



Economic Effects of the Proposal

Any fundamental reform of the health care system could have profound effects on the structure of the U.S. economy, and the Administration's proposal is no exception.

Supporters of the Administration's approach argue that it would improve the efficiency of labor markets by reducing insurance-related job lock and the work disincentives Medicaid beneficiaries face. They claim that it would also improve the allocation of resources in the economy by increasing the efficiency of the health sector and strengthen the competitive position of U.S. producers, particularly those with large health burdens for retired workers. Critics of the proposal have argued that it would raise business costs, devastate small enterprises, put some low-wage workers out of their jobs, encourage many workers to leave the labor force, and adversely affect the competitive position of U.S. industry.

This chapter examines the probable impact of the Administration's proposal on important aspects of the economy--business costs, employment, labor markets, and international competitiveness. The complexity of the proposal and of the current U.S. health insurance system makes analyzing these topics especially difficult, and few conclusions can be reached with great precision.

Several conclusions can, however, be drawn with relative confidence. First, the proposal would increase the cash wages of U.S. workers (see Chapter 2). Second, the proposal would without doubt involve a substantial redistribution of costs within the economy, and thus would have important consequences for individual workers and firms. Third, some low-wage workers would lose their jobs be-

cause their employers would have to pay for insurance, but this group is likely to be quite small; some others may gain jobs in community-based care for the disabled. Finally, more workers would voluntarily leave employment in response to new incentives created by the proposal, and some workers would enter employment for this reason.

Although the complexity of the proposal makes quantitative inferences imprecise, the Congressional Budget Office estimates that the plan might reduce the number of people in the labor force by one-quarter of a percent to 1 percent, though it would alter the unemployment rate little. Perhaps more important than its effect on the overall labor supply, the proposal is likely to affect the current pattern of where people work.

The Administration's proposal would affect labor markets both by eliminating or reducing existing distortions in these markets and by introducing new ones. Among the distortions that would be reduced are the tendency of the current system to lock people into certain jobs or into welfare because they fear the loss of insurance. It would also end the advantages big firms have in purchasing health insurance. These are important gains. But the proposal would also introduce some distortions of its own: it would encourage early retirement; it would in some cases reduce the attraction of having more than one adult in each family work; it would increase the cost of hiring most minimum-wage workers; and it would encourage the grouping of workers in firms on income lines that may not be efficient.

On balance, the new distortions in the labor markets could outweigh the ones eliminated; should that happen, the productive potential of the econ-

omy would go down, and fewer people would be engaged in market activities that produce income. But the potential loss of market income would overstate any loss to the economy. People who leave work would be doing so from choice and would be able to do things they could not do while working. Although the value of this leisure is certainly not zero, it is not counted in gross domestic product.

A full accounting of the proposal's effect on the economy would have to include its possible impact on the efficiency of the health care system. Few analysts doubt that the current health care system wastes resources (see Box 4-1). The proposal hopes to reduce many of these inefficiencies. The Admin-

istration aims to cut administrative costs, foster the growth of health maintenance organizations and other types of plans that might be able to reduce costs below those of fee-for-service providers, and make it easier for consumers to pick more cost-effective health plans. For the most part, this report does not address these questions of the efficiency of the health sector.

Finally, any proposal to reform the current health care system would introduce its own distortions while eliminating others. Evaluation of the Administration's proposal should, therefore, be based on how its costs and benefits compare with those of the alternatives--including current policy.

Box 4-1.

Inefficiencies in the Current Health Care System

For many economists and policymakers, the large proportion of national income going to the health sector--some 14 percent of gross domestic product in 1993--is cause for considerable concern. Behind this concern is a belief that health care markets as currently structured are not efficient and are prone to excessive and unnecessary spending.¹ A successful restructuring of the health care system would correct some of these inefficiencies.

