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001. memo w/attach	Chris Jennings, Steve Edelstein to Hillary Clinton Re: Congressman Clay (7 pages)	7/28/93	P5

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Domestic Policy Council
Chris Jennings (Health Security)
OA/Box Number: 23754

FOLDER TITLE:
July 1993 HSA [5]

gf97

RESTRICTION CODES

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P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
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b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
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U.S. Department of Labor

Pension and Welfare Benefits Administration
Washington, D.C. 20210

July 11, 1993

MEMORANDUM FOR: THE FIRST LADY

FROM: RICHARD P. HINZ
U.S. DEPARTMENT OF LABOR

SUBJECT: Job Losses and National Health Care Reform

There has been considerable speculation recently about job losses that might result from an employer mandate contained in the health care reform proposal. Some estimates have placed the number of jobs that could be lost in the millions.

There is little empirical basis for most of these projections. The few reputable analyses that have been attempted in the context of employer mandates contained in prior proposals have set the number of job losses as low as 60,000 and as high as 1.5 million. The attached paper provides a brief discussion of the major issues relevant to the analysis of employment impacts and contains summaries of the major studies in an appendix.

The existing analyses may not be applicable to the Administration's forthcoming proposal. Their conclusions are extremely sensitive to the specific elements of earlier proposals, particularly the level of benefits mandated, the financing mechanism (premium versus payroll) and most importantly the absence of subsidies for low wage workers.

All jobs impact analyses have some common elements. These are discussed in greater depth in the attached paper. The two key issues are:

Who ultimately pays: Labor market theory expects workers to pay for most of the increased benefits through reduced wages. The extent to which this occurs lowers any employment effects. Shifting of costs from employers to workers increases with time but is constrained for low wage workers. Minimum wage workers cannot have wages reduced. This requires employers to pay the full amount of any additional benefits.

How sensitive to labor costs are employment levels: Economists vary widely on the estimate of the employment loss that will result from labor cost increases. There is agreement that the employment losses from a given level of higher employer costs increases with time. High sensitivity estimates use factors ten times those of the low end. Mainstream estimates are that over the long-run there is a

0.5 percent decline in employment for a one percent increase in employer costs.

The results of any analysis are highly dependent on the assumptions about these key variables. Studies showing large job impacts are generally short term projections that assume employers will pay the full cost of benefits, use high sensitivity to cost employment assumptions and presume no subsidies. The studies showing minimal job losses are long term projections that assume wage adjustment will be made through the normal operation of labor markets and incorporate large subsidies.

Studies such as the recent NFIB sponsored report that purport to to indicate "jobs at risk" (some as high as 15 to 20 million) show only workers whose benefit costs may increase and incorporate none of the key analytical processes. These are essentially meaningless.

Administration staff are currently working on a complete employment impact projection that will be based on the specifics of the reform proposal. This cannot be completed until key design issues are resolved, most critically the cost of the benefit package and the subsidies directed to small firms and low wage workers. A complete analysis should be available shortly after the President reaches final decisions on these issues.

A reasonable expectation is that there will be some employment losses concentrated among very low wage workers and in small businesses because they do not currently provide health benefits to these workers. Some of the potential employment losses can be avoided through subsidies directed to the employers of low wage workers. These types of subsidies are extremely difficult to design, complicated to administer and can be very expensive.

Over the long term there should be significant realignment of employment from health insurance and other sectors into direct health care. This effect is separate from the consequences of the employer mandate.

A BRIEF REVIEW OF THE POTENTIAL EMPLOYMENT EFFECTS OF MANDATORY HEALTH BENEFITS

RICHARD P. HINZ
U.S. DEPARTMENT OF LABOR
JULY 1993

The imposition of an employment based health benefits mandate will result in a significant increase in the cost employers must pay to provide benefits. This could cause employers not currently providing health benefits, mostly small businesses, to face a major change in their cost of labor. An employer mandate will also substantially alter the amount and pattern of health care consumption. Both the labor cost and health care spending ramifications of mandatory coverage have potential employment consequences.

The direct labor market effects of a mandate may be considered in terms of three closely related categories:

* A potential loss of jobs due to a higher cost of labor - A reduction in the demand for labor.

* Changes in the willingness of some groups to enter or remain in the labor market - Labor supply effects.

* Changes in the number and distribution of jobs within the health care industry.

LABOR DEMAND

Most analyses of employment effects focus on the general employment demand effect of health care reform. The underlying basis of these projections is the concept that mandating benefits that have not previously been provided, or which are above the current level, will increase the cost of labor. When the utilization of labor is price sensitive (a competitive market) an increase in costs will lower the demand for labor and lead to decreasing employment.

Over the past several years a number of analyses have sought to estimate the labor demand effects of an employer mandate. These estimates range from employment losses as low as 60,000 to as high as 1.5 million jobs. Most of the variation in these estimates is the result of differences in the basic characteristics of the mandate proposal such as the generosity of the benefits package and the nature of the financing mechanism (payroll tax or premium). The sensitivity to these basic design parameters tends to obscure much of the comparability of these analyses. Several critical issues are, however, common to the

evaluation of any labor demand analysis.

WHO PAYS FOR THE BENEFITS - THE INCIDENCE OF COSTS.

If the costs of the mandate are paid entirely by the employer and, therefore, represent an increase in the cost of labor the employment effects can be expected to be negative and in proportion to the cost increase. Conversely, if wages or other compensation are lowered to completely offset any increased benefits the total labor cost is unchanged and there should be no employment effects. The degree to which costs are effectively passed on to workers is likely to be dependent on the interplay of factors related to the timing of the mandate, underlying economic conditions and the nature of any particular labor market.

The general equilibrium theory is that market forces limit the compensation of workers to the value of their marginal production. Externally imposed increases in labor costs, therefore, require downward adjustments in compensation. The dynamics of labor markets are such that these changes tend to occur over a period of years due to rigidities in the wage structure imposed by a range of factors including collective bargaining agreements and the often less formal, but equally restrictive, compensation setting practices of employers.

A mandate imposed with short notice or a great deal of uncertainty regarding its cost provides minimal opportunity for compensating wage adjustments. Conversely, a long phase in period greatly increases the likelihood that employers and workers will forgo wage increases or otherwise adjust the value of compensation packages (labor costs) so that the workers bear the full cost of the mandate.

General economic conditions are relevant to this process. A period of high inflation will facilitate wage decreases by permitting employers to achieve real wage declines simply by holding nominal wages constant. Increases in labor productivity may similarly facilitate the shifting of cost burdens. During a transitional period, productivity gains exceeding real wage increases can offset increased benefit costs. This can maintain the marginal product of labor versus cost equilibrium preventing changes in employment levels.

