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*file - Kenan*

bc-Clinton-health-plan

-- NEWS ADVISORY -- TO NATIONAL AND HEALTH/MEDICAL EDITORS:  
A CRITIQUE OF THE ADMINISTRATION'S HEALTH CARE PLAN;  
PRESS CONFERENCE JAN. 13;

MORE THAN 550 ECONOMISTS TO SEND OPEN LETTER TO PRESIDENT CLINTON

More than 550 economists from all 50 states and the District of Columbia will send a letter to President Clinton next week about the administration's health care plan. The group, organized by Professor John Lott of the Wharton School at the University of Pennsylvania, will release the letter and a list of signatories at a press conference on Jan. 13 at the National Press Club.

WHAT: Press conference to release an open letter to President Clinton signed by more than 550 economists

TOPIC: Clinton health care plan

WHEN: Thursday, Jan. 13, 10 a.m. (A)

WHERE: National Press Club  
Lisagor Room, 13th Floor  
529 14th St. N.W.  
Washington

SPEAKERS: -- John R. Lott Jr., Wharton School  
-- William A. Niskanen, Cato Institute,  
former member, Council of Economic Advisers  
-- Other speakers TBA

(A) The Lisagor Room will be open at 9 a.m. for set up. Coffee will be available at that time.

CONTACT: Cathi Smith, 202-543-1743, for Lott, or John Lott, 215-898-8920.

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US HEALTH: Economists to warn Clinton that plan will harm economy

Knight-Ridder

Washington--Jan 10--A group of 550 economists Thursday will send a letter to President Bill Clinton warning that price controls in his health-care plan will wreak economic havoc.

John Lott, of the Wharton School, said the plan's impact on the economy and on the availability of health care would be roughly analogous to the high prices and tight supplies that resulted from the oil price controls in the 1970s.

Lott said he and the others who signed the letter believe the underlying premise of Clinton's plan is based largely on a government attempt to limit price increases.

Lott cited such provisions as authority for the state-chartered health cooperatives to limit fees that doctors and hospitals can charge for services, and the legally mandated limits on health-insurance premiums.

Lott said he and some of the others who signed the letter will explain their concerns more fully in a press conference Thursday. The economists traverse the political spectrum, Lott said. End

(By Steve Marcy, Knight-Ridder Financial News)





David J. Theroux  
President

November 1, 1993

Professor David Cutler  
Harvard University  
Cambridge, MA 02138

Dear Professor Cutler:

I am writing to urge you to join with numerous prominent economists and other scholars as a signer of a public letter to President Clinton, critiquing his proposed health reform plan's mandated use of price controls.

The letter will appear as a full-page ad in *The Wall Street Journal*. The ad is being independently organized and sponsored by a group of scholars seriously concerned with the Clinton proposal, and I was asked to be of assistance.

As you may know, the proposed Clinton plan would control prices charged by doctors and hospitals, cap annual spending on health care, limit insurance premiums, impose limitations on new and existing drugs, and much more.

The impact of such price controls would be extremely harmful to any health care system, especially for the disadvantaged, as health care quality would seriously decline and health care services would become severely rationed.

As you may also know, the Independent Institute is a scholarly, public policy research organization, and we are taking a major interest in this issue through our health care policy research program, the Center for Health Policy Innovation, under the direction of Simon Rottenberg (Professor of Economics, University of Massachusetts).

Time is of the essence since the ad is scheduled to run soon! Please mail or FAX your response using the enclosed form to arrive here no later than November 15.

I look forward to hearing from you. Thank you.

Sincerely yours,

David J. Theroux

DJT:js  
Enclosure

## An Open Letter to President Clinton on Health Care Reform

Dear President Clinton:

Price controls produce shortages, black markets, and reduced quality. This has been the universal experience in the four thousand years that governments have tried to artificially hold prices down using regulations.

You insist that your health-care plan avoids price controls. We respectfully disagree. Your plan sets the fees charged by doctors and hospitals, caps annual spending on health-care, limits insurance premiums, and imposes price limitations on new and existing drugs.

In countries that have imposed these types of regulations, patients face delays of months and years for surgery, government bureaucrats decide treatment options instead of doctors or patients, and innovations in medical techniques and pharmaceuticals are dramatically reduced. Here in America, the threat of price controls on medicines has already decreased research and development at drug companies, which will lead to reduced discoveries and the loss of life in the future.

In the 1970s, government tried to regulate the price of a simple homogenous product, gasoline. The result was a social and economic disaster. People were forced to waste hours waiting in lines to purchase gasoline. Long waits for surgery and other medical care will have far more serious consequences.

Caps, fee schedules, and other government regulations may appear to reduce medical spending, but such gains are illusory. We will instead end up with lower quality medical care, reduced medical innovation, and expensive new bureaucracies to monitor compliance. These controls will hurt people, and they will damage the economy. We urge you to remove price controls, in any form, from your health-care plan.

Please sign your name \_\_\_\_\_ Date \_\_\_\_\_

Please print your name \_\_\_\_\_ Telephone \_\_\_\_\_

Affiliation \_\_\_\_\_

Please sign your name \_\_\_\_\_ Date \_\_\_\_\_

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file  
Economics &  
Health Care

## Chapter 4: The Economics of Health Care Reform

Reforming America's health care system is vital for the health of our citizens and the health of our economy. America's health care system is a curious mix of both the best and the worst. People who are insured receive treatment that is the highest quality in the world. At the same time, however, decades of medical cost increases two to three times as fast as income growth have lead health insurance to take up a growing share of workers' benefits packages, thus limiting wage growth, and have also burdened Federal and State and local governments. Over 15 percent of Americans are without health insurance, and others face exorbitantly high costs for insurance or are locked into their jobs because they or a family member have a serious medical problem that might not be covered if they were to switch insurers. On many measures of health outcomes, such as infant mortality or life expectancy, the United States ranks among the lowest in the developed world.

The challenge that we face is to preserve the quality of health care while solving three fundamental problems. First, we must provide real health care security. One essential component of security is universal coverage. Individuals can never be fully secure if they might lose their health insurance when they lose or change their job, or if a family member gets sick. More importantly, however, insurance must guarantee affordable coverage for those who do have insurance. This means an end to restrictions on pre-existing conditions, lifetime limitations on spending, and experience rating.



Second, health care costs must be brought under control. Firms that are constantly paying more for health insurance cannot pay more in wages. Governments that pay more for health care cannot invest in research and development, infrastructure, and human capital formation. Families that pay more for health care cannot spend those resources on other goods. Slowing the growth rate of health care spending is a necessary step in improving the standard of living of the American people.

Third, we must make the health sector more efficient. High administrative costs drive up spending needlessly. Up to one-third of many procedures are unnecessary, and another one-third may be inappropriate. There is inadequate information on the quality of different treatments, or of different health plans.

These problems are all a result of the organization of the current health care market. In the current market, there is a lack of competition among health providers and health plans, resulting in higher spending than is warranted. For many individuals, in fact, there is no effective choice over medical utilization or over insurance plans. There is insufficient information for consumers and providers to decide on appropriate care. Information about the quality and price of different providers, for example, is almost never available to consumers. Finally, incentives are distorted throughout the industry. Consumers have incentives to overconsume care, because their direct payments are limited. Providers have incentives to provide too much care, because they are reimbursed for each test or procedure

performed. The Health Security Act is designed to address the problems above by addressing the causes of poor information and misplaced incentives.

## **I. Health Care Security**

The first problem with the current health care system is the issue of security. For many individuals, the health insurance system promotes, rather than removes, insecurity. The current system does not provide true insurance to those who are insured; it leaves a large number of individuals uninsured; and it distorts individual employment decisions. In an era of increasing economic change and dislocation, it is vital that our health insurance not trap people into jobs or make job loss an even more terrifying prospect than it already is.

### **I.A How Americans Receive Health Insurance**

Chart 4-1 shows the sources of health insurance for Americans in 1992. Thirty-four million Americans — largely the elderly — have Medicare as a primary source of coverage. Among the remaining population, most people (159 million) are insured through an employer-based policy. This includes 69 million people who have direct coverage through their current or former employer, 69 million with other employer-sponsored insurance, and 21 million with individual (non-group) coverage. Four million Americans are insured through CHAMPUS or the VA, without employer or Medicare coverage. Of the remaining

57 million Americans, 20 million have Medicaid coverage.

The remaining 37 million people (almost 15 percent of the population) are uninsured. In no other industrialized country is the share of people uninsured above xx percent. In addition, a large number of insured Americans are underinsured -- they have insurance policies with very high deductibles or large out-of-pocket spending limits so that they are subject to more spending risk that could lead them to become financially crippled. Estimates suggest that about xx percent of people have insurance policies with deductibles above \$yy (get from Jim Mays).

#### **I.B Security for the Insured**

Perhaps the most important problem with the current health care system is that it does not provide true insurance for people who are insured.

*Limitations on Covered Expenses:* Many insurance policies exclude coverage of health problems that existed prior to the beginning of the insurance policy. A typical rule, for example, is to exclude for six months conditions present in the six months prior to joining the plan. Up to 40 percent of insurers impose exclusions of this form.

In addition, most current insurance policies have limits on the maximum amount that



the insurer will pay over the lifetime of the individual. The limits generally range between \$250,000 and \$1 million. These limits are counter to the economic theory of insurance. Economic theory suggests that insurance should cover these types of risks, since they are generally unforecastable and rarely a result of individual choices.

The exclusion of pre-existing conditions coverage is a response of insurers afraid of "adverse selection". Any insurer that offered to cover pre-existing conditions at the actuarially fair price would find itself with the sickest risks, and thus higher costs than expected. By raising prices to cover these additional costs, however, the insurer would drive away people who are less likely to use these services. As a result, the fear of insuring only high cost cases leads insurers to omit coverage for pre-existing conditions coverage.

*Lack of Intertemporal Insurance:* A second source of insecurity is the inability of groups to guarantee a fixed price of insurance in future years. Most insurance is "experience rated," meaning that the group's premium is based on its expected cost that year. Since individuals that are sick one year tend to be sick in subsequent years, insurers often increase the price for a group, or drop the group entirely, if they suffer an adverse claims experience. This kind of health insurance is not true insurance.

## I.C Security for the Uninsured

Beyond the insecurity created for the insured, there is the additional problem of the uninsured and underinsured. The uninsured are a very fluid population. Table 4-1 shows how long people had health insurance coverage in the 28 month period from February 1987 through May 1989. In this period, over one-quarter of Americans were uninsured for at least one month. Four percent were insured between 24 and 27 months. Twelve percent were insured between 12 and 24 months, and 7 percent were insured at some point but for less than 12 months. About 4 percent of the population was uninsured continuously over the period.

The popular conception of America's 37 million uninsured is that they are unemployed. In fact, however, most uninsured people have some connection to the labor force. Fifty-three percent of the uninsured are in families with a full-time, full-year worker, and 31 percent are in families with a part-time or part-year worker.

It is also a myth that insured people do not need to worry about the uninsured. In the current system, the insured pick up the bill when the uninsured face catastrophic costs. As Chart 4-2 indicates, the uninsured currently pay only 20 percent of the health care costs they incur, while the privately insured pay 130 percent of their actual health care costs.

According to recent estimates, there will be about \$25 billion of "uncompensated care" paid

for by the insured in 1994. Providing universal coverage could therefore lower premiums for the currently insured.

#### **I.D Insurance and Labor Market Mobility**

Because health insurance is closely tied to employment, the presence or absence of health insurance can affect individuals' employment decisions. In many cases, this is because individuals who change jobs may lose coverage for pre-existing conditions. In other cases, individuals fear that a new employer will not offer the same benefits or the same health plans. Empirical research suggests that the mobility rate of married men would be up to one-third higher if health insurance was not tied to a specific job.

Other individuals do not form small businesses or become self-employed because of the difficulty of obtaining insurance or the exorbitant prices in the current market. Empirical research on this question is limited. In surveys, however, 64 percent of small business owners report that they would like to provide some or better insurance for their workers, but the cost of insurance in the current market prevents them from doing so.

Finally, many people remain on welfare because they will lose their Medicaid coverage if they take a job. Some estimates are that one-quarter of the roughly 4 million AFDC recipients would take a job if health insurance coverage were available continuously.



Providing universal, seamless health insurance coverage is a step towards more fundamental welfare reform.

## **II. The Cost Problem**

Health care is an enormous part of the American economy. In 1994, it is estimated that the United States will spend \$982 billion on health care, or \$3,825 per person. This represents one out of every 7 dollars spent in the economy. This compares to one out of every 14 dollars in 1970, and one out of every 11 dollars in 1980. By comparison, the entire automobile and steel industries account for only \$yy billion.

### **II.A What is the Cost Problem?**

The United States spends more of its income on health care than any other industrialized nation. In 1991, we spent 13.2 percent of GDP on health care. Only two other countries spent as much as 9 percent of GDP on health care -- Canada at 10.0% and France at 9.1%. The average in other OECD countries was xx percent. In the absence of reform, health care costs are likely to continue to increase. The Congressional Budget Office forecasts that, without reform, real health care costs would rise by 7 percent annually between 1993 and 2000.

The fact that the United States spends more on health care than any other country is partially attributable to its higher income. Empirically, countries with higher incomes spend a larger fraction of their incomes on health care. Nevertheless, Chart 4-3 shows that the United States spends more on health care than would be predicted just given higher per capita income.

Add information about other sociodemographic factors.

The high level of spending is a problem for several reasons. To the extent that waste and inefficiency are responsible for some of our high health care spending, consumers would like to spend less on health care and more on other goods. In addition, high health care costs burden governments that may be unable to shift spending to other areas. Finally, the high cost of health care makes it difficult for poor people to purchase insurance.

The second concern over health care costs is that health care spending is rising more rapidly in the United States than in other countries. In the 1980s, real per capita health spending rose at an annual rate of 4.4 percent, compared to 3.2 percent in other G-7 countries. As Table 4-2 shows, in the 1960s and 1970s, health care cost increases in the United States were below average compared to the G-7 countries. In the 1980s, however, health care spending growth slowed in the other G-7 countries but not in the United States.

Most of the increase in health spending over time is due to increases in the quantity of care received, rather than in the price. In the 1980s, one-half of health care cost growth was due to increase quantity of care, one-third was due to increased prices, and the remainder was due to aging of the population. Even this degree of price increase is overstated, however, because no adjustment is made for quality changes or for differences between transactions and list prices. The importance of quantity growth in large part explains the difficulty that public sector programs have had in controlling health care costs. In the 1980s, prices paid by Medicare were constant in real terms, but quantity increases averaged over 4.5 percent annually. With no effective incentives to limit the volume of care, government programs have been unable to address the underlying cause of health care cost growth.

## **II.B Who Pays for Health Care?**

Table 4-3 shows who paid for health care in 1991, and where the money was spent. The largest amount of health care spending (38 percent) is for hospital care. Spending on physicians and other health care professionals is second largest, at 29 percent of total spending. The remainder of personal health care is for home and nursing home care (9 percent), and drugs and other medical devices (12 percent). The costs of insurance administration are estimated at 6 percent of health spending. Finally, there are public health activities and research and construction that total 6 percent of spending. This care is financed in three principal ways:



*Businesses:* Businesses pay for health care directly through health insurance premiums (\$153 billion), and workers compensation and disability insurance (\$18 billion). Total business spending was \$171 billion in 1991, about 23 percent of total health spending and 6.4 percent of total compensation.

