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CLINTON HEAVY: THE KENNEDY HEALTH BILL

INTRODUCTION

The Senate soon may consider health care reform legislation marked up by the Committee on Labor and Human Resources, chaired by Senator Edward M. Kennedy (D-MA). The Kennedy bill, a version of the Clinton plan, passed the committee by a vote of 11-6. The Kennedy bill is one of the two Senate health bills marked up by committees. The other is the bill reported out by the Senate Finance Committee.

This committee-passed Kennedy legislation contains many of the same features as President Clinton's plan.[1] But in several instances, it expands upon the President's prescription to broaden and deepen the federal government's direct involvement and control in virtually every aspect of America's health care system.

With the Clinton plan continuing to lose support in Congress and among the American people, liberals in Congress are resorting to a different strategy. Instead of voting on the original Clinton plan as such, they are taking various provisions of it, modifying or renaming them, and re-arranging them into a new package in an effort to attract broader political support.

Thus, Chairman Kennedy's bill, like the Clinton plan:

- **Establishes a powerful National Health Board;**
- **Introduces employer mandates;**
- **Creates powerful health alliances (renamed consumer purchasing cooperatives); and**
- **Imposes explicit price controls on insurance.**

1 For a discussion of the detailed provisions of the Clinton plan, see Robert E. Moffit, "A Guide to the Clinton Health Plan," Heritage Foundation *Talking Points*, November 19, 1993.

In many respects, however, the Kennedy bill goes even farther than Clinton's. It expands the size of the government-mandated standardized benefits package, for instance, thereby increasing the cost of health insurance premiums. It creates new corporate payroll taxes to be paid by larger employers, which will add an estimated $4 billion to the tax bill of U.S. corporations, with heavy new tax burdens on many loss-making firms in hard-hit industries, such as airlines, and on firms in states with faltering economies, such as California. For instance, the new payroll tax would cost Dallas-based American Airlines, which lost $110 million last year, an estimated $30 million. Businesses in California would have to pay an additional $500 million in payroll taxes each year in addition to paying for their workers' health care. The Kennedy bill also eliminates co-payments and deductibles for abortion services, making abortion essentially "free" to anyone who wants one —with the cost shifted to other insured services.

Furthermore, the Kennedy bill was reported out of the Labor Committee without a price tag attached. Nobody yet knows with any certainty what it will cost. But a preliminary estimate by Heritage Foundation analysts, based on revised Census Bureau data and using 1993 as the benchmark year, puts the additional cost to businesses at $23.7 billion had the Kennedy bill been in place that year. That is equivalent to an average of $254 per employee. But small employers with low-wage workers can elect to pay a 1 percent payroll tax instead of enrolling their workers in a plan, and yet these workers can get a comprehensive package heavily subsidized by the government. Heritage analysts estimate this would cost the taxpayers $18.4 billion in the base year.

Responding to political pressure, Senator Kennedy does seem to give the American people the same options and choices Members of Congress have when it comes to choosing health benefit plans. But there is a twist: Kennedy's proposal to open up the Federal Employees Health Benefits Program (FEHBP) to all Americans comes with major new regulations which would turn the FEHBP into a clone of the Clinton plan.[2]

Thus, while Senator Kennedy and his supporters on the Senate Labor and Human Resources Committee say they have improved the Clinton plan, close scrutiny of the details shows the Kennedy bill makes the President's proposal even worse. There is no attempt to compromise or even to soften the Clinton plan. Far from being "Clinton Lite," the Kennedy bill is "Clinton Heavy."

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2 For a detailed explanation of the Kennedy turnaround, see Robert E. Moffit, "Kennedy's Bait and Switch Health Reform," Heritage Foundation *Executive Memorandum* No. 380, May 16, 1994.

SIMILARITIES WITH THE CLINTON PLAN

The Kennedy Bill Creates A Powerful National Health Board

The Clinton plan creates a powerful, presidentially appointed board to oversee the health care system and determine what standard services each American will receive. The board will decide how regional alliances are to enforce public and private spending on health care and will have general oversight of drug pricing.

Under the Kennedy bill, as marked up by the Labor Committee, the "National Health Board will review the benefits prior to their effective date and recommend changes to meet budget targets. Congress must accept or reject the changes within 45 days, without amendment."[3] This differs little from the Clinton plan. The National Health Board will consider the cost and benefit of service within the standardized package. If the Board decides that a certain benefit is too expensive compared with its view of the benefit to patients, it could take several steps. The Board could strike that benefit from the package, forcing Americans who may need that service to pay more for treatments out of their own pockets on top of the cost of the standard package. The Board alternatively could scale back on the availability of services under that benefit, deciding, for example, to adopt the Clinton Administration's proposal which permits coverage for breast cancer exams to women over 65 years of age only once every two years. In summary, the National Health Board could reduce the federal government's obligation to contribute to the financing of the health care system should unprojected increases in the deficit occur—leading to either rationing of health care or higher costs to businesses and individuals through taxation.

While some in Congress will argue that good medical science indicates the proper frequency of certain examinations or treatments, the harsh reality is that costs are often the main factor for limiting access to certain medical services or procedures in a government-run or government-managed system.[4] In the Kennedy bill, the federal budget ultimately will determine which services are available. Page 10 of the Chairman's summary explains:

> The National Health Board is required to perform a cost analysis of the benefits package prior to its effective date. If the analysis demonstrates that the cost of the benefits package will increase the deficit, the Board must recommend changes to the plan to make it deficit neutral.

A significant feature of the National Health Board is its plenary powers, which seldom can be reviewed and overturned. Sections 5231 and 5232 detail the powers afforded to this nine-member board. The only issues subject to judicial review are the National Health Board's decisions regarding review and approval of state

3 Summary of the Health Security Act, as Reported by the Senate Committee on Labor and Human Resources, June 9, 1994, p. 2.

4 Edmund F. Haislmaier, "Problems in Paradise: Canadians Complain About Their Health Care System," Heritage Foundation *Backgrounder* No. 883, February 19, 1992.

health systems. States that believe they have been unfairly reviewed or treated by the Board may seek judicial review in the U.S. Court of Appeals for the circuit in the affected state. However, Section 5232 effectively prohibits any administrative or judicial review of the bill's provisions on price controls. This one section, nestled away toward the back of the legislation, shields the board from any responsibility or accountability for its actions in restructuring one-seventh of the nation's economy.

In other words, nine bureaucrats in Washington, D.C., will be granted enormous powers as they determine what benefits Americans will have and not have. Benefits which are not included in the standardized benefit package will be excluded in the name of budget neutrality and classified as nonessential benefits and services.

The Kennedy Bill Sets Up Monopolistic Regional Health Alliances

Kennedy's Committee bill, like the Clinton plan, creates a new state-based system of health insurance "Consumer Purchasing Cooperatives," commonly referred to as "health alliances." These will control the availability of health plans, enforce nationally set health budgets, enroll employees and employers in this new system, collect and distribute premiums, and enforce the national insurance rules and regulations promulgated by the National Health Board. However, the name change from "alliance" to "consumer cooperative" does not change their function and will do nothing to reduce public opposition to the bureaucratic monopolies. Every American will be required to purchase health insurance through a health alliance, or through a similar corporate-sponsored alliance if he or she works for a large firm.

