons: (a) since most people are insured, there is less uncompensated care and therefore less cost shifting; (b) all insurers must cover all employees in a group, regardless of medical condition or risk; (c) the two dominant insurers voluntarily established an adjusted community rating system which allows small businesses to offer their employees health care benefits comparable to those offered by large employers. The Prepaid Health Care Act facilitated the use of community rating by requiring that all employees obtain insurance, thus preventing healthy people from opting out of the system.

No Strong Cost Controls: Hawaii's reforms have not shielded it from the national trend of rising health care costs, although state officials note that while Hawaii's health care spending tracked the national average, it was providing increased access to health care for all its citizens.

Copyright 1994 The New York Times Company
The New York Times

May 6, 1994, Friday, Late Edition - Final

HEADLINE: Hawaii Is a Health Care Lab As Employers Buy Insurance

BYLINE: By ADAM CLYMER, Special to The New York Times

DATELINE: HONOLULU, May 3

BODY:

The toughest question in the health care debate is whether to require employers to buy insurance for their workers.

But if members of Congress could overcome their fears of being accused of junketeering and actually visit Hawaii, they would find compelling evidence about how such a system actually works, and they would not have to rely on a range of absolute, if uninformed, opinion.

About 96 percent of Hawaiians have health insurance. Employers, regardless of the size of their work force, must pay for most of it. Nonetheless, they have thrived, despite frustration over expanding benefits and rising costs.

Moreover, Hawaiians seem healthier, and more satisfied with their health care, than other Americans.

Recent surveys by both the Northwestern National Life Insurance Company and by the American Public Health Association have rated overall health in Hawaii better than in any other state. The Federal Centers for Disease Control and Prevention ranked Hawaii at or near the top in low infant mortality, longevity and early death from heart and lung disease and cancer.

Two opinion surveys sponsored by the Kaiser Family Foundation found that 82 percent of Hawaiians, compared with 71 percent of Americans overall, were satisfied with their health care services. Only 18 percent of Hawaiians, compared with 39 percent of Americans, said their health care system worked badly.

There are no comparable surveys of doctors, many of whom complain that they make less money in Hawaii than they could elsewhere. But Jonathan R. Won, executive director of the Hawaii Medical Association, said that in a very portable profession few doctors had moved away. "Physicians really say, 'I choose to practice here,' " he said. "Nobody has come up with a better idea as yet," he said.

Hawaii is also the only state where a recent United States Chamber of Commerce survey of its members, who are mostly engaged in small business, found a majority backing compulsory payments.

Hawaii is the only state with experience with that system, but it is a little-used laboratory. Only one Congressional subcommittee has come here this year to hold a hearing. Nor is there significant academic research, even by the University of Hawaii.

Still, 20 years of Hawaiian experience does offer support for requiring employers to pay, as President Clinton has urged, but also for some of the fears that the proposal raises among small businesses.

It is clear that the "employer mandate," as the requirement to buy workers insurance is known here and in Washington, has succeeded in bringing Hawaii to the threshold of universal health insurance coverage. That seems to have helped restrain health care inflation, a serious problem here but less critical than on the mainland: health insurance premiums are about 30 percent cheaper here, while almost everything else in Hawaii is more expensive.

The state health director, John C. Lewin, argues that the system has done more than that. "By emphasizing primary care, it has improved the health status of the people of Hawaii," he said. As one example, he said, early detection of breast cancer -- despite a high rate of it in Hawaii -- had enabled the state to achieve the nation's lowest rate of mortality from the disease.

Yet Hawaiians seem rather blase about the fact that they have something unique. So they may not notice being free of the mainland fears that their employers will cancel a health plan, or that existing medical conditions will either keep them locked in their jobs, force up their rates or deny them insurance altogether.

Nor is there an echo of the intense lobbyists' argument in Washington that compelling most employers to pay for insurance will cost millions of jobs and force thousands of companies out of business. That did not happen when Hawaii's mandate took effect in 1975, nor during the worst of the recession of the 1980's, nor in the last few years, when insurance premium inflation occasionally reached double digits.

Full-Time Workers Covered

Part-time workers under 20 hours a week do not have to be insured, but no matter how small a company is, it must cover all its other workers -- and without the kind of subsidies contained in President Clinton's proposal. A report this year by the General Accounting Office, the investigative arm of Congress, said, "We found no evidence that the employer mandate resulted in large disruptions in Hawaii's small-business sector."

But a different, less shrill concern of small business heard in Washington does echo here, that Congress may include enough exemptions and subsidies to make the employer mandate bearable when it takes effect, but not forever. That has been a problem in Hawaii. As Bette Tatum, state director of the National Federation of Independent Business, put it here the other day, "Subsidies come and go; mandates last forever.".

There is no doubt that Hawaii's system is tougher on employers now than when it was enacted.

Limits on Worker Premiums

Over the years, Hawaiian officials have been prevented by Federal law from raising the ceiling on worker contributions to health care that the state law set in 1974. It is limited to 1.5 percent of a worker's salary, and no more than half the premium. For a minimum-wage worker in 1975, the limit of $5.20 a month was nearly a third of that year's $18.62 monthly cost of basic health insurance.

But health insurance costs have grown much faster than the minimum wage, which was $2 in 1975 and is $5.25 here now, or $910 a month based on a 40-hour week. The most that can be deducted from a minimum-wage worker now is $13.65 a month; that is such a small share of the $131.02 premium for a worker's basic coverage that many employers do not bother to collect it.

Though Federal law blocked Hawaii from requiring workers to pay a bigger share of their insurance premiums, Hawaii's lawmakers found a way to add benefits.

Barred from amending their 1974 Prepaid Health Care Act, Hawaiian legislators changed the basic insurance laws, requiring all health insurers and health maintenance organizations to add coverage for mental health and drug and alcohol treatment, mammograms, more well-baby care and in-vitro fertilization.

More Benefits, But Low Cost

Marvin Hall, president of the Hawaii Medical Service Association, the local Blue Cross-Blue Shield group that covers just over half of Hawaiians, says those additions amount to less than 10 percent of a premium.

Beyond the cost, the fact that the heavily Democratic, pro-labor Legislature shoved the changes down its throat rankles small business. Don Moore, who runs the hardware store in Kula, on the island of Maui, said scornfully, "They keep adding bells and whistles."

Teena Rasmussen, a wholesale flower grower who produces leis and bouquets in Kula, said the combination of new mandates and health care inflation "was not something the employer had any method of covering, except by lowering the coverage." She said foreign competition prevented her from raising her prices. While she once voluntarily

helped cover workers' families. she no longer does so and is buying the cheapest coverage she can for her nine full-time employees. But there is no business revolt. "Employers are very resigned to it over here," she said.

'Hardly Worth It'

Mr. Moore certainly fills that bill. "There are costs in any business," he said, "and certainly health insurance is one of them. It's pretty consistent that it goes up, but I wouldn't say that it has gotten out of hand." He could deduct a total $200.85 from his nine insured workers every two weeks. But, he said: "The 1.5 percent is hardly worth it. You've got an employee relationship to maintain."

