MANDATING HEALTH INSURANCE

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EXECUTIVE SUMMARY

A proposal put forth by Senator Edward Kennedy would require all U. S. employers to provide health insurance for their employees. The problem this proposal addresses is about $4 billion in annual unpaid hospital bills, incurred by employees who lack health insurance. Yet the cost of the Kennedy bill would be more than 25 times that amount. Specifically,

- The Kennedy bill would impose an annual cost on the private sector of at least $108 billion, and perhaps as much as $159 billion.
- As a result of these costs, at least one million workers would lose their jobs, with the largest burden falling on low-income employees and employees of small business.
- Because of reduced employment, our Gross National Product would be reduced by at least $27 billion.
- Because of reduced output and because billions of dollars of taxable income would be diverted to a fringe benefit, tax revenues would decline and the federal deficit would increase by at least $46.5 billion.
- Those workers who retain their jobs would face a reduction in take-home pay in excess of $100 billion in return for a Cadillac package of health insurance benefits that they may not want or need.

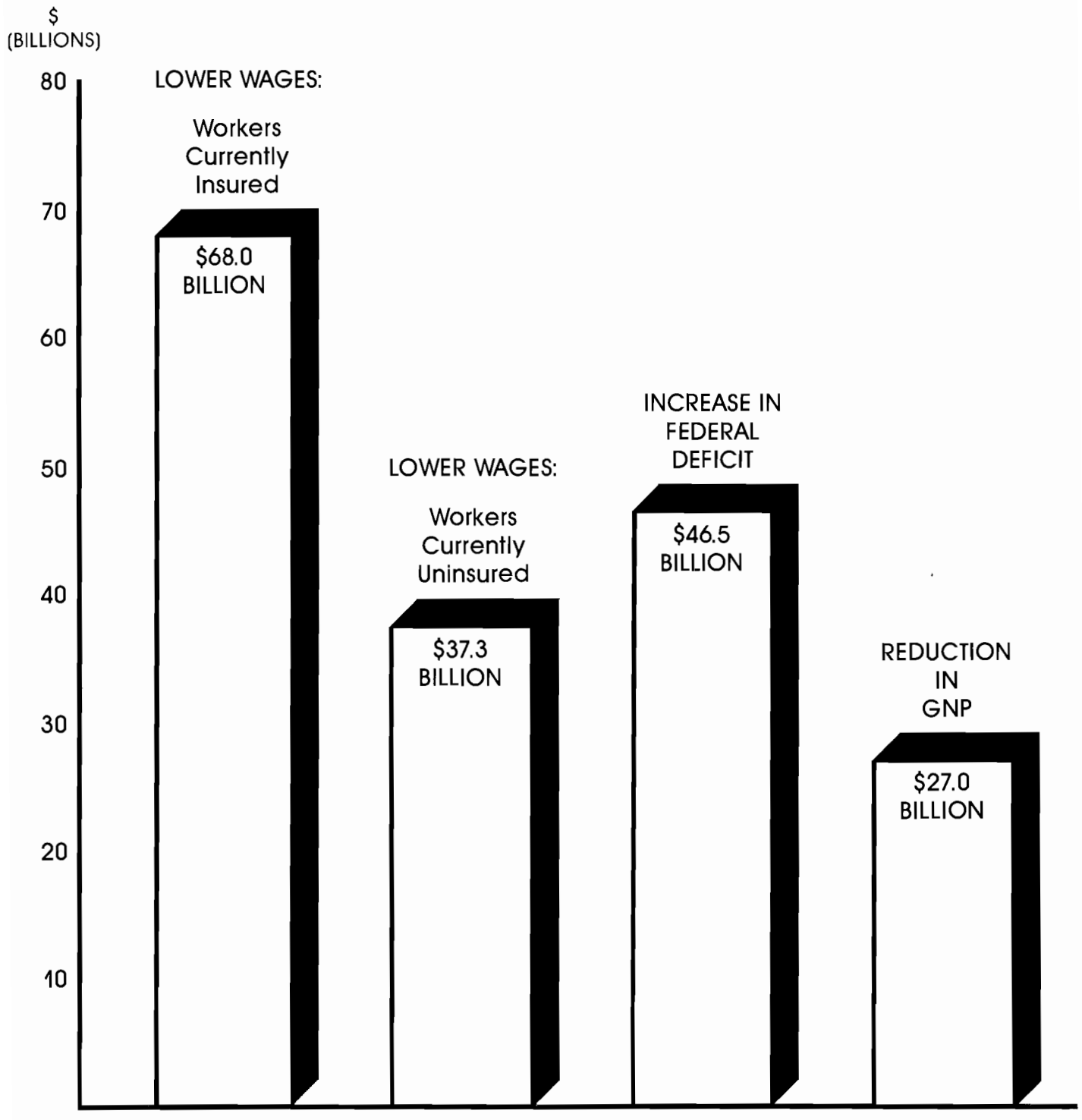
The Massachusetts health care plan was enacted in 1988 and will be fully implemented in 1992. A number of Congressional proposals for mandated health are based on this plan. Proposed by Governor Michael Dukakis as a model for the nation, this plan is a "pay or play" proposal which gives employers the option of paying taxes to government or spending a certain amount of money on employee health insurance.

- In its first year of operation in Massachusetts, the plan is expected to cost private industry at least $642 million and lead to 9,000 fewer jobs for Massachusetts workers.
- If the plan were adopted nationally, the additional private sector cost would be $23 billion and the loss of jobs would be as high as 358,000.

The Dukakis proposal is less expensive than the Kennedy proposal, in terms of the cost it imposes on employers and workers. But the Kennedy plan at least has the virtue of causing some additional people to have health insurance. Not so the Dukakis plan, which will cause the number of people who lack health insurance to increase.

It would be far less expensive to subsidize unpaid hospital bills from public funds. And close inspection of the market for health insurance reveals that existing government regulation is a major cause of the rising number of people without health insurance. Before enacting new regulations, we should first repeal old ones and give market forces a chance to work.

COSTS OF THE KENNEDY PROPOSAL TO MANDATE HEALTH INSURANCE



INTRODUCTION

By some estimates, as many as 37 million Americans are without health insurance, and the number has been growing. Since 1980, the number of non-elderly people without health insurance has increased by 25 percent. Although there is little evidence that people without health insurance are being denied basic health care, the problem of unpaid hospital bills becomes increasingly acute as the hospital marketplace becomes more competitive.

At the urging of Governor Michael Dukakis, the state of Massachusetts has passed legislation intended to provide all Massachusetts residents with health insurance beginning in 1992. Several bills in Congress would implement the Massachusetts plan at the national level. Other legislation to require employers to provide health insurance for all employees nationwide has been introduced in Congress by Senator Edward Kennedy. The principal problem addressed by these proposals is that of unpaid hospital bills. Yet these proposals carry a concealed price tag many times greater than any benefits the regulation could create.

WHAT DIFFERENCE DOES LACK OF HEALTH INSURANCE MAKE?

It is believed widely in this country (and even more prevalently in Europe) that people who lack health insurance in the United States are routinely denied access to health care. This belief is quite wrong. What is true is that the existence or nonexistence of health insurance makes a big difference in determining how health care is paid for. Health insurance primarily is a financial issue that has important financial implications for individuals and for society as a whole. What follows is a brief summary of how and why health insurance makes a difference.

Health Insurance and Access to Medical Care

Health economists generally accept two propositions: (1) people who lack health insurance consume fewer health care services than people who are insured; and (2) people who lack health insurance, on the average, are somewhat less healthy than people who are insured.

When people who are insured purchase health care services, they are spending someone else's money rather than their own. Thus it is hardly surprising that, even among healthy people, those with health insurance consume more medical services.Moreover, the more fully insured people are, the more medical services they consume.[1]

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[1]See Joseph P. Newhouse, et.al., "Some Interim Results from a Controlled Trial of Cost Sharing in Health Insurance," *New England Journal of Medicine*, 305, December 17, 1981, pp. 1501-1507; and Charles E. Phelps, *Health Care Costs: The Consequences of Increased Cost Sharing*, (Santa Monica, California: The Rand Corporation, November, 1982).

That people who lack health insurance are somewhat less healthy than those who are insured stems primarily from the fact that the uninsured tend to have lower incomes, less education, and other characteristics associated with poorer health status.[2] There is no evidence that the uninsured are systematically denied access to medical care, however. Nor is there any evidence that poor health is preventing people from obtaining health insurance. According to the National Health Interview Survey (1984),[3]

- More than half of all people without health insurance gave "cannot afford" it as the primary reason why they lacked health insurance.

- Less than one percent gave "poor health" or "age" as a reason for not having health insurance.

Note that the answer "cannot afford" should not be taken literally. Better phrasing would be: "the price is too high." In Massachusetts, which recently enacted a universal health care plan, 58.1 percent of the people who lack health insurance live in families with annual incomes of $20,000 or higher.[4]

In general, lack of health insurance does not appear to be a barrier to obtaining medical care. As Table I shows,

- Among people who see a physician in any given year, health insurance does not appear to have any effect on the number of physicians visits.

