COMPARING THE OPTIONS FOR UNIVERSAL COVERAGE

by Edward G. Grossman

Prologue: *Whether health care reform incrementally builds on the existing U.S. system or introduces dramatically new features, many complex issues must be addressed. As Congress attempts this massive legislative task, author Edward Grossman argues here for the need to examine the policy alternatives in a more structured manner—precisely because there are so many issues and variables at stake. "It is far better to do this in a systematic way rather than get blindsided" down the road when critical issues arise that were not addressed in the legislation. Drafting health reform legislation is difficult when policymakers "lose sight of the forest because they are focused on a few very large trees," said Grossman. In this paper Grossman systematically describes the forest of health care reform issues to consider in pursuit of universal coverage. He then evaluates eight legislative proposals under debate in Congress. Grossman is particularly qualified to undertake such a systematic examination, given his position as assistant counsel in the House of Representatives' Office of the Legislative Counsel since 1975. He knows the health reform bills intimately—he wrote them. He drafted most of the legislative language for the managed competition bill (Breaux/Cooper/Grandy), the single-payer plan (McDermott/Wellstone), the Republican alternative (Michel), the Pepper Commission bills, and others—as well as many Medicare and Medicaid provisions in the Omnibus Budget Reconciliation bills from 1980 to the present and the ill-fated Medicare Catastrophic Coverage Act of 1988. Most recently, at the request of the House leadership, Grossman managed the drafting of President Clinton's massive Health Security Act. Hill staff praise his ability to understand the breadth of the plans and the depth of each nuance. Grossman received his law degree from Yale.*

Abstract: This paper identifies and evaluates eight legislative policy options for achieving universal coverage. These options are reviewed systematically by addressing three distinct, although related, issues: defining the "universe" covered, defining the nature of the coverage to be provided, and providing legal incentives to assure the coverage and financing. In particular, this paper focuses on the obligations of employers and individuals under these proposals and appropriate governmental policies to promote compliance.

As Congress seeks to reach agreement on health care reform legislation, it must consider many important and complex issues. For instance, unless the terms *universal*, *coverage*, and *mandate* are carefully defined and commonly understood, it will be difficult for Congress and the nation to reach the consensus necessary to enact health reform legislation meeting President Bill Clinton's "bottom line" of health security for all.

First, it is critical to distinguish between coverage and financing.[1] *Coverage* means securing benefits for individuals and identifying and enrolling these persons.[2] *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.

On the issue of employer versus individual mandates, it is instructive to examine instead the incentives or disincentives (or "obligations") that may be imposed on individuals and employers. By taking this angle, one can explore a wider range of tools available to governments to induce persons to comply with public policy—the "carrots" and "sticks" of penalties, taxes, subsidies, and so on. In this regard, policymakers also must examine the degree of compliance needed to achieve their health reform policy goals.[3]

The first part of this paper analyzes different ways in which the universe can be defined. The second part briefly analyzes the different ways in which coverage can be specified. The third part analyzes models for enforcing coverage and financing requirements and implementing related financial subsidies. The final part analyzes how the major legislative proposals now under discussion have approached the roles of employers and individuals with respect to coverage, financing, and subsidies.

Examining The Universe

One approach to universal coverage would be to treat everyone alike. However, taking this approach for the purpose of covering the uninsured could be perceived as unnecessarily disrupting current coverage and financing arrangements of the majority of Americans. An opposite approach is to recognize and preserve current distinctions, particularly those based on employment, geography, and family composition, not only for coverage but also for financing and service delivery.

However, drafting language to formalize such distinctions is fraught with problems. It is exceedingly difficult even to describe the current system, which is in great flux.[4] A simplified description may result in unintended changes in other areas. Providing a state-based approach to coverage and financing may complicate the lives of those who live in one state but work or receive health care services in another state. Requiring employers to provide financing only for full-time employees may create a financial incentive to hire part-time employees.[5] Even if a distinction is well intentioned and merely designed to maintain a status quo, it adds complexity in administration, may diminish public understanding, and may potentially diminish public support because of perceived favoritism and inequities.

An inevitable response to the legislation of these distinctions is "gaming the system:" an artificial restructuring of employment or social relationships to maximize individual benefits. This occurs particularly in "notch" cases, where a seemingly inconsequential difference in status (such as a one-dollar difference in income, a difference of one day in date of birth, or a difference of thirty minutes per week of employment) produces a disproportionate, unfair difference in treatment. Lastly, whether intended to maintain the status quo or create equity, these variations in treatment can undermine other key, practical objectives, such as maintaining portability of coverage.

