PRICE CONTROLS

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PRICE CONTROLS

file

SUMMARY OF PREMIUM CAPS

- Slowing health costs is a fundamental goal of health care reform.
- HSA would constrain health care growth rates through management, insurance market, and administrative reforms that enhance competition.
- As a backstop to competition, HSA also includes premium caps. Caps are also critical for CBO scoring.
  - Health plans compete for enrollees through their bids. Bidding and competition are the primary way that cost growth will be slowed under health reform.
  - The backstop premium cap is really a way to throw out bids that are too high.
- Controls must (1) insure the initial premium level confers no windfall on the health industry and (2) moderate the growth rate of health care costs thereafter.

MANAGED COMPETITION UNDER HSA

- Under HSA's managed competition:
  - In the first year the National Health Board (NHB) calculates premium targets for each alliance, reflecting cost of services in the benefits package and health costs in the alliance area. NHB updates targets annually based on a health care inflation factor.
  - If the average premium for all of an alliance's plans exceeds target, the over-target plans may resubmit lower bids. Ultimately, payments to over-target plans would be cut according to an HSA formula. Over-target plans also would have to reduce payments to their providers.
  - Annual cap increase is based on CPI plus changes in alliance population. A cushion of 1.5 percentage points is also allowed in 1996, dropping to 1.0 in 1997, 0.5 in 1998 and no cushion in 1999 and 2000.
- This process differs from price controls, which are inflexible government regulation of product prices in the economy. Such controls are difficult to implement and regulate; interfere with private sector decision making; and limit efficiency improvements.
- Premium caps, in contrast, do not involve micro regulation. They are budgetary limitations within which private health plans have the freedom to manage their operations to provide quality care and control costs in a variety of ways, including through more efficient administration, more reasonable provider reimbursement, and more flexibility to determine the best allocation of resources.

PREVENTING AN UNDESERVED WINDFALL: IMPORTANCE OF SETTING THE INITIAL PREMIUM

- Reform must include a mechanism under which the health industry does not get paid twice for uncompensated care.

- Today, uncompensated care costs of the uninsured are passed on to those with private insurance in the form of higher premiums.

- Under health care reform, all Americans will have health insurance -- the health care industry will be compensated for all individuals. **Private insurance premiums need no longer be inflated to cover the shortfall from the uninsured.**

- If the uncompensated care surcharge built into the current premium is not taken out, the health industry would get a windfall by being paid twice for the uninsured, while businesses, families and government would have to pay billions of dollars in higher premiums.

- The HSA's initial premium holds the health industry harmless by fully compensating insurers for the currently uninsured, and maintaining current treatment of Medicaid costs. CBO estimates that HSA's initial premium would give providers the same payments, on average, that they get today.

- Absent a mechanism to deal with uncompensated care, there is no guarantee that competitive forces will constrain first year premiums.

- In fact, the Health Insurance Association of America and Hewitt & Associates estimate that, absent constraint, insurers would set premiums higher than the initial premium in the HSA.

- While many believe that managed competition will moderate health costs, health care reform legislation is governed by CBO scoring. CBO will not score significant savings from managed competition alone. It will score full anticipated savings only if there is a back-up in place, like premium caps.

- CBO scoring is critical because a 60 vote point of order lies against legislation which CBO estimates increases the deficit over ten years. Without premium caps, CBO would substantially increase its estimate of HSA's costs. Absent substantial cuts to offsets these additional costs, the bill would increase the deficit and have a 60 vote point of order against it.

IMPORTANCE OF SETTING THE INITIAL PREMIUM
AN EXAMPLE

- The importance of setting the initial premium is illustrated by a premium cap structure under which the initial premium is not constrained, but subsequent growth is controlled by the HSA caps.

- Under this example, total costs relative to HSA could increase significantly between 1996 and 2004, transferring as much as $600 billion from businesses and families to the health industry. Federal costs over that period could also increase substantially due to higher premium levels.

- These amounts are windfalls to providers and insurance companies, who would increase their profits at the expense of businesses, families and government.

- Further delaying implementation of the annual cap constraint could worsen the financial impact on government, families and business, transferring even more windfall to the health industry.

ALLOWING HIGHER GROWTH RATES AFTER THE FIRST YEAR

- If an appropriate initial premium is set, allowing greater-than-HSA growth rates in subsequent years would not be as costly as proposals which don't constrain the initial premium.

