POLICY BACKGROUNDER No. 133
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The Clinton/Gephardt Bill

House Majority Leader Richard Gephardt (D-MO) released the health care reform bill of the House Democratic leadership on July 29. It is a composite based on President Clinton's original proposal and on the work of the House Ways and Means and House Education and Labor committees.

While Gephardt has sought to emphasize the differences between his bill and President Clinton's plan, what is remarkable is how little has changed. The proposal still contains:

- Employer and individual mandates, although phased in more slowly;
- Global budgets and price controls, although disguised;
- A uniform, government-specified benefit package that everybody is forced to buy; and
- Community rating, which forces insurers to sell to everyone at the same premium, regardless of expected health care costs.

"Gephardt's proposal calls for even more government power and control than Clinton's."

The only significant differences between the proposals are in the greater degrees of government power and control that Gephardt's contains:

- Gephardt adds a large new tax increase on the middle class that was not included in the original Clinton proposal — a 2 percent tax on health insurance premiums.
- While Clinton sought to expand private insurance coverage, Gephardt creates a massive new government health insurance program, Medicare Part C, to provide coverage to as many as 90 million Americans.

Even as Gephardt proposes Medicare Part C, actuaries note that Medicare Parts A and B are technically bankrupt, since expected future revenues are well below expected future costs.[1] Indeed, Gephardt proposes to make the overall Medicare program even more insolvent by adding expensive new coverage for prescription drugs and other benefits while at the same time financing health care reform largely through reductions in Medicare funding.

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"Instead of solving the problems of the middle class, Gephardt's proposal would create new burdens for them."

Although Gephardt advanced his proposal as the means for solving the problems of the middle class, it would instead create new burdens for them in the following ways:

- Employer and individual mandates would mean a sharp reduction in wages and in some cases a loss of jobs;
- Global budgets and price controls would lead to health care rationing, reduced access and lower-quality care for the middle class, including the elderly middle class;
- A uniform, government-defined benefit package would eliminate freedom of choice for all Americans;
- Pure community rating of health insurance premiums would mean substantially higher costs for young, healthy people with lower incomes;
- Higher taxes would be imposed on the middle class; and
- The subsidies for private insurance, expanded benefits for those covered under government programs and the Medicare Part C program would lead to even higher taxes for the middle class in the future to cover higher-than-projected spending.

These and other problems with the proposed legislation are discussed in more detail below.

Employer and Individual Mandates

The Gephardt proposal, like the original Clinton proposal, would require employers to pay 80 percent of the cost of health insurance for their employees. Employees would be required to pay the remaining 20 percent, and self-employed and unemployed individuals would be required to pay 100 percent of the premium.

Employer Mandates. These would become effective in 1997 for firms with 100 or more employees and in 1999 for all smaller firms. Employers would be required to offer their workers at least one fee-for-service insurance plan with unrestricted choice of health care providers and one managed care plan with limits on access to health care providers. Employers of 100 or fewer workers could also insure their employees by enrolling them in the Federal Employees Health Benefits Program, under which people can choose among numerous participating health plans. Alternatively, those employers could provide coverage through the Medicare Part C program described below. In addition, all employers could offer their employees a Medical Savings Account.[2]

Subsidies similar to those in the original Clinton plan would be offered to small businesses. Firms with 25 or fewer employees and an average payroll of $12,000 or less would receive a tax credit equal to 50 percent of the 80 percent

employer share of the Medicare Part C premium. The credit would be reduced for employers with an average payroll above $12,000 and would be phased out completely at $26,000. Firms with 25 to 50 employees would receive a tax credit equal to 37.5 percent of the health insurance premiums at $12,000 average payroll or less. This credit also would be phased out completely at $26,000.

Individual Mandates. While Gephardt and his supporters emphasize the employer mandate, the proposal also has an individual mandate. Gephardt's own outline explicitly states, "In 1999, all individuals would be responsible for paying the full premium of the health plan in which they enroll, minus their employer's contributions."[3] Individuals who do not have an employer to make the mandated employer payments are required to pay the full insurance costs on their own.

Subsidies would be available to cover an individual's share of the premium for anyone below the poverty line. Smaller subsidies would be available for those above the poverty level, and the subsidy would be phased out completely at an income equal to 240 percent of poverty, or $38,400 for a family of four in 1994.

Cost of Mandates: Lost Wages and Lost Jobs. In promoting the proposal, Gephardt and his allies argue that employees would have to pay only 20 percent of insurance costs, with employers paying the rest.[4] But Gephardt must know that the reality is very different. As is the case with all other employer mandates, economists have marshaled convincing evidence that the cost of a health insurance employer mandate would be borne by employees in lost wages and lost jobs. Employers would reduce the wages they would otherwise pay employees by the amount of the mandated insurance costs to keep total employee compensation equal to the level of worker productivity.[5] Where employers could not reduce wages, they would lay off employees, because when total compensation exceeds worker productivity, firms are losing money by continuing to employ workers and they can become more profitable by laying the employees off. This is most likely to occur at the lower income levels, where the minimum wage law and other regulations may prevent employers from reducing wages sufficiently to offset the costs of mandated health insurance.

"Economic studies have consistently estimated that employer mandates would cost about $100 billion per year in lost wages."

Several econometric studies have now estimated the magnitude of the wage and job losses that would result from such an employer mandate.

