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THE STEALTH CLINTON HEALTH PLANS: A GUIDE TO THE HOUSE AND SENATE BILLS

INTRODUCTION

President Bill Clinton reminded Americans at his recent press conference that any final health care legislation will be the product of conference negotiations between the House and the Senate. Thus, lawmakers contemplating their votes on the majority leadership bills in each chamber should remember that the bill their chamber passes will become a vehicle for that conference bill. Hence they should examine the common elements of these bills, recognizing that these are the elements most likely to be in the final conference bill—and recognizing also that the White House and majority leadership will have the loudest voices in shaping conference decisions.

Moreover, the common elements do not even have to survive in both bills to become law. If the White House and its Hill allies succeed in retaining a feature they desire in either version, the conference committee can keep it in the conference report. Given the likely makeup of the conference, this is very likely. And many liberals in the Senate also have indicated that their strategy is to accept a bill without certain features they really want (such as an employer mandate or, better still, a single-payer Medicare Part C provision) with the expectation that some or all of these elements will be in a conference bill.

It thus becomes clear why President Clinton spoke so warmly of a Senate bill that may seem to depart from many of his health care objectives. The fact is that the leadership bills developed by Senator George Mitchell (D-ME) and Representative Richard Gephardt (D-MO) contain key common elements that are the same as the central features of the original Clinton plan. And if they are not in both bills, they are key elements in one. Despite protestations from the House and Senate majority leadership—and even the White House—that the new bills are not merely slight modifications of Clinton's increasingly unpopular plan, an examination of the bills shows otherwise. The conference bill emerging from them likely would be much closer to the Clinton plan than Mitchell and Gephardt seem prepared to admit.

In other words, the central, unpopular features of the Clinton plan are alive and well in the Mitchell and Gephardt bills. Among them:

- ✔ **Both bills contain employer mandates.** In Gephardt's bill, an employer mandate goes into effect immediately. In Mitchell's, a mandate goes into effect if a virtually unattainable target percentage of coverage is not achieved voluntarily.

- ✔ **Both bills introduce a government-chosen standardized benefits package.** Like the Clinton plan, the Gephardt bill places in statute the benefits each American and his employer will be forced to buy, leaving families to buy other services they need out of their own pockets with no tax relief. The Gephardt standard package, for instance, does not include protection for catastrophic medical expenses, so a family with the required standard plan could be wiped out by a serious medical problem. The Mitchell bill allows a commission to set the package within certain guidelines, so Americans will not know exactly what is covered until after the bill becomes law.

- ✔ **Both bills pave the way for direct federal control of health care.** Gephardt introduces a new Medicare Part C for those currently on welfare and for millions of working Americans. The federal government will run this nationwide alliance, setting fees and budgets. In Mitchell, the approach is more subtle. The federal government establishes an exclusive alliance for certain workers in areas where states do not create their own alliances. Rules governing this system would be drawn up by Washington.

  The New York Times, in a recent editorial, accurately described the implications of the new Medicare Part C program:

  > Medicare Part C, unlike the program limited to the elderly, threatens to trigger an inevitable roll toward government-run medicine for most Americans.[1]

- ✔ **Both bills introduce price or spending controls.** Like the Clinton plan, both bills establish mechanisms to limit spending on health or to control prices, each of which would lead to government rationing. With the creation of a Medicare Part C program, the Gephardt bill means physicians and hospitals serving almost half the population would be subject to price controls and spending limits. Moreover, if health plans do not sharply reduce the growth of costs, "stand-by" federal price controls would be applied to the entire health industry.

  The Mitchell bill, on the other hand, gives vague powers to a new National Health Care Coverage and Cost Commission to recommend ways to hold down costs and requires Congress to vote on its recommendations in an expedited up-and-down process. The Mitchell bill also claims to contain a "fail-safe" provision to prevent any increase in the deficit due to new federal subsidy programs. But if the bill's sequester mechanism actually were invoked, observes the Congressional Budget Office, it "could make previously eligible people ineligible for subsidies and would reduce the extent of health insurance coverage."[2] It seems unlikely that Congress would permit

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1 Editorial, "The Failed House Health Bill," *The New York Times*, July 30, 1994, p. 18.