- Two options presented at the retreat illustrate this:

  -- Allowing annual growth rates 1 percentage point higher than HSA; and

  -- Allowing 1999 and 2000 growth rates to be 1 percentage point higher than HSA.

- The first option could increase federal subsidy costs by $27 billion between 1996 and 2000, and by $74 billion between 1996 and 2004. Businesses and families could also pay substantially more than under HSA.

- The second option could increase federal subsidy costs by about $6 billion between 1996 and 2000, and by $16 billion between 1996 and 2004. Costs to businesses and families could also increase relative to HSA.

- While these options could erode some of the deficit reduction possible under other models, the risk is substantially less than an option which fails to set an appropriate premium level in the first year of reform.

FEDERAL COSTS OF RELAXING HSA GROWTH RATES
($ billions)

	1996-2000	1996-2004
Increased Costs Relative to HSA:		
Growth rate 1% higher than HSA every year.....	$27	$74
Growth rate 1% higher than HSA in 1999 & 2000.....	$6	$16

Administration estimates based on CBO premium estimates.

CONCLUSION

- Slowing health costs is a fundamental goal of health care reform.
- HSA would slow growth of health care costs through enhanced competition, with premium caps as a backstop. Caps are also necessary for CBO scoring.
- Effective cost controls must (1) set a first year premium which does not confer a windfall onto the health industry, and (2) moderate the growth rate of health care costs thereafter.
- Failing to set the initial premium at an appropriate level has severe financial risks for American families, businesses, and government.
- Once the initial premium is set, relaxing future growth rates could increase costs relative to the HSA, but would not be as expensive as proposals which would not constrain the initial premium.

TO: Hillary
FR: Lisa
RE: Health Care Briefing for Editors of Women's Magazines
DT: May 24, 1994

You are scheduled to do an on the record health care briefing with the editors in chief (or health editors if the editors in chief cannot come) of the major women's magazines on Tuesday at the Waldorf Astoria from 3-4:30 pm. Your presentation should be similar to what it was at the networks. You should talk about the 10 most frequently asked questions on health care as well as the myths about the President's approach to health care reform. I will pass out the same handouts we gave to the networks.

The list of attendees is as follows:

1. Linda Wells, editor in chief, Allure (circ. 200,000)

2. Helen Brown, editor in chief, Cosmopolitan (circ. 2.6 million)

3. Elaina Richardson, managing editor, Elle (circ. 875,000)

4. Susan Ungaro, editor in chief, Family Circle (circ. 5.25 million)

5. Ruth Whitney, editor in chief, Glamour (circ. 2.2 million)

6. Donna Dehan, health editor, Good Housekeeping (circ. 5.18 million)

7. Myrna Blythe, editor in chief, Ladies Home Journal (circ. 5.23 million)

8. Dana Points, features editor, Mademoiselle (circ. 1.2 million)

9. Kate White, editor in chief, McCall's (circ. 5.14 million)

10. Grace Mirabella, editor in chief, Mirabella (circ. 400,000)

11. Ellen Levine, editor in chief, Redbook (circ. 3.95 million)

12. Alexandra Penny, editor in chief, Self (circ. 1.14 million)

13. Peggy Northrop, health editor, Vogue (circ. 1.25 million)

14. Jane Chesnutt, editor in chief, Women's Day (circ. 4.85 million)

15. Lynn Povich, editor in chief, Working Woman (circ. 1 million)

16. Jackie Leo, vice president, Child and Fitness magazines

17. Susan Taylor, editor in chief, Essence (circ. 942,000)

18. Ann Marie Iverson, health and beauty editor, Harper's Bazaar (circ. 750,000)

19. Karen Walden, editor in chief, New Woman (circ. 1 million)

(Most Frequently Asked Questions)

QUESTIONS AND ANSWERS

1) Doesn't the Clinton plan add more layers of government bureaucracy?

No. The President specifically rejected a government-run system in favor of guaranteed private insurance. America basically faces 3 choices:

- government insurance for everybody
- guaranteed private insurance (the President's approach)
- leaving people without insurance

The President's approach is guaranteed private insurance. Everyone will have comprehensive coverage that can never be taken away.

2) But what about these so-called "alliances"?

The purpose of them is very simple -- to give bargaining power to small businesses and individuals and take it away from the insurance companies. Today, the deck is stacked against small businesses and individuals. Small businesses are paying 35% more than big business for the same insurance, and individuals pay even more.

So we have these consumer-controlled alliances to allow people and small businesses to band together and get more consumer clout in the marketplace. Consumer-controlled -- that's the President's idea, not government-controlled.