With this in mind, it is helpful to analyze the different groups that make up the eligible population in terms of how they are treated under the current system and how they may be treated under health care reform. These groups are categorized by citizenship, geography, Medicare or Medicaid eligibility, employment, beneficiaries of other government programs, income and economic status, and family status. People who fall into more than one group pose particular problems for policymakers; for instance, significant federal savings result from policies regarding Medicare beneficiaries who are employed.

Citizenship and residence. Federal law distinguishes citizens, who have constitutional rights of residence and equal treatment, from aliens, whose rights are those provided by Congress consistent with the Constitution. Generally, Congress has accorded the class of aliens lawfully admitted for permanent residence the same rights as citizens in most programs.[6] Other classes of aliens may be distinguished and provided benefits in descending order of connection to the United States. Those such as refugees and other aliens "permanently residing in the United States under color of law" (PRUCOL for short) may be accorded treatment similar to permanent residents; other aliens, such as foreign visitors, other short-term nonimmigrants, and undocumented aliens, may not.[7] Even if there is no political desire to provide health benefits to undocumented aliens, there may be a practical need to deal with them in those communities in which they

constitute a significant proportion of the population receiving care, particularly if the care is publicly financed or if the absence of such care could have an adverse impact on the health of the general public.

Geography. Making distinctions by geography poses particular problems, for both coverage and financing. The health care delivery system is both local and national. A person may seek primary care locally and advanced care in another state. The costs and style of practice vary widely both nationally and regionally within a state. Persons may reside in one state, work in another, and receive health care services in a third.

Medicare. The Medicare population is particularly important because it consumes such a large proportion of health care spending and because the federal government pays for much of the expenditures. There are three separate bases for Medicare eligibility: age, disability, or having end-stage renal disease. Each of these subgroups has different age, family, economic, and actuarial characteristics. In addition, Medicare is composed of Parts A and B, with separate but related eligibility standards. Although most Medicare beneficiaries are entitled to Part A benefits without payment of a premium and elect coverage under Part B, some must pay a premium to obtain Part A benefits and others do not elect coverage under Part B.

A subgroup of the Medicare population is either working or living in a family with an employed person. Although this group represents a small portion of the overall Medicare population because Medicare is a secondary payer to employment-based insurance, there are significant financial implications for federal spending in having this population receive primary coverage through employment rather than through Medicare.[8]

Economic status may affect Medicare policies. Low-income beneficiaries are now provided Medicare cost-sharing benefits through the Medicaid program. By contrast, the Clinton plan and others would effectively increase the Medicare Part B premium for upper-income individuals. Lastly, the presence of supplemental insurance or health plan enrollment affects costs under the Medicare program by increasing utilization through lower cost sharing.

Medicaid. Medicaid can be described as two distinct programs: a program of comprehensive, acute care for children, pregnant women, and their families and a program of long-term care for the aged and for disabled persons of all ages. The income characteristics of the Medicaid population vary. There are cash recipients with incomes well below the poverty level. There are qualified Medicare beneficiaries with incomes below 120 percent of the national poverty level. There are children in families with incomes below 185 percent of the national poverty level. And there are institutionalized beneficiaries with incomes below 300 percent of the Aid to Families with Dependent Children (AFDC) benefit level.

Lastly, although Medicaid is a fee-for-service program, an increasing proportion of the Medicaid population receives acute care benefits through a managed care arrangement, such as a health maintenance organization (HMO) or primary care case management. The use of managed care has consequences for the financing of the program, as well as access to (and the provision of) services.

Persons also may be grouped according to benefits they receive under government health programs other than Medicare and Medicaid. Health programs of the armed forces provide care through military facilities for active duty military personnel and through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) for their dependents. Health programs of the Department of Veterans Affairs (VA) provide acute and long-term care services for veterans with or without service-connected disabilities. The Indian Health Service provides a wide range of health and environmental services to Native Americans, directly and through contract, both on reservations and in urban areas. The Federal Employees Health Benefits Program (FEHBP) provides insurance coverage to millions of federal employees, their dependents, and federal retirees; there are similar programs sponsored by states and local governments for employees, their dependents, and retirees. Lastly, those incarcerated in federal and state penal institutions receive medical care through those institutions.