Like the Clinton plan, the Kennedy bill permits states to request the National Health Board to permit the state to act as the cooperative sponsor in one or more health care coverage areas (regional alliances). The bill also prohibits the formation of more than one cooperative in a "multiple health care coverage area." Therefore, any overlapping competition between alliances is illegal under the Kennedy bill.

Each regional alliance must be governed by a board of directors, which is to be composed of, in equal number, representatives of "community rated" employers, eligible employees, and other eligible individuals. Section 1301(c) states that "the board members are to be selected consistent with rules established by the State." In other words, the Kennedy bill turns what is supposed to be a "private, nonprofit" entity into a body that will be subject to political pressures at the state level.

Not only will the alliances organize the health system in each region, but under the Kennedy bill, like the Clinton plan, they are given the power to impose "prospective budgeting" and fee schedules on doctors. Therefore, the traditional fee-for-service doctor used by most Americans who choose their own doctor will likely be squeezed out of private practice and forced to join some form of managed care in which the doctor is restricted in what he can do for his patients.

Another draconian power given to the regional health alliances is the right to exclude a health insurance plan, making it illegal for Americans to buy such a plan. The Clinton plan allows these alliances to exclude a health plan if its proposed premium price exceeds the average premium within the alliance by more than 20 percent, or if it does not offer coverage for "all of the required services and benefits" detailed by the National Health Board's standardized benefits package. The Kennedy bill goes even further by allowing them to exclude a health plan whose premiums merely exceed the target premium set for the alliance. Fee-for-service plans with unlimited choice of doctors and hospitals, typically costing above the average premium standard, thus probably would not be available in most states.

The Kennedy Bill Requires "Community Rating" For Health Insurance Premiums

A community rating requirement forces every insurer to offer an insurance plan to any individual at the same premium. Factors affecting insurance risk, such as age, gender, geography, group size, occupation, health risk, or lifestyle, must not be considered when insurers determine what premiums they will need to charge in order to remain solvent while paying out on claims. As a result, younger, healthier individuals are overcharged for their health insurance premiums when community rating is in effect while older and less healthy individuals are undercharged for theirs.

Community rating generally leads to higher insurance costs and can have serious side-effects. Consider the recent experience of New York state. In 1993, the New York legislature passed a law requiring that every insurer desiring to provide health insurance within the state use community rating in setting its health insurance premiums. The result, according to the New York State Insurance Department, has been a sharp increase in premium prices for younger, healthier people and a drop in rates for older, sicker customers. Thousands of younger New Yorkers dropped coverage as their rates rose. Notes *The Wall Street Journal*:

> Now, insurers are raising prices again in order to cover the medical needs of those older, sicker people left in the pool. New York State Insurance Department figures show that as of January 1, 1994, nine months after the new [community rate] law took effect, 25,477 fewer people had health insurance individually or in small employer groups.[5]

The drop in the number of insured New Yorkers amounted to a 1.2 percent reduction in the rate of coverage.

Both the Kennedy bill and the Clinton plan propose to "solve" the problem of increased premiums under community rating by capping the price of insurance premiums through the National Health Board and regional alliances. But, as hap-

5 Hillary Stout, "Community Rated Health Plans Prove Popular, But Success May Depend on Universal Coverage," *The Wall Street Journal*, June 15, 1994.

pens with all kinds of price controls, this inevitably will lead to a rationing of services or the denial of benefits.

Another negative consequence of community rating is the potential for an unstable and insolvent insurance market. If a health plan is unfortunate enough to attract an unusually high number of higher-risk individuals and groups yet is restricted in its pricing, it will be forced to make huge payouts without the security of a fiscally solvent reserve from premiums collected. Under such government-imposed economic constraints, some insurance firms, particularly smaller ones, will go out of business. This will mean a future market dominated by a few huge and powerful insurers.

The Kennedy Bill Means New Taxes and Mandates On Many Companies

Both the Kennedy bill and the Clinton plan require every employer to pay part of employees' premiums. Under the Clinton plan, an employer must pay at least 80 percent of the average premium in the alliance for the employee's individual or family coverage. Through bargaining, however, employees may be able to persuade employers to pay more than 80 percent. The employee does not have to pay more than 20 percent of the average cost plus any extra premium for selecting a higher cost plan.

Table 1

Employer Mandates and Taxes in Kennedy's Health Plan

Employer Size	Employers That Choose to Purchase Through Regional Alliance	Employers That Choose to Go Outside Regional Alliance
5,000+	Prohibited from purchasing insurance through "Consumer Purchasing Cooperative" (Regional Alliance). Not an option.	Must purchase insurance from an insurer or self-insure. Additionally, the employer must pay a 1 percent corporate payroll assessment and at least 80 percent of their employees' health insurance premiums.
500-999 "Dual-Choice Employer"	May purchase insurance through the Purchasing Co-op. Must pay at least 80% of employee health insurance premiums. Not subject to 1 percent payroll tax; or	May either contract directly with an insurer or self-insure. Must pay 1 percent payroll tax and is responsible for at least 80 percent of the employee health insurance premiums.
76-499	Must purchase insurance through a Co-op and pay the lesser of 80 percent of employees' premiums or 12% of payroll.	Not an option.
1-75	Must purchase insurance through a Co-op and pay the lesser of 80 percent of employees' premiums or a maximum of 12 percent of payroll. Subsidies are available to employers based on average wage and firm size.	Not an option.
Exceptions -- If a firm's average wage is $24,000 or less:		
6-10*	May choose to not provide health insurance, and pay a 2% corporate payroll tax.	
1-5*	May choose to not provide health insurance, and pay a 1% corporate payroll tax.	

*Employees in such firms are still required to purchase health insurance. They may either purchase health insurance through the Co-op, go directly to an insurer, or purchase through the Federal Employee Health Benefit Program (FEHBP). Should the employee purchase insurance directly from an insurance company, the insurer is prohibited from selling plans directly to individuals at a lower rate than the plans offered through the Co-op. Employees who purchase insurance on their own will receive subsidies based on their income level. See Table 2 for size of subsidies (limits to employer contribution).

Employers are faced with only two options under the Clinton plan. First, they may place their employees in a community-rated regional alliance. Employers choosing this path have been told there will be a cap on the total contribution expected of them. The taxpayers will make up the difference between this cap and 80 percent of the average premium in the alliance in the form of a subsidy from the federal government. With this new subsidy, the employer contribution for firms with 75 or fewer employees, as a percentage of payroll, will range from 3.5 percent for low-wage employees to 7.9 percent of payroll for high-wage employees.