The character of individual labor and product markets also play a role in the incidence of benefit costs. Workers are generally presumed to accept a benefit for wage exchange to the extent they perceive the benefits of the mandate to have value equivalent to the level of wage reductions required to obtain them. Tax considerations and community rating requirements are important to this process. The replacement of taxable wages with tax preferred benefits should be desirable to workers facing tax rates above

zero providing the benefits are perceived to exceed the difference between their nominal cost and the tax rate (the true after tax or wage equivalent cost).

If the costs of health benefits were calculated on an individual basis and were perfectly aligned with each workers expected utilization of services this exchange would be simple. Problems arise with group rates (in particular community rating) and from workers facing low tax rates. Workers with below average utilization (young and healthy) paying a cost averaged across a large population may not accept wage offsets equal to the employers costs because they believe that their benefits are not matched with the cost. This is exacerbated by the fact that these same workers are often those with no taxable income (below $15,000) and who therefore do not effectively obtain a subsidy in the exchange of taxable wages for non-taxable benefits.

The extent to which these circumstances may lead to a cost incidence on the employer, the consequent employment impact will vary with the nature of the employer and the labor market in which the employer operates. Some industries may be able to pass along the costs of mandated benefits in the form of higher prices, particularly if there is no substitute product and all of their competitors face equivalent increases in labor costs. Employers may also be able to impose wages decreases if workers face few alternatives employment opportunities (where labor markets are highly segmented). Conversely, readily available substitute products and a sellers market for labor will, to a greater extent, impose the cost on the employer.

Constrained labor and product market conditions may apply to the Hawaiian experience with mandated benefits. The unique geographic circumstances place a high cost on substitute products, especially in a service oriented economy. This facilitates absorption of increased benefits costs through higher prices. Limited labor mobility may also enable employers to more readily impose wage constraints on workers. The interaction of these may explain the limited employment effects of Hawaii's health benefits mandate.

The most rigid constraint that will impose the full incidence of a benefit mandate on employers are minimum wage laws. Employers of minimum wage workers who provide no current health benefits will experience an increase in labor costs of the full amount of the benefit mandate as they are legally constrained from negotiating a wage offset. Unless these employers are able to pass along the cost in the price of products their workers are likely to incur the greatest level of employment effects.

Labor economists generally agree that over the long term the compensation equilibrium will be maintained through adjustments in prices or wages following the imposition of a benefits mandate

except where specific constraints (minimum wage laws) are applicable. Most research shows that this has generally occurred except among younger and low wage workers. There is broad agreement that any job losses that occur will be concentrated in this segment of the workforce.

The analyses of employment impacts which conclude that there would be modest effects (less than 100,000 jobs) are those which take a long term perspective and assume that, to the extent legally possible, the incidence will fall on the worker. They conclude that employment effects will be primarily concentrated in minimum wage workers, implicitly believing that the effects on this group can be somewhat mitigated through price increases although there is no specific analysis of individual labor and product markets.

Analyses concluding employment losses in excess of 1 million are generally short term in perspective. These studies assume a highly rigid wage structure resulting in significant labor cost increases. They generally do not take into account potential price increases and assume that the mandate is imposed over a short term and effective immediately, thus precluding wage adjustments during a phase in period. Implicitly, due to the short term perspective, these analyses discount the effects of productivity increases, inflation or the tax preferred nature of health benefits in facilitating compensation tradeoffs that might limit employment impacts.

SENSITIVITY OF EMPLOYMENT TO LABOR COST - DEMAND ELASTICITY

The second major aspect of a labor demand analysis is the sensitivity of employment to the total cost of labor. While it is generally accepted that increased costs lead to a diminished utilization of labor there is little consensus regarding the magnitude of these changes. One of the reasons for this is the absence of any comparable experience from which to draw conclusions.

This is a problem both in regard to isolating the "pure labor cost" effect from other factors that may be affecting a natural experiment and in the applicability of prior experience to health care reform. It is particularly problematic in the context of a health benefits mandate because the potential magnitude of the cost increase that may be imposed is beyond the scope of what has been observed. The employer of a minimum wage worker required to provide family coverage might experience a 40% increase in labor costs. Extrapolating to this level of cost increases from much smaller increases that can be observed introduces a great deal of uncertainty to the estimates.

The sensitivity of employment to cost changes is generally expressed as a "demand elasticity", the ratio of the percent

change in employment to the percent change in labor costs. Estimates of this relationship in recent years have ranged from as low as 1/10th of percent decline in employment for each one per cent increase in costs to as high as nearly a 2% decline in employment. Recent general estimates based on observation of mandatory benefits such as Worker's Compensation cluster around a 1/2 percent decline in employment resulting from a one percent labor cost increase. These relationships vary for individual markets, by wage levels and from the long to the short term. The short term sensitivity is generally accepted to be significantly less than over the long term.

The labor demand sensitivity estimate, in combination with the assumption about the incidence of costs, are the crux of virtually all analyses of the employment impact of health care reform. An assumption that workers bear the full incidence of cost makes the demand elasticity far less important, and of relevance primarily to minimum wage workers. The view that there are significant impediments to cost shifting makes the elasticity of demand for labor paramount.

Analyses that reach the conclusion that there will be very large employment effects place all or most of the cost incidence on employers and posit a high sensitivity of employment to labor costs. These may be criticized as matching a short term cost incidence assumption with a long term labor demand elasticity. Analyses that find minimal impacts generally anticipate a high level of cost shifting and a relatively low level of sensitivity of employment.

A complete analysis would provide estimates over the short and long term and vary the incidence and cost sensitivity parameters appropriately. This would be likely to conclude that the two factors will tend to offset one and other as they vary in opposite directions (cost shifting minimizing the impact while the negative elasticity of demand is accentuated with time). The level of cost shifting can be anticipated to have a proportionately greater effect over time as a full cost shift eliminates a worker from the group potentially affected by labor demand shifts. This interaction should result in a declining employment impact over time.

The lack of this type of dynamic projection is a major deficiency of the analyses to date. In addition to the uncertainty and very generalized assumptions about the key elements of cost incidence and labor demand, most present either a fully phased in system that has reached an equilibrium state or presume an immediate mandate with no opportunity for compensating adjustments in labor markets. The former obscures what is likely to be a complex process played out over several years in a widely varying manner across different industries and labor markets. The latter is simply an unrealistic possibility, the analysis of which sheds

little light on what is likely to occur.

The consideration of these two key determinants of possible disemployment effects highlights the importance of several design aspects of a reform proposal. Any employment effects will be directly proportional to the cost of the mandated benefit package. In combination with a community rating requirement, as discussed above, an expensive mandatory benefit level will impose significant problems in regard to wage shifts for young and low wage workers. The degree to which legal (minimum wage) and other rigidities lead to increased labor costs for this group will be the primary determinant of job losses.