Employment. Most Americans obtain health insurance coverage through employment, as employees or as family members of employees. Employees can be grouped based on a single category or condition of employment (such as minimum-wage workers) or a combination of such terms (such as temporary, part-time, minimum-wage workers).[9]

Employees often are categorized as full time or part time, based on the number of hours per week (or per month) of employment.[10] They may be treated differently as permanent, temporary, or seasonal employees.[11] Some might categorize workers based on whether the employment is the primary or sole employment for the person (or family), or whether it merely supplements other employment, as is often the case with student employment.[12]

Individual workers may be categorized based on wage level.[13] Employees also may be distinguished based on whether or not their employment is covered under a collective bargaining agreement; the type of work they perform (migrant farmworkers might be treated differently from other workers because of the transient and often interstate nature of their work); or whether they are now provided employment-based health insurance, with or without employer financing.[14]

Employees may be treated differently depending on characteristics of their employers, such as average number of workers, average wage level, and period of time the employer has been in business.[15] Furthermore, certain

employers, such as the federal or state government, foreign governments or companies, and household employers, may be treated differently because of the nature or type of employment.[16]

Income and economic status. Persons also may be distinguished by their income or economic status. In distinguishing by income, one confronts a variety of policy decisions relating to what is included in income, what is the process for determining and verifying income, what is the time period over which income is measured, and whether and how to consolidate the income of family members.[17]

Family status. Insofar as health insurance coverage or financing may be "family-based," there are significant issues involving the definition of what constitutes a "family."[18] The core of a family typically is a spousal or parent/child relationship. Some may wish to treat a domestic partner as a spouse. Children may include stepchildren, foster children, and children placed for adoption but not yet adopted, but children above a certain age or under certain circumstances may be treated as separate from the parental unit. Families may include members who may be treated differently from others; examples include an elderly spouse under Medicare, a poor child under Medicaid, a parent who is an illegal alien, an incarcerated family member, or a family member living away from home because of education or employment circumstances.

Coverage Issues

A national health insurance policy may address a variety of coverage-related issues. A health care proposal may specify, directly or by reference to other law, a detailed benefit package or may designate an official or a commission to develop the package. A detailed package is more informative to the public and permits the Congressional Budget Office (CBO) and others to estimate more accurately the proposal's likely cost. However, it also provides a huge red flag that attracts endless lobbying efforts and may not be responsive to changes in medical technology.

Should the minimum benefits be the same for all eligible persons, or can benefits differ based on "actuarial equivalence" or other reasons?[19] A lack of uniformity may complicate administration and public comprehension of the plan and may result in inequities and adverse selection among plans in a competitive system. However, there are several reasons for accommodating a lack of uniformity in benefits. First, because Medicare benefits are significantly different from those now commonly offered in the private sector, uniformity would require a change in such benefits. Such a change would be controversial either because it would decrease the benefits or because additional funds would have to be raised (through taxes or program

savings) to pay for an increase. Second, there are populations with special needs, such as disabled children, who are now provided additional benefits. Lastly, because of a group's poverty, disability, or medical need, there may be justification for additional or special benefits, such as case management services for persons with chronic conditions.

Proposals may have special treatment of supplemental benefits regarding coverage of additional services, reduction of cost sharing, or both. This treatment may range from an outright prohibition of supplemental insurance to market restrictions or tax or financial disincentives. Proposals also need to address the potential coordination or overlap of benefits among basic plans, as well as between such plans and under other types of insurance that include health benefits, most notably workers' compensation insurance and automobile liability insurance.

Lastly, a plan may include standards for the delivery system or systems permitted to provide the specified benefits, whether fee-for-service, managed care, or other. There clearly is a close relationship between the specification of benefits and the delivery model; it may be very difficult for a traditional HMO to deliver benefits designed with a high deductible (as in the case of "catastrophic" health insurance) or other significant deductibles and cost sharing.[20]

Enforcing Coverage And Financing Requirements

Assuring compliance with coverage and financing requirements involves an enforcement process with three distinct elements: identification of eligible individuals or premium payers, enrollment of the individuals or collection from the payers, and legal incentives and disincentives to promote compliance.

Identification and monitoring. Two overall strategies exist for monitoring compliance with coverage and financing requirements in a given health reform plan. The first strategy is to identify all eligible persons, enroll them in plans, and not permit them to disenroll without explicit authority unless they demonstrate enrollment in another plan. The success of this strategy depends upon a complete initial identification and a system (such as a national enrollment database) to regulate enrollment. Because the initial census is likely to be flawed, there would need to be periodic audits to assure complete coverage. This strategy works best if individuals' circumstances change infrequently. An alternative strategy is to periodically monitor compliance of the entire eligible population through information filings or other means. This strategy would not rely upon a complete initial census and would not distinguish previous enrollees from new entrants.

Within each strategy there are a range of methods for identifying eligible

persons and monitoring compliance. An optimal method would (1) cover the entire eligible population, (2) occur frequently enough to assure coverage on a continuing basis, (3) if attached to another program, not unduly interfere with program goals, (4) safeguard the privacy of eligible individuals, (5) be simple to administer, (6) permit verification, and (7) be coordinated with enforcement roles. A centralized database would greatly enhance the effectiveness of any method.