One more local business gripe is a counterpart of the widespread doubt that Congress will subject itself and Federal workers to the same terms it imposes on the rest of the nation. Consider the way state government treats itself here. It pays 60 percent of the cost of insurance and requires workers to pay 40 percent.

Big business has less trouble with the system. Of the 17 percent of Hawaiians in 1974 who lacked insurance that would cover both doctor and hospital bills, most worked for small companies, in small factories, shops, restaurants and similar businesses. This is a heavily unionized state, and most union contracts had ample health insurance 20 years ago. But other big businesses, to compete for workers, matched that benefit.

Putting Theory to Work

Peter Lewis, vice president of Hawaiian Electric, the islands' major power company, said: "Speaking for most big businesses, we support the idea of the Prepaid Health Care Act. As a company, we are very much focused on the preventive end. In the long run, it will save us money."

After 1975, commercial insurers, denied the chance to avoid unhealthy clients, quickly dropped out of the market, and the H.M.S.A., the Blue Cross carrier, with about half the market, has competed ever since with Kaiser Permanente, whose H.M.O.'s have about a fifth of the market. The competition has kept prices down and encouraged the sort of preventive care that means a slightly above-average rate of doctor visits yearly but also lower hospitalization rates, shorter hospital stays and less frequent surgery.

There are disputes about how complete the insurance coverage really is. Speaking for the independent-business group, Mrs. Rasmussen, the flower grower, told Congress that 3 percent to 7 percent of Hawaiians were not covered and "many experts estimate that the numbers may be higher." Dr. Lewin often claims 98 percent coverage.

Analyses based on the Census Bureau's monthly household survey suggest that 93 percent of Hawaiians have health insurance. A much larger survey, conducted by the state Health Department, indicates that 96 percent of Hawaiians are insured.

bc-health hawaii - a2124
(ATTN: National editors) (Includes optional trims)
Hawaii Presents Possible Archetype for Clinton Health Plan (Waianae)
By Edwin Chen= (c) 1994, Los Angeles Times=

WAIANAE, Hawaii Atop a wind-swept bluff with an aquamarine vista that a resort would envy, the Waianae Comprehensive Health Clinic on Oahu's leeward coast offers a compelling view of the benefits and limitations of the employer mandate the controversial linchpin of President Clinton's health reform plan.

After 20 years under a state law that requires employers to pay a portion of their workers' health insurance, 96 percent of Hawaiians enjoy medical insurance, easily the highest percentage of any state. Yet this rural clinic still provides $1 million a year in uncompensated care to those lacking coverage, mostly people who drift in and out of odd jobs, seeking treatment only when a serious problem arises.

``Hawaii's not perfect,'' says Dr. Jack Lewin, a chief architect of the state's recent efforts to cover everyone. ``But we have powerful lessons for the future. We're not theoretical. We're real.''

Many lawmakers and analysts, the president among them, believe requiring employers to pay the lion's share of their workers' health costs is the most feasible way to achieve universal coverage and that spiraling costs cannot be contained until everyone including the nation's 38 million uninsured is covered. But others believe cost containment must come first, with the savings used to gradually extend coverage. They also believe an employer mandate would pose severe financial burdens on many businesses, costs that will only grow.

Hawaii's unique experience as the only state with an employer mandate offers lessons for all participants in the debate.

Some of the results of the state's experiment:

Hawaii has contained costs, even while expanding coverage, and is approaching universal coverage, with 96 percent of its 1.2 million residents insured. The explosive growth of insurance costs for all, especially small businesses, has been lowered by 30 percent or more.

An employer mandate alone does not guarantee that all will be insured. Other programs must be put into place to pay for the medical care of those who slip through the cracks.

Independent studies have shown that the employer mandate has not resulted in ``disruptions'' or high unemployment among small businesses here, but the costs to such firms have clearly grown over the years. The employer's share of premium payments have skyrocketed in relation to employee contributions and the state has required a slew of new benefits that must be covered, which have further driven up costs.

A Louis Harris and Associates poll, sponsored by the California-based Kaiser Family Foundation, found that 56 percent of small businesses in Hawaii cited health insurance as ``a major problem,'' more so than any other government mandate. And yet, the identical percentage also said they would support an employer mandate if one were proposed today.

Nearly universal coverage can dramatically improve overall public health, further reducing spending and leading to a more productive work force. Hawaii officials cite the infant mortality rate, which is down 50 percent from its 1974 high of 16 deaths per 1,000 births and the state's life expectancy of 78, the highest in the nation.

When Hawaii adopted the Prepaid Health Care Act in 1974, most of the state's then-million residents already were insured. The employer mandate was designed to reach the 17 percent believed to be without coverage, roughly the same percentage of Americans nationwide who now lack health insurance.

All employers were required to pay for at least 50 percent of an employee's health insurance premiums. But the state law capped a worker's contribution at 1.5 percent of wages. A minimum-wage worker in the mid-1970s, when health costs were much lower than they are now, paid almost one-third of the cost of his insurance premiums.

Over the years, insurance premiums skyrocketed, far outpacing the growth in wages. Yet the 1.5 percent cap remained, meaning that employers were forced to pay an increasingly disproportionate share.

``Workers are not being asked to share the burden. There has to be more of ared responsibility,'' said Russell R. Watanabe, president of a
1 ly-owned flower and floral supplies business in Honolulu.

(Begin optional trim)

State officials concede the point. Lewin, the former state health director who is now seeking the Democratic gubernatorial nomination, says the cap on individual contributions should be raised to ``somewhere between 3 percent and 6 percent'' to make the arrangement more equitable.

(Originally, Hawaii had intended a 50-50 split between employer and employee.)

Watanabe and many other small business owners also complained that the frequent addition of new and costly benefits such as in-vitro fertilization and mental health have forced many small business owners to reduce other benefits, to lay off employees, to hire more part-time workers, or simply to ``throw in the towel'' and close their doors.

(End optional trim)

While Clinton would require employers to pay the premiums of part-time employees working as little as 10 hours a week, Hawaii placed the cut-off at 20 hours or more per week.

Watanabe and other entrepreneurs said some business owners have attempted to duck the mandate by hiring part-timers to work only 19 hours a week. In the Harris poll, three out of 10 companies said they had engaged in the practice in the last two years, specifically to avoid the requirement. But state cials dispute such claims, noting that the percentage of part-time workers he Islands (18.2 percent) is lower than on the mainland (19.2 percent).

(Begin optional trim)

A Government Accounting Office study this year concluded that the employer mandate in Hawaii ``has not resulted in large disruptions'' among small businesses.

Despite such efforts to reach universal coverage in the state, as many as 20 percent of patients who show up at the Waianae clinic are uninsured, says administrator Richard Bettini.

And it's the same story at the bustling Queen Emma Clinic in downtown Honolulu. Of the 38,000 patients who visit the clinic each year, one in four is uninsured, according to director Chuck Duarte.