*Households:* Households pay for health care through insurance premiums (\$52 billion) and out-of-pocket expenses and non-patient revenue (\$178 billion). The total amount is \$230 billion, or 31 percent of national health spending. The average household spent about \$2,440 on health care in 1991.

*Governments:* Governments pay for 46 percent of health spending. Most of government spending is for Medicare and Medicaid. There is additional spending on the Veterans Administration and the Department of Defense, as well as spending on government employees. Government spending on health care is \$xx per person. Over yy percent of Federal government spending and over zz percent of State and local government spending is devoted to health care.

Governments also subsidize health care indirectly, through the exclusion of employer-provided health insurance from individual income and social security taxes. Unlike wage and salary payments, payments for health insurance are not taxable to the employee. The loss to the government from this tax expenditure was estimated to be \$63 billion in 1993. Many

economists believe that the excludability of health insurance from taxes encourages individuals to purchase excessive insurance coverage.

## **II.C Economic Explanations of Cost Increases**

Economic research suggests several explanations for the high level and growth of health care costs over time. These explanations result from poor incentives in the current health care market. Therefore, the cost problem will not be solved without changing the incentives facing individual patients and health care providers.

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### **Box: Productivity growth and health care costs**

Health care costs, like all service goods, have continually grown faster than the economy as a whole. Some of the explanation for this comes from the lack of productivity growth in the service sector. Many goods, such as manufacturing and agriculture, have rapid productivity growth. When firms are more productive, they can lower the price of the goods they sell. There is little measured productivity growth in service-oriented industries such as health care, however. The time required by a doctor to see a patient has not changed substantially over time. Therefore, the cost of producing each visit is not changing. Without changes in the quantity of service goods demanded, relative prices would increase along with

relative costs. This phenomenon is termed the "cost disease" of the service sector.

How important is this effect on health care costs? If there were no productivity growth in health care, the relative price of health care, and thus spending on health care, would increase at the rate of productivity growth in the economy as a whole. This is about 1.5 percent per year. Added to this is the fact that as society gets richer, we demand more medical care. Empirical estimates suggest that each 10 percent increase in income raises the relative demand for medical care by about 3 percent. Finally, there is a countering effect that as the relative price of health care increases, demand for health care services will fall. Evidence suggests that each 10 percent increase in the price of health care lowers demand for health care by about 2 percent. The net of these three effects is that real per capita health care costs should rise at about 1.1 times the rate of productivity growth in the economy as a whole.

Empirically, health care costs have risen at about 4.4 percent annually, about 3 percentage points about the level predicted on the basis of cost disease alone. This additional increase is likely due to changes in technology that have increased the cost of treating given patients. Because we do not measure changes in mortality or morbidity in determining productivity growth, however, changes in technology are not counted as productivity improvements.

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*Moral Hazard:* The first explanation for the high level of health care costs is the role of insurance in increasing demand. What a consumer normally pays for health care is usually only a small percentage of the total bill. Once an insured consumer has used up his or her deductible, the consumer faces only a share of the cost of medical care -- usually no more than 20 percent. Once the out-of-pocket maximum is reached, there is no additional payment for any services -- the marginal cost to the individual of each additional service is zero. The result is that individuals will choose to consume excessive amounts of health care. The effect of insurance on increasing the amount of spending is referred to as "moral hazard".

Moral hazard is particularly acute for Medicare beneficiaries. Almost three-quarters of Medicare beneficiaries have "Medigap" coverage -- coverage that pays for the deductibles and copayments required in Medicare. This coverage induces individuals to use more medical care, however, and thus drives up Federal health care spending. Estimates are that the presence of these policies raises Federal Medicare spending by 24 percent. The government does not attempt to collect for this increased spending, however.

*Incomplete information:* One of the requirements for effective competition is that consumers be sufficiently well informed to make price and quality comparisons. In the health care market, there are substantial barriers to consumer information. Often, treatment is provided on an emergency basis, where there is no ability to make comparisons across providers. Even in non-emergency cases, many patients do not feel qualified to decide on the

appropriate course of treatment. The inability to comparison-shop for health care makes price competition less effective than it otherwise would be.

*Lack of Choice:* Even individuals who are not well enough informed to decide on the appropriate treatment or provider can still choose among insurance plans. There are substantial barriers to choosing among insurance plans in the current system, however. Because different plans cover different services, consumers may be unaware of the exact coverage when they choose a policy. In addition, there is no systematic information about the quality of different plans. In the absence of quality information, many consumers seem to assume that more expensive health plans must be of higher quality. Finally, many firms do not offer their employees any choice of health insurance plans. In many cases, the limitation of choice is a requirement of the primary insurer; in other cases, it is because the transactions costs of establishing multiple health plans are too large. Fewer than 10 percent of employees in firms of under 25 workers have a choice of health plans, and only a quarter of employees in firms with 100 to 999 employees have a choice of plans. Overall 55 percent of workers have a choice of plans.

*Fee-for-service reimbursement:* Providers who are reimbursed for each service they perform have incentives to increase the volume of the services they provide. Patients, many of whom do not have sufficient information to know which tests or procedures are appropriate for them, and who are insulated from the true cost of the services anyway, are unlikely to put



pressure on physicians to limit the quantity of services provided to them. As a result, providers will perform excessive amounts of services. For a fully insured patient, providers would have to perform all tests and procedures that are not iatrogenic. In addition, since health care providers may be sued for failure to perform procedures or diagnose specific diseases, there is an incentive for providers to do additional tests and procedures beyond the appropriate level. This "defensive medicine" leads to unnecessary care.

*Defensive Medicine:* An additional factor leading to increased health care spending is the malpractice system. Malpractice costs account for xx percent of the cost of health inputs. In addition, since health care providers may be sued for failure to perform procedures or diagnose specific diseases, there is an incentive for providers to do additional tests and procedures beyond the appropriate level. This "defensive medicine" leads to unnecessary care. While some defensive medicine is certainly present, defensive medicine does not appear to explain a great deal of health care spending. Estimates of the amount of defensive medicine are about \$20 to \$30 billion annually.

*Technological Change:* A final contributor to increases in health care spending is technological change. The introduction of new types of technology may lead to increases or decreases in health care spending, depending on whether the technology is a substitute or complement for existing methods of treatment. In addition, however, some technological change consists applying previously existing technologies to new patients. (Any quantitative



measures of the importance of these?)

The role of technology in explaining long-term health care costs is a difficult question. If technological change continues at its current pace and continues to increase spending, there may be no reduction in the long-term rate of growth of health care spending. On the other hand, if the form of technological progress responds to payment incentives, health care reform may contribute to a reduction in the long run growth rate of health care costs.

#### **II.D Implications of Rising Health Care Costs**

The rising cost of health care has implications for businesses and governments.

*Businesses:* In response to higher health care costs, businesses can do several things. They can:

- Lower workers' wages so that total compensation does not rise;
- Lower returns to shareholders;
- Reduce payments to other factors of production;
- Reduce investment in plant, equipment, and research and development;
- Raise prices to consumers.

Economic theory suggests that most of the increase in health care costs should be reflected in lower wages to workers. If employees value business spending on health insurance at its cost, workers should be willing to trade lower wages for increased health insurance premiums. Since wages are taxed and health insurance premiums are not, a dollar of health insurance is worth more than a dollar of wages. At the margin, employees will be willing to "buy" increased health insurance until each dollar of health insurance is worth the equivalent of one dollar of wages *after-tax*, or about 65 cents for a typical family. At this point, both the worker and the firm would be indifferent between contributing more to health insurance or to wages.

In fact, empirical research suggests that the dominant long-run response of businesses to rising health care costs has been to lower the rate of increase of workers' wages. Between 80 and 100 percent of increases in health care spending appear to be reflected in lower wages. As Chart 4-4 shows, the share of GDP devoted to employee compensation -- including health insurance -- has been essentially constant in the post-war period, even as the share of GDP devoted to business health insurance spending has increased markedly.

This wage response is both good and bad news for employees. By cutting back on wage increases, firms limit the extent to which the costs of hiring labor increase, and thus limit the job losses from rising health care costs. On the other hand, the reduction in wage growth has led to slower increases in family incomes than would otherwise have occurred.

If business spending on health care had remained the same share of compensation that it was in 1975, real wages per employee could be over \$1,000 higher than they currently are.

To the extent that increases in business spending are not entirely reflected in lower wages, total compensation will rise. The higher compensation paid to labor may induce firms to substitute capital for labor than to produce in other countries. To the extent that rising health care costs limit firms' cash flow, it may have an effect on the amount of investment. Economic research has not explored these types of responses in any detail.

*Governments:* Rising health care costs are a major cause of the fiscal crises in both the Federal and State and local governments. Governments can respond to increasing health care costs in several ways. They can:

- Increase taxes;
- Reduce other spending, such as education and research and development;
- Borrow, in which case future taxes will need to be raised or future spending will need to be cut.

Economic research suggests that the dominant effect of higher taxes is to lower the take-home pay of workers. Thus, increasing taxes for health care are another contributor to the slow growth of family incomes. To the extent that rising health care costs crowd out



other forms of government spending instead, society loses the benefit from these projects. Whether greater government health spending comes at the expense of higher taxes or lower spending on other goods and services is not generally known.

*Overall Burden:* Total business, household, and government health care spending is a substantial expense for insured families. As Table 4-4 shows, health care spending per insured worker is expected to be over \$7,000 in 1994. This includes almost \$2,000 of family premiums and out-of-pocket expenses, over \$3,400 of employer contributions for health insurance and workers compensation, and over \$2,100 of taxes for government health spending.

### III. An Inefficient Industry

The amount that consumers choose to spend on any particular good is not normally a matter of public policy concern. Indeed, the level of health care spending would not be a significant economic issue if the health care market were efficient and there were little waste. There is substantial evidence, however, that the health care sector is not efficient and that much of public and private money is not well spent.

### III.A High Administrative Expense

Administrative costs in the health care system are extremely high. As noted above, the costs of insurance administration alone are estimated at more than the total amount of public health service spending. Some of this administrative expense lowers the direct costs of care and thus saves money overall. Estimates suggest, for example, that each \$1 spent on utilization review saves \$9 in direct health care spending.

Some of the cost of insurance administration is a consequence of insurance companies seeking to price each group at its expected cost, however — a process known as "risk selection". Since large groups tend to have diverse workers, there is less need for insurance companies to spend resources evaluating risks for them. In addition, many of the costs of risk selection are fixed costs, leading to higher per capita administrative costs for small groups. The result is that the "load" that firms pay — the difference between the costs of insurance and the expected amount of claims — is much larger for small firms than for large firms. A typical large firm may face administrative expenses as low as 5 percent of claims. For very small groups, however, the administrative cost averages 40 percent of claims.

The administrative expense in selecting good risks bears private returns but is socially wasteful. It is clearly profitable for any insurer to select healthy risks, since that insurer's expected costs will be lower. For society, however, money spent selecting only the good

risks is a waste. After all, someone must cover less healthy people. They will either obtain private insurance; receive insurance through public sector programs; or use "uncompensated" health care, the costs of which are passed on to the insured population through higher premiums.

In addition to administrative costs in insurance companies, there are additional administrative costs for hospitals and doctors that must deal with multiple insurance forms and different sets of covered services. Estimates of these costs range from 1 to 10 percent of hospital and physician expenses.

### **III.B Inappropriate and Unnecessary Care**

The most important example of waste and inefficiency is the amount of inappropriate and unnecessary care in the current system. Economically, care is inappropriate if the benefits from the care are less than the cost of providing the care -- including the direct costs to the patient as well as the costs paid by insurers.

In practice, studies that examine the amount of inappropriate or unnecessary care rely on medical determinations of whether care is appropriate or inappropriate. Chart 4-5 presents estimates of inappropriate and unnecessary care for several common medical procedures. Estimates suggest that up to one-third of many procedures are inappropriate,



and another one-third may be unnecessary. It is estimated that up to \$1 billion is spent on unnecessary Cesarean sections each year.

Additional evidence comes from the sharp variation in health care utilization across areas of the country. In different parts of the country, and in smaller regions within the same area of the country, there are large differences in the amount of medical care that people receive. In 1989, Medicare payments ranged from \$822 per beneficiary in Minneapolis to \$1,874 in Miami.

At least some of the variation in care across areas of the country reflects patients that need medical treatment. Studies have found, for example, that areas with greater spending have more appropriate as well as more inappropriate medical care. Much of the inappropriate or unnecessary care, however, is likely due to insufficient information on the part of providers about what types of care are truly necessary. In a well-functioning market, providers would observe these differences and adjust utilization patterns accordingly. One sign of inefficiency in the current market is that such data is not commonly available.

#### **IV. Principles of Reform**

Three broad approaches to reform would address the problems noted above. The first is to establish a single-payer health system in which everyone is insured through a

government program. The government raises revenue, generally through a broad-based income- or value-added tax, and uses the proceeds to provide private health insurance or pay for medical care directly. Commonly, single-payer proposals in the United States involve extending the Medicare system to the entire population. Thus, doctors would be reimbursed on a relative value scale, and hospitals would be reimbursed on the diagnosis of the patient.

Single-payer systems succeed in achieving universal coverage. They also attempt to control costs by limiting the increase in hospital and physician fees over time. Finally, to the extent that the government supercedes insurance companies, they are not subject to adverse selection or risk selection practices on the part of insurers. All of these are valuable features of reform.

Single-payer systems have a number of drawbacks, however. First, they involve more government control of private decisions, such as how much providers can be paid and what type of care is provided. Second, there is more disruption in moving from the current system to a single-payer system. New taxes need to be raised, and most existing health insurance would be eliminated. Finally, government programs have not been particularly successful at controlling health care costs. Even with the shifting of costs from Medicare and Medicaid to private insurers that occurred in the 1980s, health care spending grew more rapidly in public programs than in private programs.

A second approach to reform is to foster more competition. There are a number of variants on this theme. One common proposal is to create individual savings accounts, where people would be allowed to put money away tax-free to be used for small medical expenses. In exchange, individuals would be encouraged to purchase catastrophic coverage for large expenses. These proposals clearly create incentives to limit health care utilization. This type of plan, however, does not guarantee universal coverage, nor does it remove the fear that individuals could be charged a higher price if they or a family member became sick.

A second variant on the competitive proposal is to focus on insurance market reform. Insurers would be prohibited from excluding pre-existing conditions, and the government would enforce community- or age-rating. Potentially, there would also be pools for small firms and single individuals, although in many proposals these pools are optional. Insurance reform proposals address most of the problems facing small firms that want to purchase insurance. They fail to guarantee universal coverage, however, since insurance will never be affordable for many people without government subsidies. In addition, if alliances are optional rather than mandatory, there will be some adverse selection, which must be balanced against the increased choice that these plans allow.

The Health Security Act attempts to blend the benefits of the competitive and single-payer approaches to reform, through a proposal known as "managed competition". Like the single-payer systems, the Health Security Act guarantees universal insurance with a



comprehensive set of benefits. It also sets a limit on insurance premiums, to guarantee cost control if private incentives fail.

