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

INTRODUCTION

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

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

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

The Heavy Cost of An Employer Mandate

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

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

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

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

Why an Individual-Based System Is Needed

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

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

Goals of Health Care Reform

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

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

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

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

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

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

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

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

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

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

ceive substantial services under the current legal obligations faced by hospitals. But if the goal is instead to achieve reasonably close to universal catastrophic coverage, a mandate may be unnecessary if there are incentives to purchase coverage and some penalties for those seeking to be free riders.

ELEMENT #3: The current structure of tax relief would have to be changed, with greater assistance to low-income families.

The current tax exclusion provides generous tax relief to upper-income households, in high tax brackets, and little or none to lower-income families. If lower-income families are to be able to afford at least a basic plan, the method of tax relief would have to change, to provide more assistance to low-income families.

A better form of tax relief would be to replace the current tax exclusion for company-sponsored insurance with a refundable tax credit for a family's purchase of insurance, savings for health, or medical services. To maintain budget neutrality, any net shortfall in revenue by this tax change would have to be offset with other program reductions.

ELEMENT #4: There would have to be changes in insurance regulations.

If households are to choose and own their own plans, and to be secure in the knowledge that they have insurance that cannot be cancelled, there would have to be certain changes in insurance law. For one, states would have to be prohibited from mandating certain insurance benefits beyond any minimum required by federal law. This would prevent medical special interests from lobbying to obtain state laws forcing families to include their services in any insurance policy they bought. For another, insurance companies would have to permit policyholders to renew coverage each year, at the choice of the policyholder and without singling out any policyholder for abnormally high increases.

In addition, there would have to be some limitations in the medical risk factors an insurance company could include when determining a premium. If this change is not made, many high-risk households would otherwise not be able to afford catastrophic protection, even with tax changes and government subsidies. Moreover, many sicker families with renewable policies would find themselves facing prohibitive rules for renewal, as many discover today. And even if companies faced legal restrictions on the premiums they could charge for renewals, policyholders could find themselves "locked in" to policies with deteriorating services, since the cost of moving to another insurer, and having to buy a new policy based on their risk, would be prohibitive.

The alternative to such "limited underwriting" requirements might seem to be some form of government-sponsored and subsidized risk pool for households that could not obtain affordable insurance on the open market. But that means creating a large new taxpayer-subsidized federal-state program (potentially a "Medicare, Part C"), and with it another potential source of out-of-control federal health care spending and counterproductive price controls. This would be a foot in the door for those who wish to create a national health system, since liberals would no doubt seek to expand the risk-pool system over time to more and more Americans.

HOW THE CONSUMER CHOICE BILL ADDRESSES THESE ELEMENTS

The Consumer Choice Health Security Act, introduced in the Senate (S. 1743) by Senator Don Nickles (R-OK) and in the House (H.R. 3698) by Cliff Stearns (R-FL), would change the current health system such that families could choose the health plan and benefits that suited them best and could afford at least basic insurance protection. Under the bill, they could obtain a plan directly from an insurer, or through a large group (such as a union, church, or farm bureau), and so obtain the advantages of a large buyer. However families obtained the coverage or paid for care, they would enjoy the same tax support. Families also would own their plan, and it would move with them from job to job.

Among the main features of the Nickles-Stearns bill:

✔ **A refundable individual tax credit would replace the current exclusion available to households for company-sponsored health insurance.** Under the bill, employer-paid health benefits would be subject to taxation—but these benefits, and other spending by the employee, would henceforth be eligible for the credit.

The credits would be structured as follows:

Health Insurance Premiums and Unreimbursed Medical Expenses as a Percentage of Gross Income	Tax Credit
Less than 10%	25%
10% - 20%	50%
Above 20%	75%

✔ **A credit of 25 percent would be available for contributions to a medical savings account.** In any year, new contributions eligible for the credit in each household would be limited to $3,000 for the head of household and an additional $500 per dependent. Thus a family of five could contribute $5,000 each year to the account.

✔ **Every individual or family would have to obtain at least a minimum package of health insurance to cover medically necessary acute care to qualify for the tax credit.** The maximum deductible would be $1,000 for an individual ($2,000 for a family) and an out-of-pocket limit of $5,000. Anyone not complying with this requirement would lose the personal exemption in the tax code.

✔ **Employers would have to make a payroll deduction equal to the premiums for the plan chosen by the employee and send that money to the plan.** The employer also would have to adjust the employee's tax withholdings to reflect the estimated credit available to the employee.

