The Clinton Health Plan

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Executive Summary

President Clinton has offered the nation a dramatic health reform plan that promises universal coverage, benefits as comprehensive as those of Fortune 500 company plans and lower costs. The actual results of the plan, however, would be quite different from the promises.

- Most people would have their current insurance canceled and be forced to obtain insurance through a government bureaucracy.
- People would be forced to buy the full range of government-mandated benefits, rather than a no-frills policy tailored to individual and family needs.
- The benefits people receive would be micromanaged from Washington, with national rules governing even the age at which a woman could receive a mammogram.
- Despite the president's promise of free choice of physicians, most people would be forced into health maintenance organizations (HMOs), where access to physicians and health care services would be restricted.
- And despite the White House promise that everyone would be able to pay any price for any service to any physician, virtually all outside-of-plan transactions would be either illegal or highly impractical under the requirements of the Clinton reforms.

In an effort to contain costs, the plan would impose global budgets and price controls that almost certainly would lead to rationing. In addition, because the sick and the healthy would pay the same average premiums, health plans would have even stronger incentives to avoid the sick and attract the healthy than they do today. These plans also would have a strong financial incentive to underprovide services to people with expensive-to-treat conditions. The result would be a serious decline in the quality of care Americans receive.

The Clinton plan would be mainly financed by regressive taxes and benefit cuts for the poor — a hefty increase in cigarette taxes and cuts in Medicaid and Medicare spending. But middle-class tax hikes to fund the program would be inevitable:

- Under the Clinton administration's own assumptions, revenues to health plans would fall at least $1 trillion short of expenditures over the period from 1995 to 2000.
- More realistic projections place the shortfall at almost $2 trillion.
- Closing the gap would require raising the mandated employer and employee premium payments from 7.9 percent of payroll — the administration's projection — to over 14 percent in the year 2000.

By the administration's own estimates, 30 to 40 percent of all insured workers would pay more for their health care coverage than they do today; independent analysts put the number even higher. And the plan has many anomalies:

- The heaviest additional premium costs would be borne by young, healthy people who would be forced to subsidize insurance for those in other age groups, all of whom have at least twice the assets and much higher incomes.

- Although its purported purpose is to help the currently uninsured, these individuals would be forced not only to buy health insurance but to pay up to twice its true market value.

- Another stated goal is to help low-income families, but low-income employees of most companies would either see their wages fall by one-fourth or be laid off in the face of Clinton's costly mandated health insurance.

The plan contains so many arbitrary subsidies and penalties that it would be difficult for an average family to determine whether it would gain or lose. For example:

- The plan subsidizes up to 80 percent of the premium of high-income early retirees, while forcing a $40,000-a-year self-employed person to pay in full.

- The plan discriminates against teenagers and elderly people who work, relative to those who don't.

- Workers who have more than one job and two-earner families may have to pay twice for the same coverage.

The Clinton plan would have powerful negative effects not only on the availability and quality of health care but also on the nation's economy. Mandating employer payments for an expensive, government-dictated health insurance policy would result in heavy job losses, particularly among low-income workers.

- Estimates of job losses range from 780,000 to 2.4 million.

- Even the Clinton administration acknowledges that its plan would likely eliminate 600,000 jobs in the early years alone.

The fundamental question is, who should have control over your health and its care — you or the government. With this plan, President Clinton answers "the government."

The alternative to the Clinton plan would shift power and control over health care away from government, insurance companies and employers, to individuals. This approach is known as patient power. Through such measures as Medical Savings Accounts, health insurance vouchers for the poor and other reforms, each individual can have choices about and gain control over his or her own health care.

Introduction:

How the Clinton Health Plan Would Work

"Government intervention under the plan would be larger than the New Deal or the Great Society."

President Clinton has proposed a national health care plan that would give the federal government the power not only to regulate the trillion-dollar-a-year health care industry but also to become intimately involved in the type of care every American receives. The vast majority of people would be forced to join a governmental entity called a "purchasing alliance" and to choose among government-accredited health plans. Each plan would contain the same government-mandated health insurance benefits.

Although the Clinton administration claims its plan would reduce paperwork and lead to a simpler, more streamlined health care system, a close look reveals that the plan would:[1]

- Create 59 new federal programs or bureaucracies;
- Expand 20 other federal programs and bureaucracies;
- Impose 79 new federal mandates; and
- Make major changes in the tax code.

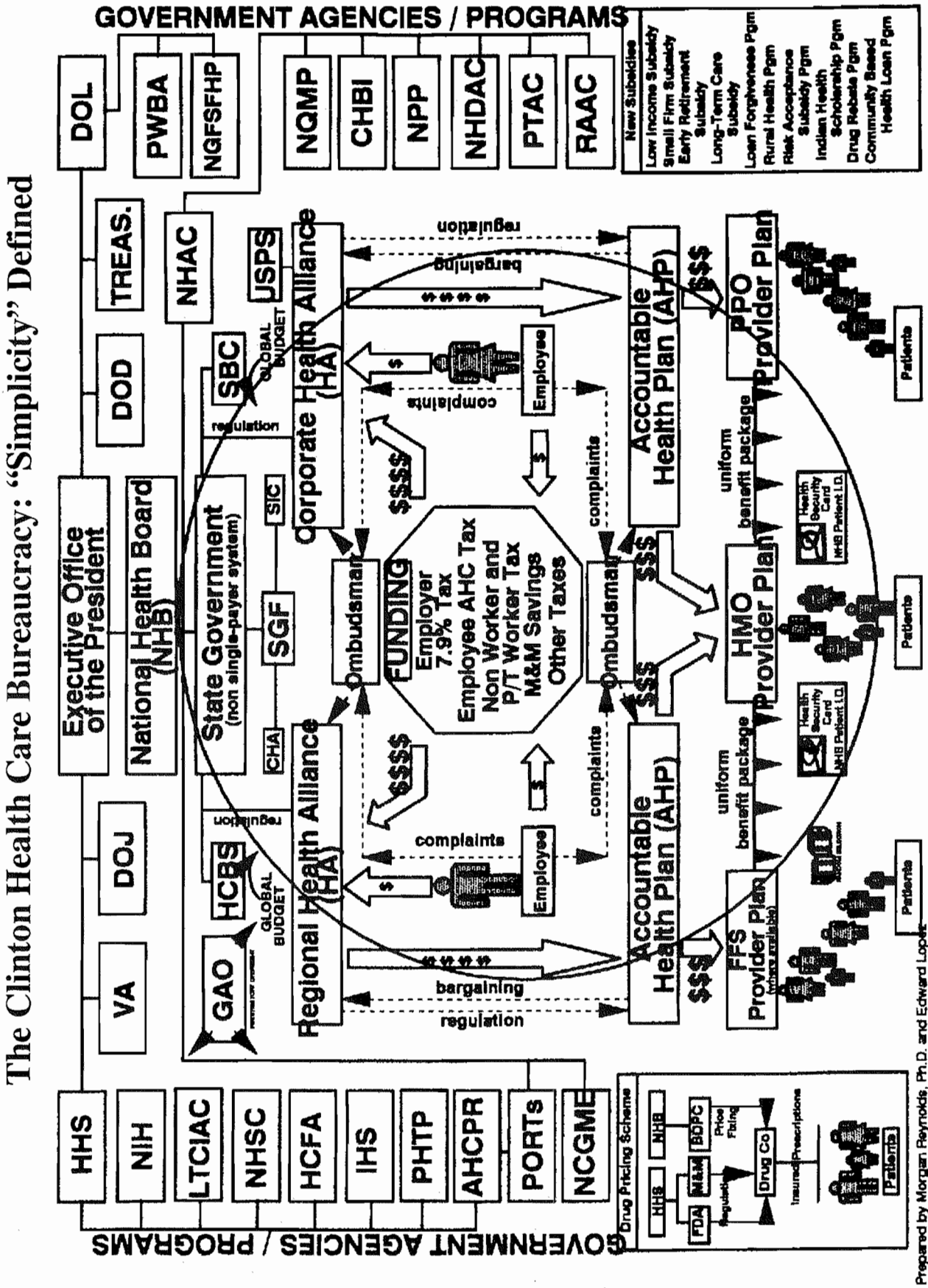
Figure I clearly shows that the Clinton plan is anything but simple. Overall, the Clinton health care plan would represent the largest increase in government intervention in our nation's history — larger than the New Deal, larger than the Great Society.

"Most current health care insurance would be abolished."

Federal Control. A National Health Care Board, with seven members appointed by the president, would have independent authority to impose new rules and regulations, determine what benefits would be in every American's health plan and impose sanctions on any state that failed to comply with its regulations.

One Size Fits All. A 55-year-old schoolteacher who has no need or desire to be covered for pregnancy, drug and alcohol abuse or abortion would have to pay for those benefits anyway. Bureaucrats in Washington would determine everyone's health insurance benefits down to the smallest detail. For instance, a woman over the age of 50 would be able to get a free mammogram every two years, while women under 50 would have no such option.[2] Under the fee-for-service option, a child's vaccination for whooping cough would be exempt from the deductible set by the plan; a flu shot would not.

FIGURE I


The Clinton Health Care Bureaucracy: "Simplicity" Defined
GOVERNMENT AGENCIES / PROGRAMS
DOL
PWBA
NGFSFHP
NQMP
CHBI
NPP
NHDAC
PTAC
RAAC
New Subsidies
Low Income Subsidy
Small Firm Subsidy
Early Retirement Subsidy
Long-Term Care Subsidy
Loan Forgiveness Pgm
Rural Health Pgm
Risk Acceptance Subsidy Pgm
Indian Health Scholarship Pgm
Drug Rebate Pgm
Community Based Health Loan Pgm
TREAS.
DOD
NHAC
USPS
SBC
GLOBAL BUDGET
Executive Office of the President
National Health Board (NHB)
State Government (non single-payer system)
SIC
SGF
CHA
Corporate Health Alliance (HA)
Regional Health Alliance (HA)
HCBS
GLOBAL BUDGET
GAO
DOJ
VA
regulation
bargaining
complaints
Employee
$$$$
Ombudsman
FUNDING
Employer 7.9% Tax
Employee AHC Tax
Non Worker and P/T Worker Tax
M&M Savings
Other Taxes
Accountable Health Plan (AHP)
PPO Provider Plan
HMO Provider Plan
FFS Provider Plan
uniform benefit package
Health Security Card NHB Patient I.D.
Patients
GOVERNMENT AGENCIES / PROGRAMS
HHS
NIH
LTCIAC
NHSC
HCFA
IHS
PHTP
AHCPR
PORTs
NCGME
Drug Pricing Scheme
NHB
BDPC
M&M
FDA
Prior Filing
Drug Co
Insured
Prescriptions
Patients
Prepared by Morgan Reynolds, Ph.D. and Edward Lopez
JEC / GOP

State Governments as Surrogates. The federal government would force the states to establish "purchasing alliances" through which people would have to purchase health insurance. These purchasing alliances would have a great deal of power over the health plans and all money — and therefore all power — would be channeled through them.

The Abolition of Private Health Insurance. The vast majority of people would see their current insurance canceled, and no one would be able to buy insurance outside of an alliance to cover any medical service included in the mandated plan.

Employer Mandates. Government would require employers to pay at least 80 per cent of the premium for their employees. Subsidies would be available for small firms with lower-income employees, but not for larger firms. All firms would have an incentive to pay for the cost of health insurance by lowering wages and to lay off workers whose productivity did not cover the cost of their wages plus the cost of their health care benefits.

"The vast majority of people would have to join HMOs."

Individual Mandates. The unemployed and the self-employed would be forced to buy their own insurance. Early retirees would get an 80 per cent government subsidy, regardless of their income. Others would get subsidies only if their income was low enough.

Community Rating. The law would require insurers to charge the same premium to everyone — young or old, sick or healthy. As a result, the young and the healthy (who frequently have below-average incomes) would be overcharged, while many of those with above-average incomes would be generously subsidized.

Price Controls on Health Insurance Premiums. State governments would decide how much insurance companies could charge in premiums. As part of a national global budget, the federal government might refuse to let premiums rise as much as health care costs are rising, thus forcing doctors and hospitals to ration health care.

Price Controls on Physicians. Government would be able to impose a fee schedule on all fee-for-service physicians, and every doctor would be paid the same fee for a given service — regardless of the physician's skills and regardless of the actual costs.

HMOs for Everyone. Although Clinton promises that fee-for-service plans would still exist, the goal of his plan is to force most people into health maintenance organizations (HMOs) and other "managed care" plans. To achieve this goal the Clinton plan would (1) set the deductible for fee-for-service plans so low that the plans would be unreasonably expensive; (2) impose premium controls that would discriminate against the fee-for-service plans, which — unlike most HMOs — would be unable

to instruct physicians to limit medical care; and (3) create an artificial market for health insurance under which the sicker, more expensive enrollees would gravitate to the fee-for-service plans, swamping them with huge costs.

Fewer Specialists. The government would establish a National Council on Graduate Medical Education and 10 regional councils to control the number of physicians allowed to practice and their specialties. One goal would be to limit specialists to 45 percent of all physicians. Not only would the average doctor be less knowledgeable and less well trained, but the mix of medical students would be much more "politically correct."

Fewer New Drugs. The government would establish a National Drug Price Advisory Committee to determine if drug prices are "fair" and impose sanctions on pharmaceutical companies if they are not.

Making the Poor Pay More. Most of the money to pay for the plan would come from regressive taxes and benefit cuts for the poor and the elderly. The administration proposes to cut $124 billion from future spending on Medicare, $65 billion from Medicaid and $40 billion from other federal health care programs. The plan also would impose an additional 75-cent tax on every pack of cigarettes, even though cigarette taxes are among the most regressive of taxes.

President Clinton claims that "managed competition," the term given to the new system, would eliminate waste, cutting costs by 20 percent in Medicare and Medicaid. Independent analysts, however, expect a reduction in real services. Medicaid reimbursement levels are already so low that many doctors won't see Medicaid patients. And although Medicare patients can generally see the doctors of their choice, both programs pay below cost for hospital services, causing massive cost shifting to the private sector. If the hospital marketplace becomes more competitive, as the administration hopes it will, cuts in Medicaid and Medicare spending would result in fewer benefits and more rationing.