- Economic studies have consistently estimated that mandates similar to the ones proposed in this bill would cost about $100 billion per year in lost wages.[6]
- On the average, the studies predict that the mandates would also cost the economy about one million jobs.[7]

Employer mandates attempt to hide the fact that the full costs of the regulations would be born by employees. Ultimately, these mandates would burden middle-class employees and their families.

Cost of Mandates: An Invitation to Government Control. Mandates also would inevitably lead to government control of the health care system. Mandates require that the government detail what benefits people must buy. Next, political pressures lead to government subsidies to help lower-income workers and employers pay for the required benefits. Then, to keep down the costs of these subsidies and the cost of premiums for everyone else, the government imposes global budgets and price controls that force providers to ration health care.[8] Eventually, every decision about the allocation of medical resources becomes a political decision.

Global Budgets and Price Controls

The Gephardt proposal retains the global budgets and price controls that were in the original Clinton plan, with some modifications. As under the Clinton plan, a global budget would be established to reduce the growth of total national health expenditures to the per capita rate of growth in Gross Domestic Product (GDP). If expenditures in each state did not fall into line with this spending goal by 2001, a system of price controls on the fees of doctors, hospitals and other health care providers would go into effect. The fees would be set so that total health care spending would not exceed the national global budget.

Since there is no chance that the restrictive national spending goals would be met, the imposition of price controls would be inevitable. While a National Health Cost Commission would be created to recommend alternative cost controls, there is no reason to think the commission's proposals would be significantly different from Gephardt's. Moreover, if Congress did not enact commission proposals, the Gephardt global budget/price control system would automatically go into effect. This system is the same as in Clinton's proposal, except that Clinton proposed price controls on health insurance premiums while Gephardt would impose the controls on doctors, hospitals and other health providers.

"The cost of global budgets and price controls would fall mainly on middle-class patients and the middle-class elderly."

Cost of Price Controls: Health Care Rationing. The cost of global budgets and price controls would fall mainly on middle-class patients and, since the system would apply to Medicare as well, on the middle-class elderly.[9] Through these budgets and controls, the government would sharply and arbitrarily reduce the resources for health care that would otherwise be available — forcing doctors and hospital personnel to ration health care. Specifically:

- According to one recent study, meeting global budget goals similar to the ones in the Gephardt proposal would require a reduction in health care resources of 18 percent by the year 2005 — causing almost one in six medical services to be rationed.[10]
- Another study concluded that the required reduction would be 24 percent by the year 2000 — causing almost one in four medical services to be rationed.[11]

"Reductions in health care resources would cause sharp and arbitrary reductions in the quality of care."

Cost of Price Controls: Lower-Quality Care. Such reductions in health care resources would cause similarly sharp and arbitrary reductions in the quality of care and access to care. Doctors and hospitals would have to cut back on the services and care they provide to meet these resource limits. They would no longer have the resources to provide the best, most advanced, most sophisticated care, as they do today. They would no longer be able to rapidly acquire and offer the latest innovations, newest technologies and most cutting-edge treatments, as they do today. Over time, patients would be subjected to long waiting lines and delays for diagnostic tests, surgery and other care, as patients are today under the global budget systems that have been adopted in such other countries as England, Canada and New Zealand — three countries with cultures very similar to our own.[12]

The Government-Defined Benefit Package

Under the Gephardt plan, the government would define one uniform health insurance benefit package.

Loss of Freedom of Choice. Everyone would be forced to buy the health insurance coverage chosen by government and influenced by powerful special interests in Washington, rather than the coverage that meets their individual and family needs. For example, all families would be forced to pay for abortion coverage, drug and alcohol rehabilitation, open-ended mental health benefits and counseling and many routine health services that might be cheaper if purchased directly.

While people could buy coverage for additional benefits, they could not replace coverage in the mandatory package with other benefits they prefer. Moreover, the Gephardt plan would limit additional benefit purchases to one of 10 supplemental packages specified by the government. Consequently, to get one or more additional benefits they want, people would have to buy other benefits chosen by government.

Higher Health Insurance Premiums. Forcing people to pay for benefits they do not want forces them to bear unnecessary costs. For example, mandated drug and alcohol rehabilitation benefits at the state level have been shown to raise premium costs by 6 to 8 percent.[13] Mandated state benefits for outpatient mental health care and counseling have been found to raise costs by 10 to 13 percent.[14]

An Invitation to Special Interests.[15] Over time, special interests likely would add even more expensive benefits, as they have at the state level.

- Thirty-seven states require health insurance coverage for the services of chiropractors, three states mandate coverage for acupuncture and two require coverage for naturopaths (who specialize in prescribing herbs).

- Laws in 40 states mandate coverage for alcoholism, 20 states mandate coverage for drug addiction and 30 states require coverage for mental illness.
- Five states even mandate coverage for in vitro fertilization.

Mandated benefits cover everything from life-prolonging procedures to purely cosmetic devices. They cover heart transplants in Georgia, liver transplants in Illinois and hairpieces in Minnesota. Collectively, these mandates have added considerably to the cost of health insurance, and they prevent people from buying no-frills insurance at a reasonable price.

Encouraging Waste. A mandated benefits package would add to the third-party-payment problem and its cost-increasing incentives. As insurance coverage for everybody is extended to more and more required services, people would be encouraged to overconsume those services by the fact that someone else was paying the bill.[16]

The only provision that has the potential to offset these perverse incentives is the opportunity to choose high deductibles and place the premium savings in a Medical Savings Account. MSAs currently used in the private sector have been shown to control costs.[17] However, the bill unnecessarily restricts the ability of people to make MSA withdrawals for nonmedical purposes, and therefore may not appeal to most employees.[18] In addition, the MSA provision is not certain to survive.