Like the more competitive systems, however, managed competition relies in the first instance on private market competition to control costs. Individuals are pooled into health alliances, where they are given a wide variety of insurance choices and where the ability of insurers to select risks is limited. Insurers thus have incentives to control costs and increase quality, rather than just to select good risks. Consumer choice is relied on to judge quality and choose coverage. The idea is that expanding choice and improving people's ability to make decisions over health plans gives a natural incentive to individuals to limit the cost of health care.

Economically, the Health Security Act is driven by five specific principles:

*Principle 1: The government should guarantee universal coverage with a comprehensive set of benefits.*

Universal coverage is essential because security can never be fully realized without it. If individuals are in danger of losing their insurance when they lose a job or leave the labor force, people will feel locked into their current job. Comprehensive benefits are equally important. Some plans promise universal insurance but only for catastrophic expenses. For

many Americans, this implies that their insurance coverage will deteriorate if they lose their job, just when their income is falling. Catastrophic insurance policies also encourage individuals to postpone preventive care, potentially increasing future health care spending. Finally, a large share of health care spending is above even high catastrophic limits, so that catastrophic policies would not provide large incentives to everyone.

An important component of providing universal coverage is guaranteeing that individuals will not be discriminated against because of age or health status when they purchase insurance. In order to sell insurance in the regional alliance, insurers will be required to:

- Charge only one price (community rating);
- Accept all people who want to join the plan, provided the plan is accepting anyone (guaranteed issue);
- Accept anyone who wants to renew membership (guaranteed renewability);
- Eliminate pre-existing conditions exclusions;

Further, all non-workers and people employed in small firms will be required to purchase insurance through a regional health alliance. Because there will be only one health alliance in each geographic area, healthy people will naturally be pooled with sicker people. While the healthy people will pay more for health care than is actuarially required, they will

benefit from the knowledge that, if they become sick, they will still be able to obtain insurance at an affordable price.

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Box: How much money will insurance reform save?

Insurance reform will save money through lower underwriting costs. On average, groups of fewer than 5,000 people face administrative costs of 18.2 percent in purchasing insurance, while groups of more than 5,000 face costs of only 5.8 percent. About two-thirds of employees now are in groups below 5,000 workers. Under reform, administrative costs in the health alliances are expected to be 13.5 percent. For groups of over 5,000, administrative costs are projected to increase by 1 percentage point, to account for the new data and reporting requirements. On net, therefore, the cost of insurance administration should decline by about 3 percentage points. Since current premiums for the population covered by the reform are about \$200 billion, the savings from insurance reform are therefore about \$6 billion annually.

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*Principle 2: There should be incentives to control costs, and an enforceable budget if the incentives fail to work.*



The Health Security Act will affect costs by reforming the incentives in the health care system. Under the Health Security Act, all people are in pre-paid health plans. Since plans receiving fixed reimbursement have a greater incentive to control costs than open-ended plans, the level of costs should fall.

Because benefits will be standardized across plans, individuals will know what type of insurance they are purchasing. It is widely speculated that health plans in the current market do not price aggressively, since cheaper plans are often perceived as lower in quality than more expensive plans. In a market with standardized coverage, customers are less likely to judge quality by price, and so plans may have more incentive to bid aggressively for patients. Individuals will also be given better information about the quality and price of different health plans, and a greater ability to choose among plans. Quality report cards available within the Health Alliances will aid individuals in making cost-conscious choices of insurance policies.

Further, individuals will be given greater incentives to choose less expensive health plans. In many firms, employers pay a fixed percentage (generally 80 percent) of whichever plan is chosen by the employee. There is thus a considerable "tax" on choosing less expensive plans: for each dollar the employee saves by choosing a less expensive plan, 80 cents is taken by the employer and only 20 cents is realized by the individual. In some cases, even this 20 cents is taxed by Federal and State and local governments -- at up to 35-

40 percent marginal tax rate -- making the effective savings only 10 to 15 cents on the dollar. Employees naturally have little incentive to choose less expensive plans.

Under the Health Security Act, families will be required to pay all of the difference between what their employer contributes and the cost of the plan they select. The family thus gets to keep, subject to taxes, all of the savings from cost-conscious decisionmaking. Further, if an employer contributes more than the required amount, they must give a rebate to employees who choose a less expensive plan. The rebate has the effect of again allowing families to realize the savings from choosing less expensive plans.

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Box: The evidence on competition and costs

A number of governments and corporations have experimented with fixed contribution rules for their employees. Empirical studies confirm a large effect on plan choice. The State of Minnesota implemented a fixed-dollar contribution for public sector employees in 1988, for example. Within five years, the share of employees in the high cost plan fell from 42 to 17 percent, while the share in the lowest cost plan increased from 28 to 54 percent. The State of Wisconsin implemented a similar system for its public employees in 1984, and found that enrollment in the lowest cost plan increased from 15 to 60 percent in one year. Similar changes have been observed in private sector companies like Alcoa, Xerox, and

Digital Equipment. If these examples are extrapolated to the nation as a whole, estimates are that health care costs could fall by about \$50 billion annually by the end of the decade.

There is additional evidence that wide-ranging reform can affect costs for an entire group of people. Discussion of California evidence.

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Many economists have argued that the Federal government should tax employer contributions for health insurance as if these benefits were paid as wages. Such a change in the tax treatment would raise the price of more expensive health plans, thereby providing incentives to limit health care spending. Several types of health benefits can be considered for reformed tax treatment. First, employees can be prohibited from contributing to "cafeteria" plans that allow them to deduct their insurance premiums from income. This limitation is a part of the Health Security Act. Second, employer payments for services beyond the basic benefit package -- reduced cost sharing or additional services -- could be considered taxable income. This limitation is set to occur in the year 2003 under the Health Security Act. Finally, all or part of the cost of a basic benefit package above some level could be considered taxable income. These benefits are not taxable under the Health Security Act.



*Principle 3: Reform should minimize disruptions in moving from the current system to a new system.*

Any wholesale reform of one-seventh of the economy is bound to produce some disruption. Nevertheless, the Health Security Act attempts to minimize the disruptions in moving from the current system to the reform system. The most important step in this effort is the employer mandate. There are three potential ways to pay for universal coverage: an employer mandate; an individual mandate; or a broad-based tax such as a value-added tax. Employer mandates require employers to pay for some health insurance — the same way most people receive coverage now. Individual mandates require individuals to purchase health insurance. The employer has no legal obligation to pay for coverage. Finally, governments could impose large new taxes on consumption or income, and use the proceeds to provide everyone health insurance.

Under an individual mandate or broad-based tax, however, there would be severe transition problems in moving from the current employer-based system to the new system. While employers that drop coverage are likely to pay higher wages to their workers, the timing of the wage substitution is not generally known. Under an employer mandate, there are far fewer changes in existing payments.

An additional step to minimize disruption is to allow large firms to continue operating

self-insured plans. These firms generally provide good health benefits and have managed to control health care spending. For workers in these firms, the change associated with the Health Security Act will be small.

*Principle 4: The health care system should maintain maximal choice at all levels – states, providers, consumers, and firms.*

It is clear that no single system can work in every state. In many states, competition is well developed and competing health plans are already a reality. In other states, providers are too sparsely distributed to have much competition. The Health Security Act allows states to form single payer systems or otherwise adjust the new system for particular local circumstances.

Providers are free to choose the plans in which they will work. Indeed, they are allowed to join more than one plan. Physicians might join a preferred provider network, for example, while also treating patients in a fee-for-service plan.

To encourage consumer choice, the Health Security Act creates regional health alliances where all non-working families and employees of firms with fewer than 5000 workers can buy insurance. Within the pools, there are choices of fee-for-service insurance, HMOs, and PPOs. To avoid a situation where people cannot receive care outside of a

predetermined site, HMOs will be required to have a Point-of-Service option allowing recipients to use providers outside of the plan. Finally, while all employees of small firms are required to be in a regional alliance, firms of over 5000 workers can either form their own corporate alliance, or join the regional alliance.

*Principle 5: Health care reform should be deficit neutral in the short run and deficit reducing in the long run.*

Long-term deficit reduction is a fundamental precept of reform. Even with the President's economic plan, the federal budget deficit is expected to increase around the turn of the century. The main reason is growing health care costs. Success in balancing the federal budget is directly tied to success in reducing the growth rate of federal health spending.

In the short term, reform is dominated by new costs -- for discounts, the drug benefit for seniors, and long term care. The savings from slowing the rate of growth of health care spending are also small. Over time, the revenues from reducing cost growth are larger. The deficit reduction should thus increase accordingly.



## **V. Architecture of the Health Security Act**

The Health Security Act will change the way that health insurance is bought and sold. There are three important features about the Health Security Act: the organization of the health care market; payments for insurance; and system oversight and enforcement.

### **V.A The Organization of the Health Care Market**

The organizing mechanism for health care under the Health Security Act is a health alliance. Health alliances serve as brokers between individuals and health plans. On the consumer side, alliances collect funds for health insurance and track the enrollment of individuals in different plans. On the provider side, alliances accept bids from providers and monitor compliance with insurance rules and the premium caps.

*Alliances:* The Health Security Act sets up two types of Alliances. Regional health alliances are designed for non-workers, workers in firms with fewer than 5000 employees, and Medicaid recipients. A firm with over 5,000 employees has the option of joining the regional alliance or establishing its own corporate alliance. If the firm chooses to organize its own corporate alliance, it must offer the same plan choices as the regional alliance, and does not receive any subsidies.

Each state will have one or more regional health alliances. However, only one will cover any particular geographical area. Boundaries of the regional alliances are not allowed to be drawn to segregate high cost people in one area.

*Providers:* Doctors will belong to one or more health plans. A typical doctor might be in a managed care plan as well as see fee-for-service patients.

*Health Plans:* All of the health plans must offer a guaranteed set of benefits. Plans may differ, however, in the cost sharing they impose and the way they deliver services. There are three types of health plans. The first is a traditional fee-for-service plan. The Health Security Act specifies a deductible of \$400 for a family, with 20 percent cost sharing up to a \$3,000 maximum payment. The deductible and out-of-pocket maximum are in 1994 dollars and are indexed in subsequent years by the rate of premium growth. The second type of plan is a Health Maintenance Organization (HMO). HMOs have a \$10 copayment for every doctor's visit, but require gatekeepers or other forms of utilization management. Under the Health Security Act, HMOs would have to offer a point-of-service option, which would allow enrollees to seek care from providers outside of the plan for an additional fee. Finally, individuals could choose a Preferred Provider Organization (PPO). PPOs generally have some doctors in a network, for which the copayment is \$10 per visit, but allow individuals to see doctors outside of the network, with cost sharing is similar to the fee-for-service plan.

*Firms:* For most firms, health reform will mean less attention paid to health care. Firms with fewer than 5000 employees will stop providing coverage and their employees will join the regional alliance. Firm with over 5000 employees can continue providing coverage or join the regional alliance.

Firms will be required to pay at most 80 percent of the weighted average premium in the alliance in their area. Firms will pay less if this exceeds a given share of their payroll, but all firms will be required to pay something. Employers can supplement the basic contribution if they wish. If they do so, however, they must offer the same contribution for all employees in a given class, and must give a full rebate if an employee chooses a less expensive plan than the employer pays for.

*Consumers:* Within an alliance, consumers have a choice of health plans. If the employer contributes only the required 80 percent share, the price to the consumer is the amount by which the plan exceeds 80 percent of the weighted average premium. For each dollar of increased plan cost, the employee would be required to pay the full dollar for coverage. There are subsidies for low-income families.

There is an annual open enrollment period during which the consumer can switch health plans. To facilitate such switching, the alliance will publish price and quality information for consumers. The quality information is intended to cover both consumer



satisfaction and objective measures of quality such as morbidity and mortality.

Individuals or their employers are allowed to purchase health insurance for additional benefits beyond the basic plan, or for wrap-around policies to reduce out-of-pocket payments. The Health Security Act specifies a floor through which individuals should not fall, rather than a ceiling on the generosity of health care an individual can receive.

#### **V.B Paying for Insurance**

The Health Security plan classifies people into four rating pools: single people; couples with no children; families with 1 adult; and families with 2 adults. Table 4-5 shows the estimated premiums in 1994 for these four policies. For a 2 adult family, for example, the national average premium in 1994 is estimated to be \$4,360. The average family payment would be 20 percent of this amount, or \$872.

*The Employer Mandate:* The required employer contribution is based on the number of workers in each pool. For single individuals, there is one worker per family. An employer of a single worker therefore pays 80 percent of the \$1,932 premium cost, or \$1,546. In the case of couples, there are about 1.46 workers per family. Since 80 percent of the premium is \$3,092, the amount per worker is only \$3,092/1.46, or \$2,125. Workers in families with children -- whether 1 adult or 2 adults -- are pooled. The alliance computes total

requirements (roughly \$3,500 per family) and divides this by the number of workers per family (about 1.5). The employer payment for a family with children is therefore \$2,479. Self-employed people are treated like small firms. However, if the self-employed worker has wage and salary income as well, payments from their employer are subtracted from the amount they owe on self-employment income. Employer payments for part-time workers are pro-rated, based on the share of a 30 hour week that the person works. No payment is required if the individual works fewer than 10 hours per week.

At least one employer premium must be collected for each family. If members of the family worked at least 12 months full-time during the year, the family does not owe any additional employer share. If the family worked fewer than 12 full-time months, the family owes the remainder of the employer share. For example, a family with only one half-time worker would owe one-half of an employer premium as well as the family's share of the premium. The employer share is to be paid out of income less wages and unemployment benefits, but including tax-exempt interest receipts. The exception for labor income is because this income is presumed to already reflect required employer contributions.

*Providing Discounts:* There are four types of discounts in the Health Security Act: discounts to families on their share of the premium; discounts to families that owe some employer payments; discounts to firms; and discounts for poor individuals faced with high out-of-pocket payments.



Low income families in the regional alliances receive a discount on their 20 percent share of the premium. No payment at all is required on the first 1,000 of income. The discount phases out at 150 percent of the poverty level. The \$1,000 disregard and the poverty line are indexed to the CPI. For families that owe part of an employer payment, additional discounts are provided. No payment is required if the family earns below \$1,000, and full payment is expected at 250% of the poverty level. If the individual is between ages 55 and 64 and meets the Social Security earnings test, however, the government pays the entire employer share. This retiree discount supplants any payment for the employers share that the individual or their employer would have made. Total household discounts are \$59 billion in the year 2000, including \$47 billion of non-retirees, \$7 billion as non-worker subsidies to retirees, and \$4 billion as additional payments to early retirees.

Firms may also receive discounts on their mandated payments. All firms in the Alliance are capped at 7.9 percent of payroll. Small firms receive additional discounts — as is detailed in Table 4-6. It is estimated that about yy percent of workers in firms with fewer than 5000 employees will receive a discount. These discounts total \$29 billion in 2000, about three-quarters of which are for firms wth fewer than 25 employees.

Finally, low-income individuals who live in areas where there are no HMOs available can receive discounts for their out-of-pocket payments. These discounts phase out at 150 percent of the poverty level. The total cost is \$3 billion in the year 2000. Finally, there is a



15 percent subsidy add-on designed to account for changes in behavior that would increase the amount of money the government pays.