Policymakers could consider using a variety of current government programs to identify individuals and monitor coverage: the census, voter registration, school registration, drivers' registration, applications for government benefits, and income tax returns. Although the census covers the entire population, it is only conducted every ten years, and its information cannot be disclosed for these purposes. Voter registration covers an incomplete list of adult citizens and is not conducted on a consistent basis nationwide. Drivers' registration also is incomplete and is updated relatively infrequently. Annual student registration (which could include postsecondary students) may be a useful tool for youth but may not distinguish eligible and ineligible persons. Providing information in connection with applications for government assistance may be easy to administer but would only sporadically cover the eligible population and would require administration by a variety of agencies. Using annual income tax returns would miss many low-income persons who are exempt from filing.

A nongovernmental alternative is to have employers collect (and make available to enforcement officials) information from employees to establish their health insurance coverage.[21] This process, however, would cover only employees (and potentially their dependents). In addition, health care providers could be required to gather health insurance information at the point of service. Providers would notify enforcement officials of individuals failing to demonstrate coverage. This method would obtain information only when individuals seek care and may interfere with the doctor/patient relationship, even though providers have a financial interest in assuring that patients have insurance or other means to pay for care.

Enrollment and collection processes. Health reform legislation must set out a process for health plan selection and a process for assigning plans to eligible persons who fail to choose their own. This process also must provide for timely changes in enrollment when changes occur in residence, basis for eligibility, and family composition.

The collection of premiums is most efficiently done as part of other payment processes, such as payment of wages or taxes. Premiums can be collected through employers; public and private agencies that pay pensions and benefits; and banks, mutual funds, brokers, and other financial institutions that hold assets and make periodic payments.

Models for coverage and financing compliance. Policymakers can use various incentives and disincentives to ensure that people comply with the coverage and financing requirements in a given health reform plan. These include criminal penalties, civil money penalties, tax-based enforcement, direct governmental or private action, setting conditions on government benefits, and indirect enforcement through a third party.

In evaluating each "carrot" and "stick," one should take into account (1) how well it covers the eligible population; (2) its timeliness in responding to noncompliance; (3) its simplicity and efficiency of administration; (4) how consistently and fairly it can be applied; (5) how quickly it can be initially implemented and adapted in the future; and (6) whether it creates incentives for inappropriate action. Last, as a more pragmatic matter, legislators must take into account which congressional committee will have initial and continuing jurisdiction over the underlying legal obligation.[22]

Criminal penalties, including imprisonment and fines, apply more readily to individuals than to corporations, are not very flexible, and might be considered unduly harsh. Civil money penalties are fines imposed through an administrative process. They avoid the criminal stigma, can be imposed on the entire population, and allow significant discretion in enforcement. Many proposals, including the Clinton plan, use this tool. Tax-based enforcement (through tax deductions, exclusions, exemptions, credits, or even excise taxes) may miss low-income persons and others who are not now part of the income or excise tax system. However, unlike criminal and civil penalties, the tax enforcement system does have extensive monitoring capabilities that are useful for verification and enforcement.

A government agency or a variety of private parties may file a direct action before an administrative agency or a court to obtain compliance. This type of enforcement model does not necessarily require government initiative and can cover the entire population. However, it frequently relies upon the development of case law or regulations to clarify legal obligations. Reliance on private initiative has the danger of potential collusion and inconsistent enforcement.

Setting conditions on specific nontax, governmentally controlled benefits (such as welfare and issuance of a driver's license) as a means of enforcing universal coverage or payment for health care has its own flaws. It would be limited to only those people that desire the benefit. Also, the agency responsible for the benefit may not be motivated to enforce a seemingly unrelated requirement.

Lastly, delegating enforcement to a state or other third party could lead to various levels of compliance since the third party would differ from area to area. This method requires a credible fall-back policy if the third party does not adequately enforce the health reform coverage and financing

provisions. Its success depends on the tools, resources, and incentives available to each entity and the standards set by the federal government.

To optimize compliance, there may be a need for a judicious mix of overlapping enforcement tools, such as combining civil money penalties with tax-based and benefit-conditioned enforcement. However, the more different enforcement tools that are used, the more congressional committees may become involved and the more likely that an enforcement agency may pass the buck to another enforcement agency.

Models for financial subsidies. Health reform proposals may provide financial subsidies for those payers unable to afford the full financial obligation. Systems for providing subsidies may be based on the tax system, employment, the welfare system, the premium collection system, or states. Some models (such as the welfare system) may apply better to individuals than to employers, or vice versa.