"Although the plan is mainly financed with regressive taxes, middle-income families can expect higher taxes as well."

More Taxes for the Middle Class. The administration hopes to get about $30 billion over five years by eliminating flexible spending accounts, to which employees now make pretax deposits and with which they pay for their portion of health insurance premiums and for unreimbursed medical expenses. The administration also projects $41 billion in increased income and payroll taxes resulting from the higher wages and profits it expects due to an overall reduction in health care costs. Medicare premiums would be increased for elderly single people with incomes above $90,000 and elderly couples with incomes above $115,000. And the plan would impose a 1 percent payroll tax on employers with more than 5,000 workers who choose to run their own plans rather than join a regional alliance.

More Taxes to Come. Almost everyone agrees that President Clinton's numbers are wrong. Senate Finance Committee Chairman Pat Moynihan (whose help is essential for passage in the Senate) called the Clinton funding plan a "fantasy."[3] And House Ways and Means Committee Chairman Dan Rostenkowski has said that a new "broad tax increase" would be necessary to fund the plan.[4]

Bureaucratic Vision. Behind the plan there's a vision, a vision that puts its faith in bureaucracies rather than the market. In the Clinton medical marketplace, prices would not be determined by supply and demand. They would be determined by fiat. When prices are fixed and therefore cannot serve their normal function, markets collapse unless there is some other force to keep things on track. In the Clinton scheme that other force is bureaucrats. This is clearly a plan written by bureaucrats for bureaucrats. The important question is, what happens to all the rest of us?

"The Clinton plan almost certainly would lead to health care rationing."

Health Care Rationing

Instead of granting individuals more power and control over health care decision making, the Clinton plan would centralize power and control in the hands of major insurance companies and government. The result would almost certainly be health care rationing. In particular, rationing would be produced by the following features of the plan:

- Global budgets and price controls;
- Expanded enrollment in HMOs and similar managed care systems;
- Federal insurance regulation that would create powerful incentives for health plans to provide low-quality care for the sickest patients;
- National practice "guidelines" that would limit the freedom of physicians and hospital personnel to provide the best medical care;
- Controls that would stifle the development and adoption of new medical technology, new drugs and other health care innovations; and
- Federal regulation of medical education designed to limit the supply of specialists.

Each of these components is discussed in detail below.

The Ten Most Asked Questions

1. Will I have to pay more for health insurance? *Yes.* In testimony to Congress, HHS Secretary Donna Shalala estimated that 40 percent of insured Americans will pay more for health care coverage. Immediately afterward, the administration cut her estimate to 15 percent and later doubled that to 30 percent. All of these estimates are based on the economic fiction that employee benefits are paid by employers rather than by employees in lieu of wages. On the average, premiums will increase by $200, and for some people the increase will be as much $1,000 a year. Futher, independent analysts estimate that the actual cost of Clinton's mandated health insurance coverage will be as much as 80 percent higher than the administration's estimates. [See Table I.] Thus, the number of people who will pay more and the amount they will pay may be significantly higher than the White House claims.

2. Will my taxes go up? *Yes.* Despite the president's call for $341 billion in new spending over the next five years, the administration claims that the federal deficit will actually be reduced by $58 billion. The claim is based on higher cigarette taxes, speculated savings in Medicare and Medicaid and higher employment taxes as employers cut back on employee health benefits and pay taxable wages instead. Independent analysts disagree. Martin Feldstein, former Chairman of the Council of Economic Advisors, and his colleagues at the National Bureau of Economic Research estimate that $120 billion extra per year will be needed to fund the plan. This would require approximately a 24 per cent increase in marginal tax rates. A taxpayer now paying a 15 per cent tax rate would face an 18.6 per cent rate. The top rate of 39.6 percent would jump to 49 percent.

3. Will jobs be lost? *Yes.* Even the Clinton administration admits that 600,000 people will lose their jobs if the president's plan is adopted. One study puts the number as high as 3.1 million. The reason is that employers will not employ people who cannot produce enough to cover the cost of their wages plus their new health care benefits.

4. Can I keep my current health insurance? *No.* With the exception of a few large company plans, all existing health insurance plans will be illegal. You will have to purchase a policy that includes government-mandated benefits through a government "health alliance," regardless of whether you are satisfied with your current health insurance. Further, it will be illegal for you to purchase a private insurance policy that duplicates any of the mandated benefits.

5. Can I keep my current doctor? *Probably not.* The vast majority of people will be enrolled in health maintenance organizations (HMOs) and will be allowed to see only those doctors specifically covered by their HMO. Although the administration has promised that people will be able to pay a higher premium and join a fee-for-service plan that allows a choice of physicians, health policy analysts believe that fee-for-service plans are unlikely to survive. It is also most unlikely that you will be able to step outside the Clinton health system and purchase physician services with your own money.

6. Will my quality of care increase? *It will probably decrease.* Although people will be encouraged to move back and forth among health plans, everyone will (directly or indirectly) pay the same premium, regardless of their state of health. As a result, health plans will view sick people as unprofitable and will have strong financial incentives to avoid them and to reduce the quality of care they receive — if for no other reason than to encourage them to switch to another plan.

7. Will health care be rationed? *Yes.* The Clinton plan requires that national health care spending grow no faster after a few short years than per capita national income. To force the private sector to reach this goal, the plan will impose both global budgets, which will arbitrarily limit the resources available to doctors and hospitals, and price controls. Although the administration denies that these measures will result in rationing, a provision making it a federal crime to pay extra money to a physician for covered services would seem to be superfluous in the absence of rationing.

8. Will the currently uninsured be better off? *They may not be.* The uninsured are predominantly young and healthy. As a result, under the Clinton plan's community rating system, they would pay more than necessary for their coverage, so that older and wealthier workers (most of whom already have coverage) can pay less. Indeed, over 50 percent of the uninsured would have to bear added costs of $1,000 to $2,500 per year for health care under the Clinton plan, and more than 15 percent would have to bear added costs of over $2,500 per year. When Australia forced the uninsured to buy health insurance, the government made a profit because the previously uninsured paid more in premiums than they used in health care resources. Our own experience is likely to be similar.

9. Will the extra costs of the plan be paid by the rich? *No.* Virtually every funding source in the Clinton plan is highly regressive — imposing the highest financial burdens on those least likely to be able to afford them. A cigarette tax, for example, is perhaps the most regressive of all taxes — given that smoking is inversely related to income. Cuts in Medicaid and Medicare spending combined with other features of the plan will undoubtedly force a reduction in benefits for the poor and the low-income elderly and lead to more rationing in both programs. Finally, a general system of community rating will lead to a massive shift of income from people who make less to people who make more.

10. Will members of Congress be part of the plan? *No.* Members of Congress and all other federal employees are covered under the Federal Employees Health Benefits Program (FEHBP). The Clinton health plan proposes to abolish the FEHBP and make federal workers part of the same system as everyone else, *but not until 1988.* By exempting federal workers from the laws that will apply to the rest of us until after the next presidential election, the president gives federal employees plenty of time to extend that exemption indefinitely and avoid the wrath of the voters. In the past, Congress has routinely exempted itself from regulations it has imposed on the rest of us. Health care is unlikely to be the exception.

Suggested reading: Michael D. Pettengill, *20 Most Asked Questions: Analysis of the Clinton Health Care Plan*, Capitol Resource Institute, 4825 J Street, Suite 100, Sacramento, CA 95819.

Source of Rationing: Global Budgets and Price Controls

"Under global budgets, health plans would have to deny people medical care when the money runs out."

While the Clinton administration refuses to acknowledge the terms, its plan includes a comprehensive system of global budgets and price controls. The resources available to health plans and the amount that could be spent on health care under those plans would be severely restricted. Overall, national health care spending would be allowed to grow no faster than the economy as a whole, plus an adjustment for population growth.

The following is a brief description of how controls would work.

A National Global Budget. A National Health Board would set a budget specifying how much the entire country should spend on health care.

Budgets Imposed on States. The Board would then allocate this global budget into subbudgets for each state and for every regional alliance covering a specific geographic area. Each state and regional alliance would be responsible for ensuring that health spending within its area did not exceed its assigned portion of the national global budget.

Budgets Imposed on Health Plans. Each regional alliance would negotiate premiums for each of its area's health plans to ensure that they did not spend more than the alliance's assigned portion of the national global budget. A health plan that exceeded its budget would be penalized with lower premiums the following year to make up the difference.

Budgets Imposed on Medicaid and Medicare. Caps also would apply to annual spending under Medicare and Medicaid so that those programs would spend no more than their assigned portion of the national global budget.

Price Controls for Health Insurance Premiums. Federal regulation would strictly limit the premiums that could be charged by private health plans to hold their spending within the national global budget. Given these restraints, the plans would have no alternative but to ration care.

Price Controls for Doctors and Hospitals. As part of its established budget, each regional alliance would mandate a fee schedule for all doctors and hospitals practicing fee-for-service medicine. In addition, each state would have independent legal authority to impose price controls on these doctors and hospitals.

Outlawing Private Transactions. To further enforce the global budgets, the Clinton plan would prohibit "balance billing." Doctors and hospitals would be banned from directly charging patients any fee beyond

the payments provided through the patient's health plan, aside from certain minor deductible and copayment fees. Indeed, Section 5434 of Clinton's proposed plan makes it a federal crime for patients to pay, and for doctors and hospitals to receive, such additional fees.

Why Pressures to Ration Will Mount Over Time. The Clinton administration claims that global budgets and price controls are stopgap measures, which probably would not be needed because managed competition would hold down costs. But the Congressional Budget Office[5] as well as independent health economists have little faith that managed competition will curtail health care spending.[6] In any event, huge spending reductions would be required to make the Clinton plan work. Specifically:[7]

- To meet the Clinton plan's financial targets and cost control goals, health care spending in the year 2000 would have to be almost 25 percent lower than where it would be under current trends.
- Medicare spending for the elderly would be cut by $124 billion by 2000, and Medicaid spending for the poor would be cut by $65 billion over that period.

"Twenty years from now, the Clinton plan would cut health care resources in half."

Moreover, allowing health spending to grow at no more than the rate of growth of national income would constrict health resources more severely over time and leave them far below the levels that would otherwise prevail. Specifically:

- The rate of growth of health spending would be cut in half — from about 10 to 12 percent per year over the past three decades to around 6 percent per year.[8]
- Reducing the rate of growth of spending from 10 percent to 6 percent would cause health resources to be only about half of what they would be otherwise after 20 years.

Effects on Patients. Meeting President Clinton's global budget goals would require severe cutbacks in medical services provided by doctors and hospitals. Health care providers would no longer be able to rapidly acquire and offer the latest innovations and newest technologies. They would no longer have the resources necessary to provide prompt care. In many cases, they would be unable to provide the most sophisticated care for the critically ill.

Moreover, since the Clinton global budget would allow only limited real growth in per capita health spending, the system would be less and less able to meet the health care needs of the aging baby boom generation.

"In other countries, global budgets cause more waste and inefficiency."

Why Spending Controls Won't Reduce Waste. The Clinton administration argues that fewer health care resources would be needed because its plan would reduce waste and inefficiency. Yet there is no reason to believe that limitations on available health care resources would eliminate waste and inefficiency.[9] Indeed, the experience of three other English-speaking countries with cultures similar to our own supports the conclusion that global budgets *increase* waste, while at the same time causing patients to wait for needed care. For example:

- Currently, the number of people waiting for surgery totals more than one million in Britain,[10] 60,000 in New Zealand[11] and 177,000 in Canada.[12]
- Although those waiting represent a small percent of the total population (2 percent or less), they probably represent a large portion of those who need access to modern medical technology.[13]
- Yet in spite of the lengthy waiting lists, at any one time about one-fifth of all hospital beds are empty in all three countries[14] and another one-fourth are being used for expensive nursing home care by nonacute elderly patients.[15]

Lessons From the Medicare Program. Some may wonder whether quality really can deteriorate in the face of regulations and tort law. In fact, there is plenty of evidence that a drop in the quality of care coincides with inadequate reimbursement rates in current government programs. Take Medicare, for example:

- Although hearing loss is the most prevalent chronic disability among the elderly and affects one-third of all Medicare patients, Medicare's reimbursement rate for cochlear implants is so low that only a handful of Medicare patients have received the treatment.[16]
- When Medicare reduced the reimbursement rate (in real terms) for kidney dialysis in the 1980s, many physicians reduced the treatment time — a practice that reduced their patients' chances of survival as well.[17]
- A survey of 21 medical conditions for which an implanted medical device was indicated found that for 18 of them the government's payment was well below hospital cost, and in more than half the cases Medicare patients did not receive the device.[18]

In general, Medicare reimburses hospitals at the same rate for a given procedure, ignoring differences among patients that lead to significant differences in the actual cost of care. This practice discriminates

against above-average-cost patients, who tend to be the sickest patients and more often than not low-income and nonwhite. For example, blacks and Hispanics have more severe illnesses, longer hospital stays and higher hospital costs than white patients, on the average.[19]

"Rationing is already taking place in the Medicaid and Medicare programs."

Lessons From the Medicaid Program. Strict limitations on reimbursements to doctors and hospitals have already produced waiting lines, delays and lower-quality care for patients in the Medicaid program. For example, the *Chicago Tribune* sent reporters under cover over several years and discovered that:[20]

- Some physicians who treat Medicaid patients exclusively boast that years of experience have made them efficient enough to see between 60 and 70 patients a day.
- One physician who made $120,000 from Medicaid in 1991 didn't even take his Medicaid patients' vital signs until his office reimbursement was increased from $8 to $18 per patient.