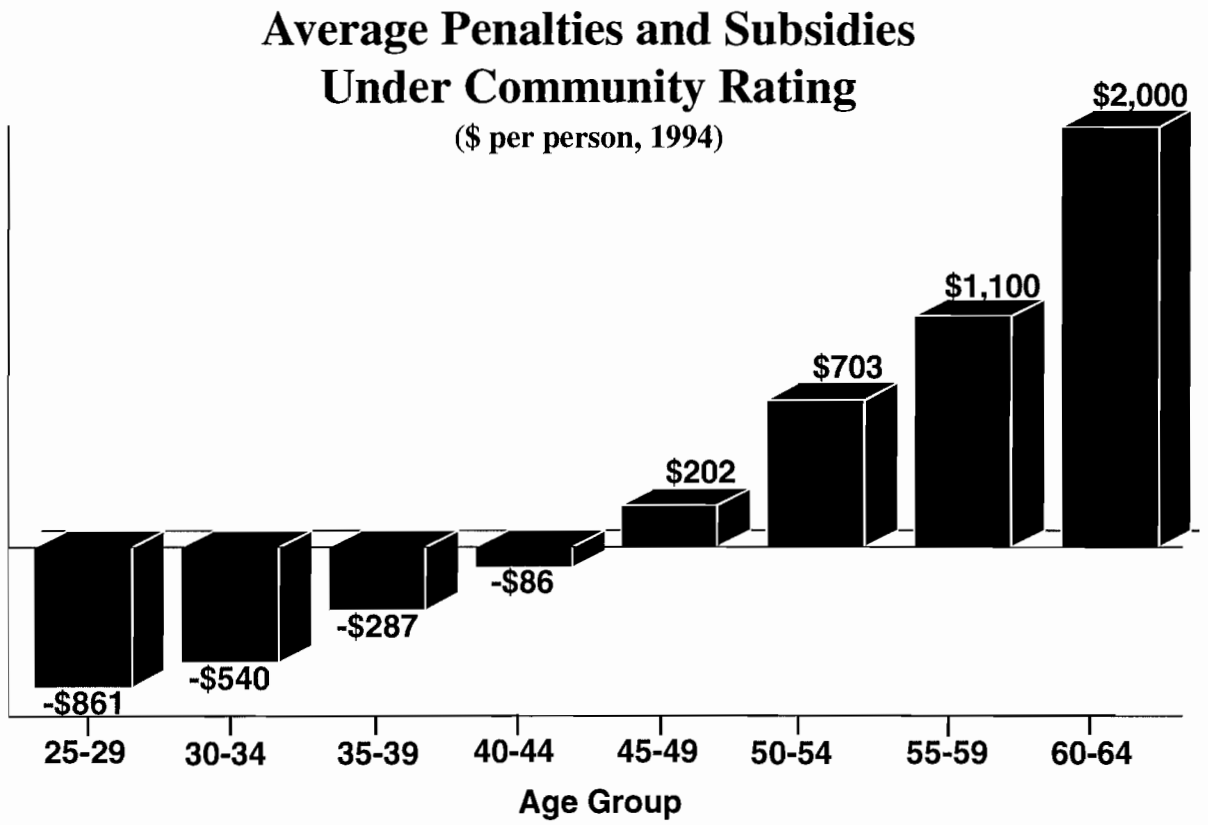
Eliminating the Search for Ways of Controlling Costs. In recent testimony before Congress,[19] Harvard Business School Professor Regina Herzlinger explained that *the* most important reason why the rate of increase in health care spending has been declining in recent years is that over the past decade employers have been free to innovate and experiment with the design of their employee health insurance benefit package. The ability to change benefits (and the terms and conditions under which services are available) has been absolutely essential in discovering vital information about which cost-control strategies work and which do not. A uniform benefit package would preclude employers from searching for solutions to our most serious national health care problem.

Community Rating

Under the Gephardt plan, pure community rating would apply to all health insurance sold to individuals in groups of 100 or less. This means that the premiums would have to be the same for everyone, regardless of age, health condition or any other indicator of health care costs. A new health insurance applicant with AIDs or cancer could not be charged any more than a healthy applicant.

"An applicant with AIDs or cancer could not be charged any more than a healthy applicant."

FIGURE I



Source: David A. Bradford and Derrick A. Max, "Soak-the-Young Economics of Clinton's Health Care Plan," American Enterprise Institute, 1994.

Higher Premiums for Most People. As a result of community rating, younger and healthier people would have to pay artificially high premiums in order to cover the higher costs of older and sicker people. In general, expected health care costs for adults ages 60 to 64 are two to three times as high as for people 25 to 29. As a result, under pure community rating, premiums for people 25 through 29 would be 50 percent higher than otherwise, and people 26 through 34 would pay $26 billion more per year.[20] As Figure I shows, almost everyone below the mid-40s would pay more under community rating,

"Younger people with lower incomes and fewer assets would pay more to subsidize older people with more income and assets."

Penalizing Those Who Have Less to Subsidize Those Who Have More. While older employees would pay less under community rating, on average they have more income and assets than the younger employees who would pay far more:

- The median income of people ages 35 thorough 44 is about one-third higher than for those 25 through 34 and more than double the income of those 15 through 24.[21]
- The median income for people ages 45 through 54 is about 50 percent more than for those 25 through 34 and more than double the income of those ages 15 through 24.[22]

- Moreover, those under 35 have substantially less than half the assets of those ages 45 through 64.[23]

Consequently, community rating results in a perverse redistribution from those who have less to those who have more.