In evaluating the appropriateness of each model, one should take into account (1) how well the model covers the population to be subsidized; (2) how timely subsidies are provided; (3) how administratively simple and efficient it is; (4) how consistently, fairly, and confidentially it can be applied; (5) how readily it can be initially implemented and how easily adapted to future circumstances; and (6) whether it creates incentives for inappropriate action. As with enforcement models, there is the additional consideration of legislative jurisdiction in the choice of models.[23] There also are key issues of who administers the subsidy program and what process is available to verify eligibility for subsidies and their amounts.

Tax-based subsidies, like the tax-based enforcement model described earlier, provide confidentiality and permit verification of eligibility and amount of subsidies. However, this system may not work well to accommodate short-term changes in income and subsidies based on assets (rather than income). Also, the Internal Revenue Service (IRS) may have uneven experience in reaching out to low-income persons.

An employment-based subsidy system would be simple to administer but would apply only to employees and would impose additional burdens on employers (particularly small employers). Other potential problems are inconsistent administration, given the large number of employers, and inefficient targeting of subsidies, since low-wage workers at one firm may have other uncounted family income. Government oversight would be needed, as would a backup system for employers that failed to administer the subsidies properly.

Using the welfare system to provide subsidies allows accounting for a person's total resources, could permit an outreach program, and could foster "one-stop shopping" with centralized administration for welfare recipients, even if eligibility standards for the programs were not identical. However,

some policymakers view the welfare system as bureaucratic, expensive, and stigmatizing.

Providing subsidies through the premium collection systems of health plans or regional alliances would reach the entire population without the stigma of the welfare system. However, because these entities are non-governmental, they may have little experience in making income-related determinations, assuring confidentiality and due process in appeals, and gaining access to tax and welfare information to verify eligibility. Also, their large number may lead to inconsistent administration. A government backup system may be needed.

Lastly, states may administer the subsidies using any of the above models. This strategy could ensure coverage of the entire population, provide assurance of confidentiality and due process, and avoid welfare stigma but may be less efficient administratively.

As with enforcement models, there is no obvious preferred subsidy model. The welfare model appears to be a flexible and proper strategy, particularly for those already in that system. For those outside the welfare system, the tax model provides an accessible but somewhat less flexible system. The employment-based and premium-based models may be more user-friendly, but they impose new duties on untested systems and do not provide the same assurances of consistency of administration, due process, and confidentiality that exist in the tax and welfare models. Although this would be more complex, there could be determinations of eligibility and amount of subsidy under a tax or welfare model and subsidy administration through an employment or premium-based model.[24]

Strategies Used In Eight Health Reform Proposals

A review of eight prominent legislative proposals for health care reform helps to demonstrate how the various strategies for coverage, financing, and subsidies might work. The plans are named for their chief sponsors: the Clinton administration, Sen. John H. Chafee (R-RI), Rep. Jim Cooper (D-TN), Sen. Phil Gramm (R-TX), Rep. Jim McDermott (D-WA), Rep. Robert H. Michel (R-IL), Rep. Don Nickles (R-OK), and the Pepper Commission. In particular, I look at the implications for employers and individuals.

Employers. Exhibit 1 compares employer roles in coverage and financing for the eight proposals. With respect to coverage, four of the eight bills impose some obligations on employers. The Clinton plan requires very large employers not electing to participate in regional alliances to provide coverage (enforceable through denial of corporate employer status). The Chafee bill requires all employers to offer coverage (enforceable through

Exhibit 1
Role Of The Employer In Key Health Reform Proposals

Financing	Coverage: Must provide coverage	Coverage: Must offer coverage	No role
Premium payment required	Pepper Commission (play) Clinton (very large employer)		Clinton (most employers) Pepper Commision (pay) McDermott
Payroll tax			Clinton (smaller employers) Pepper Commision (pay) McDermott
Tax incentive (only)	Chafee (large employer)	Chafee (not large employer) Michel	Cooper
No role			Gramm Nickles

Note: The Pepper Commission plan contained a "play-or-pay" mechanism, whereby employers that choose not to cover employees (play) would pay a tax for their coverage (pay).

the tax code and civil money penalties). Michel's proposal requires all employers to offer coverage (enforceable through civil money penalties and direct government action under the Employee Retirement Income Security Act, or ERISA). The Pepper Commission requires all but the smallest employers to provide coverage (enforceable through administrative orders, including civil money penalties and direct enforcement). The employer role in coverage is quite limited under the proposals of Cooper, Gramm, McDermott, and Nickles.

Only two of the bills impose a direct financial obligation on employers. The Clinton plan requires employers to pay 80 percent of a per worker premium (enforceable through direct action of regional alliances, with backup civil money penalty authority in the Department of Labor, or as a condition of corporate alliances). The Pepper Commission similarly requires employers to pay 80 percent of the premium (enforced much like the Social Security tax-based system).

