Universal Coverage: Health Reform Hot Button

BY JANE H. WHITE

As Washington, DC, sweated through one of its hottest summers, the healthcare reform debate boiled over in the halls of Congress. Four out of the five congressional committees with jurisdiction on the topic managed to pass bills before July 4. The fifth—Energy and Commerce—threw in the towel. Then the roll-up-your-sleeves negotiations, counterproposals, and vote counting by party leaders, committee chairpersons, and the White House began in earnest.

At press time it was not clear whether compromise bills in the House and Senate could be fashioned before the traditional August recess. What was evident, however, were the political hot buttons that would drive the compromise process and the ultimate floor debate in the House and Senate. Health reform advocates, however, still hoped that votes on a joint conference bill would take place by October.

The hottest of the hot buttons is universal coverage—President Bill Clinton's goal of healthcare for all. How universal is universal—95 percent, 100 percent? How can it be ensured—through employer mandates, individual mandates, or voluntary means? And, of course, how much will it cost and how will it be paid for?

In this month's column, I offer a sampling of some of the policy debates surrounding universal coverage that erupted this summer. Policy researchers issued voluminous reports that examined the costs and effects of different levels of healthcare coverage. Businesses furiously lobbied Congress against employer mandates. Various healthcare trade groups, including hospitals, pushed hard for universal coverage and comprehensive healthcare reform. Members of Congress, each of whom had an eye cast on this autumn's election, struggled to reconcile the competing interests. And the White House, fearing lost momentum for its goals, launched a campaign-style effort, complete with the "Health Security Express" bus caravan to reinvigorate support for universal coverage.

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The View from Congress

When the Senate Finance Committee finally passed its version of health reform—the last of the congressional committees to do so—it signaled just how difficult an issue universal coverage would be for Congress as a whole. The Senate Finance bill was the only one to pass with significant bipartisan support—nine Democrats and three Republicans in favor of it versus six Republicans and two Democrats against it. It was also the only committee bill to drop the Clinton plan idea of employer mandates as the vehicle for reaching universal coverage. Instead, insurance would be voluntary, with market reforms and subsidies instituted to make coverage more affordable. Under the Senate Finance plan, if fewer than 95 percent of Americans have insurance by 2002, then a commission would recommend measures to fulfill the goal.

The Senate Labor and Human Resources Committee, House Ways and Means Committee, and House Education and Labor Committee all passed bills requiring employers to pick up 80 percent of the premium costs for their workers. The Labor and Human Resources Committee, however, exempted from the mandate businesses with 10 or fewer workers. Both House bills were passed by Democrats alone. The Senate Labor and Human Resources Committee picked up one Republican in its 11 in favor, 6 against vote. The House Education and Labor Committee also passed a second bill for a single-payer reform plan. Since the only bipartisan effort to date excludes employer mandates or another means of guaranteeing universal coverage that has real teeth, it does not bode well for Clinton's goal of health security for all.

What Policy Analysts Say

As Congress has struggled with the politics of reform in recent months, the nation's health policy analysts have churned out report after report trying to undergird the debate with some substance. Some have reached the halls of Congress,

but much is drowned out by political posturing and skewed information from some vocal special-interest groups.

Beyond the lofty goal of healthcare for all, policy analysts have argued that universal coverage is critical to reform for economic reasons. As Princeton economists Alan B. Krueger and Uwe E. Reinhardt note:

> Absent a mandate, millions of American families would simply choose to remain uninsured, even if they could afford to buy insurance with some subsidies and some belt-tightening. A strategy to remain uninsured is not completely reckless, because this nation already has a more or less universal catastrophic health insurance system: the hospital emergency rooms that are obligated to treat all comers, and the hospitals attached to these emergency rooms.[1]

The problem with this system—well known to *Health Progress* readers—is that it costs much more to treat people in hospital emergency rooms than if they received preventive and primary care outside the hospital. To get a handle on these costs and the consequent cost shifting that has become commonplace, it is important to get as many people into the insurance pool as possible.

Cost of Insurance under Nonuniversal Scenario A study by Lewin-VHI that was commissioned by the Catholic Health Association (CHA) and released July 18, 1994, expands on this idea.[2] Comparing several reform scenarios, the study estimated the number of persons remaining uninsured and how much more the average insured family would have to pay for its insurance (see also p. 8).

If only insurance market reforms were implemented, without universal coverage, Lewin-VHI found that only 1.1 million new persons would become insured, leaving 36 million still uninsured. Insurance market reforms alone would also increase the average annual premium for an insured family by $104.