*Sources of Premium Money:* In total, the alliances receive revenue from three sources: employer payments; family payments; and government discounts. Estimates are that about 59 percent of the money for the non-Medicaid population will come from employer payments; 17 percent will come from family payments; and 24 percent will come from government discounts.

## **V.C System Oversight**

*Health Alliances:* The Health Alliance has four responsibilities. The first is to monitor the practices of insurers. The health alliance enforces community rating, guaranteed issue and renewability, and no pre-existing conditions. The alliances can also exclude any plan whose premium is above than 120 percent of the average premium. Second, the alliance gathers and disseminates quality and price information about the plans in the alliance.

The third responsibility is to implement a risk adjustment mechanism. While each plan is required to charge a community rate, without any compensation plans with more sick individuals would have to charge a higher premiums. As a result, plans would attempt to avoid high cost people. One way to minimize this possibility is to make compensating

payments to plans with sicker people. A system of "risk-adjustment" transfers from plans with better risks to plans with worse risks. In a perfect risk-adjustment system, plans can would price entirely at average cost, and there would be no incentive for plans to select more or less health individuals.

Finally, the alliance is responsible for collecting on bad debt. Some allowance for bad debt is allowed for in the premiums. If the actual amount is greater than anticipated, however, the alliance imposes a premium surcharge on all payers to cover the shortfall.

*National Health Board:* Overseeing the health care system is the National Health Board. The Board determines the premium targets for each alliance, given the national spending total.

In addition, the Board enforces the premium caps. After the plans submit bids, the alliance projects the weighted average premium, using its guess of enrollment in the next year. If the weighted average premium is above the premium cap, the Board reduces the premiums of plans above the average, so that the target is met. If, *ex post*, more people than expected joined high cost plans, the Board reduces the allowed increase in future years so that the target is met.

#### **V.D Implications for National Health Expenditures**

This section to be written.

#### **V.E The Effects on the Federal Budget**

The Health Security Act spends money in five major areas (see Table 4-7). The first is new spending on Veterans Affairs, Public Health, and Administration. This totals \$12 billion in 2000. The second area of spending is the drug benefit for Medicare recipients, costing \$16 billion in 2000. Related to this is long-term care spending, which will largely benefit the elderly. This spending is \$20 billion in 2000, most of which is for a new home- and community-based long-term care program. Fourth, giving 100 percent tax deductibility of health insurance premiums for the self-employed will cost \$3 billion. Finally, there are premium discounts and subsidies, totalling \$43 billion in 2000. These discounts are the difference between \$104 billion in gross costs and \$61 billion of Medicare and Medicaid savings, as people leave these programs and receive private coverage. Total new spending is \$94 billion.

These new costs are covered through 6 sources of savings. First, there is a tobacco tax and 1 percent payroll assessment on corporations who choose to remain outside the regional alliance. These taxes raise \$15 billion. There are also savings in public sector



programs. Medicare savings are projected to \$42 billion, and Medicaid savings are \$28 billion. In addition, there are savings in other federal health programs, including the Veterans Administration, the Department of Defense, and the Federal Employees program. These total \$14 billion. Fifth, the plan will raise \$31 billion of additional revenue. Most of this revenue is from slower health care cost growth leading to increased wages and salaries, from removing health insurance premiums from "cafeteria plans" offered by employers, from assessments on corporations benefitting from the early retiree provisions, and from dedicated premium revenue for academic health centers. Finally, the plan generates \$4 billion of lower debt service.

In total, the plan raises \$132 billion through these sources of savings. Since savings are greater than new spending, there is \$38 billion of deficit reduction.

## **VI. Economic Effects of the Health Security Act**

Reforming one-seventh of the nation's economy has enormous economic effects. Payments by almost all families and businesses will be affected by the reform. In such a situation, there are bound to be both positive and negative economic effects of the program.

### **VI.A Changes in Wages**

As noted above, the dominant effect of increases in health care costs over time has been a reduction in the real wages received by employees. As health care reform lowers employer health insurance payments over time, there should be a corresponding increase in workers wages. The estimates above suggested that after reform, employer payments for health insurance would be \$xx billion below their expected level in the year 2000. Wage and salary compensation should therefore increase by .8\*xx to xx billion, or about yy percent.

#### **VI.B Employment Effects of Reform**

An important concern about health care reform is its effect on employment. Employer mandates increase labor costs to firms which are not now providing or are underproviding insurance. This fact has led to fears that there will be a large amount of involuntary job loss as a consequence of reform. It is clearly true that there will be increased costs for firms that are not now providing insurance. But, there are also cost reductions for firms that are currently offering coverage, however. These reductions come from three sources. First, spreading the cost of universal coverage over all workers benefits firms that are already providing insurance. Second, insuring the uninsured reduces the markup over their costs that currently insuring firms face. Finally, slower cost growth over time lowers payments for firms currently providing coverage.

Table 4-8 shows changes in average contributions for firms in the year 2000. Firms

not currently offering insurance will see costs increase by \$1,281 on average. This is well below average premiums because of the discounts available to these firms. Firms that are now offering insurance to their workers will see an average spending decline of \$391 per worker, from \$2,887 without reform to \$2,496 with reform. Any analysis of the employment effects of reform must take all of these changes into account.

A second employment issue is that reform may induce some individuals to leave the labor force entirely. Some individuals who work mainly to obtain health insurance coverage may voluntarily leave the labor force after health reform is passed. The most important form of voluntary labor force reduction is retirement. Evidence from Continuation of Coverage (COBRA) laws passed by the Federal government and many state governments suggests that about 1 percent more individuals decide to retire when they have the option to purchase coverage through their former employer after retirement. Increasing these estimates to account for the lower price of insurance under reform, about 350,000 to 600,000 people could decide to retire early because of the Health Security Act.

A final employment issue is that some welfare recipients will decide to enter the labor force when health benefits are universal. For a welfare recipient who is currently receiving Medicaid benefits, taking a job can amount to a tax of two-thirds or more on earnings because of the reduction in AFDC benefits, food stamps, and Medicaid benefits that accompany entering the work force. When health care is available continuously, however,



the average "tax rate" associated with leaving welfare should fall by up to 10 percentage points. A number of studies suggest that many more welfare recipients will decide to work in response to these lower implicit tax rates. One estimate, for example, is that up to one-quarter of the 4 million welfare recipients would leave welfare because of health care reform.

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Box: Will health care reform lead to job loss?

Existing models do not allow us to predict the employment effects of health care reform with great precision. In many other areas of economics, there are models that have been tried and tested for decades, and economists generally place at least some faith in the outcomes they predict. Such models do not exist in health care, however. The appropriate model for such an exercise would have to make distinctions both between firms that currently provide insurance and those that do not and among the many ways that firms in either group might respond to a change in their health care costs. Such a model would also have to predict how individuals might respond to new incentives in the plan, particularly those affecting small business creation, job mobility, welfare lock, and retirement.

In the absence of an appropriately specified model, one can generate either small net positive or small net negative effects of the Health Security Act on employment, depending on the assumptions one is willing to make in existing models. Not surprisingly, several

private-sector economists have concluded, as has the Council of Economic Advisers, that the net effect of health reform on the aggregate employment level is likely to be small — plus or minus one-half of 1 percent of the aggregate employment level. This is because there are factors in the plan that will tend to both decrease and increase employment, as well as change its composition. These offsetting factors are likely to cancel each other out. However, as we move through time and business health care spending falls further and further below baseline, the factors encouraging an increase in employment and wages are likely to strengthen.

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#### **VI.C Changes in Firm Behavior**

In order to limit the adverse effects of the mandate on small firms, the Health Security Act subsidizes firms with low-wages. The subsidies create incentives for some firms to alter their behavior to collect a subsidy, however. Any firm that has high enough wages so that its costs are below 7.9 percent of payroll will pay the full cost of insurance for each of its low-wage workers. If the firm splits into a high-wage and a low-wage firm, however, the new low-wage firm can receive employer subsidies. The high-wage firm can then purchase the services of the low-wage firm and together, the two firms will produce the same amount of output but will have saved premium money. This type of "outsourcing" has the potential to split apart a number of current firms.

Incentives for outsourcing are also created by the employer subsidy. Any employee earning a high wage in a capped firm may be contributing more than the actuarial cost of the premium, since 7.9 percent of payroll can be greater than the required employer contribution. If the high-wage individual moves to a high-wage firm, therefore, that person's health insurance payments would decline. The person could then contract out their services to the original firm and output could be the same, but with lower insurance costs.

The ability to outsource is a cause of both economic and financial concern. Outsourcing would clearly raise the subsidy costs to the Federal government. In fact, this is one of the reasons for the subsidy cushion implicit in the Administration's estimates. In addition, outsourcing could cause segregation of the labor force into "high-wage" and "low-wage" firms. The extent to which outsourcing will occur, however, has not been effectively analyzed in the economic literature.

#### **VI.D Labor Supply and Tax Evasion**

A related behavioral concern is that individuals in capped firms will have incentives to work less hard or to shelter income. For workers in these firms, the cap is similar to a payroll assessment -- for each dollar of earnings, the firm pays 7.9 percent more in health insurance. In response to this, labor supply might fall, or tax evasion may rise.



Labor supply effects are unlikely to be large, however. Most estimates of labor supply elasticities suggest they are relative small, about 0.2. More importantly, however, for many individuals the cost of health insurance will fall under reform, leading to wage increases and a greater incentive to work. Finally, tax evasion is unlikely to be large. For very wealthy people, there is some evidence that reporting elasticities are larger, although this evidence is still debated. For people below the top of the income distribution, however, there is little evidence to suggest a large evasion response.

#### **VI.E Effects in the Health Sector**

Health care reform will have two effects on the health sector. First, reform will result in greater health care employment in the short run. In the first few years, reform is characterized by increased spending on the uninsured and underinsured. Estimates are that universal coverage by itself would create over 400,000 net new jobs in the health care sector. These jobs are not all new jobs in the economy, however. Many of these additional workers will move from other industries and occupations. Over time, as the growth rate of health spending falls, employment in health care will grow less rapidly. The number of employees still increases, since spending on health care is still increasing.

Over time, the other factor affecting the health sector is increased productivity in the provision of care. Eliminating administrative expense and inappropriate or unnecessary care

will increase the productivity of this part of the economy. As the health sector becomes more productive, the economy will be able to produce more output than it could before reform. We will be able to consume the same amount of health services, as well as more of other goods and services. This productivity increase will raise living standards.

## **VII. Summary**

Health care reform is both a social and economic issue. Socially, one of the goals of reform is to provide universal coverage and guarantee health security.

Economically, health care reform is vital to increasing the standard of living of American families, containing the growth of government spending, and increasing the mobility of the American workforce. One-seventh of our nation's economy is characterized by incomplete competition, inadequate information, and distorted incentives. By changing these incentives, increasing competition, and increasing the availability of information, reform can contribute to cost savings and universal coverage.

Table 4-1: Health Insurance Coverage For a 28 Month Period

| Months of Coverage (Public or Private) | Percent |
|----------------------------------------|---------|
| 28 months                              | 73.5%   |
| <u>Less Than 28 Months</u>             | 26.5%   |
| 25-27 Months                           | 3.6%    |
| 13-24 Months                           | 12.3%   |
| 7-12 Months                            | 3.7%    |
| 1-6 Months                             | 3.0%    |
| 0 Months                               | 3.9%    |

Source: Commerce Department.  
Period is February 1987 through May 1989.



Table 4-2: Growth of Real Per Capita Health Care Spending

|                  | 1960-70 | 1970-80 | 1980-85 | 1985-90 |
|------------------|---------|---------|---------|---------|
| United States    | 6.0%    | 4.2%    | 4.1%    | 4.6%    |
| Canada           | 6.1     | 3.7     | 5.0     | 3.6     |
| France           | 7.8     | 5.3     | 3.3     | 3.2     |
| Germany          | 5.6     | 6.3     | 1.9     | 1.0     |
| Italy            | 8.9     | 6.2     | 1.6     | 4.8     |
| Japan            | 14.0    | 7.1     | 3.1     | 4.4     |
| United Kingdom   | 3.7     | 4.4     | 2.6     | 3.6     |
| Average (non-US) | 7.7     | 5.5     | 2.9     | 3.4     |

Source: OECD.

Average for non-US countries is weighted by GDP per capita (in U.S. dollars) in 1990.

Table 4-3: Sources and Uses of Health Care Funds, 1991

| Uses of Funds               | Total | Private Spending |               |           |               | Government |          |          |       |
|-----------------------------|-------|------------------|---------------|-----------|---------------|------------|----------|----------|-------|
|                             |       | Business         |               | Household |               | Medicare   | Medicaid | Employer | Other |
|                             |       | Premiums         | Workers Comp. | Premiums  | Out-of-pocket |            |          |          |       |
| Total                       | \$752 | \$153            | \$18          | \$52      | \$178         | \$123      | \$101    | \$40     | \$89  |
| Hospital                    | 289   | 102              | 8             |           | 25            | 73         | 43       |          | 38    |
| Physician                   | 142   | 67               | 7             |           | 26            | 33         | 7        |          | 3     |
| Other Professional, Dentist | 73    | 29               | 1             |           | 34            | 4          | 4        |          | 1     |
| Home Health, Nursing Home   | 70    | 1                | 1             |           | 29            | 7          | 31       |          | 1     |
| Drugs, Vision, Other        | 87    | 10               | 1             |           | 54            | 3          | 12       |          | 7     |
| Administration              | 44    | 35               | 1             |           | 1             | 3          | 4        |          | 0     |
| Public Health               | 25    | 0                | 0             |           | 0             | 0          | 0        |          | 25    |
| Research and Construction   | 23    | 0                | 0             |           | 9             | 0          | 0        |          | 14    |

Source:

Note: Breakdown of business premiums includes household and employer premiums.

Table 4-4: Health Care Spending Per Insured American, 1994

| Category                                                  | Amount         |
|-----------------------------------------------------------|----------------|
| <b>Total</b>                                              | <b>\$7,423</b> |
| <b>Health Insurance</b>                                   | <b>4,132</b>   |
| - Employer Share                                          | 3,163          |
| - Employee Share                                          | 969            |
| <b>Medicare Payroll Tax</b>                               | <b>926</b>     |
| <b>Workers Compensation/Disability/Industrial Implant</b> | <b>246</b>     |
| <b>Out-of-pocket</b>                                      | <b>782</b>     |
| <b>Other Spending at Health Facilities</b>                | <b>113</b>     |
| <b>Federal Taxes, Fees and Other Payments</b>             | <b>654</b>     |
| - Federal Employees' Health Premiums                      | 53             |
| - Federal Contribution to Medicare HI                     | 11             |
| - Medicare (general revenue)                              | 169            |
| - Medicaid                                                | 246            |
| - Other Federal Health Programs                           | 174            |
| <b>State and Local Taxes, Fees and Other Payments</b>     | <b>569</b>     |
| - State/Local Employees' Health Premiums                  | 149            |
| - State/Local Contributions to Medicare HI                | 24             |
| - Medicaid                                                | 186            |
| - Hospital Subsidies                                      | 81             |
| - Other Programs                                          | 130            |

Source: ASPE.