- Among people who enter a hospital in any given year, health insurance does not appear to have any effect on the number of days spent in the hospital.

This generalization also applies to people known to have low health status. In fact, among people with below-average health status, those without health insurance make more trips to physicians and spend more days in the hospital than those who have insurance.[5]

Access to medical care by those who lack the financial resources to pay for it is guaranteed by numerous state and federal laws. Currently, 47 states have laws that require state, county and/or city governments to provide indigent care for the poor and the uninsured, and numerous court decisions are upholding the right of hospitals to sue state and local governments for reimbursement for such care.[6] Moreover, federal law now requires all hospitals treating Medicare patients to accept all patients with

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[2]See Attiat F. Ott and Wayne B. Gray, *The Massachusetts Health Plan: The Right Prescription?*, (Boston: The Pioneer Institute for Public Policy Research, 1988), pp. 26-31.

[3]*Ibid.*, Table 2.11, p. 30.

[4]*Ibid.*, Table 2.2, p. 17.

[5]*Ibid.*, Table 2.15, p. 36.

[6]Patricia Butler, "Legal Obligations of State and Local Governments for Indigent Care," in the Academy for State and Local Government, *Access to Care for the Medically Indigent*, pp. 13-44.

TABLE I

USE OF MEDICAL SERVICES[1]

Medical Service	People With Insurance	People Without Insurance
Annual Physicians' Visits[2]		
1-2 visits	52.9%	51.4%
3-5 visits	24.9%	22.1%
6 or more visits	22.2%	26.6%
Annual Hospital Stays[3]		
1-5 days	56.9%	59.8%
6-10 days	22.3%	19.1%
11 or more days	20.8%	21.2%

[1] Refers to nonelderly people.

[2] Refers only to people who saw a physician.

[3] Refers only to people who entered a hospital.

Source: National Health Interview Survey. Reported in Attiat F. Ott and Wayne B. Gray, *The Massachusetts Health Plan: The Right Prescription?,* (Boston: Pioneer Institute for Public Policy Research, 1988), Table 2.15, p. 36.

emergency health problems and prohibits these hospitals from transferring indigent patients to another hospital unless the patient's condition is stabilized, the transfer is requested by the patient, or the transfer is medically indicated because of the availability of superior care at another hospital.[7]

The upshot is that in the United States we have already achieved the goal of socialized medicine: the removal of financial barriers to health care. Indeed, except for random and isolated instances, we have probably gone further in removing financial barriers to medical care than any other country in the world.

Health Insurance and the Protection of Financial Assets

If health insurance is not a prerequisite to health care, why do people purchase it? For the same reason why many people purchase life , automobile liability, and fire and casualty insurance: to protect assets.

A major, catastrophic illness can wipe out a family's savings and investments. To protect these assets against unexpected medical bills, most families purchase health insurance. It is hardly surprising that the more assets a family has, the more likely the family is to have health insurance. The more assets there are to protect, the more valuable health insurance is to the insured.

If people with very few assets choose not to purchase health insurance, their choice may be very rational. Choice does, however, have social consequences. If society is committed to providing basic health care to all who need it, regardless of whether all are insured, then some way must be found to pay the medical bills of uninsured individuals who cannot pay themselves. This financial issue is the primary reason for the political support for universal health insurance.

Most proposals for mandatory health insurance, such as the Massachusetts health care plan and the Kennedy bill discussed below, are not primarily proposals to insure access to health care. Instead, they are proposals designed to force people to purchase health insurance whether they want to or not. The argument most frequently used in favor of mandatory health insurance is that it will reduce the burden of hospital bad debts and charity care.

For example, Susan Sherry, a spokesperson for Health Care for All (a coalition of consumer activist groups supporting Michael Dukakis' Massachusetts health care plan), recently explained to the *Washington Times* why individuals should not have the choice to buy or not buy health insurance. "That's not fair to the rest of us who have to pay when that person gets into an accident," she said.[8]

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[7]Deborah J. Chollet, "Financing Indigent Care," in Frank B. McArdle, ed., *The Changing Health Care Market* (Washington, D.C.: Employee Benefit Research Institute, 1987), p. 188.

[8]Michael Hedges, "Study Finds Massachusetts Health Law Will Cut Jobs, Help Non-Poor," *The Washington Times*, October 6, 1988, p. A.4.

WHY ARE PEOPLE UNINSURED?[9]

Why do so many people lack health insurance? One reason is that, for many, health insurance has little value. Since lack of health insurance is not a major barrier to receiving health care, health insurance is of value primarily to those who wish to protect their assests against catastrophic health care expenses. For those with few or no assets, the price of health insurance may far exceed its value.

A second reason is that many of the uninsured have to buy health insurance with post-tax dollars, whereas most insured people are able to buy health insurance with pre-tax dollars. Under federal tax law, employer-paid premiums for health insurance are not counted in the taxable income of employees. This tax advantage is not available to the self-employed or to people who purchase health insurance on their own, although the tax reform act of 1986 does allow self-employed people to deduct 25 percent of their premium payments. Employees of large firms have their health insurance subsidized by the federal government.[10] The same subsidy is not available to employees of small firms, the self-employed and the unemployed.

A third reason is that state regulations prevent people from buying insurance policies tailored to individual and family needs. In recent years there has been an explosion of state laws requiring that health insurance policies cover specific diseases and specific health care services. These laws are called mandated health insurance benefit laws.

- In 1970, there were only 30 mandated health insurance benefits in the United States.

- Today there are 686 mandated benefits, including legislation passed by every state in the union.

Mandated health insurance benefits cover ailments ranging from AIDS to alcoholism and drug abuse, and services ranging from acupuncture to *in vitro* fertilization. These laws reflect the fact that special interest groups now represent virtually every disease and disability and virtually every health care service. Currently,

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

- At least 13 states limit the ability of insurers to exclude people who have AIDS or a high risk of getting AIDS.

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[9]This section is based largely on John C. Goodman and Gerald L. Musgrave, "Freedom of Choice in Health Insurance," NCPA Policy Report No. 134, November, 1988.

[10]The tax subsidy to employer-provided insurance becomes less important at lower marginal tax rates, however. Thus, the lowering of tax rates in the 1980s also reduced the attractiveness to employees of employer-provided health insurance. See Gary A. Robbins, "Economic Consequences of the Minimum Health Benefits for All Workers Act of 1987 (S.1625)," Testimony presented to the U. S. Senate Committee on Labor and Human Resources, November 4, 1987.

- 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. Using an econometric model of the health insurance marketplace, we estimate that[11]

- As many as one out of every four uninsured people lack health insurance because state regulations have increased the price of insurance.

- This means that as many as 9.3 million people lack health insurance because of current government policies.

Ironically, mandated health insurance benefit laws do not directly affect all people, or even a majority of people. Under federal law, companies with self-insured health care plans are exempt from state mandates, and virtually all large firms and a large percent of medium-sized firms are self-insured. Federal law also exempts federal employees and all people covered by Medicare. Most state governments also exempt state employees and Medicaid patients. As a result, the full burden of these state regulations tends to fall on the unemployed, the self-employed and employees of small firms. Yet these are the very groups that are most likely to be uninsured. Specifically,[12]

- About half of the uninsured population is not working.

- Among those who are working, about two-thirds are either self-employed or employees of firms with fewer than 25 workers.

THE MASSACHUSETTS HEALTH CARE PLAN[13]

On April 21, 1988, Governor Michael Dukakis signed legislation requiring employers to contribute toward health insurance premiums for their employees. Perhaps because of confusion created by last year's presidential campaign and election-year rhetoric, discussion of this plan has led to a number of misunderstandings. The following is a brief attempt to clarify those misunderstandings.

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[11]*Ibid.*, Appendix A.

[12]Employee Benefit Research Institute, *Issue Brief No. 66*, May, 1987, pp. 4-5. Statistics given are for the nonagricultural population under 65 years of age.

[13]This section is based largely on Ott and Gray, *The Massachusetts Health Plan;* and Gail R. Wilensky, "The 'Pay or Play' Insurance Gamble: Massachusetts plan for Universal Health Coverage." Paper presented to the House Wednesday Group, Washington, D.C., September 26, 1988.

1. **No one in Massachusetts currently is covered under the plan.** Except for some disabled individuals, there are just as many uninsured people in Massachusetts today as there were when the law establishing the Massachusetts health care plan was passed. That's because the plan does not take full effect for four more years -- in 1992. Moreover, because many details of the plan are still unknown, any statement about what benefits have been created for Massachusetts residents is premature.

2. **The Massachusetts law will require employers to spend money on health insurance for their employees, but will not mandate a specific package of health insurance benefits.** Technically, employers will be assessed a state tax equal to 12 percent of salary up to $14,000 for each employee. However, employers may deduct from the tax any amount spent on health insurance for the employee. This means that employers must spend (either in taxes or on health insurance) $840 for an employee earning $7,000 per year and $1,680 for an employee earning $14,000 or more per year. Massachusetts would be in violation of federal law if it attempted to dictate specific benefits to self-insured plans.

