The Heritage Foundation Issue Bulletin

No. 136 | The Heritage Foundation • 214 Massachusetts Avenue • N.E. • Washington, D.C. • (202) 546-4400

January 29, 1988

MINIMUM HEALTH BENEFITS ACT: MANDATING NEW PROBLEMS

INTRODUCTION

As many as 35 million Americans currently lack any private health insurance coverage yet are ineligible for government health care programs such as Medicare, Medicaid, or veterans' benefits. As a result, they are unprotected against the possibility of incurring unaffordable--or "catastrophic"--medical bills. This uninsured population constitutes one of the biggest gaps in the United States health care system and has become a major concern of policy makers.

Congressional committees are considering legislation designed to reduce this gap by mandating that virtually all employers provide their workers with a minimum level of health insurance. There is a real danger, however, that this legislation would do more harm than good. While these proposals might help some workers and employers, they still would leave many Americans unprotected and, at the same time, would destroy jobs and drive health care spending and costs even higher, to the detriment of all Americans and the U.S. economy.

It is estimated that businesses and workers initially would be forced to spend an additional $27 billion to $100 billion on health insurance annually to meet the requirements of this legislation. These costs would increase in future years. At the same time, even the bill's supporters concede that it would destroy 100,000 jobs; opponents point out that the job loss could exceed one million.

Risky Bandaid. The problem with mandatory health insurance, as with the Medicare catastrophic legislation that Congress has been debating this past year, is that it is an attempt to apply a bandaid to one of the symptoms of the sick U.S. health care system without addressing the need for overall reform of the system's basic structure. Just as in medicine, health care policies that treat only the symptoms and not the disease run the risk not just of being ineffective but of harming the patient even more. Needed instead is a broader approach to solving America's health care problems, based on a better understanding of why this and other gaps exist in the first place.

In recent decades, the normal market functions of consumer choice have been steadily eliminated from America's health care system. Without market incentives encouraging doctors and patients to control costs, health care spending and inflation have escalated. These costs are responsible for creating the present gaps in the system. Until Congress enacts reforms that restore competition and consumer choice to health care, problems such as underinsurance will grow and multiply.

WHO ARE THE UNINSURED?

In an effort to address the problems of the uninsured, Senator Edward Kennedy, the Massachusetts Democrat and Chairman of the Senate Committee on Labor and Human Resources, has introduced legislation that he calls the "Minimum Health Benefits for All Workers Act of 1987" (S. 1265). This would require employers to provide basic health insurance coverage to their workers. Similar legislation (H.R. 2508) has been sponsored in the House by Representative Henry Waxman, the California Democrat. Both bills are in committee.

It is estimated that approximately 50 million Americans are either uninsured (have no health insurance at all) or underinsured (do not have enough health insurance). While estimates of the number of underinsured rest on debatable assumptions about what constitutes "adequate" health insurance, the population without any health insurance is more clearly defined. In 1985, according to Census Bureau figures, there were 34.8 million uninsured Americans among the under 65, nonmilitary, nonagricultural population.[1] Almost half of the uninsured in 1985 were workers, and another third were children under the age of 18. Some 52 percent lived in families where the head of the household worked full-time during the entire year. Another 25 percent lived in families where the head of the household worked part-time all year, or full-time for most of the year. And roughly two-thirds of the uninsured lived in families with incomes above the poverty level.

Younger Americans. Uninsured workers tend to be younger Americans; over half are between the ages of 18 and 30 and more than a third between the ages of 18 and 24. Almost three-quarters of uninsured workers are low-wage earners with incomes of less than $10,000 a year, and over two-thirds of uninsured workers are either self-employed or work in the retail trade or service sectors.

The theory behind the Kennedy proposal is that, since most uninsured have jobs or are dependents of workers, most of the problem can be solved simply by expanding the existing system of employer-provided health insurance to include Americans who have fallen through the cracks. Kennedy's way of doing so is by requiring those employers who currently do not provide health benefits to cover their workers. Kennedy's rationale, however, is flawed. Problems such as

---

1. Data on the composition of the uninsured population are from: Employee Benefit Research Institute, "A Profile of the Nonelderly Population Without Health Insurance," *Issue Brief* No. 66, May 1987. EBRI's tabulations are based on the Census Bureau's March 1986 Current Population Survey. The elderly, military, and agricultural populations are normally excluded from calculations of the uninsured population. The elderly are generally covered by Medicare and the military has its own health care system. The current agricultural population is 3.1 million.

uninsurance tend not to be the result of capricious or arbitrary decisions by employers, but arise because of solid economic factors. Addressing these factors is the best means of closing the medical uninsurance gap.