Lessons From Canada. As noted above, the Canadian health care system imposes global budgets similar to those called for in the Clinton plan. As a result, patients often are denied prompt access to the care their doctors say they need:

- About 45 percent of the 177,000 Canadians waiting for surgical procedures say they are "in pain" while they wait, and the Canadian press is full of horror stories about patients who died while waiting for heart surgery. [21]
- On a per capita basis, the United States has 10 times as many magnetic resonance imaging (MRI) units — which use magnetism instead of x-rays — as Canada.[22]
- In Ontario, patients wait up to six months for a CAT scan, up to a year for eye surgery and orthopedic surgery, up to a year and four months for an MRI scan and up to two years for lithotripsy treatment.[23]

Source of Rationing: Managed Care

"The number of people waiting for surgery because of global budgets is more than one million in Britain, 60,000 in New Zealand and 177,000 in Canada."

A second way in which the Clinton plan would create health care rationing is by forcing consumers to join HMOs or similar managed care systems. These plans already engage in some health care rationing. Under the Clinton plan they would engage in much more.

Why Fee-for-Service Plans Won't Survive. President Clinton insists that under his proposal everyone would have the choice of at least one fee-for-service plan and could, therefore, avoid HMOs. But that promise is likely to be broken for several reasons.

If a health plan's revenue is strictly limited, then the plan can survive only by strictly limiting its expenses. A traditional fee-for-service plan that allows patients to choose any doctor, obtain any amount of justifiable medical care and send the bill to the insurer cannot survive without the freedom to raise its premiums to cover its costs. Consequently, fee-for-service plans would be driven out of business by the Clinton premium caps, leaving consumers only a choice among HMO/managed care plans, which have more direct control over physician behavior.

Moreover, even if they could survive in principle, fee-for-service plans probably would not be allowed to survive in practice. This is because regional alliances would be empowered to exclude any health plan that costs more than 20 percent above the average-cost plan. The alliances also would have the power to exclude any plan that they deemed not financially viable. Since fee-for-service plans could be considered inherently nonviable for the reasons discussed above, alliances could effectively exclude all of them. Or they could allow only one such plan and limit its enrollment. Or they could allow only those fee-for-service plans that operate like managed care plans, imposing strict controls and limits on affiliated doctors and hospitals.

"Although President Clinton promises free choice of doctors, experts agree that fee-for-service plans won't survive."

Another factor that would effectively force fee-for-service plans to become managed care plans is the regulation that would apply specifically to such plans. If a plan exceeded its budget, the excess would be recouped by reducing reimbursements to doctors and hospitals. As a result, doctors and hospitals would directly bear the risk of any excess costs over the global budget limits, including costs due to a rash of illness or an epidemic. If an area experienced a sudden rise in AIDS cases, for example, the above-budget costs would be taken out of the providers' fees. Moreover, as indicated above, price controls would apply to doctors and hospitals operating under fee-for-service plans.

Under such circumstances, few if any doctors or hospitals might be willing to operate under fee-for-service plans. Alternatively, the doctors and hospitals who regularly receive reimbursement under the plan might be forced to form a managed care network in order to stay within budget.

"Global budgets and premium controls favor HMOs and penalize traditional health insurance."

Finally, fee-for-service plans would be unlikely to survive because of the structure of managed competition. [See the discussion below.] If people can join any plan and pay only a community-rated premium, HMOs will try to protect themselves against an influx of expensive-to-treat patients by limiting access to the best doctors and perhaps not even contracting with them. By contrast, under fee-for-service plans people would be free to see any doctor. As a result, the truly sick would naturally gravitate to the fee-for-service plans, and their high medical costs could bankrupt the plans.

"Fee-for-service doctors may be forced to practice under price controls — where all doctors of the same specialty are paid the same fee regardless of differences in skill and ability."

These are some of the reasons why Alain Enthoven, father of managed competition, believes that fee-for-service plans will not survive.[24] Dr. John Ludden, medical director of the Harvard Community Health Plan, agrees. Fee-for-service insurance under the Clinton plan, he predicts, would "vanish quickly."[25] Even proponents of various managed competition proposals see no role for fee-for-service plans. For example, Jim Cooper (D-TN) says, "My guess is that fee-for-service medicine will be discouraged and mostly die out."[26]

Adding to these problems is the attitude of the Clinton administration. The administration's entire health reform plan is based on greatly increasing the power and scope of managed care bureaucracies to reduce costs by controlling services. True fee-for-service plans that allow medical services to be determined by doctors' professional judgments and the doctor-patient relationship do not fit into the proposed Clinton health care framework. If most people escaped HMOs and joined fee-for-service plans, the Clinton cost-control strategy would be entirely ineffective. Financing shortfalls of potentially hundreds of billions of dollars each year would result. Consequently, under the Clinton plan, the government could be expected to sharply limit any fee-for-service alternative.

"HMO administrators have financial incentives to underprovide care."

How HMOs Ration Care Under the Current System. HMOs combine insurance with the delivery of health services by doctors and hospitals in the same organization. The doctors are either employed by the HMO or practice under contract. As a result, the HMO often influences the medical practices of the doctors. The HMO also can limit quality and availability of facilities and medical equipment. In most cases, the patient can see specialists or obtain access to expensive diagnostic procedures only with authorization from the HMO bureaucracy. These restrictions can have an adverse impact on patients:

- One persistent physician reports that it took five hours to contact an HMO surgeon so he could get a patient with acute appendicitis to the operating room, putting her at risk of a ruptured appendix and possibly death.[27]
- Other physicians contend that an HMO patient who develops a high-cost condition such as cancer at the end of a year when the budget is low may be told that chemotherapy would not be beneficial and may be treated with the lowest-cost drugs available.[28]

How HMOs Would Function Under the Clinton Plan. HMO/managed care organizations have incentives to satisfy patients in the present health care system because they are subject to the discipline of

competition in the marketplace. If they become too strict in using their power to ration or deny care, their customers have alternatives. For example, in the market for individual and family policies, people can choose among a wide range of alternatives — including hundreds of fee-for-service plans, nonprofit Blue Cross/Blue Shield plans and modestly restricted preferred provider organizations (PPOs).

Under the Clinton plan, this market discipline would be removed. For the reasons discussed above, the only alternatives would be *other* HMO or managed care plans. And people would be required to purchase their coverage from among the limited number of them offered by their local regional alliances.[29] As a result, there would be less competition than advertised. In fact, the HMO/managed care organizations could come to dominate an oligopolistic market in which collusive health plans effectively function as a cartel.

Source of Rationing: Federal Insurance Regulations

The Clinton plan would abolish the current system of health insurance and replace it with an artificial market in which insurers (or health plans) would be subject to considerable regulation. For example, the Clinton plan would:

- Require health plans to accept all applicants regardless of health status;
- Prohibit health plans from excluding coverage or charging a higher premium for preexisting conditions; and
- Require all health plans to charge the same premium (community rating) to all applicants, regardless of their health.

"People who have AIDS would pay the same premium as those who do not."

Because of these regulations, a person who has AIDS would pay the same premium as someone who does not, and people in hospital cancer wards would pay the same premiums as people who do not have cancer. Thus, the premiums sick people pay would be well below the expected cost of their treatment, while the premiums of healthy people would be substantially higher. As a result, the incentives for the plans to avoid the sick and attract the healthy would be far greater than under the current system.[30] Indeed, the plans that attracted a disproportionate number of sick people would eventually fail and leave the market.

Perverse Incentives for Health Plans.[31] Under this system, people would have an incentive to shop for medical services when selecting a health plan. For example, heart patients would tend to choose the plan with the best cardiologists, while cancer patients would tend to choose the plan with the best oncologists. By contrast, healthy people would tend to choose plans with the best primary care services and amenities — secure

in the knowledge that they could always switch plans if they became seriously ill.

This would create perverse incentives for the managers of the health plans. For example, *no plan could afford to be known as the best for those with expensive-to-treat illnesses.* Such a reputation would attract sick people paying the community-rated premium and needing expensive medical treatment. Moreover, each health plan would have an incentive to underprovide services to the sickest people and overprovide services to the healthy. The reason is that the plan would become more profitable as the sick left and the healthy stayed.

"No health plan could afford a reputation as being the best at treating serious illnesses."

The quality of care delivered to the sick would probably not deteriorate immediately. Nor would all diseases be affected in the same way. Health policy analysts believe the patients at greatest risk initially would be those with chronic conditions — patients in need of mental health care, custodial care or long-term care. Where physicians have discretion, as in the treatment of leukemia or in efforts to save premature babies, the tendency would be to save money rather than prolong life. There would be a substantial decrease in the number of CAT and MRI scans and other costly tests that detect brain tumors, cancer and other life-threatening conditions. Where possible, expensive surgery (such as bypass operations) would be delayed — if for no other reason than the hope that the patient might switch health plans and have the surgery performed by a competitor.

The Results of Competition. A number of health economists are convinced that the end result of competition under the Clinton plan would be a market in which each person received medical care costing exactly the same as the community-rated premium that person paid. Specifically:

"Managed competition would force health plans to attract the healthy and avoid the sick."

- The tendency of managed competition would be to compete the amount health plans spent for the care of the sick down to the level of the premiums the sick paid.
- By contrast, there would be a natural tendency to compete the amount health plans spent on the healthy up to the level of the premiums the healthy paid.
- As a result, seriously ill people would be progressively denied access to the benefits of modern medical science, while healthy people would have access to services that are medically unnecessary and only tangential to health care.

These conclusions follow from well-known principles of the economics of regulation. In competitive markets, price tends to change until it equals average cost. But if prices are constrained, competition will cause cost to change until it equals price, primarily through changes in

quality. For example, when housing rents are kept artificially low by rent control, landlords tend to allow housing quality to deteriorate until housing costs fall to the level of the government-controlled rents. When airfares were kept artificially high under airline regulation, the airlines tended to increase quality by adding more flights and amenities until their costs rose to the level of the government-controlled fares.[32]

"Health plans would be able to spend no more on sick people than the amount of premium they pay."

Example: Incentives to Avoid High-Cost Patients. Mark has AIDS. His HMO could spend $75,000 per year to offer him the latest, most advanced treatments. But the HMO receives a premium payment for Mark of only $2,500, the same premium it charges to all its patients. Consequently, if the HMO provides Mark with state-of-the-art medical care, it will lose $72,500 per year for as long as Mark lives. Moreover, if Mark's HMO developed a reputation for providing the best treatment for AIDS patients, it would attract other AIDS patients, causing it to lose even more money.

Mark's HMO, therefore, has a financial self-interest in *not* providing the best care. In fact, it has a financial self-interest in *not* keeping Mark alive. What the HMO will actually do might depend on government regulations, tort liability considerations and other factors. But suppose there is a medically acceptable way of treating Mark for only $25,000, although the his prospects would not be as good. The HMO would tend to choose the lower-cost treatment, saving $50,000 per year in costs.

"Health plans would gain financially when sick people leave and join some other plan."

Mark's case is not entirely hypothetical. Under the current system, HMOs tend to choose lower-cost therapies whenever they can be justified. As noted above, for chronic illnesses the appropriate standard of care often is not well defined. And where the norms are vague, prepaid plans provide significantly reduced levels of treatment.[33]

Example: Incentives to Avoid New Technology. An entrepreneur develops a medical device that offers great advances in treating cancer. The device costs $3 million. A health plan buying the device could use it for many patients. But the incentives are not to buy it. Because of the Clinton plan's requirement of community rating, the health plan cannot raise the premiums just for cancer patients. Instead, it must raise the premium by the same amount for all of its enrollees.

Since buying the device would necessitate raising everyone's premium, the health plan would risk losing healthy patients to its competitors. And after it bought the device, it would likely be swamped by all the other cancer patients in the area. Each would pay no more than the community-rated premium, but their treatment costs would result in huge, potentially bankrupting losses for the HMO. Even if the device actually reduced the overall cost of cancer treatment — thus supporting President

"Health plans would tend to avoid new technology for fear that it will attract too many patients who need it."

Clinton's effort to control costs — the HMO would have an incentive not to purchase it.

Why "Risk Adjustments" Won't Solve the Problem. The Clinton plan tries to deal with this problem through a "risk adjustment" mechanism. The National Health Board would guide each regional alliance in taking away some of the income of the HMOs with lower-risk patients and giving it to those with higher-risk patients.

The most common proposals would tax or subsidize health plans based on the health of people *at the time they joined a plan.* Thus, sicker people would have a subsidy added to their premium payments and healthier people would have a tax deducted from theirs. Although enrollees would *pay* the same community-rated premium, health plans would *receive* a risk-adjusted premium. In theory, this would make the health plans indifferent between potential enrollees. In fact, health economists have concluded that, at most, 20 percent of the variation in health expenditures for individuals can be predicted by such observable factors as health status and prior health expenditure.[34] Therefore, even in principle, no risk adjustment mechanism can compensate health plans for more than 20 percent of the potential adverse selection.

If adjustments cannot solve the problem based on *prior* knowledge of patients, the only alternative is to base them on *past* knowledge, the experiences of patients after they enroll.[35] The problem is that if we reimburse health plans for what they spend, we are merely replicating the cost-plus system of health care finance that helped to create the crisis we now face.[36] On the other hand, if we pay health plans based not on actual costs but on fixed fees determined by the patient's diagnosis, we would have all of the problems we have in Medicare's current system of hospital reimbursement.[37]

"Clinton would give health plans incentives to provide poor-quality care and rely on government to keep them from doing so."

Why Quality Controls Won't Solve the Problem. Nor can this problem be solved through quality control regulations. Quality health care will not result from creating incentives for health plans to provide poor-quality care, then relying on government regulators to keep them from doing so. The highest-quality care will result only from a system that creates market incentives to provide that care in the first place.

Source of Rationing: National Practice Guidelines

Under the Clinton plan, the National Health Board and another new federal bureaucracy, the National Quality Management Council, would establish "national practice guidelines." These guidelines would specify in detail what medical services and treatments the federal government considers appropriate in what circumstances. Their primary purpose would be to avoid "unnecessary care."

Although the administration claims that the guidelines would maintain quality, it is likely that they would be driven by federal cost control and global budget concerns. Quality is subjective, while cost savings could be objectified by concrete estimates. The political pressures would be *not* to sacrifice the national global budget policy goal for subjective, contentious quality concerns — especially when those hurt by the decisions would seldom be aware that they have been injured.