(End optional trim)

But despite some problems in achieving total coverage, officials here generally agree that the employer mandate is the essential building block of universal coverage.

``Without it,'' says Marvin Hall, Hawaii's top private health insurance executive, ``you are just not going to do the job.''

-END-OF-AUTOBREAK(1)-

-AUTOBREAK(2)-FOLLOWS

**** filed by:LAWP(--) on 07/08/94 at 03:04EDT ****
**** printed by:WHPR(160) on 07/08/94 at 07:26EDT ****

United States General Accounting Office

GAO

Report to the Chairman, Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, House of Representatives

February 1994

HEALTH CARE IN HAWAII

Implications for National Reform

RESTRICTED--Not to be released outside the General Accounting Office unless specifically approved by the Office of Congressional Relations.

GAO/HEHS-94-68

demographic characteristics of the communities they serve. In addition, the representatives are concerned about the centers' financial viability under QUEST.

Center representatives believe that some of these problems would be alleviated if an individual or a group of community health centers could successfully bid to become a QUEST managed care plan administrator However, they believe QUEST performance-bond and geographic-coverage requirements are significant barriers to successful center bids.[24]

Overall Costs Parallel National Trend but Premiums Are Lower

The cost experience in Hawaii is seemingly anomalous because, while per capita health care costs are similar in Hawaii and the nation, insurance premiums are lower in Hawaii. PHCA was intended to expand access to coverage, but it did not include explicit efforts to control health care costs.[25]

Per capita expenditures in Hawaii have been very similar to the national average since 1974, and both have increased more rapidly than the overall rate of inflation. The same factors in the health care economy have influenced this trend in Hawaii and the rest of the nation. At the same time, however, health insurance premiums are generally lower in Hawaii than in the nation as a whole and have risen at a slightly slower rate than nationally.

Hawaii Per Capita Expenditures Track National Average

Hawaii's per capita health care expenditures continue to be similar to national levels. We reported earlier that Hawaii's per capita health care expenditures from 1974 to 1982 tracked the national average at the same time the state widened access to coverage through its employer mandate.[26] Similarly, from 1980 to 1991, Hawaii's per capita expenditures for hospitals, physicians, and prescription drugs tracked the national average

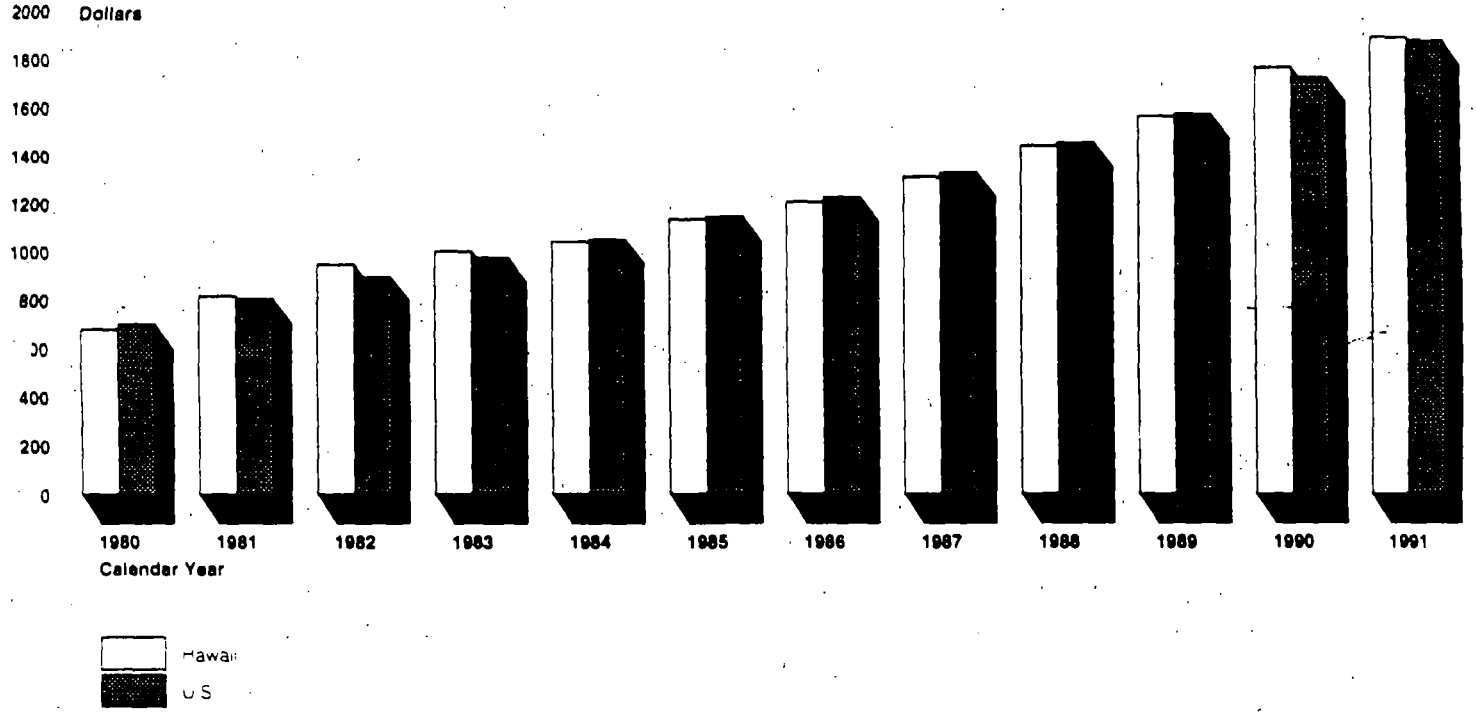
[24]The QUEST request for proposals requires successful bidders to obtain a $1 million performance bond for the state to hold as security against the proper performance of the contract. The bond will be adjusted according to the number of recipients enrolled. After adjustment, the bond must be sufficient to cover approximately 2 months of capitated payments. A center representative estimated that this would require a $2 million to $3 million bond. Regarding geographic coverage, successful bidders must accept recipients from all geographic areas on a particular island, except on the island of Hawaii, which due to its size is divided into two geographic regions.

[25]Hawaii, however, does have certificate-of-need requirements for hospital construction; changes in service; and major capital equipment purchases, such as magnetic resonance imaging machines.

[26]Access to Health Care: States Respond to Growing Crisis (GAO/HRD-92-70, June 16, 1992).

(see fig. 1). Between 1980 and 1991, those expenditures increased at an average annual rate of 9.8 percent in Hawaii and 9.4 percent in the nation.

Figure 1: Hawaii and U.S. Per Capita Expenditures for Hospitals, Physicians, and Prescription Drugs (1980-91)



Source: Health Care Financing Administration.