Now, Congress will figure out exactly how they should be structured, but this is an idea that has bipartisan support. The insurance companies don't like it because it means they have less power, but that's what alliances are intended to do. And that's why the insurance industry is spending millions to weaken or destroy the idea.

3) One of those TV ads says that the President's plan will limit my choice of doctor. Is that true?

No, it's not. You'll be able to choose your own doctor and health plan. In fact, to make sure that you get the high-quality care you deserve, the President's approach actually increases the choices most consumers will have. Because you will choose your doctor and health plan -- your boss

won't and the insurance company won't. So you can choose any doctor and health plan in your community. Remember who's paying for these ads: the insurance companies -- who are trying to scare you and preserve their profits.

4) Won't this plan mean that I'll pay more and get less?

No. In fact, the independent Congressional Budget Office (CBO) analysis that the Republicans praised said that the President's plan would cost Americans less money and give them more health benefits. Young, healthy people may pay a little more -- but that's because we're prohibiting the insurance companies from charging older people more than younger people.

Under the President's approach, you'll be guaranteed affordable insurance you can depend on. We'll make it illegal for insurance companies to jack up your rates or drop you if you get sick, use lifetime limits to cut off your benefits, or take away your benefits. The insurance companies won't be allowed to bleed you dry.

And the President's proposal calls for comprehensive benefits, including preventive care and prescription drugs. Under the President's approach, no one -- not your boss, not your insurance company -- can take those benefits away.

5) Won't your <u>employer mandate</u> cause massive job loss and cause thousands of small businesses to go bankrupt?

There is no credible evidence to support that claim. The independent Congressional Budget Office (CBO) analysis that the Republicans praised said that the Clinton plan would not result in the loss of jobs, and would benefit <u>all</u> small businesses.

Studies predict that there will, in fact, be job gains as a result of the plan. The Economic Policy Institute predicts 258,000 manufacturing jobs created over the next decade, Lewin-VHI, a widely-respected, bipartisan firm, predicts over one million jobs created by providing long-term care, and the Employee Benefit Research Institute predicts that the President's proposal could produce as many as 660,000 jobs.

The President specifically designed his proposal to help small businesses -- the biggest victims of today's health care crisis. Small business owners will be able to get rock-solid, comprehensive coverage for their families and employees. And no longer will they be subject to insurers jacking up their rates or dropping their coverage when one employee gets sick. Because those insurance company abuses will be illegal.

6) Why do we need an employer mandate anyway?

If we want to guarantee every American health insurance, we've got to figure out how to achieve that goal. The President believes every job should come with health benefits. Most jobs do today because most employers accept this responsibility to provide worker health benefits. And yet 8 out of 10 Americans who have no insurance are in working families. We want everyone to have health benefits guaranteed at work. And under the President's approach, the government will provide discounts for small businesses, help cover the unemployed, and continue Medicare for older Americans. That's how we'll cover everybody.

7) When you try to cut costs and limit the amount premiums can rise, won't that just lead to rationing?

Absolutely not. The key to this is insurance company premiums can't continue to rise unchecked. Your money will go to buying you the highest quality of care and service, not padding the insurance company red tape. That's why there's a limit on how much insurance companies can raise your rates. In fact, it will be illegal for insurance companies to drop your coverage or take away your benefits. You'll be guaranteed affordable insurance you can depend on.

The President's approach is all about keeping you healthy. You'll have the right to choose your own doctor and health plan. We want to make sure you get high-quality care by giving you the choice, not your boss or insurance company.

8) I've got good insurance. What's in this plan for me?

First -- and most important -- you'll get something that no amount of money can buy in today's insurance market: guaranteed private insurance. Comprehensive coverage that can never be taken away. Second, you, not

your boss or insurance company, have the choice of doctor and health plan to make sure you get the high-quality care you deserve.

Third, unfair insurance company practices will be outlawed. 3 out of 4 insurance policies -- that's 133 million people -- have these lifetime limits which mean that your coverage could be cut out just when someone in your family is sickest. No more. No more jacking up prices when you get sick. You'll have affordable insurance you can depend on. Fourth, we protect Medicare. We'll cover prescription drugs under Medicare, and give new options for long-term care in the home and community. And fifth, everyone will have health benefits guaranteed at work, with the government providing discounts to small businesses and the unemployed. Even if you lose your job, you will never have to worry about losing benefits or being forced to change doctors.

