Forecasting the Effects of the Clinton Health Plan

by

Gary Robbins

and

Aldona Robbins

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National Center for Policy Analysis
12655 North Central Expressway
Suite 720
Dallas, Texas 75243
(214) 386-6272

Executive Summary

The Clinton health plan promises to insure the uninsured and to replace existing coverage with more generous health insurance benefits for most people. At the same time, the administration claims that under its plan health care spending would be lower than it would have been without reform, both in the public and private sectors.

How can we expand health insurance benefits and at the same time lower health care spending? The administration proposes that we (1) encourage most people to join health maintenance organizations (HMOs) practicing managed care, (2) require people to purchase their insurance in an artificial market called managed competition and (3), if all else fails, impose global budgets and price controls.

Yet the administration and its allies in Congress are increasingly retreating on the concept of managed care and repeatedly have said, "Under the Act, you can pay 'out-of-pocket' for anything you want at any time, to any physician or hospital willing to treat you." The Congressional Budget Office has observed that managed competition is a theory that has not yet been put into practice anywhere in the world and that there is little reason to believe it can control costs. Even Canada — with a full-blown system of global budgets, price controls and health care rationing — has been unable to achieve spending targets as low as the Clinton plan promises.

Because there is so much uncertainty about how a reformed health care system would function, we have produced three forecasts of the Clinton health plan — optimistic, intermediate and pessimistic. The optimistic forecast assumes that the administration will be able to make cuts in Medicare and Medicaid spending of a magnitude no previous administration has achieved and to hold private sector spending constant in real terms after a few short years. The intermediate forecast assumes that Clinton can make his proposed cuts in federal health programs but will fail to control private health spending beyond the constraints of normal market forces.

The third and most likely forecast assumes that the plan not only will fail to control private sector spending but also will fail to achieve the cuts in Medicare and Medicaid. This pessimistic forecast assumes that the Clinton plan — like every other major health care program in the modern era, both here and abroad — will expand benefits and fail to control costs. Specifically, under the pessimistic forecast:

- Health care spending soars — adding at least $1,000 per household to the nation's annual health care bill within five years.
- Attempting to meet the demand for more health care services causes the economy to pay an increasingly higher price — and to lose $300 billion per year in other goods and services by the year 2005.
- The inefficiencies caused by attempting to expand health care output combined with the impact of higher taxes harms the economy as a whole and leads to 783,000 fewer jobs by the year 2000.
- Despite the higher taxes, costs to the federal government exceed revenues, producing deficit spending that would accumulate to $1.6 trillion over the next decade.

If those results are averted, say because the administration succeeds in artificially restricting the supply of health services, patients will suffer. The demand for health care will exceed the supply by more than $3,000 per household and almost one out of every six medical procedures will have to be rationed.

Introduction:

Major Features of the Clinton Health Plan[1]

The Clinton administration has proposed sweeping changes for the U.S. health care system. The purpose of this study is to forecast the effect those changes would have on the average family, the U.S. health care system and the economy as a whole. As we prepared this study, various congressional committees were making important changes to the Clinton plan. By identifying and quantifying the plan's underlying problems, we hope to provide policymakers with information that is useful to their deliberations.

"For many, the standard benefits would be more generous than the benefits in their current health insurance."

Mandated Health Insurance for Everyone. All Americans under age 65 would be required to purchase a standard health benefits package through a regional health alliance. For many, the standard coverage would be more generous than their current health insurance. The package would include the following services: hospital; health professionals; emergency and ambulatory medical and surgical; clinical preventive; family planning; hospice care; home health care; extended care; ambulance; outpatient laboratory, radiology and diagnostic; outpatient prescription drugs; outpatient rehabilitation; durable medical equipment and prosthetic and orthotic devices; vision care; dental care; health education classes; and certain treatments under clinical investigation in approved research trials. Some benefits such as dental and mental health care would be phased in over time.

Premiums for the Standard Benefit Package. The cost of this package is a key determinant of how much the overall proposal will cost the country. The Congressional Budget Office (CBO) estimates that premiums in 1994 would range from $2,100 for an individual to $5,565 for a two-parent family.[2] Other estimates put the price tag higher. [See Table I.] Despite the fact that the actuarial cost of insurance differs considerably by age, occupation and other characteristics, "community rating" would require health plans to charge the same premium to all their enrollees.

Employer Contributions. Employers would be required to provide health insurance for their workers. Although nominally 80 percent of premiums would be paid by the employer and 20 percent by the worker,[3] economists are convinced that fringe benefits and other labor costs are substitutes for wages. Health insurance, therefore, would replace other forms of labor compensation and its full cost would be borne by workers.[4] Businesses with fewer than 5,000 employees would have to purchase insurance through regional health alliances. Larger firms could form their own corporate alliances but would pay a tax of 1 percent of total payroll.

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; and 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.

"Most estimates put the cost of premiums higher than either the Clinton administration or the Congressional Budget Office."

People without access to employer-provided coverage would have to purchase insurance on their own. As discussed below, some individuals and businesses would be eligible for federal tax help to pay the premiums.

Tax Subsidies. Employers would receive federal tax assistance to purchase insurance. The subsidies would be designed to limit premium payments by employers participating in regional alliances to 7.9 percent of payroll. Similar subsidies would be available for those in corporate alliances after four years. Premiums would be further reduced for small firms that pay low wages. Firms with fewer than 25 employees and average annual wages of $12,000 or less would pay premiums of only 3.5 percent of payroll. Subsidies would phase out entirely when firm size reached 75 employees or when the average wage reached $24,000. [See Table II.] Finally, self-employed persons could deduct 100 percent of their premiums from their income taxes.[5]

Low-income individuals and families also would receive federal tax assistance to purchase health insurance through regional alliances. Families receiving welfare assistance or with incomes below $1,000 in 1994 would not have to pay any premium for a standard package. For those who obtain insurance through an employer, the employee's share of the premium (20 percent of the total) would be limited to 3.9 percent of income for all families with

incomes below $40,000. Subsidies also would be available to those who have to pay the full premium if their incomes are below 250 percent of poverty.[6]

"The administration will try to reduce spending while expanding health care benefits for most people."

Medicare and Medicaid. Major funding for the administration's reform plan would derive from spending cuts in Medicare and Medicaid. Medicare spending, which is currently projected to grow at an annual rate of 11 percent, would be reduced by $132 billion between 1995 and 2000, primarily through further reductions in payments to hospitals and doctors. [See Table A-II in the appendix.] At the same time Medicare funding is to be cut, Medicare benefits would be expanded to include prescription drugs at a cost of $69 billion. Starting in January 1996, Medicare Part B would cover prescription drugs after a $250 deductible, a 20 percent copayment and a $1,000 out-of-pocket limit.

Medicaid outlays also would drop substantially under the administration plan. People currently receiving Medicaid benefits, but not cash welfare benefits, would obtain their coverage from regional health alliances. The low-income tax subsidies previously discussed would help offset the cost of insurance. Medicaid would continue to cover people receiving cash welfare payments, but health benefits would be provided through regional alliances. Initially, the federal government would pay only 95 percent of what it would have paid under current law. Afterwards, premiums for Medicaid recipients would grow at the same rate as other premiums in the alliance. Medicaid also would no longer make payments for disproportionate-share hospitals.[7]

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

"Subsidies would be given to small firms with low-wage employees."

[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.

In Medicaid as in Medicare, the Clinton administration proposes to expand benefits while reducing funding. For example, the plan would liberalize eligibility for Medicaid long-term care benefits and establish a new entitlement program for home care and community-based care for the severely disabled. Despite these new benefits, the administration projects that, on net, Medicaid outlays would be $153 billion lower than otherwise between 1995 and 2000.

"In addition to requiring the purchase of health insurance, the plan would raise taxes by $196 billion."

Tax Increases. The Clinton administration would raise taxes by $196 billion between 1995 and 2000 to help pay for its health reform plan. Of this, $88 billion would come from higher taxes on individuals. These would include a 75-cent increase in the tobacco tax, an extension of the Medicare Hospital Insurance tax (the Medicare portion of the FICA tax) to all state and local government employees, an increase in the Medicare Part B premium for higher-income retirees and an end to the exclusion of (medical) flexible spending accounts from employees' taxable income.[8] Another $61 billion would come from higher taxes on businesses, primarily a 1 percent payroll tax on corporations that set up their own health alliances.

The National Health Board. The Clinton administration's health care plan would create two complex new bureaucracies: the National Health Board and regional alliances. The National Health Board, administered by the Health and Human Services and Labor departments, would specify the minimum standard benefit package. The board also would set the initial maximum per capita premium that could be charged in each regional alliance and the limits on the growth of that premium over time.

Regional Health Alliances. Regional alliances would collect premiums from individuals, employers and governments and disburse those payments to health care plans. Alliances would contract with health care providers, enroll people in plans, collect and distribute information about plan cost and performance and set premiums. To pay for these administrative tasks, alliances could collect an annual fee of up to 2.5 percent of premiums.

Price Controls and Global Budgets. The Clinton administration hopes that its plan will control health care costs through competition and incentives. (See the discussion below.) However, as a backup, the plan would limit the growth of premiums over time. The goal is to restrict the increase in the national average per capita premium charged by regional alliances for the standard benefit package to the limits shown in Table III. The plan also would limit total federal payments to alliances and would allow governments to impose price controls on doctors and hospitals in order to help meet the national global budget.

Winners and Losers Under Clinton Health Reform. Virtually every important economic group would experience gains and losses under the Clinton plan. And because so many changes affect everyone, it is very difficult to determine how much any one group would gain or lose on net.

TABLE III

Clinton Plan Limits on the Rate of Growth in Private Health Insurance Premiums[1]

1996	1997	1998	1999	2000	2001
CPI[2] + 1.5%	CPI + 1%	CPI + 0.5%	CPI	CPI	CPI + Real GDP

[1] National average per capita premium charged by regional alliances for the standard benefit package.

[2] CPI = Consumer Price Index.