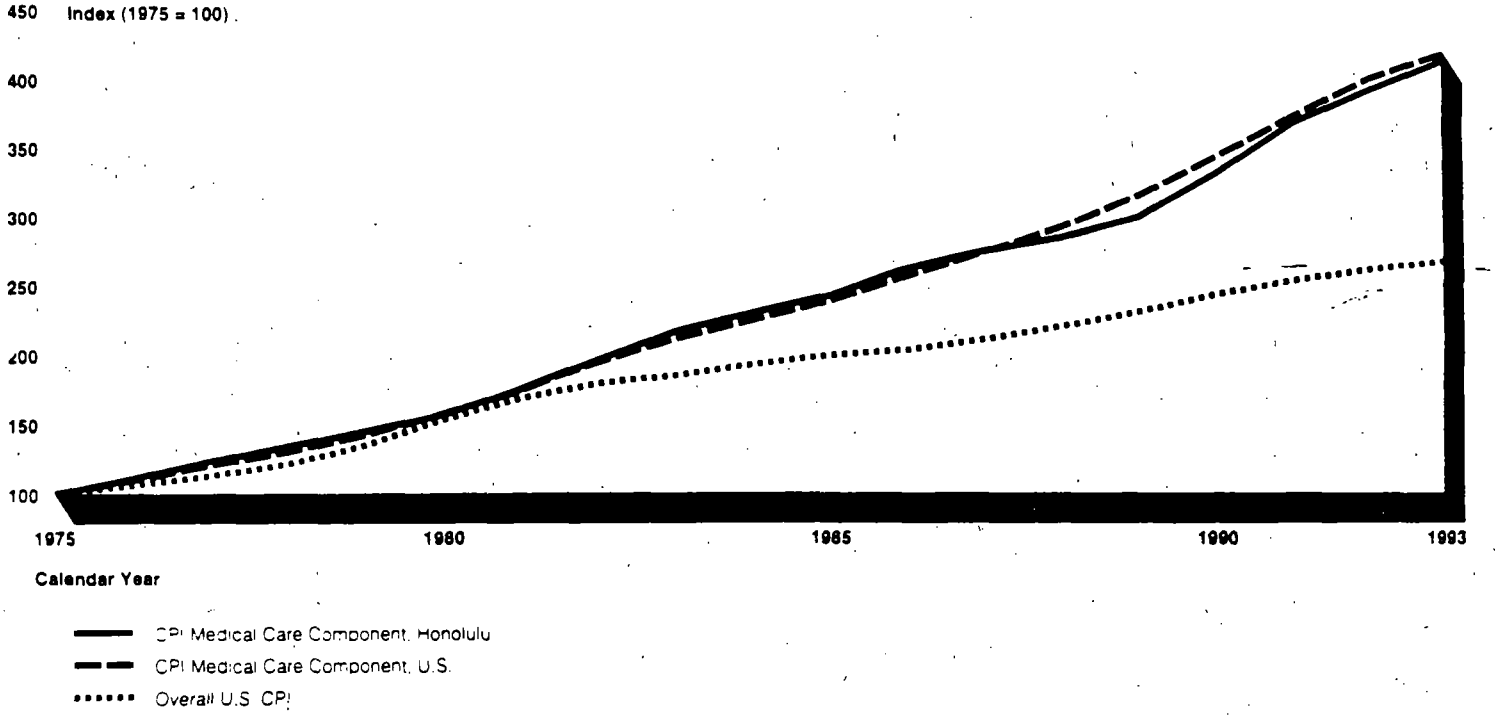
Same Factors Drive Up Health Care Costs in Hawaii and the United States

In both Hawaii and the nation as a whole, health care costs have been rising more rapidly than the average rate of inflation for other goods and services (see fig. 2).[27] State officials, insurers, and health care providers told us that Hawaii is not immune to the factors that have driven up health care costs nationally. These officials said that administrative costs are high and rising; wages for health care professionals, particularly nurses and

[27] Figure 2 uses the rate of inflation for Honolulu because statewide data are not available. The Honolulu data are representative of Hawaii's experience because 75 percent of Hawaii's population resides there.

some technical specialists, have risen significantly in recent years; and medical equipment costs are rising due to advances in technology.[28]

Figure 2: Consumer Price Index (CPI) Medical Care Component for Honolulu and the United States Compared to Overall CPI (1975-93)



Note: The 1993 data are based on the first 6 months of the year.
With 75 percent of Hawaii's population, Honolulu is representative of the entire state.

Cost of Medicaid Program Has Escalated

The cost of Hawaii's Medicaid program has increased significantly in the past few years. During this period, Medicaid expenditures nationwide also rose dramatically (see table 1).[29]

[28]We reported on the roles of technological advances and administrative costs in the growth of hospital costs nationwide in Hospital Costs: Adoption of Technologies Drives Cost Growth (GAO/HRD-92-120, Sept. 9, 1992).

[29]Nationwide, Medicaid enrollment increased by 2.7 million beneficiaries from fiscal year 1990 to fiscal year 1991; the largest single-year increase in the program since the mid-1970s.

Table 1: Growth in Hawaii and U.S. Medicaid Expenditures

	Fiscal year		
	1990	1991	1992
Hawaii	17%	10%	32%
U.S.	18%	27%	30%

Source: Hawaii State Department of Human Resources; Health Care Financing Administration (HCFA).

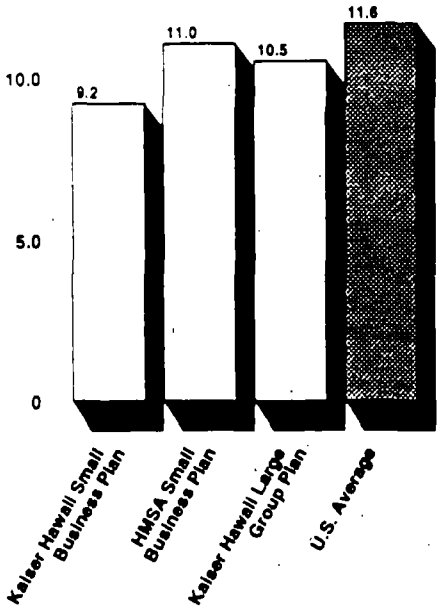
In fiscal year 1992, Hawaii experienced a shortfall in its Medicaid budget, requiring the state legislature to appropriate an additional $64 million to cover costs. Most of the upsurge in Hawaii's Medicaid costs occurred because of increased enrollment prompted by expanded federal program eligibility, Hawaii's recent economic downturn, and the SHIP outreach program, which enrolled additional eligible people in the Medicaid program. The cost per Medicaid beneficiary also increased; from fiscal year 1989 to fiscal year 1991, Hawaii's average cost per recipient rose between 7 and 9 percent each year,[30] primarily due to the escalating cost of health care. (See app. II for additional information on the costs of Hawaii's Medicaid program.)

Health Insurance Premiums Lower in Hawaii

Health insurance premiums are lower and have been rising less rapidly in Hawaii than in the nation as a whole (see fig. 3). In 1991, annual premiums for three of the most prevalent health plans in Hawaii—one large-business plan and two small-business plans—were lower than the U.S. average cost of $1,604 for comparable coverage by $358 to $396 (see fig. 4). Because the figure for the national average includes costs for both large and small companies—and premiums for large companies typically cost less than those for small companies—the lower cost for the two Hawaii small-business plans is especially notable. Moreover, insurance officials in Hawaii told us that premiums for small businesses in Hawaii are not much different from those for large businesses.