2 Congressional Budget Office, "A Preliminary Analysis of the Health Security Act As Reported By the Senate

such a fail-safe provision to go into effect if it consigned insured Americans to the ranks of the uninsured.

✔ **Both bills would discourage self-insurance.** Like the Clinton plan, the Mitchell and Gephardt bills strongly discourage larger firms from designing self-insured plans that cater to their employees' specific needs. Both bills, for instance, contain excise taxes on self-insured plans, part of which would be passed through to employees. The Mitchell bill in addition places a 25 percent tax on the value of a plan above a government-specified target. This would hit the more generous plans common in unionized firms. The CBO points out that because the excise tax would not be a deductible expense for employers, the effective rate would be as much as 38.5 percent.[3] The Gephardt bill, by including almost half the population under the price-controlled Medicare system, would trigger huge "cost-shifting" to private insurance and self-insured firms, pushing up the cost of such plans and making them far less attractive—an effect *The New York Times* describes as "devastating. Fees to private patients would skyrocket, driving premiums up...."[4]

✔ **Both bills create huge new bureaucracies and place unfunded mandates on the states.** Like the Clinton plan, both bills would place many new requirements on states. In its analysis of the Senate Finance Committee bill, on which the Mitchell bill is based, the CBO notes that:

> states would bear the brunt of many of the responsibilities for implementation, and it is uncertain whether—and if so, how soon—some states would be ready to assume them.[5]

These responsibilities include determining eligibility for subsidies (which the CBO calls "an enormous [task] for states") providing wraparound Medicaid benefits, establishing and running health alliances, and monitoring health plans.

These new state obligations, as well as new responsibilities for the federal government, mean that the Mitchell bill would create dozens of new federal and state agencies. Summing up these new powers for government officials, *The Washington Post* comments:

> [The new government agencies] would have untested authority to centralize, reorganize, monitor and enforce the way medical care is bought, sold and, to a lesser extent, practiced in this country.[6]

The Mitchell and Gephardt bills thus should be seen as two parallel legislative vehicles for enactment of the central elements of the Clinton plan. As lawmakers are courted by the majority leadership in each house, and even by the White House, with claims that their bill "is not the Clinton bill," they should not be fooled. Supporters of the Clinton plan are trying desperately to gain votes for bills which, in isolation and by careful reformulation,

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Committee on Finance," July 28, 1994, p. 5.

3 CBO, "A Preliminary Analysis," p. 10.

4 "The Failed House Health Bill," *op. cit.*

5 CBO, "A Preliminary Analysis," p. 6.

6 Dana Priest, "Health Bills May Have No Substitute for Bureaucracy," *The Washington Post*, August 7, 1994, p. A1.

seem to differ significantly from the Clinton plan. They do not. A vote for either of the majority leadership bills can best be described as a vote for the Clinton-Mitchell-Gephardt bill.

HOW EMPLOYERS WOULD FACE HEAVY MANDATES

The House and Senate majority leadership bills both include an employer mandate. The House version would require all employers to pay for at least 80 percent of a standardized benefits package; the Senate version would include a 50 percent employer mandate if less than 95 percent of Americans are fully insured by 2000. It is a near certainty that this "hard trigger" would go into effect, partly because the modified community rating system for premiums means that younger Americans would face insurance costs that generally would be significantly higher than if they simply paid their medical bills themselves.[7] Thus, many young employees, young self-employed individuals and employers with a young workforce would have little incentive to obtain insurance coverage. Moreover, even in Hawaii, a state which already has an employer mandate, only 93 percent of the population is covered.[8]

So there is little doubt that there will be an employer mandate if the Senate bill becomes law—and equally little doubt that the conference bill will include a mandate if it survives in either bill. Proponents argue that since a majority of Americans already receive their health care insurance through their place of employment, it makes sense to provide coverage to uninsured and "underinsured" Americans through a mandate on employers. In addition, they maintain that requiring employers to pay part of the cost of coverage will reduce or even eliminate the burden on employees. Nothing could be further from the truth.