Second, employers with 5,000 or more employees under the Clinton plan may set up their own "corporate alliance." This means that large firms may form their own health purchasing cooperatives through which their workers obtain health insurance, choosing from at least three plans: a fee-for-service option and two managed care plans. Employers in this category are not eligible for government subsidies, however, and the oversight of corporate alliances is the responsibility of the Secretary of Labor. Furthermore, corporate alliance employers are subject to a new 1 percent payroll tax for not enrolling in a traditional health alliance (consumer purchasing cooperative).

Table 2

Kennedy's New Limits to Employer's Health Care Tax

Average Wage	Maximum Employer-Paid Health Care Payroll Tax: Less than 15 Employees*	15-25 Employees	25-50 Employees	50-75 Employees
$0-$12,000	4.2%	5.5%	6.8%	8.1%
$12,001-15,000	5.5%	6.8%	8.1%	9.4%
$15,001-18,000	6.8%	8.1%	9.4%	10.7%
$18,001-$21,000	8.1%	9.4%	10.7%	12%
$21,001-24,000	9.4%	10.7%	12%	12%
More than $24,001	12%	12%	12%	12%

*Average number of full-time equivalent employees.
Source: Kennedy *Health Security Act*, Section 6123(b)(2).

Clinton's Original Limits to Employer's Health Care Tax

Average Wage	Maximum Employer-Paid Health Care Payroll Tax: Less than 25 Employees*	25-50 Employees	50-75 Employees
$0-$12,000	3.5%	4.4%	5.3%
$12,001-15,000	4.4%	5.3%	6.2%
$15,001-18,000	5.3%	6.2%	7.1%
$18,001-$21,000	6.2%	7.1%	7.9%
$21,001-24,000	7.1%	7.9%	7.9%
More than $24,000	7.9%	7.9%	7.9%

*Average number of full-time equivalent employees.
Source: Clinton *Health Security Act*, Section 6123(b)(2).

The Kennedy bill also contains new taxes and mandated cost

sharing on employers, but the requirements are even more complex than under Clinton. Specifically:

Firms with 1,000+ employees. Employers are *prohibited* from purchasing insurance through the local "consumer purchasing cooperative" (regional alliance). Instead, they *must* purchase insurance from an insurer or self-insure. If they self-insure, they still must provide benefits at least as good as the standard benefits plan. In addition, they must pay a 1 percent corporate payroll assessment and contribute at least 80 percent of their employees' health insurance premiums.

Firms with 500-999 employees. The employer is referred to as a "dual choice" employer. This means the employer can choose to be treated as a large employer (1,000+) or as a "small employer" (500 or less). Therefore, employers in this range may purchase insurance through the purchasing cooperative (alliance)—and so escape the 1 percent payroll tax—or go outside the alliance and either contract directly with an insurer or self-insure. Should they decide to go outside the alliance, employers are subject to the 1 percent payroll tax and are responsible for at least 80 percent of employee health insurance premiums.

Firms with 76-499 employees. Employers *must* purchase insurance through an alliance and pay the *lesser* of 80 percent of employees' premiums or 12 percent of payroll.

In general, firms with 1-75 employees. Employers must purchase insurance through an alliance and pay the lesser of 80 percent of employees' premiums or 12 percent of payroll, or the subsidized rate based on firm size and average wages. (See Table 2 for sliding-scale payroll cap.)

Exception: If a very small firm's average wage is $24,000 or less,

> **Firms with 6-10 employees.** The employer may choose not to provide health insurance and instead pay a 2 percent corporate payroll tax.
>
> **Firms with 1-5 employees.** The employer may choose not to provide health insurance and instead pay a 1 percent corporate payroll tax.
>
> **NOTE:** Employees in these small firms are still required to purchase health insurance. They may purchase health insurance through the cooperative (alliance), go directly to an insurer, or purchase through the Federal Employee Health Benefit Program (FEHBP). Should the employee purchase insurance directly from an insurance company, the insurer is prohibited from selling plans directly to individuals at a lower rate than the plans offered through the co-op (alliance). Employees who purchase insurance on their own will receive subsidies based on their income levels.

Table 3

The Kennedy Bill's New Health Tax on Large Firms: A State-by-State Comparison

State	Total Cost to Large Firms in State	Firms with Over 1000 Employees	Average Cost per Firm with Over 1000 Employees
AL	$49,877,000	84	$594,000
AK	$4,132,000	5	$826,000
AZ	$50,011,000	62	$807,000
AR	$18,062,000	47	$384,000
CA	$531,687,000	612	$869,000
CO	$55,906,000	74	$755,000
CT	$94,290,000	89	$1,059,000
DE	$24,316,000	24	$1,013,000
DC	$24,657,000	34	$725,000
FL	$133,317,000	216	$617,000
GA	$77,830,000	131	$594,000
HI	$13,152,000	27	$487,000
ID	$8,737,000	17	$514,000
IL	$233,978,000	315	$743,000
IN	$109,039,000	133	$820,000
IA	$34,412,000	65	$529,000
KS	$33,013,000	47	$702,000
KY	$36,278,000	63	$576,000
LA	$34,331,000	60	$572,000
ME	$14,111,000	20	$706,000
MD	$74,714,000	103	$725,000
MA	$150,893,000	189	$798,000
MI	$235,657,000	222	$1,062,000
MN	$86,759,000	111	$782,000
MS	$14,151,000	30	$472,000
MO	$94,430,000	118	$800,000
MT	Not Available	4	Not Available
NE	$15,426,000	31	$498,000
NV	$31,536,000	64	$493,000
NH	$12,960,000	19	$682,000
NJ	$142,520,000	204	$699,000
NM	$8,550,000	11	$777,000
NY	$481,087,000	574	$838,000
NC	$101,398,000	162	$626,000
ND	$1,369,000	4	$342,000
OH	$216,699,000	285	$760,000
OK	$29,171,000	45	$648,000
OR	$20,655,000	39	$530,000
PA	$198,220,000	300	$661,000
RI	$11,634,000	24	$485,000
SC	$45,018,000	75	$600,000
SD	$3,405,000	7	$486,000
TN	$67,853,000	109	$623,000
TX	$244,548,000	342	$715,000
UT	$21,459,000	36	$596,000
VT	$7,397,000	10	$740,000
VA	$87,453,000	136	$643,000
WA	$88,641,000	78	$1,136,000
WV	$12,983,000	20	$649,000
WI	$62,071,000	104	$597,000
WY	Not Available	1	Not Available
U.S.	**$4,151,347,000**	**5,582**	**$744,000**

Note: Figures have been rounded. No specific information for Montana and Wyoming is available, due to data suppression. The national figures, however, reflect the inclusion of these two states.

Source: Heritage calculations, based on 1990 *County Business Patterns* from the Bureau of the Census and were modified by using 1991, 1992 and 1993 Consumer Price Index figures.