This makes the structure and extent of subsidies for low wage workers a critical aspect of the system design. A design that efficiently targets subsidies to the employers of workers subject to the dual problems of wage rigidities and highly cost sensitive labor demand can potentially mitigate most of the adverse employment impact of a mandate. This is an extremely difficult task due to the complexity of possible subsidy schemes and the lack of prior experience on which to base expected outcomes and because the level and targeting of these subsidies is contingent on an accurate assessment of the dynamics of this segment of the labor market. Subsidies that fully offset employment effects are also likely to be very expensive.

The manner in which dependents and part-time workers are treated under a reform is also important. The extent to which employers are required to pay the full benefit costs of less than full time workers will create potentially significant cost advantages for employers to substitute fewer full time workers for part timers. In general a fixed benefit cost for full time workers and any cost for others will make it more attractive for employers to use existing workers at overtime rates rather than to add to their workforce during cyclical upswings or the early stages of an expansion.

The treatment of dependents under a mandate may also have employment substitution ramifications. Employers facing a differential cost for workers with and without dependents may have cost incentives to substitute single workers for those with families. The potential for this will be dictated by the pricing and coverage requirements for dependents, particularly those who are working.

LABOR SUPPLY

The imposition of a health insurance mandate on employers may also have an impact on the willingness of some workers to enter or remain in the labor market. While a great deal of attention

has been focussed on the consequences of labor demand changes these potential labor supply effects have been afforded little interest.

When the total level of labor costs maintains a long term equilibrium through compensating adjustments in wage levels some workers wages may be expected to fall more than the value of the additional benefits they receive. This is particularly an issue when a community rate for benefits such as health insurance is mandated.

Community rating by definition results in half of the population receiving benefits below the mean. This imposes a potential disincentive for young and healthy workers to incur the average cost in the form of a wage reduction. A family rate structure and subsidies for non workers poses similar problems. The non-worker, through subsidies, may be able to keep coverage at no cost. Likewise a family member who, when not working, is simply an addition to a family policy, faces a similar zero cost of coverage while out of the labor force. This potentially diminishes the incentives for some workers to enter or remain in the labor force.

When the incidence of benefit costs fall on workers and coverage is universal a mandate may function as a "tax" on some labor resulting in a diminution of labor supply. Estimating the sensitivity of labor supply to this "tax" has all of the difficulties attendant to estimating demand elasticities, particularly the lack of a comparable precedent from which to project behavior.

The generally accepted view is that the labor supply behavior of workers who are the sole or primary earners for a family and who have no alternative sources of support is unaffected by marginal changes in the effective tax rate at the level imposed by a health insurance mandate. High wage earners (above the median) are also presumed to be have inelastic labor supply behavior.

This leaves several sub-groups on which the mandate may have some effect. The two of greatest relevance are older workers nearing retirement and individuals currently out of the labor force and receiving medicaid.

Currently many workers eligible for retirement benefits but not yet eligible for medicaid (55 to 64 year olds) may be remaining in the labor force primarily to retain health benefits as part of an employment based group. Their implicit cost of this coverage is usually far below the benefits received and much less than alternatives they would face upon leaving employment. This is especially true of those with pre existing conditions who could not purchase coverage at any price upon leaving employment. Universal coverage, elimination of pre existing condition

exclusions and community rated prices could induce many of these older workers to leave the labor force.

Alternatively, families now receiving medicaid often face loss of coverage upon entering the labor force. This imposes an effective "tax" on their labor that may be as high as 50% by some estimates, creating a powerful disincentive to work. An employer mandate with subsidies directed toward these low wage workers could remove this barrier because these families would continue to maintain coverage at presumably low costs even upon entering the labor force at low wage levels. This could potentially create a significant positive labor supply response.

As with the labor demand analysis considerable uncertainty exists regarding the magnitude of labor supply responses to a mandate. There has been no significant analysis of this issue to date that has attempted to assign a number or project outcomes. Because any supply effects are likely to occur primarily among narrow subgroups of the population that are the focus of some of the major elements that must be considered in the design of a reform proposal, the treatment of these groups (older workers, medicaid recipients, low wage secondary workers) will dictate any labor supply results.

The conventional wisdom, to the extent it exists, is that there are likely to be offsetting supply changes that will leave net labor supply essentially constant but cause a relatively low level of substitution among workers. Low wage older workers remaining in the labor force primarily to retain health benefits and low wage spouses of high wage workers will depart to some extent. Current medicaid recipients, to the degree that they now remain out of the workforce to retain health benefits, will presumably replace them.

HEALTH CARE INDUSTRY EFFECTS

The universal health insurance coverage that will result from a mandate and expanded programs to cover non-workers has potentially very significant consequences for employment. The utilization of health care services can be anticipated to increase commensurately with the increased coverage and spending. A reform which leads to changes in the pattern of health care consumption, away from acute care and toward preventative and long term care, also has ramifications due to the differing level and types of labor required for these services.

A managed competition type of reform with mandated universal coverage will likely have three types of effects on employment within the health care industry. It will substantially reduce employment in the administrative occupations prevalent in the

current structure of the industry, increase employment overall in health care services, and alter the mix of jobs within the industry.

It reasonably certain that major employment reductions will occur in the insurance industry and in hospital administration. This will be due to the standardization of administrative practices such as claims processing and the reduction of experience rating and medical underwriting in most insurance contracts.

Most analysts project a significant consolidation in the insurance industry as smaller insurers face increased competition for larger groups. Consolidation of small employers in purchasing groups will also reduce employment in the marketing and administration of insurance. The savings in all of these sectors will provide some of the resources to finance universal coverage. The employment losses in these areas will be directly proportional to the savings achieved and are likely to be in the hundreds of thousands.

Increased expenditures on health care (financed partially through these savings) and the reallocation of resources toward health care resulting from the mandate will lead to substantial increases in employment in the health care industry. This employment growth will be enhanced to the extent consumption of services is redirected toward preventive practices and long term care both of which are relatively labor intensive. Large increases in the employment of nurses, nurse practitioners, physicians assistants, all of the occupations related to the operation of long term care facilities can be expected.

As with the general labor market effects these trends will develop over time. It is likely that the job losses in the administration of insurance and health care will come early in the process with the job gains occurring somewhat later as consumption of health care slowly increases. This time variance will also be caused by the lags required to train workers to fill the demand in the health care sector in occupations such as nursing that have often had labor shortages and which require substantial training.

It is not unreasonable to expect, however, that because the reduction in expenditures on administration will be less than the increase in spending on health care, over the long term there will be a net increase in employment in the health care sector. This will be preceded, however, by a period of some employment losses in conjunction with dislocation and retraining of workers before a new, stable, and potentially higher level of employment is reached.

CONCLUSIONS

A definitive analysis of the total employment effects of health care reform has yet to be developed. The results of any analysis are highly sensitive to the specifics of fundamental design issues such as benefit levels and the subsidies afforded low income workers. Projections made in the context of prior proposals are, therefore, generally not applicable to alternative designs.