In theory, these guidelines are supposed to be advisory and non-binding. In practice, doctors would likely feel pressure to follow the guidelines rather than their own judgment. HMO administrators would tend to challenge any departure from the guidelines that added to costs. Regional alliances concerned about meeting the global budgets would tend to challenge any HMO that allowed significant guideline departures. And the National Health Board would tend to challenge any regional alliance that allowed widespread departures. As a result, centralized, cookbook medicine would tend to replace the professional judgment of local doctors.

"Cookbook medicine will tend to replace the on-the-spot professional judgment of physicians."

Moreover, the National Health Board would have the legal power to make any guideline effectively binding and mandatory. The Clinton plan provides for coverage only for medical services and treatments that are "medically necessary and appropriate" as defined by the National Health Board. The Board could change a guideline's status from advisory to mandatory by defining care outside the guideline as not "medically necessary and appropriate."

While it is true that insurance companies today routinely limit their coverage to care they deem "medically necessary and appropriate," granting this power to a federal bureaucracy would represent a radical departure from the current system. Since insurers now compete in an open market, they risk losing customers if they deny access to effective new treatments and technologies. Under the Clinton plan, a federal bureaucracy could issue a single judgment for the entire country. Moreover, vesting such statutory power in a federal bureaucracy would allow the government to pursue a policy of aggressive, mandatory health care rationing that could not and would not be pursued by any insurer in a competitive market.

Source of Rationing: Stifling Innovation and New Technology

Like national health care plans in most other developed countries, the Clinton plan has a fundamental bias against new technology. Overall, the plan establishes a daunting, intractable gauntlet for any new medical technology or innovation to run before reaching the marketplace.

Controls on New Technology. To be covered under the Clinton health plan, any new medical technology or treatment would require initial approval by the National Health Board. If the experience of other developed countries is a guide, the board would be much more concerned with costs and meeting its national global budget than with quality improvements.

Gaining the approval for new technologies and innovations under Medicare is increasingly a problem under the current system, and some new technologies have languished in an underfunded evaluation bureaucracy for more than three years.[38] Under the Clinton plan these problems would become much worse. Because Clinton's global budgets could grow no more than the national income, new technology or innovation that added to costs would require cuts elsewhere. The special interests commercially benefiting from any existing service cut could be expected to lobby heavily against new innovations, mobilizing their clients and the general public, who would not be fully aware of the potential benefits of the innovation.

"The plan makes it difficult for any new medical technology to reach the market."

To be fully utilized, the new technology or innovation would have to become part of the national practice guidelines issued by the federal government. But bureaucratic inertia alone would likely leave these guidelines years behind the latest developments. Overriding cost control and global budget concerns would tempt bureaucrats to use the guidelines to minimize new and costly technologies and treatments.

Perverse Incentives for Health Plans. After approval for coverage was obtained, the HMO/managed care organizations would have to be convinced to adopt and use the innovation. But, as explained above, these organizations often would have incentives not to adopt it. The question is whether the health plan could raise premiums for *everyone* to cover the cost, not just the premiums of those who benefit from the innovation. But, as explained above, these organizations often would have incentives not to adopt it if it would attract more of the sickest patients.

"Concern for meeting the global budget is likely to override concerns about quality."

Controls on Drugs. The Clinton plan would significantly harm the ability of pharmaceutical companies to develop, produce and market new and innovative drugs. The newly created Advisory Council on Breakthrough Drugs would decide on the "reasonableness" of the price of new drugs by comparing them to drug prices in other countries and to producer costs, ignoring the cost of unsuccessful research.[39]

There would be a mandatory 17 percent across-the-board discount for all drugs reimbursed by Medicare, plus a negotiated rebate for Medicare based on the lowest manufacturer's price in any one of more than 20 countries.[40] If the provider refused to sell at the government-determined price, the government could exclude the drug from Medicare coverage,

"The Clinton plan would bring a halt to the development of new drugs."

effectively denying it to the nation's elderly and disabled. Roughly speaking, these regulations would tend to force pharmaceutical companies to charge prices that reflect the development costs for the new drug alone, ignoring the cost of unsuccessful research. Since for every successful drug there are hundreds of development failures, pharmaceutical companies need to be able to make enough profit on the few successes to cover the costs of the many failures. According to the Office of Technology Assessment, it costs about $359 million to develop a new drug,[41] and less than one drug in 10 recovers its developmental cost.[42]

To see what difference the proposed controls might make, compare drug policies in the United States and Britain:[43]

- Under the price control system in the United Kingdom, 80 percent of all drugs prescribed are at least 20 years old.
- In contrast to Britain and other countries, the relatively open pharmaceutical market in the U.S. has permitted an explosion in world-class drugs.

Allowing recovery of costs only for successful drugs would halt research into new drug development. The people hurt the most would be those most in need of drug therapies, especially the elderly and disabled. Children around the world also would be adversely affected, since between 6 million and 12 million children die each year due to diseases for which vaccines are being developed.[44]

Source of Rationing: Federal Regulation of Medical Education

"Canada restricts the number of specialists the way Clinton proposes to do — and patients there wait months for treatment."

The Clinton plan provides that by 1998 only 45 percent of young doctors would be permitted to become specialists. The rest would become primary care practitioners. This policy proposes to reduce costs by reducing the supply and availability of high-cost specialists. But it would lead to health care rationing, with reduced access to and waiting lines for sophisticated specialists. In Canada, where the number of specialists is limited in a similar way, patients can wait months in order to see one. For example: [45]

- The average wait to see an eye specialist in Prince Edward Island is six months — and it takes another six months on the average to be treated.
- On the average, it takes almost seven weeks to see a gynecologist in New Brunswick and another six months to be treated.
- To see an ear, nose and throat specialist takes a little more than two weeks in Newfoundland — but it takes another six months to be treated.

Isn't Rationing Necessary?

"The issue is, who should choose between health care and other uses of money?"

The Clinton administration's response to criticism that its plan involves rationing is that we already have health care rationing. The administration argues that the uninsured are effectively rationed out of access to care, especially the best, most advanced care, because they lack the funds to pay for it. Even if true, that is not an argument for extending rationing to everyone else.

A more basic question is whether some sort of rationing is necessary in order to control health care costs. Health economists agree that health care spending will soar unless someone is asked to choose between health care and other uses of money. For example, someone must decide whether one more MRI brain scan is really worth $1,000 or the money is better spent on other goods and services. The important question is not *whether* someone must choose. It is *who* chooses. Under the Clinton plan, the choices would be made by HMO bureaucracies and government. The alternative is to allow patients to make their own decisions in consultation with their doctors.[46]

Restricted Freedom of Choice

"The Clinton plan uses the word 'penalty' 59 times."

The Clinton plan would impose comprehensive restrictions that leave consumers with very little control over what happens to them in the health care system. The 1,342-page Health Security Act uses the word "penalty" 59 times, "mandatory" 24 times, "prohibit" 51 times, "restrict" 54 times, "enforce" 87 times, "obligation" 56 times and "limit" 269 times.[47] What follows is a brief description of some important freedoms Americans are being asked to give up.

Important Freedom Lost: The Right to Choose Health Insurance Benefits. Under the Clinton plan, the government would specify a standard health insurance policy that everyone would be forced to buy. This would not be a basic, minimum policy, but a broad, expansive plan meant to provide full coverage. In particular, consumers would have to pay for expensive, nonessential benefits they might not want, such as drug and alcohol rehabilitation and mental health counseling. People would not be allowed to choose policies tailored to individual and family needs. Nor would they be allowed to buy a no-frills policy for a lower price.

"No one would be allowed to buy no-frills health insurance for a lower price."

There is no sound policy reason for the government's mandating that everyone have the same health insurance benefits. Individual needs can be met in a less costly way by allowing people to choose their own benefit packages. And whether or not a person intends to take advantage of a particular benefit, insurance coverage for nonessential items often can be significantly more expensive than paying for such items out of pocket.

"No one would be allowed to buy private insurance that duplicates any benefit covered by the Clinton plan."

Important Freedom Lost: The Right to Choose a Health Insurer. The Clinton plan also would force most consumers to buy their required coverage from the insurers offered by their local regional alliance. Current policies would be canceled, and it would be illegal to buy a policy outside of an alliance.

Limiting consumers' choices to their alliance's offerings grants the insurers a degree of market power that could lead to an oligopolistic cartel, destined to abuse rather than benefit patients. Mandatory participation might also allow the alliance to serve its own interests rather than those of the general public.

"The health plans would determine which doctors you could see."

Important Freedom Lost: The Right to Choose Your Own Doctor. While President Clinton says that patients would have free choice of physicians under his plan, in reality that choice would be greatly restricted. For the reasons discussed above, most people would be forced to buy their coverage and receive their health care from an HMO or similar managed care organization. While patients might be able to choose an HMO that includes their current doctor, they probably would not be able to see other doctors outside the HMO's network. Moreover, most families use multiple specialists. For example, a family might have a primary care physician, a pediatrician, a gynecologist, an allergist, an ophthalmologist and a cardiologist. A single HMO would be unlikely to include all of the family's current doctors.

In addition, patients could see specialists only with the permission of the HMO administrators. And the HMO would have a financial incentive to deny such permission, because specialist visits add to the HMO's costs without adding to its revenues. In addition, patients generally would be restricted to the hospital affiliated with their HMO/managed care organization. And they would be unable to enter a hospital without permission from the HMO bureaucracy.

"A woman could have a mammogram at age 50 but not at age 49."

Important Freedom Lost: Free Access to Modern Medical Technology. HMO/managed care organizations would determine what diagnostic tests, advanced medical technology, surgery and drug therapies patients could have access to, and when. These decisions would be made under financial incentives to underprovide care and government pressures to hold down costs and meet global budget targets.

The ability of patients and their doctors to choose services and treatments also would be limited — by the national practice guidelines and by the power of the federal bureaucracy to determine what care is covered under the Clinton plan. As noted above:[48]

- The Clinton plan would pay for an annual mammogram for women age 50 and over; but women under age 50 would be insured for mammograms only if their family histories showed breast cancer.
- This is because the Clinton administration has decided that mammograms for women under age 50 are not cost-effective.
- However, the American Cancer Society and the American Medical Association disagree, and almost 20 percent of the women diagnosed with breast cancer each year — more than 30,000 in all — are under age 50.

Important Freedom Lost: No Exit. Despite Clinton administration assurances to the contrary, dissatisfied patients would be effectively precluded from using their own money to obtain services or purchase insurance coverage outside the Clinton national health care system.

"You would not be able to use your own money to purchase covered services outside the plan."

The Clinton plan explicitly prohibits consumers from using their own money to purchase insurance that covers any of the broad range of services and treatments covered by the plan. Suppose the HMOs in a patient's regional alliance could not provide high-quality care or imposed long waits. The patient would be prohibited from buying additional insurance that would make it possible to obtain better quality or quicker services, since that would "duplicate" Clinton plan coverage.

Could patients pay out of pocket for medical services? As a practical matter, no.

- The Clinton plan prohibits patients from making outside-the-plan payments to any doctor or health provider affiliated with any health plan to obtain services covered by the mandatory benefit package; such payments would be considered a federal crime.
- Moreover, doctors and hospitals are considered "affiliated" if they received any payment at all from an accountable health care plan.
- Thus, to pay out of pocket, patients would have to find doctors and hospitals that operate entirely outside the system, accepting no insurance reimbursement at all.[49]

"A doctor or hospital could operate independently only if it accepted no money from any accredited health plan."

In addition, direct out-of-pocket payment for expensive services is a realistic option only for the rich, since the great majority of patients could not afford it. Indeed, the Clinton plan's centerpiece is universal coverage that would erase this concern.

Outlawing Private Sector Plans That Work

"Under the fee-for-service option, families would be at risk for as much as $3,000 out-of-pocket."

Under the Clinton plan's fee-for-service option, families would be exposed to potential out-of-pocket payments as high as $3,000. Yet the administration apparently cannot see beyond old, outmoded ways of handling this risk. The president's plan would require a deductible of $200 for individuals and $400 for families and a 20 percent copayment up to an out-of-pocket maximum of $1,500 for individuals and $3,000 for families. This requirement would outlaw some of the most innovative employer plans in the country — which provide more generous coverage and less out-of-pocket risk for employees.

Take the United Mine Workers, for example. Last year they had a health plan with first-dollar coverage for most medical services. This year they accepted a plan with a $1,000 deductible. In return, each employee receives a $1,000 bonus at the beginning of the year, and employees get to keep whatever they don't spend. The mine workers still have first-dollar coverage — but now the first $1,000 they spend will be their own money rather than their employers'. If the mine workers are like other employees, they and their families will respond to the new incentives by finding ways to reduce their health care spending.

"But the Clinton plan would outlaw the United Mine Workers plan, which limits out-of-pocket costs to only $1,000."

Saving Money by Empowering Employees. Most health economists agree that the primary reason why health care costs are rising is that most of the money we spend in the medical marketplace is someone else's. More than a decade ago, the Rand Corporation discovered that when people are spending their own money on health care they spend 30 percent less, with no adverse health effects.[50] Some employers are putting this principle to work:[51]

- Since 1982, Quaker Oats has had a high-deductible policy and has annually paid $300 into the personal health accounts of employees, who get to keep any unspent balance. The result: over the past decade the company's health care costs have grown an average of 6.3 percent per year, while premiums for the rest of the nation have grown at double digit rates.
- *Forbes* magazine pays each employee $2 for every $1 of medical claims they do not incur up to a maximum of $1,000. The result: *Forbes'* health costs *fell* 17 percent in 1992 and 12 percent in 1993.
- Dominion Resources, a utility holding company, deposits $1,620 a year into a bank account for the 80 percent of employees who choose a $3,000 deductible rather than a lower deductible. The result: the company has experienced no premium increase since 1989, while other employers faced annual increases of 13 percent.