WHY THE UNINSURED LACK COVERAGE

When an employer calculates the costs of hiring a worker he looks at the total compensation package (cash and non-cash) for the worker. The most common items are salary, payroll taxes, paid leave, health insurance, and pensions. Increasing any element of this package raises the employer's costs of hiring new employees and retaining existing ones.

Of all the elements in a worker's compensation package, employers probably have the least control over health insurance costs. Health benefits essentially constitute a promise by the employer to pay for something whose cost may change sharply and with little warning. In recent years, rapidly escalating health care costs have turned employee health plans into a major headache for U.S. businesses.

Example: At a hearing last June on the Kennedy bill, the Director of Employee Benefits for the Chrysler Motors Corporation testified that, in spite of aggressive cost control efforts, his company's 1987 health care bill would be about half a billion dollars; this adds roughly $300 to the price tag of every Chrysler Corporation car.[2]

Businesses, particularly larger corporations, have responded to surging health costs with various strategies, including self-insurance, under which the employer directly pays doctors and hospitals and eliminates the insurance company as a middleman. Many large companies have also shifted to prepaid plans such as Health Maintenance Organizations, which pay providers fixed amounts in advance. Firms also are increasing their employees' share of health care costs through higher deductibles and coinsurance or by reducing the extent of the coverage they provide.

Limited Options. In small businesses, where fixed costs (such as employee compensation) can account for a much larger share of expenses, and where cash flow can be more irregular than in bigger companies, the options are limited. Small firms also are less able to absorb the high overhead of administering health plans or implementing the cost saving strategies of large companies. For a small business, the economies of health care often makes the choice one of either new benefits or new employees.

Over half of those employers who responded to surveys of why they do not provide health insurance for their workers said either the business was insufficiently profitable or that premiums were too expensive.[3] Between 16 percent and 19 percent of respondents said that they were too small to qualify for lower-cost group coverage. In general, the smaller the business, the more likely it was to attribute lack of coverage to cost factors.

---

2. Statement of Walter B. Maher, Director-Employee Benefits, Chrysler Motors Corporation, U.S. Senate Committee on Labor and Human Resources, Hearings on S. 1265, June 24, 1987, p. 3.

Among businesses in which some, but not all, employees had coverage, the top reason for not extending coverage was the high turnover rate for employees. Another reason given was that many employees were secondary wage earners and already covered under a spouse's or parent's policy. Between 5 percent and 15 percent of the respondents in all categories said that their employees were not interested in coverage or preferred cash compensation to health benefits.

These responses make good economic sense. A businessman obviously hesitates to offer his employees benefits when he has little or no control over their cost. And if a sizable portion of the employees are likely to leave their jobs after a relatively short period of work, the employer is inclined to avoid the burdensome and costly paperwork involved in providing health insurance. Moreover, providing benefits to employees who are secondary wage earners can amount to a significant expense with little or nothing in return; such workers generally prefer to see more money in their paychecks. And since the added compensation needed for health benefits means higher labor costs, as would a general pay raise, employers reason that they would have to cut back on other forms of compensation or reduce employment levels.

THE "MINIMUM HEALTH BENEFITS ACT" (S. 1265)

Extent of Coverage

◆◆ All employers subject to the provisions of the federal minimum wage law must provide a minimum level of health insurance to each employee who normally works more than 17.5 hours per week, and to the employee's spouse and children under the age of 18, or under the age of 23 if the dependent is a full-time student.

◆◆ Employers must pay at least 80 percent of the costs of the premiums for their workers' health insurance and must pay the total premium for any employee earning less than 125 percent of the minimum wage.

◆◆ Coverage must begin within 30 days after an employee starts working for the firm.

◆◆ In families where both the husband and wife work, they must receive coverage through separate policies from their separate employers. If the couple has dependent children (under 18 or full-time students under 23), one spouse must include the children under his or her coverage (purchase a family policy) and the other spouse may waive coverage for the dependents and purchase an individual policy only. Working children who can prove they are covered under a parent's policy may also waive individual coverage. Families with two earners thus must

---

3. Statistics on why employers do not provide health insurance are taken from the following two surveys: ICF Incorporated, *Health Care Coverage and Costs In Small and Large Businesses: Final Report*, April 1987, prepared for the Office of Advocacy, U.S. Small Business Administration, table III-9. This survey was conducted in August 1986. National Federation of Independent Business, *The Cost and Availability of Health Care Benefits for Small Businesses*, testimony before the U.S. Senate Small Business Committee, April 23, 1987, pp. 20-23, tables 19 and 20. The testimony presented the findings of the NFIB's *Small Business Employee Benefits Survey* conducted in September 1985.

have "split coverage." This provision is referred to in many discussions of the bill as "duplicate coverage." Technically, however, "duplicate coverage" means one person covered by two policies for the same benefits, which is a separate problem not addressed in this bill.