Previous studies have provided estimates addressing only the effects of an employer mandate on the overall demand for labor. These analyses project a decline in labor demand ranging from 60,000 jobs to up to 1.5 million jobs. These projections incorporate widely varying assumptions about the ability of employers to shift costs and the sensitivity of employment to these costs, factors about which there is no broad consensus among analysts. The high job loss analyses use worst case assumptions and make a short term point in time estimate. The low estimates are long term equilibrium state projections. This fundamental difference further obviates their comparability.

It can be expected that a mandate will have some negative employment consequences as employers (primarily small businesses) react to increased benefits costs. These can be minimized with a transition period that facilitates wage adjustments and effectively targeted subsidies, particularly if the subsidies efficiently reach employers of low and minimum wage workers. These types of subsidies are complicated and potentially very expensive but are the key element of a system design in regard it's employment effects.

A complete picture of employment effects should incorporate an analysis of labor supply shifts and changes in the health care industry. Universal coverage may induce movements both in and out of the labor force that could be offsetting. The health care industry can be expected to increase its share of employment after a period of some dislocation. Some of this increased employment will be a realignment from other industries, however, which decline in size as the health care industry grows.

A reasonable expectation of the employment consequences of health care reform would anticipate some job losses in general and considerable short term dislocation within the health care industry. This would be followed by considerable job growth in the health care industry, as people enter work there instead of other industries. The long term result of the reform would, therefore, be the job losses associated with the increased employer costs of hiring workers and some degree of shifting of employment into the health care industry.

APPENDIX

SUMMARY OF STUDIES AND TESTIMONY OF THE EMPLOYMENT IMPACT OF MANDATED BENEFITS

- Sheils, John. Vice President, Lewin-ICF. Testimony before the United States Senate Committee on Finance, June 9, 1992.

The witness was asked to discuss the potential for lost employment under the Health America Act, a pay-or-play plan under which employers would face the option of providing health insurance or covering workers under a payroll tax contemplated to be about 8 percent of payroll. Most economists agree that any loss of employment resulting from this plan would be concentrated primarily among minimum wage workers. It is believed that most employers of low-wage workers would choose to pay the tax rather than provide insurance.

There is remarkable consensus among economists that the loss of employment due to increases in the minimum wage has historically been small, with most of the impact concentrated among young teens. Lewin-ICF estimates that the loss of employment under the Health America Act would be between 23,000 and 63,000 jobs. This estimate is consistent with independent job loss estimates developed by Dr. Kenneth Thorpe, Dr. Karen Davis, and the Congressional Budget Office.

- Custer, William S. Director of Research, Employee Benefit Research Institute. Testimony before the United States Senate Committee on Finance, June 9, 1992.

Based on a simulation done by the Employee Benefit Research Institute (EBRI), between 200,000 and 1.2 million workers could become unemployed as a result of a mandate that employers provided health benefits. These estimates assume that wages and other benefits do not change as health benefits are added.

Under a play-or-pay plan, with a 9 percent payroll tax, EBRI estimates that between 130,000 and 965,000 jobs could be lost if wages and other components of total compensation do not adjust.

- "Run From Coverage: Job Destruction from a Play or Pay Health Care Mandate." Prepared for Richard A. Armey, Joint Economic Committee (1992), April 9, 1992.

This study estimates that according to conservative estimates, a pay or play mandate with a 7% tax will cause over 712,742 workers to lose their jobs in the first year of implementation, with 43% of this job loss falling on workers in businesses with under 20

employees. The four states of California, Texas, New York, and Florida would account for 42% of these job losses. A 9% payroll tax would result in the loss of 807,416 jobs.

This study utilized data on payroll costs from the paper, "Pay or Play Employer Mandates: Effects on Insurance Coverage and Costs," by Sheila Zedlewski, Gregory P. Acs, Laura Wheaton, and Colin Winterbottom, published in the U.S. Department of Labor's Health Benefits and the Workforce. It then took these costs and calculated firm-specific costs and the negative employment effects they generated by assuming a demand elasticity of -.73 for those workers currently uninsured and a demand elasticity of -.40 for those workers requiring upgraded insurance. These estimates of demand elasticity were considered to be conservative in light of the evidence that the short run demand is very elastic (-0.87 to -1.20) for workers with the characteristics of uninsured workers.

- The following three studies by CONSAD Research Corporation were each designed to measure the potential impact of an employer mandate on the levels of employment for different groups. Information from each study is partly taken from previous CONSAD studies.

  - "Jobs-At-Risk and Their Demographic Characteristics Associated With Mandated Employer Health Insurance." Prepared by CONSAD Research Corporation for The Partnership on Health Care and Employment, April 1992.

  Findings indicate that under a federal pay or play health insurance plan, about 9.1 million jobs would be at-risk (12% of private sector jobs where workers are employed more than 18 hours per week). "At-risk" entails dramatic changes in the employee compensation package through wages, hours, benefits and/or loss of job. It is measured by comparing the additional premium costs to wages. By definition, only workers earning under $10,000 can be considered to hold an at-risk job. One-third of all employees working more than 18 hours per week who do not receive own-employer coverage would be part of this at-risk group.

  Slightly more than half of the jobs-at-risk are held by workers ages 19-34 and 57% are held by women. Three-fourths of the jobs-at-risk are held by white workers, while one-fifth are held by people who have not completed high school. 28% of jobs-at-risk are held by members of families with annual incomes less than $10,000.

  Three-fourths of workers ages 18 and younger hold jobs-at-risk. 18% of women (9% of men), 16% of African-Americans

risk. 18% of women (9% of men), 16% of African-Americans and Hispanics (12% of white workers), and 83% of workers earning less than $5,000 per year also hold jobs-at-risk.

This analysis excludes workers employed less than 17.5 hours per week and assumes an employer premium share of 75%.

- "Employment Impacts Associated With Proposed Employer Health Insurance Options." Prepared by CONSAD Research Corporation for the Health Care Financing Corporation, March 1, 1993.

This study estimates the effects of four health care reform proposals on employment- H.R. 5936, S. 1227, the California proposal, and the Jackson Hole Group proposal. The study concludes that H.R. 5936 would have the smallest impact on employment (200,000 to 400,000 jobs-at-risk), the California proposal would have the second smallest impact (7.3 to 9.4 million jobs-at-risk), S. 1227 would have the third smallest impact (12.5 to 15.6 million jobs-at-risk), and the Jackson Hole proposal would have the largest impact (20.1 to 21.8 million jobs-at-risk). By comparison, the study estimates the number of jobs-at-risk to be 16.3 million in a scenario where employers would be required to contribute all employees' health care coverage at the same rate they currently contribute to their insured employees.

The study found that the demographic characteristics of workers who experience the greatest job impact for one health proposal would be most affected by the other proposals.

- "The Employment Impact of Proposed Health Care Reform on Small Business." Prepared by CONSAD Research Corporation for The NFIB Foundation, May 6, 1993.