Table 4

Additional Cost to Business of the Kennedy Bill in 1993

State	Estimated Cost to Business of Health Benefits for 1993	Estimated Cost of the Kennedy Bill for 1993	Additional Cost to Business of Kennedy Bill	Total State Private Sector Employment	Cost Per Employee
AL	$2,226,241,000	$2,770,417,000	$544,175,000	1,342,993	$405
AK	$339,315,000	$318,935,000	($20,380,000)	157,798	($129)
AZ	$1,815,065,000	$2,550,012,000	$734,947,000	1,236,401	$594
AR	$986,438,000	$1,522,212,000	$535,773,000	750,877	$714
CA	$22,106,852,000	$23,913,029,000	$1,806,178,000	11,318,516	$160
CO	$2,115,564,000	$2,560,086,000	$444,522,000	1,248,022	$356
CT	$3,306,187,000	$3,185,045,000	($121,142,000)	1,482,023	($82)
DE	$525,747,000	$664,761,000	$139,014,000	311,017	$447
DC	$235,900,000	$946,746,000	$710,846,000	426,959	$1,665
FL	$6,187,443,000	$9,333,064,000	$3,145,621,000	4,607,247	$683
GA	$3,409,623,000	$5,176,365,000	$1,766,742,000	2,498,877	$707
HI	$899,587,000	$899,145,000	($442,000)	432,663	($1)
ID	$562,011,000	$596,701,000	$34,689,000	300,163	$116
IL	$10,361,443,000	$9,913,191,000	($448,252,000)	4,647,094	($96)
IN	$4,761,415,000	$4,525,527,000	($235,888,000)	2,150,168	($110)
IA	$1,922,366,000	$2,068,834,000	$146,468,000	1,007,900	$145
KS	$1,856,903,000	$1,841,179,000	($15,725,000)	893,830	($18)
KY	$1,931,640,000	$2,431,877,000	$500,237,000	1,186,001	$422
LA	$1,632,061,000	$2,594,043,000	$961,982,000	1,271,219	$757
ME	$890,009,000	$859,497,000	($30,512,000)	424,027	($72)
MD	$2,701,214,000	$3,774,156,000	$1,072,942,000	1,810,796	$593
MA	$5,608,747,000	$5,939,084,000	$330,336,000	2,772,444	$119
MI	$8,877,015,000	$7,372,179,000	($1,504,837,000)	3,411,784	($441)
MN	$3,342,976,000	$3,858,451,000	$515,475,000	1,832,156	$281
MS	$1,035,245,000	$1,456,901,000	$421,656,000	723,174	$583
MO	$3,790,297,000	$4,205,682,000	$415,385,000	2,013,560	$206
MT	$352,185,000	Not Available	Not Available	221,851	Not Available
NE	$960,292,000	$1,185,549,000	$225,257,000	587,044	$384
NV	$857,294,000	$1,144,792,000	$287,497,000	536,607	$536
NH	$1,094,145,000	$903,035,000	($191,110,000)	439,636	($435)
NJ	$6,791,727,000	$6,793,571,000	$1,844,000	3,220,178	$1
NM	$646,180,000	$830,319,000	$184,139,000	417,986	$441
NY	$11,985,489,000	$15,125,966,000	$3,140,478,000	7,075,441	$444
NC	$3,818,157,000	$5,550,427,000	$1,732,269,000	2,678,669	$647
ND	$303,857,000	$381,977,000	$78,120,000	196,675	$397
OH	$9,769,648,000	$9,010,617,000	($759,031,000)	4,245,977	($179)
OK	$1,327,941,000	$1,901,625,000	$573,684,000	940,800	$610
OR	$2,362,125,000	$2,058,112,000	($304,013,000)	1,017,239	($299)
PA	$10,071,286,000	$9,633,719,000	($437,567,000)	4,598,441	($95)
RI	$921,845,000	$813,322,000	($108,522,000)	393,456	($276)
SC	$1,725,759,000	$2,608,263,000	$882,503,000	1,266,320	$697
SD	$352,205,000	$422,360,000	$70,155,000	215,104	$326
TN	$2,643,018,000	$3,877,840,000	$1,234,821,000	1,869,268	$661
TX	$7,924,595,000	$12,138,742,000	$4,214,147,000	5,864,637	$719
UT	$722,022,000	$1,180,695,000	$458,673,000	870,830	$453
VT	$503,233,000	$431,727,000	($71,507,000)	215,222	($332)
VA	$3,606,320,000	$4,794,298,000	$1,187,978,000	2,321,517	$512
WA	$4,067,260,000	$3,688,021,000	($379,239,000)	1,762,046	($215)
WV	$783,163,000	$971,287,000	$188,124,000	482,517	$390
WI	$4,101,816,000	$4,064,048,000	($37,769,000)	1,948,856	($19)
WY	$251,131,000	Not Available	Not Available	132,061	Not Available
U.S.	$171,570,000,000	$195,309,790,000	$23,739,790,000	93,476,087	$254

Note: Figures have been rounded. No specific information for Montana and Wyoming is available, due to data suppression. The national figures, however, reflect the inclusion of these two states.

Source: Heritage calculations, based on 1990 *County Business Patterns* from the Bureau of the Census and were modified by using 1991, 1992 and 1993 Consumer Price Index figures.

Notes on Health Care Cost Estimates

1) Estimated [illegible] cost is based on data developed by Cathy A. Cowan and Patricia A. McDonnell in an article in *Health Care Financing Review* (Cathy A. Cowan, M.B.A. and Patricia A. McDonnell, "Business, Households, and Governments: Health Spending 1991" *Health Care Financing Review* 14(3):227-247, Spring 1993). They developed a cost for employer contributions for private business for 1991 that integrates and refines data from the Bureau of Economic Analysis (BEA), the U.S. Chamber of Commerce, the Health Care Financing Administration, the U.S. Bureau of the Census, the Office of Personnel Management, the U.S. Bureau of Labor Statistics, and the Health Insurance Association of America. The Heritage Foundation preliminary estimates apply the 1992 and 1993 Medical Care CPI to the Cowan/McDonnell figure to generate a national cost for private business employer contributions for 1993.

2) The estimated cost by state is based on the distribution of employer contributions to individuals working in private business as identified in the March 1993 *Current Population Survey*. This distribution figure was applied to the derived 1993 national figure to estimate a 1993 cost per state.

3) The estimate of the cost to business of the Kennedy bill is based on the Census Bureau's 1990 County Business Patterns database. The cost is based on two components, the first being cost of the plan, the second being the distribution of the type of plan. CBO estimates that the cost of premiums for the Kennedy plan will be similar to the Clinton plan. The second component involved the distribution of the type of plan (individual, single-parent family, two-parent family) and is based on the distribution of those worker types as defined in the March 1993 *CPS* survey.

4) Finally, in developing the cost of the Kennedy bill, an assumption is used that businesses with under 10 employees will opt out of the health plan if their average salary qualifies them by being under $24,000. The average salary for business between 1-4 employees (adjusted by 1991 and 1992 CPI) is $24,900. The average salary for businesses with 5-9 employees is $19,400. As a result, the assumption was made that about 50% of the businesses with 1-4 employees would be able to opt out, while 66% of the businesses with 5-9 employees would opt out.