◆◆ Employers may not discriminate in hiring on the basis of whether the worker has dependents for whom the employer would be required to provide health insurance.

Required Benefits

◆◆ The policy must cover all in-patient and out-patient hospital and physician care and diagnostic tests, as well as prenatal and well-baby care, as defined by the Secretary of Health and Human Services.

◆◆ Mental health treatments, routine physical examinations, preventive care, experimental procedures, and items that are not medically necessary are exempted from coverage. (Kennedy is considering amending his bill to include some coverage for mental health services.)

◆◆ The annual deductible must be no more than $250 for an individual or $500 for a family.

◆◆ Coinsurance charges, the portion of the bill paid by the patient in addition to a deductible, may not exceed 20 percent. Coinsurance may not be charged for prenatal or well-baby care.

◆◆ The policy must include a "stop loss" feature, limiting a family's out-of-pocket payments for deductibles and coinsurance to $3,000 per year, indexed for inflation.

◆◆ The policy may not exclude or limit coverage for any worker or dependent on the basis of any pre-existing medical condition.

Additional Provisions

◆◆ Employers offering "actuarially equivalent" plans are exempted from most of the requirements of the legislation. An actuarially equivalent plan is defined as one where the total value of the potential benefits exceeds the total amount which the policy holder might have to pay by the same (or greater ratio) as the specific plan enumerated in the bill. Actuarially equivalent plans are exempted from covering inpatient and outpatient hospital and physician care and diagnostic tests. They do not have to meet the requirement that the employer pay at least 80 percent of the premium, nor must they conform to the limits set on deductibles, coinsurance, copayments, and out-of-pocket expenses. However, all employers are still required to provide 100 percent coverage for the stipulated pre-natal and well-baby care. They are also still subject to the requirement that coverage begin within 30

days after an employee starts work, and employers are still prohibited from limiting coverage on the basis of pre-existing conditions.

◆◆ The Secretary of Health and Human Services is required to divide the U.S. into between six and eight "health insurance regions" and to certify, through a "competitive process," between two and five insurers per region as qualified to offer minimum health insurance plans to groups of small businesses within the region.

◆◆ Any business with fewer than 25 employees that does not have a health insurance plan on the day before the legislation takes effect, or which changes insurers or plans later, is required to purchase coverage through a regional insurer.

◆◆ Any employer found guilty of failing to comply with this legislation may be fined up to 10 percent of the employer's total payroll for the year and is liable for damages.

◆◆ Kennedy intends to amend the bill to waive the limits on deductibles and coinsurance for businesses that are less than two years old and have fewer than 10 employees. These firms also would be exempted from the requirement that they purchase such coverage through a regional insurer.

PROS AND CONS OF THE KENNEDY BILL

Kennedy and other supporters offer essentially three arguments in favor of the Minimum Health Benefits Act:

1) **It would extend health insurance coverage** to approximately two-thirds of the currently uninsured population.

2) **It would relieve companies that now provide** health benefits to their workers of the burden of indirectly paying, through higher premiums, for uncompensated care for the uninsured, which hospitals pass on to their patients who have insurance. This puts those companies at a disadvantage with respect to their foreign and domestic competitors.

3) **It would solve these problems without requiring** large government expenditures or bureaucracy and that the costs be relatively minor and have little adverse impact on the economy as a whole.

Critics of the bill point out that supporters of the legislation drastically underestimate its real costs and the resulting social and economic impact. Kennedy's bill could decrease employment significantly, increase business failures, and lower federal tax revenues sharply. The bill also would further exacerbate America's problem of rapidly increasing health care spending and inflation. And because the bill does nothing for the uninsured who are also unemployed, say the bill's critics, any increase in unemployment caused by the legislation would reduce the number of the uninsured it would help.