Table 4-5: Estimated Premiums in the Regional Alliance, 1994

| Rating Pool           | Average Premium | Payments By: |          |
|-----------------------|-----------------|--------------|----------|
|                       |                 | Family       | Employer |
| Singles               | \$1,932         | \$386        | \$1,549  |
| Couples (No Children) | 3,865           | 773          | 2,125    |
| 1 Adult Family        | 3,893           | 778          | 2,479    |
| 2 Adult Family        | 4,360           | 872          | 2,479    |

Source: HCFA.

National averages; will differ by alliance.

Table 4-6: Schedule of Small Firm Discounts

| Average Wage        | Firm Size   |               |               |
|---------------------|-------------|---------------|---------------|
|                     | <25 workers | 25-50 workers | 50-75 workers |
| <\$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           |
| >\$24,000           | 7.9         | 7.9           | 7.9           |

Table 4-7: Sources and Uses of Health Care Funds, Year 2000  
 (billions of dollars)

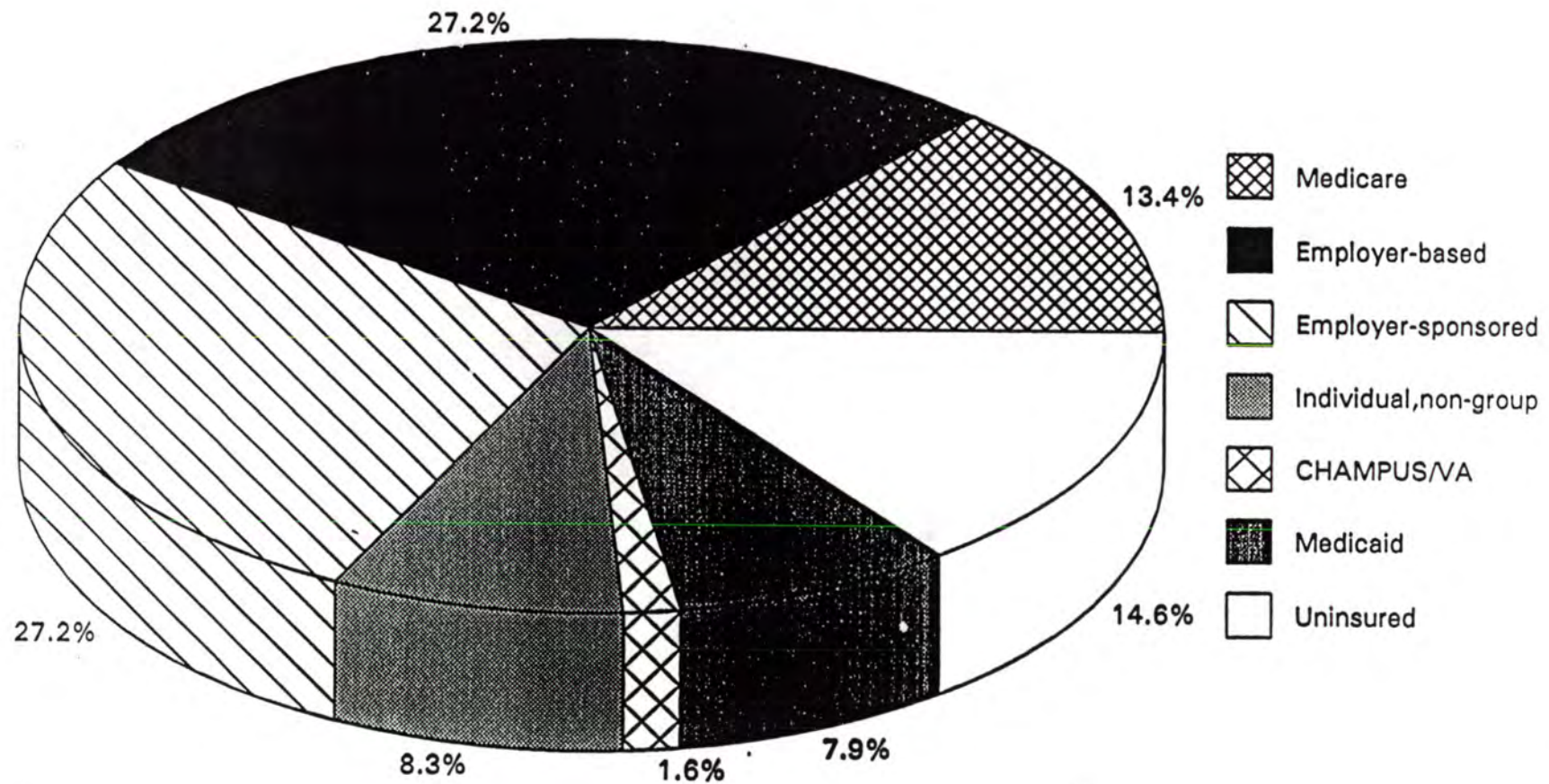
| Sources of Funds                 |              | Uses of Funds                           |             |
|----------------------------------|--------------|-----------------------------------------|-------------|
| Source                           | Amount       | Use                                     | Amount      |
| Tobacco Tax/Corporate Assessment | \$15         | Veterans, Public Health, Administration | \$12        |
| Medicare                         | 42           | Medicare Drug Benefit                   | 16          |
| Medicaid                         | 28           | Long-term Care                          | 20          |
| Other Federal Programs           | 14           | 100% Tax Deduction for Self-employed    | 3           |
| Other Revenue Effects            | 31           | Subsidies                               | 43          |
| Debt Service                     | 2            |                                         |             |
| <b>Total</b>                     | <b>\$132</b> | <b>Total Spending</b>                   | <b>\$94</b> |
|                                  |              | <b>Deficit Reduction</b>                | <b>\$38</b> |
| Source: White House              |              |                                         |             |



Table 4-8: Employer Payment for Health Care, Baseline and Reform  
 Year 2000  
 (billions of dollars)

| Insurance Status of Firm                                   | Number of<br>Workers<br>(millions) | Average Spending |         |        |
|------------------------------------------------------------|------------------------------------|------------------|---------|--------|
|                                                            |                                    | Current          | Reform  | Change |
| All                                                        | 122.7                              | \$2,267          | \$2,214 | -\$53  |
| Currently Offers Insurance                                 | 96.3                               | 2,887            | 2,496   | -391   |
| Does Not Offer Insurance                                   | 24.4                               | 0                | 1,281   | 1,281  |
| <u>Among Firms That Offer Insurance:</u>                   |                                    |                  |         |        |
| < 25 employees                                             | 13.4                               | \$2,470          | \$1,908 | -562   |
| 25-99 employees                                            | 13.5                               | 2,206            | 2,101   | -105   |
| 100-499 employees                                          | 17.2                               | 2,641            | 2,315   | -326   |
| 100-999 employees                                          | 7.0                                | 2,953            | 2,420   | -533   |
| 1000-4999 employees                                        | 25.4                               | 3,091            | 2,582   | -409   |
| > 5000 employees                                           | 21.8                               | 3,238            | 2,938   | -300   |
| Source: Urban Institute. These data are still preliminary. |                                    |                  |         |        |

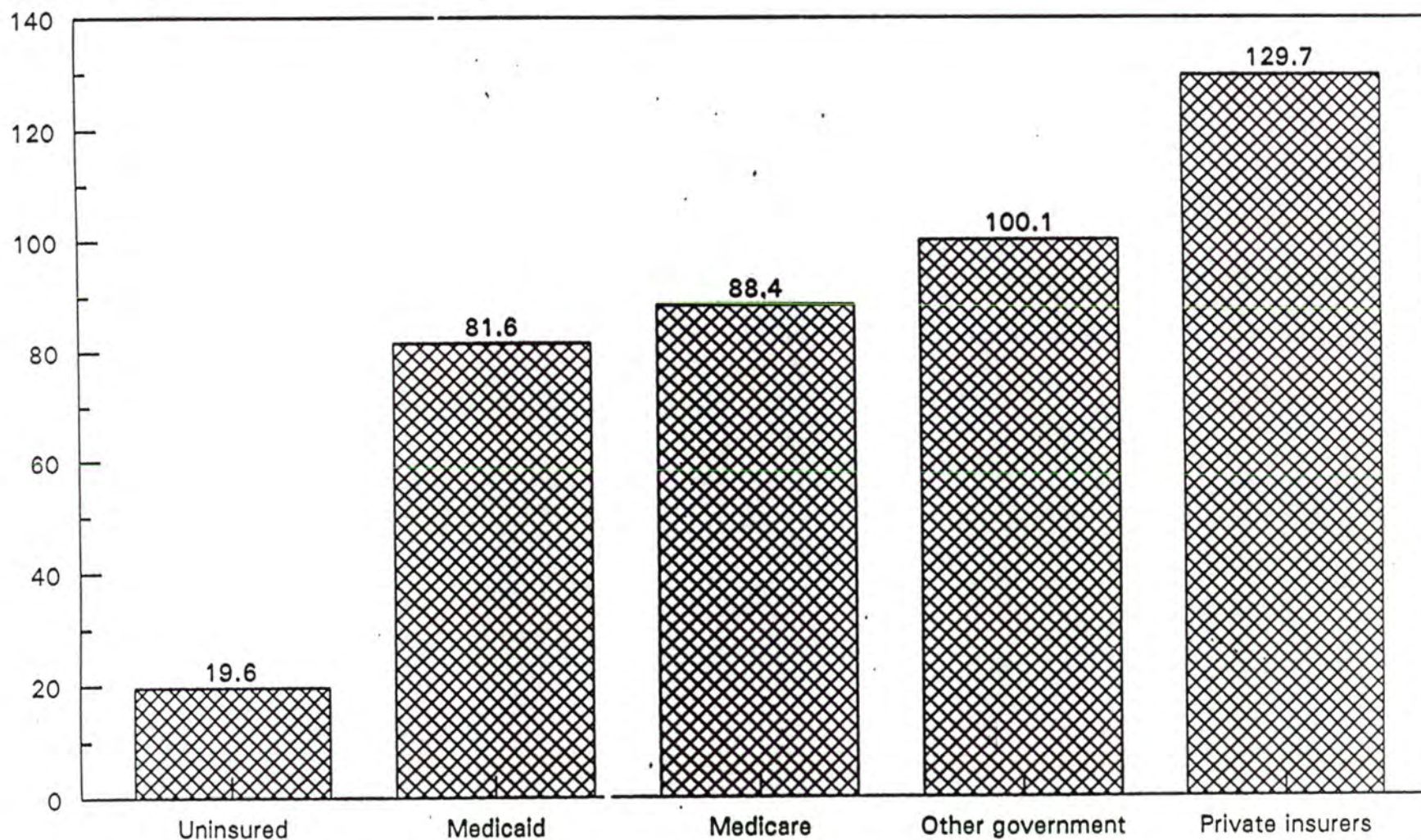
## Sources of Health Insurance, 1992





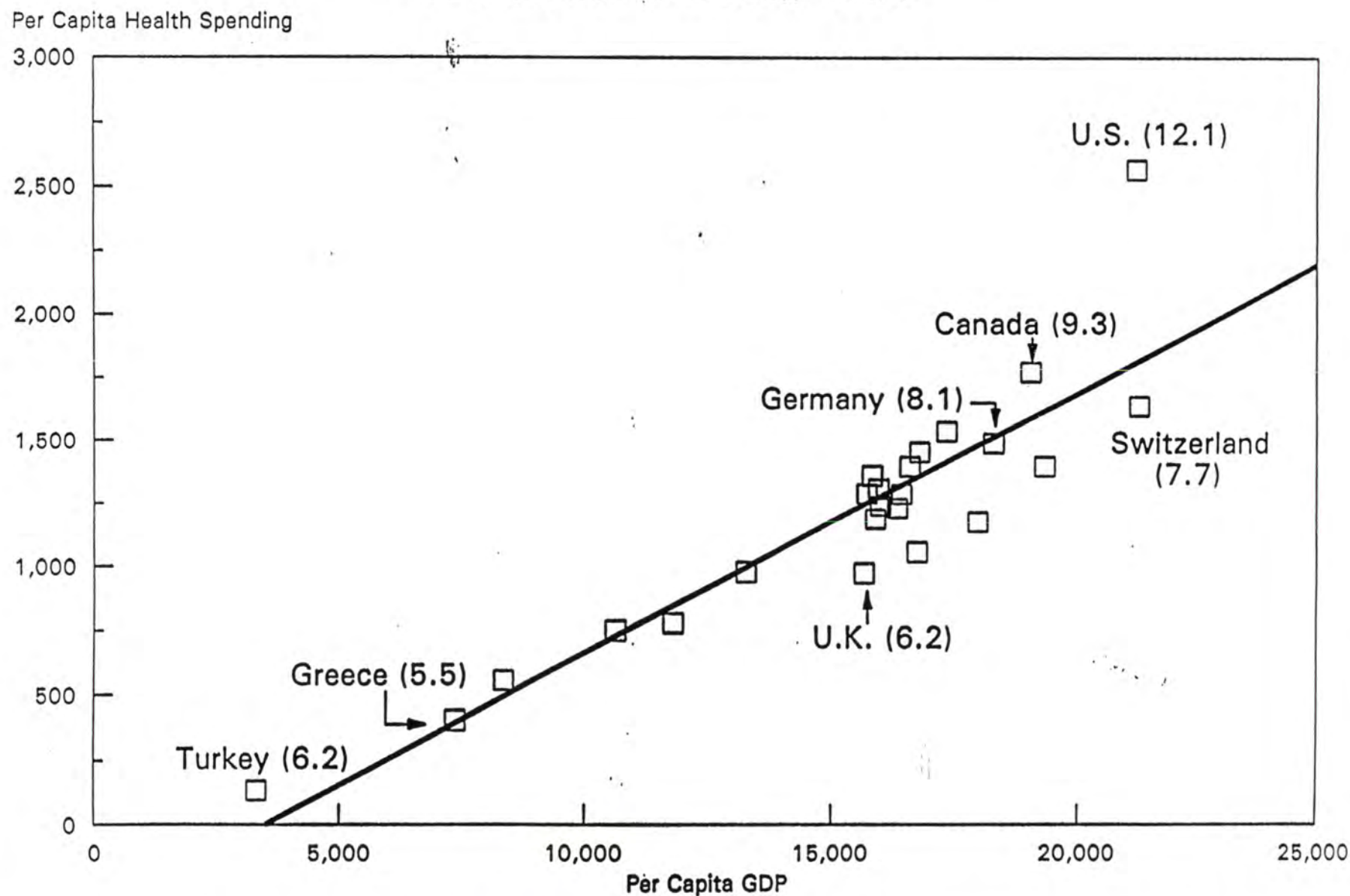
## Privately Insured People Pay for Inadequate Reimbursement in the Public Sector and for the Uninsured