Several factors now hinder the efficient operation of the health sector. First, consumers lack key information about the quality and price of medical services. Treatment costs are difficult to obtain in advance, and comparison shopping can be costly and impractical for sick people. Patients delegate a considerable amount of decisionmaking to their doctors, who are trained to provide the best possible care rather than the most cost-effective care.

Second, the widespread prevalence of health insurance (and other third-party payers) insulates consumers from the full cost of medical care when they are sick. Moreover, health insurance is tax deductible when employers offer it as a fringe benefit, which reduces the incentive for workers to select less expensive policies. Because employers pick up

most of the bill, most employees have little idea how much their insurance truly costs.

Because of these shortcomings, health care markets are not truly competitive. Providers generally do not compete as aggressively over price as in other sectors of the economy. Instead, their competition focuses on the nonprice aspects of medical care. For example, hospitals try to attract patients by offering the best and latest medical technologies or the most comfortable surroundings--not the lowest price. At the same time, consumers lack sufficient bargaining clout to offset the tendency of the system to spend too much. The payment system is relatively fragmented, and providers are able to shift costs from large organized payers (like government) to private payers with little countervailing power.

Perhaps most important, technological change is very rapid in the health care sector, but market constraints that might ensure that new technologies are used in cost-efficient ways may not operate effectively. As long as health insurance pays for new technologies, the private sector is encouraged to develop any innovation, regardless of cost, that is likely to improve the quality of care. Other countries strictly control the supply of new technology to the health sector. But there is no effective mechanism in the current U.S. system--neither a market nor a government regulatory plan--to ensure that the costs of new technologies will be kept in line with their benefits.

1. Congressional Budget Office, *Economic Implications of Rising Health Care Costs* (October 1992).

Key Aspects of the Proposal That Would Affect the Economy

The Administration's proposal contains literally hundreds of provisions that would make fundamental changes in the delivery and financing of the nation's health care. Nevertheless, the most important economic effects can be traced to just a few features.

Universal Coverage

The Administration's proposal would entitle all citizens and certain other people residing in the United States to a standard package of health insurance benefits. Unlike the current system, benefits would no longer depend on whether or where a person worked.

Community Rating

Insurance premiums could not vary with age or health status. The new system would therefore incorporate the cost and spread the burden for people who present the greatest health risks.

Controls on Health Insurance Premiums

The Administration's proposal would limit the growth of health spending by fostering competition and capping premium costs.

Employers' Responsibilities

Employers would be required to pay a significant share of the health insurance premiums for virtually all of their employees. Health benefits would no longer be a flexible component of employee compensation but rather would become an inflexible levy on employing workers.

Subsidies to Employers

A firm in a regional alliance would not have to pay more than 7.9 percent of its wage and salary payroll for its share of health insurance; instead, the government would pay for premiums for the standard insurance package above that amount. Lower limits would apply to firms with 75 or fewer employees and low average wages.

Subsidies to Early Retirees

The government would subsidize the average premium for early retirees. This would reduce the incentive to continue to work, thus changing the size of the work force.

The Effects on Health Spending by Business

The Administration's proposal would maintain the central role of employers in financing health care in the United States, but would significantly alter the distribution of costs among businesses and workers. After 1996, the proposal would most likely reduce the total spending of business on health care. Of course, businesses would be asked to pay directly for insurance for those workers who are currently uninsured, and the Administration's proposed insurance package is more generous than many firms currently offer. Employers who formed corporate alliances would pay an additional 1 percent payroll tax. But although these factors would tend to increase businesses' costs, they would be more than offset after 1996 by the limits on premium growth and the subsidies from the government.

Big Cost Reductions Overall for Business

When all these factors are taken into account, the total cost that all businesses together would pay for health insurance for active workers would be about \$20 billion less in the year 2000 if the proposal were implemented than if the current system were

to continue unchanged.¹ The estimated reduction in the cost for active workers from the proposal would be even larger in subsequent years, reaching slightly above \$90 billion in 2004.

Businesses would also benefit from a large reduction in costs for workers taking early retirement. This reduction would amount to more than \$15 billion in the year 2004, and more thereafter.