A Regressive Hidden Tax. The Gephardt plan also includes a guaranteed issue regulation that require insurers to accept everyone who applies, regardless of health condition. Sick people who are currently uninsurable would be able to buy health insurance. Yet, because of the community rating requirements, they would be paying only a fraction of the cost of their care. The rest would be paid through higher premiums for everyone else.[24]

These premium increases would effectively finance subsidies for the uninsurable through a regressive hidden tax, hurting those with lower incomes more than those with higher incomes. Premiums would rise by a flat amount unrelated to income, which would be a higher percentage of the incomes of the less affluent. For example:

- If the proposed health insurance regulation causes the premiums for family policies to rise by $1,000, that's a 10 percent tax on a family with a $10,000 annual income, but only a 1 percent tax on a family with $100,000 in annual income.
- As a result, the tax rate on the family with a $10,000 annual income would be ten times as high as the rate for a $100,000-a-year family.

A Better Solution Not in the Gephardt Bill: Risk Pools. The Gephardt plan's problems discussed above could be dealt with through risk pools. These pools, subsidized by state governments, would provide affordable coverage to the uninsurable. Ideally the subsidies would be provided out of general revenues — a funding method much fairer than the regressive hidden taxes the Gephardt bill proposes. But even if they were funded by a tax on all health insurance premiums in a state, they would be much less onerous for low-income families than the Gephardt bill would be.

"Risk pools could cover the uninsurable for less than one-tenth of 1 percent of total health care spending."

Risk pools are already in operation in 28 states, covering about 100,000 people. One recent study found that extending such risk pools to cover all uninsurable people nationwide would have cost only about $300 million per year in state subsidies in 1989, less than one-tenth of 1 percent of the nation's annual health care bill.[25] That's because only 0.7 percent of the U.S. population has been denied health insurance due to a medical condition, according to the U.S. Public Health Service.[26]

Higher Taxes

Last year, Congress enacted a huge tax increase on the grounds that it was necessary to get the federal budget under control. This year, Gephardt wants to impose another huge tax increase to finance the largest increase in government spending and entitlements in history. The new taxes include the following:

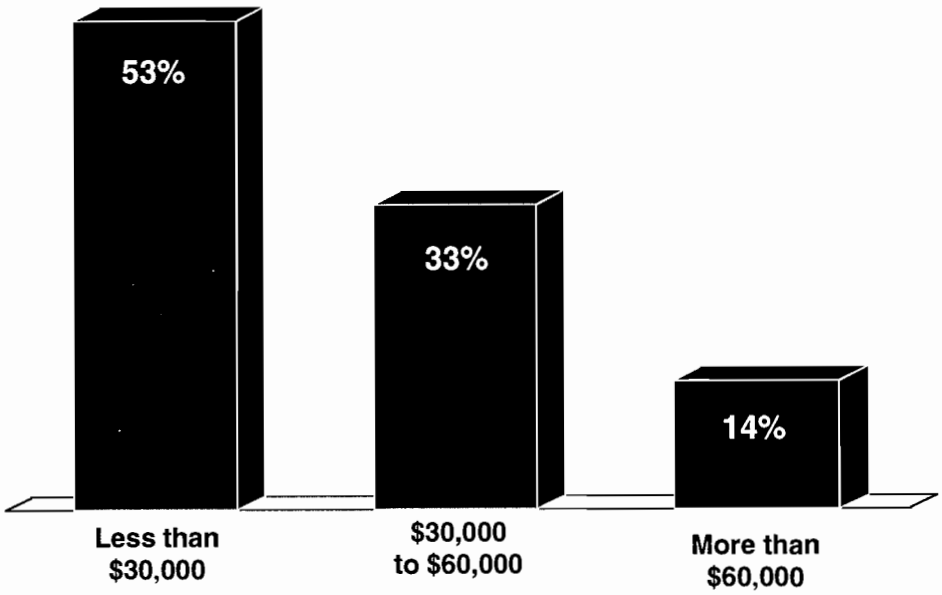
- A 2 percent tax on all private health insurance premiums and on self-insured health plans;
- Abolition of Flexible Spending Accounts (FSAs), under which employees are able to pay medical expenses not covered by employer plans with pretax dollars;[27]
- An almost threefold increase in the tax on cigarettes;[28] and
- Extension of the Medicare hospital insurance tax to all state and local employees.[29]

Since smoking varies inversely with income, the huge increase Gephardt proposes in the cigarette tax would fall disproportionately on lower-income families. In fact, the cigarette tax is probably the most regressive of all federal taxes. [See Figure II.] The remaining Gephardt taxes would fall mainly on the middle class.

"The cigarette tax would fall disproportionately on lower-income families."

FIGURE II

Who Pays Cigarette Taxes?



Note: The figure shows the share of all cigarette taxes paid by families at different income levels.

Source: "Measuring the Impact of Increasing Excise Taxes on the Progressivity of the Federal Tax System," The Policy Economics Group, KPMG Peat Marwick, March 1993.

Medicare Part C

The Gephardt bill would create a massive new federal program called Medicare Part C. This program would directly provide insurance coverage for those who join it. Employers with 100 or fewer workers could choose to pay the premiums so that their employees could enroll in the program rather than in a private plan. The program also would be open to all unemployed individuals, part-time and seasonal workers, low-income individuals and their families.