PROJECTED COSTS OF MINIMUM HEALTH BENEFITS ACT

Kennedy cites a study by the Congressional Budget Office (CBO) which estimates that the bill would require employers and employees to spend $27.1 billion more each year on health insurance. Of that, $25.1 billion would go for purchasing new coverage for currently uninsured workers and the remaining $2 billion for upgrading benefits for currently insured workers to include the prenatal and well-baby coverage required by the bill.[4] CBO further estimates that the federal government could save up to $5.1 billion because some Americans now covered by Medicare, Medicaid, or Defense Department health programs would receive private coverage under the legislation. CBO adds, however, that these savings would be offset by a $5 billion reduction in tax revenues because employers receive tax deductions for the money they spend on health insurance.

In sharp contrast to these projections, a study by the Institute for Research on the Economics of Taxation (IRET) estimates that Kennedy's bill would require businesses and workers initially to spend an additional $100.2 billion annually on health insurance. Of this, $36.9 billion would go to purchasing new coverage for uninsured workers, $16.3 billion to upgrade coverage for currently insured workers and $2 billion to increased administrative costs. The remaining $45 billion would be for the extra individual policies that two-earner couples would be forced to purchase as a result of the "split coverage" provision.[5] The IRET study also finds that the revenue loss to the federal government would be $30 billion.

Reasons For Differences in the Cost Estimates

The authors of the conflicting studies agree that their widely divergent estimates of the costs of the Minimum Health Benefits Act are attributable to variance in such key assumptions as:

1) The effects of the "split coverage" provision, which requires two-earner couples to obtain separate coverage through their different employers.

Using Census Bureau data on family composition (the number of single earner and two earner families), the IRET study estimates that this provision in the legislation would result in 35 million extra individual policies, costing $45 billion. The study notes that this estimate is for the initial period after the legislation takes effect and concedes that this cost would decrease over time, as insurance companies gained new data on family health care utilization patterns under the new law and adjusted their policies accordingly to compensate for the overlap.

In contrast, CBO notes that the effective date of the legislation is between one and two years after enactment (depending on the time of year it is passed) and

---

4. Congressional Budget Office, Statement of Edward M. Gramlich, Acting Director. U.S. Senate Committee on Labor and Human Resources, Hearings on S. 1265, November 4, 1987, pp. 7-8 and 14-18.

5. Aldona Robbins and Gary Robbins, "Mandating Health Insurance," Institute for Research on the Economics of Taxation, *Economic Policy Bulletin* No. 39, July 8, 1987, pp. 11-13.

assumes that this will be sufficient time for insurance companies to adjust their policies before the legislation takes effect. CBO assumes insurance companies will adjust the costs of the two separate policies for two earner families so that neither they nor their employers wind up paying more than they currently would for one family policy. As a result, CBO estimates no additional costs due to this provision.

2) The extent to which employers who already provide health benefits will need to upgrade their coverage to meet the new requirements.

The IRET study bases its higher estimate on surveys of businesses currently providing health benefits that indicate that many of those firms fail to meet one or

Comparison of Estimates of Added Costs for S. 1265
(In Billions of Dollars)

	CBO	IRET
New Policies:		
Employers	21.8	29.5
Employees	3.3	7.4
Total Cost of New Policies	25.1	36.9
New Benefits Under Existing Policies:		
Employers	2.0	21.1
Employees	0.0	-4.8
Total Cost of New Benefits	2.0	16.3
Split Coverage:		
Employers	NE	36.9
Employees	NE	9.0
Total Cost of Split Coverage	NE	45.0
Administrative Costs:	NE	2.0
Total New Spending on Health Insurance:	27.1	100.2
Federal Outlays:	-5.1	NE
Federal Revenue Loss:		
Income Tax	2.2	16.7
Payroll Taxes	2.8	13.3
Total	5.0	30.0
Effect on the Federal Deficit:	-0.1	+30.0

Both CBO and IRET estimates are in 1988 dollars. NE denotes no estimate given.

more of the requirements of the legislation.[6] CBO, however, assumes that most of those employers would qualify for the "actuarial equivalence" exemption and thus would have to increase their coverage only by adding the mandatory prenatal and well-baby care.

3) The anticipated premium cost for the new coverage.