Diverse Effects Among Individual Firms

Even though the plan would quite dramatically reduce the overall cost of health insurance for business, it would have widely differing effects on individual firms and industries, in some cases causing costs to rise and in others reducing them. Three factors account for most of the diversity.

Requiring All Employers to Pay. The requirement on all employers to contribute would raise spending by firms that do not currently offer insurance--or that offer a less generous insurance package--to their workers. These firms are disproportionately small--in 1989, over 94 percent of firms with 25 or more employees offered health insurance, but only 39 percent of firms with fewer than 25 employees did so.²

Community Rating. Currently, the cost of health insurance varies tremendously among firms, depending on the size of the firm and the age and health status of its workers. Under the Administration's proposal, insurance premiums would be community rated, which would greatly reduce this variation in health spending. For example, community rating would increase the costs of firms that employ younger and healthier workers and those in low-risk jobs, and decrease the costs of firms employing

older and sicker workers and those in risky jobs. Further, community rating would benefit smaller firms that typically pay much higher premiums than larger firms. This leveling of costs could benefit all small businesses--not just those that provide insurance today. With access to more affordable insurance, small businesses would be better able to attract workers who now demand health insurance as a condition of employment.

Estimating the effect of these two factors--community rating and requiring all firms to pay--on various industries is beyond the scope of this study, but estimates prepared by Henry Aaron and Barry Bosworth at the Brookings Institution provide a rough guide (see Table 4-1).³ These calculations do not capture some key aspects of the Administration's proposal. For example, they do not include the effects of subsidies to firms, nor do they allow for variations in the premiums among regional alliances that would occur under the proposal. Most important, they do not include the cost savings that controls on premiums would bring about.

Nevertheless, Aaron and Bosworth's estimates suggest that community rating and requiring firms to pay would cause an enormous redistribution of resources among workers in different industries. The redistribution would be even greater among subsectors of industries and individual firms not shown in the table. For example, Aaron and Bosworth's detailed estimates suggest that these two factors would decrease the annual cost of health insurance by almost \$6,000 per worker in the coal mining industry--but increase it by \$1,300 in the retail sector.

These redistributions are not unique to the Administration's proposal. Most proposals to reform the nation's health care system involve some community rating, and some also require all employers to pay. Those proposals would also redistribute large amounts of resources among firms and workers.

Subsidies to Firms. The subsidies to employers in the Administration's proposal would also affect how

1. The Administration also predicts that the plan would reduce business spending, compared with current policy, by similar amounts. By contrast, another analysis, by the consulting firm Lewin-VHI, estimated that the proposal would increase business spending by about \$16 billion in 2000. See Lewin-VHI, *The Financial Impact of the Health Security Act* (Fairfax, Va.: Lewin-VHI, December 1993).

2. Congressional Budget Office, *Rising Health Care Costs: Causes, Implications, and Strategies* (April 1991).

3. The premiums under community rating in Table 4-1 are not identical among industries because each industry pays a different amount for retirees.

Table 4-1.
Effects of Community Rating and Requiring Firms to Pay
on the Health Insurance Costs of Private Employers, by Industry, 1992

Industry	Employer Contributions for Health Insurance				
	Current Costs		Costs with Community Rating and All Firms Paying (Dollars per worker) ^{a, b}	Difference	
	Dollars per Worker ^a	Percentage of Wages		Dollars per Worker ^{a, b}	Percentage of Wages
Agriculture, Forestry, and Fishing	394	2.5	2,041	1,647	10.3
Mining	4,776	11.4	3,048	-1,728	-4.1
Construction	1,572	5.4	2,373	800	2.7
Manufacturing	3,466	10.7	2,416	-1,050	-3.2
Durable goods	3,801	11.2	2,452	-1,349	-4.0
Nondurable goods	3,017	10.0	2,367	-649	-2.2
Transportation	2,221	7.1	2,412	191	0.6
Communications	6,572	15.6	3,070	-3,502	-8.3
Electric, Gas, and Sanitary Services	4,871	11.3	2,804	-2,067	-4.8
Wholesale Trade	2,426	7.1	2,177	-249	-0.7
Retail Trade	788	4.5	2,090	1,303	7.5
Finance, Insurance, and Real Estate	2,123	5.9	2,190	67	0.2
Services	1,480	5.5	2,177	697	2.6
Private Households	0	0	2,041	2,041	16.5
All Industries	2,017	7.2	2,253	236	0.8

