Paying for Universal Coverage: Employer or Individual Mandates?

BY JANE H. WHITE

President Bill Clinton's stated number-one goal for healthcare reform is universal coverage—or, as the president's number-one healthcare adviser, Hillary Rodham Clinton, put it in February, "guaranteed private health insurance that will always be there and can never be taken away." Mrs. Clinton, in her February 15 remarks at the Group Health Association of America health policy conference in Washington, DC, went on to say that the key problem facing Congress as it now seeks to draft healthcare reform legislation is, How do we reach the goal of universal coverage, and especially, how do we pay for it?

According to Mrs. Clinton, "there are only three ways" to finance universal coverage. The first is to "raise a big tax to replace private financing [and] have government basically run the system. The president has rejected this," she said. The second financing mechanism is an individual mandate. With this type of mandate it is "difficult to determine and monitor who is in the system and who's not. . . . It would require IRS to engage in enormous administrative oversight of the system," argued Mrs. Clinton. Other problems with an individual mandate include equity and cost issues, she added. The third, "sensible approach is to build on the employer/employee system that already serves 100 million Americans. An employer mandate is the key to achieving universal coverage," said Mrs. Clinton.

On March 23d, the employer mandate passed its first test in Congress. The House Ways and Means Subcommittee on Health, led by Rep. Fortney H. "Pete" Stark, D-CA, passed by a 6 to 5 vote legislation that includes an employer mandate to achieve universal coverage. Stark's subcommittee was the first in Congress to "mark up" and vote on healthcare reform legislation. The subcommittee used legislation drafted by Stark rather than the Clinton plan as its basis; however, it contains many of the key elements in the president's plan, including the employer mandate.

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Whether the employer mandate survives the full Ways and Means Committee is another matter. And it does not end there. Two other major House committees (Energy and Commerce, and Labor and Education) and two Senate committees (Finance, and Labor and Human Resources) are set to tackle healthcare reform legislation.

This column explores the issues behind using mandates to reach universal coverage. This issue, with both economic and political dimensions, is at the heart of the current healthcare reform debate.

Understanding Mandates

To understand mandates, it is important to clarify the language of the debate up front. As House Legislative Counsel Edward G. Grossman explains:

> First it is critical to distinguish between coverage and financing. Coverage means securing benefits for individuals and identifying and enrolling these persons. Financing means the process of collecting payments to finance the benefits and may include explicit financial subsidies (or discounts) for those who cannot afford payment.[1]

The debate about achieving universal coverage via employer versus individual mandates thus is really about how to *pay* for such coverage, not how to extend benefits to all Americans. Employers are not being asked to provide healthcare benefits under an employer mandate. They are asked to be the conduit for payment, the accountable entity for financing healthcare coverage.

The Clinton proposal for financing universal coverage relies primarily on an employer mandate that requires employers to pay for 80 percent of a healthcare plan premium for its employees. Yet Clinton's Health Security Act also mandates that individuals pay the remaining 20 percent of the premium and that the self-employed purchase

their own insurance. Subsidies would be provided for those with low incomes. The Clinton plan thus actually blends an employer mandate with an individual mandate: however, the employer mandate is the dominant financing mechanism for universal coverage.

There are a number of reasons—historical, economic, and political—why the Clinton plan relies primarily on employer mandates to achieve universal coverage.

History of Mandates

On the historical front, the employer mandate builds on the predominant way most Americans already receive health insurance coverage—through their employer. According to former Health, Education, and Welfare Secretary Joseph A. Califano, Jr., "Almost all nations with universal coverage have built on their existing systems." In a March 20, 1994, *Washington Post* op-ed piece, Califano, who served in the Carter administration, explained America's long history with employer-provided health insurance:

> The American link between health benefits and employment dates back 50 years to World War II. . . . The War Labor Board held the line on pay hikes, but it allowed increases in fringe benefits. Health insurance quickly became the premier fringe, and employers generously doled it out. The number of Americans in group hospital plans bolted from less than 5 million in 1941 to 26 million by the end of the war.[2]

Economics of Mandates

The economic reasons for using mandates, whether employer or individual, are linked to principles of equity and efficiency.

Efficiency Most economists agree that an individual mandate is the most efficient means of financing universal coverage. The individual mandate puts the cost of healthcare in a bright light for all citizens and does not route payments through a layer of employers, which can hide true costs, add inefficiencies, and lower incentives to keep costs down.

In the current patchwork system of health insurance, most persons have no idea how much their healthcare or even their total insurance premiums cost. They do not see the cost shifts that take place between well-insured persons, who pay more for the same service, and publicly insured (Medicare or Medicaid beneficiaries) or uninsured persons.