The impression is given by proponents that an employer mandate is the proverbial "free lunch"—that a payment by an employer imposes no cost on the employee. But the evidence suggests there can be large costs in terms of employment and wages.

A health insurance mandate is an additional cost to employers of hiring or retaining workers. The Fairfax, Virginia, econometrics firm Lewin-VHI recently estimated the impact on employees of the mandate in the original Clinton plan, which is quite similar to the Gephardt mandate. Lewin-VHI noted two effects.

First, when an employer has to pay additional payroll taxes or mandated benefits for an employee, part of that cost is "passed through" to the employee in lower wages. As the CBO explains in a March 1994 report:

> 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]

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7 The Mitchell bill does allow premiums to be adjusted by age, but it limits the variation to a ratio of 2:1, which would still mean younger workers typically would be paying well above the actual cost of their care if they bought insurance, while older workers would be paying much less.

8 GAO Report,GAO/HEHS-94-68, "Health Care in Hawaii, Implications for National Reform," February 1994, p. 5.

Based on the economic literature, Lewin-VHI assumes that an average of 88 percent of a mandate's cost is passed on to employees in lower wages. Using this assumption, Lewin-VHI calculates that if the Clinton plan were enacted, the wages of employees not now receiving insurance would decrease in 1998 by an average of approximately $1,243, or 6.1 percent (See Table 1). The average wage cut, combining today's insured and uninsured workers, would be about $400.[10]

An analysis of the Gephardt bill, using the same assumption and utilizing the simulation model of the Gephardt bill developed by The Heritage Foundation, reveals that the wages of all workers (combining insured and uninsured workers today) would fall by an average of $378.[11]

The second effect noted by Lewin-VHI and other analysts is job loss. Low-wage workers are particularly vulnerable to layoffs if the cost of employing them rises because of a mandate on employers to provide insurance. Lewin-VHI calculates that approximately 350,000 jobs would be lost under the employer mandate in the Clinton plan.[12] Other studies put the job loss as high as 850,000.[13]

As the table by Lewin-VHI indicates, job losses are concentrated in the services and retail trade industry, with approximately one-third coming from the service industry (See Table 2). Furthermore, losses are especially heavy among Americans earning less than $10,000 per annum (See Table 3).[14] The impact of a mandate would vary by income (See Table 4).[15]

Proponents of an employer mandate often point to Hawaii as the model of the benign effects of an employer mandate. Hawaii is the only state which currently mandates all employers to provide health insurance to most of their employees. Its health plan, enacted in 1974, requires employers to provide health insurance to their employees, with the employee share limited to 1.5 percent of wages or 50 percent of the cost of the premium, whichever is lower. This is much lower than the Gephardt requirement of 80 percent and roughly the same as the eventual mandate under Mitchell.

Despite the mandate, however, Hawaii still has not achieved universal coverage.[16] The General Accounting Office notes that "[E]ven some residents with insurance encounter

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9 Congressional Budget Office, *The Tax Treatment of Employment-Based Health Insurance*, March 1994, Introduction.

10 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. 19. See also Stuart M. Butler, "How the Clinton and Nickles-Stearns Health Bills Would Affect American Workers," Heritage Foundation *Issue Bulletin* No. 188, April 11, 1994.

11 Stuart M. Butler with David H. Winston and Christine L. Olson, "Health Care Debate Talking Points #1: Cost to Business of the Gephardt Bill," Heritage Foundation *FYI* No. 21, Updated August 9, 1994.

12 Lewin-VHI, "The Effects of the Health Security Act," p. 39.

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

14 Lewin-VHI, "The Effects of the Health Security Act," p. 39.

15 *Ibid.*, p. 18.