This is the most important assumption and accounts for most of the differences in estimates. If both studies used the same premium assumption, even differences attributable to the first two assumptions would be much less.[7] The IRET study estimates that the annual premium costs for policies under the legislation would be $1,200 for single coverage and $2,892 for family coverage. The starting point in deriving these estimates was the total amount that employers spent on health insurance in 1985, according to the National Income and Product Accounts report, based on IRS employer tax returns. IRET then adjusted those figures for inflation and, using Census Bureau data on the distribution of workers by family type, translated the total employer contributions into premiums for single and family coverage.[8]

The authors of the CBO study took as their starting point premium estimates calculated for Kennedy, at his request, by the Actuarial Research Corporation (ARC), a consulting firm. Those estimates are: $780 for single coverage and $1,798 for family coverage. ARC derived its estimates from its own economic model of health expenditures by population group, based on the 1977 National Medical Care

---

6. The results of the ICF Incorporated survey (*op. cit.*) show how employers would not meet various provisions of S. 1265: 17 percent did not cover physician office visits; 16 percent did not offer maternity benefits; 15 percent had plans with a stop-loss provision of $5,000 or more; 28 percent required workers to pay more than 20 percent of the premium for single coverage; 38 percent required workers to pay more than 20 percent of the premium for family coverage; 68 percent did not cover part-time workers; 50 percent did not cover seasonal or temporary workers; and 55 percent required a waiting period of more than one month before coverage begins (tables IV-4, 5, 8, 9 and III-10, 12). A recent survey by Towers, Perrin, Forster & Crosby, a New York-based benefit and management consulting firm, showed similar results, (Jerry Geisel, "Health Plans Fail Mandate: Survey," *Business Insurance*, August 31, 1987). The firm surveyed a cross-section of its clients and found that: 53 percent do not provide full coverage for well-baby care; 28 percent require workers to pay more than 20 percent of the premium for single coverage; 54 percent require workers to pay more than 20 percent of the premium for family coverage; 74 percent do not cover part-time workers; 46 percent require a waiting period of more than one month before coverage begins; and 65 percent have pre-existing condition limitations.

7. For example, the difference between IRET's estimate of a $45 billion cost for "split coverage" and CBO's estimate of no cost can be accounted for as follows: If CBO accepted IRET's argument that cost of extra policies would not be offset by lower premiums, then CBO would have to add another $10.1 billion to their estimate, based on CBO's lower assumptions for both the number of extra policies and their cost. However, if the cost were calculated using CBO's assumption of 13 million extra policies and IRET's assumption of $1,200 premiums, the figure would be $15.6 billion. Conversely, if the cost were calculated using IRET's assumption of 35 million policies and CBO's assumption of $780 premiums, the figure would be $27.3 billion. In short, the $420 difference in the premium assumptions accounts for between $34.9 and $17.7 billion of the difference in the estimates, depending on which assumption about the number of extra policies is used.

8. Robbins and Robbins, *op. cit.*, pp. 18-19.

Expenditures Survey, the RAND Health Insurance Experiment, and the National Health Expenditures estimates of the Department of Health and Human Services.[9]

Critics of the IRET study argue that its premium estimates are too high because the data on which they rest include health care plans that are much more extensive (and therefore, costly) than the "minimum" requirements of Kennedy's legislation. On the other hand, critics of the CBO study contend that the ARC premium estimates are too low because they use data a decade old, and are based on a theoretical model of health care costs rather than actual spending on health insurance policies.

EVALUATING THE ASSUMPTIONS

Premium Costs. While the IRET study may have overestimated premium costs, its estimates could prove to be closer to the real costs of the bill than ARC's. First, ARC's premium estimates of May 1987 originally were even lower, but were raised 10.25 percent, according to testimony in November by ARC President Gordon Trapnell, in response to insurance company announcements of large premium increases for 1988. The way these figures were adjusted raises questions about the credibility of ARC's methods and its economic model.[10] Second, several insurance companies are in the process of calculating their own premium estimates, which are expected to fall somewhere between the IRET estimates and ARC's second estimates used in the CBO study.

Split Coverage. There would appear to be some sound basis for IRET's assumption that "split coverage," at least initially, will be very costly. The insurance industry advises, for example, that in setting premiums no amount of preparation can completely compensate for hard data based on actual experience. This certainly would be the case under the Kennedy bill because it not only requires "split coverage," it also changes other variables such as deductibles and coinsurance rates which influence how much policy holders use their policies.

Upgrading Benefits. This is the most important unresolved question of the bill. If CBO is correct in assuming that most employers currently providing health benefits would fall under the "actuarial equivalence" exemption, then that provision essentially constitutes a giant loophole in the legislation. Employers' current policies would be able to meet the bill's requirements with coverage for routine, inexpensive items such as dental benefits or prescription drugs or with coverage for high cost items of questionable value such as mental health benefits. This would undermine one of Kennedy's main objectives in sponsoring the legislation--to provide all workers and their dependents with the minimum level of health benefits necessary to protect them from catastrophic medical expenses.

