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THE STEALTH CLINTON HEALTH PLANS: A GUIDE TO THE HOUSE AND SENATE BILLS

INTRODUCTION

President Bill Clinton reminded Americans at his recent press conference that any final health care legislation will be the product of conference negotiations between the House and the Senate. Thus, lawmakers contemplating their votes on the majority leadership bills in each chamber should remember that the bill their chamber passes will become a vehicle for that conference bill. Hence they should examine the common elements of these bills, recognizing that these are the elements most likely to be in the final conference bill—and recognizing also that the White House and majority leadership will have the loudest voices in shaping conference decisions.

Moreover, the common elements do not even have to survive in both bills to become law. If the White House and its Hill allies succeed in retaining a feature they desire in either version, the conference committee can keep it in the conference report. Given the likely makeup of the conference, this is very likely. And many liberals in the Senate also have indicated that their strategy is to accept a bill without certain features they really want (such as an employer mandate or, better still, a single-payer Medicare Part C provision) with the expectation that some or all of these elements will be in a conference bill.

It thus becomes clear why President Clinton spoke so warmly of a Senate bill that may seem to depart from many of his health care objectives. The fact is that the leadership bills developed by Senator George Mitchell (D-ME) and Representative Richard Gephardt (D-MO) contain key common elements that are the same as the central features of the original Clinton plan. And if they are not in both bills, they are key elements in one. Despite protestations from the House and Senate majority leadership—and even the White House—that the new bills are not merely slight modifications of Clinton's increasingly unpopular plan, an examination of the bills shows otherwise. The conference bill emerging from them likely would be much closer to the Clinton plan than Mitchell and Gephardt seem prepared to admit.

In other words, the central, unpopular features of the Clinton plan are alive and well in the Mitchell and Gephardt bills. Among them:

- ✓ **Both bills contain employer mandates.** In Gephardt's bill, an employer mandate goes into effect immediately. In Mitchell's, a mandate goes into effect if a virtually unattainable target percentage of coverage is not achieved voluntarily.
- ✓ **Both bills introduce a government-chosen standardized benefits package.** Like the Clinton plan, the Gephardt bill places in statute the benefits each American and his employer will be forced to buy, leaving families to buy other services they need out of their own pockets with no tax relief. The Gephardt standard package, for instance, does not include protection for catastrophic medical expenses, so a family with the required standard plan could be wiped out by a serious medical problem. The Mitchell bill allows a commission to set the package within certain guidelines, so Americans will not know exactly what is covered until after the bill becomes law.
- ✓ **Both bills pave the way for direct federal control of health care.** Gephardt introduces a new Medicare Part C for those currently on welfare and for millions of working Americans. The federal government will run this nationwide alliance, setting fees and budgets. In Mitchell, the approach is more subtle. The federal government establishes an exclusive alliance for certain workers in areas where states do not create their own alliances. Rules governing this system would be drawn up by Washington.

The New York Times, in a recent editorial, accurately described the implications of the new Medicare Part C program:

Medicare Part C, unlike the program limited to the elderly, threatens to trigger an inevitable roll toward government-run medicine for most Americans.¹

- ✓ **Both bills introduce price or spending controls.** Like the Clinton plan, both bills establish mechanisms to limit spending on health or to control prices, each of which would lead to government rationing. With the creation of a Medicare Part C program, the Gephardt bill means physicians and hospitals serving almost half the population would be subject to price controls and spending limits. Moreover, if health plans do not sharply reduce the growth of costs, "stand-by" federal price controls would be applied to the entire health industry.