Equity These cost shifts raise questions of equity: Why should some pay more, and why should some not pay at all if they are capable of paying something? Finally, most workers with employer-provided health insurance do not realize that the high cost of their health insurance limits their employer's ability to raise wages.

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At a late January meeting in Princeton sponsored by the Robert Wood Johnson Foundation ("Universal Coverage: How Best to Achieve It?"), economist C. Eugene Steuerle of the Urban Institute provided a chilling example of the effect of these hidden costs:

> If we forced individuals with $14,000 a year in total compensation to buy insurance for $4,000, or if we taxed them $4,000 to support a government plan, there would be a loud howl of protest. Yet this level of cost is paid by many with moderate incomes today—they simply do not realize it. Households will contribute on average about $6,700 in fiscal year 1994 in taxes and reduced cash wages to support the nation's health care systems. These numbers are higher on average for those who actually pay.[3]

Economists distinguish between horizontal and vertical equity. The goal of horizontal equity is that people or employers in similar financial positions should pay similar amounts. For vertical equity, payment should be linked to ability to pay: Those who can afford to pay more should; those who need help should receive discounts or subsidies.

Economists disagree, however, on whether individual or employer mandates are more equitable. Mark V. Pauly, a University of Pennsylvania economist, favors what he calls an "employer-enforced individual mandate." He points to several key economic rationales for using an individual-type mandate:

- "An individual mandate can be much more precisely targeted, and therefore be both fairer and more efficient, than an employer mandate. Presumably, for example, we desire to subsidize the health insurance purchase of low-income families, not low-wage individuals or families."
- An individual mandate avoids the controversial issue of whether jobs will be lost under an employer mandate. Some estimates have predicted a loss of up to 4 million jobs if all employers who are not now providing insurance are required to finance a health benefit for their workers. Other estimates, however, show no job loss.
- Since an individual mandate does not base premiums on public subsidies, employment sta-

tus, or wage levels, "problems associated with part-time workers, two-worker families, or independent contractors simply will not arise."[4]

Economist Karen Davis, who is executive vice president of the Commonwealth Fund, and Cathy Schoen of the University of Massachusetts, Amherst, point out the economic advantages of an employer mandate. They argue that by building on the employer payment base, "the employer premium mandates moderate swings in the distribution of financing when compared with mandates financed entirely by payroll, income, or other taxes."[5] Indeed, a study by the Urban Institute released in February found that the Clinton plan, which is based primarily on an employer mandate, would have a very minor redistributional effect.[6] The only segment of the population to feel a financial shift would be the poorest fifth, whose spending on healthcare would fall from 20 percent of per capita income to 17 percent.

Davis and Schoen also suggest that an individual mandate would require government to pay out more in subsidies to the poor than would an employer mandate. They argue that with government vouchers or subsidies under an individual mandate plan, some employers may decide to drop the health coverage they once provided. "Even if employers were required to cover all employees equally, employers could provide incentives for workers to turn down employer-paid coverage in favor of public subsidies," write Davis and Schoen.

Economists agree, however, that both employer and individual mandates are regressive. A tax-based system where people pay for health insurance through a payroll-type tax would be less regressive economically, but not politically likely.

Politics of Mandates

The political pros and cons of mandates are every bit as important to the future direction of healthcare reform as the economics—maybe more so.

White House health adviser Walter Zelman told participants at the January Princeton meeting, "Once you say you're for universal coverage, you have to answer the tough questions" of how to get there. "We looked at VAT [value-added taxes], tax financing, and a tax cap." However, the politics of proposing a new tax during an antitax era put a roadblock on this line of thinking. Indeed, the political advantage of keeping a major portion of the financing off the federal budget by making employers pay is a major reason for the employer mandate in the Clinton reform plan.

The key political advantage of an individual mandate, however, is that it avoids placing a new burden on business—especially small business. The National Federation of Independent Business (NFIB), which lobbies for small businesses, is adamantly opposed to the employer mandate. In a lobbying coup, the NFIB in December managed to convince the American Medical Association to reverse its support of an employer mandate. Lobbying efforts on healthcare reform are so intense that not only are politicians being buttonholed, but so are other influential interest groups in the debate.

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Business is not of one mind on employer mandates, however. "The most important determinant of business's reactions will not be the concept of the mandate itself, but rather the way in which it is structured and implemented," suggests economist Frank B. McArdle, director of research in Hewitt Associates' Washington, DC, office.[7] Some factors noted by McArdle include the size of the financial obligation placed on employers; whether it includes part-timers (and how they are defined), dependents, or spouses; the level of employer subsidy by the government; and the degree of flexibility in shaping the benefit package. He proposed that "if we were to craft an employer obligation that was more respectful and reflective of that diversity [in the current employer-based system] instead of obliterating it, the odds of gaining greater acceptance by business could improve significantly."