---

9. Congressional Budget Office, *op. cit.*, p. 5, footnote 3, and letter from Gordon R. Trapnell, President of Actuarial Research Corporation to Senator Edward M. Kennedy, May 18, 1987, in the *Congressional Record*, p. S7081 (daily ed. May 21, 1987).

10. Testimony of Gordon R. Trapnell, President of Actuarial Research Corporation, U. S. Senate Committee on Labor and Human Resources, Hearings on S. 1265, November 4, 1987. The earlier premium estimates were contained in Trapnell's May 18 letter to Senator Kennedy, *op. cit.* These estimates were: $642 for single coverage and $1,631 for family coverage.

If, on the other hand, IRET is correct in assuming a stricter enforcement of the legislation's specific requirements, CBO's cost projection of $27 billion (even using the lower premium assumption) would be pushed into the $35 to $40 billion range. CBO also would have to recalculate its projections for federal revenue losses, and probably would be forced to estimate at least a several billion dollar increase in the federal deficit. Employers who might take a neutral or even supportive position toward the legislation in the belief that it will have little effect on them because of the "actuarial equivalence" exemption should consider the possibility that this loophole could turn into a noose, gradually tightened by future regulation or litigation.

THE HIDDEN COSTS OF KENNEDY'S BILL

Medical Inflation. A major danger of this legislation is that it would exacerbate the already serious problems of uncontrolled health care spending and medical cost inflation. During the past five years the medical inflation rate has averaged more than twice the general inflation rate.[11] During the same period, total health care spending by Americans has increased at an average annual rate of 8.9 percent, or between $33 and $38 billion each year.[12] A large part of this spending represents higher costs, not more medical services. Kennedy's bill would make the situation even worse.

Escalating Premium Costs. The cost of the premiums for the new coverage under the bill likely will escalate in future years to compensate for the fact that neither the deductibles nor the stop-loss are to be indexed to the medical inflation rate. The deductibles are fixed at $250 for individuals and $500 for families and the $3,000 stop-loss is indexed only to the general inflation rate. This means that, at the current 7 percent annual medical inflation rate, within three years after enactment of the legislation the value of the deductibles in current 1988 dollars will have dropped from $250 to $198 and from $500 to $395, and the real value of the stop-loss, even after increases to compensate for general inflation, will have dropped from $3,000 to $2,685.

Insurance deductibles discourage policy holders from billing their insurance companies for every minor cost they incur, just as car insurance deductibles discourage minor but costly claims. When the value of a deductible decreases, policy holders have an increased incentive to charge more items to the policy. Also, because policy holders are directly paying a smaller portion of the bill, providers have incentives to raise their prices and to encourage consumers to purchase more of their goods and services. In the case of health care, decreased deductibles reduce the incentives for patients and doctors to restrain medical costs. Both act as if the insurance company is paying for the bill. Insurance companies, however, ultimately pass the costs back to the consumer in the form of higher premiums.

---

11. Bureau of Labor Statistics, *Monthly Labor Review*, November 1987, p. 72, table 30 and p. 76, table 32. 1987 figures are based on the average of the first nine months only.

12. Health Care Financing Administration, *Health Care Financing Review*, Volume 8, Number 1, Fall 1986, p. 13, table 1 and Volume 8, Number 4, Summer 1987, p. 24, table 12.

Of the strategies that employers have used in recent years to control the soaring costs of employee health plans, one of the most effective has been to increase the cost to the consumer at the point of purchase. This is done by raising deductibles, copayments, or coinsurance rates.[13] From the perspective of health care cost control, the fixed deductible amounts in the Minimum Health Benefits Act would be a giant leap backwards.

The same is true of the stop-loss provision. This is designed to protect families against "catastrophic" medical expenses by requiring that policies pay 100 percent of the costs above $3,000. Aside from the question of just how "catastrophic" $3,000 in annual medical expenses is to upper-middle class or wealth policy holders, any erosion of the value of this limit through inflation will steadily lower the point at which patients and doctors have any incentive at all to question medical costs.[14]

Costs of Pre-Natal Care. All employers, regardless of whether they qualify for the "actuarial equivalency" exemption, must include this coverage and are prevented from charging any deductibles, copayments, or coinsurance for these services. This provision essentially is a giant subsidy for obstetricians. Their patients are more likely than those of other doctors to lack insurance coverage for their services or to have insurance that covers proportionally less of the costs.[15] However, they are also the doctors most likely to be sued for medical malpractice. As a result, they are forced to pay the highest rates for malpractice insurance and have enormous incentives to practice "defensive" medicine--prescribing multiple tests and expensive treatments so that, if brought to court, they can prove in their defense that they did everything possible.