The Mitchell bill, on the other hand, gives vague powers to a new National Health Care Coverage and Cost Commission to recommend ways to hold down costs and requires Congress to vote on its recommendations in an expedited up-and-down process. The Mitchell bill also claims to contain a "fail-safe" provision to prevent any increase in the deficit due to new federal subsidy programs. But if the bill's sequester mechanism actually were invoked, observes the Congressional Budget Office, it "could make previously eligible people ineligible for subsidies and would reduce the extent of health insurance coverage."² It seems unlikely that Congress would permit

1 Editorial, "The Failed House Health Bill," *The New York Times*, July 30, 1994, p. 18.

2 Congressional Budget Office, "A Preliminary Analysis of the Health Security Act As Reported By the Senate

such a fail-safe provision to go into effect if it consigned insured Americans to the ranks of the uninsured.

- ✓ **Both bills would discourage self-insurance.** Like the Clinton plan, the Mitchell and Gephardt bills strongly discourage larger firms from designing self-insured plans that cater to their employees' specific needs. Both bills, for instance, contain excise taxes on self-insured plans, part of which would be passed through to employees. The Mitchell bill in addition places a 25 percent tax on the value of a plan above a government-specified target. This would hit the more generous plans common in unionized firms. The CBO points out that because the excise tax would not be a deductible expense for employers, the effective rate would be as much as 38.5 percent.³ The Gephardt bill, by including almost half the population under the price-controlled Medicare system, would trigger huge "cost-shifting" to private insurance and self-insured firms, pushing up the cost of such plans and making them far less attractive—an effect *The New York Times* describes as "devastating. Fees to private patients would skyrocket, driving premiums up...."⁴
- ✓ **Both bills create huge new bureaucracies and place unfunded mandates on the states.** Like the Clinton plan, both bills would place many new requirements on states. In its analysis of the Senate Finance Committee bill, on which the Mitchell bill is based, the CBO notes that:

states would bear the brunt of many of the responsibilities for implementation, and it is uncertain whether—and if so, how soon—some states would be ready to assume them.⁵

These responsibilities include determining eligibility for subsidies (which the CBO calls "an enormous [task] for states") providing wraparound Medicaid benefits, establishing and running health alliances, and monitoring health plans.

These new state obligations, as well as new responsibilities for the federal government, mean that the Mitchell bill would create dozens of new federal and state agencies. Summing up these new powers for government officials, *The Washington Post* comments:

[The new government agencies] would have untested authority to centralize, reorganize, monitor and enforce the way medical care is bought, sold and, to a lesser extent, practiced in this country.⁶

The Mitchell and Gephardt bills thus should be seen as two parallel legislative vehicles for enactment of the central elements of the Clinton plan. As lawmakers are courted by the majority leadership in each house, and even by the White House, with claims that their bill "is not the Clinton bill," they should not be fooled. Supporters of the Clinton plan are trying desperately to gain votes for bills which, in isolation and by careful reformulation,

Committee on Finance," July 28, 1994, p. 5.

3 CBO, "A Preliminary Analysis," p. 10.

4 "The Failed House Health Bill," *op. cit.*

5 CBO, "A Preliminary Analysis," p. 6.

6 Dana Priest, "Health Bills May Have No Substitute for Bureaucracy," *The Washington Post*, August 7, 1994, p. A1.

seem to differ significantly from the Clinton plan. They do not. A vote for either of the majority leadership bills can best be described as a vote for the Clinton-Mitchell-Gephardt bill.

HOW EMPLOYERS WOULD FACE HEAVY MANDATES

The House and Senate majority leadership bills both include an employer mandate. The House version would require all employers to pay for at least 80 percent of a standardized benefits package; the Senate version would include a 50 percent employer mandate if less than 95 percent of Americans are fully insured by 2000. It is a near certainty that this "hard trigger" would go into effect, partly because the modified community rating system for premiums means that younger Americans would face insurance costs that generally would be significantly higher than if they simply paid their medical bills themselves.⁷ Thus, many young employees, young self-employed individuals and employers with a young workforce would have little incentive to obtain insurance coverage. Moreover, even in Hawaii, a state which already has an employer mandate, only 93 percent of the population is covered.⁸

So there is little doubt that there will be an employer mandate if the Senate bill becomes law—and equally little doubt that the conference bill will include a mandate if it survives in either bill. Proponents argue that since a majority of Americans already receive their health care insurance through their place of employment, it makes sense to provide coverage to uninsured and "underinsured" Americans through a mandate on employers. In addition, they maintain that requiring employers to pay part of the cost of coverage will reduce or even eliminate the burden on employees. Nothing could be further from the truth.