✔ **If an employee currently with employer-sponsored insurance chose to obtain health insurance coverage from another source, employers would be required by law to "cash out" the actuarial value of the employee's existing benefits.** This is sometimes called a "maintenance of effort" requirement. The actuarial value would be based on age, sex, and geography. In this case, employers would continue to make a payroll deduction and to adjust withholdings according to the cost of the new plan.

✔ **The Medicaid Disproportionate Share program would be converted into a flexible grant program for the states to help low-income individuals not eligible for Medicaid to obtain health care.** The aim of the grant would be to keep total net out-of-pocket costs to no more than 5 percent of income for families with incomes below 150 percent of the poverty level.

Insurers could no longer exclude coverage for preexisting conditions, nor could they cancel coverage (except for non-payment of premiums). Health insurance underwriting for individual or family plans would be limited to age, sex, and geography. Discounts could be given to promote healthy behavior or early detection of illness, and to reflect reduced marketing costs associated with group coverage.

THE LEWIN-VHI ANALYSIS OF THE CLINTON AND NICKLES PLANS

The Heritage Foundation contracted with Lewin-VHI to carry out two analyses:

(1) **Re-estimate the impact on families in 1998 of the Clinton Administration's Health Security Act (S.1757, H.R. 3600), factoring in the effect on wages of the bill's employer mandate provision.** A Lewin-VHI analysis of the Clinton plan last December confined itself to estimating the net effect on health spending.[2] The new evaluation represents the true "bottom line" for families. Lewin also estimated job losses associated with the Clinton plan.

(2) **Carry out the equivalent analysis of the Nickles-Stearns Consumer Choice Health Security Act.** This estimated the net impact of the loss of the tax exclusion, the gain of the credit, changes in premiums and out-of-pocket health spending, and adjustments to wages of "cashing out" company - provided plans.

Including the effects on household wages of an employer mandate substantially changes the "winners" and "losers" under the employer mandate approach of the Clinton legislation. The distribution of winners and losers under the Nickles-Stearns individual tax credit approach turns out to be far more attractive to households than under the Health Security Act, even for very low-income workers. Thus as a means of moving towards universal coverage, the individual tax credit approach has significant advantages.

Among the main Lewin-VHI findings:

✔ **Assuming that 88 percent of the cost of a mandate takes the form of reduced wages, a figure based on the academic literature, the Health Security Act would mean a cut in total wages in 1998 of an estimated $20.6 billion.** The average wage cut for workers not now covered by company-sponsored insurance would be $1,243.60. The largest number affected would be in the retail and service sectors.

✔ **Under the employer mandate in the Health Security Act, between 155,000 and 349,000 Americans would lose their jobs, chiefly among the lowest-income workers (see Tables 1 and 2).**

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2 *Ibid.*

- ✔ **Prior to taking wage effects into account, Lewin-VHI estimated that the Health Security Act would reduce household spending on health care in 1998 by about $26.5 billion, assuming its system of price and expenditure controls worked perfectly.** But when wage effects of an employer mandate are included as a health cost for families, as they really are, net health spending in 1998 falls by just $7.7 billion. By comparison, the Nickles-Stearns Consumer Choice Health legislation would reduce total health spending in 1998 by $35.5 billion.

- ✔ The Lewin-VHI estimate for spending under the Nickles-Stearns bill does not include any assumption that consumer choice and competition will achieve a long-term downward trend in the growth of health care spending (even though the bill's sponsors claim that will happen). On the other hand, the Lewin-VHI analysis of spending under the Clinton bill assumes that the plan's premium price controls and expenditure controls will be 100 percent effective (an assumption that is disputed by the Congressional Budget Office and most analysts).

- ✔ **Charts 1 and 2 indicate the change in health spending under the Health Security Act when wage effects are not taken into account (Chart 1) and when they are (Chart 2).** As the charts indicate, taking wage effects into account sharply changes the total net effect on average non-elderly households, especially in the case of the currently uninsured.

- ✔ **When wage effects are included, the proportion of working-age households whose spending rises under the Clinton Health Security Act by at least $1,000 more than doubles, from 16.7 percent (ignoring wage effects) to 30.7 percent.** The proportion of working-age households experiencing a net decrease of income (including wages and health costs) is 53.4 percent under the Health Security Act when wages are considered (Table 3), up from 49.5 percent if wage effects are ignored.