For example, between 1995 and the year 2000, Medicare spending would be cut by $132 billion, even though $61 billion in new benefits would be created. On balance, it looks as though the elderly could be shortchanged. However, as we show below, under the plan the elderly will see their share of our total health care resources increase substantially over the next decade.

Medicaid spending would be cut by $132 billion, even as $71 billion in new benefits are created. It might seem that Medicaid beneficiaries will be shortchanged. However, the ability of Medicaid recipients to join the health alliances probably means there will be an expansion of their health care consumption.

Private employers would see their health costs capped and post-retirement health expenses for early retirees picked up by the federal government. However, they would also face higher taxes that would be imposed in a number of ways.

"Because there are so many changes, it is difficult to determine how much any one group would gain or lose on net."

One thing seems clear, however, from the forecasts presented in this study: if everything goes as planned, any savings will go to government. Specifically, the federal government's share of health care spending will drop from 52 percent to 43 percent by the year 2005. By contrast, the share paid by private insurance (purchased mainly through the workplace) will rise from 31 percent to 40 percent.

Can the Clinton Plan Succeed in Controlling the Rise in Health Care Spending?

The Clinton plan would extend health insurance to the uninsured and expand the benefits of most of the currently insured. This expansion of third-party payment of medical bills would undoubtedly add fuel to health care inflation. At the same time, the administration is counting on other changes to more than offset this increased spending:[9]

- Health care spending would actually be $30 billion lower than otherwise in the year 2000 if the plan works as advertised.
- By the year 2004, health care spending would be about 6.7 percent lower than otherwise, if Clinton's national spending targets are met.

How does the administration plan to expand health insurance and at the same time reduce overall spending? By (1) substituting managed competition for the current market for health insurance, (2) replacing traditional fee-for-service with managed care and (3) imposing global budgets and price controls. Let's look briefly at these three changes.

Managed Competition.[10] Under managed competition, employees would choose from an array of health insurance plans. The employer's contribution would be a fixed sum of money, and the employee would pay the balance of the premium. If an employee chose a more expensive plan, the extra cost would come out of that employee's pocket. Presumably this would make employees more price-conscious and encourage health insurers to be more competitive by holding down the cost of their plans. Insurers would be forced to charge the same premium to every applicant (community rating) and to accept all applicants regardless of health conditions (guaranteed issue). Thus insurers, precluded from competing on the basis of their ability to price and manage risk, would be forced to compete on their ability to provide health care and manage its cost.

"Managed competition would be unlikely to control costs because buyers would never confront prices that reflect the real cost of services."

Proponents claim that managed competition can control health care costs. Yet this conclusion has been questioned by the Congressional Budget Office[11] and by independent health economists.[12] One reason why managed competition would be unlikely to control costs is that buyers would never confront prices that reflect the real cost of services they intend to use. For the sickest patients, who are most likely to comparison-shop carefully, the expected benefits of treatment would be so much higher than the premium payment that quality of care would tend to govern choices. And for the healthiest patients, who would be overcharged, competition would induce insurers to offer additional services and thus add to total cost.[13]

Managed Care. Although the term managed care is applied to a wide range of activities designed to make medical care more cost-effective, in almost all of its versions it involves third-party interference with the practice of medicine.[14] Supporters of managed care argue that they can make the health care system more efficient and more affordable, in part by promoting primary and preventive care and reducing the need for specialized acute care. By encouraging physicians to follow "practice guidelines," they maintain, they can improve quality at the same time they control costs.

The most common setting in which managed care is fully implemented is a health maintenance organization (HMO), in which patients pay virtually

nothing at the time they consume medical services (e.g., no deductibles or copayments). Since these patients perceive medical care as free, they have incentives to overconsume it. The HMO bureaucracy must institute barriers to keep that from happening. Just as managed competition creates an artificial market for health insurance, managed care creates an artificial market for medical care in which the price system is almost completely suppressed.

Do HMOs control costs? The evidence is mixed.[15] Some studies indicate that the adoption of managed care techniques can lead to a one-time reduction in costs of about 10 to 15 percent by substituting less expensive for more expensive therapies. For example, since physician visits and drugs are both less expensive than hospitalization, managed care tends to substitute the former for the latter whenever possible.

On the other hand, because HMOs make services virtually free to patients at the time they are consumed, they face the problem of overconsumption.[16] The National Center for Policy Analysis/Fiscal Associates Health Care Model indicates that substituting less expensive for more expensive therapies could reduce the nation's annual health care bill by as much as 15 percent. However, reducing out-of-pocket spending from the current average of 21 percent to 10 percent of total health care costs would lead to a consumption increase that would wipe out the savings.[17]

Even if HMOs do reduce costs initially, managed care costs grow at the same rate as costs in other types of health care delivery systems — if not faster.[18] The reason managed care cannot reduce costs significantly over time is that it does not address the primary problem of the health care industry: most consumers entering the medical marketplace are spending someone else's money. Economic studies and common sense confirm that people are less likely to be prudent shoppers if someone else is paying the bill.[19] Ultimately, if costs are to be controlled, *someone* must choose between health care and other uses of money.

"Managed care does not address the primary problem: most consumers in the medical marketplace are spending someone else's money."

Moreover, whether or not HMOs can control health care costs becomes increasingly irrelevant as the Clinton administration and its congressional allies retreat from the idea of imposing managed care on the nation's health care system. Although the original proposal was to push almost everyone into an HMO,[20] the administration now says that everyone will have a fee-for-service option and that HMO subscribers will be able to pay more and see doctors outside their plans. The administration has even explicitly stated, "Under the Act, you can pay 'out-of-pocket' for anything you want at any time, to any physician or hospital willing to treat you."[21]

Global Budgets. Real per capita health care spending has been increasing in virtually every country. In the United States, for example, it increased by 4.6 percent per year between 1985 and 1990. Yet, as Table III shows, the Clinton administration would reduce that number to 1.5 percent in

1996 and to zero by 1999 in the private sector. Reaching this goal would be virtually impossible without severe health care rationing.[22]

As noted above, if all else fails the administration plans to rely on global budgets to control the volume of services. Defenders of this approach point to the experience of Canada and other developed countries with global budgets. Yet Canada has come nowhere near achieving the spending limits projected by the Clinton plan,[23] and there is no reason to believe that limitations on available health care resources would eliminate waste and inefficiency. Indeed, the experiences of three other English-speaking countries with cultures similar to our own — Canada, England and New Zealand — show that global budgets *increase* waste while causing patients to wait for needed care.[24] Moreover, even if severe rationing were theoretically possible, it is not clear that either our judicial system or our political system would permit it.

"Experiences in other countries show global budgets increase waste while causing patients to wait for needed care."

Simulating the Effects of the Clinton Health Care Plan

We used the National Center for Policy Analysis/Fiscal Associates Health Care Model to simulate the effects of the Clinton health care proposal. The Health Care Model is linked to the rest of the economy by the Fiscal Associates Tax Model that explicitly incorporates detailed information on tax policy and how it affects the economy, capital investment, output and jobs.

Our *dynamic* simulations forecast what would happen to the health care sector and the economy if the Clinton plan were enacted with respect to the *baseline* — based upon the Congressional Budget Office's latest projections of economic performance and health care spending under current law.[25] [See Table A-II.] We used the CBO's initial estimates of the national average premiums charged by regional alliances and the Clinton plan's effect on spending by government health programs to project health spending by type of payer from 1995 through 2005.[26] We used the administration's February budget estimates for tax revenues and tax subsidies under the Clinton health care proposal.[27]

Assumptions. We have produced three distinct forecasts based on three different assumptions. As Table IV shows:

- The *optimistic forecast* assumes that the administration will meet its spending targets.
- The *intermediate forecast* assumes that the planned cuts will be made in Medicare, Medicaid and other government health programs — either because of increased efficiency or health care rationing — but that private sector health spending will not be deterred.

- The *pessimistic forecast* assumes that planned cuts in government health programs will not be made and that private health spending will not be deterred beyond the constraints of normal market pressures.

Conservatism of the Assumptions. Virtually every administration in modern times has projected significant cuts in Medicare and Medicaid, and all of these attempts have been thwarted. If the past is a guide to the future, we cannot expect the administration's planned cuts in government health programs to be successful. Moreover, even if the administration succeeds in cutting Medicare spending, the result is likely to be a shifting of costs to the private sector rather than a net reduction in health care spending. According to the Physician Payment Review Commission, an independent group that advises Congress on Medicare and Medicaid, Medicare currently pays physicians only 59 percent of what private insurance companies pay. Under the Clinton plan, that figure would drop to between 43 percent and 52 percent.[28] Moreover, for the reasons given in the previous section, it also is most unlikely that the Clinton spending targets will be met in the private sector. Thus neither the optimistic nor the intermediate forecast seems likely to be realized.

"If the past is a guide to the future, the most likely results are those predicted by the pessimistic forecast."

The results that are the most likely are those predicted by the pessimistic forecast. However, even the assumptions behind this forecast are very conservative. It by no means depicts the worst that can happen. As Table I

TABLE IV

Assumptions Behind the Forecasts

Variable	Optimistic Forecast	Intermediate Forecast	Pessimistic Forecast
Cost of Premiums[1]	**CBO**	**CBO**	**CBO**
Cuts made in federal health programs	**Yes**	**Yes**	**No**
Alliance premium limits	**Yes**	**No**	**No**
Value placed on additional mandated insurance[2]	**60%**	**60%**	**60%**
Labor supply elasticity	**0.3**	**0.3**	**0.3**

[1] Congressional Budget Office estimate.

[2] Actual value placed on health insurance by those who would otherwise not purchase it expressed as a fraction of the community-rated premium.

shows, the premiums for the mandated package of benefits (and therefore spending on health care) could be 50 percent or more greater than we have assumed.

Forecast of the Clinton Plan: Effects on the Health Care Sector

Our forecasts of the general effects of the Clinton health plan on the economy are shown in Table V. Let's turn first to the health care sector.