Regarding financial subsidies for employers, the Clinton plan provides for employer premium discounts for small employers (administered by regional alliances), and the Pepper Commission effectively limits premiums through permitting election of a public plan. Dollar limits are imposed on the current tax incentives for employer-purchased insurance by Chafee and Cooper, and the Clinton plan limits the scope of services for which tax benefits will be provided.

Individuals. Five bills impose some coverage obligations on individuals and employees. The Clinton plan requires full-time workers of large firms to obtain coverage through corporate alliances and requires coverage through

regional alliances for others (enforceable by regional alliances as a condition of qualification and requiring use of point-of-service enrollment and using a national health information system). The Chafee bill requires individual coverage (enforceable through an excise tax and the use of a Health Insurance Coverage Data Bank). The McDermott plan requires individual coverage independent of employment (enforceable through state health security programs as a condition of qualification). The Nickles proposal provides incentives for individual coverage independent of employment (through disallowance of personal exemptions and as a condition of state health plans, which are required of states to obtain any federal health funding). The Pepper Commission requires coverage of employees through employment and individual coverage through a public plan (enforceable through "deemed" enrollment with tax-based monitoring and a financial penalty for late enrollment).

Neither Cooper, Gramm, nor Michel would require employee or individual coverage, although these bills provide an additional, nonitemized tax deduction for individual premium payments to encourage enrollment. The Cooper bill does provide for a report on the need for such a requirement.

Individual financial obligations are imposed by four of the bills, two only implicitly. The Clinton proposal provides authority in regional alliances to collect family premiums (through payroll withholding in the case of employees and with backup authority in the Department of Labor to enforce the requirement through civil money penalties). The Pepper Commission requires payment by employees through payroll withholding and payment by other persons through prospective payment to the secretary of the Department of Health and Human Services (HHS). The Chafee and Nickles plans have implicit requirements for financing as part of the individual coverage requirement (with payroll withholding in the case of an employee but with no separate enforcement).

Lastly, all of the bills but McDermott's provide subsidies for individuals and employees to obtain coverage.[25] The Clinton plan provides premium discounts for low-wage workers of large employers (administered by large employers as a condition of participation in a corporate alliance), provides premium discounts for others (administered by regional alliances and states), and extends tax benefits for self-employed individuals. Chafee provides a health care voucher (administered by the HHS secretary), extends tax-favored treatment to individually paid premiums, and extends tax benefits for self-employed persons. Cooper provides reduced premiums (with eligibility determined by a national commission and administered through health plan purchasing cooperatives), extends tax-favored treatment to individually paid premiums, and extends tax benefits for self-employed persons. Gramm provides a refundable tax credit for low-income

persons for premiums for catastrophic health insurance plans. Michel provides a phased-in tax-favored treatment to individually paid premiums and extends tax benefits for self-employed persons. Nickles provides tax credits for purchase of health insurance and federal grants to states to assist in assuring health insurance coverage. The Pepper Commission provides reductions in premiums and cost sharing for low-income persons (administered by the HHS secretary).

Concluding Observations

As Karen Davis and Cathy Schoen note in their paper in this volume of *Health Affairs*, the primary reason universal health insurance coverage does not exist in the United States today is affordability; a significant proportion of the working and nonworking population is too poor to afford coverage without outside assistance from employers or government.[26] If this is so, the fundamental issue in achieving universal coverage becomes the issue of how the coverage is financed.

There is an apparent political unwillingness to use any form of broad-based taxes as the means to finance universal coverage, perhaps because such a strategy is perceived as redistributive.[27] Instead, Clinton and some other proposals use mandated premium contributions principally to finance coverage. Because of the concern that the use of mandated premiums may result in an unacceptable burden on lower-income persons and smaller employers, these proposals almost inevitably include a system of financial subsidies for these individuals and employers to ameliorate this impact. In turn, for administrative simplicity and efficiency, these subsidies may be administered through the same tax system that was previously rejected because of its redistributive features. An outside observer may query whether the political discomfort of using a financing and subsidy scheme linked to the tax system justifies the creation of a potentially more complicated premium-based mechanism that imposes financial burdens that the tax system ultimately is called upon to moderate.

However it may be ignored or camouflaged, I believe that redistribution is at the heart of the health care debate. The concept of insurance, particularly health insurance, involves the sharing of common risk. Major health care reform inevitably will require a significant degree of personal and political commitment to sharing resources. So the ultimate issue may be whether after a decade of focusing on self-interest the voting public and their elected officials are willing to sacrifice and share enough to assure health coverage for all Americans. The polls remain open on this.

This paper does not represent the views of the Office of the Legislative Counsel or of the House of Representatives; the author is solely responsible for its content. The author does not advocate any position with respect to whether legislation should be proposed providing for universal health care coverage or with respect to what particular methods should be used in seeking to achieve such coverage.