9) Is it true that my doctor can be fined $10,000 for treating me outside the system?

A: No, that's not true. You can see any doctor you want and pay for any procedure or treatment. The $10,000 fine refers to the President's crackdown on insurance company fraud. Fly-by-night insurance companies will be fined if they try to dupe you by selling you "supplemental" benefits that you're already guaranteed by law.
[Note: By law, you'll be guaranteed the right to pay to see any doctor in the country, even if you are in an HMO.]

10) What's going to happen to my Medicare benefits?

A: Older Americans who receive Medicare will continue to receive all the benefits you do today. And you'll keep the doctor you now have. In addition, we'll strengthen Medicare by adding prescription drug coverage. Older Americans will also benefit from new long-term care options in their homes and communities, where they want to receive care.

11) What happens if the money runs out?

A: Today, when insurance companies go out of business, patients get struck without health care, and doctors don't get paid. The President's approach prevents that. It bans fly-by-night insurers, forcing the insurance industry to set aside funds to protect against bankruptcy or failure.

file premium caps

EXECUTIVE OFFICE OF THE PRESIDE

10-Jan-1994 07:50pm

TO: (See Below)

FROM: Jeffrey L. Eller
Office of Media Affairs

SUBJECT: Health Care Talking Points 1/11

The White House
Health Care Reform Today
January 11, 1994

* As we head into this week, it's important to keep in mind the distinction between price controls and premium caps. The President's plan uses premium caps -- limits on how fast your health care premiums can go up each month -- to control costs.

* We have considered -- but specifically rejected -- a policy imposing price controls on health care. Our primary strategy for cost containment is private sector competition -- creating the right economic incentives to bring costs in line and encourage health plans to compete on price and quality.

* We strongly believe that, regardless of how quickly or how firmly competitive reforms take hold, we need to build some discipline and certainty into our system -- so that businesses and consumers know that their health insurance premiums will not be allowed to suddenly spiral out of control one year, and that the federal government will not spend without accountability. That is why we reinforce the competitive system with a limit on health care premium increases.

* This is the most sensible approach to ensuring cost control. As Stephen Zuckerman and Jack Hadley, two leading health policy analysts wrote, "...it seems far preferable that insurance companies that are responsible to their subscribers make these decisions than having the federal government involved in detailed price

negotiations and review procedures with individual hospitals and physicians."

* In contrast to our plan, price controls call for government micro-management of every health care service, drug, technology and product. Price controls would have the government substitute its views for the markets in hundreds -- maybe thousands -- of decisions. We reject that type of micro-management in favor of letting a market that truly competes work.

* Last week, New York Newsday reported that many NYC-area small companies "...feel the high cost of health care is their most serious problem but surprisingly many business owners expect

Clinton's health plan to provide help by controlling costs. Chemical Bank surveyed 932 small businesses with annual revenues ranging $1-million - $10-million and found over 80% described health care costs for employees as a serious or somewhat serious problem and rated it higher than other problems including government regulation and taxes. (Source: Healthline)

Health Care Reform Today * The White House * 202-456-2566 * Fax: 202-456-2362

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file- price controls

1/14). CNN's Judy Woodruff: "A letter signed by more than 500 economists ... warned that the proposed Clinton plan would reduce the quality of care and force long waits for such things as surgery" ("Inside Politics," 1/13). NPR's John Ydstie: "Most of the luminaries who signed the letter are conservatives ... or veterans of the Reagan and Bush administrations. However, leaders of the effort said a number of the signers had also signed a well-publicized letter supporting President Clinton during the campaign" ("All Things Considered," 1/13). REUTERS/ WASH. TIMES reports Univ. of PA's John Lott said the group of 565 economists represents "a broad political spectrum" (Donna Smith, 1/14). FINANCIAL TIMES reports the group of "right-wing economists" includes Prof. Milton Friedman, a Nobel prize-winner, and Michael Boskin, fmr. Pres. Bush's "top economic adviser" (George Graham, 1/14). AP/WASH. POST reports that "signers include conservatives" like Friedman; Boskin; William Niskanen, a fmr. CEA member under Reagan; and NFIB's William Dunkelberg (Dave Skidmore, 1/14). W.S. JOURNAL reprints the letter and includes a list of some of the signatories. Among them is Stanford Univ.'s Alain Enthoven (see AHL, 1/13).

LETTER EXCERPTS: "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" (1/14).