3. **The Massachusetts plan is not "universal health insurance"; it would leave many uninsured people with the option of purchasing health insurance.** Technically, the only Massachusetts residents who will be "forced" to have health insurance are college students. All employees not covered by employer-provided health insurance and all nonworking people will have the option of buying or not buying health insurance from the state.

4. **Under the plan, all Massachusetts residents may not have access to "affordable" health insurance.** The clear intention of Massachusetts is to offer health insurance at subsidized prices to low and moderate-income families. Yet the specifics of the benefit package to be offered by the state are unknown. As a result, the cost of the state health insurance policies and the cost of the subsidies are unknown. Nor is it known how many people will rely on the state for health insurance. Thus, it is not clear that Massachusetts will be able to offer its residents affordable health insurance.

5. **Although Massachusetts intends to force the private sector to provide health insurance to employees, the system may evolve into a state-run version of national health insurance.** This is because the required contribution of employers is low relative to the cost of health insurance, and the benefits in the state insurance policy are likely to be quite liberal. Nationwide, the average employer contribution for an employee's health insurance in 1991 will probably be about $1,739 -- $1,292 for single coverage and $2,887 for family coverage.[14] In Massachusetts, employer contributions to health insurance may be $500 or $600 higher than these amounts.[15] Moreover, the state insurance plan will include benefits (such as mental health care and well-baby care) that are not now included in many private plans. Thus, many employers may decide to pay the state health insurance tax (12 percent of wages) and turn the

[14]Details of this estimate are presented in Appendix A.

[15]Ott and Gray, *The Massachusetts Health Plan*, p. 51.

obligation of providing health insurance over to the state. Indeed, given the difficulties employers now have in managing their health care plans, it would be surprising if this did not happen.[16]

6. **After the plan is enacted, the number of uninsured Massachusetts residents may actually increase.** Because employers have the option of paying the state tax and not providing health insurance for their employees, and because uninsured individuals do not have to purchase insurance from the state, the number of uninsured people in Massachusetts may increase. The more perverse the incentives created by the state plan, the higher the increase will be.

Although details of the Massachusetts health care plan are still unclear, economists Attiat Ott and Wayne Gray have estimated the minimum costs of the plan, based on requirements already written into law. Among their other findings, Ott and Gray have concluded that,[17]

- The plan will force Massachusetts businesses to increase spending on employee health insurance by at least 32 percent.
- The additional cost to employers will be at least $642 million in the first year of operation.
- Because of the increased costs of employing workers, as many as 9,000 jobs will be eliminated, with low-paid employees the most likely job losers.

While it is difficult to generalize from Massachusetts to the rest of the nation, estimates of the effect of elevating this plan to the national level are as follows:

- If the Massachusetts health care plan were adopted nationally, the additional cost to business would be $23 billion.
- As many as 358,000 jobs would be lost nationwide.

Despite the considerable cost of the plan, Ott and Gray found little evidence of a problem that needed to be solved. For example, Massachusetts already has an uncompensated health care pool, designed to spread the cost of uncompensated hospital care among all hospitals and thus among all patients. Moreover, there is virtually no evidence that the uninsured in Massachusetts lack access to adequate health care, and most of the state's uninsured are far from poor. More than 58 percent have family incomes of $20,000 or higher, and 15 percent have family incomes in excess of $50,000.[18]

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[16]The plan does create tax-credit subsidies to encourage small business to provide employee health insurance during the first two years, however.

[17]Ott and Gray, *The Massachussetts Health Plan.*

[18]*Ibid.* Table 2.2, p. 17.

THE KENNEDY PROPOSAL

Senator Edward Kennedy has proposed legislation that would require employers to provide health insurance for their employees, and this legislation has been endorsed in principle by Michael Dukakis. At the time the legislation was proposed, Sen. Kennedy circulated a very low estimate of the cost of the proposal, prepared by Gordon Trapnell of the Actuarial Research Corporation. The Congressional Budget Office (CBO) -- which did not make an independent premium estimate -- promulgated even lower cost estimates, based on an apparent misreading of the Trapnell study. As Table II shows, both the Trapnell estimate and the CBO premium estimates are well below the market price of comparable coverage under the Blue Cross/Blue Shield "low option" policy made available to federal employees.

The most thorough analysis of the cost of the original Kennedy proposal was made by Gary and Aldona Robbins for the Institute for Research on the Economics of Taxation.[19] Subsequently, the Robbins' reestimated the cost of the proposal for the National Center for Policy Analysis, based on the version that was reported out of the Senate Labor and Human Resources Committee and is currently before Congress. The Robbins' analysis of this latest version of the proposal is contained in Appendix A of this report and forms the basis for many of the conclusions of this section.

Economic Effects of the Kennedy Bill

Far from being a solution to our current problems, the Kennedy bill would reduce the take-home pay of the vast majority of workers, increase the cost of health care for all Americans, increase unemployment by as many as one million people, increase production costs in every industry, increase the federal deficit, create billions of dollars of economic waste, and prevent the private sector from taking reasonable measures to control health care costs.

Lower Take-Home Pay. The Kennedy bill would impose on the private sector a cost of at least $108 billion and possibly as high as $159 billion in its first year of operation (1991).[20] Since the bill does nothing to increase productivity, the cost of the bill will tend to fall on employees themselves. This means that employees will lose as much as $108 billion or more in wages and other fringe benefits.

Most discussions of the Kennedy bill focus on the problems of workers who lack employer-provided health insurance. However, about two-thirds of the cost of the bill would be the cost of expanding coverage for currently insured workers in order to comply with the package of mandated benefits. As Table III shows, many existing employer-provided health care plans are not as generous as the Kennedy plan. The inclusion of mental health benefits in the revised bill makes the discrepancy even greater, since mental health care is among the most expensive of all health insurance benefits.

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[19]Gary Robbins and Aldona Robbins, "Mandating Health Insurance," Institute for Research on the Economics of Taxation, July 8, 1987.

[20]For an explanation of these estimates, as well as other estimates appearing in this section, see Appendix A.

TABLE II

ESTIMATES OF PREMIUM COSTS UNDER THE KENNEDY BILL

Estimate	Original Kennedy Proposal[1] Single Worker Premium	Original Kennedy Proposal[1] Family Premium	Original Kennedy Proposal[1] Average Employer Cost	Revised Committee Version[2] Single Worker Premium	Revised Committee Version[2] Family Premium
Robert R. Nathan & Associates[3]	$1,470	$3,732	$2,170	--	--
Gary and Aldona Robbins[4] Institute for Research on the Economics of Taxation/NCPA	1,200	2,892	1,600	$1,465	$3,529
Gordon Trapnell Actuarial Research Corp.	891	2,248	1,308	--	--
Congressional Budget Office[5]	708	1,798	1,090	--	--
Blue Cross/Blue Shield Low Option Plan for Federal Employees	1,300	2,730	--	--	--

[1]In 1988 prices.

[2]In 1991 prices.

[3]Based on the assumption that employer contributions will be 80 percent of the premium.

[4]The estimate for the original Kennedy proposal is for the IRET; the estimate for the revised committee version is for the NCPA.

[5]The CBO did not make an independent estimate, but published figures based on an apparent misreading of Gordon Trapnell's estimate.

Source: Institute for Research on the Economics of Taxation and Appendix A.

TABLE III

PERCENT OF EMPLOYERS WHOSE HEALTH INSURANCE POLICY IS NOT IN COMPLIANCE WITH THE KENNEDY BILL

Violations of the Provisions of the Kennedy Bill	ICF Survey[1]	Towers Perrin Survey[2]
Requires employees to pay more than 20 percent of single coverage premium	28 %	28 %
Requires employees to pay more than 20 percent of family premiums	54 %	38 %
Does not cover part-time workers	68 %	74 %
Waiting period of more than one month	55 %	46 %
Limitation on preexisting conditions	--	65 %
Does not cover seasonal or temporary workers	50 %	--
Does not provide full coverage for well-baby care	--	53 %
Does not cover physician office visits	17 %	--
Does not offer maternity care	16 %	--
Does not cover mental health care	18 %	--

[1]ICF, Incorporated, *Health Care Coverage and Costs in Small and Large Businesses: Final Report*, Prepared for the U. S. Small Business Administration, April, 1987, Tables IV-4, IV-8, IV-9, III-10 and III-12.

[2]Survey by Towers, Perrin, Forster & Crosby. Reported in Jerry Geisel, "Health Plans Fail Mandate: Survey," *Business Insurance*, August 31, 1987.

Rising Health Care Costs. The Kennedy bill would result in at least $108 billion in additional health care spending and administrative costs in its first year of operation. Yet past experience shows that about half of each additional dollar of health care spending buys additional services, while the other half is consumed by higher prices.[21] This means that as much as $54 billion of the additional health care spending would be consumed by medical inflation, escalating health care costs for all Americans.