- ✔ **When the Clinton Health Security Act is compared with the Nickles-Stearns Consumer Choice Health Security Act, the Nickles bill produces a far better balance of "winners" and "losers."** For example, under Nickles-Stearns only 18.8 percent of working-age households see a total increase in costs of more than $1,000 after wage effects are considered (Table 4), compared with 30.7 percent under Clinton. And under Nickles-Stearns, 39.4 percent of working-age families would experience a net reduction in costs of at least $1,000, but only 28.1 percent under Clinton.

- ✔ **When the distribution of winners and losers is broken down by income group (see Tables 5 and 6), the Nickles-Stearns tax credit approach leads to substantially more gainers in every income group — even among the working poor — than the Clinton employer mandate approach can accomplish.** Tables 5 and 6 indicate how the "bottom line" is derived for each income group under each bill, including tax changes, changes in premiums and out-of-pocket spending, and adjustments to wages.

CONCLUSION

These two bills represent two very different approaches to the goal of universal coverage, an employer mandate (the Clinton bill) and a more explicit obligation on individuals, combined with a tax credit (the Nickles-Stearns bill). The Lewin-VHI analysis shows two crucial things. One is that an employer mandate has huge hidden costs, in the form of wage reductions and job losses, that must be taken into account and will no doubt lead to public reaction if such a system is ever put into place. The second is that an individual credit approach can achieve the same stated coverage goal as the Clinton plan, and yet do so while reducing total health costs for all income groups, cutting public programs less than the Clinton plan, and without depending (as the Clinton plan does) on damaging price controls or mandatory private health spending cuts.

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APPENDIX

Table 1

Estimated Job Losses Due to the Clinton Health Security Act By Industry (Full and Part Time Workers) in 1998

Industry	Employment	Losses	
		Elasticity - -0.2	Elasticity - -0.5
Construction	6,645,856	5,229	13,074
Manufacturing	21,875,590	28,022	41,767
Transportation	6,931,161	6,078	15,200
Wholesale Trade	4,121,199	1,023	2,536
Retail Trade	16,664,639	30,627	76,578
Service	29,735,649	47,914	110,511
Finance	6,937,199	4,057	10,135
Federal Government	3,433,223	5,150	12,875
State Government	5,121,197	9,081	22,704
Local Government	10,052,903	11,532	28,892
Other	4,619,694	5,857	14,639
TOTAL	**116,148,310**	**154,571**	**348,915**
Total Less Government	**91,330,987**	**128,808**	**284,439**

Source: Lewin-VHI.

Table 2

Estimated Job Losses Due to the Clinton Health Security Act By Earnings (Full and Part Time Workers) in 1998

Earnings	Employment	Losses	
		Elasticity - -0.2	Elasticity - -0.5
Less than $10,000	15,130,637	149,534	336,314
$10,000-29,999	40,149,316	5,037	12,601
Over $30,000	60,868,357	0	0
TOTAL	**118, 148, 310**	**154,571**	**348,915**

Source: Lewin-VHI.

Table 3

Distribution of Families By Change in Health Spending Net of Changes in After Tax Income Under the Clinton Health Security Act in 1998 [a, b]

Changes in Health Spending Net of Changes in Income[c]	
Net Increases of $20 or More	**53.4 %**
$1,000 or More Increase	30.7
$500 - $999 Increase	9.3
$250 - $499 Increase	6.9
$100 - $249 Increase	4.7
$20-$99 Increase	2.3
No Net Change (less than $20)	**2.3 %**
$20-$99 Decrease	1.8
$100 - $249 Decrease	3.0
$250 - $499 Decrease	4.4
$500 - $999 Decrease	6.5
$1,000 or More Decrease	28.1
Net Decrease of $20 or More	**43.8 %**
All Families	**100.0 %**

a Estimates are for the initial year of program implementation. The net impact of the plan on individual families will vary over time due to year to year fluctuation in health services utilization.

b Includes only families headed by persons under age 65.

c Includes the increase in wages under the program less the net change in household health spending including:changes in premiums and out-of-pocket spending taxes on increased wages;and tax credits..