Instead of dealing with the serious problem of uncontrolled medical malpractice liability, for which lawyers can be blamed as much if not more than doctors, Kennedy's legislation would simply stick insurance companies with the entire bill. They in turn will pass the bill to employers through higher premiums, who will then pass it back to consumers and workers in the form of higher prices, lower wages, and lost jobs. In the end, everyone will suffer, except the lawyers who will view obstetricians as even more inviting targets for law suits.

Regional Insurers. Another provision of the legislation with a disquieting potential to drive up health care spending and inflation is the regional insurance system. Virtually all businesses with fewer than 25 employees would be forced to purchase their policies from the regional insurers, while all businesses with more than 25 employees would be prevented from doing so. This means that, if the regional insurers' rates were unfavorable, small businesses could not go elsewhere; if the rates were favorable, large businesses could not take advantage of them. The effect would be to establish a set of insurance cartels with guaranteed markets and monopoly powers.

---

13. ICF Incorporated, *op. cit.*, tables V-1, V-2 and V-3. See also, Sara S. Bachman, David Pomeranz and Eileen J. Tell, "Making Employers Smart Buyers of Health Care," *Business and Health*, September 1987.

14. On the questions involved in trying to define what constitutes "catastrophic" medical expenses, see, Deborah J. Chollet and Charles L. Betley, "Identifying Real Costs of Major Illness," *Business and Health*, September 1987.

15. See, ICF Incorporated, *op. cit.*, table IV-4, and Geisel, *op. cit.*

The rationale behind this provision is that, by establishing monopolies that group small businesses into large pools, costs can be reduced through economies of scale. However, to guard against monopolistic price fixing, regional insurance contracts periodically would be re-bid. The system could work as envisioned for a couple of years. The problems would come later. Companies losing out during the first few rounds of contract bids would be excluded from a huge potential market. It is unlikely that they then would have the assets necessary to offer and support a competitive bid the next time around. The only exception would be a company without a regional insurance contract, which held an overwhelming share of the remaining market. Should such a company then acquire a regional contract as well, it would be in an even more monopolistic position.

Job Losses. The Minimum Health Benefits Act would destroy jobs. Employers could raise the prices of their products to compensate for increased health insurance costs, but would probably do so only as a last resort since this would reduce sales. More likely, employers would adjust their payroll by limiting cash wage increases, reducing other fringe benefits, or simply laying off workers. The problem is, as the CBO study notes, that, while employers can compensate by reducing wages or benefits for high paid workers, the minimum wage sets a floor below which they cannot reduce wages for low paid workers.

Even using the lower premium estimates, the CBO study calculates that for workers earning the minimum wage the legislation would increase their required compensation level by 20 percent.[16] This could reduce employment by as much as one million jobs. Even supporters of the bill concede that 100,000 jobs could be lost. This drag on employment will continue to increase in future years as the premium costs continue to grow.

Bitter Irony. The bitter irony is that the workers most likely to lose their jobs are those who currently lack health insurance. They are workers who earn less than 150 percent of minimum wage, are employed only part-time or seasonally, or work in jobs with high turnover rates. According to Census Bureau figures, 50.3 percent of all uninsured workers earn less than 125 percent of minimum wage, and 27.3 percent earn between 125 and 200 percent of minimum wage.[17]

As a practical example of these effects, the IRET study notes that the federal government alone employs about 475,000 part-time or temporary workers for whom it does not provide health insurance. Depending on the cost of the premiums, the government would have to spend between $300 and $800 million to provide those workers with the new coverage, not counting what it might have to spend to upgrade coverage for its 2.3 million permanent, full-time workers. The alternative would be to lay off some of those part-time and temporary employees.[18]

Health care inflation and decreases in employment of course will have secondary effects. Higher medical inflation will lead to higher costs for government health care programs such as Medicare and Medicaid, while decreased employment will reduce the income and payroll tax revenues needed to fund all such programs.

---

16. Congressional Budget Office, *op. cit.*, pp. 10-15.

17. Employee Benefit Research Institute, *op. cit.*, p. 19, table 11.

18. Robbins and Robbins, *op. cit.*, pp. 10-11.

FINDING A BETTER SOLUTION

Kennedy drafted this legislation with the noble objectives of helping the disadvantaged and resolving one of the biggest problems in health care financing. He started with the assumption that the current system of employer-provided health insurance works adequately for the majority of Americans and thus could be expanded to include people who have fallen through the cracks. Operating from this assumption, a logical result would be legislation mandating that employers provide certain health benefits.