SOURCE: Congressional Budget Office based on Henry Aaron and Barry Bosworth, "Economic Issues in the Reform of Health Care Financing," *Brookings Papers on Economic Activity* (forthcoming).

a. Based on full-time-equivalent workers.

b. Includes a 13 percent increase in average costs to cover uninsured workers and assumes uniform costs for nonretirees (community rating). Does not reflect the effects of the cost controls in the Administration's proposal. Retiree health costs account for the variation among industries.

insurance costs are distributed among companies. Other things being equal, firms with low wages would be more likely to be subsidized. Many small firms would also face lower caps (and receive larger subsidies per person) than large firms. Finally, firms located in regions of the country with high medical costs might receive higher subsidies because their premiums would be higher. Yet some regions with high medical costs also pay higher wages, so it is difficult to infer the regional impact of the Administration's proposal without more information about how the boundaries of the alliances would be drawn.

Who Bears the Burden of Health Spending by Business?

Although businesses initially pay a large portion of the bill for health insurance, people ultimately bear these costs. Workers may pay them in the form of lower wages, consumers in the form of higher prices, and shareholders through lower returns on their investments. But for the most part, the nation's workers shoulder the cost of employers' premiums for health insurance. Thus, the signifi-

cant savings that the Administration's proposal would produce compared with current policy would be largely passed on to workers in the form of higher wages.

Why Workers Pay for Health Costs

The primary reason that workers as a group bear the cost of employers' health premiums--and would realize the savings under the Administration's proposal--is that the supply of labor is relatively insensitive to changes in take-home wages. Recent empirical studies suggest that the total hours supplied by U.S. workers would decline only 0.1 percent to 0.2 percent for each 1 percent reduction in their take-home wage.⁴ Because most workers continue to work even if their take-home pay declines, businesses have little trouble shifting most of the cost of health insurance to workers' real wages. Similarly, workers gain the lion's share of any reductions in employers' health costs.

Two recent studies of mandated benefits mirror this view.⁵ In one study, firms shifted 85 percent of the cost of mandated "workers' compensation" accident insurance to workers in the form of lower real wages; another study found that virtually all of the cost of federal and state mandates for childbirth coverage was passed into lower real wages.⁶

Of course, because labor supply is not completely insensitive to changes in wage rates, share-

holders would bear some of the changes in health insurance costs in the short run. But they would probably bear virtually none of these costs in the long run. The United States operates in a world economy and, if businesses attempted to shift such costs to capital, shareholders would move their investments to other countries that offered them higher returns.

Shareholders, however, would benefit from reductions in the cost of retirees' health insurance. The Administration's proposal would reduce costs for companies that currently have large retiree health obligations. The government would take over a significant portion of companies' responsibility for health insurance for early retirees and drugs for older retirees. The companies' workers and their unions would probably fight for a portion of that windfall, and the gain would therefore be split among shareholders, workers, and retirees.

How Savings Might Be Distributed

Although the wages of workers (as a group) would increase to reflect reductions in the cost of health insurance for current employees under the Administration's proposal, the benefits would not be spread evenly among individual workers for at least two reasons.⁷ First, by evening out the costs of insurance, community rating would raise the costs of employing some individuals relative to current policy, but reduce them for others. Second, individual firms could respond differently to these changes in costs. Some might change the nominal wages of their workers; others might adjust their prices.