SOURCE: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

Table 4

Distribution of Families By Change in Health Spending Net of Changes in After Tax Income Under the Nickles-Stearns Individual Tax Credit Program in 1998[a, b]

Change of Health Spending Net of Changes in Income[c]	
Net Increases of $20 or More	**31.4 %**
$1,000 or More Increase	18.8
$500 - $999 Increase	6.0
$250 - $499 Increase	3.4
$100 - $249 Increase	1.9
$20-$99 Increase	1.3
No Net Change (less than $20)	**11.5 %**
$20-$99 Decrease	1.8
$100 - $249 Decrease	2.7
$250 - $499 Decrease	4.7
$500 - $999 Decrease	8.5
$1,000 or More Decrease	39.4
Net Decrease of $20 or More	**57.1 %**
All Families	**100.0 %**

a Estimates are for the initial year of program implementation. The net impact of the plan on individual families will vary over time due to year to year fluctuation in health services utilization.

b Includes only families headed by persons under age 65.

c Includes the increase in wages under the program less the net change in household health spending including: changes in premiums and out-of-pocket spending taxes on increased wages; and tax credits.

SOURCE: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

Table 5
Average Net Impact of Health Security Act on Families By Family Income 1998 [a]

		Family Income								
	All Households	Less Than $10,000	$10,000-$14,999	$15,000-$19,999	$20,000-$29,999	$30,000-$39,999	$40,000-$49,999	$50,000-$74,999	$75,000-$99,999	$100,000 or More
Household health spending under current law	$2,532	$1,567	$1,501	$1,779	$1,990	$2,574	$2,868	$3,079	$3,492	$3,801
CHANGES IN HEALTH SPENDING										
Change in premium payments [b]	(293)	(342)	(147)	(65)	(95)	(284)	(472)	(410)	(478)	(204)
Change in out-of-pocket payments for care	(125)	(509)	(323)	(409)	(207)	(169)	(79)	111	73	285
WAGE EFFECTS										
Changes in wages (counted as an offset to health spending)	283	136	504	380	307	294	217	307	275	720
TAX CREDITS (FEDERAL AND STATE)										
Net Change in Taxes	104	210	111	113	119	116	140	128	99	(73)
CHANGE IN AFTER-TAX HEALTH SPENDING NET OF AFTER-TAX CHANGE IN INCOME										
Net Change	($31)	($505)	$145	$19	$124	($43)	($194)	$136	($31)	$728

a Estimates are for the initial year of program implementation. Includes only families headed by persons under age 65.
b Includes taxes earmarked for funding health reform along with change in taxes due to wage change including: federal income taxes, employee's share of OASDI and HI payroll taxes, and state income taxes..
SOURCE: Lewin-VHI estimates using the Health Benefits Stimulation Model (HBSM).

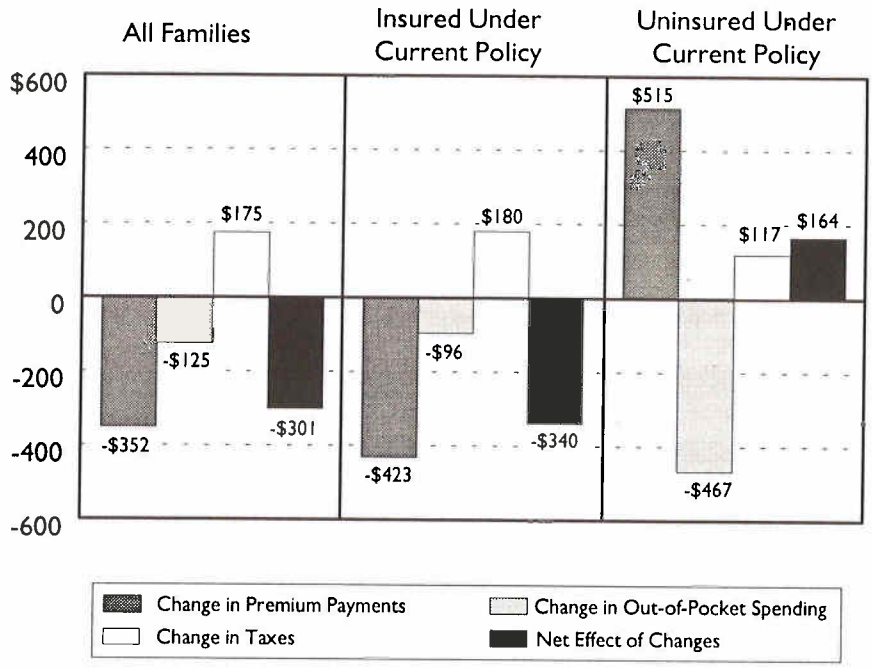
Table 6
Average Net Impact of Individual Tax Credit Program on Families by Family Income 1998[a]