Share of costs





# Per Capita Total Expenditures on Health Care vs. GDP (in U.S. Dollars), 1990



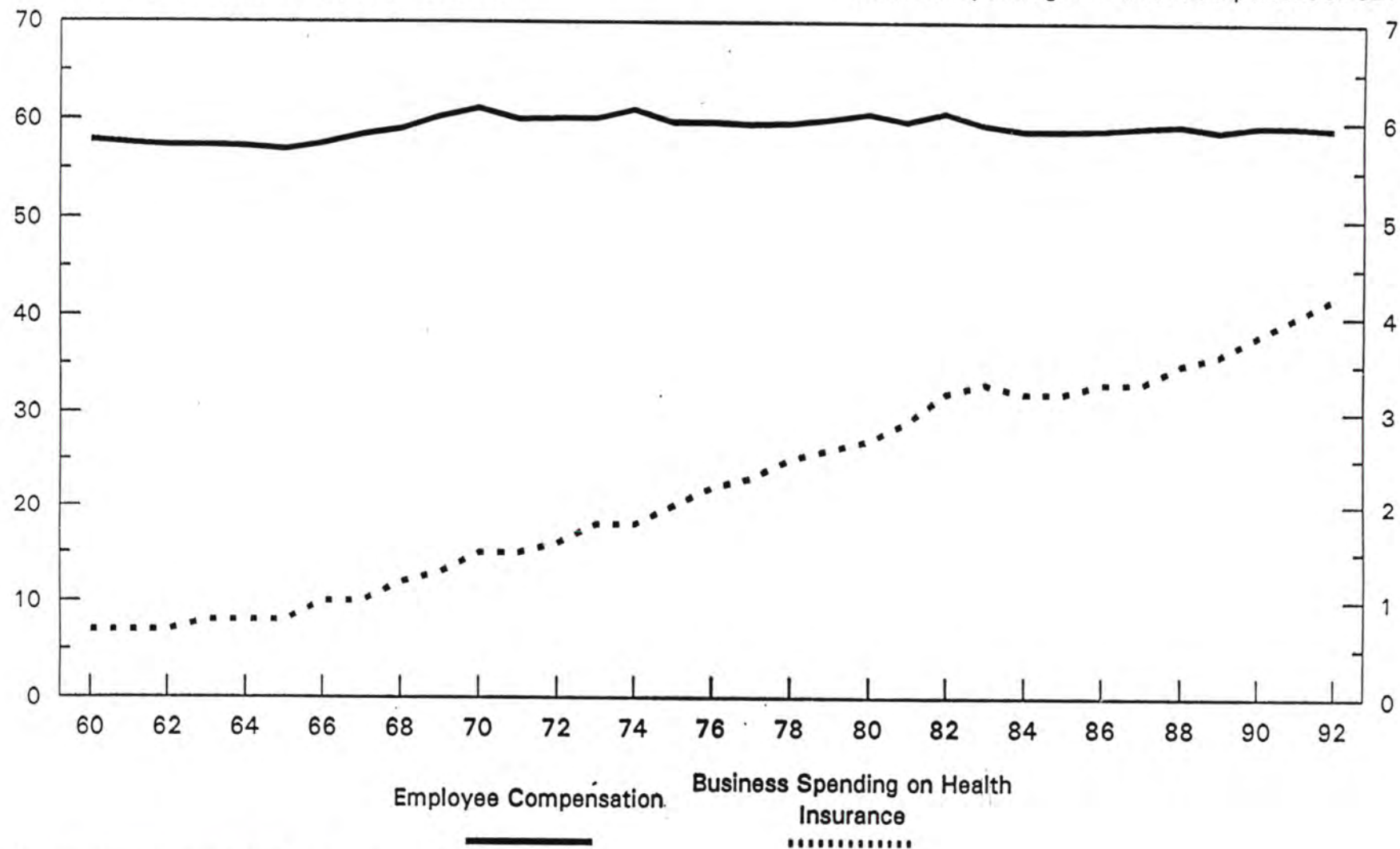
Note: Numbers in parentheses are percent of GDP spent on health care.

Source: OECD.

**Chart 4-3**  
**Employee Compensation and Business Spending on**  
**Health Insurance as a Share of GDP**

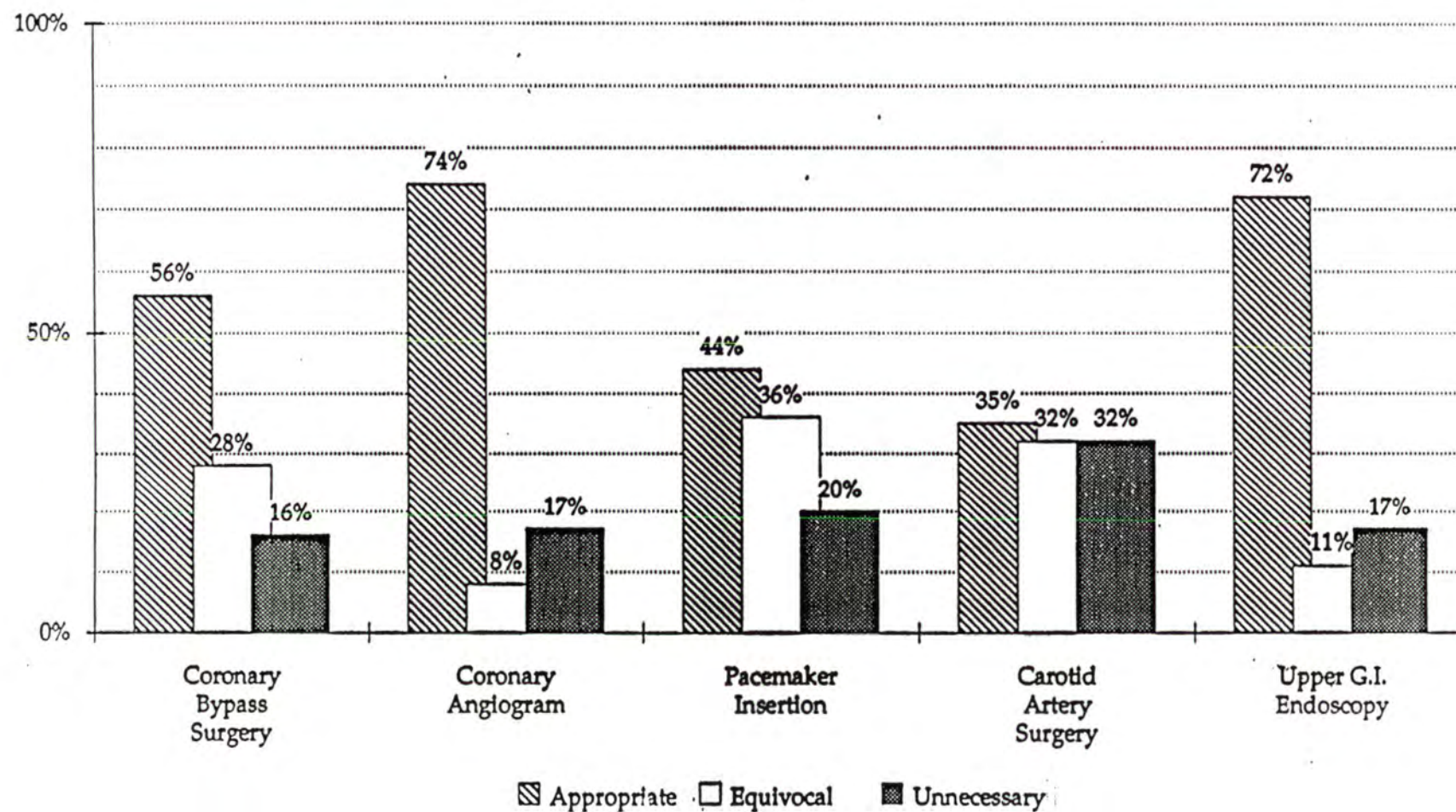
Employee Compensation as a percent of GDP

Business Spending on Health as a percent of GDP



Source: Department of Labor.

## Careful Studies Document High Rates of Unnecessary Care for Five Major Procedures





## DO THE PRESIDENT'S NUMBERS ADD UP?

Uwe E. Reinhardt, Ph.D.  
James Madison Professor of Political Economy  
Princeton University  
October 2, 1993

In the spring of 1993, the Congressional Budget Office forecast that, at current trends, the United States will spend 19% of our GNP on health care in the year 2000. "Impossible!" shouted America's pundits. That level of health spending would bankrupt America.

In the fall of 1993, President Clinton proposed to take that projected growth down to "only" 17% of the GNP by the year 2000. "Impossible!" shouted America's pundits. Projecting such a steep decline in spending would lead to "rationing" of care.

While Americans are, thus, meandering from despair over the prospect of physical deprivation at 17% of the GNP to despair over the prospect of financial collapse at 19%, no other industrialized nation would even contemplate spending as much 17% of its GNP on health care by the year 2000, and none of them spend as much as 10% of their GNP on health care today. Why, then, should President Clinton be made to show cause that it is plausible to project a "decline" in American health spending from the current 14% of GNP to 17% by the year 2000? Why should not the shoe be on the other foot, that is, why should not the President's critics be made to demonstrate that 17% is unattainable?

Let us examine, for example, the projected "cuts" in spending on Medicare, the health-insurance program for America's elderly. For that program, the President would allow annual spending to increase from \$ 128.8 billion in 1993 to as much as \$ 207.8 billion in the year 2000. That represents an average annual compound growth rate of +7.1%. Can America's physicians really look the American taxpayer straight in the eye and argue that, for "only" \$ 207.8 billion, they could not possibly treat America's elderly properly in the year 2000?

To put that question in perspective, let us review some fascinating data published in *The New England Journal of Medicine* of March 4, 1993. In that study its authors found that, in 1989, after adjusting for differences in age and gender, Medicare spending on physician services, per beneficiary, varied from lows of \$ 822 in Minneapolis, \$ 872 in San Francisco, and \$ 954 in New York City to highs of \$1,493 in Detroit, \$ 1,637 in Fort Lauderdale and \$ 1,874 in Miami. Among policy wonks such enormous and inexplicable differentials in spending have been well known for some time.

Should not America's physicians, and the legislators from the high-cost states, be made to defend these differentials to the tax-paying public? If the spending level for Florida were



appropriate, are we to infer that physicians in Minneapolis, New York and San Francisco routinely subject their elderly patients to brutal "rationing"? Alternatively, if the elderly in New York and San Francisco are being properly treated by their physicians, why then must the federal government budget over twice as much money for the treatment of elderly Americans in Detroit and in Florida?

Suppose Congress arbitrarily slashed Medicare reimbursements for Miami physicians by a global 20%. Could these physicians really argue that their patients would be harmed thereby? If so, how would these physicians explain that to their colleagues in San Francisco, in Minneapolis or in New York? After all, even after this budget cut, Miami physicians would still be absorbing 57% more Medicare dollars per beneficiary than would their colleagues in New York, and over 80% more than would their colleagues in Minneapolis.

One could raise similar questions for private-sector spending, where similar variations occur; but the point has surely been made. Cries of "rationing" in response to the President's plan hide something else. They hide a pervasive sense of impotence. Read carefully between the critics' lines. None of them is saying that spending 19% of the GNP on health care is reasonable, or that spending only 17% is unreasonably low. These critics are saying that, even if these spending levels are unreasonably high, during the next seven years or so neither the private sector nor the United States Congress will muster the courage to challenge the providers of health care on the issue of "rationing," and that neither payer will have the moxy to constrain American health spending to levels that would still be judged ludicrously high by any other nation.

Now, the President does propose to bring some 37 million currently uninsured Americans into the fold of comprehensive insurance. Many critics argue that so many additional people could not possibly be accommodated by our health system at spending levels of "only" 17% of the GNP. Oddly enough, many of these same critics also calm the champions of the uninsured with the soothing assertion that uninsured Americans merely lack health insurance, but not health care, for they allegedly receive adequate treatment at the expense of paying patients to whom the cost of that charity care is shifted. But how can both arguments be true? If the uninsured already do get the care they need, why then should extension of insurance to these people all of a sudden break the national bark? On this point, too, the President's critics should try harder to get their stories straight.

The President's proposal is complex enough to offer any would-be critic many targets of opportunity. It is puzzling that his spending forecast is chief among those targets. Sure, the President could explain his cost forecast better than he has so far. The secrecy surrounding the underpinnings of his numbers is a bit puzzling. But the burden of proof on this issue ought not to rest with the President. It rests on the shoulders of his critics, for it is they who have much explaining to do.





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October 4, 1993

Mrs. Hilary Rodham Clinton  
The White House  
Washington, D.C. 20500  
Fax #: (202) 456-2357

PAM [REDACTED] 4 1993

Attention: Ms. Pam Barnett  
West Wing, 2nd Floor

Writer's phone #:  
(212) 998-8943

Dear Mrs. Clinton:

Thank you once more for the very nice note you sent me by way of *Ira* Magazine. I really don't get much mail from the White House. I am, of course, an enthusiastic supporter of your very valuable health-care initiative, and will do everything I can to help in its promotion, as I have been doing with the reporters who call almost daily.

This letter is, I suppose, a last attempt to dissuade you from advocacy of your demanding cost growth containment goal, though I agree fully that there is plenty of room for once-and-for-all and continuing savings. These should be pursued avidly, and here your program offers very substantial promise.

There is, however, a crucial difference between the reduction in cost level that these savings can achieve and the goal of zero growth in real costs thereafter, once these savings are achieved. What that target requires is a set of new and cumulative savings every year. Manufacturers of computer chips reap the rewards of increased productivity consistently and cumulatively year after year. In health care, there is absolutely no evidence that there can be year after year reductions in the number of labor hours expended per illness, yet it is this miracle that is needed for health care to achieve the average rate of productivity growth in the U.S. economy. Without it, zero real cost growth is unattainable. Once one has simplified administration, cut litigation and eliminated duplication of equipment, where are these annual added improvements in productivity to come from? The vast majority of the world's free market economies have failed to come even close to achievement of your goal.

It seems to me that you have little to gain and everything to lose by promising to achieve zero real cost growth. The media report widespread skepticism about this part of the plan. Why feed that skepticism?

There is another serious danger, which is becoming an unfortunate reality all over Europe. As health-care cost increases exceed political promises, the uniform

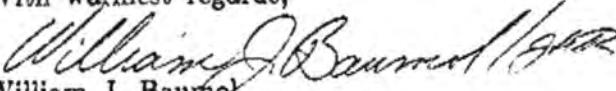


response is to cut services, reduce quality and turn to rationing. Why can we be an exception? Surely, one should not implant a time bomb that can one day undermine the health-care system.

To sum up, there is plenty of evidence that there are opportunities for substantial reductions in the level of costs, which in the U.S. is probably the highest in the industrial world. I have seen no evidence that any way is known to reduce the long-run growth rate of costs, in which U.S. performance is just about average. With credibility of the figures being one of the toughest tasks facing proponents of the program, it seems to me that much more-guarded public statements on prospects for long run cost growth under the program have much to recommend them.

I apologize for this letter's length; my excuse is the importance and complexity of the issue.

With warmest regards,

  
William J. Baumol

WJB/jar

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Uwe E. Reinhardt  
James Madison Professor  
of Political Economy

September 30, 1993

Mr. Larry Levitt  
Old Executive Office Building  
17th and Pennsylvania Ave., NW  
Washington DC 20500

|                                          |              |                    |
|------------------------------------------|--------------|--------------------|
| Post-It™ brand fax transmittal memo 7671 |              | # of pages > 2     |
| To                                       | L. Levitt    |                    |
| From                                     | U. Reinhardt |                    |
| Co.                                      | Co.          |                    |
| Dept.                                    | Phone #      |                    |
| Fax #                                    | 202-456-7739 | Fax # 609-258-2809 |

Dear Mr. Levitt:

The Woodrow Wilson School of Public and International Affairs of Princeton University and Project Hope's *Health Affairs* are jointly organizing a policy workshop on President Clinton's health-reform proposal. The workshop will be held on October 29-31, 1993 on the campus of Princeton University. The workshop is supported through a grant from the Robert Wood Johnson Foundation.