The self-employed and unemployed would have to pay the full premiums themselves, but they would be eligible for the subsidies for lower-income individuals and families described above. The program would directly pay the covered medical expenses, much the way Medicare currently does, and would be financed by premiums paid by those who choose to be covered under it.

"Half the population would end up in the Medicare program."

Making Government the Insurer of Half the Population. Although Medicare Part C would compete with private alternatives, the government plan would have a distinct advantage. As discussed below, Medicare currently pays less than the full cost of treatment, forcing doctors and hospitals to shift costs to the private sector. For this reason, the premiums for Medicare Part C might be about 70 percent of private insurance premiums covering the same benefits.

Most people with the opportunity to join Medicare Part C could be expected to do so, with the program covering about 89 million Americans by 1998.[30] This is two to five times more than Medicare Parts A and B, which now cover about 37 million beneficiaries. All told, half the population, or 126 million people, would be in the program.

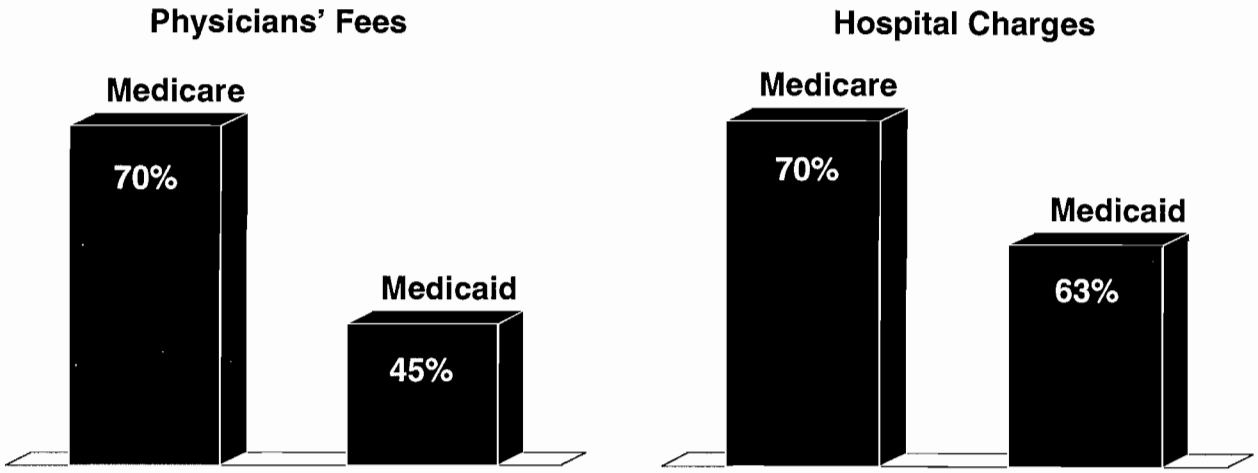
Making Government the Payer of Most Medical Bills. Gephardt's proposed government insurance would give the government direct control over the benefits, medical services and treatments received by those covered by the program. It would also give government enormous power over the health care system. Doctors and hospitals would receive over half their income from Medicare. They and their patients would be totally dependent on government as a payer of medical bills. Over time, the temptation to expand this power and control to all medical bills and all patients could prove irresistible.

Massive Cost Shifting. Medicare Part C would have the same payment system as Medicare Parts A and B, which significantly underpay doctors and hospitals. According to the Congressional Budget Office:

- Medicare pays doctors and hospitals about 70 percent as much as private patients pay. [See Figure III.]
- As a result, Medicare accounts for about 33 percent of all uncompensated costs in the U.S. health care system, almost 50 percent more than uncompensated care for the uninsured.[31] [See Figure IV.]

FIGURE III

Medicare and Medicaid Reimbursement Rates as a Percent of Fees Charged to Private Patients



Source: Congressional Budget Office, "Single-Payer and All-Payer Health Insurance Systems Using Medicare's Payment Rates," CBO Staff Memorandum, April 1993, p. 13.

These uncompensated costs are shifted onto the bills of other patients, and even the liberal *New York Times* has concluded that the effects of a huge increase in the numbers of Medicare patients would be "devastating." In a recent editorial, the paper's editors predicted that "Fees to private patients would skyrocket, driving premiums up and private insurers out of business through no fault of their own."[32]

Runaway Costs. Even though government underpays medical bills, costs under the new program are likely to explode. In addition to providing insurance for the uninsured and creating generous new benefits for many who are currently covered, Medicare Part C would eliminate virtually every vehicle for cost control.

"The only cost control device for the new Medicare program would be price controls."

The private sector is currently trying to control costs in two ways: (1) with managed care programs that restrict physician choice and impose cost-benefit standards on the practice of medicine and (2) by raising deductibles and giving individual patients incentives to control costs, sometimes through Medical Savings Accounts. As noted above, the bill would encourage MSAs by making deposits to them tax free.

Enrollees in Medicare Part C, however, would not have an MSA or managed care option. Participants in the program could see any doctor or enter any hospital, without concern for the overall costs. The only cost control device in the Gephardt plan — for the half of the population that spends the most on health care — is price controls.[33]

Making Global Budgets and Health Care Rationing Inevitable. For the reasons given above, if almost 90 million more beneficiaries are added to Medicare's payment system under the new Part C, cost shifting will increase dramatically and cause private health costs to soar even higher. Coupled with exploding utilization by Medicare enrollees, it would ensure the triggering of global budgets and price controls in 2001. This would extend the Medicare payment system to the entire health care market.