- Golden Rule Insurance Company deposits $2,000 a year into a Medical Savings Account (MSA) for employees who choose a $3,000 family deductible [see the figure]. The result: in 1993, the first year of the plan, *health costs were 40 percent lower than they otherwise would have been.*

"Companies that empower their own employees and give them incentives to be prudent are seeing their health care costs fall."

These plans are popular with employees because (1) they can save money in an amount directly related to their own efforts, (2) they are not deterred from seeking medical care by the traditional out-of-pocket deductibles, (3) they can usually use their medical savings to buy services not covered by the employer's plan, and (4) they are usually not restricted to certain doctors as they would be under managed care plans.

Case Study: Golden Rule. Golden Rule employees can choose a traditional policy with a $500 deductible and a 20 percent copayment up to a maximum of $1,000. If they choose a high deductible, however, Golden Rule deposits $1,000 (individual) or $2,000 (family) into their Medical Savings Account in 12 equal installments.

Last year, 80 percent chose the MSA option, and in 1994 the number is up to 90 percent. It's not hard to understand why. At year-end 1993, employees withdrew the surplus remaining in their MSAs — an average of $602 per employee. These funds were a direct reward for being a prudent shopper in the medical marketplace. Moreover, when employees save money for themselves, they save for their employers as well. At Golden Rule, 1993 medical costs above the catastrophic limits were about 60 percent of what had been projected.

"The most successful cost-control innovations in the country would be illegal if the Clinton plan becomes law."

Some critics claim that MSAs will encourage people to avoid preventive care. Yet experience shows that the reverse is true. MSAs make money available immediately when the medical need for it exists. This allows people to make purchases they might not make if they had a traditional deductible requiring an immediate out-of-pocket payment. A survey of Golden Rule employees who opted for MSAs found that *one out of every five used their MSA for a medical service they would not have purchased under the traditional insurance plan.*

Even though employees are getting more care and better care than they would under the Clinton plan, Golden Rule's health care plan, along with the other health care plans described in this section, would be abolished if the Clinton bill became law.

How Much Will it Cost?

Ever since the 1992 election campaign, Bill Clinton has been strong on verbalizing the goals of health reform but weak on explaining how much it would cost and who would have to pay.

"One out of every two people would have to pay more for health insurance and ultimately would pay for their employers' contributions by earning lower wages."

Most People Will Pay More for Health Care. As noted above, the Clinton administration admits that 30 to 40 percent of all insured workers would pay more for their health insurance coverage under the Clinton plan.[52] Outside analysts put the number even higher. A study conducted for the administration by Lewin-VHI, the top private sector health care consulting firm, concluded that about half of all workers would pay more under the Clinton plan.[53] And this finding ignored the fact that employer payments are made in lieu of wages.

The Lewin estimate is also based on the conservative assumption that premiums under the Clinton plan will only be 17 percent higher than what the administration predicts. As Table I shows, independent analysts estimate that the real cost of health insurance premiums could be as much as two-thirds higher. Overall, most workers will face higher costs for several reasons:

- People would be forced to pay for items that most current health plans do not include, such as mental health counseling, drug and alcohol abuse rehabilitation, etc.
- Under community rating, in which everyone pays the same premium for health coverage regardless of expected health care costs, young workers and healthy workers would pay substantially more than they do today.
- The uninsured would be forced to bear the costs of an expensive, government-mandated health plan.
- The Medicaid population would be included in the same general pool as everyone else. Since they tend to be sicker and higher-cost than average, under Clinton's community rating system their costs would be paid in part by other workers.

However, these preliminary estimates do not take into account the one factor most likely to force most workers to pay more under the Clinton plan than they do today.

"Even under the administration's own assumptions, revenues would be at least $1 trillion short of expenses by the year 2000."

Employer Payments Will Lead to Lower Wages. Although the Clinton plan would require employers to pay 80 percent of the cost of health insurance premiums, this burden ultimately would be borne by workers, as employers paid less in wages over time to accommodate this mandated fringe benefit. In general, employers will not pay more in total costs for a worker than the added productivity the worker brings to the firm.[54] If employment costs go up because of the mandated benefit, then wages must decline by the same amount. Otherwise, the employer would suffer a net loss by employing the worker and would be better off not doing so.

TABLE I

Estimates of the Cost of Health Insurance Premiums Under the Clinton Plan

Premium Category	Clinton	CBO	EBRI	Wyatt	Hewitt	HIAA
Single Adult	$1,932	$2,100	$2,202	$2,285	$2,440	$2,509
Couple without Children	3,865	4,200	4,404	4,570	4,880	5,419
Single Parent	3,893	4,095	4,008	4,603	4,619	4,270
Two Parents	4,360	5,565	6,210	5,155	6,946	7,278

Estimates: *Health Security: The President's Report to the American People* (Washington, DC: U.S. Government Printing Office, 1993); Congressional Budget Office, "An Analysis of the Administration's Health Proposal," February 1994; Employee Benefit Research Institute simulations using the March 1993 supplement to the Current Population Survey (CPS). Employer contributions are derived from the National Medical Expenditure Survey, adjusted for inflation and imputed to the CPS; the Wyatt Company, *The Economics of Health Reform: A Report Prepared for the Business Council on National Health Policy* (Washington, DC: The Wyatt Company, 1994); testimony of Dale Yamamoto and Frank McArdle, U.S. House Subcommittee on Health and the Environment, Committee on Energy and Commerce, November 22, 1993; and "Health Insurance Association of America Actuarial Memorandum: Premiums Under the Proposed Health Security Act," January 31, 1994.

Source: William Custer, "Health Reform: Examining the Alternatives," Employee Benefit Research Institute, *EBRI Issue Brief,* No. 147, March 1994, Table 7, p. 22.

The Total Cost Is Much Higher Than the Administration Estimates. Almost everyone agrees that the Clinton administration has underestimated the cost of its plan. In fact, the numbers don't add up, even on the administration's own assumptions.

- Under the Clinton administration's own assumptions, revenues to health plans would be at least $1 trillion short from 1995 to 2000.[55]
- Under more realistic projections, the financing gap is almost $2 trillion over this period.[56]
- Closing the gap would require raising the mandated employer and employee premium payments from 7.9 percent of payroll — the administration's projection — to over 14 percent in the year 2000.[57]

"Under more realistic assumptions, the financing gap would be almost $2 trillion."

Powerful Interest Groups Will Cause the Costs to Be Even Higher. Many benefits the Clinton plan covers are the very items the private sector avoids today to keep insurance costs down. And other provisions favored by politically powerful special interest groups rather than average consumers are likely to be added over time, further increasing costs.[58]

- At the state level, for example, mandated benefit laws — requiring insurers to cover items regardless of the preferences of the buyers — cover services ranging from acupuncture to in vitro fertilization and providers ranging from chiropractors to naturopaths.
- Mandates cover everything from the serious to the trivial: heart transplants in Georgia, liver transplants in Illinois, hairpieces in Minnesota, marriage counseling in California, pastoral counseling in Vermont and deposits to a sperm bank in Massachusetts.

Subsidies for Low-Income Families Will Add to Total Costs. The Clinton plan proposes to cap the required employer payments for employee health insurance, as shown in Table II. The maximum employer payment is 7.9 percent of payroll. Smaller businesses with moderate- and lower-income workers have lower caps. The lowest is 3.5 percent of payroll for businesses with fewer than 25 employees averaging less than $12,000 in income. The federal government would then be responsible for covering any necessary payments above these caps.[59]

"The Clinton plan proposes to cap payments by employers and workers, with the federal government covering necessary payments above the caps."

The Clinton plan also proposes to cap payments by workers for health coverage at 3.9 percent of income for families with incomes below $40,000 per year. Lower payments would be required from families earning less than 150 percent of the poverty level. The federal government would again have to pay any required payments above these caps.

Unnecessary Subsidies Will Add to Total Costs. The Clinton plan also includes a broad range of unnecessary government health care

TABLE II

Premium Caps for Small Businesses

(Percent of Payroll)

Average Wage[1]	Less than 25 Employees[2]	25-50 Employees	50-75 Employees
Less than $12,000	3.5	4.4	5.3
$12,000-15,000	4.4	5.3	6.2
$15,000-18,000	5.3	6.2	7.1
$18,000-21,000	6.2	7.1	7.9
$21,000-24,000	7.1	7.9	7.9
More than $24,000	7.9	7.9	7.9

[1] Average annual full-time equivalent wage.

[2] Average number of full-time equivalent employees.

Source: Health Security Act, Title VI, Subtitle A, Section 6123.

"The Clinton plan would generously subsidize health insurance for high-income retirees while forcing a struggling self-employed person to pay full fare."

subsidies, which would require taxes to be higher than otherwise. For example, new benefits for prescription drugs and long-term care are added to Medicare, despite the fact that Medicare enrollees have more aftertax income and more wealth than the rest of the population. The government will pick up 80 percent of insurance premiums for retirees age 55 to 64. In some cases, this will relieve employers of the cost of health insurance for early retirees.

The Health Care Bureaucracy Will Add to Total Costs. Further health costs would be added by the new bureaucracies and regulations that would be adopted under the Clinton plan. The new regional alliances are estimated to cost about $30 billion from 1995 to 2000 and to employ approximately 50,000 new health bureaucrats. The National Health Board, the National Quality Management Council and other new federal bureaucracies would add even more to costs. Moreover, the Clinton plan would impose costly new record-keeping and reporting requirements on doctors, hospitals, insurers and virtually everyone else in the health care system. Further, the information would have to be gathered, processed and disseminated through a new national health data bank that would also have to be funded.

"The Clinton plan would expand third-party payment of medical bills, which is the principal cause of health care inflation."

Expansion of Third-Party Payment of Medical Bills Will Add to Total Costs. The Clinton plan would add to the root cause of rapidly rising costs in our health care system: third-party payment of medical bills. For the health care system as a whole, patients currently pay only 21 cents out of pocket every time they consume a dollar's worth of services. The rest is paid by a third party (employer, insurance company or government). Moreover, the explosion in health care spending over the past three decades parallels the rapid expansion of third-party payment of medical bills. The patient's share of the bill over that period has declined from 52 percent in 1965 to 21 percent today.[60] Both economic studies and common sense confirm that patients spend more when they are spending someone else's money:[61]

- Over the past 30 years, the share of our income spent out of pocket on health care has actually declined — falling from 4 percent of total consumption expenditures in 1960 to 3.6 percent in 1990.
- Over the same period, the amount spent from all sources has more than tripled — rising from 4.2 percent of consumption in 1960 to 13.3 percent in 1990.

These numbers suggest that when we are spending our own money we are conservative consumers in the medical marketplace. The explosion in spending has occurred because someone else is paying the bill.

Instead of correcting this cost problem, the Clinton plan would perpetuate and extend it in several ways. The plan would:

- Extend such third-party coverage to all of the uninsured;
- Extend third-party coverage to an array of additional benefits for which most workers do not have coverage today; and
- Increase third-party coverage by imposing lower deductible and copayment fees than most people choose in their policies today.

Individuals in fee-for-service plans would be allowed an annual deductible of no more than $200, and copayments of 20 percent. Consumers in HMOs would pay a coinsurance fee of only $10 per visit. As noted above, Medical Savings Accounts and other plans with higher deductibles would become illegal.

Winners and Losers

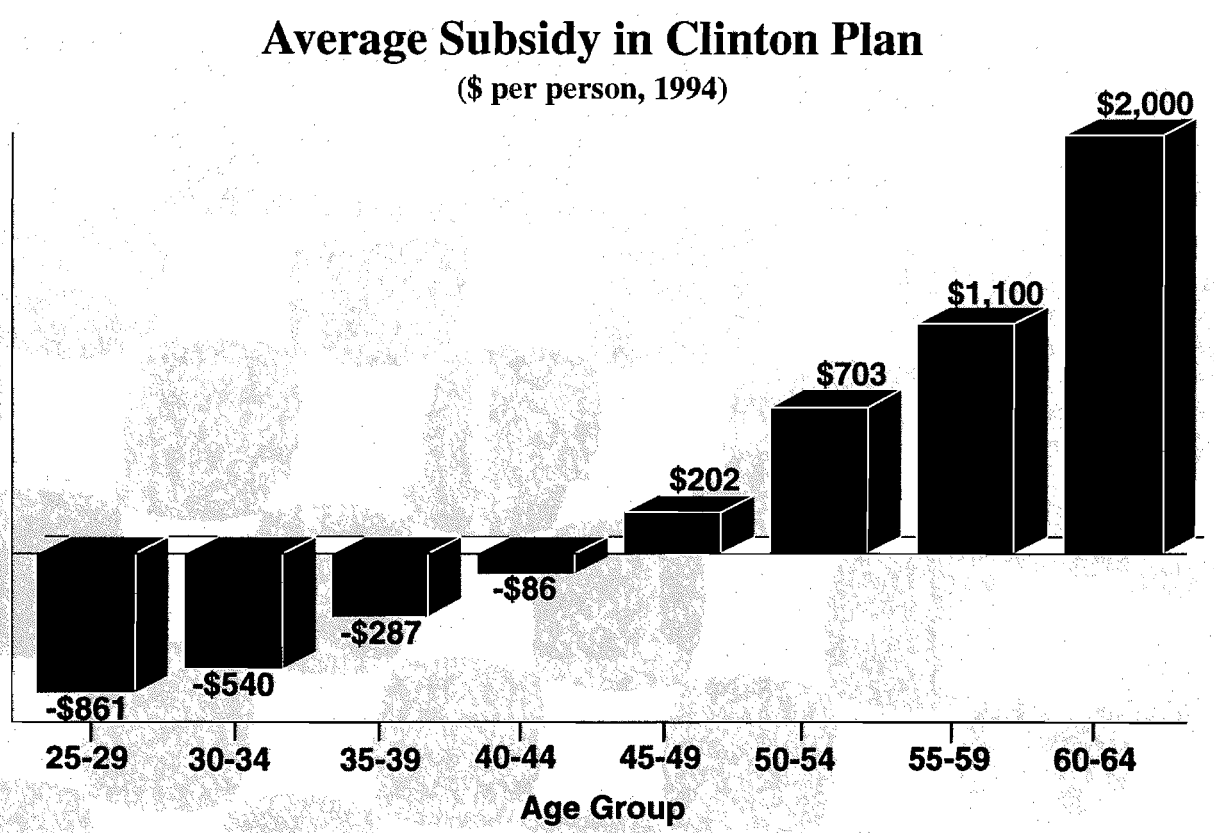
If the analysis in this report is correct, almost everyone would be worse off if the Clinton plan were adopted. But some would be affected more severely than others. What follows is a brief description of who would be subsidized and who would pay the subsidies.