16 GAO "Health Care in Hawaii," p. 1.

Table 1

Average Wage Change Per Worker (Full and Part-Time), by Major Industry: Firms Not Currently Offering Health Coverage

Industry	Employment	Average Change	Percent of Wages
Construction	3,406,608	($1,241.90)	-4.5%
Manufacturing	4,603,829	($1,400.70)	-6.2
Transportation	1,477,531	($1,503.10)	-4.8
Wholesale Trade	1,201,073	($1,311.00)	-5.8
Retail Trade	9,854,295	($1,102.20)	-7.1
Service	13,292,267	($1,109.90)	-6
Finance	1,987,476	($1,358.90)	-4.7
Federal Government	850,866	($1,638.70)	-5.9
State Government	1,767,051	($1,621.40)	-6.6
Local Government	3,507,845	($1,562.20)	-7.8
Other	2,351,029	($1,089.40)	-5.8
Total	**44,299,870**	**($1,243.60)**	-6.1

Source: "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, prepared for The Heritage Foundation by Lewin-VHI, Inc.

Table 2

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

Industry	Employment	Job Losses (Elasticity = -0.2)	Job Losses (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	3,443,223	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: "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, prepared for The Heritage Foundation by Lewin-VHI, Inc.

Table 3

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

Earnings	Employment	Job Losses (Elasticity = -0.2)	Job Losses (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	**116,148,310**	**154,571**	**348,915**

Source: "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, prepared for The Heritage Foundation by Lewin-VHI, Inc.

Table 4

Distribution of Families by Change in Household Spending Under Reform in 1998 with Wage Effects*

Family Income	All Families (in millions)	Increase in Family Costs					Change of less than $20	Reduction in Family Costs				
		$1,000+	$500-$999	$250-$499	$100-$249	$20-$99		$20-$99	$100-$249	$250-$499	$500-$999	$1,000+
Less than $10,000	14,690.8	3.6%	5.9%	9.6%	9.5%	7.0%	6.8%	6.1%	7.7%	9.2%	10.0%	24.6%
$10,000-$14,999	9,620.6	22.1	8.5	5.7	5.6	2.5	1.7	6.7	6.4	6.8	8.8	25.1
$15,000-$19,999	7,514.7	26.7	7.4	5.1	4.0	1.7	2.2	5.1	4.8	7.7	9.0	26.3
$20,000-$29,999	15,748.1	26.7	10.4	6.7	4.4	2.9	1.9	2.8	4.8	6.2	8.9	24.1
$30,000-$39,999	12,309.6	27.8	7.8	7.2	3.7	1.5	0.6	3.0	3.7	5.6	8.2	31.0
$40,000-$49,999	10,707.1	27.1	7.9	5.8	3.7	2.3	0.8	2.5	3.1	6.3	7.3	33.3
$50,000-$74,999	16,659.4	32.9	8.8	4.5	3.1	2.1	0.7	2.2	3.2	3.9	7.7	30.8
$75,000-$99,999	7,149.5	36.3	7.1	3.6	2.9	1.5	0.5	1.0	2.9	4.4	7.8	31.9
More than $100,000	7,113.1	43.9	7.6	5.1	2.2	1.6	0.7	1.2	2.8	2.3	6.8	25.8
Total	101,512.8	26.0	8.1	6.2	4.6	2.8	2.0	3.5	4.5	6.0	8.4	28.0

Note: *Includes changes in premiums, out-of-pocket expenses and taxes earmarked to fund health care, excluding instututionalized persons.
Source: Lewin-VHI estimates using the Health Benefits Simulation Model.

problems obtaining access to health services and need community health centers and other safety net programs."

Even with a 50 percent mandate, let alone the 80 percent requirement in Gephardt, Hawaii's employment experience is not encouraging, despite a traditionally tight labor market in the state. According to a 1993 Kaiser Foundation study of the experiences of Hawaiian businesses after the mandate was introduced:

- ✔ 4 out of 10 employers had to reduce their workforce.
- ✔ 1 out of 10 hired part-time workers to avoid paying health insurance.
- ✔ 55 percent restricted wage increases.
- ✔ 33 percent restricted other employee benefits paid to workers.[17]

AMERICANS WOULD HAVE TO BUY A STANDARD BENEFITS PACKAGE

The Gephardt and Mitchell bills would require all working-age Americans who want health insurance to enroll in a plan that includes a comprehensive standard benefits package. The package would be designed by Congress or by a commission under guidelines established by Congress.