A number of independent health economists have been asked to present their assessment of the President's plan, as it has been set forth in the President's Working Group Draft dated September 7, 1993. At this time, the following economists have been asked to present first drafts of their papers at the workshop:

Henry Aaron of the Brookings Institution  
Stuart Altman of Brandeis University  
Alain Enthoven of Stanford University  
Martin Feldstein of Harvard University  
Victor Fuchs of Stanford University  
Joseph Newhouse of Harvard University  
Mark Pauly of the University of Pennsylvania  
Uwe Reinhardt of Princeton University  
Gail Wilensky of Project Hope

Although all authors will act as discussants of the other authors' papers, the debate on each paper will be initiated by a discussant who, typically, will not be an economist. All of the papers will be published in an early-spring volume of *Health Affairs*. The discussants may have their (shorter) statement published along with the corresponding paper, if they wish. It is planned to ask a panel of health-care providers to offer their reactions to the papers and to the President's reform proposal in general. Finally, we would like to invite representatives of the Administration as well as bi-partisan representation from Congress to react to the commentary offered by the economists and by the panel of health-care providers.

John Iglehart of Project Hope's *Health Affairs* and I would be delighted if you could join us at this workshop.

Space at the workshop is limited. Would you therefore please let us know at your earliest convenience, by telephone (609-924-7625), fax (609-924-6083) or mail, whether you will be able to join us. We have reserved a block of rooms at the Nassau Inn in Princeton. The hotel will hold these reservations only until October 6. Would you please make your hotel reservation directly with the Nassau Inn (tel. 609-921-7500, fax 609-921-9385) if you do intend to join us.

Looking forward to hearing from you, and with John's and my best regards,

Sincerely,

A handwritten signature in black ink, appearing to read "Uwe Reinhardt" with a stylized flourish at the end.

Uwe E. Reinhardt



July 26, 1993

## **Health-Care Reform and the Laws of Economics**

***Robert J. Shapiro***

President Clinton's plans to reform America's health-care system can succeed, but only if he does not try to accomplish everything at once and only if the plan's economic logic is sound. To ensure universal coverage and reduce medical-care inflation without damaging the economy, the reforms will have to be implemented gradually, foster more economic competition among providers, and demand more economic responsibility from every patient.

At the heart of the issue is one of the oldest problems in economic policy: What should government do when people want more of some good than the economy will produce at prices they are willing or able to pay? Presidents facing this problem can look for ways to balance the people's desires with the laws of supply and demand, or try to satisfy them and risk injuring the economy. The test of leadership for this President, elected to cure both the economy and the health-care system, will be his ability to shape a package that provides everyone a measure of security while respecting the manner and pace of economic change.

### ***Facing the Problem***

So far, both health-care reformers and skeptics have demonstrated that it is easier to identify problems than to find sound solutions. The most ambitious reformers are clearly correct that fundamental change has to come soon. In no other advanced country does one of every seven persons have to manage without routine care -- one of the reasons why life expectancy in the U.S. now ranks 15th in the world. Furthermore, the enormous costs of the medical system producing these dismal results injure the American economy. For nearly a decade, health-care costs have been the principal factor driving both federal borrowing and federal spending. Rising insurance costs have cut the wage gains of most workers. Moreover, the doubling of the share of the nation's resources claimed for medical services, from barely seven percent of GNP in 1970 to roughly 14 percent today, has dampened investment and growth elsewhere in the economy by reducing the profits of nearly all firms and bidding-up the price of capital and skilled labor. Put another way, so long as health care grows much faster than the rest of the economy, the rising bill can't be paid without sacrificing investment, productivity and income growth for most Americans.

Reform *is* imperative; but the skeptics are also correct that no government or group of experts have the knowledge or means to reform, all at once, an extraordinarily complex, \$900 billion-a-year sector that accounts for one-seventh of the largest economy in the world. In such an industry -- with billions of annual transactions carried out at tens of thousands of facilities, using millions of workers and hundreds of thousands of different goods to produce tens of thousands of services -- sensible reforms must proceed incrementally and in ways that do not conflict with the normal operations of the economy. Further, they must take into account differences among regions and states.

Two of the basic laws of economics are at issue here. The first is that prices rise when demand increases and supply does not expand as quickly. Simply extending or mandating insurance coverage for the 35 million people who lack it today will inevitably spark faster-rising medical prices and costs. If this coverage includes long-term care, prescription medicines, mental-health, dental treatments and more -- as many reformers want -- medical-care inflation will rise even faster.

The second law confronting health-care reform is that economic demand for most things responds to prices. So long as conventional insurance and the current health-care system let most Americans use medical services without paying directly for them -- with little practical recognition of the costs -- demand for health care will never be disciplined and prices will continue to rise. These arrangements not only encourage the demand for routine medical treatment, they also guarantee a broad market for expensive new medical technologies. Once developed, costly new technologies quickly become generally available and broadly applied, greatly intensifying cost pressures.

If these economic forces *did not* matter, the President and Congress could simply tell business and government to cover everyone for every condition right away. But they *do* matter, as our current problems with medical care demonstrate. Public and private insurance for elderly and poor people, and for most workers and their families, has vastly expanded demand for health-care services, pushing up the costs for those paying the bills. As a result, insurers and businesses have been forced to exclude more workers and more conditions from basic coverage, especially small firms expanding their payrolls and mature companies obliged to cover large numbers of older employees. The paradox for health-care reform is that in our current "cost-unconscious" medical marketplace, universal coverage tends to price itself out of the reach of those guaranteed it.

The principles of economic competition can begin to resolve this paradox by creating powerful economic inducements to discipline the demand for medical treatment and increase the supply of efficiently-delivered care. Managed



competition, the most prominent policy strategy based on these principles, would try to restructure our health-care markets by creating new incentives that (1) force insurers to compete more on the basis of value and price; (2) require everyone to assume more personal economic responsibility for their health-care choices; and (3) constrain providers to meet people's basic needs more efficiently, principally through health maintenance organizations (HMOs).

### ***Pointing a Way***

Over several years, we *can* provide basic coverage for everyone without injuring the economy. No one should doubt that we must do so. It will require that we extend coverage gradually, and even then the additional demand will raise health-care prices for everyone. It also will require that the President and Congress resist appeals to add new benefits to basic insurance. By most estimates, adding benefits for mental-health and dental services, medicines and long-term care could increase the nation's health-care bills by as much as \$100 billion a year. Ensuring basic coverage for everyone will mean reforming the basic ground rules of our health-care markets so that there, as everywhere else in the economy, consumers bear more of the costs of their own choices, forcing health-care businesses to become more efficient in order to survive. In short, it requires a new medical-care marketplace that satisfactorily can balance supply and demand.

If we choose this path, its incentives should reorganize the practice of medicine. Most of us will have to accept treatment less often from doctors and more often from nurses and other non-physicians. All but the truly poor will have to pay more for insurance and more for every service; everyone will have to forgo any prospect of a huge malpractice award. Most physicians will have to practice through HMOs; but, if high-quality medicine is part of the equation, they will still retain control over their own professional decisions.

This asks a lot of the vast majority of Americans who *already are insured*. Yet it is this majority, *not* the uninsured minority, driving the demand for universal coverage covering virtually any medical condition. According to surveys, most of us want a guarantee that we *always* will have the services we need, now and when we are older. We want to be certain that whatever our medical condition or job status, we and our families can get all the medical care we need.

Among the legions of health-care reformers, the proponents of market competition are challenged by those who see government mandates and price regulation as the only practical means of extending coverage and controlling costs. This alternative, however politically expedient it may seem, can only defer the remorseless logic of supply and demand at great economic cost.



## ***The Shape of Tough-Minded Managed Competition***

The strategy for managed competition has two basic parts, addressing in turn patients and providers. First, discipline demand for medical services by compelling people to pay more for them. For years, the standard proposal has been to limit the deduction that businesses can claim for insurance premiums they pay for their workers in order to raise the pressure on firms to search for more efficient coverage. But raising the cost of insurance coverage for business will not be enough to restrain demand, judging from the fact that a decade of determined insurance-shopping by most companies has not slowed health-care inflation.

This approach should be taken two steps further. First, limit the amount that companies can deduct for providing health insurance to the cost of the least-expensive package of basic benefits on the market, thereby providing a direct incentive for firms to select the most lean and competitive health plan. Second, heighten the pressure on everyone by counting as part of a person's taxable income any premiums exceeding this minimum amount paid in his or her name by an employer.

The object is not to increase anyone's financial burdens, but to use tax policy to promote an insurance marketplace where consumers weigh the purchase of economical coverage against other plans and insurers have stronger incentives to compete for their business on the basis of price and value. This can happen by maintaining the current taxpayer subsidies, both the deduction for business and the income-exclusion for their employees, but only up to the cost of the lowest-priced package of basic benefits. At first, these incentives could attract more business for the most-efficient insurers and providers than they could handle; but, this tax reform can be phased-in over several years.

Building competitive health-care markets requires reforms affecting demand for particular medical services as well as insurance. Under managed competition, everyone but the poor pays part of the cost of nearly every service they choose so that people have to assess the value of every health-care choice. To be sure, choice means nothing when your life is at stake, and people will always look to medical insurance for the security that life-saving treatment will always be available. But if people accept more economic responsibility for the rest of their care -- if copayments for most routine medical treatments are more like auto-insurance deductibles for collision damage -- prices for these routine services should rise at rates more like those for other goods and services.

### ***Mandating Coverage***

The principle challenge to this view comes from some reformers who want

to piggyback an employer mandate requiring every company to insure every worker onto reforms requiring that most people pay more of the costs of insurance but not most treatments. The leading proposal would require that all employers contribute either 7 percent of their annual payroll costs to cover most of the cost of basic insurance for every employee (80 percent of the basic premium). In addition, to cover the rest of the cost of basic coverage, workers would pay either about 2 percent of wages or the remaining 20 percent of the premium.

The economics of a mandate are equivocal, at best. With more than three-fourths of U.S. companies now voluntarily including insurance coverage in their employees' market compensation, evidence that an employer mandate would devastate business is not strong. Why doesn't normal market competition for workers compel the rest to offer coverage? From the worker's perspective, the pool of low-skilled people seeking jobs is large enough so they usually cannot bargain effectively for health-care benefits. By most employers' calculations, the productivity of most low-wage workers cannot justify health-care coverage that would, in effect, substantially raise their total compensation. Far from guaranteeing benefits to all low-skilled workers, therefore, the economics of a rigid employer mandate would probably cost many of them their jobs. Forced to make the choice, many companies would replace many, newly-expensive low-skilled workers with equipment or contracts to foreign facilities.

Until a stronger economy and managed competition make coverage more economical for these firms, reform should move cautiously on any employer mandate. On both economic and equity grounds, there is a strong case for making the federal government the financier of last resort for universal coverage, using revenues from a progressive income tax, rather than forcing companies to trade off health-care costs against job creation and using the regressive payroll tax. This could be achieved by providing either a substantial subsidy for small firms employing low-wage workers or a refundable tax credit for uncovered individuals to purchase their insurance.

The problem with a direct public subsidy for universal coverage -- whether the mandate falls on the firm or the individual, and whether the government subsidizes small employers or their low-paid workers -- is the incentive it would create for some firms to eliminate their current benefits. Until a more competitive health-care marketplace lessens the problem, it should help if both the subsidy and any mandate are phased in over several years, beginning with families with small children, and the subsidy phased out as a family's income rises. As labor conditions vary greatly across the country, each state could be allowed to choose which form of subsidy is best suited for its economy. With these limits, the costs could be covered by the revenues derived from limiting the business deduction and employee exclusion for employer-paid premiums.



## ***Reforming the Health-Care Industry***

The second part of a market-based strategy involves reforms of the health-care industry itself, driven principally by powerful statewide or regional insurance-purchasing pools called health alliances. These organizations would operate something like the New York Stock Exchange, bringing together buyers and sellers and setting rules of trade that, in effect, compel insurers to compete more on the basis of price and value.

To begin, the health alliances would collect most people's insurance premiums and help consumers choose among competing insurers and plans by publishing simple, standard information about the benefits and outcomes of every plan. It is vital that consumers be able to genuinely evaluate the benefits and performance of every plan since the powerful tax incentives for purchasing the lowest-priced coverage will encourage some insurers and providers to try to compete by cutting-back on basic benefits and reducing quality.

In addition, the alliances' new rules of trade for insurance would end the price discrimination that today can deny people coverage or set their premiums on the basis of their pre-existing conditions. Instead, the alliances would define a standard package of basic benefits that all insurers would have to offer everyone at prices unaffected by a person's health status. Insurers would have to agree to these terms or lose the right to sell coverage through the alliances - a serious threat when nearly everyone is paying their premiums through them. By agreeing, an insurer will have to compete with rivals offering the standard package at less cost or with better outcomes, or face the commercial consequences.

The health alliances must have the authority to maintain a transparent and non-discriminatory marketplace for insurance without broader regulatory powers that could stifle competition or even evolve to a government-managed, single-payer system. Like a stock exchange, the alliances would be chartered not to regulate insurance prices or micro-manage the operations of medical providers, but only to oversee the terms of trade for the health-insurance market.

These reforms, however, would quickly bring about a major shakeout in the insurance industry. To compete and survive, insurers would have to contract with providers that find ways of delivering basic services more efficiently. There is no mystery about where these cost-saving efficiencies would be found. Managed competition will produce a fierce rush to HMOs, which offer blanket coverage for a per-person price by staffs of doctors, nurses and other assistants paid by salary or on a per-patient basis, instead of fee-for-service medicine by physicians and specialists of patients' own choosing. (It may also



spur the growth of preferred provider organizations, or PPOs, a variant on the HMO in which groups of doctors combine for a collective practice. Thus far, PPOs have not demonstrated the HMO's potential for efficiency gains and cost restraint.)

In theory, this strategy packs real economic power; by one reasonable estimate, a doctor in an HMO can cover two to three times the patient-load of private, fee-for-service physicians. Yet to date HMOs have *not* spread quickly. Most Americans prefer choosing all of their own doctors, and most doctors prefer conducting their own practices -- and for most people, the incentive to change has been modest since most HMOs still price their services only a whisker under fee-for-service. In short, so far HMOs have not achieved (or perhaps not passed on) the cost savings required to make universal coverage work without injuring the economy.

There is some evidence, drawn from recent experience with health coverage for California public workers and for Minnesota state employees, that HMOs can deliver medical care more efficiently and cheaply when they are part of a managed-competition system. More intense competition *will* help. In addition, economics can help identify incentives not only for HMOs to contain costs, but also for HMO doctors and nurses to recommend fewer and less costly services.