Making "Single-Payer" Health Insurance Inevitable. According to the *New York Times,* even without the imposition of price controls and global budgets, the Medicare Part C program "threatens to trigger an inevitable roll toward government-run medicine for most Americans."[34]

Once Medicare Part C was established, the government could very easily open it to everyone. By keeping premiums below full costs, heavily subsidizing the program and pricing private insurance out of the market through cost shifting, the government could encourage more and more people to join. Once such huge numbers were in the program, the pressure to end its voluntary nature and force everyone to join would increase. The argument would be that only the healthiest are choosing private insurance and that they must be forced into the program to end this "adverse selection."

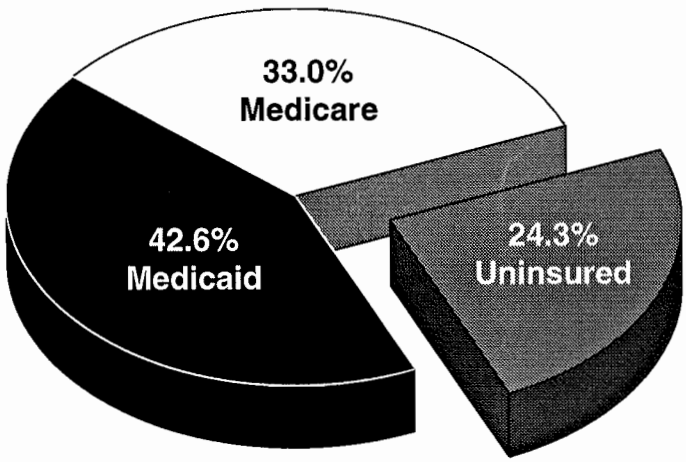
Thus Gephardt's Medicare Part C program would only be a few small steps from fully socialized health insurance, with government paying everyone's medical expenses and controlling everyone's health care.

"Medicare and Medicaid account for about three-fourths of all uncompensated care."

FIGURE IV

Source of Uncompensated Health Care

(1995)



Source: Congressional Budget Office, "Single-Payer and All-Payer Health Insurance Systems Using Medicare's Payment Rates," CBO Staff Memorandum, April 1993.

Building on a Program That Is Technically Bankrupt. Gephardt proposes to create this huge new program even though, as previously stated, Medicare Parts A and B are technically bankrupt. According to the latest annual reports of the Boards of Trustees for the program, under intermediate assumptions Part A will run short of funds to pay promised benefits by 2001.[35] Paying all promised benefits at that time will require an increase of about 40 percent in the payroll taxes that finance the program. By 2015, payroll tax rates will have to double to pay promised benefits. By the time those entering the workforce today retire, payroll tax rates will have to climb from 2.9 percent to 9.5 percent of wages, including both the employer and employee shares of the tax.

Under the same intermediate assumptions, the annual general revenue subsidy for Medicare Part B will have to double from $36 billion today to $73.6 billion in constant 1994 dollars by the year 2000, triple to $110 billion by 2005 and climb by about six times to $213.9 billion by 2015. The premiums paid by the elderly to finance Part B also will have to double in real terms by 2000, triple by 2005 and grow by six times by 2015.

Under the so-called pessimistic assumptions, which are actually quite plausible,[36] the Part A payroll tax rate will have to climb by 50 percent by 2000 and double by 2005. Paying all the benefits promised to those entering the workforce today will require the tax to increase by six times over. The Part B general revenue subsidies and premiums paid by the elderly will have to triple in real terms by 2000 and grow by almost six times by 2005, just 10 years from now.

To propose a massive expansion of government insurance in the face of these problems is irresponsible. Based on our experience with Medicare Parts A and B, we could expect the same problem with Medicare Part C, on a proportionally larger scale. In addition, the 90 million beneficiaries in the new program would exert powerful political pressure to keep their premiums down, ultimately creating even larger deficits that would have to be financed through higher federal deficits or higher taxes.

"Based on our experience with Medicare Parts A and B, we would expect Medicare Part C to experience skyrocketing costs."

Alternatives. With Medicare Part C, Gephardt has exceeded even President Clinton's appetite for increasing the size of government. And the new program is unjustified. Private insurance is available from hundreds of insurance companies, and the same subsidies proposed under Medicare Part C could help the poor buy private coverage.

Runaway Government Spending

When the Clinton administration embarked upon health care reform, the principal goal was to control health care costs. Even now, the administration hints that cost control is the real goal –- occasionally asserting that universal coverage (the Clinton litmus test) is needed in order to control costs. Yet with the Gephardt bill, all realistic chances to improve health care cost control would vanish.

Medicare Part C Spending. The Gephardt bill proposes the largest increase in government spending in history. With 90 million beneficiaries, the Medicare Part C program alone could be expected to increase federal spending by over $300 billion per year. Current projections of future Part C spending are likely to be woefully inadequate. When Medicare Part A was adopted in 1965, it was projected to cost $9.6 billion in 1990.[37] The actual cost in that year was $67.0 billion.[38]

Home Health Care Services. The Gephardt bill proposes a new government program to provide a full range of so-called home health care services for the disabled, regardless of age or income. These services are not health care but assistance in basic activities of daily living, such as cooking, cleaning, bathing, dressing, housekeeping, etc. Most such care is provided today on a voluntary basis by families and friends. Gephardt's program would replace voluntary care with costly, taxpayer-financed, professional care.