While the bills vary in the size and scope of the benefits mandated, each uses the Clinton standardized package as its basis. The Clinton package has been said by the Administration to match or exceed that of the "average *Fortune* 500 company." While this may sound attractive at first, several questions need to be addressed: Does every household need or want such a generous package? Can every household afford such a generous package? Can the country afford to guarantee such a generous package, free of charge, to those below the poverty line?

By adopting a comprehensive standardized benefits package approach, rather than trying to assure that all Americans can obtain at least a basic catastrophic plan, the leadership has chosen to ignore the fact that millions of Americans, most notably younger and healthier individuals, may not want, and possibly cannot even afford, such a generous package. Furthermore, those who needed a service not included in the standardized benefit package would have to buy the service out of their own pockets or buy supplemental coverage—without any tax relief.

Requiring all Americans to enroll in a comprehensive standard plan also makes it extremely difficult to hold down the growth of health care spending without tight price controls or rationing. As the American Academy of Actuaries concludes in a recent study:

> Designing a guaranteed standard benefit package within a limited health care budget is not an easy task. The ultimate design will depend upon the ability to balance the desire to provide affordable coverage to all with the reality of limited funding.[18]

17 *Ibid.*, citing Kaiser/Harris Survey of Small Business Owners in Hawaii, 1993, Preliminary Findings.

The Academy points out that many Americans would prefer to purchase a leaner, lower-premium package with basic insurance coverage.[19] A comprehensive benefits package, on the other hand, covers the broad range of medical services that families might expect to need over time.[20] With such a mandated package, households and employers would be required to purchase an expensive package that likely would include services they did not want while including services they did want.

Once a standard benefit package has been established, modifying and updating it becomes a bureaucratic and political nightmare. Consider the Medicare program, which covers over 35 million elderly and disabled Americans. This program establishes and excludes certain types of medical services from coverage. The Health Care Financing Administration (HCFA), the federal agency that administers the Medicare program, must endure a myriad of bureaucratic obstacles whenever it seeks to add or withdraw a benefit. Should HCFA decide to expand coverage for what might appear to be a promising medical technology, for instance, it must request an evaluation from the Office of Health Technology Assessment (OHTA), a branch of the Agency for Health Care Policy and Research (AHCPR) within the Department of Health and Human Services. If an official were to propose eliminating a benefit, that official would have to be prepared to do battle with Congress.

Americans should be wary of allowing Congress or a commission to establish a comprehensive benefits system for all plans, especially in an era where medical technology is improving and making rapid advances. According to a recent study of the Medicare system by Senator David Durenberger (R-MN) and Susan Bartlett Foote, a congressional health policy analyst, Medicare technology evaluation has been underfunded because of competing budgetary priorities, such as payment for a growing volume of medical services. Durenberger and Foote note that the evaluation of medical technology has been hampered by questionable assessments of the cost-effectiveness of technology due in large part to the politicization of HCFA's decision-making process.[21]

What is true of Medicare's benefit changes is inevitable for a nationalized standard benefits package: only through organized political action will benefits be added or subtracted. According to Jeremy Rosner, a researcher with the Progressive Policy Institute and now a Clinton Administration official, "The history of Medicare is replete with cases of organized groups acting through Congress to add coverage for specific illnesses or procedures, or to affect changes in specific prices."[22] The current campaigns to include specific benefits in the standard package, from abortion to chiropractic services, is an indication of how insurance coverage will be determined under a standardized benefits system.

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18 "Actuarial Issues Involved in Evaluating a Guaranteed Benefit Standard Package Under Health Care Reform," American Academy of Actuaries Monograph No. 5, March 1994, p. 18.

19 *Ibid.*

20 Robert E. Moffit, "A Guide to the Clinton Health Plan," Heritage Foundation *Talking Points*, November 19, 1993, p. 20.