This study utilizes the same methods as CONSAD's earlier report for HCFA, only this report also includes the Heritage Foundation proposal.

In establishments with fewer than 500 employees (representing 68.7 million private-sector workers), it was concluded that both the Heritage Foundation proposal and the House proposal would result in a negligible total of jobs at risk, while the California proposal would result in 9.6% of total private sector employment in jobs-at-risk (6.6 million workers), the Senate proposal would result in 16.7% in jobs-at-risk (11.5 million workers), and the Jackson Hole Group proposal would result in 23.6% in jobs-at-risk (16.3 million workers).

- Mitchell, Olivia. "The Effects of Mandatory Benefits Packages." In Research in Labor Economics. Eds. L. Bassi, D. Crawford and R. Ehrenberg. Greenwich, CT: JAI Press, 1991: 297-320.

In general, the literature suggests that when labor costs rise by 10 percent, overall labor demand will be reduced by 1 to 5 percent. Mandating employers to provide health benefits is likely to alter relative labor costs in addition to overall labor costs; this will likely induce employers to substitute away from low-wage, low-skilled employees toward more highly-skilled labor and capital.

Many researchers have equated the mandating of health benefits to an increase in the minimum wage. Nearly every study done in this area has concluded that raising the minimum wage by 10 percent results in a 0.5 to 3 percent reduction in employment among teenagers, with a much lesser effect among adults.

The literature also suggests that absenteeism would increase as a result of an employer mandate, since the value of the benefit to workers is not affected by a few additional absences. If health coverage were mandated, changing jobs would be made easier, leading to higher recruitment and training costs, which reduces productivity and output. In addition, more people might be induced to enter the labor force, as was seen in a study where an increase in unemployment insurance payments by 20 percent increased the fraction of women working by 1 percent and raised the hours worked by women by 12%.

- Klerman, Jacob Alex. "Employment Effects of Mandated Health Benefits." In Health Benefits and the Workforce. U.S. Department of Labor, Pension and Welfare Benefits Administration, 1992.

In this study, Klerman compares the first order effects of mandated health benefits to the impact of raising the effective minimum wage. Estimates of the employer cost of mandated coverage range from 10 to 40 percent of the annual wages of full-time workers earning the minimum wage. From this, it was concluded that a ten percent rise in the minimum wage would yield a less than two percent decrease in employment. However, it should be noted that the recent increase in the minimum wage combined with the potential imposition of a mandated benefit will result in increased uncertainty as to the exact magnitude of the employment effects.

In terms of the affected population, workers who would lose their jobs and/or wages will be concentrated among those who currently do not have employer-provided insurance (about 13 percent of all

workers), as well as among those who are currently covered by another family member's employer (about 25% of all workers). These workers are likely to be young and part-time workers of small employers, many of the same workers who are currently uninsured.

- Karen Davis, Professor of Economics and Chairman, Department of Health Policy and Management, Johns Hopkins University School of Hygiene and Public Health. Testimony before the United States Senate Committee on Labor and Human Resources, 100th Congress, November 4, 1987.

The testimony was regarding S. 1265, the Minimum Health Benefits For All Workers Act of 1987. In her testimony, Ms. Davis cited a study which used the Data Resources Institute econometric model to predict that there would be a loss of about 100,000 to 120,000 jobs from mandating insurance coverage on employers (adding about .1 percentage points to the unemployment rate). Much of the unemployment effect will be concentrated among African American teenagers. It was emphasized that this study may actually overestimate the loss of jobs, since it does not consider the creation of jobs from new health services (which Davis estimates to be about 100,000 new jobs).

The sectors of the economy most likely to be affected by the mandate are retail trade, the service sector, and the construction sector--sectors which have less impact on international competitiveness.

In her testimony, Davis criticized a study done by Gary and Aldona Robbins for the Institute for Research on the Economics of Taxation (IRET), which estimated a loss of one million jobs from the same proposed legislation. Davis claimed that the IRET study overestimated the per worker cost of the S. 1265 benefit package, it assumed that most employers would have to upgrade existing coverage, it failed to account for coordination of benefits to avoid duplicate coverage, and it did not consider the creation of any health services employment.

- Dr. Edward M. Gramlich, Acting Director Congressional Budget Office. Testimony before the United States Senate Committee on Labor and Human Resources, 100th Congress, November 4, 1987.

While the testimony does not focus on unemployment resulting from mandated benefits as much as it does on cost estimates, some unemployment estimates are provided. Gramlich believes that Karen Davis is likely to be close to reality in her estimate of a

loss of 100,000 jobs from an employer mandate of a minimum health insurance package.

Gramlich also cited the Minimum Wage Study Commission, which concluded from the existing literature that a ten percent rise in the minimum wage would reduce total employment among teenage workers by one percent to three percent. The overall effect on adults would likely be minimal.

- Gary Robbins, President of Fiscal Associates, Incorporated. Testimony before the United States Senate Committee on Labor and Human Resources, 100th Congress, November 4, 1987.

Gary Robbins and Aldona Robbins are co-authors of Mandating Health Insurance, a project done for the Institute for Research on the Economics of Taxation (IRET). They estimated that S. 1265 would result in a loss of 1 million jobs (largely as a result of an estimated $100 billion increase in employer-provided health insurance costs.

In reconciling the differences between their estimates and the estimates of researchers who found less of an impact on employment, Robbins claimed that survey data indicate that many existing employer-provided plans would not meet the minimums specified in S. 1265.

The burden of increased payroll costs would fall more on those in labor intensive sectors of the economy, more on small businesses, and more on low wage workers.

- Brown, Charles. "Minimum Wage Laws: Are They Overrated?" Journal of Economic Perspectives, Volume 2, Number 3, Summer 1988, pp. 133-145.

The author points out that the literature on the impact of raising the minimum wage on employment is generally in agreement. The more than two dozen time series studies on the estimated impact of a 10 percent increase in the minimum wage on teenage employment find that the reduction in employment amounts to 1 to 3 percent. This translates into an estimated increase in the teenage unemployment rate in a range from 0 to 3 percentage points. The popular belief that these employment effects adversely affect African American teenagers more than white teenagers has only been verified from about half of the studies done.

The author also indicates that the reduction in employment predicted is not necessarily caused by workers being discharged,

since turnover rates in minimum wage jobs are very high. One surprising conclusion is that even under the assumption that the minimum wage had no employment effect, its effect on poverty or the income distribution is not very large. For example, in 1976 when the minimum wage was $2.30, earnings of workers making less than $2.80 per hour accounted for only 11 percent of the after-tax, after-transfer income of the poorest fifth of all households. Thus, raising the minimum wage substantially does not raise the income of the poorest households by much at all.

- Chollet, Deborah. "Public Policy Options To Expand Health Insurance Coverage Among the Nonelderly Population." In Government Mandating of Employee Benefits. Edited by Dallas Salisbury. Washington D.C.: Employee Benefit Research Institute, 1987.