5) For businesses with more than 500 employees, an assumption was made that employers would not reduce a benefits package down to the Kennedy level, if the package were higher. This would be due to either existing contractual agreements or the desire to remain competitive for good personnel.

6) The cost to businesses would be an increase of $23.7 billion in 1993, while government would have to pay $18.4 billion more for the premiums of the workers in small businesses that opted out of the Kennedy bill.

7) Specific data for Montana and Wyoming are not available due to Census Bureau data suppression techniques designed to maintain confidentiality. However, the aggregate national figure include data from these two states.

The tax penalty levied on firms that self-insure, together with other requirements on these firms, will make self-insurance less and less attractive to them. Thus the Kennedy bill, like the Clinton plan, likely will lead to an increasing number of firms choosing to join the alliance system. However, firms with over 1,000 employees will be banned from joining an alliance and forced to pay a 1 percent corporate payroll tax. Since the tax must be paid whether or not they make a profit, this would have a devastating effect on many loss-making companies. Consider the hard-hit airline industry:

> **Arlington, Virginia-based USAir,** which lost $393 million in 1993, would have to pay an estimated $20 million each year in new taxes.
>
> **Dallas/Fort Worth-based American Airlines,** which lost $110 million in 1993, would be hit with roughly $30 million each year in additional taxes.

Companies that are "doing well" would also be hit with a sizable tax. AT&T, with a payroll of some $11 billion for its U.S. workforce, would have to pay an additional $110 million to help finance the Kennedy plan.

Using Census Bureau payroll data, Heritage Foundation analysts estimate the cost of the Kennedy bill's new tax at just over $4 billion annually using 1993 as the base year (see Table 3). As payroll costs increase in future years, the tax also will increase. The impact varies widely, depending on the number of larger firms in each state and their payroll. A typical large business in New York, for instance, will have to pay an estimated $838,000 each year in new taxes, while large firms in neighboring Connecticut will have to pay an average of over $1 million. Typical large firms in Michigan and Washington state also will be hit with over $1 million each in new payroll taxes — whether or not they are profitable.

The mandates on firms also would have other, equally disastrous effects on companies and their employees. The Fairfax, Virginia, econometrics firm Lewin-VHI recently estimated that approximately 350,000 jobs would be destroyed under the employer mandate in the Clinton plan.[6] Other studies put the job loss at as much as 850,000.[7] Lewin-VHI also forecast a significant decrease in wages for many workers as the cost of the mandate is passed on in lower cash compensation. Wages of employees in firms that do not currently offer coverage will be lower by about $1,243, or about 6.1 percent.[8] The reason for this wage reduction effect was explained by the Congressional Budget Office in a March 1994 report:

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6 Lewin-VHI, "The Effects of the Health Security Act on Employee Wages and A Comparison of the Effects of the Health Security Act and The Individual Tax Credit Program on Households," March 9, 1994, p. 39.

7 Scott E. Daniels and William R. Mattox, Jr., "Job Losses and the Clinton Health Plan: A Family Impact Analysis," Family Research Council *Insight*, p. 1, June 14, 1994. Estimates of job losses calculated by CONSAD, a Pittsburgh-based econometrics firm.

8 Lewin-VHI, *op. cit.*

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

These job and wage effects are likely to be even more severe under the Kennedy bill. One reason is that the Kennedy bill imposes a heavier employee contribution level and corporate payroll tax. It also requires a larger government-approved standardized benefits package. Moreover, it creates even more bureaucracies and regulations which will impose additional costs on insurers and businesses.

The Kennedy Bill Makes Every American Buy A Standardized Benefit Package

Like the Clinton plan, Senator Kennedy's standardized benefit package forces all individuals into a one-size-fits-all health plan. A standardized benefit package does not take into account the different needs and desires of individuals and families. While some Americans may want (and can even afford) such a generous package, millions of others, notably younger and healthier individuals, may not. And if a person suffers from a particular disease that is not included in the standardized benefit package, that person could be medically disadvantaged if he cannot pay for extra services he needs. If a Hollywood movie star or celebrity is willing to take up the cause of persons with a rare disease, replete with appropriately colored ribbon, Congress will add treatment for such a disease to the government's standardized benefit package. Otherwise sufferers will have to buy their own care without tax relief.

Not surprisingly, since the Clinton plan was introduced in Congress, congressional staffers as well as Members of Congress have been inundated with office visits, mail, and phone calls from Americans asking that the particular benefit or service they need be included in the Clinton package. If the group of patients is large enough and powerful enough, the benefit likely will be added by Congress. But the more benefits that are included, the higher the price tag of the standard package.

While both the Kennedy bill and the Clinton plan outline in detail what benefits every American must purchase, the Kennedy bill's benefit package is even more expansive, and thus more expensive, than Clinton's. Both standardized benefit packages include not only major medical services, but also such things as routine ear and eye examinations, elective abortions, expensive treatment programs for alcohol and drug abuse, and mental health treatment. If an individual or family re-

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9 Congressional Budget Office, "The Tax Treatment of Employment Based Health Insurance," March 1994, Introduction. For an analysis of the CBO report, see John C. Liu, "What the CBO Says About the Tax Treatment of Employment Based Health Insurance," Heritage Foundation *F.Y.I.*, May 25, 1994.

quires or wants any other benefits, these services must be paid for with their own after-tax dollars.

According to a ten-member Guaranteed Standard Benefit Package Work Group formed by the American Academy of Actuaries, another drawback of a standard package is that it would take away most of the choice of coverage available today in the individual and group health insurance market. "Individuals who have chosen plans with high deductibles or limited benefits for a reduced premium would likely see a significant increase in their premium rate as their coverage is increased under the Clinton health plan."[10]

The original Clinton plan's standardized benefit package covers 56 pages, with many unspecified details left up to the National Health Board.[11] Under the Kennedy version of the Clinton plan, the standardized benefit package is even more detailed than the original Clinton proposal's. The Kennedy package includes:

- ✓ **Hospital services,**
- ✓ **Emergency services,**
- ✓ **Services of physicians and other health professionals,**
- ✓ **Clinical preventive services,**
- ✓ **Mental health and substance abuse services,**
- ✓ **Pregnancy related and family planning services,**
- ✓ **Hospice services,**
- ✓ **Home health, and extended nursing care services,**
- ✓ **Lab and diagnostic services,**
- ✓ **Prescription drugs,**
- ✓ **Rehabilitation services,**
- ✓ **Durable medical equipment, prosthetic, and orthotic devices,**
- ✓ **Vision care, and hearing care,**
- ✓ **Preventive dental services for children,**
- ✓ **Option to purchase coverage beyond the basic benefit package,**
- ✓ **Investigational treatments.**

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10 "Actuarial Issues Involved in Evaluating a Guaranteed Benefit Standard Package Under Health Care Reform," American Academy of Actuaries Monograph No. 5, March 1994, p. 1.