Moreover, the government is unlikely to be able to control such personal services provided within the home. Once government-financed housekeepers and cooks began working for a disabled person in the home, it would be administratively difficult to limit the benefit of those services only to the disabled recipient. Other family members would benefit as well.[39]

"The best estimate is that the home health care proposal would cost more than $30 billion per year."

Consequently, the costs of home health care services would be uncontrollable. Based on recent studies of comparable proposals,[40] the best estimate is that Gephardt's proposal would cost more than $30 billion per year. All such new spending is unnecessary. Government can properly finance home health care for those who would otherwise be in more expensive nursing homes at government expense and often does so through Medicaid.

Prescription Drugs and Other New Benefits for the Elderly. Gephardt further proposes to expand Medicare benefits for prescription drugs, mental health care and preventive services, adding to the program's financial crisis. The combination of these new benefits with his proposed reductions in Medicare spending could only occur with massive rationing of health care for the elderly.

Small Business Subsidies. As noted above, the Gephardt bill contains extensive subsidies for small businesses to pay for employee health insurance. But such subsidies are made necessary only by Gephardt's employer mandates. The rational way to subsidize those who cannot afford health coverage is directly.

Subsidies for Individuals. As also noted above, the Gephardt bill provides excessive subsidies — including subsidies for those with family incomes close to $40,000 a year. Such subsidies make no sense, as they would have to be financed by the same middle-class taxpayers. Subsidies to 150 percent of poverty, about $24,000 for a family of four, as proposed under Senator Dole's plan, seem reasonable.

Conclusion

Gephardt has produced a proposal that includes virtually all of the major features of the original Clinton plan. And it goes further, imposing more taxes and moving almost 90 million Americans into a government-run system. The middle class and the elderly would be big losers. Eventually, so would we all, as the nation's entire health care system fell under government control.

Peter J. Ferrara

Notes

[1] Medicare Part A is the federal government's hospital insurance program, which is financed by payroll taxes paid by employers and employees. Medicare Part B covers physicians' fees and other expenses and is financed one-fourth by premiums from the elderly and three-fourths from general revenues. The government's own actuarial reports show gaping deficits and rapid cost increases in both.

[2] Medical Savings Accounts (MSAs) are tax-free and are the property of the employee, who could withdraw money without penalty to pay medical expenses or health insurance premiums, even during periods of unemployment. Money not spent would grow tax free, and the employee could use it for medical expenses after retirement or roll it over into an IRA or pension plan. It would become part of a person's estate at death. See John C. Goodman and Gerald L. Musgrave, "Controlling Health Care Costs With Medical Savings Accounts," National Center for Policy Analysis, NCPA Policy Report No. 168, January 1992. See also Goodman and Musgrave, "Personal Medical Savings Accounts: An Idea Whose Time Has Come," National Center for Policy Analysis, NCPA Policy Report No. 128, July 1993. For a review of the causes of the nation's health care problems and an explanation of how Medical Savings Accounts and other ways of empowering people could help solve these problems, see John C. Goodman and Gerald L. Musgrave, *Patient Power: Solving America's Health Care Crisis* (Washington, DC: Cato Institute, 1992) and abridged version (Washington, DC: Cato Institute, 1994).

[3] Highlights of House Democratic Reform Bill, p.1.

[4] See e.g., "Questions and Answers About the House Democratic Health Reform Proposal," pp. 6-7; and House Health Bill, Democratic Caucus Information Packet, July 29, 1994, pp. 9, 18.

[5] See Peter J. Ferrara, "The Health Policy Debate: Options for Reforms," National Center for Policy Analysis, NCPA Policy Backgrounder No. 131, July 7, 1994, pp. 2-7; "Why Employer Mandates Hurt Workers," NCPA Brief Analysis No. 110, June 22, 1994; and Gary Robbins and Aldona Robbins, "Forecasting the Effects of the Clinton Health Plan," NCPA Policy Report No. 185, June 1994.

[6] See Peter J. Ferrara et al., "The Clinton Health Plan," National Center for Policy Analysis, NCPA Policy Report No. 184, May 1994, pp. 38-40.

[7] At the low end, the administration admits that some 600,000 jobs might be lost in the early years, while economists Lawrence Hunter and Morgan Reynolds estimate 1,151,000 jobs would be lost and labor economists June O'Neill and Dave O'Neill estimate the elimination of 2.1 million jobs. See Ferrara et al., "The Clinton Health Plan." Economists Gary Robbins and Aldona Robbins expect 783,000 fewer jobs under the Clinton plan. See Gary Robbins and Aldona Robbins, "Forecasting the Effects of the Clinton Health Plan," National Center for Policy Analysis, NCPA Policy Report No. 185, May 1994.

[8] For further discussion of the problems of employer mandates, see Ferrara, "The Health Policy Debate," pp. 2-7.

[9] Mechanically, the system of price controls on doctors and hospitals would be similar to what applies under Medicare today, but there would be an important difference. When Medicare underpays in the current health care system, the elderly usually get health care anyway and the deficit is made up by shifting costs to other payers. Under the Gephardt plan, the price controls would be imposed on all payers. In that case, there would be no possibility of cost shifting and providers would have no choice but to ration care until its cost was equal to the artificial reimbursement rates. These rates would be tied to a global budget system.

[10] Gary Robbins and Aldona Robbins, "Forecasting the Effects of the Clinton Health Plan," National Center for Policy Analysis, NCPA Policy Report No. 185, May 1994.