"Young people would have to pay 50 percent more than the real cost of their health insurance."

The Effects of Community Rating by Age. Community rating — the practice of charging everyone the same premium — would benefit some and penalize others. Those who have above-average expected health care costs would gain, while those with below-average expected costs would lose. One way in which expected costs differ across individuals is by age. In general, adults ages 60 to 64 have expected health care costs that are two to three times as high as the expected costs for those age 25 to 29. In order to see what difference community rating would make, health economists David Bradford and Derrick Max analyzed the distribution of expected medical expenses and concluded that:[62]

- Although the average cost of health insurance (the community-rated premium) under the Clinton plan is predicted to be about $2,000 in 1994, the real cost of health insurance is $1,350 for people ages 25 to 29 and $4,000 for people 60 to 64. [See Figure II.]
- Community rating under the Clinton plan would overcharge young people by about $650 per year and subsidize older people by about $2,000.
- The Clinton plan would tax people ages 25 to 34 about $26 billion a year in order to help provide an annual subsidy of about $33 billion to those 55 to 64.

FIGURE II



Source: David A. Bradford and Derrick A. Max, "Soak-the-Young Economics of Clinton's Health Care Plan," American Enterprise Institute, 1994.

Is this enormous transfer of income fair? As Figures III and IV show, young workers have far less income and assets then older workers. Specifically:

- The median income for householders age 15 to 24 is $18,313 and for households 25 to 34 is $30,842 — well below other age groups.
- Persons under age 35 have less than half the assets of any other age group.

"People ages 25 to 34 would pay a $26 billion tax; those age 55 to 64 would get a $33 billion subsidy."

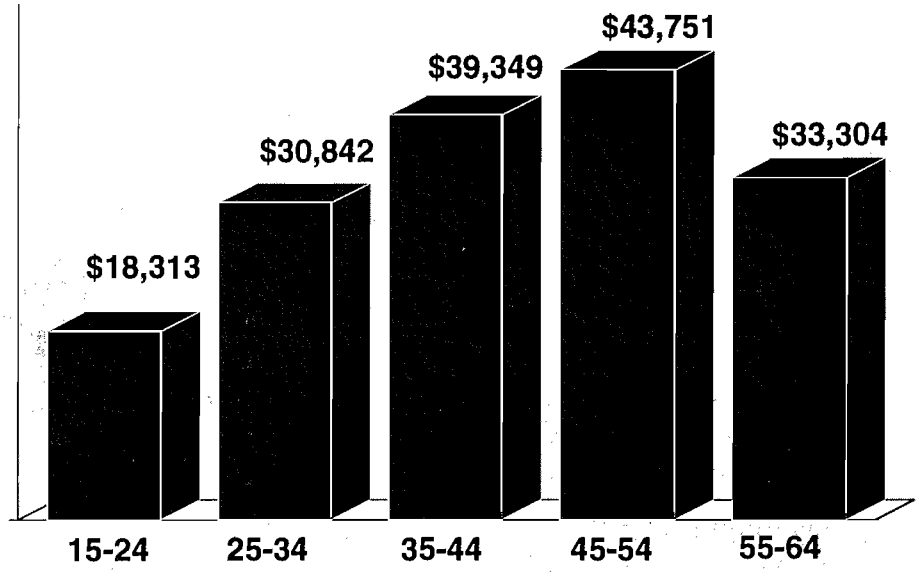
Community rating under the Clinton plan would, therefore, be enormously unfair and regressive. It would overcharge those who have far less income and assets in order to undercharge those who have far more.

The Effects of Community Rating by Industry. Community rating also would affect different sectors of the economy differently. Businesses that have young, relatively healthy workforces would face higher health care costs, while those with older, sicker workforces would see their health care costs fall. Table III shows what the combined effect of an employer mandate (requiring employers to pay 80 percent of premiums for all workers) and community rating would have been for different industries in 1992. As the Table shows:

"Community rating would overcharge those with far less income and assets and undercharge those with far more income and assets."

FIGURE III

Median Income By Age of Householder
(1991)

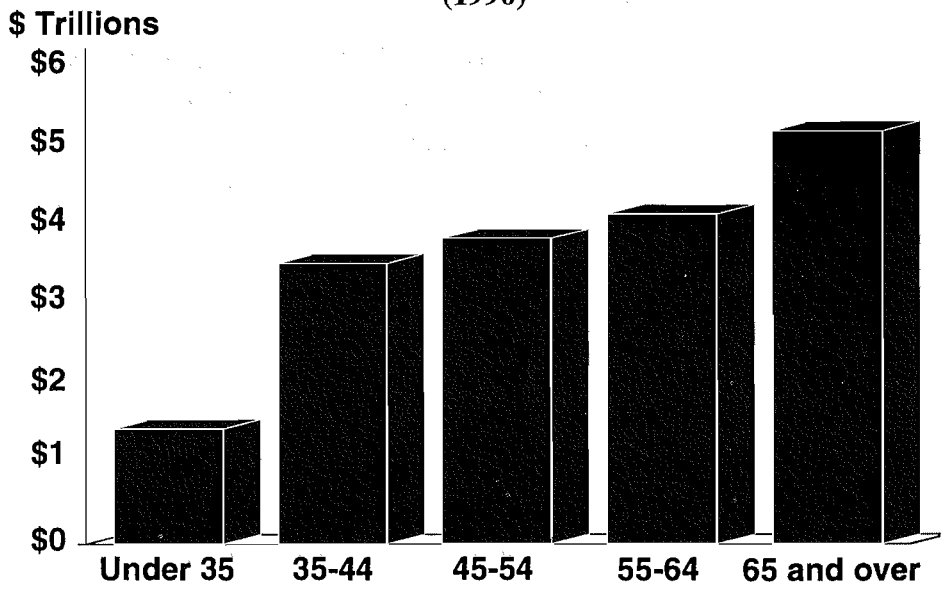


Source: Householder 1991 Current Population Survey (median income for householders). "Money Income of Households — Percent Distribution, by Income Level, for Selected Characteristics: 1991" in *Statistical Abstract of the United States,* 1993, p. 458 (Table No. 713).

"People under age 35 have less than half the assets of any other age group."

FIGURE IV

Who Has the Money: Distribution of Assets[1]
(1990)



[1] Assets exclude pensions and social security wealth.

Source: *Changing Times,* March 1990.

"There would be an enormous shift of wealth, including a 10.3 percent payroll tax on agriculture and an 8.3 percent subsidy for communications."

- The Clinton plan would add costs equal to $1,303 per retail worker and $1,647 per agricultural worker.
- By contrast, health costs per worker would fall by $3,502 in communications and by $2,067 in the electric, gas and sanitary services industries.
- These changes reflect an enormous shift of wealth — including a 10.3 percent payroll tax on agriculture and a 8.3 percent payroll subsidy to communications — that is based on the politics of medicine rather than the economics of production.

TABLE III

Effects of Community Rating and Employer Mandates by Industry[1]

Industry	Change in Health Care Costs in 1992: Dollars Per Worker	Change in Health Care Costs in 1992: Percentage of Wages
Agriculture, forestries and fishing	$1,647	10.3%
Mining	-1,728	-4.1
Construction	800	2.7
Manufacturing	-1,050	-3.2
Durable goods	-1,349	-4.0
Nondurable goods	-649	-2.2
Transportation	191	0.6
Communications	-3,502	-8.3
Electric, gas and sanitary services	-2,067	-4.8
Wholesale trade	-249	-0.7
Retail trade	1,303	7.5
Finance, insurance and real estate	67	0.2
Services	697	2.6
Private households	2,041	16.5
All industries	$236	0.8%

[1] Based on full-time equivalent workers; 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.

Source: *Medical Benefits*, March 15, 1994. Original Sources: Congressional Budget Office, 1994; *Brookings Papers on Economic Activity*, 1994.

The Effects on Low-Income Families. On the surface it might seem that low-income people would gain — especially in view of the subsidies they would receive. But that assumes they would otherwise pay a higher price for health insurance and that they are not already receiving free care at someone else's expense. If they already have access to free care, the Clinton plan promises increased burdens, with little increase in benefits.

"Low-income employees who work for large companies could lose one-fourth of their income."

Moreover, the subsidies would not be available unless low-income workers purchased their own health insurance or worked for a small business. Absent these conditions, low-income workers would be heavily penalized for two reasons. First, they would have to endure substantial wage reductions or face unemployment. Second, since low-income workers tend to be younger workers, they would be forced to pay 50 percent more than the real cost of their insurance. For example, consider that:

- A person who works 30 hours per week at $5 an hour for 50 weeks per year has an annual income of $7,500.
- If the Clinton plan's community-rated premium is $2,000, this employee's gross income will decrease more than one-fourth in order to pay the premium.

The Effects on Small Business. As Table II shows, the Clinton plan explicitly subsidizes small employers with low-income employees. This doesn't mean that the plan is good for small business, however. Even at the subsidized rates, costs will go up for most small enterprises, making it harder for then to create jobs. As Table III shows, industries where small businesses proliferate will be hard hit with increased costs, including retail trade and the service industries.

The Effects on the Uninsured. Surveys indicate that the uninsured already consume about two-thirds as much health care as those who have health insurance.[63] And given the presumption that they are on the whole healthier than people who are insured, it is not clear how much the uninsured would gain as a result of the Clinton health plan in terms of increased health care services.

"The uninsured would not only be forced to buy insurance, they would be forced to pay twice as much as it is really worth."

What is clear, however, is that the currently uninsured would face a stiff financial penalty. As Figure V shows, the uninsured are predominantly young (and healthy). As a result, they would pay far more under the Clinton plan for their coverage then necessary, in order to subsidize older and wealthier workers who mostly already have coverage. Indeed, over 50 percent of the uninsured would have to bear added costs of $1,000 to $2,500 per year under the Clinton plan, and more than 15 percent would have to bear added costs of over $2,500 per year.[64]

"Some of the largest companies could shift much of the cost of health care for their retirees the government."

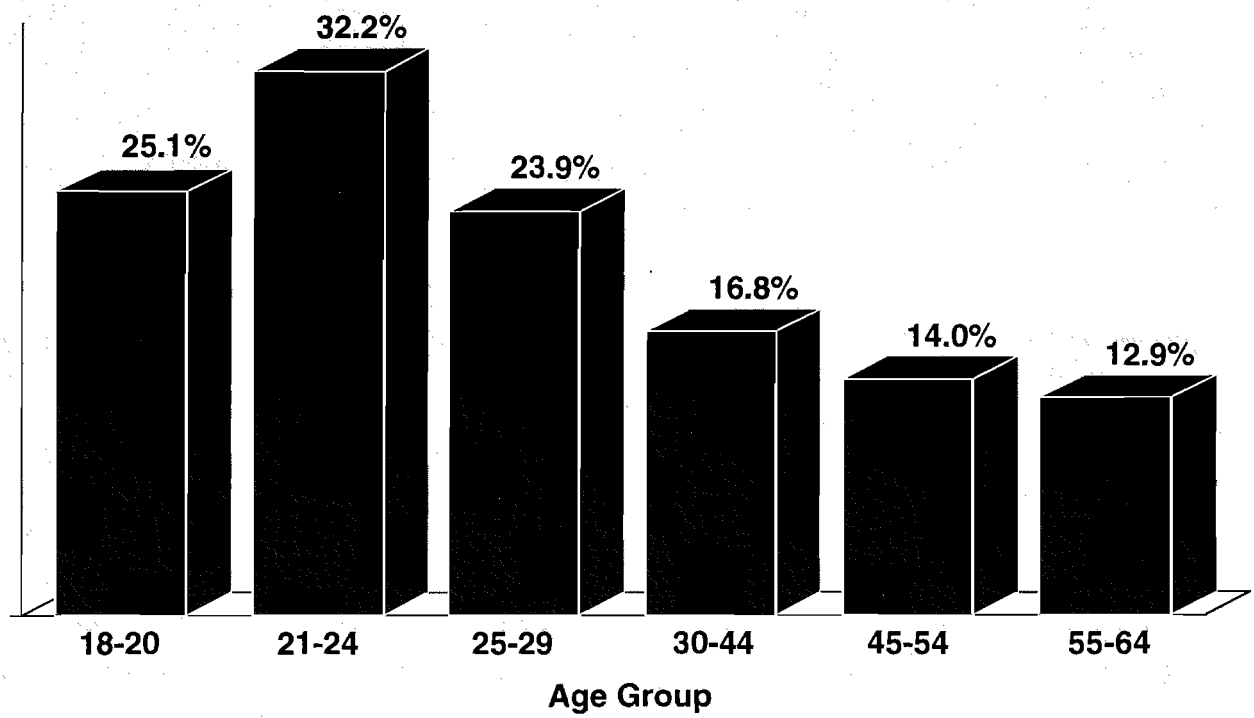
The Effects on Early Retirees. The Clinton plan proposes that the government pay the 80 percent employer share for the health coverage of retirees between 55 and 64. This mostly would benefit the largest companies, like the Big Three automakers, who have high health costs for lavish worker and retiree health plans. These companies could shift most of these costs to the government by laying off older workers with the high health costs. The older workers themselves would lose as a result, because they would be forced out of their current high paying jobs, into early retirement.

Other Effects of the Clinton Plan. Space does not permit a full discussion of all the ways in which the Clinton plan creates arbitrary winners and losers. The list of potential losers, however, is quite long and includes teenagers, elderly workers, workers with more than one job, two-earner families and others. [See the sidebar on Unusual Features.]