Economic Waste. In the aggregate, the Kennedy bill would force the private sector to incur from $108 to $159 billion in additional costs to solve a problem that is estimated at only $4 billion -- about half the cost of uncompensated hospital care.. The primary, stated objective of the Kennedy bill is to solve the problem of uncompensated hospital costs, or unpaid hospital bills. Yet the price tag for this "solution" is more than 25 times the size of the problem it purports to solve.

In 1986, uncompensated hospital care amounted to $8 billion -- about 4.4 percent of total hospital revenues.[22] This is the amount of money hospitals spent on health care for people who would not, or could not, pay their bills.[23] Since only two-thirds of the currently uninsured are affected by the Kennedy proposal, uncompensated hospital care would at most be reduced by two-thirds. But the actual reduction would probably be much less. One of the big ticket items contributing to hospital bad debts is premature babies by unwed mothers, and many of these mothers would not be covered under the Kennedy plan. Our best guess is that hospital bad debts would be reduced by $4 billion at most under the Kennedy plan.[24]

Unemployment and Decreased Production. Forcing employers to provide employees benefits raises the cost of hiring unless employers can reduce wages or fringe benefits. In many cases, employers would be unable to offset the higher cost of health insurance benefits by lowering other types of labor compensation. In the case of workers earning the minimum wage, the worker's salary legally cannot be lowered. Yet, as is shown below, for part-time minimum-wage workers, the cost of mandated health insurance may be higher than the worker's salary. As a result of these additional burdens, there would be as many as 1.1 million fewer jobs and as much as $27 billion in reduced output for the economy as a whole.

Increasing the Federal Deficit. Although the Kennedy proposal purports to place the full cost of mandated health insurance on the private sector, it would impact the federal deficit for two reasons. First, because the required premiums are so high and because the bill mandates that employers pay 80 percent of these premiums, an

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[21]Gary Robbins and Aldona Robbins, "Mandating Health Insurance," p. 21.

[22]Deborah J. Chollet, "Financing Indigent Health Care," p. 185. When unpaid physicians bills are included, total uncompensated care in 1986 may have been as high as $13 billion. For a discussion of the factors contributing to uncompensated hospital care, see Frank A. Sloan, Joseph Valvona, and Mullner Ross, "Identifying the Issues: A Statistical Profile," in Frank A. Sloan, James F. Blumstein and James M. Perrin, eds. *Uncompensated Hospital Care: Rights and Responsibilities* (Baltimore: Johns Hopkins University Press, 1986).

[23]It is important to note that the existence of unpaid hospital bills does not necessarily mean that patients were unable to pay them. That is, there is an important distinction between "bad debts" and "charity care," even though hospital records often do not accurately make this distinction. See Chollet, "Financing Indigent Health Care," pp. 154-185.

[24]See Gary Robbins and Aldona Robbins, "Mandating Health Insurance," pp. 11-12.

enormous amount of employee income would be diverted to health insurance and would not be subject to either income taxes or Social Security taxes. Second, federal tax collections would be lower because employment and output would be lower.

In general, federal revenues would be reduced by $17.9 billion because of lower Social Security tax collections and by $23.2 billion because of lower income tax collections. Reduced employment and reduced output would lower federal revenues by an additional $5.4 billion. The net increase in the federal deficit by 1991 would be $46.5 billion.

Eliminating Freedom of Choice. Rather than helping the private sector forge new strategies to contain rising health care costs, the Kennedy bill would needlessly eliminate many workable programs now in place. For example, the proposal would deny employees the right to choose high-deductible plans and keep the savings for themselves. Under the bill, the mandated employee deductible would be $250 and the cap on employee copayments would be $600, regardless of employee preferences. The bill also would force employees to pay for coverage for low-cost services (such as physicians office visits and well-baby care) even though many employees might prefer to save money by self-insuring for such expenses.

The Kennedy plan would place even greater restrictions on freedom of choice for employees of small business. Under the plan, small businesses would be grouped by regions and forced to choose among plans administered by only a few insurers. As a result, small firms would have far fewer options than large firms to innovate, experiment and employ new cost-control techniques.

Special Victims of the Kennedy Bill

The burden of the Kennedy bill is not spread evenly throughout the economy. Certain groups of workers and certain types of business would be especially disadvantaged.

Low-Income Workers. The minimum wage has not changed in seven years. Yet because of inflation, the real value of the minimum wage has steadily decreased over time -- leading to the creation of hundreds of thousands of new jobs for low-skilled workers. The Kennedy bill would reverse this trend and eliminate job opportunities. Specifically,

- Among full-time employees earning the minimum wage, the Kennedy bill would increase labor costs by 21 percent for single workers and by 51 percent for workers with families.
- Among part-time employees earning the minimum wage, the Kennedy bill would increase labor costs by 48 percent for single workers and by 116 percent for workers with families.[25]

[25] Assumes 17.5 hours per week. Note: About two-thirds of all workers earning the minimum wage are part-time workers.

TABLE IV

COSTS OF THE KENNEDY BILL

Direct Costs for the Private Sector:	
Cost of Providing Insurance for Workers Currently Uninsured	$37.3 billion
Cost of Expanding Coverage for Workers Currently Insured	$68.0 billion
Administrative Costs	3.0 billion
Total Increase in Insurance Costs	$108.3 billion
Indirect Costs for the Private Sector:	
Loss of Jobs	1.1 million
Reduction in GNP	$27.0 billion
Increase in the Federal Deficit	$46.5 billion
Problem the Bill Attempts to Solve: (Unpaid hospital bills for uninsured workers)	$4.0 billion

Source: Gary Robbins and Aldona Robbins. Calculations reported in Appendix A.

To get a perspective on what these increases mean, consider that recent Congressional proposals to increase the minimum wage from $3.35 an hour to $4.65 an hour would increase labor costs for minimum wage workers by 38 percent -- much less than the economic impact of the Kennedy bill. Yet studies estimate that the minimum wage increase would destroy from 750,000 to 882,000 jobs by 1991.[26]

Minority Workers. Because the minimum wage has a disproportionate effect on minority employees, the Kennedy bill (which increases the effective minimum wage by more than 100 percent for some workers) also would have an especially devastating impact on minority workers. This impact would be greatest for minority youth, whose unemployment rate is as high as 30 percent in many major cities.

Working Wives. As many as 48 million workers live in two-earner families. In many of these families, working wives rely on the health insurance coverage provided by the husband's employer. Yet under the Kennedy bill, these women would be forced to carry health coverage even if they currently are covered under their husbands' health insurance plan. This would raise the cost to the employer of hiring such women and would make them less employable.

Workers With Families. Under the Kennedy bill, employers rather than employees themselves would be required to pay 80 percent of the cost of insuring the family members of workers. Unless employers are able to pay employees with families a lower wage than single workers -- which is highly unlikely -- the cost of hiring these workers would be higher and they would become less employable.

Unemployed People With Existing Health Problems. Most existing health insurance policies exclude or limit coverage for preexisting health problems. The Kennedy bill would require employers to provide coverage for such conditions. But the bill would not require employers to hire employees with preexisting conditions and, indeed,would offer strong incentives not to hire them.

Effects on Small Business. By design, the Kennedy bill would have a marginal effect on large employers with generous health insurance plans. This is one reason why some large companies support the legislation. Small businesses are a different matter. For example,[27]

- In retail trade and in construction, two industries with a high proportion of small businesses, 23 percent of employees are currently uninsured.

- In the service industry, which also is dominated by small businesses, 15 percent of employees are currently uninsured.

Thus, it is precisely in the industries where small businesses predominate that the Kennedy bill would have its most adverse economic impact. Moreover, the cost per employee of meeting the Kennedy mandates also would be highest in these industries. For example,[28]

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[26]The higher estimate was made by Richard B. McKensie and Curtis L. Simon, "The Proposed Minimum Wage Increase: Associated Job Loss by State, Region, and Industry," National Chamber Foundation, 1988. The lower estimate was made by Robert R. Nathan and Associates.

[27]Employee Benefit Research Institute, *Issue Brief No. 66*, May, 1987, Table 12, p. 20.

[28]Estimates of the impact for all major industries are given in Appendix A.

- In durable goods manufacturing, the cost of mandated family coverage would be about 8.8 percent of labor compensation.

- That cost would be 11.8 percent in the service industry, 16.7 percent in retail trade, and 20.5 percent in agriculture.

These new burdens would come at a time when the small business sector is sustaining America's economic expansion. Currently, small business employs 48 percent of the workforce and creates from 50 to 80 percent of all new jobs.

Regressive Taxation and Uncompensated Hospital Care

The problem of uncompensated hospital care is a real problem for some of our nation's hospitals. Moreover, as the hospital marketplace becomes increasingly competitive, hospitals (especially county hospitals) with disproportionate numbers of charity patients will face greater financial problems.