[30]From 1988 to 1991, nationwide Medicaid expenditures per capita grew at an average annual rate of 12.3 percent.

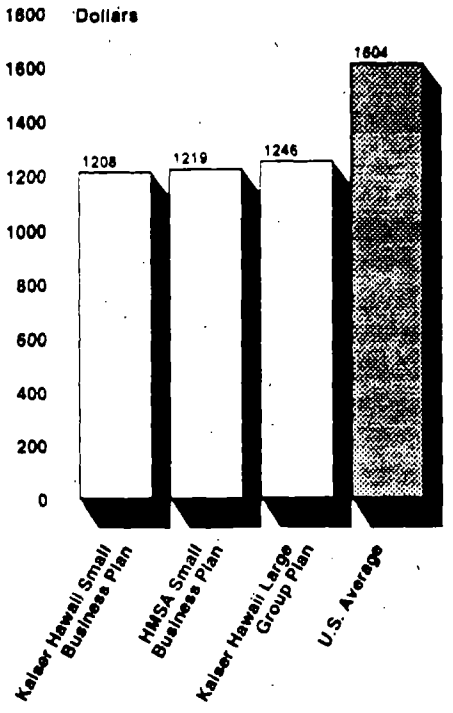
Figure 3: Average Annual Increases in Kaiser Hawaii and HMSA Premiums Compared to the United States
(1984-92)



Note: Data for Hawaii are based on annualized changes for single coverage plans for 1984-92.

Sources: Kaiser Foundation of Hawaii, HMSA, and Foster Higgins Health Care Benefits Survey for 1984-92.

Figure 4: Annual Medical Plan Costs for Single Coverage in Hawaii Compared to the United States in 1991



Source: Kaiser Foundation of Hawaii, HMSA, and 1991 Wyatt COMPARE Data Base.

Several factors may contribute to Hawaii's lower premium costs. One is the reduced amount of cost shifting in Hawaii. In general, health care providers pass on the cost of providing uncompensated care to patients with private insurance coverage. Because relatively few Hawaii residents are uninsured, the need for people with insurance to cover such extra costs is minimized. As a result of the state's requirement that all eligible employees accept health insurance, healthy people cannot opt out of the system. Total health care costs, therefore, are spread over wider risk pools that include both healthy and less healthy people. An additional factor that lowers costs for many small businesses is the major insurers' use of

modified community rating for small businesses.[31] (See app. III for detailed information on health insurance premiums in Hawaii.)

Small Businesses Report Little Adverse Impact From Employer Mandate

Most small businesses in Hawaii expressed general satisfaction with the Hawaii health insurance system, but they regard the mandatory provision of insurance as a burden. We found no evidence that the employer mandate resulted in large disruptions in Hawaii's small business sector.[32]

Preliminary results from a Louis Harris and Associates, Inc. survey of small businesses[33] in Hawaii conducted for the Kaiser Family Foundation[34] found that taxes and health insurance are viewed as the top two problems facing small business. Fifty-six percent of small businesses that were surveyed considered the cost of health insurance to be a major problem—more than any other government requirement.[35] However, more small businesses in Hawaii considered the inflation of their health care costs to be under control (54 percent) rather than out of control (41 percent).[36] This is a more favorable view than the view of small businesses in the rest of the country, 62 percent of which characterized the inflation of their health care costs as somewhat or totally out of control.

[31]When insurers use community rating, they base premiums on the anticipated health care utilization of all subscribers in a particular geographic area or other broad grouping. This contrasts with the more common practice of experience rating, in which insurers base premium rates on the medical experience of each insured group. The major fee-for-service insurer in Hawaii uses a system of modified community rating for businesses with fewer than 100 employees. Small businesses are placed in one large risk pool, but their premiums may be adjusted up or down by up to 20 percent, depending on their utilization. For large businesses, however, Hawaii's major insurers determine rates from a company's experience. This results in a wider range of insurance premiums for large companies, with some large businesses paying higher premiums than small ones.

[32]State officials point to the limited use of a State Premium Supplementation Fund as evidence that Hawaii's employer mandate has not overburdened small businesses. PHCA established the fund to subsidize employers with fewer than eight employees, and to pay health care benefits for employees of bankrupt or noncompliant employers. Since July 1975, the state has paid less than $110,000 from this fund. However, business leaders told us that few businesses knew of the existence of the fund until recently, and state officials said that the limitations on the use of the fund are very restrictive. Consequently, the use of the fund may not be a good indicator of the effect of the mandate on small businesses.

[33]These were businesses with 100 or fewer employees; firms of this size employ over half of the state's work force.

[34]Kaiser/Harris Survey of Small Business Owners in Hawaii, 1993 (preliminary findings).

[35]Other requirements include worker's compensation, unemployment compensation, and occupational safety and health requirements.

[36]Forty-six percent of the companies surveyed in Hawaii considered health care cost inflation to be somewhat under control and 8 percent considered these costs to be completely under control.

Premium History of Prevalent Insurance Plans in Hawaii (1984-93)

	Kaiser[a] Small Business Plan B		HMSA[b] Small Business Plan 4		Kaiser[a] Large Group Plan B	
	Monthly premium	Percent change	Monthly premium	Percent change	Monthly premium	Percent change
1984	$52.92		$47.52		$52.92	
1985	67.92	28.34%	47.52	0.00%	67.92	28.34%
1986	61.62	-9.28	55.72	17.26	61.62	-9.28
1987	63.88	3.67	64.70	16.12	63.88	3.67
1988	66.24	3.69	73.12	13.01	66.24	3.69
1989	72.68	9.72	87.58	19.78	72.68	9.72
1990	90.36	24.33	94.62	8.04	90.36	24.33
1991	100.70	11.44	101.58	7.36	103.80	14.87
1992	107.20	6.45	109.72	8.01	117.65	13.34
1993	115.49	7.73	128.38	17.01	130.49	10.91

Note: All premiums are for individual coverage.

[a]Kaiser Foundation Health Plan

[b]Hawaii Medical Service Association

Source: Kaiser Foundation Health Plan and Hawaii Medical Service Association.

Coverage

UNIVERSAL COVERAGE AND ECONOMIC GROWTH

OVERALL MESSAGE:

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

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

PRESENTATION:

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

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

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

With universal coverage, all these problems are eliminated.

WITHOUT UNIVERSAL COVERAGE:

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

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

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

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

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

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

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

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

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

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

FACT SHEET

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

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

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

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

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

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

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

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

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

ATTACHED ARTICLES

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

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

3) Page from an EBRI survey on job lock.

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

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

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

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

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

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

WORKING PAPER SERIES

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

Brigitte C. Madrian

Working Paper No. 4476

NATIONAL BUREAU OF ECONOMIC RESEARCH, INC.