Effects on Overall Health Spending. If the administration fails to make the planned cuts in government health care spending and if normal market forces prevail in the private sector, Table V shows that the expansion of health insurance benefits would lead to greater health care spending:

- Under the pessimistic forecast, health care spending would be 8.6 percent higher than otherwise after five years.
- The country would spend $112 billion per year more than otherwise by 1999 — an amount that exceeds $1,000 per year per household.

"Under the pessimistic forecast health care spending will soar."

The only surprising aspect of this prediction is that the results do not get worse over time. Compared to the baseline forecast shown in Table A-II in the appendix:

- Health spending would be 6 percent higher than otherwise and rising in 1998.
- But the increase would moderate and then fall, so that by the year 2005 health spending would still only be 6 percent higher than otherwise.

One reason for this result is that some provisions of the Clinton plan, discussed below, may actually make the health care system more efficient. Another reason relates to the negative effects of the Clinton plan on the rest of the economy, also discussed below. Since health spending varies with income, a lower national income would cause lower health spending — partly offsetting the effects of the expansion of third-party payment of medical bills.

Table V also shows the results of the other two forecasts. And Figure I shows that the three forecasts produce very different results over time:

- If the Clinton spending targets are actually met (optimistic forecast), health care spending in the year 2005 will be about 10 percent lower than otherwise.
- If cuts are made in government programs but normal market forces are allowed to work in the private sector (intermediate forecast), the changes in the two sectors will tend to cancel each other out.

Effects on Specific Health Care Spending. In a previous NCPA study, we demonstrated that third-party payment of medical bills distorts incentives faced by doctors and patients because the reimbursement rates differ markedly for different kinds of health care services. For example, on the average patients pay less than 5 percent of hospital expenses out-of-pocket, but they pay more than 68 percent of expenses for drugs and medical nondurables. This has the effect of making hospital therapy appear inexpensive and drug therapy appear expensive, although the social reality may be the opposite. As a result of these distortions we currently spend too much on hospitals and too little on drugs, nurses and other nonphysician personnel.[29]

Despite other inefficiencies that the Clinton plan would create, the plan might somewhat improve the allocation of health resources by making the reimbursement rate more uniform. For example, moving the Medicaid population into regional alliances should reduce the number of hospital emergency room visits and increase the use of primary care physicians. Adding prescription coverage to Medicare would encourage greater use of prescription drugs by the elderly and less use of hospitals and doctors. More drugs and fewer hospitalizations would mean less long-term care. As Table VI shows:

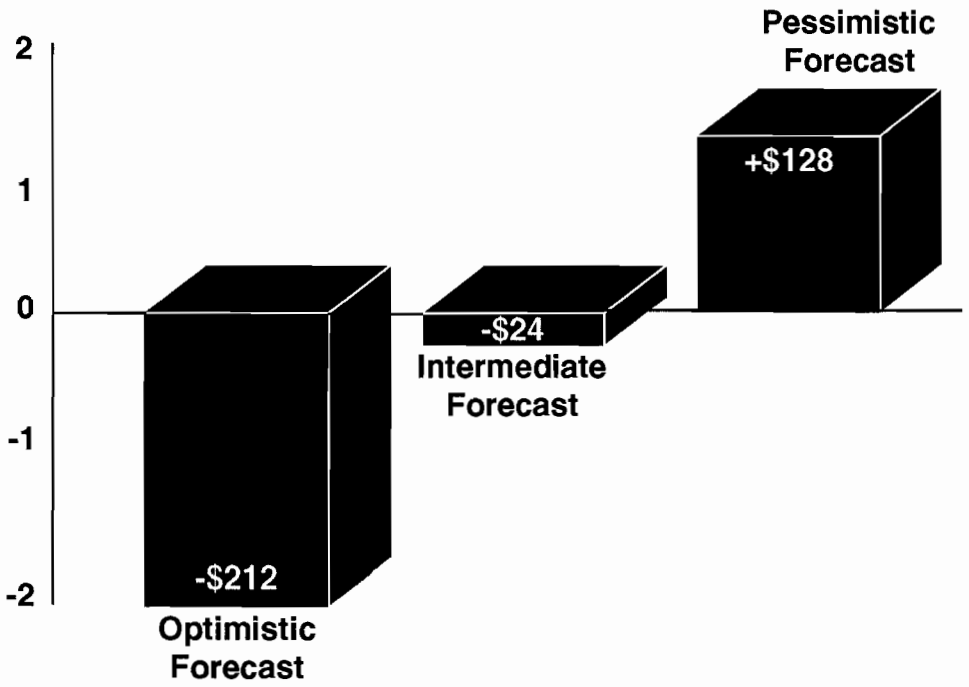
"The forecasts of health spending vary widely, depending on the assumptions that are used."

FIGURE I

Forecast of the Clinton Plan: Change in Health Care Spending in the Year 2005

(Relative to CBO baseline projection)

($ billions)



"Pessimistic forecast: health care spending would increase by more than $1,000 per household within five years."

TABLE Va

Economic Effects of the Clinton Plan: Pessimistic Forecast

(Dollar amounts in $ billions)

Year	Private Output	Non-Health Output	Health Output	Employment (in thousands)
1995	-10.4	-11.9	1.4	-65
1996	-23.9	-29.1	5.2	-119
1997	-50.8	-99.7	48.9	-324
1998	-93.3	-164.8	71.5	-567
1999	-118.0	-229.7	111.7	-740
2000	-134.7	-227.8	93.1	-783
2001	-146.5	-241.6	95.1	-747
2002	-157.2	-279.9	122.7	-718
2003	-162.9	-282.0	119.1	-611
2004	-170.5	-293.6	123.1	-528
2005	-181.9	-310.0	128.1	-473

TABLE Vb

Economic Effects of the Clinton Plan: Intermediate Forecast

(Dollar amounts in $ billions)

Year	GDP	Non-Health Output	Health Output	Employment (in thousands)
1995	-10.4	-7.4	-3.0	-62
1996	-23.6	-22.1	-1.5	-113
1997	-49.7	-81.9	32.2	-309
1998	-90.1	-123.6	33.6	-530
1999	-111.0	-163.9	52.9	-670
2000	-122.8	-143.7	20.9	-677
2001	-129.1	-139.4	10.3	-605
2002	-133.8	-158.1	24.3	-540
2003	-131.9	-136.2	4.3	-397
2004	-130.8	-121.7	-9.1	-276
2005	-131.7	-107.5	-24.2	-179

"Optimistic forecast: health care spending after a decade will be about 10 percent lower than otherwise."

TABLE Vc

Economic Effects of the Clinton Plan: Optimistic Forecast

(Dollar amounts in $ billions)

Year	GDP	Non-Health Output	Health Output	Employment (in thousands)
1995	-10.4	-7.4	-3.0	-62
1996	-23.2	-8.0	-15.2	-104
1997	-51.0	-64.3	13.3	-292
1998	-87.9	-82.0	-5.9	-501
1999	-108.9	-114.8	6.0	-626
2000	-111.4	-56.9	-54.5	-603
2001	-108.2	-18.8	-89.4	-492
2002	-108.8	-27.9	-80.8	-395
2003	-92.3	40.7	-133.0	-207
2004	-76.8	93.9	-170.7	-38
2005	-61.1	151.1	-212.2	109

Note: All changes are relative to the CBO baseline. The first three columns show the change *in* the year indicated. Employment totals show the full-time equivalent loss of jobs *as of* the year indicated.

National Center for Policy Analysis/Fiscal Associates Health Care Model simulation.

"The Clinton plan is designed to shift resources from hospitals to drugs, nurses and even to physicians."

TABLE VI

Percent Change in Spending in the Year 2005

(Relative to CBO baseline)

Service	Pessimistic Forecast	Intermediate Forecast	Optimistic Forecast
Hospitals	**+10.3%**	**-2.9%**	**-13.0%**
Doctors	**-5.3%**	**-5.5%**	**-4.9%**
Drugs[1]	**+5.7%**	**+11.7%**	**+6.5%**
Nurses and Other Professionals	**+20.5%**	**+15.8%**	**-5.7%**
Long Term Care	**0.0%**	**-11.1%**	**-22.9%**
All Health	**+6.0%**	**-1.1%**	**-9.9%**

[1] Ignores the effects of price controls and other proposed regulations.

National Center for Policy Analysis/Fiscal Associates Health Care Model simulation

TABLE VII

Potential Rationing Under the Clinton Plan

(In billions of dollars)

Year	(1) Health Spending Baseline	(2) Clinton Health Spending With Global Budgets[1]	(3) Clinton Health Spending Without Global Budgets[2]	(4) Health Rationed[3]	(5) Percent of Health Rationed[4]
1995	929	926	930	4.4	0.5%
1996	1,014	999	1,020	20.3	2.0%
1997	1,103	1,116	1,152	35.6	3.2%
1998	1,201	1,195	1,272	77.5	6.5%
1999	1,305	1,311	1,417	105.7	8.1%
2000	1,418	1,364	1,511	147.6	10.8%
2001	1,542	1,452	1,637	184.5	12.7%
2002	1,674	1,593	1,797	203.5	12.8%
2003	1,818	1,685	1,937	252.1	15.0%
2004	1,974	1,803	2,097	293.9	16.3%
2005	2,143	1,931	2,272	340.3	17.6%

[1] Spending totals under the optimistic forecast.

[2] Spending totals under the pessimistic forecast.

[3] The gap between supply (Col. 2) and demand (Col. 3).

[4] Amount of health care rationed (Col. 4) as a percent of the amount of care supplied (Col. 2).

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- Under the optimistic forecast, overall spending would be down almost 10 percent, but hospital spending would be down by 13 percent and spending on nurses would be down by less than 6 percent.
- Spending on drugs would increase.
- If it evolved as intended, the Clinton plan would shift resources from hospitals to drugs, nurses and even to physicians.

Without cuts in Medicare spending (the pessimistic forecast), however, hospital spending would continue to grow faster than health care spending as a whole and we would not see a shift toward greater relative use of drugs.

"To meet the spending targets would require rationing almost one out of every six medical procedures."

