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HOW THE CLINTON AND NICKLES-STEARNES HEALTH BILLS WOULD AFFECT AMERICAN WORKERS

INTRODUCTION

The primary reason that many Americans with insurance fear they will lose it, and that millions of working Americans want insurance but are unable to obtain or afford it, is because most health insurance is employer-based. This employment-based system is an historical accident. It continues because families normally face a huge tax penalty for obtaining insurance in any other way, such as buying it directly or obtaining coverage through some alternative group, for instance their union or their church. This tax penalty, and the lack of any significant federal assistance other than this form of tax relief, explains part of the uninsurance problem.

The second, related reason is that under the employer-based system, the employer actually owns the plan and decides the benefits (either arbitrarily or by bargaining with employees or a union). The employer also controls the amount of a worker's total compensation that will be devoted to coverage. Thus unlike life insurance or homeowner's insurance, a health insurance policy typically does not belong to the person insured. Hence a change of job, or any employer-decided change in benefits, can mean the loss of insurance, or at the very least a change in coverage.

Until this system is changed, there will always be a problem in America of families unable to acquire the plan that is best for them, and always a fear that coverage will be interrupted or lost. Until it is changed, it will not be possible for all Americans to afford at least a basic level of medical services and insurance protection.

The Heavy Cost of An Employer Mandate

Some Members of Congress, as well as officials of the Clinton Administration, maintain that the way to resolve these problems is to require all employers to provide comprehensive coverage, with subsidies to certain employers and workers to reduce this cost. But an "employer mandate" is in practice merely a disguised individual mandate. Thus if Congress is determined to mandate some level of coverage, there is no alternative to an

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individual mandate. Moreover, as a new analysis of the Clinton Administration's Health Security Act shows, the "pass-through" of an employer mandate in the form of reduced wages would be heavy.

An employer mandate is really a grossly misleading term because in practice it means simply that employers are required to earmark a specific portion of a worker's total compensation and use it to purchase health insurance. Most of the money to buy coverage, in other words, comes out of the worker's paycheck, not from the employer's profits or higher prices charged by the firm. In a review of the economic literature, the econometrics firm of Lewin-VHI notes that approximately 88 percent of the cost of any such mandate would be passed on in reduced wages.

According to a new Lewin-VHI analysis of the Administration's Health Security Act, conducted for The Heritage Foundation, the employer mandate in the Act would, in 1998, mean reducing the wages of workers in firms not currently providing insurance by an average of about \$1,243, or 6.1 percent. This wage cost is in addition to the change in family health costs associated with the plan, the details of which were identified by Lewin-VHI in a December 9, 1993, analysis of the Health Security Act.¹ In addition, Lewin-VHI points out that in the case of many lower-income employees, a loss of job is more likely in practice than a reduction in wages. Lewin-VHI estimates the range of job losses at 155,000 to 349,000, heavily concentrated among lower-paid workers.

Why an Individual-Based System Is Needed

If Americans really do want universal coverage, they must appreciate that the only possible method to meet that goal would be to require all individuals to obtain some level of coverage and to provide lower-income households with the means necessary to comply with that requirement. An employer mandate is merely a hidden and incomplete mandate on individuals. The Clinton Administration evidently recognizes this, since the Health Security Act actually places the ultimate obligation on individuals to choose a plan and to pay their share of the premium.

There can and should be debate over what universal coverage actually means, and whether it is even desirable. Does it mean an assurance that anyone who actually wants some minimum level of insurance protection can obtain it at an affordable cost (including any subsidy they may receive)? Does it mean people should be required to have a certain level of insurance whether they want it or not? Does it mean protection against catastrophic costs or "insurance" against the cost of a \$20 prescription?

Goals of Health Care Reform

As Congress considers health reform, lawmakers should perhaps view their task as trying to achieve three goals. The first is that all Americans not in government health programs should in some way be able to obtain an adequate, minimum level of health care, including protection against catastrophic health care costs, at a reasonable cost to the household.

¹ For a summary of that analysis, see Stuart M. Butler, "What the Lewin-VHI Analysis of the Clinton Health Plan Really Shows," Heritage Foundation *FYI*, January 7, 1994.

The second goal should be for as many Americans as possible—ideally all—to carry at least catastrophic insurance. In a sense, Americans already have a form of catastrophic protection, since hospitals are legally obligated to provide emergency acute care, even if an individual does not have the means to pay for it. So trying to reach the goal of universal catastrophic insurance protection would in large part be to protect society from the potential cost of an individual with adequate means who refused to buy insurance. In other words, it would be a form of liability insurance, paid for by each individual, to protect the rest of society for uncompensated care costs.

The third goal would be to achieve this objective of near-universal catastrophic protection as far as possible through incentives, not by coercion. Most uninsured Americans do want the protection of insurance, and would willingly purchase it if it were affordable. On the other hand, there are some “free riders” who will demand expensive medical care yet refuse to insure themselves against the cost of it, relying on the legal or moral obligation of more responsible citizens to pick up the tab. The goal should be to reduce the number of such free riders to an acceptable level, recognizing that to end that problem completely, say through a fully enforced mandate to buy coverage, likely would be too intrusive.

If these are the goals of Congress, then to achieve them health care reform would have to contain certain key elements.

ELEMENT # 1: Families must be free to choose any plan (and set of benefits) irrespective of their place of employment, and with the same tax relief wherever they obtain their plan or care.

The current tax code heavily penalizes households that do not obtain care through an employer-owned plan. To open up more methods for families to obtain coverage, the tax code would have to be neutral with respect to where a family obtained its plan. Thus the tax code would have to treat the family the same, whether the plan was sponsored by an employer (as today), a union, a church, some other sponsoring group, or directly from an insurer. Ideally, the tax code also should not discriminate between paying for health care through insurance, out-of-pocket, or by disbursements from a special account (sometimes called a “medical savings account”). This latter tax neutrality would enable families, without any tax distortion, to decide the most economical balance of insurance savings, and direct health spending to deal with their health care needs.

To enable families to make a rational choice between obtaining coverage through an employer-based group or some other group, employees with company-sponsored plans would have to have the right to “cash out” the actuarial value of their current benefits and put this money toward an alternative plan.

ELEMENT #2: All working-age households not in Medicaid should be encouraged to obtain at least a catastrophic plan.

There is widespread agreement that Americans should be able to obtain at least a basic level of health care, including major emergency services, without facing bankruptcy. If Congress’s objective were to achieve—literally—insurance protection against catastrophic medical costs for every American, then obtaining such coverage would have to be a legal requirement for all Americans. Without that mandate the goal could not be achieved because some individuals would refuse to insure themselves and yet could re-