Kennedy's assumption, however, is flawed. How sound is a system that generates medical care inflation at more than twice the general rate, grows in size by over $30 billion a year, consumes an increasing percentage of the gross national product--and at the same time reduces access to quality medical care? Even the most basic figures on health care spending suggest that there is something seriously wrong with the current U.S. health care financing system.

In large part, what is wrong is that health care has become divorced from the normal market functions of consumer choice. In other sectors of the economy, competition and consumer choice encourage providers to supply adequate quantities of goods and services at reasonable prices. Providers who find ways to offer better products and/or better prices are rewarded. In today's health care, however, consumers may have incentives to demand more services, but neither providers nor consumers have any incentives to control costs.[19]

Consumers Poorly Served. The result: health care cost control increasingly is left in the hands of the bureaucrats in businesses, insurance companies, and government agencies. They seek cost control by ever larger doses of regulation and oversight. The inevitable, though unintentional, result is a system that poorly serves the consumer. Health care providers feel pressured to save money by cutting services, and consumers are lectured about their need to "face reality" and accept less for more. If this trend continues, Americans will find themselves with a health care system that is both overpriced and steadily declining in quality.

Kennedy's bill simply grafts more regulations onto this weak base. Instead of this, Congress should start treating the disease that afflicts America's health care system, not its symptoms. Congress should restore normal market functions through major reforms of health insurance, health-related tax policies, and government health care programs. In the absence of such reforms, treating the symptoms with proposals such as Kennedy's bill or the pending Medicare catastrophic legislation will only make bad conditions worse.

A starting point on the road to genuine health policy reform would be to investigate how the current system of employer-provided health insurance drives up health care costs, making coverage prohibitively expensive for a growing number of

---

19. For a more extensive critique of the failures of the present health care financing system, see, Edmund Haislmaier, "Taking America's Health Care System Off the Sick List," Heritage Foundation *Backgrounder* No. 612, October 23, 1987.

low-income workers. Congress then should consider how restoring consumer incentives to the health care marketplace could reverse this trend. Examples:

◆◆ Shifting most health care tax deductions from the corporate side to the personal side of the tax code.

◆◆ Giving taxpayers large deductions for out-of-pocket medical expenses, without having to itemize.

◆◆ Limiting corporate health care tax deductions to money spent on preventive health services and "wellness" plans.

◆◆ Allowing taxpayers to deduct medical expenses for needy relatives even if they provide less than 50 percent of those relatives' total support.[20]

Major reforms take a long time to legislate. In the short run, the uninsured could be helped if employers were required to report periodically to designated state or local agencies the health insurance coverage status of their workers. The agencies would ask uninsured workers about the kinds of coverage they needed, determine the extent to which employers would contribute to that coverage, pool the uninsured workers into groups and, finally, solicit competitive bids for group coverage from insurance companies. To make the arrangement more attractive, workers who participated in it could be given a special tax deduction, or even tax credit, for their share of the premiums.

This would be a way to provide coverage quickly to many of the uninsured. It also would target more readily those workers who need help by operating at the state or local level (instead of through the Kennedy bill's six to eight large regions), and it would not restrict competition within the insurance industry. Not only would it keep the costs to government fairly small, it would avoid the negative side effects of increased health care inflation and job losses that the Minimum Health Benefits Act would generate.

CONCLUSION

Senator Edward Kennedy is to be commended for his willingness to tackle the serious problem of the medically uninsured. His conversion to seeking a private sector solution, rather than a tax-financed national health system, is a welcome change of heart. His proposed solution, however, will have side effects that outweigh its positive effects. Causing some low-income workers to lose their jobs so that other low-income workers can receive better benefits is neither compassionate nor progressive. There has to be a better solution.

Finding this solution requires Congress to recognize that the problem of uninsurance is linked inextricably with the other gaps and problems in America's health care system. All of these problems are being generated by a health care financing structure which is fundamentally unsound and in urgent need of major

---

20. For a more detailed discussion of these and other reform proposals, see, Haislmaier, *op. cit.*

reforms. It will take vision and perseverance to accomplish such reforms, but the reward will be a health care system that is affordable and effective--for all Americans.

Edmund F. Haislmaier
Schultz Fellow for Health Policy