NOTES

1. A brief comparison of the proposals from the Clinton administration and Rep. Robert H. Michel (R-IL) demonstrates the linguistic confusion between these two concepts. Although the Clinton plan has been characterized as imposing an "employer mandate," most employers are not required to arrange coverage for their employees but are responsible for financing such coverage through per worker payments to regional alliances. By contrast, although the Michel proposal is not considered to have an employer mandate, it requires employers to offer three different forms of health insurance coverage for their employees but does not require them to finance such coverage (other than through assisting in payroll withholding of premiums). Alan Krueger, Uwe Reinhardt, and other economists elsewhere in this volume as well as in the Congressional Budget Office's (CBO's) *Analysis of the Administration's Health Proposal* (8 February 1994), 56, find that employer premium payments in the long run are passed through to employees as reduced wages. If one accepts this, it may be argued that Michel imposes a greater employer mandate on employers than Clinton does, insofar as it imposes coverage obligations that the Clinton plan does not impose and, in either case, employer financing is ultimately passed through to employees.

   For this paper, the following legislative proposals are referred to by reference to their principal sponsor (all bills are 103d Congress, except the Pepper Commission's, which is 102d Congress): Clinton (Health Security Act, H.R. 1200 [Rep. Richard A. Gephardt]/S. 1757 [Sen. George J. Mitchell]); Chafee (Health Equity and Access Reform Today Act of 1993, S. 1770/H.R. 3704 [Rep. William M. Thomas]); Cooper (Managed Competition Act of 1993, H.R. 3222/S. 1579 [Sen. John B. Breaux]); Gramm (Comprehensive Family Health Access and Savings Act, S. 1807/H.R. 3918 [Rep. Rick Santorum]); Michel (Affordable Health Care Now Act of 1993, H.R. 3080/S. 1533 [Sen. Trent Lott]); McDermott (American Health Security Act of 1993, H.R. 1200/S. 1533 [Sen. Paul Wellstone]); Nickles (Consumer Choice Health Security Act of 1993, S. 1743/H.R. 3698 [Rep. Cliff Stearns]); and Pepper Commission (Pepper Commission Health Care Access and Reform Act of 1991, H.R. 2535 [Rep. Henry A. Waxman]/S. 1177 [Sen. Jay Rockefeller]).
2. The fact that an eligible person is by law "covered" under a health care system does not itself assure access to medically necessary services. Even if access were assured, this does not assure appropriate use of services, and the mere provision of services does not necessarily promote the health of beneficiaries. This paper treats a person as being "covered" when the person has been issued a health plan card or other evidence of entitlement to specified benefits.
3. For example, it may be sufficient to cover 94 percent of the population to achieve a politically acceptable sense of equity, but 98 percent of the population may need to be covered to avoid problems associated with cost shifting.
4. The perceived complexity of the Clinton plan may be attributed in part to the administration's effort to maintain special treatment for different groups under the current system.
5. I have been told that in response to the fact that the employer mandate in Hawaii applies only to employees who work twenty or more hours a week, a new class of

part-time workers who work only nineteen hours a week has evolved.

6. The U.S. Supreme Court in *Mathews v. Diaz*, 426 U.S. 67 (1976), found it constitutional to restrict Medicare benefits to those aliens lawfully admitted for permanent residence who had resided in the United States for five years.
7. Even within the undocumented alien population, one can distinguish between those who are employed in the United States (even if in violation of law) or who may be immediate relatives of a citizen or alien lawfully admitted for permanent residence and for whom legal status is just a matter of waiting until an immigrant visa becomes available, and those other aliens who have no palpable legal or economic claim.
8. Expansion of this policy is an important source of financing for President Clinton's plan.
9. Initially, there is the basic issue of whether a worker should be characterized as an "independent contractor" rather than an "employee." This has significant financial consequences for employment-based taxes. The Clinton plan (Subtitle C of Title VII) recognizes the importance of this provision in attempting to provide for more uniform rules for independent contractors. For a discussion regarding the complexity of this area, see M.J. Graetz, "Universal Health Coverage with an Employer Mandate," *Domestic Affairs* (Winter 1993/94): 90–91.
10. Even within the subgroup of part-time employees there may be very part-time employment (such as less than ten hours a week or forty hours a month) as contrasted with less-than-full-time employment (less than 120 hours per month), as provided in the Clinton plan. Eugene Steuerle, in his paper in this volume, specifically questions the ability of employers to account reliably for the number of hours employees work. Note that the Clinton plan, Section 1901(b), uses hours of employment per month (rather than per week) to level out some of the daily fluctuations. It recognizes the need for special rules, taking into account rules used under the Fair Labor Standards Act and the consideration of "industry practice" (such as for pilots and teachers), in cases where employment that would appear to be part time is actually full time.
11. The latter classification is frequently used in setting a waiting period before employees may become eligible for certain fringe benefits, including health insurance benefits. As Frank McArdle suggests in this volume, there may be a meaningful distinction between permanent part-time employees and temporary part-time employees.
12. McArdle suggests this approach in his paper to respond to business and to adjust to supplemental employment of family members. Except for the special treatment of children, the Clinton administration appears to have considered, and rejected, this distinction, probably for reasons associated with simplicity of administration and assuring equity among employers.
13. For example, the Clinton plan, Section 6104(a)(2), requires corporate alliance employers to provide additional premium payments for "low-wage employees" who are full-time employees receiving wages at an annual rate of less than $15,000.
14. There is also the separate employment-related population of former employees, particularly those for whom an employer has a contractual or other obligation to provide continued health benefits coverage in retirement.
15. As McArdle suggests, a significant problem in creating separate subgroups based on characteristics of employers is incentives that may be created for employers to restructure employment to minimize their costs. These changes may be contrary to desired employment policy. CBO, *Analysis of the Administration's Health Proposal*, 62–63, describes reallocation of workers among firms that may result from the Clinton plan.
16. There also may be particular problems associated with providing health benefits for employees working outside the United States. In such cases, there may be dependents of employees who are U.S. citizens and who continue to reside in the United States.
17. The income tax system uses many different concepts of income, such as gross income,