For the economy as a whole, lower prices for some products would largely be offset by higher prices for others.⁸ But because individuals purchase

4. Congressional Budget Office, "Taxes and Labor Supply," CBO Memorandum (forthcoming); Mark Killingsworth, *Labor Supply* (Cambridge, England: Cambridge University Press, 1983); and James Heckman, "What Has Been Learned About Labor Supply in the Past Twenty Years?" *American Economic Review*, vol. 83, no. 2 (May 1993), pp. 116-121.

5. Jonathan Gruber and Alan B. Krueger, "The Incidence of Mandated Employer-Provided Insurance: Lessons from Workers' Compensation Insurance," *Tax Policy and the Economy* (1991); and Jonathan Gruber, "The Incidence of Mandated Maternity Benefits," *American Economic Review* (forthcoming).

6. Lawrence H. Summers, "Some Simple Economics of Mandated Benefits," *American Economic Review*, vol. 79, no. 2 (May 1989), pp. 177-183. The Administration's proposal would probably have a smaller effect on real wages--and a larger effect on employment--than implied by these studies. Unlike a pure employer mandate, the Administration's proposal would entitle everyone to insurance whether they worked or not and would finance the proposal through a compulsory payment.

7. Henry Aaron and Barry Bosworth, "Economic Issues in the Reform of Health Care Financing," *Brookings Papers on Economic Activity* (forthcoming).

8. Because the Administration's proposal would cause the labor force and output of the economy to fall slightly, the overall price level could rise somewhat in the long run compared with current policy. The effect on output and prices would be somewhat larger in the short run because firms that would face cost increases might not be able to reduce the nominal wages of their workers. Over time, these firm would be able to bring nominal wages back in line by simply not compensating their workers for general inflation. Finally, this discussion excludes any possible actions by the Federal Reserve.

different bundles of goods and services, individual workers and consumers could experience significantly different effects.

In some respects, the Administration's proposal would reduce the likelihood that firms with cost increases would raise prices. Community rating virtually assures that competing firms would face very different changes in their insurance costs. Unless most competitors in an industry faced similar changes in their costs, it would be difficult for any single firm to raise its prices much without losing market share.

What Would Happen to the Labor Force and Unemployment?

The Administration's health proposal would sharply change the terms of the employment bargain for many workers, reducing some distortions implicit in the current system and imposing others. Overall, the proposal would probably impose greater employment-related distortions than it removed. The supply of labor would probably fall slightly, somewhat reducing the productive capacity of the economy, but unemployment would be little changed.

In summary, the proposal would:

- o Encourage workers nearing retirement age to retire early, by subsidizing their health insurance in early retirement;
- o Reduce the value of working for people who receive insurance through their spouses and currently work at firms without insurance;
- o Reduce the current incentive for recipients of Aid to Families with Dependent Children to remain on the welfare rolls and out of work in order to maintain their Medicaid benefits; and
- o Raise the cost of hiring some adult workers who earn close to the minimum wage, thus slightly reducing their employment.

These direct effects of the plan--which would result on balance in a reduction in labor supply--would in turn produce a partially offsetting change. Competition among employers for the reduced labor supply would slightly raise real wage rates. But the effect of a rise in wages would not completely offset the direct effects of the proposal.

Increase Early Retirement

Three features of the Administration's proposal would create significant incentives for workers between 55 and 64 years old to take early retirement. First, because the proposal would guarantee universal coverage and premiums would not vary with health or employment status, early retirees need not fear becoming uninsured. Thus, older people would no longer have to work simply because they need access to affordable health insurance. Most analysts would regard this as a clear improvement over the current situation, even though it would reduce the supply of labor.

Second, the proposal goes further and would subsidize health insurance for retired people between the ages of 55 and 64. However, people in this age group who worked full-time (or whose spouses worked full time) would not receive this benefit. The subsidies would sharply reduce costs for those firms that currently offer health insurance to early retirees, and might induce them to sweeten the other components of their retirement package.⁹ Aside from any consideration of fairness, this provision would clearly reduce the incentive to work.