		Family Income								
	All Households	Less Than $10,000	$10,000-$14,999	$15,000-$19,999	$20,000-$29,999	$30,000-$39,999	$40,000-$49,999	$50,000-$74,999	$75,000-$99,999	$100,000 or More
Household health spending under current law	$2,532	$1,567	$1,501	$1,779	$1,990	$2,574	$2,868	$3,079	$3,492	$3,801
CHANGES IN HEALTH SPENDING										
Change in premium payments[b]	2,631	1,603	1,973	2,183	2,273	2,577	2,744	3,162	3,412	3,764
Change in out-of-pocket payments for care	912	289	636	317	584	835	1,019	1,220	1,445	1,925
Elimination of state and federal tax expenditures[c]	1,183	65	183	355	626	982	1,270	1,880	2,443	2,825
WAGE EFFECTS										
Increased wages (counted as an offset to health spending)	(3,121)	(446)	(1,107)	(1,624)	(2,292)	(3,047)	(3,719)	(4,423)	(5,428)	(5,778)
TAX CREDITS (FEDERAL AND STATE)										
Federal Tax Credit	(2,050)	(1,631)	(1,883)	(1,805)	(1,748)	(1,959)	(1,997)	(2,269)	(2,483)	(2,893)
State Subsidy for Low-Income[d]	198	(759)	(688)	(383)	(155)	(33)	(6)	—	—	—
CHANGE IN AFTER-TAX HEALTH SPENDING NET OF AFTER-TAX CHANGE IN INCOME										
Net Change	($643)	(879)	($886)	($957)	($712)	($645)	($689)	($430)	($611)	($157)

a Estimates are for the initial year of program implementation. Includes only families headed by persons under age 65.
b Includes taxes earmarked for funding health reform along with change in taxes due to wage change including: federal income taxes, employee's share of OASDI and HI payroll taxes, and state income taxes.
c Includes the additional taxes paid on employer benefits converted to income including: federal income taxes; the employee share of OASDI and HI payroll taxes; and state income taxes.
d States will supplement the federal tax credit for persons below 150 percent of poverty.
SOURCE: Lewin-VHI estimates using the Health Benefits Stimulation Model (HBSM).

Chart 1

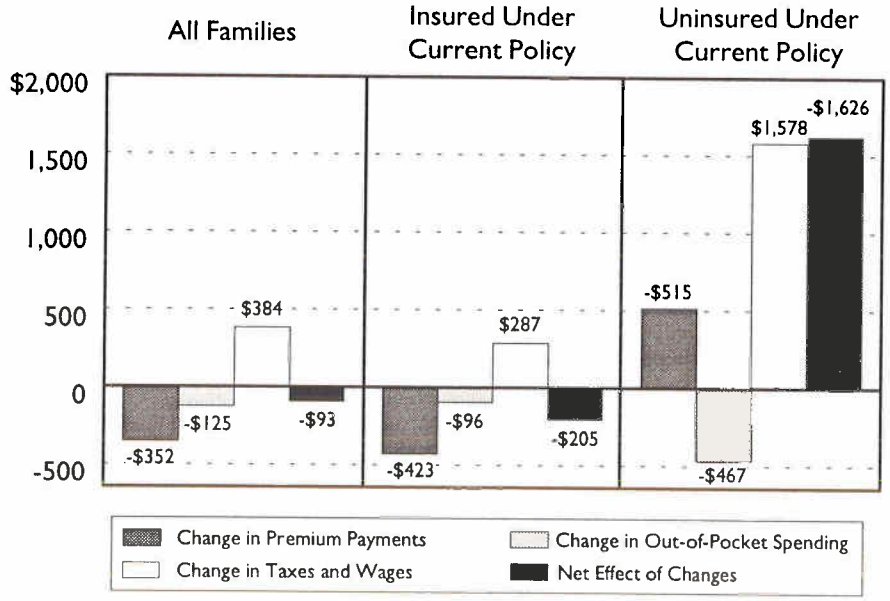
Change in Health Spending for Non-Aged Families Due to Clinton Heath Security Act by Currently Insured Status *Without* Wage Effects



Note: Non-Aged Families are defined as families Headed by an Individual Under the Age 65.
Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

Chart 2

Change in Health Spending for Non-Aged Families Due to Clinton Heath Security Act by Currently Insured Status *With* Wage Effects



Note: Non-Aged Families are defined as families Headed by an Individual Under the Age 65.
Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).