Under a reform scenario of insurance market reforms based on the Managed Competition Act (MCA), with 100 percent premium subsidies for persons earning below the poverty level (a much higher subsidy level than the actual act), 14.9 million more Americans would become insured, leaving 22.3 million uninsured. However, the annual cost of insurance would rise more substantially—$260 on average for an insured family. The researchers explain this finding as follows: "Because persons who obtain coverage under the MCA will tend to be less healthy and more costly than persons who do not obtain coverage, average premiums will rise more for those already insured than they would under universal coverage," which would also add the healthier uninsured to the overall pool. Under a universal coverage scenario, a family's average annual premium increase would be $78.

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Cost of Covering All the Uninsured A study by RAND economists Stephen H. Long and M. Susan Marquis estimated that providing universal coverage would increase total U.S. health spending by only about 2 percent.[3] This study was sponsored by the Congressional Office of Technology Assessment, the Congressional Research Service, and the Robert Wood Johnson Foundation.

Long and Marquis estimate that under universal coverage, ambulatory care contacts and hospital inpatient days would increase by less than 4 percent. They estimate the dollar cost of providing this coverage to the currently uninsured at $19.9 billion. "Turning to inpatient hospital care," the authors note, "6.1 million added days of care would be sought by the newly insured, 3.6 percent more days of care than provided in 1991 to all patients. Certainly, on average, there is ample capacity in the system of short-stay hospitals in the United States to handle the added demand." The researchers estimate that hospital occupancy would increase only 1.6 percentage points.

Cost of a Mandate for Business One of the most politically contentious parts of the universal coverage debate has surrounded the use of employer mandates as the primary way to reach the universal goal. Employers argue that requiring them to pay 80 percent of their workers' health insurance premiums would force them to lay off workers. Economists Krueger and Reinhardt explain, however:

> The stories of business closing presented to policymakers by concerned business people seem to spring from an imagined scenario in which one firm in the market is saddled with the additional labor cost of an employer mandate, while all other firms in the market remain unscathed. But if all firms in the market were made to bear the same additional labor costs, the bulk of them probably would adjust in the short run through a combination of higher prices for their output, lower wages for their employees, and lower profits for the owners. . . . Economists are convinced, however, that in the longer run more and more of the cost of the employer mandate would likely be shifted backward to employees, not through outright and irritating wage cuts, but through small real (inflation-adjusted) increases in wages.[4]

Policy researchers from the University of Michigan recently estimated the effect of an employer mandate on small business.[5] Catherine G. McLaughlin and colleagues surveyed more than 2,000 small businesses and found that under the Clinton plan's version of an employer mandate, with payroll caps for small employers, almost 60 percent of the small firms that now offer insurance would see a decrease in their premium costs, averaging about $1,500 per full-time equivalent worker per year. Among the firms whose insurance premiums would increase, most would see increases of less than $1,000 per full-time worker. For small businesses that do not currently offer insurance, the cost of a mandate per full-time worker ranges from $350 at those firms whose employees' average annual salary is less than $12,000, to $2,000 for high-wage small businesses (average employee salaries more than $21,000).

The University of Michigan survey found that without a mandate, voluntary efforts are not likely to get many small employers to insure their workers. "Even with lower-cost options in the market, a third or more of small businesses in our survey do not offer insurance to their employees, more than half of employees working more than seventeen hours a week were without employment-based coverage, and more than one-fifth were without any coverage at all." The survey also found that "some small business owners just do not want to offer health insurance to their employees. Fewer than one-third of those not offering health insurance said they were interested in making a health plan available to their workers."

Employer Versus Individual Mandates All House and Senate committee bills with employer mandates also included an individual mandate. These bills split employer/individual responsibility for covering premium costs at 80/20. Sens. George Mitchell, D-ME, and Edward Kennedy, D-MA, proposed a 50/50 split in a negotiating effort this summer to keep universal coverage alive and soften the burden on businesses.

A June 1994 study by the Urban Institute compared the effect employer and individual mandates would have on costs to employers, individuals, and government.[6] The researchers found that an 80 percent employer mandate with subsidies, as proposed in the Clinton plan, would result in the lowest direct cost for individuals, a larger share of costs for employers (which would eventually be shifted back to workers), and relatively high government subsidies. This type of mandate would be less redistributive than others the researchers examined, however, since "much of the financing comes in the form of employer payments for health insurance, which means a reduction in cash incomes equivalent to the employer payments."