If society is committed to providing health care to all citizens, that commitment can be funded by paying for charity care with general taxes. The Kennedy bill, by contrast, would attempt to pay for charity care by imposing a highly regressive tax on American workers. Under the bill's terms, high-income workers with generous health insurance plans would notice negligible effects while low-income workers would experience substantial real-income reductions and might lose their jobs.

An Invitation to Special Interests

The Kennedy bill cost estimates presented here and detailed in Appendix A apply only to the initial package of benefits. Experience at the state level teaches that once this legislative door has been opened, hordes of special interest lobbyists will descend on Washington. Every group from acupuncturists to naturopaths will pressure Congress for inclusion in the federal mandates. The initial package of benefits will inevitably grow. The initial costs will eventually soar.[29]

In the politics of health insurance at the state level, special interests exploit the politically weak, i.e., those not represented by a disease lobby or a provider lobby. The Kennedy bill would elevate this process to the status of national policy.

MANDATED EMPLOYEE BENEFITS AND LOWER TAKE-HOME PAY

Mandated health insurance is only one of a number of mandated employee benefits proposed during the last session of Congress. Others include mandated family and medical leave, advance notice of plant closings and employee layoffs, and high-risk

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[29]This process already has begun. Mental health providers successfully lobbied to get mental health benefits included in the revised committee version of the Kennedy bill.

occupational disease notification. All of these legislative proposals have two characteristics in common: (1) they remove freedom of choice from the labor market and substitute the preferences of politicians for the preferences of workers; and (2) they threaten to lower the take-home pay of workers by reducing productivity and/or requiring employers to substitute fringe benefits for wage income.

A basic principle of labor economics is that employers will not hire employees unless the value of what they produce is at least equal to the total compensation they receive. As a result, when employers are forced by law to provide certain benefits, the cost of those benefits ultimately will be borne by workers -- either in the form of reduced wages or reductions in other fringe benefits. To the extent that mandated benefits legislation also lowers productivity in the workplace, employees will bear an additional cost. Lower productivity ultimately means lower compensation.

Workers already are worse off today because they often are forced to accept fringe benefits which they do not want and do not need, instead of receiving higher wages. In addition, total labor compensation today is lower than it needs to be because of lower productivity -- in part caused by legislation which purports to protect employees. Mandated benefits legislation currently being considered in Congress would cause even lower productivity and lower take-home pay.

Government Regulations and Productivity. Many health, safety and environmental regulations were created in order to protect employees. Yet numerous studies have shown that the goals of this legislation could be achieved at a fraction of the cost. Meanwhile, the American worker is paying a price for these unnecessary and wasteful policies. Specifically,[30]

- Between 1959 and 1969, productivity in U.S. manufacturing increased by almost one percent annually.
- Between 1973 and 1978, productivity in U.S. manufacturing fell by more than one-half of one percent annually.
- Regulation by the Occupational Safety and Health Administration (OSHA) and the Environmental Protection Agency (EPA) caused about one-third of this slowdown in U.S. manufacturing productivity in the 1970s.
- The cost of the slowdown amounted to $1,000 for each manufacturing worker in 1987.

Fringe Benefits and Take-Home Pay. Although the U.S. economy has grown over the last 15 years, workers' paychecks have shrunk in real terms. Specifically,

- Since 1972, total employee compensation (per hour worked) has increased in real terms.
- Yet real wages (per hour worked) are lower today than they were in 1972.

In other words, employers are paying more but employees are receiving less. One reason for this anomaly is the "wedge" created by employment taxes and fringe

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[30]Wayne B. Gray, "The Cost of Regulation: OSHA, EPA and the Productivity Slowdown," *American Economic Review*, December, 1987.

benefits. This wedge has grown from 12 percent of employee compensation in 1972 to 16 percent today.[31] In many cases, workers are worse off because they are "forced" to take fringe benefits which they do not want and do not need.

LOSS OF JOBS: LESSONS FROM EUROPE[32]

One way to appreciate how far things could go is to consider what has already happened in Europe. Mandated benefits -- either through legislation or country-wide collective bargaining at the encouragement of government -- are a permanent feature of European labor markets.

- In Sweden, both parents are entitled to parental leave at 90 percent of pay for up to nine months to stay home with a newborn child.
- Overall, benefits as a percent of wages are nearly 100 percent in Italy, 80 percent in Germany and France, and more than 70 percent in the Netherlands and Sweden.

European governments regulate virtually every aspect of employment, while at the same time providing lucrative benefits to the unemployed.

- In Belgium, Italy, Denmark, and Ireland, wages are set and indexed through national income policies.
- Overall, European unemployment compensation ranges from 60 to 90 percent of previous pay and extends from one to three years.
- By contrast, U.S. unemployment compensation averages about 50 percent of previous pay and extends from six to nine months.

A major consequence of the European approach to labor markets is economic stagnation.

- Since 1970, the United States has created 34 million new jobs.
- Over the same period, Europe -- with a population 50 percent larger than the U.S. -- added only two million jobs.
- In every one of the last four years, the U.S. has created more jobs than Europe has created in 17 years.

European economic stagnation also is reflected in high levels of long-term unemployment.

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[31]Taken from the National Income and Product Accounts data reported in U. S. Department of Commerce, Bureau of Economic Analysis, *Survey of Current Business*, Vol. 68, No. 7, July 1988, Tables 6.4B and 6.5B.

[32]The statistics in this section are taken from William J. Dennis, "New World Jobs and Old World Policy: Turbulence, Small Business and Employment Growth," paper presented to the American Association of Private Enterprise Educators, April, 1988.

- Whereas the U.S. unemployment rate is now below 6 percent, double-digit unemployment is common throughout Europe.

- Whereas only one in ten unemployed workers in the U.S. is out of a job for more than 12 months, the figure exceeds 40 percent in France, Ireland, the Netherlands, Spain, and the United Kingdom.

- In Belgium, 68 percent of the unemployed have been out of a job for more than 12 months.

CONCLUSION AND POLICY RECOMMENDATIONS

Like state-mandated benefits already written into law, the Kennedy and Dukakis proposals would prevent the private sector from finding innovative, imaginative solutions to the problem of rising health care costs. At the same time, the proposals would increase health care costs for all Americans. Thus, it is virtually certain that these plans would lead to new political pressure for more regulation of the medical marketplace and eventually for a program of national health insurance.

A better strategy would be to remove regulations that prevent the operation of a fully competitive market for health insurance. The following are policy recommendations designed to:

1. Encourage all Americans to purchase basic, no-frills, catastrophic health insurance.

2. Encourage individuals who currently have insurance to expand coverage, or continue coverage, for their spouses and dependent children.

3. Allow all Americans to purchase insurance policy benefits tailored to their individual and family needs.

4. Create opportunities for the self-employed, the unemployed, and employees of small business to purchase insurance on terms now largely restricted to government employees and employees of large businesses.

5. Encourage insurers to offer high-risk insurance for individuals and families who cannot buy insurance in the normal marketplace.

6. Encourage cost control and prudent buying decisions through individual self-insurance for small medical expenses.

Creating Access to No-Frills Health Insurance. A new, national market for health insurance should be created. In this market, people would be able to choose from a wide range of health insurance benefits and select a policy tailored to individual and family needs. Insurers would be able to participate in this market by offering federally qualified policies with the following characteristics:

1. Insurers should be obligated to pay out a minimum percentage of total premium income in the form of policy benefits.

2. Insurers should be subject to certain non-discrimination provisions.

3. Federally-qualified plans should be exempt from all state-mandated health insurance benefits including mandates covering specific diseases and disabilities, specific medical services, and specified types of health care providers and provider organizations.

4. Federally-qualified plans should be exempt from the payment of state premium taxes and assessments for risk pools.

5. Federally-qualified plans should be exempt from state rate regulations.

Creating Equity in Taxation. Individuals should be able to deduct insurance premiums on their federal income tax returns up to a Premium Limit, adjusted for age and family size. Employer payments for employee health insurance should continue to be excludable from the employee's taxable income up the the Premium Limit. In general, the tax code should be neutral with respect to the manner in which health insurance is purchased -- whether by employers or by individuals.

Encouraging Cost Control Through Group Insurance. In recognition of the fact that there may be economies of scale and opportunities for effective cost management through group insurance, corrections in the IRS code should be made to encourage the sale of group insurance through multiple employer trusts, trade groups and other nonprofit associations, and associations organized by employers.

Encouraging Cost Control Through Individual Self Insurance. In recognition of the fact that individuals are more prudent managers of their health care dollars than are third party payers, individuals should be encouraged to self-insure for small medical expenses and to rely on third party insurers only for large medical expenses. Specifically,

1. Individuals should have the opportunity to make tax-deductible deposits to individual Medisave accounts.

2. Funds in Medisave accounts would accumulate tax free and could be used to pay medical expenses without tax penalty.

3. The maximum allowed deduction for deposits to Medisave accounts plus the deduction for health insurance premiums should be the Premium Limit described above.