21 See Moffit, "A Guide to the Clinton Health Plan," citing David Durenberger and Susan Bartlett Foote, "Medical Technology Meets Managed Competition," *The Journal of American Health Policy*, May/June 1993, pp. 24-25.

22 Jeremy Rosner, "A Progressive Plan for Affordable, Universal Health Care," in Will Marshall and Martin Schram, eds., *Mandate for Change* (Washington, D.C.: The Progressive Policy Institute, 1993), p. 122.

In the Gephardt bill, the standardized benefit is established in statute by Congress, as it is in the Clinton plan. The Mitchell bill specifies the basic outline of the package, but gives the power to select specific benefits to a commission.

PRICE CONTROLS

Like the Clinton plan, the Gephardt bill would establish a national spending target for health care. If this were exceeded, sweeping price controls would be applied to the health care system. To meet the target, and thereby avoid the controls, the growth of health care spending would have to be reduced more rapidly than has been possible so far in any industrialized nation—including those with government controls on health care spending.

Specifically, the Gephardt bill requires the Secretary of Health and Human Services to compute a baseline private per capita estimate for 1995, based on 1993 data inflated forward to 1995. The target rate of growth would be set in statute so that the rate of growth in private spending on health care would be reduced by two percentage points in 1996 and by an additional one percentage point in each subsequent year until the rate of growth is slowed to the five-year average per capita rate of growth in the gross domestic product (GDP). Such a severe limitation on how much health care expenditures may increase has never been tried in the Western world and is almost inconceivable without tight price controls and severe rationing.

To appreciate why the Gephardt target is so unrealistic, consider the chart to the right, which shows the average annual growth rate in health expenditures for Western countries, adjusted for inflation and population growth, for the years 1985-1991.

The budget impact of the Gephardt bill depends on keeping the growth in health spending down to these levels which would be unprecedented in any industrialized country. If spending was not kept within these targets, federal outlays on subsidies would soar.

Average Annual Growth in Per Capita Health Expenditures 1985-1991
(Adjusted for Inflation)

Country	Percentage Increase (1985-1991)
Turkey	9.61
Spain	6.69
Italy	5.55
Finland	4.97
Iceland	4.48
Norway	4.30
Japan	4.24
Belgium	3.95
United Kingdom	3.84
Canada	3.58
France	3.26
Austria	3.05
Germany	2.05
Switzerland	1.82
Sweden	0.48
Gephardt target for the United States after 1996	0

1 Numbers are the percentage by which the increase exceeds the rate of inflation, as measured by the GDP inflator.

2 Figure from Sec. 6001(c)(2)(c), Committee on Ways and Means Report 103-601, Part 1, p. 105.

Sources: Organization of Economic Cooperation and Development, 1985-1991 comparison; H.R. 3600 as reported out of the House Committee on Ways and Means.

GEPHARDT'S SINGLE-PAYER SYSTEM

Liberals in the House and Senate who advocate a single-payer Canadian-style system succeeded in creating the infrastructure for such a system within provisions in the House Ways and Means bill. These provisions are included in the House Majority Leader's bill and, if retained in the floor-passed version, easily could end up in conference version.

Gephardt creates a single-payer system for up to half the U.S. population by expanding one of the nation's largest entitlement programs, the Medicare system, to include millions of working Americans and the welfare population. The current Medicare program, restricted to Americans age 65 and over and certain disabled persons, already is the nation's largest health care program; in 1993, approximately 35 million Americans were enrolled at a cost of $134 billion. The Gephardt bill would add as many as 60 million more Americans to this government-operated system by creating a new Medicare Part C. Most of the working Americans in Part C would not be enrolled by choice, however, but because their employers decided to put them in the program.

In general, Medicare Part C is to be available to households headed by individuals who meet the following requirements:

- ✔ They are a part-time, seasonal, or temporary employee.
- ✔ They are full-time employees in a business or organization with 100 or fewer employees which opts to cover employees under Medicare Part C instead of under a government-approved private health plan.
- ✔ They are low-income employees of any business or organization.
- ✔ They are not employed.
- ✔ They are currently on Medicaid.