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Under individual mandates, direct payments by individuals can be much higher, while business's direct costs are lower. The researchers note: "If we assume that savings to employers are passed on to workers in the form of higher wages under an individual mandate, business does not benefit from lower costs, but individuals would have higher cash incomes than under an employer mandate." Government subsidies would not be substantially greater than under the 80 percent employer mandate, the researchers report. Individual mandates would be more redistributive, however, "because they target subsidies directly toward low-income people."

The Urban Institute analysts tout the 50/50 employer/individual mandate split as "perhaps a more workable compromise." The employer and government financial burdens would be lower than under the Clinton plan, and direct payments by individuals would be less than under an individual mandate.

Special-Interest Group Voices

Despite all the research and advice from policy analysts on how to make universal coverage work, the reality of politics is often driven by the loudest voices in politicians' ears—namely the special interests. Some groups, such as CHA, have turned to policy research firms to present solid evidence for their case.

Many interest groups have banded together for more clout. One such group is the Health Care Reform Project, which includes CHA and 28 other provider groups, businesses such as Chrysler, unions, and citizen groups such as the League of Women Voters and the American Association of Retired Persons (AARP). The coalition ran a particularly effective and controversial full-page advertisement in the Sunday July 17 *Washington Post* and *New York Times*. The ad's headline reads, "No Matter How You Slice It . . . Pizza Hut Does Not Deliver the Same Health Benefits in America as It Does in Germany and Japan." The ad directly goes after one large employer, Pepsico, as a case example of a company that is thriving overseas while paying its mandated share of health benefits in Germany and Japan, yet does not want to provide its American workers the same benefits and is fighting the employer mandate. Several networks refused to run TV versions of the advertisement because they feared the ads were libelous (see also p. 9).

On Friday July 22, Kennedy held a hearing to allow the CEO of Pizza Hut to air his views about what was "wrong" with the TV and print ads. After screening the TV ad at the hearing, the

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CEO could not point to specific inaccuracies.

Behind the ad is a story of the difficult politics that underlie the whole reform debate. The Wichita, KS–based Pizza Hut division of Pepsico has been an especially strong voice against employer mandates. Pizza Hut and Hallmark Cards, two of the largest employers in Kansas, lobbied hard to convince moderate Democrat Rep. Jim Slattery. The ultimate loss of a vote from Slattery, who is running for governor, was a key reason the House Energy and Commerce Committee was unable to pass a bill.

On July 21 the U.S. Chamber of Commerce issued a press release decrying the efforts of the Health Care Reform Project. In the release, the chamber's senior vice president, Bruce Josten, called the attacks on Pizza Hut "desperation tactics by the supporters of a fatally flawed health care reform scheme." He added, "The employer mandate is an issue on which there can be no compromise."

Some disparate special-interest groups have banded together to counteract the strong lobbying of business. On July 21 the American Medical Association (AMA), American Federation of Labor-Congress of Industrial Organization (AFL-CIO), and AARP ran a joint full-page ad in the *Washington Post* that read: "If the AMA, AFL-CIO, and AARP can agree on these aspects of health system reform, so can Congress." Number one on their list was universal coverage "achieved through shared employer/individual responsibility, with a required level of employer contributions."

But business groups are also banding together to fight universal coverage. The National Federation of Independent Business, the National Restaurant Association, the National Retail Federation, and some large firms, such as McDonald's, Pepsico, General Mills, J.C. Penney, Kmart Corporation, and Marriott, have formed the Anti-Mandate Coalition.

These groups are now battling it out for the attention of Congress, especially on the topic of employer mandates and universal coverage. The question is: Who will the majority of Congress listen to in the weeks ahead? □

NOTES

1. Alan B. Krueger and Uwe E. Reinhardt, "Economics of Employer Versus Individual Mandates," *Health Affairs*, Spring II 1994, pp. 34-53.
2. Allen Dobson, Jeffrey K. Blend, and Robert Mechanic, "Coverage, Premium, and Household Spending Implications of Health Reform," Lewin-VHI, Washington, DC, July 18, 1994.
3. Stephen H. Long and M. Susan Marquis, "The Uninsured 'Access Gap' and the Cost of Universal Coverage," *Health Affairs*, Spring II 1994, pp. 211-220.
4. Krueger and Reinhardt.
5. Catherine G. McLaughlin, Wendy K. Zellers, and Kevin D. Frick, "Small Business Winners and Losers under Health Care Reform," *Health Affairs*, Spring II 1994, pp. 221-233.
6. John Holahan, Colin Winterbottom, and Sheila Zedlewski, "The Distributional Effects of Employer and Individual Health Insurance Mandates," Urban Institute, Washington, DC, June 1994.