4. Medisave deposits could be combined with funds in IRA accounts, 401(k) accounts and any other qualified, defined-contribution pension plan, provided that such funds are accounted for separately.

5. Medisave accounts for separate individuals could be pooled in a common account.

6. Deductions for Medisave deposits should be allowed only for individuals who purchase health insurance.

Encouraging Health Insurance For High-Risk Individuals. Insurers should be encouraged to offer high-risk insurance for individuals and families who are unable to purchase health insurance in the normal marketplace. Specifically,

1. Insurers on their own or in combination with other insurers should be able to provide federally qualified high-risk insurance.

2. Federally qualified high-risk insurance should be confined to catastrophic insurance policies only.

3. Individuals who purchase high-risk insurance should be permitted deductions on their federal income taxes up to twice the level of the Premium Limit described above.

4. Individuals who purchase high-risk insurance should be allowed no deduction for Medisave deposits.

Above all, government policy should encourage individuals in the private sector to use their intelligence and creativity to find imaginative new solutions to health care problems and give the private sector the freedom to implement those solutions.

NOTE: Nothing written here is to be construed as necessarily reflecting the views of the National Center for Policy Analysis or as an attempt to aid or hinder passage of any bill before Congress.

APPENDIX A

THE COST OF THE KENNEDY BILL

by

Gary Robbins

and

Aldona Robbins

Fiscal Associates has estimated the costs of the "Minimum Health Benefits for All Workers Act of 1987" (S. 1265), recently voted out of the Senate Labor and Human Resources Committee.[1] This Appendix discusses: (1) the major provisions of S.1265 and changes from the original version; (2) the method used in estimating the costs of S.1265; (3) the estimated cost for the country as a whole; (4) the macroeconomic and revenue implications; and (5) reasons why the cost estimates produced here could be low.

Major Provisions of the Kennedy Bill

Key features of S.1265, including changes between the original and committee versions, are as follows:

1. Any employer subject to minimum wage regulations must enroll each employee and the employee's family in a minimum health insurance plan with certain minimum benefits, provided that the employee works more than 17.5 hours a week.[2]

2. Employees cannot waive participation in the health plan for themselves or their families. In the case of two-worker couples, however, one worker may waive coverage for the spouse and children provided proof is given that the

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[1]We estimated the costs of the original version of S.1265 in an earlier study, "Mandating Health Insurance," *IRET Economic Policy Bulletin*, No. 39, July 8, 1987. We have relied on the same methods to estimate the costs of the committee version. Differences in the estimates are due to: (1) the incorporation of higher health insurance premiums and employment levels because this study's estimates are for 1991 while those in the earlier study were for 1988; (2) changes in provisions between the original and committee versions of S.1265; and (3) the use of more recent data.

[2]The minimum wage law applies essentially to all employers regardless of the number of employees. However, the Fair Labor Standards Act does exempt firms with less than $250,000 in gross receipts -- the so-called "mom and pop" shops. The committee version of the Kennedy bill includes an exemption for employees of temporary help services firms unless the employees work 750 hours in six consecutive months (roughly 31.25 hours a week), and also provides a means by which some family farmers may be exempt from S.1265. The committee version also exempts new businesses with less than five employees for the first two years. (In its third year of operation the business must provide catastrophic coverage and, by its sixth year, must offer the mandated minimum package.)

other spouse has coverage. Despite this option, each working spouse must be covered under separate policies.[3]

3. The minimum benefit package must cover the following types of medical expenditures:

   a. Inpatient and outpatient hospital care.[4]

   b. Inpatient and outpatient physician services.[5]

   c. Diagnostic and screening tests.

   d. Prenatal and well-baby care.[6]

4. The insurance plan may not exclude or limit coverage to any worker or family member because of any current or prior disease, disorder, or condition.

5. The minimum plan must pay the following medical expenses for the covered services listed in (3) above:

   a. The insurance plan starts paying medical expenses after the worker has spent a deductible of no more than $250 out-of-pocket on medical services covered under the plan, or $500 for the family. There is no deductible for prenatal or well-baby care.[7]

   b. After the deductible has been met, the insurance plan must pay at least 80 percent of covered medical expenses, leaving the employee with a copayment of 20 percent. There is no copayment for prenatal or well-baby care.[8]

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[3]The committee version adds a section which stipulates that a special premium category for two-worker families be created. Either insurance companies or the Department of Health and Human Services would establish the premiums. The presumed purpose of this section is to prevent premiums for two workers in a family with children from being greater than the premium for one worker, a nonworking spouse, and children.

[4]The committee version added coverage for inpatient hospital care of at least 45 days annually for a mental disorder.

[5]The committee version added coverage for at least 20 outpatient psychotherapy and counseling visits a year.

[6]Required coverage will be defined annually by the Secretary of Health and Human Services.

[7]The committee version added indexation for the deductible amounts. The minimum single and family deductibles are to increase with the rate of inflation as measured by the Consumer Price Index for All Urban Consumers (CPI-U). If the CPI-U increases more slowly than medical inflation (as has been the case during the 1980s), the deductible amounts would continue to fall in real terms. NOTE: Between 1980 and 1987, the CPI-U increased by 38 percent while the Medical CPI increased by 74 percent.

[8]The committee version stipulates that the copayment for outpatient mental health care be no more than 50 percent.

c. The insurance plan must provide catastrophic coverage by paying all covered medical expenses once the worker has spent $3,000 out-of-pocket.[9]

6. The employer must pay at least 80 percent of the premiums for single and family coverage. In the case of a "low-wage" worker, the employer must pay 100 percent of single and family premiums. A "low-wage worker" is defined as someone earning less than $4.19 an hour in 1988, which is 125 percent of the $3.35 minimum wage.

7. The Secretary of Health and Human Services (HHS) will establish between six and eight "health insurance regions." The Secretary will then "certify" insurers on a competitive basis within each region, provided they offer the minimum benefit package and more generous coverage for both indemnity and managed care plans. Certification also will depend upon financial stability standards established by HHS (such standards already apply to insurance companies at the state level) and standards for the quality and types of services offered.[10]

8. Employers with less than 25 employees who do not have a health benefit plan by the effective date of the bill, or have a plan but then change insurers or plans, must purchase insurance through these regional insurers.

A Method for Estimating the Costs of the Kennedy Bill

The costs estimated in this Appendix refer to the year 1991 because the bill stipulates its effective date as January 1 of the second year after enactment. If the bill passes in 1989, 1991 would become the first year that employers and employees would have to comply with the Act.

Measuring the costs of S.1265 requires estimating the increase in costs for existing coverage and the costs for new coverage in 1991. Our approach is first to estimate the costs for the average economy-wide health insurance package in 1991 that employers are expected to provide to their employees under present law.

We looked at National Income and Product Accounts (NIPA) data, which are based on tax return records, to determine how much employers currently spend per covered employee. Employer contributions to health insurance totaled $125 billion for 94 million insured workers in 1987, or an average employer expense of $1,327 per insured worker. We extrapolated this figure to 1991, assuming an annual rate of growth

[9]Out-of-pocket expenditures for mental health benefits would also count toward the $3,000 cap.

[10]The committee version states that any number of insurers could be certified, unlike the original version which specified 2 to 5 per region. Although this change may seem to encourage competition, the certification process itself, along with the various HHS requirements that an insurer must meet, would still limit insurer competition and ultimately raise the costs of health insurance.

in medical inflation of seven percent between 1987 and 1991.[11] Thus, the projected average employer contribution in 1991 will be $1,739.

We then translated employer contributions into premiums for single and family coverage by categorizing workers by family composition.[12] We assume that single workers and married workers without children take single coverage and that the rest take family coverage. Thus, 44.5 percent of workers opt for single coverage and 55.5 percent opt for family coverage.

We derived premiums for single and family coverage by combining this family composition information with the assumption that the family premium will be 2.41 times the single premium and that employers will pay 86 percent of single premiums and 71 percent of family premiums.[13] These assumptions are incorporated in the following equation, which we solved for the single premium and the average employer contribution under existing law:

Average Employer Contribution = (Single Premium X Employer Single Contribution Rate X Proportion of Workers with Single Coverage) + (Family Premium X Employer Family Contribution Rate X Proportion of Workers with Family Coverage).

or,

$1,739 = (Single Premium X 0.86 x 0.445) + ((2.41 X Single premium) X 0.71 X 0.555)

The premium estimates for insurance coverage without S.1265 assume that deductibles will continue to rise with the increase in medical inflation. Otherwise, premiums would have to go up by more than the rate of medical inflation to cover the increased benefits that would result from the lower value of the deductible in real terms.

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[11]The Medical CPI-U is currently running at a rate of 6.6 percent for May, 1988 over April, 1987. National health expenditure projections prepared by the Health Care Financing Administration assume medical expenditures will grow at an annual rate of about 9 percent between now and 1990, while the population grows at 0.8 percent. See Division of National Costs Estimates, Office of the Actuary, Health Care Financing Administration, "National Health Expenditures, 1986-2000," *Health Care Financing Review*, Summer, 1987, Volume 8, No. 4, pp. 1-35, Table 12.