11 For a detailed explanation of the government-standardized benefits package, see Robert E. Moffit, "A Guide to the Clinton Health Plan," Heritage Foundation *Talking Points*, November 19, 1993.

The major additions in the Kennedy bill are:

- ✓ **Higher benefits for children,**
- ✓ **Higher benefits for the disabled,**
- ✓ **Higher benefits for mental health and substance abuse,**
- ✓ **Additional assistance for low-income individuals.**

Fully Insured Abortions. One notable difference between the Kennedy version and the original Clinton proposal is the elimination of any co-payments and deductibles for abortion. This means that Americans who conscientiously object to the practice of abortion on either religious or ethical grounds will be forced to purchase a plan with coverage while their premium payments are used to help cover the full cost (with no deductible or co-payment) of an abortion for anyone who wants one.

The Kennedy Bill Imposes Heavy Price Controls

While President Clinton has stated that he does not favor price controls, his plan is heavily laden with them. The central cost containment mechanism in the Clinton plan is not competition, but a fixed system of caps on public and private health insurance spending, plus fee controls for doctors choosing to stay in fee-for-service plans.[12] Beyond the specific spending and pricing restrictions in the Clinton plan, states are encouraged to adopt a "single-payer" system—a system in which all health spending is fixed by a government "global" budget and budgets are enforced with price controls. There is little doubt that the Clinton plan would change dramatically the way in which Americans have become accustomed to receiving medical care.

The Kennedy version builds upon the original Clinton plan in establishing price controls. As in the Clinton plan, premium increases will be capped and spending at the state and local levels will be fixed in accordance with regional alliance targets. But the National Health Board also is given the additional authority in the Kennedy bill to review the scope of the government's standardized benefit package and recommend revisions that Congress must accept or reject.

The immediate effect of the global budget would be a sharp reduction in prices, with severe side effects likely in the availability of services. In an effort to keep within a budget, both the Kennedy bill and the Clinton plan would impose a cap on insurance premium levels and growth rates. The caps would take effect in 1996, with the growth limited to the Consumer Price Index (CPI) plus 1.5 percent that year, to CPI plus 1 percent for 1997, to CPI plus 0.5 percent for 1998, and finally down to just the CPI by 1999. According to the Chief Actuary at the U.S. Health Care Financing Administration (HCFA):

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12 *Ibid.*, p.3

> The actuarially determined premiums for the first year of reform, 1996, are reduced by nearly 25 percent by the global budget, and the associated federal subsidies are reduced by more than 40 percent by the impact of the global budget.[13]

But if the Kennedy bill is to rely on price controls to keep within a budget, these controls would have to be even tighter than the bill requires. Data and analysis prepared by the office of Senator Judd Gregg on the Kennedy and Clinton formula suggest that construction of the baseline 1993 health care global budget *by design* understates the health care costs for that year. It does so because it greatly underestimates the benefit costs of Supplemental Security Income and Aid to Families with Dependent Children recipients whose average health care costs are higher than those of other Americans. Moreover, it excludes full health care costs of other recipients because the formula calculates "payments made" (to health care providers), and these payments represent only 45 percent to 65 percent. According to an independent analysis conducted by the American Academy of Actuaries, even if the price controls in the Clinton-Kennedy bill are assumed to be 100 percent effective—which is impossible in the real world—estimates of the national average health insurance premiums may be understated by as much as 20 percent. Without price constraints, the understatement could be 54 percent higher than original estimates by the Administration.[14]

Under the Clinton plan, health alliances that spend above the budget fixed for them by the National Health Board will be penalized by fines, which then are passed on to insurers and ultimately to physicians and hospitals. The Clinton plan calls for growth in health care spending to be cut forcibly each year until 1999, when it is to be in line with the growth of inflation as measured by the CPI. Even countries which have adopted a government national health insurance system with strong global budgets and rationing have not been able to achieve this decline in costs. For example, Canada and the United Kingdom, with government-financed health care, have not adopted the zero-growth goal of the Clinton and Kennedy bills. Canada's growth rate with global budgets has been 3.5 percent above inflation between 1985 and 1991.[15]

Price controls, moreover, always result in unintended consequences. In particular, they lead to shortages of state-of-the-art medical technology (such as medical equipment, pharmaceutical drugs, and biotechnology breakthroughs) and a black market which benefits well-connected and wealthy consumers at the expense of others.[16] Average Canadians have paid dearly in long waits for a government-controlled system replete with government spending limitations.[17]

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13 Office of Senator Judd Gregg, "Fact Sheet on the Kennedy/Clinton Health Care Plan," June 21, 1994; *The Actuary*, November 1993.

14 *Ibid.*

15 Representative Dick Armey, "The Clinton Health Care Plan: Its Impact on Health Care Spending and the Federal Budget," House Republican Conference *Issue Brief*, April 26, 1994, p. 2.

16 Edmund F. Haislmaier, "Why Global Budgets and Price Controls Will Not Curb Health Costs," Heritage Foundation *Backgrounder* No. 929, March 8, 1993, p. 3.

AVERAGE 1992 PATIENT WAIT TO SEE A SPECIALIST IN CANADA
(After Referral from a General Practitioner)

PROCEDURE	AVERAGE WAIT	LONGEST WAIT
Gynecology	5.90 weeks	10.4 weeks
Ophthalmology	8.54 weeks	27.0 weeks
Otolaryngology	4.38 weeks	8.9 weeks
General Surgery	2.74 weeks	3.8 weeks
Neurosurgery	6.35 weeks	15.0 weeks
Cardiovascular	3.80 weeks	7.0 weeks
Urology	5.82 weeks	7.5 weeks

Implications of a Standard Benefits Package with Price Controls. The Kennedy bill forces insurers to provide an even more inclusive standardized benefits package than Clinton does. It then makes it illegal for insurers to charge the price needed to cover the benefits. Therefore, insurers will have an incentive to cut reimbursements to doctors, hospitals, pharmaceutical companies, and medical equipment manufacturers to keep within the government's budget target. If that fails, Congress will be forced to intervene and set tighter price controls. Even more rationing of medical services will follow, with a decrease in research and development for state-of-the-art medical equipment and life-enhancing pharmaceuticals.

The alternative to price controls available in the Kennedy bill is equally unpleasant: to strip services from the package. The National Health Board is given broad regulatory powers over the American health care system, including the ability to determine what benefits are or are not to be included in the standardized benefit package, even after Congress decides what medical services Americans are to get.

Under Kennedy's bill, if the National Health Board realizes that the package is too expensive and that price controls embodied in the new system will not work, benefits can be struck arbitrarily from the government-standardized benefits package. Again, individuals suffering from rare diseases will be hit the hardest under such an arrangement since it is likely that coverage of benefits will be limited to politically salient and "popular" illnesses. In other words, political influence, not medical necessity, will be the deciding factor in the coverage of many medical services. Individuals who do not find their particular service/benefit covered in the government-standardized benefit package will be forced to buy this protection

17 Joanna Mihake and Michael Walker, "Waiting Your Turn: Hospital Waiting Lists in Canada," Fraser Institute, Critical Issue Bulletin, Third Edition, May 1993, p. 30.

with after-tax dollars or to join a political campaign to include them in the standard package.