[11] Morgan O. Reynolds and Lawrence A. Hunter, "A Billion Dollars a Day: The Financing Shortfall in President Clinton's Health Care Proposal," Joint Economic Committee staff, U.S. Congress, Washington, DC, January 1994.

[12] See John C. Goodman and Gerald L. Musgrave, "Twenty Myths About National Health Insurance," National Center for Policy Analysis, NCPA Policy Report No. 166, December 1991. For further discussion of global budgets and price controls, see Ferrara, "The Health Policy Debate," pp. 27-28; and Ferrara et al., "The Clinton Health Plan," pp. 8-11.

[13] See Ferrara, "The Health Policy Debate," p. 9; and Jon Gabel and Gail Jensen, "The Price of State-Mandated Benefits," *Inquiry*, Vol. 26, No. 4, Winter 1989.

[14] Ibid.

[15] See John C. Goodman and Gerald L. Musgrave, "Freedom of Choice in Health Insurance," National Center for Policy Analysis, NCPA Policy Report No. 134, November 1988.

[16] For further discussion of the problems of such a uniform government-defined benefit package, see Ferrara, "The Health

Policy Debate," pp. 7-9.

[17] See John C. Goodman, "Medical Savings Accounts: The Private Sector Already Has Them," National Center for Policy Analysis, NCPA Brief Analysis No. 105, April 20, 1994.

[18] See John C. Goodman, "Medical Savings Accounts: The Momentum Builds," National Center for Policy Analysis, NCPA Brief Analysis No. 115, July 14, 1994.

[19] Republican Members of the Joint Economic Committee and the House Republican Research Committee joint hearing on "Health Care Reform That Works," August 9, 1994.

[20] David F. Bradford and Derrick A. Max, "Soak the Young Economics of Clinton's Health Care Plan,"*On the Issues,* American Enterprise Institute, 1994. See also Ferrara, "The Health Policy Debate," pp. 16-18.

[21] "Money Income of Households — Percent Distribution by Income Level for Selected Characteristics: 1991," in*Statistical Abstract of the United States, 1993*, p. 458, Table 713.

[22] Ibid.

[23] *Changing Times*, March 1990.

[24] For a further discussion of the problems of community rating and guaranteed issue, see Ferrara, "The Health Policy Debate," pp. 13-25.

[25] Karl J. Knable, Morris Melloy and C. Keith Powell, "State Health Insurance Risk Pools,"*Health Section News,* April 1991; and Communicating for Agriculture, Inc., "Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis," June 1994. For further discussion of risk pools, see Ferrara, "The Health Policy Debate," pp. 33-35; and "Risk Pools: A Better Solution for Preexisting Conditions," National Center for Policy Analysis, NCPA Brief Analysis No. 112, June 30, 1994.

[26] Agency for Health Care Policy and Research, U.S. Public Health Service, U.S. Department of Health and Human Services, Washington, DC.

[27] For a discussion of FSAs and their treatment under the tax law, see Alain C. Enthoven, "Health Policy Mismatch,"*Health Affairs*, Winter 1985, pp. 5-13.

[28] The current federal tax on cigarettes is 24 cents a pack. The Gephardt bill, like the Mitchell bill, would increase the tax to 69 cents per pack.

[29] The tax rate is 2.9 percent, split between employer and employee, on all wage income. State and local employees were originally exempt from Medicare. In 1983, all new state and local employees were required to join the system.

[30] Price Waterhouse, "Effects of Health Reform on Pharmaceutical Profits," prepared for Pharmaceutical Research and Manufacturers of America, July 27, 1994. The Congressional Budget Office estimates there would be 90 million enrollees by 2004. See Robert Pear, "Many Health Groups Fight Proposal by Health Leaders,"*New York Times,* July 31, 1994.

[31] Sandra Christensen, CBO staff memorandum, "Single-Payer and All-Payer Health Insurance Systems Using Medicare's Payment Rates," Congressional Budget Office, April 1993.

[32] "The Failed House Health Bill,"*New York Times,* July 30, 1994.

[33] The bill would cause escalating costs in the private sector for another reason. It would force managed care plans to hire any qualified doctor who applied, thus preventing them from hiring only doctors who practiced cost-effective medicine. See "The Failed House Health Bill."

[34] "The Failed House Health Bill."

[35] *1994 Annual Report of the Board of Trustees of the Federal Old-age and Survivors Insurance and Disability Insurance Trust Funds*, Washington, DC, April 11, 1994; and *1994 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Funds*, Washington, DC, April 11, 1994; and *1994 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Funds*, Washington, DC, April 11, 1994.

[36] For an analysis of these assumptions, see John C. Goodman and Aldona Robbins, "The Immigration Solution," National Center for Policy Analysis, NCPA Policy Report No. 172, September 1992.

[37] House Committee on Ways and Means, 98th Congress, 1st Session, July 30, 1965, Public Law 89-97, p. 33.

[38] *1994 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Funds*, Washington, DC, April 11,

1994.

[39] For further discussion of these home health care issues, see Peter J. Ferrara, "Long-Term Care: Why a New Entitlement Program Would Be Wrong," Cato Policy Analysis No. 144, December 13, 1990; Peter J. Ferrara, "Pepper's $30 Billion Home Care Time Bomb," Heritage Foundation Issue Bulletin No. 141, June 1988; and Peter J. Ferrara, "Expanding Autonomy of the Elderly in Home Health Care Programs," *New England Law Review,* Vol. 25, pp. 421 ff. (1990).

[40] Ferrara, "Pepper's $30 Billion Home Care Time Bomb."

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