[12]The employment numbers for people classified as single, married, and heads of households are taken from the *1988 Statistical Abstract*, Table 612. Married couples are further subdivided using information from the March, 1987 CPS.

[13]These assumptions are based on the findings of ICF Incorporated, *Health Care Coverage and Costs in Small and Large Businesses: Final Report*, prepared for the U.S. Small Business Administration, April 15, 1987. Family premium amounts used by the Congressional Budget Office and others are as much as 2.5 times the single premium.

Based on a recent survey, the average deductible for all employer-provided plans was $230 in 1986.[14] Our assumption that medical inflation will continue at about seven percent a year implies that the average deductible for existing plans will be $320 in 1991.

S.1265, however, will require a $250 deductible -- 28 percent lower than the $320 projected for existing plans. We estimate that the single worker premium for the minimum mandated package will be $1,465 in 1991, compared to a single premium of $1,292 for existing plans.[15] If the bill were amended to increase the deductible to $305 to reflect the increase in medical inflation between now and 1991, its premium costs would be lower, as shown below.

PREMIUMS AND AVERAGE EMPLOYER CONTRIBUTIONS IN 1991

	1991 Premium	Employer Contribution
Current Coverage Continued		
Single	$1,292	$1,111
Family	$2,887	$2,209
Kennedy Bill (Low Deductible)[16]		
Single	$1,465	$1,172
Family	$3,529	$2,824
Kennedy Bill (Higher Deductible)[17]		
Single	$1,409	$1,127
Family	$3,394	$2,715

[14]ICF, *Health Care Coverage*, Tables IV-4, IV-7, and B-3. Some have used data from surveys of large firms to argue that deductibles of existing plans are lower than $230. While large firms do tend to have more generous coverage, they do not account for a majority of employment in the United States. For example, the scope of the Bureau of Labor Statistics (BLS) 1986 survey of employee benefits in medium and large firms covers less than 25 percent of U.S. employment. Furthermore, the BLS data, as well as other more recent surveys, indicate that even large firms are offering less generous health plans as premium costs increase faster than inflation. For instance, a recent study of the employee benefits of salaried employees in Fortune 500 companies concludes that there have been dramatic increases in annual deductibles, particularly in the last two years. (See Hewitt Associates, "Salaried Employee Benefits Provided by Major U.S. Employers in 1982-87," p. 3.)

[15]We use the same relationship between the existing premiums and the Kennedy bill as in our earlier study.

[16]Assumes a $250 single, $500 family deductible.

[17]Assumes a $305 single, $610 family deductible.

Increase in Total Health Insurance Costs

Based upon these premiums, we estimate that the increased cost of mandated health insurance will be between $96.5 billion and $108.3 billion in 1991. The major cost components are as follows:

INCREASE IN 1991 HEALTH INSURANCE COSTS
UNDER A $250 DEDUCTIBLE
(in billions)

Payor	Cost of New Coverage	Increased Cost of Existing Coverage	Additional Administrative Cost	Total Cost
Employers	$29.8	$38.5	$3.0	$71.3
Employees	7.5	29.5		37.0
Combined	$37.3	$68.0	$3.0	$108.3

INCREASE IN 1991 HEALTH INSURANCE COSTS
UNDER A $305 DEDUCTIBLE
(in billions)

Payor	Cost of New Coverage	Increased Cost of Existing Coverage	Additional Administrative Cost	Total Cost
Employers	$28.7	$30.1	$3.0	$61.8
Employees	7.2	27.5		34.7
Combined	$35.9	$57.6	$3.0	$96.5

New coverage. As indicated above, there will be an increase of $35.9 to $37.3 billion in health insurance costs for the 12.6 million workers projected to be without health insurance of any kind and subject to S.1265 in 1991.[18]

Existing Coverage. The minimum insurance package specified in S.1265 is more expensive than coverage currently provided by employers. This is due to the requirement of a $250 deductible; mandated benefits (such as prenatal, well-baby, and mental health care) that are often absent from current health insurance policies; a maximum 20 percent copayment for physician services; and the elimination of preexisting conditions in determining coverage. In our earlier study, the difference between the premiums for the mandated minimum package versus average economy-wide current coverage in 1988 was $100 for a single policy and $241 for a family.

Assuming that workers and their employers continue present trends and raise policy deductibles to prevent health insurance premiums from taking an ever-larger share of the pay package, there will be an increasing divergence between the costs of the mandated minimum package and existing coverage over time. Between 1988 and 1991, this difference would increase by 75 percent for a single policy and by 266 percent for a family policy.[19] For the nation as a whole, the costs of upgrading existing coverage would be on the order of $57.6 to $68 billion in 1991. Employers would pay an additional $30.1 to $38.5 billion, and workers would pay an additional $27.5 to $29.5 billion.

Administrative Costs. Proponents of S.1265 claim that premiums of small employers will be reduced by as much as 30 percent compared to the current system. This claim is based on observed differences between large and small business premiums, and it is valid only if the administrative cost of insurance (which accounts for two-thirds of the difference) is ignored. Large employers typically absorb many of these administrative costs under their general overhead.

To estimate the additional administrative costs created by S.1265, we added 20 percent to the mandated minimum insurance premium for 27 percent of the newly covered employees who are employed by small firms. This amounts to $3 billion. This estimate, however, ignores the administrative costs that might be incurred by small employers with existing plans that would eventually end up in the regional pools.

Macroeconomic Effects

The increase in health insurance costs will be paid by employers initially because the total employee compensation package cannot be changed instantaneously. This increase in payroll costs would mean a reduction in employment. In time, the employee's compensation package will be redesigned, although total compensation will still have to equal the value of workers' output. The redesigned compensation package will have less

[18]The number of uninsured workers was projected to 1991 by multiplying the ratio of uninsured workers to total employment in 1985 times total employment forecasted for 1991. This figure was then reduced to account for employees who work less than 15 hours a week (about 4.7 percent of employment).

[19]Our estimates indicate that the premium for a single employee would be up to $173 more expensive than existing coverage; a family policy would be up to $642 more expensive.

cash wages and other fringe benefits and more health insurance. The net result will not be uniform for all employees because it depends upon the type of health insurance different employees would have otherwise chosen.

Effect on Jobs. Because there will be no change in the value of the output of labor, the $96.5 to $108.3 billion increase in health insurance costs will lead to one of two outcomes:

- Other labor compensation -- money wages, pensions, and other fringe benefits -- will be reduced. This is the same as increasing the tax on labor compensation by 1.9 percent.

- Some employers will reduce employment by reducing their workforce or by slowing the rate at which they hire new employees.

The net result of a $96.5 billion increase in health insurance costs, associated with a $305 deductible, will be 950,000 fewer jobs in the economy. The $108.3 billion cost increase associated with a $250 deductible package will lead to 1.1 million fewer jobs.

Fewer jobs means fewer labor services and less output. That is, 950,000 fewer jobs will result in $24 billion less total real output in the economy in 1991, and 1.1 million fewer jobs will lead to $27 billion less total real output in 1991.

Effect on the Deficit. A federal tax loss will occur due to a reduction in the income tax base and in the Social Security tax base. Wages currently received by employees, and therefore taxable, will be paid instead in the form of employee health insurance contributions. The revenue loss from reduced Social Security taxes is the reduction in the tax base times the 15.3 percent combined employer-employee Social Security tax rate in 1991.

The income tax base will be reduced by somewhat less than the Social Security tax base because some wage income is not subject to the income tax. We assume that one-half the new employer contributions and one-half the added administrative costs will fall into that category. The revenue loss from reduced income taxes is the reduction in the tax base times the average marginal tax rate on wage and salary income of 23 percent in 1991.[20]

The combination of lower income and payroll taxes will be $41.1 billion in 1991 for a minimum package with a $250 deductible, and $36.9 billion for a package with a $305 deductible. This "static" revenue estimate does not take into account any macroeconomic changes, such as a reduction in employment that will result from S.1265. An additional $4.8 to $5.4 billion revenue loss will result from the dynamic adjustments in the economy due to the reduction in aftertax labor compensation.

[20]The estimate of the average marginal tax rate comes from the Fiscal Associates' Individual Tax Model, which uses individual tax return data from 1984 extrapolated to 1991. The economy-wide average is weighted with wage and salary incomes. The 23 percent rate implies that more wages will be taxed at the 28 percent rate than at either the zero or 15 percent rates.