Finally, community rating among age groups means that early retirees would face premiums that, even before considering subsidies, would be no higher than those paid by younger people. Because older people currently pay much higher premiums than young people, community rating would significantly reduce the savings that workers would need to accumulate for retirement, and some might find they could retire earlier.

9. Roughly half of the savings for these firms in 1998 through 2000 would be recaptured by the government. The proposal includes no provisions to recapture savings from firms after 2000.

The Administration estimates that the health proposal could increase the number of retired workers ages 55 to 64 by 350,000 to 600,000. CBO's analysis also suggests effects in about this range, although probably closer to the upper end or slightly above. These estimates are roughly consistent with the results of a recent study by Brigitte Madrian of Harvard University.¹⁰

Impose an Implicit Levy on Work

The Administration's proposal would bring about a major change in the nature of health care costs: for many workers, the cost would operate like a new levy on work. However, most people's decisions about whether to work or not are not particularly sensitive to changes in their take-home wages or salaries. Consequently, the effect of the proposal on the total labor force would be relatively small and limited largely to second workers in households in which one person already works.

The proposal would create an implicit levy on work because it would make health coverage universal without charging many nonworkers for the full cost of their insurance. In other words, coverage under the proposal would not depend on whether one worked and paid the premium or stayed at home and, often, paid much less. The premium would simply reduce take-home pay without, from the point of view of the individual worker, buying anything.

By contrast, under the current system, employers provide health insurance to many of their

workers as part of an implicit or explicit bargain, which ensures that the cost of health insurance does not stray too far from what most workers feel it is worth.¹¹ Thus, health insurance is a component of compensation that substitutes for cash wages and, therefore, has little effect on an individual's decisions about whether and how much to work.

That bargain is not perfect for several reasons. Most important, some married people who work in firms that offer health insurance are or could be covered under a spouse's policy.¹² For these people, the availability of health insurance at work is worth little. But many of these workers are not compensated in other ways for the insurance they do not use.¹³ This situation distorts decisions about whether and where to work; it also partly explains why some married women work in firms that do not offer insurance.¹⁴

The Administration's proposal would extend this distorting effect on decisions about work to everyone. However, the proposal would also reduce premiums for currently insured workers because all workers would have to pay for insurance and because administrative costs are apt to be less—particularly for small firms. On balance, the proposal would probably impose a somewhat larger distortion on decisions about work than exists under the current system.

10. Brigitte Madrian, "Labor Market Effects of Employment-Based Health Insurance" (Ph.D. dissertation, Massachusetts Institute of Technology, Cambridge, 1993), Chapter 2. Other studies suggest much larger responses. See Jonathan Gruber and Brigitte Madrian, "Health Insurance Availability and the Retirement Decision," Working Paper 4469 (National Bureau of Economic Research, Cambridge, Mass., September 1993); and Michael Hurd and Kathleen McGarry, "The Relationship Between Job Characteristics and Retirement," Working Paper 4558 (National Bureau of Economic Research, Cambridge, Mass., December 1993). Although one study found that retirees' health insurance had little effect on retirement, those results cannot be applied to the Administration's proposal; see Alan Gustman and Thomas Steinmeier, "Employer-Provided Health Insurance and Retirement Behavior," Working Paper 4307 (National Bureau of Economic Research, Cambridge, Mass., March 1993).

11. Employer-paid health insurance premiums are not included in a worker's taxable income for either income tax or payroll tax calculations. Thus, health insurance benefits that have a lower value than a given amount of cash wages before taxes may have a higher value after taxes are accounted for. The statement in the text refers to workers' after-tax valuation of insurance benefits.

12. Another reason that the employment bargain is not perfect is that some health care is available to people without insurance. Workers who pay for insurance effectively subsidize these "free riders."

13. At the few firms that offer "cafeteria" plans, workers can substitute wages or other benefits for unneeded health insurance. Similar adjustments may also occur at other firms, but it is hard to know whether this phenomenon is widespread. If such adjustments are widespread, then fewer people would be in the category described in the text.