Health Care Rationing. Under the Clinton plan, health care demand would increase substantially. Both the intermediate and optimistic forecasts assume that supply would be artificially kept from meeting that demand, however, through explicit or implicit health care rationing. How much rationing would be required? As Table VII shows:

- If the Clinton spending targets are met, by the year 2005 the demand for health care would exceed the supply by $340 billion.
- By implication, almost 18 percent of all U.S. health care spending would be rationed.
- Put another way, the results imply that the government would deny access to almost one out of every six medical procedures.

Forecast of the Clinton Plan: Effects on the Economy

"The attempt to meet increased health care demand would cause the economy to sacrifice other goods and services."

The Clinton plan would have a negative impact on the economy for two reasons. First, the almost $200 billion in tax increases between 1995 and 2000 would have a substantial negative effect on economic activity. Most damaging are the increase in tobacco excise taxes, the removal of tax benefits for flexible spending accounts, additional assessments on employers for retiree discounts and taxes imposed on employers who form their own alliances. Second, because more would be spent on health care than under current law, the attempt to meet the demand would cause the economy to increasingly sacrifice other goods and services, causing total economic output to decrease further compared with the baseline.

What about the direct effects of the employer mandates? These would have a negative impact in some sectors. But because of the $116 billion in employer tax subsidies, for every dollar of required spending by businesses that currently do not provide health insurance, business in general would receive more than a dollar in subsidies. As a result, the mandate that employers provide health coverage for their workers would not have much effect on *general* economic activity.

Loss of Gross Domestic Product. Table V summarizes the effects of the Clinton plan on the economy as a whole. As the table shows:

- Even under the optimistic forecast, the plan would cost the economy $111 billion in lost output in the year 2000.
- Under the pessimistic scenario, the loss of output that year would climb to $135 billion.

"Even under the optimistic forecast, the Clinton plan would cost the economy $111 billion in lost output in the year 2000."

Loss of Nonhealth Care Output. A better measure of the sacrifice the Clinton plan would impose is the loss of other output. Greater demand would put more pressure on supply, further increasing medical prices. As previous studies with the Health Care Model have shown, expanding the supply of services in the health care sector causes production costs to go up much more rapidly than does expanding the supply of other goods and services in the economy as a whole.[30] Specifically, moving capital and labor from other sectors requires a price increase for medical services that is six times higher than that needed to expand other goods and services.

"Under the likely scenario, the loss of other goods and services will equal about $3,000 per household."

FIGURE II

Forecast of the Clinton Plan: Change in the Output of Other Goods and Services in the Year 2005

(Relative to CBO baseline projection)
($ billions)

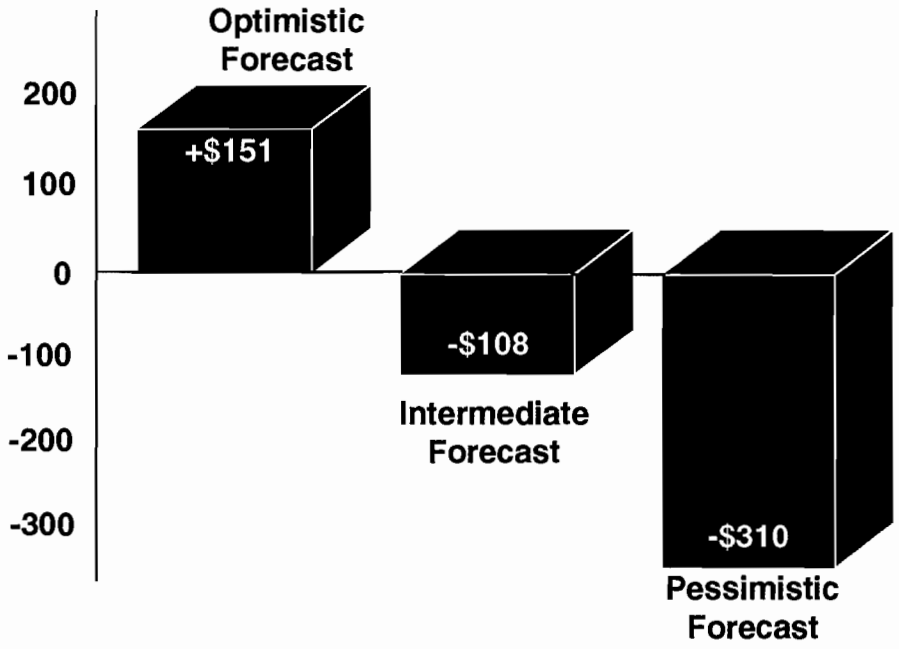


Figure II shows how widely divergent the three forecasts are, despite the crucial importance of this variable:

- Under the optimistic forecast, the ability to hold down health care spending would allow growth in the rest of the economy that eventually would offset the negative effect of the new taxes and lead to an additional $151 billion in nonhealth care output in the year 2005.
- Yet even if the administration makes all of the planned cuts in government health programs, failure to control private sector spending would crowd out production in the rest of the economy; under the intermediate forecast, this effect combined with the impact of new taxes would reduce nonhealth care output by $108 billion in the year 2005.
- Under the third and most likely scenario, the output of other goods and services would be $310 billion lower than otherwise — imposing a cost of about $3,000 per year per household.

Loss of Jobs. Another way to measure the economic impact of the plan is to consider its effect on the labor market. As Figure III shows:

- Even under the optimistic forecast, the economy will lose more than 600 thousand jobs (relative to the baseline) by the year 2000.
- Under the pessimistic forecast, the job loss will reach 783 thousand that year.

Forecast of the Clinton Plan: Effects on Government

Under the current system, the rising cost of government health care programs is crowding out other spending programs and precluding politicians from meeting the needs of other constituencies. The Clinton administration hopes to solve this problem. Let's take a closer look.

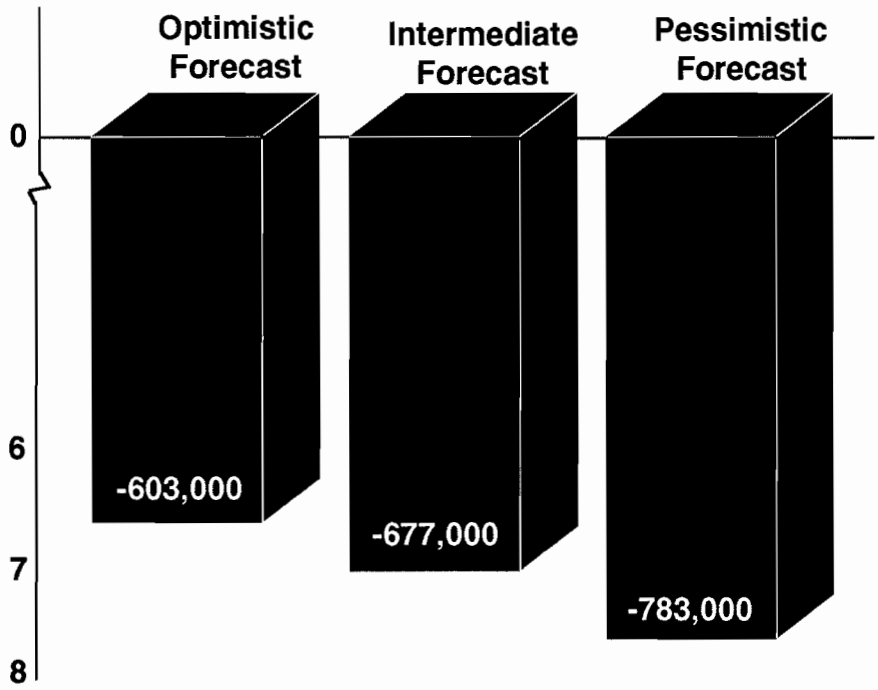
Increase in the Federal Deficit. The administration claims that passage of its health care reform plan would not only control health care spending but would reduce the federal deficit by $59 billion between 1995 and 2000. In contrast, the Congressional Budget Office estimates that the plan would increase the deficit by $74 billion. Our own estimates of the budgetary effects of the plan vary drastically, depending on which assumptions we use. As Table A-V shows:

"Fewer jobs will have been created."

FIGURE III

Forecast of the Clinton Plan: Loss of Jobs by the Year 2000

(Relative to CBO baseline projection)

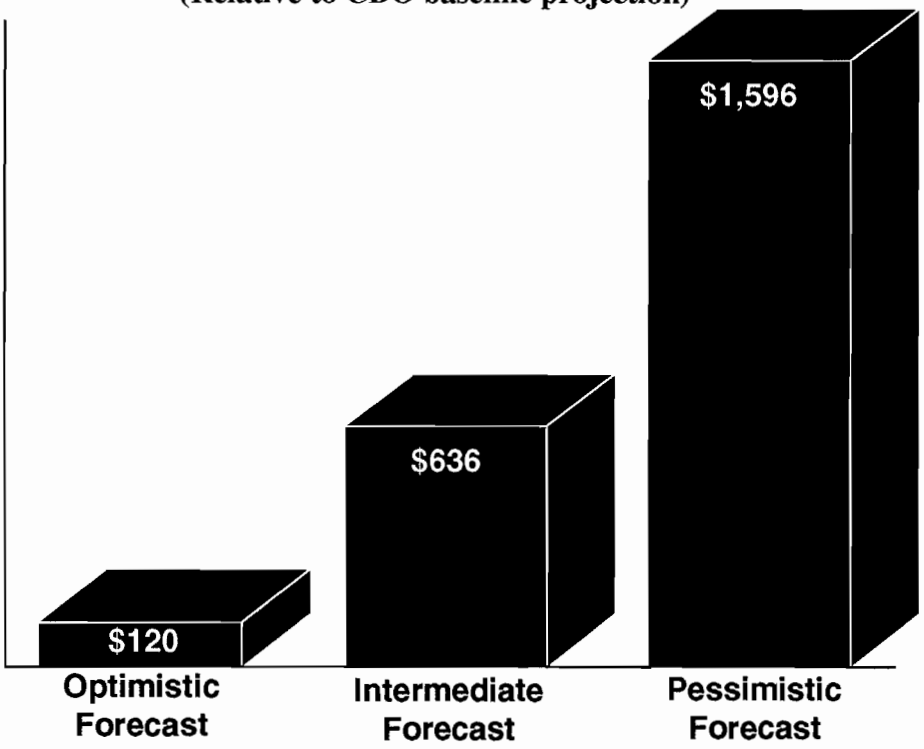


"Federal deficits will probably accumulate to almost $1.6 trillion after a decade."