The Kennedy Bill Tells Medical School Graduates Where They Will Live and Practice Medicine

Imagine the federal government telling each graduating law or engineering class that at least 50 percent of its members must work for public interest groups or spend a specific portion of their time on pro-bono work. And imagine the government instructing these lawyers and engineers to live in certain cities or rural areas.

With the support of several Senators on the Committee on Labor and Human Resources, Senator Kennedy successfully amended his bill to give the federal government the authority to tell medical graduates specializing in primary care where they will spend a portion of their residency. The Clinton bill already mandates that at least 50 percent of each graduating medical class must specialize in primary care. The Kennedy bill raises this minimum threshold to 55 percent. Furthermore, the Kennedy bill sets a precedent for funding the Graduate Medical Education program in the country.

Currently, teaching hospitals throughout the country receive federal GME funding to assist them in their training of medical residents. The Kennedy bill attaches a string to this funding by requiring teaching hospitals to place their primary care residents in designated underserved rural and urban areas for a period of their training. While the goal of this amendment is to bring more doctors to medically underserved rural and urban areas, such a federal mandate on an individual's private and professional life is unprecedented and unwarranted.[18]

The Kennedy bill will tell many medical students that the specialties they prefer are closed, or closed to them because they are not the right race or ethnicity. Both the Kennedy bill and the Clinton plan thus place medical diversity above traditional medical standards as the basis for deciding who practices where.[19]

The Kennedy Bill Includes No Substantive Medical Liability Reforms

A major factor contributing to the escalating costs of health care is malpractice insurance costs and resultant defensive medicine. Because of higher levels of litigation, many doctors perform extra, medically unnecessary procedures to protect themselves from possible future lawsuits. Most major congressional health care reform proposals make honest attempts to reform the medical liability system. The major exceptions: the Clinton plan and the Kennedy bill. The Senate Labor and Human Resources Committee rejected an amendment offered by Senator Orrin Hatch (R-UT), ranking Republican on the Senate Judiciary Committee, which would have limited punitive damages in malpractice cases to $250,000. The lawyer-friendly Kennedy bill contains no cap on punitive damage awards.

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18 "The Health Security Act," as reported out of the Senate Committee on Labor and Human Resources, Title III, Subtitle A, Part 3, S. 3081, June 26, 1994.

19 George F. Will, "The Clintons' Lethal Paternalism," *Newsweek*, February 7, 1994, p. 64.

The purpose of punitive damages is to send a clear message to the wrongdoer that willful and intentional misconduct will not be tolerated by the medical profession or society. It is not to provide a sudden financial windfall to wronged plaintiffs so that their lawyers can reap huge financial gains through litigation. Contrary to the arguments proffered by lobbyists representing the plaintiff's bar, frivolous lawsuits *are* filed constantly because doctors and hospitals would rather settle a case out of court than endure months, perhaps years, of endless litigation and significant costs to prove that no wrong was committed.

The Kennedy Bill Will Not Let Many Americans Keep Their Current Health Plan If They Change Jobs

The rhetoric coming out of the White House and from liberal Democrats is that the Clinton or Kennedy bills give Americans insurance "that can never be taken away from them." This is false. Senator Judd Gregg (R-NH) offered an amendment in Committee to clarify the language of the Kennedy bill on this issue. The Gregg amendment would have the bill specify that it would not prohibit any individual from keeping his existing health insurance policy. This freedom-of-choice amendment was defeated by a 4-12 vote. Thus, under the current language of the Kennedy bill, it is illegal for any American who is satisfied with his current health plan to keep it if the plan is not accepted by one of the government-sponsored alliances.

KENNEDY'S FEHBP BAIT AND SWITCH

In an effort to garner public support, Senator Kennedy's version of the Clinton plan appears to open the current Federal Employee Health Benefit System to the American public. Close scrutiny of the details surrounding this popular provision, however, reveals a very different story. While the FEHBP technically would be open to all Americans, several modifications are made which would turn it into a highly regulated public health care program. Thus, what the Kennedy bill actually does is convert the FEHBP into a version of the Clinton plan, and then make that new plan available to average Americans.

The Kennedy bill would change the program now covering Congress and 9 million other federal workers by imposing on the FEHBP the same standardized benefit package as other Americans would have to buy, thereby eliminating the wide personal choice of health benefits, as well as plans, currently available to federal employees and their families. In addition, the Kennedy bill would have the federal government set the level of co-payments, coinsurance, and deductible levels for plans in the FEHBP. Both changes represent a marked departure from the current system, where individuals who work for the federal government are given the freedom to choose the benefits and level of payments they think best fit their personal needs.

The Kennedy bill thus would transform the successful FEHBP into a Clinton-style program *before* making it available to the American public.[20] This change would penalize federal workers, many of whom would be forced to pay more for additional coverage that they do not want and cannot afford, and would deprive ordinary Americans of the same level of personal choice that Members of Con-

gress and federal employees now have. In short, the impact of the Kennedy plan would be to *remove* all the qualities that have made the FEHBP such an enviable program of health care choice and turn it into a government-run "one-size-fits-all" plan.

Kennedy's "reform" of the FEHBP also would undermine the one government health program that actually works. The FEHBP is a generally sound system, although it suffers from the problem of adverse selection—due largely to community rating of insurance premiums. By law, FEHBP plans must charge active and retired federal workers the same premiums, regardless of the vast differences in health risk and costs attributable to differences in age. As a result, younger and healthier workers tend to shift towards purchasing lower-priced plans with fewer benefits. At the same time, older and retired workers gravitate towards higher-cost plans with more benefits. Insurers who enroll this older and generally sicker group often find themselves with relatively higher benefit payments since not enough younger and healthier workers are enrolled in these plans at community-rated premiums. The problem could be resolved easily if Congress were to adopt simple underwriting reforms that allowed premiums to be adjusted by age.[21]

While the current level of adverse selection in the FEHBP is not high enough to make it unstable, the Kennedy bill could do exactly that. The new "FEHBP" would be open to all Americans working in firms with fewer than 1,000 employees. Small firms with an older and sicker workforce would have a powerful incentive to join the FEHBP since it would result in dramatic savings compared to their current rate of coverage. Firms with a younger and healthier workforce, however, would have much less of an incentive to join the FEHBP since they could self-insure for less. Therefore, under the Kennedy bill, the FEHBP would be a more attractive option to Americans who are likely to utilize more health care services than the average individual. The likely result: a future taxpayer bailout of the FEHBP.