Imposing a mandatory minimum health insurance benefit is presumably equivalent to raising the minimum wage in its effect on employment in low-wage jobs. In reviewing the literature, among teenagers, a 10 percent increase in the minimum wage reduces employment by 1 to 3 percent. This figure, however, might be somewhat misleading because many teenagers who would otherwise look for work, stop looking for jobs and thus are not counted in unemployment statistics. The unemployment effect might actually be greater among adults with similar wages to teenagers, because these adults have a stronger attachment to the labor force.

Workers in retail trade, services, and low-wage manufacturing may be particularly vulnerable to reduced employment. The author believes that the estimates provided are conservative.

- Anderson, Joseph. "Effects of Mandatory Pensions on Firms, Workers and the Economy." In Government Mandating of Employee Benefits. Edited by Dallas Salisbury. Washington D.C.: Employee Benefit Research Institute, 1987.

The effect of a mandatory universal pension that would provide for a minimum 3 percent defined contribution each year and a participation standard of age 20, one year of service, and 500 hours worked, with 5 year vesting would have cost $12 billion in 1982. The author estimates that this would have resulted in an increase of .05 of one percentage point in the unemployment rate in the first year. In the short run, 160,000 jobs would have been lost, while in the long run, 60,000 jobs would have been lost. One half of jobs lost would be lost by workers in firms of fewer than 25 employees and another 21 percent would be lost by workers in firms of 25 to 99 employees.

The data for this analysis was produced by the ICF Employee Benefits Cost Allocation Model, 1979-1980, using the quarterly model of the U.S. economy developed by Data Resources, Inc. (DRI).

- Mitchell, Bridger M. and Charles E. Phelps. "National Health Insurance: Some Costs and Effects of Mandated Employee Coverage," Journal of Political Economy, Vol. 84, No. 3 (1976), pp. 553-571.

This paper estimates that the consequences of mandating employers to provide insurance for their employees and dependents would cause a short-run increase in the unemployment rate of 0.3 percentage points for a low-coverage plan and an increase of 1.4 percentage points for a high cost plan. Most likely, employers would accomplish the change in the employment pattern by reducing the rate of new hiring and postponing the replacement of employees who quit. Essentially there would be no long term effects on employment, except for workers at or near the minimum wage.

The sectors with relatively large unemployment effects are agriculture, construction, wholesale and retail trade, and services. If payroll taxes were used instead of an employer mandate, similar but less pronounced employment effects would result. In addition, the authors predict that for a high coverage plan, the average increase in mandated premiums would be 2.9 percent of wages, which would be recouped in 4 to 5 months of no nominal wage increases if inflation and productivity increase at a combined 8 percent annual rate.

The data for this paper are 1975 projections of data from the 1970 Health Care Survey.

H.C. University

MEMORANDUM

TO: Steve Edelstein, Jeff Eller, Judy Feder, Christine Heenan, Jerry Klepner, Ira Magaziner, Lynn Margario, Karen Pollitz, Steve Ricchetti, Melanne Verveer

July 12, 1993

FR: Chris Jennings

RE: Thursday's 3:30-5:30 Planning Meeting for Congressional Health Care Policy Briefings (Formerly Known as the Health Care University) in the First Lady's Office--Room 100 OEOB.

As you all know, the Congressional Leadership -- in particular, Majority Leader Gephardt, Majority Leader Mitchell, and Senator Daschle have suggested and are enthused about the establishment of a health care briefing process for the Members. They believe it will serve the important purpose of educating the Members about the many problems with the health care system, the policy the President is coming up with to address the problems, and the rationale behind the various proposals.

The First Lady believes the health care briefings have great potential and has asked that we immediately move to set up the mechanism to be responsive to the Congressional Leadership's idea. As the attached agenda for the meeting helps illustrate, much has to be done in order to establish a workable briefing process.

In order to be responsive to Mrs. Clinton's desire that we be well on our way to finalizing the groundwork for the briefings by the time she returns, we have set aside a two hour block (3:30 to 5:30) for a Thursday meeting on this subject. In addition to the agenda, we are attaching the latest draft of the memo that was written, in conjunction with Jerry Klepner's shop at the Department, to give broad suggestions as to how to best implement the briefing process.

If there is anyone else you believe should attend this meeting, please contact me. Look forward to seeing you on Thursday. Thanks.

Meeting on "Health Care University"
July 15, 1993 -- 3:30-5:30 p.m.

AGENDA

- **New Name for HCU**

- **Topics for Briefings**

- **Speakers**
  - External Experts
  - Process for Selection
  - Names

- **Briefing Materials**
  - Type of Materials
    - Handouts
    - Charts and graphs
  - Who prepares
    - Speakers
    - Health Care Staff
    - Role of DPC/Democratic Caucus
  - Time Line for Production

- **Sessions**
    - Administration Briefings
    - Congressional Briefings

- **Scheduling**
  - Set Dates
  - Scheduling through DPC/ Dem. Caucus
  - Cabinet Affairs

- **Follow-up Meetings on set up of "University**
  - Schedule
  - Participants

H.C. University

HEALTH CARE UNIVERSITY CONCEPT/IMPLEMENTATION PROPOSAL

Majority Leader Gephardt, Majority Leader Mitchell, and Senator Daschle have repeatedly raised concerns about the limited education level of Members as it relates to health care. Senator Daschle and Congressman Gephardt have promoted the establishment of a kind of "health care university" for Members of Congress. They believe the "classes" should be **open to Members of both parties.** The First Lady believes that the Leadership's suggestion is excellent and should be implemented as soon as practical and advisable.

Mrs. Clinton has asked that the following proposal for a series of health care briefings (she would prefer to use a title other than Health Care University) by Administration health policy and legislative affairs representatives be given to and reviewed by the Congressional Leadership and their staffs. **Before proceeding with the outline, however, we wish to stress that the Administration believes these important presentations should be viewed as a supplement to, and not a substitute for, the consultations that have and will continue to take place with the Congressional Leadership.**

We believe that the establishment of a health care university-like entity (from now on referred to -- at least temporarily -- as **health care briefings)** has great potential. If done well, it the process should:

(1) Reinvigorate the "need for action" mentality that, until very recently, had been effectively fanning the flames of desire for comprehensive health reform in the Congress;

(2) Ease Congressional concerns about, and raise Member comfort levels with, the President's proposal to address the problems;

(3) Better enable prospective Congressional supporters to explain, defend, and sell the President's proposal; and

(4) Be utilized to help educate surrogates in home Congressional districts.