1991 FEDERAL TAX LOSS UNDER A $250 DEDUCTIBLE
(in billions)

	Tax Base	Rate	Revenue Loss
Social Security Tax	$116.9	15.3%	$17.9
Income Tax	101.0	23.0%	23.2
Static Revenue Loss			$41.1
Dynamic Revenue Loss			$ 5.4
Total Federal Revenue Loss			$46.5

1991 FEDERAL TAX LOSS UNDER A $305 DEDUCTIBLE
(in billions)

	Tax Base	Rate	Revenue Loss
Social Security Tax	$105.5	15.3%	$16.1
Income Tax	90.2	23.0%	20.8
Static Revenue Loss			$36.9
Dynamic Revenue Loss			$ 4.8
Total Federal Revenue Loss			$41.7

Cost by Industry. There also will be differential impacts across industries. Industries with high rates of labor compensation will be favored relative to industries with low rates of compensation. The premium for the minimum mandated package as a percent of total employee compensation by industry is as follows:

COST OF THE MINIMUM PACKAGE AS A PERCENT OF COMPENSATION

	$250 DEDUCTIBLE	
	Single	Family
Private industries:		
Agriculture, forestry, and fisheries	8.51%	20.51%
Mining	2.86	6.88
Construction	3.92	9.43
Manufacturing	3.63	8.75
Durable goods	3.42	8.25
Nondurable goods	3.99	9.61
Transportation and public utilities	3.18	7.66
Transportation	3.63	8.75
Communication	2.67	6.44
Electric, gas, and sanitary services	2.71	6.53
Wholesale trade	3.71	8.95
Retail trade	6.95	16.74
Finance, insurance, and real estate	3.61	8.70
Services	4.88	11.76
Government and government enterprises	3.85	9.27
All domestic industries	4.26	10.27

	$305 DEDUCTIBLE	
	Single	Family
Private industries:		
Agriculture, forestry, and fisheries	8.19%	19.73%
Mining	2.75	6.62
Construction	3.77	9.07
Manufacturing	3.49	8.42
Durable goods	3.29	7.93
Nondurable goods	3.84	9.24
Transportation and public utilities	3.06	7.37
Transportation	3.49	8.42
Communication	2.57	6.19
Electric, gas, and sanitary services	2.61	6.28
Wholesale trade	3.57	8.60
Retail trade	6.68	16.10
Finance, insurance, and real estate	3.47	8.37
Services	4.70	11.31
Government and government enterprises	3.70	8.92
All domestic industries	4.10	9.87

Retail trade and construction are the industries with the largest proportion of uninsured workers, with 23 percent each. Next highest are services with 15 percent.[21] These industries are characterized by a high proportion of small businesses. Because almost all companies with 100 or more employees already offer health insurance in these and other industries, large firms will find it easier than small firms to comply with S.1265.[22] Much of the incremental burden of the mandated coverage will fall on small employers responsible for much of the recent job creation in the U. S.

These distortions will cause prices in the unfavored sectors to rise disproportionately, thereby reducing growth in these industries. In effect, mandatory health insurance will disguise the relative costs of production among industries and lead to a misallocation of the nation's scarce resources. This, coupled with the increased demand for medical services, will tilt the development of the U. S. economy away from the largest growth sectors toward the health care sector.

Why These Estimates Could Be Low

The above estimates are based on relatively conservative assumptions. What follows is a brief discussion of some factors that could cause the actual total cost of S.1265 to be as much as 50 percent higher than the estimates given above.

Premium Increases. The latest available NIPA data on employer contributions for 1987 does not reflect the substantial premium increases that occurred in 1988 and are projected for 1989. These increases could be three to four times the rate of medical inflation. Premium increases of 15 to 30 percent were not uncommon between 1987 and 1988. Predictions that the cost of insurance for federal employees next year probably will increase by 20 to 30 percent provide an early indication that this trend will continue.[23]

Because our projections to 1991 use trends in the Medical CPI, these projections probably understate the rate of increase in premium amounts. For example, if the economy-wide increase in premiums from 1987 to 1989 were on the order of 20 percent per year, rather than the seven percent assumed above, the costs of S.1265 would be 26 percent higher. The costs of new coverage and upgrading existing coverage, therefore, would be $122 to $136 billion.

Increasing Divergence Between Mandated Benefits and Employee Preferences. To the extent that health insurance premiums increase faster than wages, employers and employees are likely to opt for less generous coverage. The 1980s have borne out this pattern. By 1991, therefore, the difference between the minimum mandated package and the economy-wide average package could be even greater than we have assumed in our estimates, which were based on 1986 and 1987 information. An increasing divergence between the mandated package and the package workers would choose in the absence of S.1265 would further increase the burden of the bill for employees.

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[21]Employee Benefits Research Institute, "A Profile of the Non-elderly Population Without Health Insurance," *EBRI Issue Brief* 66, May, 1987, Table 12.

[22]U. S. Small Business Administration, Statement of the Honorable Frank S. Swain before the Committee on Small Business of the United States House of Representatives on "New Directions for Small Business and Health Care," May 6, 1987, Chart 4.

[23] John Purnell, "Health Insurance Premiums May Rise 50% Over Two Years," *The Washington Times*, August 23, 1988, p. B5.

The Cost of Mental Health Coverage. We have not calculated the increase in the premium costs under S.1265 due to an expansion in mandated benefits from the original version. One big ticket item is the addition of inpatient and outpatient mental health coverage.

Mandatory Duplication. Our cost estimates for the original version of S.1265 included what we called "mandatory duplication" because the bill requires that all married workers purchase their own policies. A two-earner family with children, therefore, will have to purchase one single and one family policy. This duplication will apply to workers with existing coverage as well as to newly-covered workers.

Duplicate coverage would disappear if insurance companies were allowed to develop a new product that specifically addresses the overlap. But this development would take time because of the need for insurance companies to gain experience about family health care utilization patterns under S. 1265.

The Committee version of S.1265 contains a new provision to address this issue. It stipulates that a special category of premiums be established for family coverage in which a working spouse is covered under his or her own plan. The premium is to be based on actual or projected plan experience, or according to a formula established by the Secretary of Health and Human Services (HHS).

For there to be no additional costs, insurance companies or HHS must be able to divide the premiums so that the cost of a family policy for one working spouse plus a single policy for the other working spouse equals the cost of a family policy. If insurance companies, or HHS, are unable to gauge these prices instantaneously, families with children and two or more earners will pay higher costs for coverage than otherwise. This could add as much as $20 billion for the first several years to the costs of S.1265.

Increase in Administrative and Regulatory Burdens. Involvement of the Department of Health and Human Services in determining family premiums is only one example of how S.1265 would expand the role of the federal government in health insurance. A greater government role means higher costs due to the larger bureaucracy and the greater administrative and regulatory burden placed on the private sector. These costs must ultimately be paid by taxpayers, either through higher taxes to support the bureaucracy administering S.1265 or through lower employment and output resulting from the higher health insurance costs that S.1265 would impose.

Some examples of how S.1265 would expand the federal government's role include:

- A certification process for regional insurers.
- Establishment of an Advisory Board to the Secretary of HHS on actuarial equivalence and other matters related to S.1265.[24]
- Responsibility of HHS in determining the relationship among premiums charged to different types of families.

[24]Among other requirements, S.1265 will require the Secretary of HHS to publish a table which describes "variations in covered services, copayments, deductibles, limits on out-of-pocket expenses, and an employer's share of the premium or premiums under a health benefit plan as a percentage increase or decrease in the minimum plan."

It is not difficult to imagine that satisfying these new functions could lead to a bureaucracy about the size of the present Health Care Financing Administration (HCFA), which oversees Medicare and Medicaid. During fiscal year 1987, HCFA administrative costs amounted to $3.4 billion.[25] Projecting these costs to 1991, the added federal bureaucracy could cost taxpayers an additional $4 billion.

Reduced Competition Among Health Insurers. The added costs resulting from the reduction in choices available to employers and workers because of the mandated approach are difficult to quantify. The certification process and the very existence of the minimum benefit package would seriously reduce the flexibility of insurers to put together different combinations of deductibles, copayments, and covered services. Furthermore, S.1265 would forbid regional insurers from setting or adjusting premiums on the basis of "age or gender of employees (or their families), on other factors relating to projected or actual use of health services, or on geographical location within the region." These so-called "community-based" premiums would, in effect, lead to uniform fees, thereby negating one of the major cost savings of private insurance. Rather than segregate groups by use and lower insurance costs, S.1265 would seek to eliminate these differentials and cause insurance costs to rise.

The total actual costs of S.1265, therefore, could be as much as 50 percent higher than the estimates given above. The table below summarizes the cost categories not considered in the previous estimates.

[25]Executive Office of the President, Office of Management and Budget, *Budget of the United States Government Fiscal Year 1989*, Washington, D.C., 1988, Appendix I-K27 to I-K30. Administrative costs are total costs minus benefits payments for Medicare and Medicaid.

POTENTIAL ADDITIONAL COSTS OF THE KENNEDY BILL

(in billions)

Base cost estimates	$96.5 to $108.3
Adjustment for probable 1987-88 premium increases	27
Increasing divergence between the freely chosen economy-wide average coverage and the S.1265 minimum package	?
Addition of mental health care	?
Duplicate coverage if premiums cannot be adjusted instantaneously	20
Increase in federal spending due to a larger federal bureaucracy	4
Total Potential Cost of S.1265	$147.5 to $159.3

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