FIGURE IV

Forecast of the Clinton Plan: Cumulative Increase in the Federal Deficit, 1996-2005

(Relative to CBO baseline projection)



- Under the optimistic forecast, the Clinton plan would increase the federal deficit by $87 billion between 1995 and 2000 and by another $33 billion between 2001 and 2005.
- If private health care spending cannot be curtailed, under the intermediate forecast the deficit would increase by $184 billion between 1995 and 2000 and by another $452 billion between 2001 and 2005.
- With no rationing at all, under the pessimistic forecast the federal deficit would increase by $420 billion in the next six years and by $1,176 billion in the following five years.
- In other words, failure to ration health care under the Clinton plan would increase the federal deficit by almost $1.6 trillion over little more than a decade.

How Rationing Would Affect the Federal Deficit. Although we have made no attempt to calculate the consequences of pay-as-you-go finance, it should be clear that the taxes needed to fund the Clinton plan under the pessimistic scenario would be roughly double the administration's proposal. Thus, a rule that requires a balanced budget approach, as suggested by Sen. Edward Kennedy, could produce a negative impact on the economy that is about double the estimates made in this study.[31]

A different way of looking at the problem is to consider how much the federal government would gain if health care spending were held in check by rationing or other means. As Table A-Vd in the appendix shows:

- With health care rationing, direct federal spending on health care would be $263 billion lower than otherwise in the year 2005 alone.
- When increased taxes and reduced subsidies are included, Congress would have an additional $312 billion to spend that year.
- This amounts to more than $3,000 per household.

These numbers may help to explain why so many members of Congress back the concept of global budgets.

"The plan would have a positive effect on state and local budgets, but a negative effect on state and local economies."

Effects on State and Local Budgets. As Table A-VI in the appendix shows, the Clinton health plan would have a positive impact on state and local budgets even though it would have a negative impact on state and local economies. That is, the positive effects of changes in government health programs would outweigh the tax revenue lost due to slower economic growth.[32] This is largely because the plan shifts the burden of Medicaid to the private sector[33] and the burden of indigent care to the federal government. Table A-VI also shows that state and local politicians have a self-interest in global budgets and health care rationing:

- Under the optimistic forecast, state and local governments would have a surplus of $90 billion between 1995 and 2000 and of $268 billion between 2001 and 2005.
- Even if health spending is not curtailed, state and local surpluses over those two five-year periods would amount to $57 billion and $137 billion, respectively.

Forecast of the the Clinton Plan: Effects on the Private Sector

The private sector would be the big loser under any scenario. American households would spend less out-of-pocket on health care. However, the reason would be either health care rationing (optimistic forecast) or less spending on health care caused by the decline in economic growth (intermediate and pessimistic forecasts).

Reduced economic activity under the Clinton plan would lead to less aftertax income in all three forecasts, as Table A-VII in the appendix shows.

- Between 1995 and 2000, the decrease in aftertax income of American workers and businesses would range from $361 billion to $371 billion.
- Between 2001 and 2005, the loss in aftertax income would range from $594 billion to $757 billion.

The private sector would be able to consume fewer goods and services under all three forecasts. Under the optimistic forecast, a larger share of the reductions are made in health care. If the administration's spending targets are not met, however, losses would come at the expense of other goods and services while health care actually increases.

Medicare vs. Regional Alliances

A severe shortcoming of the Clinton plan is its failure to deal with the problem of Medicare. As pointed out by the public trustees in the recent Social Security Trustees report:[34]

> Although reform of the nation's health care system is expected to eventually reduce the rate of growth in health care costs and thereby reduce the financing needs of HI and SMI (Medicare part A and part B), current national health reform proposals do not adequately address the serious long-range financial imbalance in

"Medicare costs would rise from one-fifth to almost one-quarter of health care spending by 2005."

TABLE VIII

Growth in Medicare Per Capita vs. Alliance Premiums

Year	Per Capita Medicare[1] Baseline	Clinton	Alliance Premiums[2]	CPI	Medicare as % of Health
1996	9.7%	10.3%	4.5%	3.0%	20.6%
1997	10.2%	11.2%	4.1%	3.1%	20.6%
1998	10.0%	6.0%	3.6%	3.1%	20.5%
1999	9.8%	7.3%	3.1%	3.1%	20.1%
2000	9.9%	8.6%	3.1%	3.1%	21.1%
2001	10.3%	9.2%	5.6%	3.1%	21.8%
2002	10.1%	9.0%	5.6%	3.1%	21.7%
2003	10.2%	9.3%	5.6%	3.1%	22.6%
2004	10.1%	9.3%	5.6%	3.1%	23.1%
2005	9.6%	8.8%	5.6%	3.1%	23.6%

[1] Based on CBO projections of the growth in Medicare expenditures and Social Security Administration projections of the growth in Medicare beneficiaries.

[2] Based on CBO forecast of the CPI and real GDP from its January budget. After 2000, real GDP is assumed to grow at 2.5% a year.

the Medicare program. *We strongly urge the administration and the Congress to resolve the long-range financial insolvency of Medicare as part of comprehensive national health reform.* This will require a review of the substantive provisions of Medicare, including its financing provisions, and will necessitate much more than reliance on the effects of current national health reform proposals.

Not only does the Clinton plan fail to address Medicare spending, it actually would worsen the problem. Although Medicare beneficiaries would be subject to some rationing, under the optimistic scenario the bulk of cutbacks in medical services would fall on the nonaged population. This is because the Clinton plan's price controls would discriminate against the private sector (people in regional alliances) compared with those in Medicare. As Table VIII shows:

- Even with the proposed reductions in payments to Medicare providers, Medicare would grow almost three times faster than the CPI and up to twice as fast as alliance premiums.
- As a result, Medicare spending would rise from one-fifth to almost one-quarter of U.S. health spending by the year 2005.

Conclusion

The bottom line is that under the Clinton plan American households would pay more and get less. Although out-of-pocket costs for health care would decline, the real cost of the program would be in the loss in aggregate production. Under the Clinton plan, the economy would produce fewer goods and services than otherwise, and the average standard of living would fall.

"The bottom line is that Americans will pay more and get less."

The plan ignores two fundamental facts. First, higher taxes will slow the economy. Second, lowering the price of health care will increase the demand for it. But satisfying the higher demand will more than negate any savings, and preserving the savings will require rationing.

Will Congress and the administration have the political will to ration one out of every six health care dollars? If not, health care spending and the deficit will spiral still further out of control.

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] Health Security Act. For a more complete discussion of the provisions of this proposal, see Peter J. Ferrara et al., "The Clinton Health Plan," National Center for Policy Analysis, NCPA Policy Report No. 184, May 1994.

[2] See Congressional Budget Office, *An Analysis of the Administration's Health Proposal*, Washington, DC, February 1994, p. 30.

[3] The actual proportions would vary under a complex formula dealing with issues such as family composition and full-time versus part-time workers. See CBO, *An Analysis of the Administration's Health Proposal*, pp. 9-11.

[4] Labor compensation has remained remarkably stable at two-thirds of output since at least 1929. Because mandates that require business to provide insurance for workers must come out of total labor compensation, either other forms of compensation such as money wages or pensions must be reduced, or employment must be decreased, or some combination of both must occur. The employer-employee split is economically relevant only because the employer's portion is excluded from income and Social Security (FICA) taxes.

[5] As Table A-1 in the appendix shows, the administration estimates that subsidies for businesses would cost the federal government $116 billion between 1995 and 2000.

[6] The administration estimates that subsidies for individuals and families would cost $224 billion between 1995 and 2000.

[7] These are hospitals that serve disproportionately large numbers of Medicaid or low-income patients.

[8] Under current law, employees may make pretax deposits to flexible spending accounts to pay the employee's share of insurance premiums and to pay medical expenses not covered by third-party insurance.

[9] The Clinton administration has not provided an estimate of how much its plan would reduce total health care spending relative to current law. These numbers are from the Congressional Budget Office's estimates of the Clinton plan. See CBO, *An Analysis of the Administration's Health Proposal,* Table 2-1, p. 26.

[10] See Alain C. Enthoven, "The History and Principles of Managed Competition," *Health Affairs* (Supplement 1993), pp. 24-48.

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

[12] See John C. Goodman and Gerald L. Musgrave, "A Primer on Managed Competition," National Center for Policy Analysis, NCPA Policy Report No. 183, April 1994.

[13] Ibid.

[14] For a review of the effects of HMOs, see John K. Iglehart, "The American Health Care System: Managed Care," *New England Journal of Medicine*, Vol. 327, No. 10, September 3, 1992, pp. 742-47.

[15] See, for instance, CBO Staff Memorandum, "The Effects of Managed Care on Use and Costs of Health Services," Congressional Budget Office, Washington, DC, June 1992, p. 17.

[16] Ibid. The CBO contends that staff and group model HMOs "reduce hospital use significantly," but those savings are often offset by an increased use by patients of the HMO's services. Other types of managed care have produced up to 8 percent reductions in overall expenditures. See CBO, "The Effects of Managed Care on Use and Costs of Health Services," p. 13.

[17] Gary Robbins, Aldona Robbins and John C. Goodman, "How Much Inefficiency Is in the U.S. Health Care System and What Can We Do About It?" National Center for Policy Analysis, NCPA Policy Report No. 182, April 1994.

[18] This is the opinion of, among others, Robert Reischauer, director of the Congressional Budget Office. See Statement of Robert D. Reischauer before the Subcommittee on Health of the House Ways and Means Committee, March 2, 1993.

[19] See Robert H. 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.