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

V. Conclusions

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

Estimating the welfare consequences associated with job-lock is a more difficult issue. Although an explicit welfare calculation is beyond the scope of this paper, there are three factors to consider in evaluating the implications of job-lock for economic efficiency. The first is whether there is an important match specific component [illegible] If job turnover results in increased match quality between workers and firms, job-lock will result in a loss of economic efficiency. In contrast, if workers are essentially "replaceable", job-lock will only affect the distribution of output. To the extent that job-lock does lower productivity, a second important consideration is whether these losses are temporary or permanent. While pregnancy is a preexisting condition that comes and goes in a matter of months, some of individuals facing job-lock will be affected by conditions that last for years.

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

June 16, 1993

Insurance concerns affect job choices, many workers say

By Jill Hodges and Darlene DePass
Staff Writers

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

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

the national health

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

Insurance continued on page 16A

Staff Photo by Mike Zerby

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

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

Continued from page 1A

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Health insurance concerns not only

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

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

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

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

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

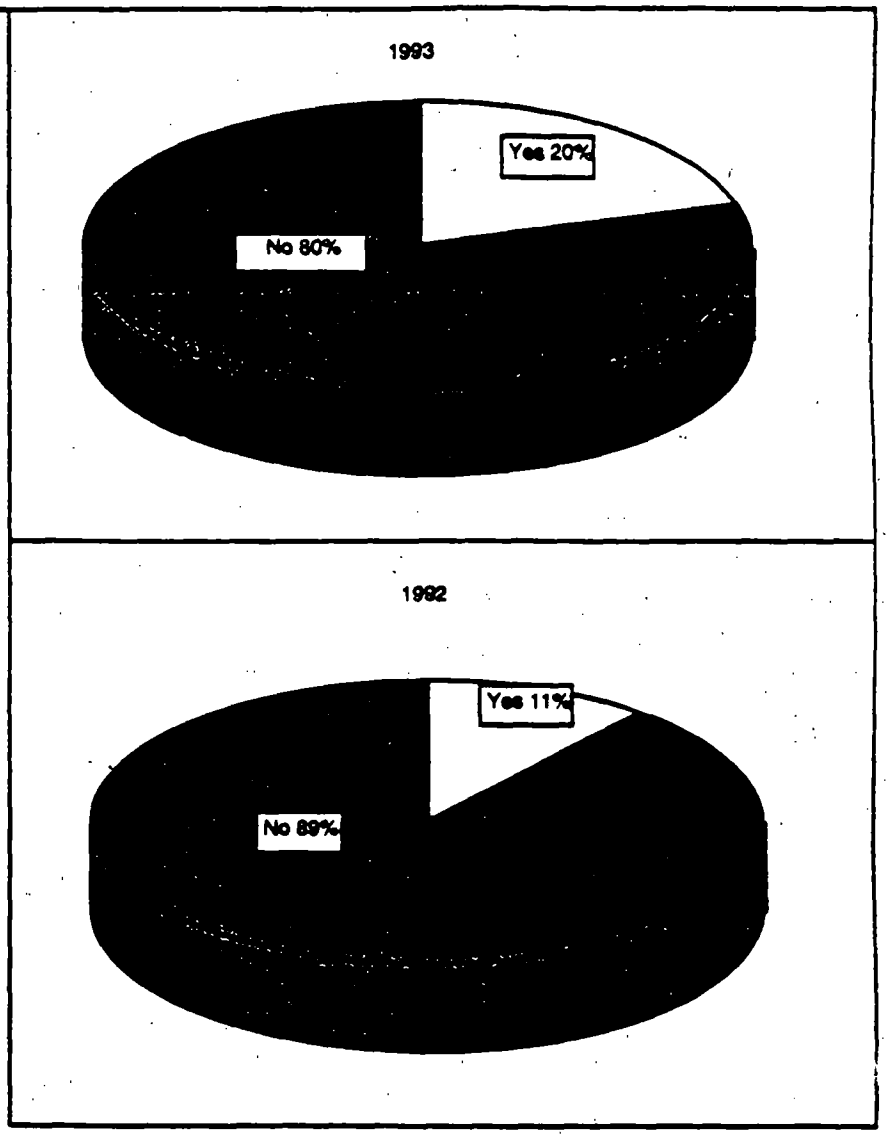
Similarly, Bruce Torgerson, a business manager in the health care industry, said health insurance costs figure prominently in his personal job decisions as well as in his business.

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

Question 9

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

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



file 6754

JAN 26 1994

PEOPLE STAYING ON WELFARE TO GET HEALTH COVERAGE

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

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

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

Bibliography

Moffitt, Robert and Barbara Wolfe, "The Effect of the Medicaid Program on Welfare Participation and Labor Supply." Discussion Paper 909-90; Institute for Research on Poverty, Madison Wisconsin, January 1990.

Keane, Michael and Robert Moffitt. " A Structural Model of Multiple Welfare Program Participation and Labor Supply." Working Paper 91-29; Brown University, Providence, Rhode Island, October 1991.

Ellwood, David and E. Kathleen Adams. "Medicaid Mysteries: Transitional Benefits, Medicaid Coverage and Welfare Exits." Health Care Financing Review, 1990 Supplement.

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

STEVE

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

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

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

INTRODUCTION

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

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

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

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

Table 4

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

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

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

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

Push and Pull Are Evident

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

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

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

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

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

PRIVATE INSURANCE: THE SUPERIOR WORK INCENTIVE

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

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

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

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

income-conditioned payments would partly reduce such costs.

CONCLUSIONS

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

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

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

TECHNICAL NOTE

Indexes of Health Insurance Values

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

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

- The Face of The 90's

THE BOSTON GLOBE • WEDNESDAY, MAY 11, 1994

The mood toughens on welfare

By Don Aucoin
GLOBE STAFF

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

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

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

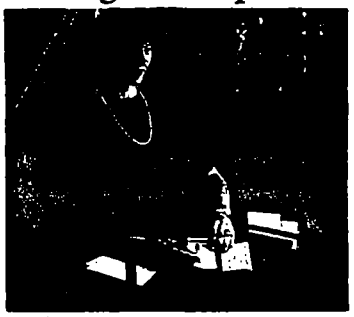
Sometimes he and his wife get so discouraged, Bryant confessed suddenly, that "we've even discussed breaking up" so she and their sons would qualify for certain benefits denied to intact working families.