FIGURE V

Uninsured by Age

(1992)



Source: "Persons Aged 18-64 with Selected Sources of Health Insurance, by Sex and Age, 1992" in "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1993 Current Population Survey," Employee Benefit Research Institute Special Report.

Especially Unusual Features of the Clinton Health Plans

Many features of the Clinton health plan are unusual. Some are stranger than others.

Unfair Penalties for Teenagers. Part-time teenage workers and their employers would have to pay health insurance premiums, *even if the teenager is already covered by a parent's policy.* This feature of the bill could severely reduce job opportunities for young people.

Unfair Penalties for Elderly Workers. Elderly workers and their employers would have to pay health insurance premiums, *even if the employee is already covered by Medicare.* Since the employer's share would undoubtedly be "paid" by lower cash wages, this feature of the bill severely penalizes elderly workers.

Unfair Penalties for Workers with More Than One Job. People with more than one job could end up paying more than once for the same coverage. For example, a person who works 30 hours per week for each of two employers would have to *pay twice* for the same insurance coverage.

Unfair Penalties for Two-Earner Families. A husband and wife — both with full-time jobs — would have to *pay twice* for the same family health insurance coverage.

Unfair Penalties for the Young. On the average, a 25-year-old male spends about $560 a year on health care, while a 55-year-old spends $2,345. Yet under the Clinton plan's community rating, both would be charged the same premium. The result would be a massive redistribution of income from those who earn less to those who earn more.

Perverse Incentives for Early Retirement. Some people who retire early would obtain insurance coverage by paying only a few hundred dollars, although they would pay (directly or indirectly) about 10 percent of wages, or several thousand dollars, if they remained in the labor market.

Perverse Incentives for Companies With Dangerous Jobs. The cost of insurance for football players and coal miners would be the same as for others. This practice would reward employers who fail to create safer work environments and punish those who do.

Perverse Incentives to Segregate High-Income and Low-Income Workers. Low-income workers would benefit from subsidies that cap insurance premiums at a percent of payroll in small firms. As a result, large employers and those who pay above-average wages would tend to outsource or contract out work done by low-wage employees. Like public housing programs that base subsidies on where people live rather than on actual needs, this feature would base subsidies on where people work.

Source: C. Eugene Steuerle, "Economic Effects of Health Reform," American Enterprise Institute, 1994.

Why The Budget Deficit Will Increase

If, as many suspect, the Clinton plan fails to contain health care costs and the proposed caps on required employer and employee payments are retained, the costs to the federal government will soar.

Federal payments for expenses above the caps would add at least $425 billion to the federal budget deficit in the year 2000, almost twice the current deficit. From 1995 to 2000, more than $1.8 trillion would be added to the federal deficit. After a decade, the total federal deficit would grow to $1 trillion per year.[65] Alternatively, trying to close this deficit by raising new revenues would require a 50 percent hike in the federal income tax or the tax equivalent thereof.[66]

"Trying to close the probable deficit with new revenues would require a 50 percent increase in the federal income tax."

Several other factors would increase the budget deficit under the Clinton plan. These are briefly discussed below.

Higher Spending Due to More Third-Party Payment. As described above, the expansion of the third-party payment would be likely to further increase costs.

Expansion of Benefits Because of Special Interest Pressures. Special interests probably would succeed in adding more required benefits to the mandated standard government health insurance policy, further increasing the subsidies the federal government would have to pay to keep the promised caps on employer and employee premium payments.

"Special interest pressures could inflate the mandated health insurance policy — adding coverage for everything from marriage counseling to sperm bank deposits."

Expansion of Subsidies Because of Changes in the Labor Market. Employers would segregate their lower-income workers in separate corporations to qualify for the lower caps on employer payments for small companies with lower-income employees. They could do this by incorporating new subsidiaries or by contracting out to entirely separate companies formed to take advantage of this opportunity. This would sharply increase the cost of the caps to the federal government, again substantially increasing the deficit.

Failure to Realize Cigarette Tax Revenues. The 300 percent cigarette tax increase proposed in the Clinton plan would likely result in far fewer cigarette purchases. If the tax increase produced only 50 percent of the predicted revenue, the budget deficit would increase by $39 billion between 1996 and 2000, according to internal projections of the Clinton administrations Office of Management and Budget (OMB).[67]

Failure to Cut Medicare and Medicaid Spending. If Congress does not enact the specific Medicare and Medicaid cuts proposed under the Clinton plan, the budget deficit would increase by $218 billion between 1996 and 2000, under OMB's internal projections.[68]

Underestimate of the Cost of New Medicare Benefits. If the new Medicare benefits for prescription drugs and long-term care cost twice what is estimated under the Clinton plan, which is quite likely, and

Congress does not enact Clinton's proposed new premium on the elderly for these benefits, the five-year federal deficit would increase by almost $200 billion according to OMB's own projections.[69]

Retreat on Rolling Back Drug Prices. The Clinton proposal to require drug manufacturers to rebate charges above government-set fees for new drugs bought by the elderly under Medicare may not be adopted. If not, the five-year budget deficit would increase by another $22 billion, according to OMB's projections.[70]

Impact of Negative Effects on the Economy

As we shall see below, the negative effects on the economy of the Clinton plan would further increase the federal deficit, since fewer jobs and lower wages would result in lower tax revenues. Harvard Professor Martin Feldstein estimates that the reduced wages described above would cause a loss of $49 billion in tax revenue in 1997 alone, increasing the federal deficit by that amount in that year.[71]

Impact on the Economy

The Clinton plan would have powerful negative effects on the economy. The following summary of those effects draws on a number of independent economic studies.

"Even the Clinton administration admits its plan would cost 600,000 jobs."

Lost Jobs. Mandating employer payments for an expensive, government-required health insurance policy for all workers would raise the cost of employing those workers. As discussed above, if employers could not offset the added cost of the required insurance by reducing wages, then they would lay off workers. The job losses resulting from the employer mandates would be concentrated among low-income workers, where employers might not be able to reduce wages to offset the extra costs because of the minimum wage and other factors. Several sophisticated studies have estimated the likely magnitude of these job losses:

- Labor economists June O'Neil and David O'Neill of Baruch College estimate that Clinton's proposed employer mandate would cause as many as 2.1 million workers to lose their jobs.[72] [See Table IV.]
- Ohio State University economists Richard Vedder and Lowell Gallaway estimate that the Clinton plan would destroy 1,021, 000 jobs.[73]
- Joint Economic Committee economist Lawrence Hunter and Texas A&M economist Morgan Reynolds estimate that the Clinton plan would eliminate 1,151, 000 jobs.[74]
- The DRI/McGraw Hill consulting firm estimates the likely job loss from the Clinton plan at 888,000 jobs, with a possible job loss of almost 2.4 million.[75]

TABLE IV

Job Losses Under the Clinton Plan[1]

(thousands)

Industry	Job Losses Without Small Business Subsidies	Job Losses With Small Business Subsidies
Eating and drinking establishments	545.0	207.3
Other retailing	517.0	229.6
Construction	95.9	24.6
Agriculture	117.0	19.2
Business services	60.3	18.4
Personal services	147.0	39.7
Educational services	75.7	60.2
Transportation, communications and public utilities	32.4	14.3
Health services (excluding hospitals)	56.9	18.9
Wholesale trade	27.9	8.3
Repair services	39.0	9.8
Insurance and real estate	21.0	6.5
Household workers	124.0	10.9
Other professionals	15.6	4.3
Public administration	18.2	18.2
Hospitals	12.4	7.7
Rest of economy	231.4	82.6
Total	2,136.7	780.7

[1] Based on premium costs estimated by Hewitt Associates.

Source: June E. O'Neill and David M. O'Neill, "The Employment and Distributional Effects of Mandated Benefits," American Enterprise Institute, 1994.

"Other estimates place job losses at more than 3 million."

- A study by the CONSAD research firm found likely job losses from the Clinton plan of over 1 million.[76]
- A study by the Employment Policies Institute projected job losses under the Clinton plan in excess of 3 million, with losses especially severe in the restaurant industry (828,000 jobs lost), retail trade (726,000 jobs lost) and agriculture (194,000 jobs lost).[77]
- Even the Clinton administration admits that its plan would likely eliminate 600,000 jobs in the early years alone.[78]

Reduced Wages. Where workers do not lose their jobs because of the employer mandate, the Clinton plan will reduce their wages by the amount of the extra cost of the mandate, as discussed above.

- Harvard Professor Martin Feldstein, who also serves as president of the National Bureau of Economic Research, estimates that the Clinton plan would result in a 6.4 percent reduction in average wages by 1997, a net loss of $115 billion for the year in worker income.[79]
- Labor economists June O'Neill and David O'Neill estimate a wage reduction under the plan of about 6 percent for uninsured workers.[80]
- Economists Richard Vedder and Lowell Gallaway estimate that the plan would cause wage reductions of about $94 billion per year, with a total loss of personal income of $112 billion.[81]
- The DRI/McGraw Hill study estimates wage losses under the Clinton plan at almost $82 billion per year.
- Economists Larry Hunter and Morgan Reynolds estimate annual wage losses of about $106 billion.[82]

The Tax on Raises. The Clinton plan's mandated employer payments, subject to a complex system of caps, effectively operates as a tax on wage increases. If an employer at the 7.9 percent cap wants to give a worker a $1,000 raise, the employer must also pay an additional $79 for the worker's health insurance. Employers will also want to restrain wages further to qualify for the lower caps at lower wage levels. The end result of these factors would be lower wages over time.[83]

"There would be a 'health tax,' discouraging employers from granting employees a raise."

Impact on the Health Industry. If health care spending in the year 2000 is constrained to almost 25 percent less than it would otherwise be — as the Clinton plan promises — employment in health care also will be substantially less. American Enterprise Institute economist Mark Pauly estimates that by 2000 the Clinton plan would result in about 1 million fewer jobs in the health care sector.[84]

Conclusion

The fundamental question raised by the Clinton plan is not one of health care economics and financing. It is one of the basic freedom of Americans to control one of the most fundamental aspects of their lives — their own health care. Simply stated, the question is: Who should make the decisions about what health care you receive — you and your physician or the government?

President Clinton effectively says it should be the government. Indeed, no president has ever proposed such a massive increase in taxes, regulatory bureaucracy and central planning.

The alternative to the Clinton plan would shift power and control over health care away from government, insurance companies and employers, to individuals. This approach is known as patient power, and it is discussed in detail elsewhere.[85] Through such measures as Medical Savings Accounts, health insurance vouchers for the poor and other reforms, each individual can have choices about and gain control over his or her own health care.

"The alternative to the Clinton plan is to empower individual people."

NOTE: Nothing written here should be construed as necessarily reflecting the views of the National Center for Policy Analysis or as an attempt to aid or hinder the passage of any bill before Congress.

Notes

[1] See Dick Armey, "Your Future Health Plan," *Wall Street Journal*, October 13, 1993.

[2] This restriction has created great controversy. See, for example, Pete du Pont, "Mammogram Rule Shows Weakness of Clinton Health Plan," *Dallas Morning News*, April 5, 1994. See also Gina Kolata, "Breast Cancer Screening Under 50: Experts Disagree If Benefit Exists," *New York Times,* December 14, 1993; and "Do Women Under 50 Need Mammograms?" *USA Today*, March 31, 1994.

[3] Associated Press, September 19, 1993.

[4] Adam Clymer, "Tax Rise Sought by Rostenkowski for Health Care," *New York Times*, April 23, 1994.

[5] See "Managed Competition and Its Potential to Reduce Health Spending," Congressional Budget Office, May 1993.

[6] The program most often cited as an operational example of managed competition is the Federal Employees Health Benefits Program (FEHBP). Despite glowing descriptions by its defenders, however, the FEHBP has few of the desirable characteristics of a competitive system. Most people familiar with the FEHBP have concluded that it needs reform. This is the opinion of the Office of Personnel Management (OPM), which oversees the program, and of other analysts inside and outside of government. See Janet P. Lundy, "The Federal Employees Health Benefits Program," Congressional Research Service, CRS Issue Brief, updated June 11, 1992; and "Statement of the Consultants of the Committee on Post Office and Civil Service Before the Subcommittee on Compensation and Employee Benefits," Testimony before the House Subcommittee, May 20, 1992.

[7] Morgan O. Reynolds and Lawrence A. Hunter, "A Billion Dollars a Day: The Financing Shortfall in President Clinton's Health Care Proposal," Joint Economic Committee Staff, U.S. Congress, Washington, DC, January 1994.

[8] Estimate of past growth is from Sally T. Burnes et al., "National Health Expenditures: Projections through 2030," *Health Care Financing Review*, Vol. 14, No. 1, Fall 1992.

[9] The factors that supposedly produce waste in the current system would not be removed by these global budget limits and price controls. Such factors, therefore, would likely continue to produce wasteful spending. Moreover, the budget limits and price controls would not substantially reduce the net incomes of doctors, hospitals and other health providers, which are not important or objectionable factors in total health costs in any event. Health providers would allocate assigned budgets to maintain their incomes first. Alternatively, some would exit the market, reducing the supply and causing the compensation of those remaining to rise again in accordence with their experience and abilities.

[10] Patricia Day and Rudolf Klein, "Britain's Health Care Experiment," *Health Affairs*, Fall 1991, p. 43. See also Bruce Pyenson, "Inflation Hits British Private Medicine," *M&M Journal,* May/June 1992.

[11] See Patricia Danzon and Susan Begg, "Options for Health Care in New Zealand," CS First Boston NZ Limited, April 1991.

[12] Joanna Miyake and Michael Walker, "Waiting Your Turn: Hospital Waiting Lists in Canada, Third Edition," *Fraser Forum,* May 1993, Fraser Institute, Vancouver, BC.

[13] The number ranges from 1/2 percent in Canada to 2 percent in Britain. Note, however, that in the United States about 4 percent of the population accounts for about 50 percent of total health care costs. These are the patients who require surgery and access to expensive technology. If the same percentage holds for the other English-speaking countries, this implies that from 1/8 to 1/2 of all patients who need access to expensive medical technology are not receiving it — at least not promptly.