In sharp contrast to the Clinton plan and Senator Kennedy's version of it, the Consumer Choice Health Security Act (S.1743, H.R. 3698), authored by Senator Don Nickles (R-OK) and Representative Cliff Stearns (R-FL), really is modeled after the Federal Employee Health Benefit Plan. In stark contrast to the Clinton or Kennedy plan, the Consumer Choice Health Security Act would give every American the same options enjoyed today by the President and Members of Congress—the right to choose and own a health plan and the benefits which they feel best suit their individual needs at prices they wish to pay. No other plan does that. The President and Senator Kennedy are grossly misleading the public when they say that their health reform proposals are similar to the system that federal employees now have. They are not.[22]

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20 Robert E. Moffit, "Kennedy's Bait and Switch Health Reform."

21 Robert E. Moffit, "Consumer Choice in Health: Learning from the Federal Employee Health Benefits Program," Heritage Foundation *Backgrounder* No. 828, February 6, 1992.

22 Stuart M. Butler, "Why Americans Need to Know That Congress's Health Plan Is Not Clinton's," Heritage Foundation *Issue Bulletin* No. 212, February 9, 1994.

THE KENNEDY BILL'S UNKNOWN PRICE TAG

Because the health care market constitutes one-seventh of the nation's economy, any legislation designed to overhaul it must have enormous economic implications. Both the Clinton plan and the Kennedy version of it will cost billions of new dollars in higher taxes, lost jobs, foregone research and development, and the practice of defensive medicine. Even if it works exactly as planned and its price controls are effective—which is very unlikely—the Clinton plan has an estimated price tag of $3 trillion in its first five years of full implementation (1998-2002).[23]

The cost of the Kennedy bill likely would exceed that of the Clinton plan. One reason is the more generous standardized benefits package. Adding higher benefits for children and the disabled, as well as for mental health and substance abuse, and providing additional assistance for low-income individuals raises the cost of the standard package. Committee staff maintain that the insurance cost will be the same as the Clinton package, because the insurance cost of additional benefits is to be offset by higher deductibles and copayments for services that were also in the Clinton plan. But that means that Americans generally will have to pay more in out-of-pocket costs for these core services. Add to this the funding that will be required to run the cooperatives (alliances), new agencies, commissions, and advisory boards as they govern this new government health care system. Moreover, the Kennedy bill includes even more generous government subsidies to certain businesses and households to offset part of their health care costs. Yet the Kennedy bill was reported out of committee without any estimate of its likely cost. So none of the members who voted for it know what the price tag will be. There is in any case enormous uncertainty about future projections because, as the Office of Technology Assessment reports, small changes in assumptions can mean huge differences in projected costs.[24] The more complex the bill, and the more it changes the health care system, the more crucial assumptions about business and consumer behavior become and the less certain budget projections become.

Bearing this in mind, Heritage Foundation analysts have made cautious preliminary estimates of the likely cost of the Kennedy bill. These calculations use 1993 as the benchmark year, since this is the most recent year for which there are reliable estimates of health care expenditures. The cost of the Kennedy bill is calculated as if it had taken effect in 1993 and it accepts Kennedy's claim that the insurance cost of his package is no more than that of Clinton's. Using 1993 thus provides a reasonable benchmark figure for the cost of the bill. Projections for any particular future year depend heavily on the behavioral assumptions made and were not undertaken by Heritage analysts.

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23 Congressional Budget Office, "An Analysis of the Administration's Health Proposal," February 1994, Table 2-1, p. 26.

24 Office of Technology Assessment, *Understanding Estimates of National Health Expenditures Under Health Reform* (Washington, D.C.: OTA, 1994), summary, pp. 11-12.

The Heritage analysis of the Kennedy bill puts the benchmark annual cost at $23.7 billion for businesses, in the form of higher taxes and the cost of mandated health benefits. That is an average cost per employee of $254, ranging from a cut of $441 in Michigan to an increase of $1,665 in the District of Columbia. Even if the cost controls in the Kennedy bill prove very effective, that cost to business is likely to grow in future years. Projecting the cost forward to future years with any accuracy is a complex undertaking, involving dozens of contentious assumptions, and is beyond the scope of this study. By comparison, the Clinton bill was projected by Lewin-VHI, a leading health care econometrics firm, to impose a net cost of $29 billion in 1998.[25]

Yet there is an additional hidden cost in the Kennedy bill beyond the cost to business. Unlike the Clinton plan, in which all working Americans would obtain coverage through their place of work, the Kennedy bill allows very small firms to escape that obligation by paying a 1 percent or 2 percent payroll tax with the government paying the remaining cost of enrolling their workers in a health alliance. Thus, a portion of the workforce covered by business in the Clinton plan is covered by taxpayers in the Kennedy bill. Heritage Foundation analysts estimate that 8.4 million working Americans (or 9 percent of the private sector workforce) would be covered in this way at a cost of $18.4 billion to taxpayers for the benchmark year of 1993.

CONCLUSION

The Senate Labor Committee, under the chairmanship of Senator Edward M. Kennedy, failed to seize the historic opportunity to make improvements in America's health care system. In terms of quality and the services of doctors, hospitals, pharmacists, nurses, and other health care professionals, the United States has the finest health care system in the world. It trains the best doctors, is home to the best teaching institutions and hospitals, and boasts a highly innovative biotechnology and pharmaceutical industry.

These features of the U.S. health system are now threatened by proposed "reforms." Shortly after the Clinton Health Security Act was introduced, several major pharmaceutical companies announced huge layoffs. Stock prices in the industry also lost about 40 percent of their equity value.[26] Similarly, the biotechnology industry has experienced a sharp decline in new investment. For the first five months of this year, fledgling biotech firms have attracted only $194 million in venture capital, just 58 percent of what they had attracted by the end of May last year.[27]

25 Lewin-VHI, *The Financial Impact of the Health Security Act* (Fairfax, VA: 1993)

26 Donald Lambro, "Side Effects of the Health Care Package," *The Washington Times*, October 28, 1993.

27 Jennifer Van Bront, "Venture Capital Financing Down—Like Everything Else," *BioWorld Financial Watch*, Vol. 2, No. 23, June 13, 1994, p. 1.

While change in the health care system clearly is needed, the Kennedy bill is little more than the increasingly unpopular Clinton plan with a new wrapper and a price tag that is even less certain. Like the Clinton plan, the Kennedy bill injects more government control through new bureaucracies and mandates while imposing new and higher taxes on our nation's employers and employees. These taxes on employers will be passed on to employees in the form of lower compensation and job losses.

At the heart of the health care reform debate are two fundamental questions. First: *Who* is going to make the *key* decision over health plans, benefit levels, services, and choice of doctors? Either it will be the federal government and government-sponsored agencies, or it will be individuals and their families. Second: *Who* is going to control the flow of dollars in the system? Either it will be the federal government and government sponsored agencies, or it will be individuals and their families.

With the Kennedy version of the Clinton plan, the answer to both questions is the same; the system will be controlled, managed, and run by the federal government and its countless bureaucrats and agencies.

John C. Liu
Policy Analyst

Cost Calculation by
David H. Winston
Senior Fellow
and
Christine L. Olson
Research Analyst