Achieving success in briefing Administration, Congressional, and other influential individuals will depend on the ability of the health care briefings to: (1) communicate our message in a simple, understandable way; (2) utilize staff resources most effectively; and (3) be responsive to the information needs and time constraints of those we will rely on to support the President's health reform initiative. To develop and implement an effective educational briefing process we will have to successfully:

- **Target the Issues**
- **Target the Best Personnel to Make Presentations**
- **Establish a Staff/Intake and Scheduling Process**
- **Prepare the Briefing Materials and Presentations**
- **Brief and Train the Briefers**
- **Develop a Workable Timetable**

TARGET THE ISSUES

The briefings should convey a simple, concise message and be responsive to what we know to be **the major thematic priorities and interests of the majority of the Congress.** As a first cut, we propose limiting the briefings to no more than 10 broad-based issues:

(1) **An Overview of the Plan, its Design and its Philosophy;**

(2) **Consumers in the New System;**

(3) **Cost Containment and Budgets;**

(4) **Savings, Costs and Financing;**

(5) **Small and Large Businesses in the New System;**

(6) **Health Care Providers in the New System;**

(7) **Federal/State Roles;**

(8) **The Elderly in the New System;**

(9) **Rural Communities and the New System; and**

(10) **Urban Communities, Underserved, and the New System.**

Issues such as Medicare, Medicaid, Veterans, Federal Employees Health Benefits, medical malpractice, anti-trust, quality, public health, benefits, etc. would be incorporated into the above mentioned categories. Special and more detailed briefings on these and the whole range of other issues would be provided to Administration representatives, Congressional Members and staff on an as-needed and requested basis.

TARGET THE BEST PERSONNEL TO MAKE PRESENTATIONS

Briefing Members of Congress always has the potential for great benefits, as well as great risks. The key is for Members to leave the presentations both impressed with the substance of the information given and the competence (and likability) of the presenters.

Included in the definition of a competent Congressional briefer is knowing -- going in -- what are the historic sensitivities of the Members present, in other words, to know what to say and how to say it and to know what not to say. If the personnel chosen meet these criteria, the benefits of these briefings are almost boundless. If, on the other hand, Members leave presentations with a sense that briefers are either incompetent, arrogant, condescending, and/or disrespectful, an effort with the best of intentions could well turn out to be a total disaster. All of this is to say that the personnel chosen for Congressional briefings is critically important.

Policy Expert Resources

Within the White House health care working groups and the Departments (in particular, HHS), the Administration has an impressive array of health care policy experts who could serve in briefing roles extremely well. (In most cases, Ira and Judy -- in particular -- have been, and likely will continue to be, very well received.) Having said this, the other briefers that we will need must be evaluated carefully -- keeping in mind not only how competent they are, but how well they will be received by different collections of Members. (We have prepared a tentative staff resource list linked to the ten topics previously mentioned, but it is undergoing final review by the White House and HHS; in any event, it will be a continually updated list based on the briefers' performance and Congressional reception.)

Legislative/Policy Resources

We strongly advise that those most familiar with the Congress and their predilections -- the Administration's Legislative Affairs staff -- play a major role in briefing the Members and the staff on this issue. The White House and Departmental Legislative Affairs staff (particularly at HHS) have strong and long-standing relationships with the Members and staff that should be utilized to the benefit of the Administration's health reform effort.

At every briefing, there should be one Legislative Affairs Administration representative who has equal status to the policy presenter. This is absolutely necessary to best assure that no situation gets out of hand, that there is a politically sensitive individual always present, that there are careful notes of the meeting, and that responsive follow-up occurs.

ESTABLISH A STAFF AND SCHEDULING PROCESS

The scheduling of the university and other requested briefings should be coordinated out of the War Room. This work should be closely coordinated with the Department of Health and Human Services' Office of the Assistant Secretary for Legislation (ASL and other Departments as necessary). In addition, we should work closely with the House Democratic Caucus and the Senate Democratic Policy Committee to help coordinate topics, schedules, and rooms. The schedule of all briefings should be updated daily, provided to Steve Ricchetti/Chris J./Jerry K./Karen P., and announced at the morning Communications meeting.

To ensure that the briefing operation is a success requires an experienced and politically sensitive staff person who can work closely with the Congressional Leadership and Administration personnel in meeting the scheduling and substantive needs of the Members. We propose that Steve Edelstein take on this role (in addition to his other responsibilities) and work with Lori Davis and other staff at HHS to assist him. Depending on the volume of and desire for briefings, additional staff (perhaps a full-time intern who is mature and responsible) may be required.

PREPARE THE BRIEFING MATERIALS AND PRESENTATIONS

In order to ensure the delivery of a consistent, simple, understandable message, we need to prepare educational materials for the presenters in advance of the briefings that all staff can and should use. Educational materials should include charts, graphs, detailed outlines to guide presentations, questions and answers as appropriate. These materials and presentations should be user friendly and targeted to specific audiences.

Working with the initial approval of Ira and Judy, as well as the Legislative Affairs staff, Steve E. will assign one policy expert to each of the issues chosen for briefings to take the lead in preparing the substance of the briefing materials and their presentation. He will make certain that each presentation is finalized on time and in the best format possible. The Communications staff will review and edit the briefing materials for clarity, directness, and consistency of message.

The presentations will also be screened by Legislative Affairs staff to ensure that they meet the needs of the audience. (They will know who is attending because we propose to limit the size of each briefing to between 25-35 Members and have them signed up in advance of the briefing; we believe that such a small structure will best assure a less lecture-like atmosphere and better encourage a give and take constructive discussion.)

Each "class" will be structured to briefly outline the problem(s) with the current system, how the President's proposal addresses the problem(s) (if relatively non-controversial), and the rationale behind the Administration's proposal. The briefings will be designed to last no longer than 60 minutes: 20-30 minutes (at most) of presentation and 30-40 minutes for questions and answers. On an as needed basis, these classes will be repeated.

Substantive and detailed presentations about the most controversial policy recommendations -- if they are even available -- of the President's proposal should be avoided. There is great concern among the Congressional Leadership that controversial recommendations -- such as financing, exact cost containment mechanisms, etc. -- could lead to public and potentially problematic disclosure. Instead, the Majority Leaders have suggested that we detail the **options** we are considering to address the most challenging issues.

BRIEF AND TRAIN THE BRIEFERS

Communications staff will be needed to provide guidance to all briefers on how to orally deliver their presentations in an easily understandable manner. In addition, before each presentation, the Legislative Affairs staff from either the White House or the appropriate Department (usually Jerry Klepner's shop) will brief the presenters on who will be in the audience, what issues are particularly sensitive, what issues to highlight, and how best to present complex, potentially controversial materials.

DEVELOP A WORKABLE TIMETABLE

We need to make a final decision as to when it would be most appropriate and useful to commence the health care seminars. Senator Daschle originally envisioned the "classes" beginning after the legislation had been introduced. Majority Leader Gephardt believes it is advisable to hold a series of briefings in one or two days of presentations in an attempt to hold a dry run -- presenting options not final decisions -- in an effort to begin to work out the kinks and determine what briefing format will work the best in September. We need to discuss the best start-up time with the Leadership.