[20] To achieve the 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 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. See Ferrara et al., "The Clinton Health Plan."

[21] Statement by the White House Press Secretary on *New Republic* health article, White House Press Office, January 31, 1994.

[22] Premiums in the private sector must cover the cost of medical services consumed. Thus unless there is a reduction in the number and type of services consumed, premiums must increase at the same rate as medical prices. However, medical prices historically have increased faster than general prices. Between 1930 and 1991, the GDP deflator (a measure of the rate of inflation) averaged 3.8 percent while the medical deflator increased by 4.5 percent. Since 1965, the medical deflator has increased an average of 1.5 percentage points faster than the general deflator. Since 1991, it has increased 2.8 percentage points faster. Thus if premiums are held to the spending limits specified in the Clinton plan, limits also will have to be placed on the *volume* of medical services.

[23] See the discussion of this issue in Alain Enthoven and Sara J. Singer, "A Single-Payer System in Jackson Hole Clothing," *Health Affairs,* Spring 1994, pp. 85.

[24] See John C. Goodman and Gerald L. Musgrave, "Twenty Myths About National Health Insurance," National Center for Policy Analysis, NCPA Policy Report No. 166, December 1991, pp. 18-21.

[25] Congressional Budget Office, "Projections of National Health Expenditures: 1993 Update," CBO Memorandum, Washington, DC, October 1993; and Congressional Budget Office, *The Economic and Budget Outlook: Fiscal Years 1995-1999*, Washington, DC: U.S. Government Printing Office, January 1994, chapter 1.

[26] CBO, *An Analysis of the Administration's Health Proposal*; and CBO, "Projections of National Health Expenditures by Source of Funds," unpublished data.

[27] Office of the President, *Budget of the United States Government, Fiscal Year 1995*, Washington, DC: U.S. Government Printing Office, February 1994, chapter 4.

[28] *Business and Health,* May 1994, p. 10.

[29] For a discussion of trade-offs among medical services, see "How Much Inefficiency Is in the U.S. Health Care System and What Can We Do About It?" pp. 5-8.

[30] See 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.

[31] The actual impact would depend on the mix of spending cuts and tax increases as well as the nature of the tax increases.

[32] This finding is consistent with the findings of an Urban Institute study, but not with the findings of an American Legislative Exchange Council (ALEC) study. See John Holahan and David Liska, "The Impact of the Clinton Health Reform Proposal on States," Urban Institute, February 1994; and Richard Vedder and Lowell Gallaway, "Concealed Costs: The Real Impact of the Administration's Health Care Plan on the Economy, a State-by-State Analysis," American Legislative Exchange Council, March 1994.

[33] The Medicaid population would be placed in regional alliances, with the federal government initially paying only 95 percent of what it would have paid under current law. States would continue to pay their share of these reduced premiums for individuals and families still eligible for Medicaid. The Congressional Budget Office estimates that state and local government health care costs would be 20 percent lower than under current law by the year 2004.

[34] Social Security and Medicare Boards of Trustees, *Status of the Social Security and Medicare Programs: A Summary of the 1994 Annual Reports*, Washington, DC, April 1994, pp. 12-13.

TABLE A-I

Administration Estimates of the Net Effects of Clinton Health Care Reform[1]

(In billions of dollars)

	1995	1996	1997	1998	1999	2000	Total
Medicare	**-2.1**	**-1.1**	**0.5**	**-10.4**	**-20.7**	**-27.1**	**-61.0**
Cuts in current program	2.1	8.2	13.9	25.9	37.3	44.9	132.3
New benefits/programs	0.0	7.1	14.4	15.5	16.6	17.8	71.3
Medicaid	**0.0**	**0.7**	**-7.3**	**-32.6**	**-52.6**	**-61.1**	**-153.0**
Cuts in current program	0.0	0.8	3.5	9.2	20.1	27.1	60.8
New benefits/programs	0.0	1.5	-3.8	-23.4	-32.5	-34.0	-92.2
Other Federal Programs	**2.7**	**4.0**	**7.5**	**1.3**	**-0.9**	**-3.2**	**11.3**
Cuts in current program	0.3	1.0	1.7	7.1	10.4	12.9	33.4
New benefits/programs	3.0	5.0	9.2	8.4	9.5	9.7	44.7
Total Federal Outlays	**0.6**	**3.6**	**0.7**	**-41.7**	**-74.2**	**-91.4**	**-202.7**
Cuts in current program	2.4	10.0	19.1	42.2	67.8	84.9	226.5
New benefits/programs	3.0	13.6	19.8	0.5	-6.4	-6.5	23.8
Taxes on Individuals	**8.0**	**2.5**	**-6.4**	**-38.5**	**-49.6**	**-51.6**	**-135.4**
Higher taxes	8.0	9.4	15.3	17.7	18.6	19.3	88.3
Tax subsidies	0.0	6.9	21.7	56.3	68.1	70.9	223.7
Taxes on Business	**3.6**	**3.8**	**-2.1**	**-17.1**	**-21.4**	**-21.7**	**-55.1**
Higher taxes	4.1	7.8	9.3	11.8	13.6	14.1	60.5
Tax subsidies	0.5	4.0	11.4	28.8	35.1	35.8	115.6
Other Taxes	**0.0**	**0.6**	**2.6**	**8.9**	**15.0**	**19.7**	**46.7**
Higher taxes	0.0	0.6	2.6	8.9	15.0	19.7	46.7
Tax subsidies	NA	NA	NA	NA	NA	NA	NA
Total Federal Revenues	**11.6**	**6.9**	**-5.9**	**-46.7**	**-56.0**	**-53.6**	**-143.8**
Higher taxes	12.1	17.8	27.2	38.4	47.2	53.1	195.5
Tax subsidies	0.5	10.9	33.1	85.1	103.2	106.7	339.3
Net Effect on Federal Deficit	**-11.0**	**-3.1**	**6.7**	**5.0**	**-18.2**	**-37.8**	**-58.8**

[1] As of February 1994. Authors have grouped individual provisions into the major categories shown in the table.

TABLE A-II

Baseline Forecast of Health Spending[1]

(In billions of dollars)

Year	All Health	Hosp	Doctors	Drugs	Dentists	Other Prof	Long-term Care	Glasses
1995	929	400	204	80	50	61	117	16
1996	1,014	434	224	86	53	69	130	18
1997	1,103	470	244	92	57	78	143	19
1998	1,201	511	267	98	61	88	156	20
1999	1,305	555	290	105	65	99	169	22
2000	1,418	604	315	112	69	110	184	23
2001	1,542	657	342	120	73	123	202	24
2002	1,674	715	370	128	78	138	219	26
2003	1,818	778	401	137	83	153	238	28
2004	1,974	847	434	147	89	169	258	30
2005	2,143	921	470	157	94	187	280	33

[1] Based on the Congressional Budget Office's October 1993 projections of national health expenditures and CBO's January 1994 economic forecast.

TABLE A-III

Percent of Health Spending By Payment Source

Baseline

	Out-of-Pocket	Private Insurance	Government	Other
1995	19.6%	31.9%	45.8%	2.7%
2000	17.4%	31.6%	48.6%	2.5%
2005	15.2%	31.0%	51.5%	2.3%

Optimistic Forecast

	Out-of-Pocket	Private Insurance[1]	Government	Other
1995	19.6%	31.8%	45.9%	2.7%
2000	15.2%	43.1%	39.1%	2.6%
2005	14.0%	40.4%	43.0%	2.6%

Intermediate Forecast

	Out-of-Pocket	Private Insurance[1]	Government	Other
1995	19.6%	31.8%	45.9%	2.7%
2000	15.3%	42.6%	39.4%	2.7%
2005	14.0%	40.0%	43.3%	2.7%

Pessimistic Forecast

	Out-of-Pocket	Private Insurance[1]	Government	Other
1995	19.4%	31.6%	46.3%	2.7%
2000	14.1%	39.8%	43.5%	2.6%
2005	12.5%	36.2%	48.9%	2.5%

[1] Includes regional alliances.

National Center for Policy Analysis/Fiscal Associates Health Care Model simulation.

TABLE A-IVa

Health Spending Under Clinton Plan: Pessimistic Forecast

(Difference from baseline in billions of dollars)

Year	All Health	Hosp	Doctors	Drugs	Dentists	Other Prof	Long-term Care[1]	Glasses
1995	1	2	-1	-1	0	0	1	0
1996	5	8	-7	4	1	1	-1	0
1997	49	35	-7	7	5	11	-1	0
1998	72	37	-4	9	11	27	-8	0
1999	112	71	-7	7	11	30	-2	0
2000	93	61	-11	8	10	28	-4	0
2001	95	65	-13	8	10	29	-3	0
2002	123	84	-15	8	11	36	-1	0
2003	119	85	-19	8	11	35	-1	0
2004	123	90	-22	8	11	37	0	0
2005	128	95	-25	9	11	38	0	0
Sum	**920**	**633**	**-132**	**75**	**91**	**272**	**-20**	**0**

[1] Includes nursing home services and home health care.

Columns may not add due to rounding.

National Center for Policy Analysis/Fiscal Associates Health Care Model simulation.

TABLE A-IVb

Health Spending Under Clinton Plan: Intermediate Forecast

(Difference from baseline in billions of dollars)

Year	All Health	Hosp	Doctors	Drugs	Dentists	Other Prof	Long-term Care[1]	Glasses
1995	-3	-1	-1	0	0	0	0	0
1996	-2	3	-8	4	1	1	-2	0
1997	32	22	-8	8	5	10	-5	0
1998	34	8	-5	11	11	25	-16	0
1999	53	25	-8	11	11	27	-14	0
2000	21	5	-12	12	10	24	-18	0
2001	10	-2	-15	13	10	25	-20	0
2002	24	6	-17	14	12	31	-21	0
2003	4	-6	-20	15	11	29	-24	0
2004	-9	-16	-23	17	12	29	-27	0
2005	-24	-27	-26	18	12	30	-31	-1
Sum	**141**	**18**	**-144**	**123**	**96**	**230**	**-179**	**-3**

[1] Includes nursing home services and home health care.