In addition:

- ✔ Illegal aliens born in the United States and who are not enrolled or otherwise covered under a private qualified health plan at the time of birth would be deemed to have been enrolled under Medicare Part C at the time of birth.

Costs and Benefits. Every man, woman, and child enrolled in the Medicare Part C program is to receive the same benefits in the government-defined and -approved standardized benefits package. The premium for the new program is to be based on the average cost of serving the eligible population. But this population will consist of the current Medicaid population, who will pay virtually nothing for a generous package of benefits, and millions of Americans generally working in small firms who will be responsible for 20 percent of the premium. This average premium will mean large extra payments by working Americans and their employers to provide extra benefits to the welfare population.

Doubtful Finances. The new program is to be financed only in part through premiums paid by enrollees and their employers into a new trust fund. The rest of the funding would come from various new taxes in the Gephardt bill. The design of the bill, and the experience of the current Medicare system, suggests strongly that there will be huge funding shortfalls in the new program. Among the reasons:

- ✘ **Medicare's costs already are exploding.** Placing Americans into the Medicare system is hardly a way to control costs. Over the last 20 years, Medicare costs have risen by an average annual rate of nearly 15 percent. Moreover, to the extent that Medicare Part C is able to control its costs at all, it will be by the same technique used in Medicare today—transferring costs to other Americans with private insurance.

✘ **Premiums are likely to fall well below actual costs.** In 1974, the Medicare Part B premium for physician coverage covered half the cost, but Congress flinched from raising the premium in future years to cover rising costs because of constituent anger. The result: premiums have been allowed to fall to a level where they cover only one-fifth of reimbursements—and because of cost shifting, reimbursements only cover a fraction of the real cost of services. Not surprisingly, this below-cost good deal for seniors has led to 97 percent of the eligible population choosing to buy the voluntary Part B coverage.

There can be little doubt that the same pressure on Congress would lead to premium revenue falling below costs, with resultant shortfalls in the trust fund. Compounding this, as below-cost Part C premiums fell further below premiums for equivalent private insurance coverage (itself driven up due to cost-shifting from Part C), more and more eligible Americans and their employers would choose Part C coverage, and others would clamor to be given eligibility.

✘ **Estimates of enrollment are likely to be too low.** The most sensible way to figure the cost of Medicare Part C would include relying on actuaries and benefits experts to estimate potential enrollment in the new program. But in a remarkable provision in the Gephardt bill, the Secretary of HHS is required—by law—to use the assumption that exactly 75 percent of the eligible population would enroll in Medicare Part C and to base the cost of the premium on that arbitrary figure.

Given this shaky but legally required assumption, it is highly likely that the determination of a Medicare Part C premium will be inaccurate. Very probably, due in part to the below-cost premiums discussed above, the enrollment estimate will be on the low side—leading to potentially huge future cost overruns.

New obligations for agencies and states. HHS is given the primary responsibility of enrolling all eligible individuals in Medicare Part C, but in reality the states would have to shoulder much of the burden of identifying the eligible population. Remarkably, the bill assumes that the new program can be established and open to enrollees and begin providing coverage by January 1, 1998.

Price controls on providers. Physicians and hospitals will be reimbursed in the same way as they are today under Part A and Part B of Medicare. That means the controlled fees and treatment reimbursements that are so unpopular with physicians today because of their mountains of paperwork and arcane regulations. Just as many physicians will not accept Medicare patients today, many no doubt will refuse to accept Medicare Part C patients unless forced to do so.

The Medicare payment system leads to huge costs being shifted to non-Medicare patients and insurers. Thus, physicians and hospitals who treat Medicare Part C patients will be forced to spread the deficient reimbursements among patients with private insurance, thereby raising their costs. In short, Americans who opt to stay in private insurance plans will be cross-subsidizing and helping to pay for the care that Medicare Part C patients receive.