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

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

WELFARE, Page 8

Levenger Lap Desk



Now you can do serious work in the comfort of your favorite chair or in bed. The unique size (13" x 31") and shape of the Levenger Lap Desk lets you spread out as you would on a regular desk. Take notes while reading, write letters, do bills– and it's ideal for a notebook computer. Choose beautiful natural or dark cherry. Weighs less than 1½ lbs. *Pat. Pend.*

$39.95 + $5.95 shipping via UPS ground
Two for **$37.95** (each) + **$11.95** shipping
MC/VISA/AMEX/DI/Check • Florida add 6%
Money-Back Guarantee • Catalog on Request
800-544-0880 or 407-276-4141

LEVENGER®
TOOLS FOR SERIOUS READERS
420 Commerce Drive, Code NYLD17, Delray, FL 33445

PSV
A Romantic Private Island Hideaway
Petit St. Vincent Resort ***800-654-9326***
Grenadines, West Indies ***Fax 513-242-6951***

GALAPAGOS
You, 9 other adventurers and our licensed naturalist will sail by yacht to explore more islands than any other Galapagos expedition. 60 trip dates. Machu Picchu option. Free brochure.
Inca Floats, 5[illegible]
1311 Y 63rd St., Emeryville CA 94608

LONDON THEATRE NEWS
Stylish monthly newsletter features reviews, recommendations, theatre and restaurant listings, and a ticket booking service. $49 - 1 yr; $29.95 - 6 months. Please send check to:
London Theatre News
Suite 620, 12 East 86th Street, New York, N.Y. 10028.
Or call: 1-800-[illegible]

CHAPEL HILL, NORTH CAROLINA
Retire to Fearrington, a Country Village full of bluebirds, hollyhocks and fascinating people of all ages. Please write, call, or come and see us.

200[illegible] ington Post, Pittsboro, NC [illegible] 130

DEPARTMENT OF DISPUTATION

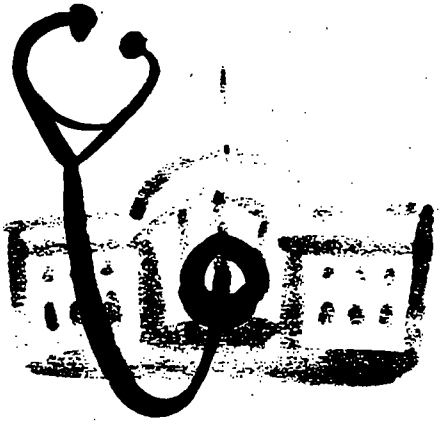
SHARE THE HEALTH

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

BY MICHAEL KINSLEY

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

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



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

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

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

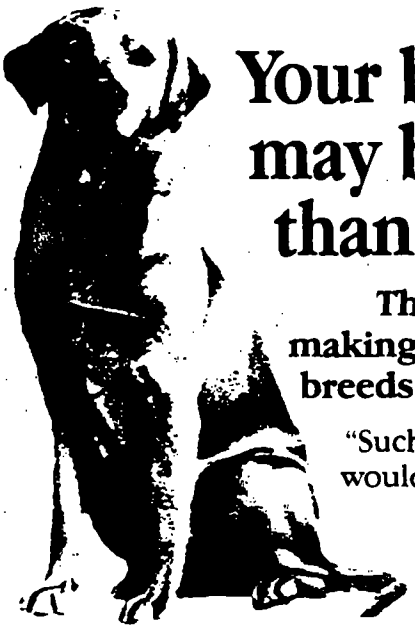
When people are all charged the same price for insurance, regardless of their likely health-care requirements, this is called "community rating." Government-mandated community rating will raise insurance costs for healthy people for two reasons. First, the insurer will have to cover the risk of your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

is then entitled to withdraw it according to need.

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

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

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



Your best friend may be smarter than you think

The book that's been making news about which breeds are the brightest...

"Such a great book...the kind would-be dog owners should be required to read."
—*The Washington Post Book World*

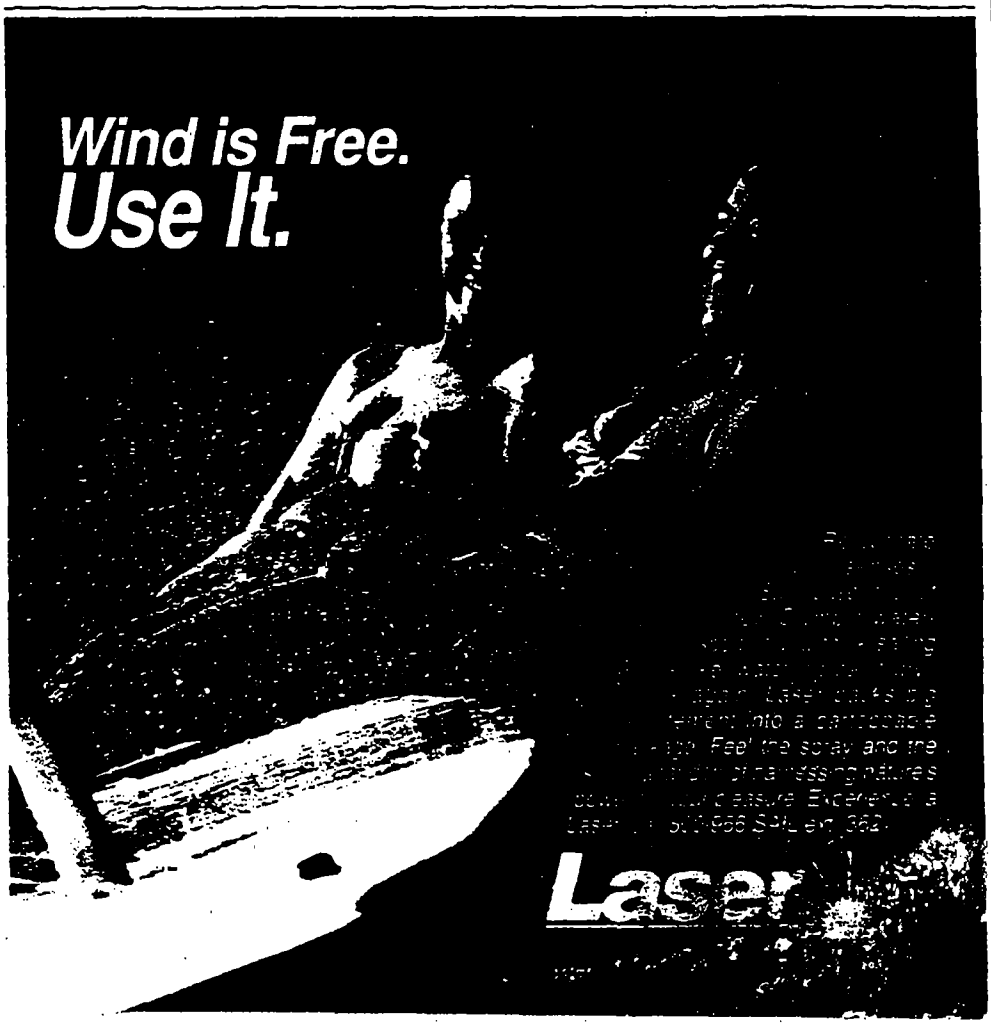
THE INTELLIGENCE OF DOGS

Canine Consciousness and Capabilities

By STANLEY COREN

At all bookstores

FP THE FREE PRESS A Division of Simon & Schuster



certain specialties will discourage those with expensive diseases.

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

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

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

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

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

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

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

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

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

PUT ON THE DOG

Now you can wear all the personality and wit of The New Yorker. Our cotton sweatshirt and t-shirt feature the irascible bull terrier created by New Yorker cartoonist George Booth.