The impression is given by proponents that an employer mandate is the proverbial "free lunch"—that a payment by an employer imposes no cost on the employee. But the evidence suggests there can be large costs in terms of employment and wages.

A health insurance mandate is an additional cost to employers of hiring or retaining workers. The Fairfax, Virginia, econometrics firm Lewin-VHI recently estimated the impact on employees of the mandate in the original Clinton plan, which is quite similar to the Gephardt mandate. Lewin-VHI noted two effects.

First, when an employer has to pay additional payroll taxes or mandated benefits for an employee, part of that cost is "passed through" to the employee in lower wages. As the CBO explains in a March 1994 report:

An often overlooked point is that the employer share of the cost of employer provided health insurance is ultimately passed on to workers in the form of lower wages and reductions in fringe benefits other than health insurance....[T]his study calls health insurance that employees receive at work "employment based" rather than "employer provided."⁹

7 The Mitchell bill does allow premiums to be adjusted by age, but it limits the variation to a ratio of 2:1, which would still mean younger workers typically would be paying well above the actual cost of their care if they bought insurance, while older workers would be paying much less.

8 GAO Report, GAO/HEHS-94-68, "Health Care in Hawaii, Implications for National Reform," February 1994, p. 5.

Based on the economic literature, Lewin-VHI assumes that an average of 88 percent of a mandate's cost is passed on to employees in lower wages. Using this assumption, Lewin-VHI calculates that if the Clinton plan were enacted, the wages of employees not now receiving insurance would decrease in 1998 by an average of approximately \$1,243, or 6.1 percent (See Table 1). The average wage cut, combining today's insured and uninsured workers, would be about \$400.¹⁰

An analysis of the Gephardt bill, using the same assumption and utilizing the simulation model of the Gephardt bill developed by The Heritage Foundation, reveals that the wages of all workers (combining insured and uninsured workers today) would fall by an average of \$378.¹¹

The second effect noted by Lewin-VHI and other analysts is job loss. Low-wage workers are particularly vulnerable to layoffs if the cost of employing them rises because of a mandate on employers to provide insurance. Lewin-VHI calculates that approximately 350,000 jobs would be lost under the employer mandate in the Clinton plan.¹² Other studies put the job loss as high as 850,000.¹³

As the table by Lewin-VHI indicates, job losses are concentrated in the services and retail trade industry, with approximately one-third coming from the service industry (See Table 2). Furthermore, losses are especially heavy among Americans earning less than \$10,000 per annum (See Table 3).¹⁴ The impact of a mandate would vary by income (See Table 4).¹⁵

Proponents of an employer mandate often point to Hawaii as the model of the benign effects of an employer mandate. Hawaii is the only state which currently mandates all employers to provide health insurance to most of their employees. Its health plan, enacted in 1974, requires employers to provide health insurance to their employees, with the employee share limited to 1.5 percent of wages or 50 percent of the cost of the premium, whichever is lower. This is much lower than the Gephardt requirement of 80 percent and roughly the same as the eventual mandate under Mitchell.