[14] George J. Schieber, Jean-Pierre Poullier and Leslie M. Greenwald, "U.S. Health Expenditure Performance: An International Comparison and Update," Health Care Financing Administration, *Health Care Financing Review,* Vol. 13, No. 4, Summer 1992, Table 11. For New Zealand, estimate of the New Zealand Department of Health.

[15] In Canada, the latest estimate is 23 percent. Edward Neuschler, *Canadian Health Care: The Implications of Public Health Insurance* (Washington, DC: Health Insurance Association of America, 1989), p. 18.

[16] Nancy M. Kane and Paul D. Manoukian, "The Effect of the Medicare Prospective Payment System on the Adoption of New Technology," *New England Journal of Medicine*, Vol. 321, No. 21, November 16, 1989.

[17] Edward E. Berger and Edmund G. Lowrie, editorial, *Journal of the American Medical Association*, Vol. 265, No. 7, February 20, 1991, pp. 909-10.

[18] Ron Winslow, "Cost Control May Harm Dialysis Patients," *Wall Street Journal*, February 20, 1991.

[19] Eric Muñoz et al., "Race, DRGs and the Consumption of Hospital Resources," *Health Affairs,* Spring 1989, p. 187.

[20] Maurice Passley, Bonita Brodt and Tim Jones, "Medicaid: System in Chaos," a series in nine parts, *Chicago Tribune,* October 31-November 9, 1993.

[21] Miyake and Walker, "Waiting Your Turn." See also Michael Walker and John C. Goodman, "What President Clinton Can Learn From Canada About Price Controls and Global Budgets," National Center for Policy Analysis, NCPA Policy Backgrounder No. 129, October 5, 1993.

[22] "Queues and Cooperation: The Canadian Approach to Rationing," *Medical Economics*, 1993.

[23] General Accounting Office, *Canadian Health Insurance: Lessons for the United States,* June 1991, Table 4.1, p. 55. See also Joan Breckenridge, "Grief, Frustration Left in Wake of Man Who Died on Waiting List," *Globe and Mail* (Ontario), January 25, 1989.

[24] Alain C. Enthoven, "The Effects of Managed Competition: Theory and Real-World Experience," in Robert B. Helms, ed., *Health Policy Reform: Competition and Controls* (Washington, DC: American Enterprise Institute, 1993), p. 226.

[25] Elizabeth McCaughey, "No Exit," *New Republic*, February 7, 1994, p. 2.

[26] Enthoven has also been quoted as saying: "We doubt that (private practice doctors) would generally be compatible with economic efficiency. We would expect this type of practice to continue, but to decline gradually in importance." See John Merline, "Can Dr. Marcus Welby Survive? Or Will Health Care Reform Kill Private Practice?" *Investor's Business Daily,* October 6, 1993.

[27] Louis J. Vorhaus II, "Let Us Journey Into the Mind of Managed Care," letter to the editor, *New York Times,* May 16, 1993.

[28] Barry B. Perlman, "At the Mercy of HMO Managers," letter to the editor, *Wall Street Journal*, January 21, 1994.

[29] Managed competition is a solution created by urban people to solve urban problems. The competition it envisions would never emerge for people living in rural areas or small to medium-size towns. One study estimates that a population of at least 180,000 people (which includes areas containing about 71 percent of the U.S. population) would be needed to support three managed care plans, but even then the plans would be limited in the services they could provide. As a result, no real competition could exist except in the most heavily populated areas. See Richard Kronick, David C. Goodman, John Wennberg and Edward Wagner, "The Marketplace in Health Care Reform: The Demographic Limitations of Managed Competition," *New England Journal of Medicine*, Vol. 328, No. 2, January 14, 1993.

[30] In today's market, people are primarily buying insurance rather than medical services. For that reason, if an insurer mistreated policy-holders after they become ill, everyone would have an incentive to avoid that insurer. The primary reason why people insure, after all, is to be well-treated if they become sick. Unlike today's market, under the Clinton plan people could switch insurers after they became sick. So people would have an incentive to choose a plan based on their health condition and the plan's reputation for treating that condition, not on the plan's reputation as an insurer.

[31] This section and the following one are partly based on John C. Goodman and Gerald L. Musgrave, "A Primer on Managed Competition," National Center for Policy Analysis, NCPA Report No. 183, April 19, 1994.

[32] A different way of appreciating this result is to consider it in terms of a basic principle taught in all introductory economics courses: when firms are maximizing profits, marginal revenue must equal marginal cost. Under managed competition, marginal revenue (the amount of premium each enrollee brings to a plan) must be the same for every enrollee. That means that marginal cost (the amount the plan spends on health care for a patient) must also be the same for every enrollee.

[33] See Paul Sperry, "Saving Money or Saving Lives?" *Investor's Business Daily,* January 17, 1994.

[34] See the review of the literature in Wynand P.M.M. Van De Ven and René C.J.A. Van Vliet, "How Can We Prevent Cream Skimming in a Competitive Health Insurance Market?" in P. Ziveifel and H.E. Frech III, eds., *Health Economics Worldwide* (Dordrecht, Netherlands: Kluwer Academic Publisher, 1992); and in Mark A. Hall, *Is Community Rating Essential to Managed Competition?* (Washington, DC: AEI Press, 1994). See also A.M. Epstein and E.J. Cumella, "Capitation Payment: Using Predictors of Medical Utilization to Adjust Rates," *Health Care Financing Review*,.Vol. 10, No. 1, 1988, pp. 51-69; and J.W. Thomas, R. Lichtenstein, L. Wyszewianski and S. Berki, "Increasing Medicare Enrollment in HMOs: The End for Capitation Rates Adjusted for Health Status," *Inquiry*, Vol. 20, 1983, pp. 227-39.

[35] See H.S. Luft, "Compensating for Biased Selection in Health Insurance," *Milbank Quarterly,* Vol. 64, 1986, p. 580; and Alain C. Enthoven, *Theory and Practice of Managed Competition in Health Care Finance* (North Holland: American Elsrvier, 1988), p. 86.

[36] For a discussion of the cost-plus system, see John C. Goodman and Gerald L. Musgrave, *Patient Power* (Washington, DC: Cato Institute, 1992), chs. 5-9.

[37] Under diagnosis-related group (DRG) systems, physicians and hospitals receive a predetermined amount from the federal government for whatever services they perform. At the most basic level, two mistakes can occur in any price-fixing scheme: either the price can be set too high or it can be set too low. If it is too high, the system encourages too many medical procedures; if it is too low, the system encourages too few. See Goodman and Musgrave, *Patient Power*, pp. 303-06.

[38] David Durenberger and Susan Bartlett Foote, "Medical Technology Meets Managed Competition," *Journal of American Health Policy*, May/June 1993, pp. 24-25. The Food and Drug Administration also is notorious for delaying new drug approvals for several years, adding to drug development costs in the process.

[39] Patricia Danzon, "Drug Price Controls, Wrong Prescription," *Wall Street Journal*, February 4, 1994. See also Henri A. Termeer, "The Cost of Miracles," *Wall Street Journal,* November 16, 1993; and Heinz Redwood, *Price Regulation and Pharmaceutical Research* (Suffolk, England: Oldwicks Press, 1993).

[40] Danzon, "Drug Price Controls, Wrong Prescription."

[41] Office of Technology Assessment, *Pharmaceutical R&D Costs, Risks, and Rewards,* Washington, DC, February, 1993.

[42] See Robert M. Goldberg, "Pharmaceutical Price Controls: Saving Money Today or Lives Tomorrow?" Institute for Policy Innovation, IPI Policy Report No. 123, September 1993.

[43] Ibid., p. 23.

[44] Ibid., p. 28.

[45] Miyake and Walker, "Waiting Your Turn."

[46] One way to allow patients to make the decisions is by encouraging Medical Savings Accounts (MSAs). These tax-free accounts would be the property of the employee. Money could be withdrawn without penalty to pay medical expenses or health insurance premiums, even during periods of unemployment. Money not spent would grow tax free and could be used for medical expenses after retirement or rolled over into an IRA or pension plan. It would become part of a person's estate at death. See John C. Goodman and Gerald L. Musgrave, "Controlling Health Care Costs With Medical Savings Accounts," National Center for Policy Analysis, NCPA Policy Report No. 168, January 1992. See also Goodman and Musgrave, "Personal Medical Savings Accounts: An Idea Whose Time Has Come," National Center for Policy Analysis, NCPA Policy Backgrounder No. 128, July 22, 1993.

[47] Based on computer search by Jane M. Orient, Executive Director, American Association of Physicians and Surgeons, Tucson, Ariz.

[48] See the discussion of the issue in Pete du Pont, "Mammogram Rule Shows Weakness of Clinton Health Plan;" Gina Kolata, "Breast Cancer Screening after 50;" and "Do Women Under 50 Need Mammograms?"

[49] Because Canadian physicians are prohibited from operating outside the system, Canadians who need immediate, sophisticated care come to America, which has become the "safety valve" for Canada. For example, in 1991 British Columbia sent 10 percent of its cancer patients to America for therapy. See Marcia Berss, "'Our System Is Just Overwhelmed,'" *Forbes,* May 24, 1993, pp. 40-41.

[50] See Robert Brook et al., *The Effect of Coinsurance on the Health of Adults* (Santa Monica, CA: Rand, 1984); and Willard Manning et al., "Health Insurance and the Demand for Health Care: Evidence From a Randomized Experiment," *American Economic Review,* June 1987. For a survey of economic studies of the demand for medical care, see Paul Feldstein, *Healthcare Economics* (New York: Wiley, 1988).

[51] John Merline, "Employees as Health Reformers," *Investor's Business Daily,* March 18, 1994; and Rachel Wildavsky, "Here's Health-Care Reform That Works," *Reader's Digest*, October 1993.

[52] Hunter and Reynolds, "A Billion Dollars a Day," p. 33.

[53] Lewin-VHI, "The Financial Impact of the Health Security Act," Fairfax, VA., 1993.

[54] In economic terms, wages, or total employment costs, for a worker will equal the marginal productivity of that worker.

[55] Hunter and Reynolds, "A Billion Dollars a Day."

[56] Ibid., p. 23.

[57] Ibid., p. 36.

[58] See John C. Goodman and Gerald L. Musgrave, "Freedom of Choice in Health Insurance," National Center for Policy Analysis, NCPA Report No. 134, November 1988.

[59] The subsidies are not indexed to inflation, so they presumably would disappear over time.

[60] See John C. Goodman, "How the Federal Government Is Causing Our Nation's Health Care Crisis," National Center for Policy Analysis, NCPA Policy Backgrounder No. 119, June, 22, 1992; and Gary Robbins, Aldona Robbins and John C. Goodman, "How Our Health Care System Works," National Center for Policy Analysis, NCPA Policy Report No. 177, February 1993.

[61] Ibid.

[62] David F. Bradford and Derrick A. Max, "Soak-the-Young Economics of Clinton's Health Care Plan," American Enterprise Institute, 1994. An earlier version of this article appeared in the *Washington Times*, February 8, 1994.

[63] A recent study by the Rand Corporation shows that adults lacking health insurance for a full year have about 60 percent as many ambulatory contacts and 70 percent as many inpatient hospital days as those covered by insurance. See H. Long and M. Susan Marquis, "The Uninsured 'Access Gap' and the Cost of Universal Coverage," *Health Affairs,* Spring 1994.

[64] Lewin-VHI, "The Financial Impact of the Health Security Act."

[65] Ibid, pp. 34-39.

[66] Ibid, p. 39.

[67] Daniel J. Mitchell, "The Economic and Budget Impact of the Clinton Health Plan," Heritage Backgrounder No. 974, January 13, 1993, p. 7.

[68] Ibid.

[69] Ibid.

[70] Ibid.

[71] Martin Feldstein, "The Impact of Health Care Reform on the Budget Deficit," address at the American Enterprise Institute's conference on the nation's health, September 23, 1993.

[72] Clinton's proposed caps on employer payments would reduce this job loss to 780,000 at the start. But since the thresholds for the lower caps below 7.9 percent are not indexed for inflation, over time these lower caps would effectively be phased out. With only the 7.9 percent employer payment cap remaining effective, almost 900,000 workers would lose their jobs. See June E. O'Neill and David M. O'Neill, *The Employment and Distribution Effects of Mandated Benefits* (Washington, DC: American Enterprise Institute, 1994).

[73] Richard Vedder and Lowell Gallaway, *Concealed Costs: The Real Impact of the Administration's Health Care Plan on the Economy* (Washington, DC: American Legislative Exchange Council, 1994).

[74] Hunter and Reynolds, "A Billion Dollars a Day."

[75] DRI/McGraw Hill, "The Administration's Health Care Reform Plan: National Macroeconomic Effects," February 1994.

[76] "The Employment Impact of Proposed Health Care Reform on Small Business," CONSAD Research Corporation, The NFIB Foundation, May 1993.

[77] June E. O'Neill and David M. O'Neill, *The Impact of a Health Insurance Mandate on Labor Costs and Employment: Empirical Evidence* (Washington, DC: Employment Policies Institute, September, 1993.)

[78] Laura Tyson, Chairman, President's Council of Economic Advisors, quoted in the *Wall Street Journal,* October 7, 1993.

[79] Feldstein, "The Impact of Health Care Reform on the Budget Deficit."

[80] O'Neill and O'Neill, *The Impact of a Health Insurance Mandate on Labor Costs and Employment.*

[81] Vedder and Gallaway, *Concealed Costs.*

[82] DRI/McGraw Hill, "The Administration's Health Care Reform Plan"; Hunter and Reynolds, "A Billion Dollars a Day."

[83] Martin Feldstein, "Clinton's Hidden Health Tax," *Wall Street Journal,* November 10, 1993.

[84] Mark V. Pauly, "Clinton Health Plan Mandates Serious Employment Distortions," *On the Issues,* American Enterprise Institute, December 1993.

[85] See Goodman and Musgrave, *Patient Power.*

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