Columns may not add due to rounding.

National Center for Policy Analysis/Fiscal Associates Health Care Model simulation.

TABLE A-IVc

Health Spending Under Clinton Plan: Optimistic Forecast

(Difference from baseline in billions of dollars)

Year	All Health	Hosp	Doctors	Drugs	Dentists	Other Prof	Long-term Care[1]	Glasses
1995	-3	-1	-1	0	0	0	0	0
1996	-15	-10	-5	7	-2	-2	-4	-1
1997	13	0	9	13	2	2	-11	-1
1998	-6	-16	22	11	8	5	-33	-2
1999	6	-10	25	12	8	5	-32	-2
2000	-54	-40	9	11	5	1	-38	-3
2001	-89	-56	1	10	4	-2	-43	-3
2002	-81	-55	7	11	6	0	-46	-4
2003	-133	-79	-6	10	3	-5	-52	-4
2004	-171	-99	-15	10	2	-7	-58	-5
2005	-212	-120	-23	10	1	-11	-64	-5
Sum	**-745**	**-486**	**23**	**106**	**37**	**-14**	**-381**	**-30**

[1] Includes nursing home services and home health care.

Columns may not add due to rounding.

National Center for Policy Analysis/Fiscal Associates Health Care Model simulation.

TABLE A-Va

Effect of the Clinton Plan on the Federal Budget: Pessimistic Forecast

(Billions of dollars)

Year	Direct Spending Changes[1]	New Insurance Subsidies[2]	Net Tax Changes	Deficit Change
1995	6.0	0.0	14.0	-8.0
1996	18.9	12.3	21.7	9.6
1997	23.1	33.4	13.5	43.0
1998	11.5	77.6	-4.9	94.1
1999	35.4	97.6	-2.7	135.7
2000	38.1	112.0	4.2	145.9
2001	57.1	132.5	11.2	178.3
2002	68.5	145.1	6.8	206.9
2003	86.4	177.6	21.6	242.4
2004	99.2	191.0	27.2	262.9
2005	113.1	204.2	31.8	285.6
1995-2000				420.2
2001-2005				1,176.1

TABLE A-Vb

Effect of the Clinton Plan on the Federal Budget: Intermediate Forecast

(Billions of dollars)

Year	Direct Spending Changes[1]	New Insurance Subsidies[2]	Net Tax Changes	Deficit Change
1995	0.5	0.0	13.9	-13.4
1996	10.5	12.4	21.5	1.3
1997	2.1	33.6	13.0	22.7
1998	-35.0	78.4	-5.9	49.3
1999	-37.6	99.0	-4.0	65.5
2000	-52.4	114.1	3.2	58.5
2001	-49.8	135.3	10.7	74.8
2002	-56.0	148.5	6.9	85.6
2003	-59.8	182.3	22.2	100.4
2004	-70.1	196.6	28.8	97.7
2005	-82.9	210.9	34.6	93.3
1995-2000				183.9
2001-2005				451.8

[1] National Center for Policy Analysis/Fiscal Associates Health Care Model simulation results.

[2] Based on CBO estimates of direct subsidies and tax subsidies as a percent of alliance income. See CBO, *An Analysis of the Administration's Health Proposal*, Table 2-5.

TABLE A-Vc

Effect of the Clinton Plan on the Federal Budget: Optimistic Forecast

(Billions of dollars)

Year	Direct Spending Changes[1]	New Insurance Subsidies[2]	Net Tax Changes	Deficit Change
1995	0.5	0.0	13.9	-13.4
1996	5.0	12.2	22.9	-5.7
1997	-6.0	33.3	13.8	13.5
1998	-49.0	77.1	-2.8	30.9
1999	-55.0	97.2	-0.4	42.6
2000	-78.0	109.6	12.7	18.9
2001	-84.0	128.3	25.1	19.1
2002	-93.0	141.2	22.9	25.3
2003	-108.0	170.6	45.1	17.5
2004	-127.0	182.4	58.1	-2.7
2005	-149.3	194.1	71.2	-26.4
1995-2000				86.8
2001-2005				32.8

TABLE A-Vd

Effect of the Clinton plan on the Federal Budget: Effect of Health Care Rationing[3]

(Billions of dollars)

Year	Direct Spending Changes[1]	New Insurance Subsidies[2]	Net Tax Changes	Deficit Change
1995	-5.6	0.0	-0.2	-5.4
1996	-13.9	-0.1	1.2	-15.3
1997	-29.1	-0.2	0.3	-29.5
1998	-60.5	-0.5	2.1	-63.2
1999	-90.4	-0.4	2.2	-93.1
2000	-116.1	-2.4	8.5	-127.0
2001	-141.1	-4.3	13.9	-159.2
2002	-161.5	-3.9	16.1	-181.5
2003	-194.4	-7.0	23.5	-224.9
2004	-226.2	-8.6	30.9	-265.7
2005	-262.5	-10.1	39.4	-312.0
1995-2000				-333.4
2001-2005				-1,143.0

[1] National Center for Policy Analysis/Fiscal Associates Health Care Model simulation results.

[2] Based on CBO estimates of direct subsidies and tax subsidies as a percent of alliance income. See CBO, *An Analysis of the Administration's Health Proposal*, Table 2-5.

[3] Difference between the optimistic and pessimistic forecasts.

TABLE A-VIa

Effect of the Clinton Plan on State and Local Budgets: Pessimistic Forecast

(Billions of Dollars)

Year	Direct Spending Changes[1]	New Insurance Subsidies[2]	Net Tax Changes	Deficit Change
1995	-0.8	0.0	-1.8	1.0
1996	-4.9	4.1	-3.3	2.5
1997	-19.6	10.3	-10.8	1.4
1998	-82.0	23.3	-21.9	-36.8
1999	-66.4	28.5	-25.2	-12.7
2000	-70.3	31.9	-25.6	-12.8
2001	-80.6	35.2	-25.4	-20.1
2002	-87.0	36.5	-27.5	-23.0
2003	-93.6	40.6	-24.7	-28.3
2004	-99.7	44.5	-23.9	-31.3
2005	-106.2	48.4	-23.7	-34.1
1995-2000				-57.4
2001-2005				-136.8

TABLE A-VIb

Effect of the Clinton Plan on State and Local Budgets: Intermediate Forecast

(Billions of dollars)

Year	Direct Spending Changes[1]	New Insurance Subsidies[2]	Net Tax Changes	Deficit Change
1995	-0.8	0.0	-1.8	1.0
1996	-4.9	4.1	-3.3	2.5
1997	-19.6	10.3	-10.8	1.4
1998	-82.0	23.3	-21.9	-36.8
1999	-66.4	28.5	-25.2	-12.7
2000	-70.3	31.9	-25.6	-12.8
2001	-80.6	35.2	-25.4	-20.1
2002	-87.0	36.5	-27.5	-23.0
2003	-93.6	40.6	-24.7	-28.3
2004	-99.7	44.5	-23.9	-31.3
2005	-106.2	48.4	-23.7	-34.1
1995-2000				-57.4
2001-2005				-136.8

[1] National Center for Policy Analysis/Fiscal Associates Health Care Model simulation results.

[2] Based on CBO estimates of direct subsidies and tax subsidies as a percent of alliance income. See CBO, *An Analysis of the Administration's Health Proposal*, Table 2-5.

TABLE A-VIc

Effect of the Clinton Plan on State and Local Budgets: Optimistic Forecast

(Billions of dollars)

Year	Direct Spending Changes[1]	New Insurance Subsidies[2]	Net Tax Changes	Deficit Change
1995	-0.7	0.0	-1.8	1.1
1996	-7.0	4.1	-2.9	0.0
1997	-23.0	10.2	-10.5	-2.2
1998	-86.0	23.1	-20.5	-42.4
1999	-72.0	28.4	-23.3	-20.3
2000	-78.0	31.2	-21.1	-25.7
2001	-90.0	34.0	-18.5	-37.5
2002	-97.0	35.5	-19.5	-42.0
2003	-106.0	39.0	-13.1	-53.9
2004	-114.0	42.5	-9.0	-62.5
2005	-122.6	46.0	-4.8	-71.8
1995-2000				-89.6
2001-2005				-267.7

TABLE A-VId

Effect of the Clinton Plan on State and Local Budgets: Effect of Health Care Rationing[3]

(Billions of Dollars)

Year	Direct Spending Changes[1]	New Insurance Subsidies[2]	Net Tax Changes	Deficit Change
1995	0.2	0.0	0.0	0.1
1996	-2.1	0.0	0.4	-2.5
1997	-3.4	0.0	0.2	-3.7
1998	-4.0	-0.2	1.4	-5.5
1999	-5.6	-0.1	1.9	-7.6
2000	-7.7	-0.7	4.5	-12.9
2001	-9.4	-1.1	6.9	-17.5
2002	-10.0	-1.0	8.0	-19.0
2003	-12.4	-1.6	11.5	-25.5
2004	-14.3	-2.0	14.9	-31.3
2005	-16.4	-2.4	18.9	-37.6
1995-2000				-32.2
2001-2005				-130.9

[1] National Center for Policy Analysis/Fiscal Associates Health Care Model simulation results.

[2] Based on CBO estimates of direct subsidies and tax subsidies as a percent of alliance income. See CBO, *An Analysis of the Administration's Health Proposal*, Table 2-5.

[3] Difference between the optimistic and pessimistic forecasts.