Lastly, Congressman Gephardt has initiated an invitation for the First Lady to speak before the House Democratic Caucus soon after she returns from her July trip (roughly the 21st). The goal for this presentation is for Mrs. Clinton to reinvigorate the Members into feeling that health care reform is a political and economic imperative.

If the President is going to unveil his package by not later than late September, the implementation of the start-up recommendations for the health care briefings must occur almost immediately. The following outlines a possible workplan timeline to help with tentative scheduling.

WORKPLAN TIMELINE

Activity	6/27 7/5	7/12 7/19 7/26	8/2- 8/30	9/6 9/13 9/20 9/27
Target Issues	¦-------¦			
Target Personnel	¦----------¦			
Finalize Staffing	¦-------¦			
Prepare Briefing Materials	¦----------¦			
Brief the Briefers		¦----------¦	(on how best to communicate/ legislative prep)	¦----------¦ (communication and leg. prep continues)
Hone the Message			¦----------¦	
HRC CAUCUS PRESENTATION		¦---------¦		
CONGRESSIONAL BRIEFINGS			¦---¦ Dry run 1st briefing before recess	¦----------¦ RETURN TO briefings and continue them even after introduction on a bipartisan basis.

Small Bus

Rough Draft

As I meet with SBA folks + small business groups over the next 2 weeks this can evolve and hopefully improve. mky

July 8

TO: Chris Jennings

FROM: Marilyn Yager

RE: Small Business Strategy

Having read through the material you provided, I found that your memo from last October is still amazingly current. I would guess that only one item has really changed: nervousness about being rolled. As the momentum has changed, and the dynamics of reconciliation play out, I believe the small business organizations are feeling more and more confident that total opposition to our reform proposal is a politically acceptable strategy.

We have already seen this with NFIB, it is very likley with the Chamber of Commerce, and unless we are able to stop the pulling back by Small Business United and the Small Business Legislative Council they will feel compelled to oppose as well.

Otherwise I would reemphasize a strategy largely outlined by you last Fall:

1). Addressing current and future affordability issues. We need to believe that our changes will be affordable to the average small business, and we need to aggressively make that argument. Everything else will just be frosting.

A. Our data needs to be believable.

B. Our rhetoric needs to be convincing.

2). The frosting: the other sellable parts of the package need to be aggressively marketed.

A. Outlaw insurance abuse.

B. Rolling workman's comp into the plan.

C. Administrative simplification.

D. Stabilize premium costs.

E. Employees will financial costs.

F. Medicaid and federal emloyees will be included.

3). At every turn we need to stress that we will not leave businesses financially stressed as a result of these changes out are their own: the rainy day fund provide assistance.

4). As with large business, we will probably need to bypass small business organizations and go directly to the small business owners for support.

5). We will need credible spokespeople for the plan:

A. Sec. Bentsen and Erskine Bowles need to be prepared to be on the stump all during the fall.

B. Possibly establish a small business team (supportive small business owners) in each state to talk to chamber of commerce meetings and local newspapers. This topic will be addressed at every single chamber commerce meeting following our introduction of the plan.

C. Give every member of congress a clear understanding of the pros of the clinton plan for small businesses: talking points and whatever else is necessary to give them cover. Target the traditional friends of small business: small business committee members.

6). We will need to speak at every small business conference held by members of congress.

7). Despite likely opposition from the larger small business groups, we should not by-pass speaking opportunities at large gatherings.

8). Throughout August, work closely with the smaller small business groups. If they are unable to fully support the plan, we should seek support for sections of the plan, otherwise neutrality.

9). Keep reminding small businesses the price of doing nothing and place the onus on those opposing our plan to do better.

10). Hold a series of small business town hall meetings to explain and respond. Hopefully televised.

1st Draft

SMALL BUSINESS AND HEALTH CARE REFORM

As the National Restaurant Association stated in their March 18 testimony "true cost containment will come from an interrelated series of changes, including, but not limited to: managed competition, insurance reforms, tax incentives, advanced technologies, and medical malpractice reforms." We agree.

The Clinton Administration believes that most small business want to provide health benefits -- and most do. **The barrier is cost and a burdensome administrative framework.** Our health care plan will work for small business, ensuring the security of affordable, predictable health care coverage, and taking away the hassle.

For businesses currently **unable** to provide insurance coverage, our reform will protect them while they make the transition. These small businesses are clearly at an enormous disadvantage in trying to attract and compete for workers with larger businesses that can afford a health care plan for their employees. While we phase-in coverage for these businesses and extend financial assistance for the changes necessary, health care costs will be curtailed and their ability to compete for workers throughout the marketplace will vastly improve.

In weighing the risks of supporting change, we must constantly remember **where we are headed without health care reform.** Small businesses that are able to still offer health insurance have seen their costs rise at an annual rate of 20% to 50% per year. On average small businesses pay 30% more for the same insurance compared to their big businesses counterparts. Small businesses' rate of growth in the cost of their insurance has increased at a 50% higher rate annually than that of big business. Unfortunately, the smaller the company, the more disproportionate is the cost of their insurance.

Small business sensitivity to price and premium changes, as well as economic conditions, result in rollar coaster cash flow struggles. They bear the burden of cost shifting from both government payers and the clout of the self-insured plans. Their administrative and marketing costs are disproportionately higher, and all this without full-time benefit staff. Periods of satisfaction with insurance policies can be shattered when they or their employees develope costly illnesses, adding new risk to either the cost or renewal of their policies.

Small business has tried almost everything it can to control the skyrocketing cost of health insurance. They have tried changing programs, managed care, self-insurance, and cost sharing. They have tried lowering benefits and asking their employees to bear a bigger share of the cost.

So, is the risk for change worth it? As Yogi Beara once said, "if you don't watch out where you are going, you are going to end up where you are headed."

The Clinton reform plan;

- Aggressively controls costs: through marketplace competition, global budgets, elimination of cost-shifting, regulatory and administrative reductions, and medical malpractice reforms.

- Outlaws insurance abuse such as redlining, underwriting, and experience ratings.

- Premium costs will be curtailed and stabilized.

- Eliminates the duplicative costs and paperwork of workers compensation by rolling it into the health plan.

- Cuts administrative burdens, as the health alliances assume the paperwork and negotiations.

- The workplace mandate assumes a shared responsibility by employer and employee on cost and healthy lifestyles.

- Reduces the differences between the public and private marktetplace by including Medicaid and public employees in the reform plan, and phasing in Medicare over the long term.

Helping small businesses make the change:

- The required health care coverage would be phased in over a significant period of time while health care costs are curtailed.

- The benefit package would be basic, with emphasis on prevention; not a 'cadillac' package.

- A rainy day fund would be established, similar to the one currently in place in Hawaii, thereby providing assistance to small employers who demonstrate real need.