14. Patricia M. Danzon, "Mandated Employment-Based Health Insurance: Incidence and Efficiency Effects," Working Paper 60 (Center for the Study of the Economy and the State, University of Chicago Chicago, Ill., April 1990).

Would everyone recognize that the proposal imposed a distortion? Perhaps not. Some workers may not recognize the implicit trade-off in the current system between employer-paid health insurance benefits and cash wages.¹⁵ For these workers, the Administration's proposal would not appear to represent such a fundamental change in the employment bargain.

Although the proposal would reduce the incentive to work for many workers, the vast majority would nevertheless remain in the labor market because they need wage and salary income to support themselves or their families. But some people--especially those whose spouse is employed--have more flexibility in their decision to work. These so-called "secondary" workers are more responsive to changes in work incentives because they can rely on their spouse's income. The Administration's proposal would thus reduce the participation of secondary workers in the labor force.

Encourage Medicaid Beneficiaries to Enter the Labor Force

The Administration's proposal would reduce the current incentive for AFDC beneficiaries to remain on welfare. Under current rules, when a welfare beneficiary goes to work and earns income above certain thresholds, the beneficiary may lose both eligibility for cash assistance and Medicaid coverage.¹⁶ Because such workers may not find employment at a firm that offers insurance, they may lose access to affordable health benefits if they work.

The Administration's proposal, by contrast, would make coverage universal. Thus, welfare beneficiaries would not risk losing coverage if they worked. Note, however, that these workers would not receive free insurance when they went to work. Like all other workers, they would ultimately pay

for the employers' share of insurance through lower cash wages. Thus, the net incentive for welfare recipients to work would be less than it may at first appear.

Still, the proposal would subsidize health insurance at many firms, and workers at such firms would have to pay, at most, 7.9 percent of their wages for insurance (and less if the firm is small and has a predominantly low-wage work force). Premiums at unsubsidized firms could, however, absorb a substantial fraction of these workers' wages; few welfare recipients would probably seek jobs in the unsubsidized sector.

These workers could also receive some subsidies for the family share. If the worker continued to receive AFDC assistance, he or she would pay nothing. Workers who were no longer enrolled in AFDC would also receive subsidies, although they would be required to pay a portion of the family share.¹⁷ These subsidies would phase out gradually as the worker's family income rose, reaching zero when income was 150 percent of the poverty level. The phaseout of the subsidy would impose an implicit levy on additional hours of work.

Empirical studies show that Medicaid has reduced participation in the labor force.¹⁸ But estimating the effects of the Administration's proposal is difficult because the available studies cannot easily be adapted to it. Nevertheless, the literature suggests that the proposal would noticeably increase participation of AFDC recipients in the labor force.

15. Aaron and Bosworth, "Economic Issues in the Reform of Health Care Financing."

16. Different thresholds apply for AFDC eligibility and Medicaid eligibility. Medicaid coverage may be maintained for a transition period of up to 12 months after starting work.

17. When a family no longer received AFDC, the family would also lose the subsidy for copayments and supplementary services for the parent. Supplementary services for children would be continued as at present.

18. Aaron Yelowitz, "The Medicaid Notch, Labor Supply, and Welfare Participation: Evidence from Eligibility Expansions" (Massachusetts Institute of Technology, Cambridge, September 1993); Sandra Decker, "The Effect of Medicaid on Participation in the AFDC Program: Evidence from the Initial Introduction of Medicaid," (New York University, New York, N.Y., 1993); Robert Moffitt and Barbara Wolfe, "The Effect of the Medicaid Program on Welfare Participation and Labor Supply," *The Review of Economics and Statistics*, vol. 74, no. 4 (November 1992), pp. 615-626; Anne E. Winkler, "The Incentive Effects of Medicaid on Women's Labor Supply," *The Journal of Human Resources*, vol. 26, no. 2 (Spring 1991), pp. 308-337; Rebecca M. Blank, "The Effect of Medical Need and Medicaid on AFDC Participation," *The Journal of Human Resources*, vol. 24, no. 1 (Winter 1989), pp. 54-87.