A Willingness to Work toward Universal Coverage

Among the key healthcare reform proposals before Congress, the Clinton plan and Stark's bill require employers to be the primary financiers of universal coverage. The other two plans seeking universal coverage are those of Rep. Jim McDermott, D-WA, who supports a single-payer plan, and Sen. John Chafee, R-RI, whose bill would use an individual mandate. Under McDermott's bill, universal coverage would be reached through a combination of tax financing and individual mandates. This Canadian-style bill was voted down in the Ways and Means Subcommittee on Health in March. The remaining congressional bills (Cooper, Nickles, Gramm, and Michel) either provide incentives to individuals for coverage or encourage employers to offer health insurance, but do not mandate such coverage and hence do not reach the goal of healthcare for all Americans.

As Congress debates and votes on health reform legislation, some blend of employer and individual mandates seems likely. A compromise

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Coming in the Next Issue of

Health Progress

TRANSFORMATIONAL LEADERSHIP

In June, Health Progress *introduces the results of the Catholic Health Association's research project,* Transformational Leadership for the Healing Ministry, *which identified 18 differentiating competencies related to superior performance in Catholic healthcare leaders (see article on p. 68). Special section articles:*

- *Define various "clusters" of competencies and discuss what motivates leaders who possess them*
- *Explore applications of this model for excellence, including implications for sponsors, trustees, and executives*
- *Highlight the role of Catholic healthcare executives as servant-leaders*
- *Present executives' views about the opportunities and barriers associated with collaboration and consolidation*
- *Urge healthcare leaders to sustain excellence at the microscopic level by "honoring operations"*

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Primary care initiatives are proliferating.

al values that fly in the face of the direction we're moving: individualism, freedom of choice, 'more is better.' What a community wants may not correspond to its genuine needs."

REALIZING THE VISION

Despite obstacles, Catholic healthcare has already taken pragmatic steps along the path participants envision. Sr. Pint pointed out that lay and religious are already sharing in sponsorship in some places and many organizations are consolidating their tertiary services and forming integrated delivery networks and advocacy and computer networks. Patient- and community-focused primary care initiatives are proliferating rapidly throughout the ministry (see *Health Progress*, January-February 1994).

Catholic healthcare can fulfill its role as a prophetic voice that speaks out for the poor and on ethical issues, participants suggested, if sponsors work together. "I don't think coming together is optional for Catholic healthcare at this point. If we don't, we will dissipate our influence, our ability to bring that prophetic dimension to the broader healing ministry," said Sr. O'Connor.

By having a vision, Catholic sponsors can influence the direction of healthcare and find a renewed sense of hope and commitment. Sr. Coyle noted, "The everyday struggles aren't going to go away, and some relinquishment is necessary, but at the same time new initiatives are going to occur. And we have the resources for those initiatives. The resources aren't measured by numbers of people or dollars, but by our original motivation and our heritage." —*Judy Cassidy*

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plan might have a smaller employer share than the 80 percent share the Clinton plan envisions, and perhaps more flexibility and a longer phase-in period for the smallest businesses.

Whether Congress is prepared to pass legislation that meets the goal of universal coverage or whether it will merely provide incentives for or improve access to healthcare coverage will be the crux of the debate. Senate Republican staffers in conversations have revealed willingness to work toward universal coverage. Said one staffer, "There are 20 to 30 Senate Republicans who want universal coverage. There's more that we do agree on than don't."

It is time for Congress to work together to forge a bipartisan compromise that will place the United States among the rest of the industrialized nations that ensure healthcare coverage for their citizens. As Mrs. Clinton commented in February, "How we handle healthcare reform will tell much about who we are as a nation." □

NOTES

1. Edward G. Grossman, "Comparing the Options for Universal Coverage," *Health Affairs*, Spring II, 1994.
2. Joseph A. Califano, Jr., "Foundation for Reform," *Washington Post*, March 20, 1994.
3. C. Eugene Steuerle, "Implementing Employer and Individual Mandates," *Health Affairs*, Spring II, 1994.
4. Mark V. Pauly, "Making a Case for Employer-enforced Individual Mandates," *Health Affairs*, Spring II, 1994.
5. Karen Davis and Cathy Schoen, "Universal Coverage: Building on Medicare and Employer Financing," *Health Affairs*, Spring II, 1994.
6. Sheila Zedlewski, John Holohan, and Colin Winterbottom, "The Clinton Health Plan: Who Would Pay?" Urban Institute, Washington, DC, February 1994.
7. Frank B. McArdle, "How Would Business React to an Employer Mandate?" *Health Affairs*, Spring II, 1994.