FOR CREDIT CARD ORDERS, CALL TOLL-FREE: 1-800-336-5510

Or send check or money order with your name and address to:
New Yorker Products
Box 10214, Dept. 672147
Des Moines, IA 50336

Back of shirt.

Sweatshirts $24.95, **T-shirts** $14.95, both come in L or XL Please add $2.50/shirt for shipping and handling.

Offer only available in U.S. and Canada. Residents of CA, CO, GA, IA, IL, KY, MA, MI, NY. Please add applicable sales tax. In Canada, 7% GST. Please allow 4-6 weeks delivery. © 1993 *The New Yorker* Magazine, INC.

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

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

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

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

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

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

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

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

be greater than that of Clinton's employer mandates.

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

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

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

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

Uniquely Inter·Continental.

Sensational "Spectacular Summer Options" rates plus miles or points with one of 12 participating airlines each night of your stay.

WILLARD INTER-CONTINENTAL WASHINGTON
1401 Pennsylvania Avenue, N.W. • Washington, D.C. • From $199*

HOTEL INTER-CONTINENTAL NEW YORK
111 East 48th Street • New York, New York • From $159*

Choose one of the valuable Options below.

☐ *Upgrade to a suite.*
☐ *Adjoining guest room for half-price.*
☐ *Double bonus miles or points for participating airlines.*
☐ *Overnight parking.*
☐ *$25 food or beverage credit.*

For reservations, contact your travel agent or call toll-free 800-327-0200.

INTER·CONTINENTAL HOTELS

** Per night, single or double occupancy, through 9/5/94. Based on availability and advance reservations. Local taxes and gratuities not included. Not available to groups. Some restrictions apply.*

10 PLAYS • 3 THEATRES • IN REPERTORY UNTIL OCTOBER

Shaw Festival

NIAGARA-ON-THE-LAKE, ONTARIO, CANADA

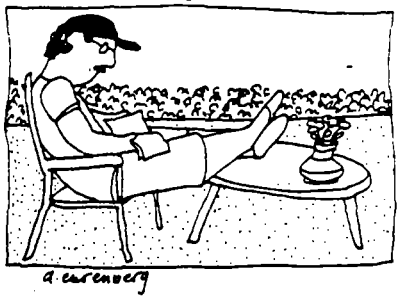
"One of the leading festivals of the English speaking world"
DETROIT FREE PRESS

ARMS AND THE MAN • THE FRONT PAGE
LADY, BE GOOD! • SHERLOCK HOLMES
AND MORE. TWO HOURS FROM TORONTO

1-800-267-4759

CALL FOR A FREE BROCHURE!
PACKAGES AVAILABLE

DO YOU TEACH?
IF SO, PLEASE READ ON...



The New Yorker is delighted to offer an education program to teachers who want to share the magazine with their students. For information and materials to help you use *The New Yorker* in your classroom, please call Elaine Berman at (212) 536-5415 or write to her at the address below:

THE NEW YORKER
EDUCATION PROGRAM
20 West 43rd Street, New York, NY 10036-7440

N.W. Connecticut
KLEMM REAL ESTATE
Rentals • Sales
203-868-0505

A NEW CHOICE FOR UNPIERCED EARS
Spring-Back Hoops
Comfortable yet Secure
(4 sizes available)
1-800-262-6026
SS $23.00 14K $75.00
(Prices are for hoops Shown)
Spring City Craftsman
190 N. Main Spring City, Utah 84662
Actual Size

a small hotel in Montana
Newly restored luxury hotel at the edge of the Rocky Mountains. Many outdoor activities. Entirely non-smoking.
1-800-POLLARD
fax 406-446-3733

FREE CATALOGUE
MINNETONKA
MOCCASINS
CALL 1-800-603-0003
Handsewn in the U.S.A. Hundreds of styles.
WORLD TRADERS
Bar Harbor Rd., Box 158-6
Brewer, ME 04412

"So, how's your snit coming?"

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

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

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

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

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

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

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

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

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

Wake Up Energized!

Enjoy the ultimate in sleeping comfort. Select Comfort supports your entire body on a cushion of air that gives you the firmness you want at the touch of a button.

Select Comfort's patented air design conforms to your body shape for relaxing sleep and perfect spinal support.

With Select Comfort, you each get exactly the firmness you need.

Studies prove our exclusive air design supports your spine more evenly than metal coil mattresses or waterbeds. And because Select Comfort has no springs to wear out and sag, we can offer you one of the longest warranties in the bedding industry – 20 years.

Why Not Feel For Yourself?

With our 90 Night No-Risk Trial, you can sleep on it for three months before you decide. For more information, call toll-free or return the coupon below.

Variable Firmness: A Comfort Breakthrough.

Dual air chambers inside the mattress can each be made firmer or softer, so you each get the exact support you need.

The Only Mattress with Push Button Firmness Control.

SELECT COMFORT
AIR SLEEP SYSTEMS

Call For Store Nearest You

1-800-831-1211

Please send me a FREE Video, Brochure and Price List.

Name_____
Address_____
City_____ State ____
Zip_____ Phone_____

Mail to: Select Comfort Corporation
6105 Trenton Lane N., Minneapolis, MN 55442
Dept 2787

LOCATORS INCORPORATED

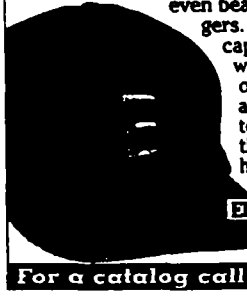
SPECIALISTS IN DISCONTINUED CHINA • CRYSTAL • SILVER
908 Rock Street
Little Rock, Arkansas 72202
800/367-9690
Call today to speak with our customer service representative.

CAT BROOCH

Based on a Japanese netsuke, this charming kitty is handcrafted in sterling silver. Designed by Chip deMatteo. 1.5" $40. PPd. Catalog $2.
Williamsburg Merchants
223 Parkway Drive
Williamsburg, VA 23185
(800) 545-4556
HAND & HAMMER SILVERSMITHS

Wear a Piece of Baseball History

From the 1920s through the 1950s, the Bushwick club of Brooklyn was the most successful independent baseball team in the country. Their field, Dexter Park was the first stadium to feature permanent lighting. The Bushwicks even beat the big league Dodgers. Jerseys, jackets, and caps from the Bushwicks and over 100 other Minor, Negro, and Latin American teams are available through our 64 page historic baseball apparel catalog.



Ebbets Field Flannels
PO Box
Seattle, WA
For a catalog call 1-800-377-9777

Study Sees Problems in Subsidies to Help the Poor Buy Insurance

By ROBERT PEAR
Special to The New York Times

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

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

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

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

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

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

On Providing Subsidies

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

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

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

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

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

Gradual Phasing Down Urged

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

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

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

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

The Use of Overtime

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

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

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

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

1 DETAILS

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

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

By ELIZABETH SHOGREN
TIMES STAFF WRITER

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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