TABLE A-VIIa

Effect of the Clinton Plan on the Private Sector: Pessimistic Forecast

(Billions of dollars)

Year	Change in Out-of-Pocket Costs	Change in Insurance Costs, Net	Change in Net Health Costs[1]	Aftertax Income Changes[2]	Other Output Changes[3]	Change in Value of Health Care[4]	Change in Value of Output[5]
1995	-1.3	-1.8	-3.1	-22.3	-11.9	1.4	-10.4
1996	-7.7	-12.7	-20.4	-41.3	-29.1	5.2	-23.9
1997	-17.6	20.0	2.3	-51.4	-99.7	48.9	-50.8
1998	-25.5	63.9	38.3	-63.1	-164.8	71.5	-93.3
1999	-30.9	50.9	20.1	-85.4	-229.7	111.7	-118.0
2000	-30.8	24.0	-6.9	-108.0	-227.8	93.1	-134.7
2001	-32.5	2.8	-29.7	-126.4	-241.6	95.1	-146.5
2002	-36.3	14.2	-22.1	-129.9	-279.9	122.7	-157.2
2003	-37.4	-23.0	-60.5	-152.7	-282.0	119.1	-162.9
2004	-38.8	-36.5	-75.4	-166.1	-293.6	123.1	-170.5
2005	-40.4	-49.6	-90.0	-181.6	-310.0	128.1	-181.9
1995-2000	-113.8	144.2	30.4	-371.4	-762.9	331.8	-431.1
2001-2005	-185.5	-92.2	-277.7	-756.7	-1,407.2	588.2	-819.0

[1] Sum of the change in out-of-pocket costs and the change in net insurance costs. Out-of-pocket costs are net of the value of the medical deduction. Insurance costs are net of direct government payments to regional alliances and of tax subsidies to individuals and businesses.

[2] Change in labor and capital income less the change in federal, state and local taxes.

[3] Change in nonhealth output from Table V.

[4] Change in health output from Table V.

[5] Change in output from Table V.

TABLE A-VIIb

Effect of the Clinton Plan on the Private Sector: Intermediate Forecast

(Billions of dollars)

Year	Change in Out-of-Pocket Costs	Change in Insurance Costs, Net	Change in Net Health Costs[1]	Aftertax Income Changes[2]	Other Output Changes[3]	Change in Value of Health Care[4]	Change in Value of Output[5]
1995	-1.0	-1.3	-2.3	-22.2	-7.4	-3.0	-10.4
1996	-7.1	-12.0	-19.1	-41.0	-22.1	-1.5	-23.6
1997	-16.3	21.7	5.4	-50.2	-81.9	32.2	-49.7
1998	-22.7	67.4	44.7	-59.9	-123.6	33.6	-90.0
1999	-26.5	56.7	30.2	-78.8	-163.9	52.9	-111.0
2000	-25.3	31.2	5.8	-97.5	-143.7	20.9	-122.8
2001	-25.9	11.2	-14.7	-111.5	-139.4	10.3	-129.1
2002	-28.6	24.3	-4.3	-110.2	-158.1	24.3	-133.8
2003	-28.4	-11.5	-39.9	-126.8	-136.2	4.3	-131.9
2004	-28.3	-23.0	-51.3	-133.4	-121.7	-9.1	-130.8
2005	-28.2	-33.7	-61.8	-140.8	-107.5	-24.2	-131.7
1995-2000	-98.9	163.7	64.8	-349.5	-542.6	135.1	-407.5
2001-2005	-139.5	-32.6	-172.1	-622.5	-663.0	5.7	--657.3

[1] Sum of the change in out-of-pocket costs and the change in net insurance costs. Out-of-pocket costs are net of the value of the medical deduction. Insurance costs are net of direct government payments to regional alliances and of tax subsidies to individuals and businesses.

[2] Change in labor and capital income less the change in federal, state and local taxes.

[3] Change in nonhealth output from Table V.

[4] Change in health output from Table V.

[5] Change in output from Table V.

TABLE A-VIIc

Effect of the Clinton Plan on the Private Sector: Optimistic Forecast

(Billions of dollars)

Year	Change in Out-of-Pocket Costs	Change in Insurance Costs, Net	Change in Net Health Costs[1]	Aftertax Income Changes[2]	Other Output Changes[3]	Change in Value of Health Care[4]	Change in Value of Output[5]
1995	-1.0	-1.3	-2.3	-22.2	-7.4	-3.0	-10.4
1996	-7.6	-15.6	-23.2	-42.5	-8.0	-15.2	-23.2
1997	-17.0	18.6	1.5	-52.5	-64.3	13.3	-51.0
1998	-31.2	61.4	30.2	-62.2	-82.0	-5.9	-87.9
1999	-34.1	49.3	15.2	-81.8	-114.8	6.0	-108.9
2000	-36.9	15.5	-21.4	-99.8	-56.9	-54.5	-111.4
2001	-40.7	-10.0	-50.7	-112.0	-18.8	-89.4	-108.2
2002	-43.5	2.3	-41.2	-109.1	-27.9	-80.8	-108.8
2003	-47.3	-40.3	-87.6	-121.9	40.7	-133.0	-92.3
2004	-50.2	-57.3	-107.4	-124.3	93.9	-170.7	-76.8
2005	-53.2	-73.9	-127.0	-126.4	151.1	-212.2	-61.1
1995-2000	-127.8	127.9	0.1	-360.9	-333.5	-59.2	-392.7
2001-2005	-234.9	-179.2	-414.0	-593.8	238.9	-686.1	-447.2

[1] Sum of the change in out-of-pocket costs and the change in net insurance costs. Out-of-pocket costs are net of the value of the medical deduction. Insurance costs are net of direct government payments to regional alliances and of tax subsidies to individuals and businesses.

[2] Change in labor and capital income less the change in federal, state and local taxes.

[3] Change in nonhealth output from Table V.

[4] Change in health output from Table V.

[5] Change in output from Table V.

TABLE A-VIId

Effect of the Clinton Plan on the Private Sector: Effect of Health Care Rationing

(Billions of dollars)

Year	Change in Out-of-Pocket Costs	Change in Insurance Costs, Net	Change in Net Health Costs[1]	Aftertax Income Changes[2]	Other Output Changes[3]	Change in Value of Health Care[4]	Change in Value of Output
1995	0.4	0.5	0.8	0.1	4.4	-4.4	0.0
1996	0.1	-2.9	-2.8	-1.1	21.1	-20.3	0.7
1997	0.6	-1.4	-0.8	-1.1	35.4	-35.6	-0.2
1998	-5.7	-2.4	-8.1	0.9	82.8	-77.5	5.3
1999	-3.2	-1.6	-4.8	3.6	114.9	-105.7	9.2
2000	-6.1	-8.5	-14.5	8.1	170.9	-147.6	23.3
2001	-8.2	-12.8	-21.0	14.4	222.8	-184.5	38.3
2002	-7.3	-11.9	-19.1	20.7	251.9	-203.5	48.4
2003	-9.9	-17.3	-27.2	30.8	322.7	-252.1	70.7
2004	-11.3	-20.7	-32.1	41.9	387.6	-293.9	93.7
2005	-12.7	-24.3	-37.0	55.2	461.1	-340.3	120.8
1995-2000	-14.0	-16.3	-30.3	10.5	429.4	-391.1	38.4
2001-2005	-49.4	-87.0	-136.4	163.0	1,646.1	-1,274.2	371.9

[1] Sum of the change in out-of-pocket costs and the change in net insurance costs. Out-of-pocket costs are net of the value of the medical deduction. Insurance costs are net of direct government payments to regional alliances and of tax subsidies to individuals and businesses.

[2] Change in labor and capital income less the change in federal, state and local taxes.

[3] Change in nonhealth output from Table V.

[4] Change in health output from Table V.

[5] Change in output from Table V.

About the Authors

Aldona Robbins, an NCPA Senior Fellow and Vice President of Fiscal Associates, has extensive experience with public and private retirement programs. Dr. Robbins served as senior economist in the Office of Economic Policy, U.S. Department of the Treasury from 1979 to 1985 and has developed a model to project Social Security benefits and tax revenues. Recent publications include NCPA Reports entitled "What A Canadian-Style Health Care System Would Cost U.S. Employers and Employees" and "Taxing the Savings of Elderly Americans"; an NCPA and Institute for Policy Innovation Report entitled "Paying People Not To Work: The Economic Cost of the Social Security Retirement Earnings Limit"; a book entitled *The ABCs of Social Security* , published by the Institute for Research on the Economics of Taxation Economic Report; and an article entitled "Encouraging Private Provision for Long-Term Care" in *Compensation and Benefits Management.* Her articles on Individual Retirement Accounts and Medicare have appeared in the *Wall Street Journal.*

Gary Robbins is an NCPA Senior Fellow and President of Fiscal Associates. Mr. Robbins has developed a general equilibrium model of the U.S. economy that specifically incorporates the effects of taxes and government spending. Before joining the private sector, he was Chief of the Applied Econometrics Staff at the U.S. Treasury Department from 1982 to 1985, Assistant to the Under Secretary for Tax and Economic Affairs from 1981 to 1982, and Assistant to the Director of the Office of Tax Analysis from 1976 to 1981. Recent publications include NCPA Reports entitled "Taxes, Deficits and the Current Recession," "A Pro-Growth Budget Strategy: Vision for the 1990s" and "Elderly Taxpayers and the Capital Gains Tax Debate"; an IPI Report entitled "Will Raising Taxes Reduce the Deficit?"; and a report for the U.S. Chamber of Commerce entitled "Adding to the S&L Solution: A Case for Lower Capital Gains Taxes." His articles on various tax policy issues have appeared in the *Wall Street Journal.*

The National Center for Policy Analysis

The National Center for Policy Analysis is a nonprofit, nonpartisan research institute funded exclusively by private contributions. The NCPA originated the concept of the Medical IRA (which has bipartisan support in Congress) and merit pay for school districts (adopted in South Carolina and Texas). Many credit NCPA studies of the Medicare surtax as the main factor leading to the 1989 repeal of the Medicare Catastrophic Coverage Act.

NCPA forecasts show that repeal of the Social Security earnings test would cause no loss of federal revenue, that a capital gains tax cut would increase federal revenue and that the federal government gets virtually all the money back from the current child care tax credit. These forecasts are an alternative to the forecasts of the Congressional Budget Office and the Joint Committee on Taxation and are frequently used by Republicans and Democrats in Congress. The NCPA also has produced a first-of-its-kind, pro-free-enterprise health care task force report, presenting the views of 40 representatives of think tanks and research institutes.