THE HEAVY EXTRA BURDEN ON STATES

The Clinton bill placed a wide array of new obligations on the states. The Mitchell and Gephardt bills also would place heavy responsibilities and costs on them. And according to CBO, behavior changes prompted by the incentives in the bills could trigger additional state costs in non-health programs.

The Mitchell bill, for instance, requires states to oversee and enforce the complicated rules governing health plans under the new system. It would also require them to operate a "risk-adjustment" system designed to transfer billions of dollars from health plans primarily serving healthier families to those with an unusually high proportion of sicker Americans. States also would have to assemble vast amounts of insurance and health data and would be responsible for creating a network of Health Insurance Purchasing Cooperatives (HIPCs). The Gephardt bill contains different requirements of a similar scale, under which states also would have to figure out how to dismantle their Medicaid programs and transfer their welfare population to Medicare Part C.

Both bills contain low-income subsidy programs, which states must operate, that would have unintended incentive effects that could rebound heavily on the states. For example, the Mitchell bill provides subsidies to cover the full cost of standard coverage for low-income individuals and families below 100 percent of the federal poverty level, and the subsidies are phased out above that level and removed entirely at 200 percent of poverty. But if the woman in the low-income household becomes pregnant, the subsidy is for the full cost of coverage for a household income up to 185 percent of the poverty level (with the subsidy phased out at 300 percent of poverty). Thus, low-income household between 100 percent and 185 percent of poverty can obtain free insurance, as opposed to paying part of the cost, merely if the woman in the household becomes pregnant—which in many states would trigger other benefits.

The phaseout rules would have other unwelcome incentives. As the CBO points out, phasing out the health care subsidies for low-income families as their income rises "would implicitly tax their income from work," making it much less attractive to work harder—or to work at all in many instances. That would lead many families to decide to remain on the welfare rolls, or to limit their earnings from work, which in turn would impose unanticipated outlays for welfare and other assistance on the states. Explains the CBO:

> In 2000, for example, the effective marginal levy on labor compensation would increase by as much as 30 to 45 percentage points for low-income subsidies and 20 to 40 percentage points for workers in families choosing subsidies for pregnant women and low-income children. Moreover, these levies would be piled on top of the explicit and implicit marginal taxes that such workers already pay through the income tax, the payroll tax, the phaseout of the earned income tax credit, and the loss of eligibility for food stamps. In the end, some low-wage workers would keep as little as 10 cents of every additional dollar they earned.[23]

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23 CBO, "A Preliminary Analysis," p. 11.

CONCLUSION

The Mitchell and Gephardt bills differ far less from the original Clinton bill than their sponsors—or the White House—are prepared to admit to the American people. Like the Clinton plan, both bills would lead to onerous mandates on employers, which in turn would mean reductions in wages and job losses. Like Clinton, both bills would force Americans to enroll in a government-designed standardized benefits package. Like Clinton, both bills would increase the likelihood of a single-payer system in the near future. Like Clinton, both bills introduce spending caps or price controls. Like Clinton, both bills place unfunded mandates on the states. And like Clinton, the financing schemes in both bills are completely inadequate to fund their promised benefits.

But worse still, nobody really knows how either bill, or a conference bill resulting from them, actually would work. For all its faults, the Clinton plan at least was examined carefully for several months. Detailed studies were carried out on the bill. It was the subject of exhaustive investigations, simulations, and conference workshops. As it was studied, some of its many unintended side-effects became more evident. The more the American people became aware of what the Clinton bill probably would do to their health system, the less they liked it.

The Gephardt and Mitchell bills have not been subjected to this close scrutiny. They are the results of back-room restructuring of the central elements of the Clinton bill, together with a collection of new provisions that have not been carefully assessed and are designed largely to win the votes of key lawmakers, not to produce good law. The result of the debate over these bills, under a timetable that is absurdly short for such momentous legislation, is likely to be a costly disaster for most Americans. The near certainty of this merely underscores the need for Congress to slow down, evaluate these bills and others meticulously and without politically motivated deadlines, and try to produce good reforms that are what Americans want and that may actually work as intended.

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