Despite the mandate, however, Hawaii still has not achieved universal coverage.¹⁶ The General Accounting Office notes that "[E]ven some residents with insurance encounter

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- 9 Congressional Budget Office, *The Tax Treatment of Employment-Based Health Insurance*, March 1994, Introduction.
- 10 Lewin-VHI, "The Effects of the Health Security Act on Employee Wages and A Comparison of the Effects of the Health Security Act and the Individual Tax Credit Program on Households," March 9, 1994, p. 19. See also Stuart M. Butler, "How the Clinton and Nickles-Stearns Health Bills Would Affect American Workers," Heritage Foundation *Issue Bulletin* No. 188, April 11, 1994.
- 11 Stuart M. Butler with David H. Winston and Christine L. Olson, "Health Care Debate Talking Points #1: Cost to Business of the Gephardt Bill," Heritage Foundation *FY7* No. 21, Updated August 9, 1994.
- 12 Lewin-VHI, "The Effects of the Health Security Act," p. 39.
- 13 Scott E. Daniels and William R. Mattox, Jr., "Job Losses and the Clinton Health Plan: A Family Impact Analysis," Family Research Council *Insight*, June 14, 1994, p. 1. Estimates of job losses calculated by CONSAD, a Pittsburgh-based econometrics firm.
- 14 Lewin-VHI, "The Effects of the Health Security Act," p. 39.
- 15 *Ibid.*, p. 18.
- 16 GAO "Health Care in Hawaii," p. 1.

Table 1
**Average Wage Change Per Worker (Full and Part-Time),
 by Major Industry: Firms Not Currently Offering Health Coverage**

Industry	Employment	Average Change	Percent of Wages
Construction	3,406,608	(\$1,241.90)	-4.5%
Manufacturing	4,603,829	(\$1,400.70)	-6.2
Transportation	1,477,531	(\$1,503.10)	-4.8
Wholesale Trade	1,201,073	(\$1,311.00)	-5.8
Retail Trade	9,854,295	(\$1,102.20)	-7.1
Service	13,292,267	(\$1,109.90)	-6
Finance	1,987,476	(\$1,358.90)	-4.7
Federal Government	850,866	(\$1,638.70)	-5.9
State Government	1,767,051	(\$1,621.40)	-6.6
Local Government	3,507,845	(\$1,562.20)	-7.8
Other	2,351,029	(\$1,089.40)	-5.8
Total	44,299,870	(\$1,243.60)	-6.1

Source: "The Effects of the Health Security Act on Employee Wages and a Comparison of the Effects of the Health Security Act and the Individual Tax Credit Program on Households," March 9, 1994, prepared for The Heritage Foundation by Lewin-VHI, Inc.

Table 2
**Estimated Job Losses Due to the Health Security Act
 by Industry (Full and Part-Time Workers) in 1998**

Industry	Employment	Job Losses (Elasticity = -0.2)	Job Losses (Elasticity = -0.5)
Construction	6,645,856	5,229	13,074
Manufacturing	21,875,590	28,022	41,767
Transportation	6,931,161	6,078	15,200
Wholesale Trade	4,121,199	1,023	2,536
Retail Trade	16,664,639	30,677	76,578
Service	29,735,649	47,914	110,511
Finance	6,937,199	4,057	10,135
Federal Government	3,443,223	5,150	12,875
State Government	5,121,197	9,081	22,704
Local Government	10,052,903	11,532	28,892
Other	4,619,694	5,857	14,639
Total	116,148,310	154,571	348,915
Total less government	91,330,987	128,808	284,439

Source: "The Effects of the Health Security Act on Employee Wages and a Comparison of the Effects of the Health Security Act and the Individual Tax Credit Program on Households," March 9, 1994, prepared for The Heritage Foundation by Lewin-VHI, Inc.

Table 3
**Estimated Job Losses Due to the Health Security Act
 by Earnings (Full and Part-Time Workers) in 1998**

Earnings	Employment	Job Losses (Elasticity = -0.2)	Job Losses (Elasticity = -0.5)
Less than \$10,000	15,130,637	149,534	336,314
\$10,000-29,999	40,149,316	5,037	12,601
Over \$30,000	60,868,357	0	0
Total	116,148,310	154,571	348,915

Source: "The Effects of the Health Security Act on Employee Wages and a Comparison of the Effects of the Health Security Act and the Individual Tax Credit Program on Households," March 9, 1994, prepared for The Heritage Foundation by Lewin-VHI, Inc.