adjusted gross income, taxable income, or modified gross income. These differ in many details from concepts of income used in welfare programs.

18. Health insurance need not be family based. Medicare coverage is based on individual coverage, as opposed to family coverage; however, a husband or wife may qualify for Medicare on the basis of the work record of the other spouse. H.R. 5050 (the UniMed Act of 1992), introduced by Rep. William D. Ford (D-MI) in the 102d Congress, proposed coverage for children (MediKids) separate from adult workers and nonworkers (MediWorkers and MediWrap) and for separate coverage for each spouse in a family. The treatment of family overlaps with virtually all of the previously discussed groups, including Medicare and Medicaid beneficiaries, as well as employees, and persons legal and illegal inside and outside the United States. Conventional health insurance classifications of family are different from the concept of "dependency" used for income tax purposes or "household" used for welfare purposes. This may cause technical problems in using family definitions of the income tax or welfare systems as a basis for determining eligibility of families for financial subsidies in the health care system.
19. For example, can persons who are covered only under Medicare Part A be considered to satisfy the mandate (even though Part A does not include outpatient services)? What about veterans, who may be entitled to a different package of benefits? Should persons be provided flexibility, such as selecting among classes of similar policies (some of which may vary in cost sharing)? For example, the Clinton plan provides for three different schedules for cost sharing.
20. The Clinton plan attempts to accommodate this potential problem in separate cost-sharing schedules, one reflecting lower cost sharing usually associated with HMOs and another reflecting higher cost sharing usually associated with fee-for-service.
21. This process could be similar to the collection of W-2 forms for tax purposes or I-9 forms for immigration purposes.
22. Generally, the House Ways and Means Committee and the Senate Finance Committee have primary jurisdiction over proposals that provide for enforcement through the tax system or welfare system. The House Energy and Commerce and Education and Labor Committees and the Senate Labor and Human Resources Committee have primary jurisdiction over proposals that use criminal penalties, civil money penalties, or rights of action.
23. The House Ways and Means Committee and the Senate Finance Committee have jurisdiction over proposals that provide subsidies through the tax or welfare system. The House Energy and Commerce Committee and the Senate Labor and Human Resources Committee have jurisdiction over proposals that rely on premium adjustments or use states.
24. This is similar to the approach taken in providing employer advances for the earned income credit. There are several other examples of mixed approaches. Premium discounts in the Clinton plan are determined and administered by regional alliances with end-of-the-year verification assisted by states, the secretary of HHS, and the IRS. In the Cooper bill, individual eligibility determinations are made by a national Health Standard Commission, with implementation through premiums imposed by health plan purchasing cooperatives. Similarly, in the Pepper Commission proposal, eligibility determinations are made by the HHS secretary, with optional direct coordination by employers and an end-of-the-year reconciliation through the secretary.
25. The McDermott bill has no assistance because it does not use premium-based financing.
26. K. Davis and C. Schoen, "Universal Coverage: Building on Medicare and Employer Financing," *Health Affairs* (Spring II 1994): 7–20.
27. This is evidenced by the decision of the House Ways and Means Subcommittee on Health to exclude any specific payroll tax from the chairman's financing package as its final action before reporting its health care reform proposal.