To achieve this, reform has to confront the high level of uncertainty characteristic of the practice of modern medicine. Doctors and nurses often cannot be certain how much testing and treatment a patient needs or, more precisely, what services a patient positively *does not* need. Many physicians over-prescribe expensive procedures whether or not they practice in HMOs to avoid being sued for *not* ordering more services that *might* prove helpful. They also bear no cost for ordering services that prove unnecessary. To drive-up the average HMO's cost-effectiveness, health-care reform has to include broad malpractice protection for physicians practicing standard but not extraordinary medicine, and perhaps incentives for employee ownership or profit-sharing by HMO physicians and nurses.

Uncertainty for patients takes a different form: How will the quality of their care be protected as its quantity and costs are reduced? The only answer is to rely on the independent judgment of highly-trained and well-paid physicians, nurses and other health professionals. Insurance premiums and co-payments have to be set sufficiently high to maintain ample incomes for medical professionals, and doctors and nurses have to retain the independent decision-making that all professionals expect -- or American medicine will have to settle for people less equipped or inclined to ensure high-quality care.

## ***The Regulatory Alternatives***

The laws of economics apparently demand a great deal of everyone -- too much for those urging the President to simply mandate universal coverage and then contain health-care costs by federal regulation. By all the evidence and theory we know, this political fix would injure both the economy and the health-care system.

The two chief regulatory options are a "global budget" and price and wage controls. With the first, the government would determine what share of the nation's income could go to health care by controlling the price of all insurance premiums. If businesses and workers are required to pay government-set fees to the health alliances to cover all insurance, and these fees are allowed to rise year by year according to a set measure such as payroll costs or the consumer price index, medical providers would have to make do with the resources allowed them by government. Everyone involved -- doctors and nurses, HMOs and hospitals, insurers and suppliers -- would negotiate or contend for their shares.

By itself, a global budget would not contain health-care inflation for long, because it does not address the market pressures driving up prices. If government tried to limit the resources, in effect, by decree, people would continue to demand levels of costly services that could not be covered by the revenues allowed by government. When these resources run out in the eleventh or twelfth month of the global budget -- when the government guesses wrong about the revenues required to cover quality treatment at a particular hospital or HMO, in a particular year, for a particular city -- something important would have to give. People would go untreated so that universal coverage contracts, or premiums would increase by more than promised and so bust the global budget, or reimbursements would fall the following year and the squeeze on revenues and treatment would recur in more virulent form.

In contrast to a global cap, a more plausible case can be made for a very limited version to discourage price increases during the transition to managed competition and universal coverage. As with a global budget, a limited budget cap would depend on the government determining by some measure how much insurance premiums should increase. The crucial difference is that the cap would apply only to premiums for basic coverage and only while the mandate for universal coverage was being phased in -- and the cost pressures on the cap would be eased by the economic incentives of a more competitive health-care system.

Still, the economics for even a limited cap remain dubious. Government experts cannot know in advance what markets can determine only in practice - namely, the cost over the coming year for the most efficient insurers and



providers to deliver their basic services. Health-care reform itself will make such determinations truly impossible, since it will quickly bring about countless changes in medical practices and treatment protocols, and upheavals in the insurance and provider markets themselves. When the government's health-care accountants guess wrong and the rates they allow cannot cover basic costs, the resulting pent-up price pressures will reignite medical inflation once the temporary cap is lifted. If the cap mechanisms were to become permanent, it would amount to government price controls for basic insurance, limiting the power of economic competition to drive down insurance prices.

### ***Price and Wage Controls, versus Quality Health Care***

The second regulatory alternative is broad price and wage controls. There is no sound economic theory or evidence to support the hope that these controls could work in health care. To begin, price and wage controls are virtually impossible to enforce in a industry like medical care, with tens of thousands of separate facilities where billions of annual transactions are carried out, providing thousands of different services and using tens of thousands of different goods. Already, health-care businesses have demonstrated a protean capacity to preserve their revenues and profits in the face of such controls. When the government froze Medicare Part-B doctors' charges in the mid-1980s, physicians reported visiting their patients more frequently, shifting to more highly-reimbursed treatments, and ordering more tests that required little of their own time -- and total costs continued to rise rapidly.

The current Medicare cost controls -- the Prospective Payment System, which reimburses hospitals at set rates for each illness rather than each procedure -- have not been much more effective. Over several years, this system has modestly slowed the growth in Medicare costs, but *total* medical costs have not been restrained because hospitals offset their losses by raising charges on everyone else. Today, hospitals recover about 90 percent of the costs of treating Medicare patients -- and charge privately insured people 128 percent for the same treatments. If government tried to control the entire system in this way, total costs would still depend on diagnosis -- over which hospitals, doctors and HMOs will always retain control.

Moreover, price and wage controls would virtually cripple the effectiveness of managed competition. The conflict comes from the squeeze they would impose on an HMO's operating margins. As the forces of managed competition enable HMOs to provide more, efficiently delivered health care, controls would prevent the most efficient ones from negotiating with their suppliers and doctors for favorable terms. This would reduce their savings and undercut their competitive edge, and so inhibit their growth just when the system requires their expansion. More generally, by targeting controls only to health care, the "reform" would



channel labor and other resources to industries paying higher, uncontrolled prices and wages, producing shortages of medical services when more are needed.

To work, price and wage controls need fixed targets to regulate, but health-care reform, if it is to work, will drive continuous changes in medical services and the practices of medical personnel.

If we are serious about providing universal coverage and slowing the growth of health-care costs -- and without injuring the economy -- government controls cannot be part of the solution. Instead, we will have to change the ways we consume and provide medical care -- once again, reorganizing the practice of medicine, receiving treatment less often from doctors and more often from nurses and other non-physicians, paying more of the cost of insurance and of nearly every procedure and foregoing the ability to win large judgments for malpractice.

Even so, health-care costs will continue to rise faster than other goods and services for some time -- and not only because insurance will always be there. In addition, the numbers of Americans who are elderly and so require costly routine care will continue to increase. The extraordinarily costly AIDS epidemic will continue to spread. And technological advances in medicine will continue to be phenomenally expensive and, under almost any imaginable reform, every costly advance will continue to be available under standard insurance and at nearly every large facility.

The President's clear task is to teach Americans that it is not the government's duty to preserve the current system nor is it right to replace it with controls. Rather, we must reform the system's basic ground rules so that, over some years, we *can* achieve universal coverage while satisfactorily balancing health-care supply and demand. Even with market-based reforms, most Americans will pay more than they do today, for years to come. But if the President and Congress will respect the laws of economics as they carry out these reforms, the additional burden could help keep everyone's coverage secure and the economy sound.

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*Dr. Robert J. Shapiro is the Vice President of the Progressive Policy Institute.*

# Economists' Advice for Clinton

## Caution Is Urged On Tax Proposals

By SYLVIA NASAR

Bill Clinton's promise to focus on the economy "like a laser beam" created great expectations among the nation's economists. But in the six months since his inauguration, many of them have been sounding increasingly disenchanted with his policies.

Some say the President promised and did not deliver. Others, who thought his can-do approach would bolster confidence and provide the economy with a catalyst, complain that uncertainties, backpedaling and prospects of much higher taxes have sown fear and confusion among business and consumers.

"We've moved from one President who seemed to be out of touch to another President who is also out of touch with what's needed in the economy," said Stephen F. Hiebsch, manager of economic research at the Oklahoma Gas and Electric Company in Oklahoma City, who said he voted for President Clinton because of campaign promises to focus on business investment, education and the nation's roads, bridges and other support systems.

### A Program Off Track?

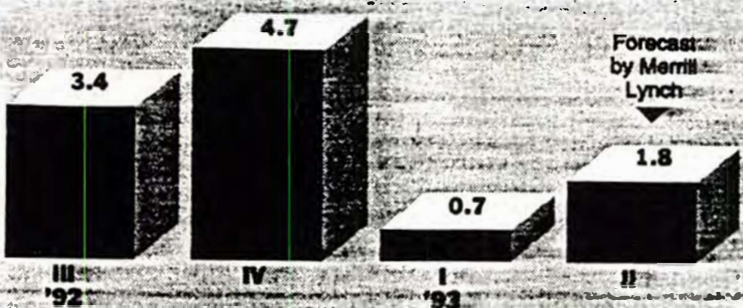
While some economists defend the budget now on Capitol Hill as a big step toward taming the Federal deficit, many complain that the economic program — from the budget to health care to trade — has veered seriously off track.

To be sure, economists are no less fickle than other Americans. Some of the unhappiness probably reflects disappointment in the President's limited power to get things done: to date, the Administration has found trouble getting its way in Congress. Paul Samuelson of the Massachusetts Institute of Technology, a Nobel laureate in economics and a longtime Democrat, has said, "You've got a President with no influence."

Further, the Administration is stuck with an economy that, while expanding at a modest pace, is struggling to overcome the lingering ef-

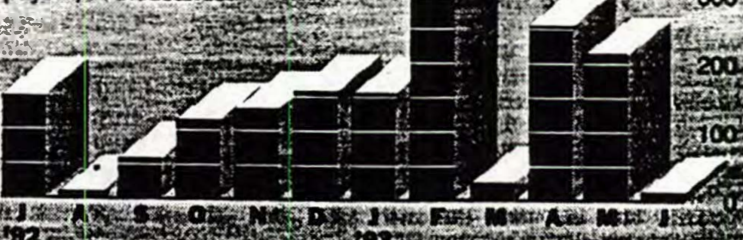
## A Surprisingly Weak Recovery

**SLOW GROWTH** Annual percentage rate of change in the gross domestic product, based on 1987 dollars; seasonally adjusted.

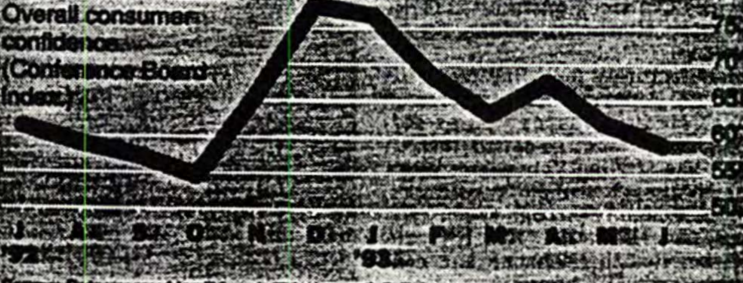


### FEW NEW JOBS

Growth of nonfarm payroll, in thousands



### THAT SINKING FEELING



fects of overbuilt real estate, military cuts and feeble growth in the rest of the world.

Still, said Richard T. Curtin at the University of Michigan, who tracks consumers' moods, "It's the lost opportunity that's frustrating." He acknowledged that the President cannot deliver fast-paced, 1960's-style economic growth, but said there was enough room "to move from a stop-and-go expansion to one that proceeds more steadily."

What do the economists want the President to do? Three themes emerge over and over again: pare or postpone tax increases while pushing for tougher, more enforceable spending caps; go slower on health-care changes, and push harder for the free-trade agreement with Mexico and Canada.

What many of them say they do not

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# Disenchanted Economists Have Advice

Continued From First Business Page

want, even if politically feasible, is to revive the \$30 billion stimulus plan that was supposed to give the economy an immediate shot in the arm but was shot down by Congress earlier this year.

"Hands off would be better," said Alan Sinai, managing director of Lehman Brothers. "Let the economy work out the kinks. We're simply going to have to live with what growth the economy can produce."

Donald Ratajczak, director of the Economic Forecasting Center at Georgia State University, said, "Most economists don't want the Administration to prime the pump, to just go out and spend."

On the budget, the concern is not only that a big tax increase could hurt economic growth next year, but that it would fail to bring the deficit under control.

Of course, the President's options are limited because the House and Senate have already passed their versions of the budget. But as the differences between the two versions are hammered out, he does have some room to press for smaller tax increases that would take effect at a later date than in the House version of the bill.

## Calling the Whole Thing Off

Some economists take an even stronger stand, urging the Administration to forget the current budget package. "The best thing they can do for the economy is to figure out a politically acceptable way to walk away from the program even if it meant less deficit reduction," said Ed Yardeni, chief economist at C. J. Lawrence. Raising taxes, said Mr. Yardeni, is likely to weaken the economic recovery without necessarily solving the deficit problem.

Many of the economists in this camp, however, did not buy the original Clinton plan, and remain opposed as much for ideological reasons as for fear that the recovery is unacceptably weak.

Still, few economists are willing to go so far, largely because they fear that interest rates would jump if the Administration failed to get a deal. And because the broad outlines of both bills — higher top income-tax rates and a 35 percent corporate tax — are similar, they urge the Administration to tinker around the edges.

"The most important thing is to get the budget passed, and erase the uncertainty," said Laurence H. Meyer, who runs an economic consulting firm with that name in St. Louis. "You don't turn back."

In fact, he and others said the President's biggest impact on the econ-

## Fears persist that higher taxes will fail to shrink the deficit.

omy so far has come not from programs themselves, but from the waiting.

"There's no question Clinton confusion is slowing the economy," said Mr. Ratajczak at Georgia State.

Worried that higher corporate taxes will undermine business investment in new plant and equipment, one of the few sources of strength in the economy, several economists want the Administration to minimize increases in the tax burden on smaller businesses.

"Even if it means a little less deficit reduction, the best package may be one that restores some of the growth provisions," said Jerry Jasinowski, an economist who is president of the National Association of Manufacturers. "If you have to make trade-offs at the margin, you are better off not increasing business taxes that will stifle growth and jobs."

Charles Wolf, dean of the Rand Corporation's graduate school and di-

## for Clinton

rector of economic research at Rand's National Defense Institute in Santa Monica, Calif., said he would favor a bill from the conference committee that "has more of the investment incentives and less of just raising taxes."

At the same time, some economists are pushing for toughening the procedures in the budget for enforcing limits on spending growth. "It will help to have a President who says he supports the concept of spending caps and I'll be faithful to them," Mr. Meyer said. "That would increase dramatically the credibility of the whole thing."

## Caution on Health Care

Many economists say a Clinton health-care program is an even bigger source of uncertainty for most businesses because it may involve higher payroll taxes. There is growing sentiment among economists that the Administration should go slower on the issue — and proceed with far greater care.

"This is too important to do fast," Mr. Meyer said. "We're changing health care. This is one of the most important bills in recent history, and it's only reasonable that it be a consensus solution."

Referring to the Administration's tough talk on health-care changes, Rudolph Penner, an economist at KPMG Peat Marwick and a former director of the Congressional Budget Office, said: "Their first rule should be 'thou shalt do no harm.' People have been particularly careless; they have not been sensitive to the damage they can cause to businesses with remarks about price controls here and payroll taxes there."

Some economists also spoke of the potentially stimulative effects of increased trade, saying the President should be pressing harder for the North American Free Trade Agreement.

"I would like to see this free-trade agreement pushed real hard," said Mr. Hiebsch of Oklahoma Gas and Electric. "If free trade is good between Texas and New York and be-

tween Kansas and Oklahoma, I can't believe free trade wouldn't be good between Mexico, Canada and the U.S."

Diane Swonk, senior regional economist and vice president of the First National Bank of Chicago, agreed. "Nafta is our insurance policy that Mexico doesn't back off from its reforms," she said. "Without it, medium and small exporters get locked out. What we're hearing from our customers is that the uncertainty has already slowed a lot of momentum."