Redirect Employment of Low-Wage Workers

The Administration's health proposal would affect employment of low-wage workers in a variety of ways. It would raise labor costs at uninsured firms and would reduce the employment of some of their low-wage, adult workers. But it would also reduce labor costs at insured firms, which could tempt some of them to employ more workers. At the same time, the proposal would increase employment of workers who provide services for the disabled and could induce a shift toward teen and student employment. On balance, the Administration's proposal would probably have only a small effect on low-wage employment.

Workers at Firms Without Insurance. The Administration's proposal would reduce the employment of adult workers who are currently uninsured and whose wages are close to the federally regulated minimum wage. The requirement that firms pay for insurance would raise the cost of employing these workers, but because of the minimum wage rules, employers would not be able to pass the increased cost fully back to the workers by reducing their cash wages. Thus, firms that could not absorb these costs in profits or could not raise their prices might resort to layoffs.

The amount of the cost increase for minimum-wage workers would vary significantly from firm to firm.¹⁹ Firms subject to the premium caps, and thus subsidized, would experience increases amounting to between 15 cents and 34 cents per hour--probably not enough to have a serious impact on employment. The increases at unsubsidized firms would be substantially larger, amounting to about \$1 per hour (or close to 25 percent) for full-time workers choosing individual policies in 1998 and almost \$2 per hour (nearly 45 percent) for workers choosing family policies.²⁰

19. For information on insurance coverage of low-wage workers, see Congressional Budget Office, "In Pursuit of Higher Wages and Employment-Based Health Insurance," CBO Memorandum (February 1993).

20. Using CBO's premium estimates for 1998 and assuming a 37-hour week for 52 weeks.

Some firms would respond to this cost increase by raising their prices; others might pass the increase on to other workers or shareholders. Some firms would reduce employment, but the effect would probably be relatively small. Past empirical studies suggest that changes in the minimum wage affect employment only modestly.²¹ Moreover, the numbers of workers earning the minimum wage will decline over time as market wages rise with general inflation.

Workers at Insured Firms. Not all low-wage workers would face increases in health costs. Although most firms that employ minimum-wage workers do not offer insurance to those workers, some firms do, and these firms would most likely see their costs go down. A firm that is subject to the payroll cap would have to pay no more than \$700 to cover the insurance cost of a full-time minimum-wage worker--considerably less if the firm is small and employs mostly low-wage workers--and this amount would be well below the cost of most current health plans. Because small, unsubsidized firms would benefit from community rating and from a reduction in administrative costs, many of them would also see their costs go down. In firms where costs could fall, employment of low-wage workers could rise, though again not by much.

Teenagers and Students. The Administration's proposal does not require employers to pay for employees who are dependents and who are either under age 18 or full-time students under age 24. Thus, the proposal would reduce the cost of hiring these workers relative to adult minimum-wage workers. This provision could induce a shift toward employment of teens and students and away from adult nonstudent workers, although it is difficult to estimate the magnitude of this effect.

21. Allison Wellington, "Effects of the Minimum Wage on the Employment Status of Youths: An Update," *The Journal of Human Resources*, vol. 26, no. 1 (Winter 1991), pp. 27-46; "New Minimum Wage Research: A Symposium," *Industrial and Labor Relations Review*, vol. 46, no. 1 (October 1992), pp. 3-88; David Card, Lawrence Katz, and Alan Krueger, "An Evaluation of Recent Evidence on the Employment Effects of Minimum and Subminimum Wages," Working Paper 4528 (National Bureau of Economic Research, Cambridge, Mass., November 1993); Janet Currie and Bruce Fallick, "A Note on the New Minimum Wage Research," Working Paper 4348 (National Bureau of Economic Research, Cambridge, Mass., April 1993).