THE OTHER SIDE: Brookings Institution's Barry Bosworth, who "refused to sign" the letter, called it "misleading" and said, "I don't see how economists (can) oppose the basic idea of a budget on something. That's what we teach people" (AP/WASH. POST, 1/14). CEA Chair Laura D'Andrea Tyson: "They must not have read the Health Security Act, which relies primarily on incentives and competition to control costs" ("All Things Considered," 1/13). Dep. Treas. Sec. Roger Altman: "You know that old saying, 'Economists never agree on anything' and I think this is an example of it. ... There are many economists who support the President's bill. ... I happen to think that this group has it wrong. We're not proposing price controls. We're proposing ceilings on the increases the premiums can see each year and those ceilings are only going to be relevant ... if the fundamental competition, managed competition ... doesn't produce the savings that we're projecting." Altman, on whether price controls are important to health reform: "Let's look at the big picture. The heart of the president's proposal is universal coverage with comprehensive benefits. ... That's going to be supported by the Congress and it's going to be there in the final bill this coming summer or fall" ("Moneyline," CNN, 1/13). WH economic adviser Gene Sperling: "Our plan relies on competition backed up by an overall limit on how much a family's premium can go up. That's far different than the type of detailed price controls that we rejected" (Judi Hasson, 1/14). WH'S HEALTH CARE REFORM TODAY: "The president considered, but specifically rejected, a plan imposing price controls on health care. The

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release September 2, 1993

REMARKS BY THE PRESIDENT
IN PRESS AVAILABILITY

The Rose Garden

12:15 P.M. EDT

THE PRESIDENT: I would like to make just a brief comment, if I might. And then I'll take a couple of questions.

I want to welcome Prime Minister Chernomyrdin here to the United States. We clearly recognize that his support for President Yeltsin's reform program has been essential to its success and will continue to be essential to its success. And we're very grateful that he's here.

I also want to express my appreciation to the Prime Minister and to Vice President Gore for successfully concluding the first round of talks and agreements under the Commission on Economic and Technological Cooperation that grew out of my meeting with President Yeltsin in Vancouver.

They have signed just now, as all of you know, some very exciting agreements which will permit us to cooperate with Russia in space. Russia has agreed to observe the principles of the Missile Technology Control Regime, which is something the United States very much appreciates. We are going to work together on matters of energy and environmental protection, which I think will be very helpful to Russia's long-term development, and also help with American business. And in general, I think this is the beginning of a lot more opportunities for mutual trade and investment between our two countries.

So I'm personally very happy about this. And because of the efforts of the Prime Minister and the Vice President, this first step has exceeded my expectations considerably, and I'm very, very appreciative.

Q Sir, on health care, are short-term price controls now dead?

THE PRESIDENT: Well, they never were alive. I never embraced them. They have been discussed. What I think you have to acknowledge is that the pharmaceutical companies and the industry as a whole and other segments of the health care providers have voluntarily offered, during the course of this debate, to keep their prices within inflation for a year or two, as we get up and get going the health care reform package. And I think they should be given the opportunity to adhere to the commitment that they've made.

And so, my own view is -- I've never been particularly hot on price controls. I believe in budgets and I believe we have to limit the amount of growth and the revenues we're spending on health care, both public and private.

So I want to point out that, as all of you know, in the last budget, you've got a decline in defense, flat domestic spending, Medicare and Medicaid is going up -- it's someplace between 11 and 15 percent in the first year, down to 9 to 11 percent in the fifth year of the budget, and still going up way too much. So we're going to

bring it down. But I don't think we have to have a bureaucratic system of price controls to do it.

Q Sir, what about the senior citizens groups that are afraid that Medicare is going to be squeezed under the plan that will be announced?

THE PRESIDENT: Under our plan, as you know because we've talked about it for a long time, we want to phase in a more comprehensive plan of long-term care for the elderly as well as access to medicine for people on Medicare that are -- who aren't quite poor enough to be on Medicaid and can't afford their drug bills. We're having a lot of extra cost in our health care system because senior citizens can't get the drugs that they need. So senior citizens will come out way ahead.

It is not logical, with inflation at three percent and the population growth of Medicare and Medicaid between one and one and a half percent, to have those programs going up between 12 and 16 percent a year. That's not right and it's not necessary, and we can do much, much better. And from those savings in the rate of increase -- we're not talking about cutting the programs, we're talking about slowing the rate of increase -- we can fund the drug and long-term care programs, which is what I propose to do.

Q With the collapse of the Bosnian peace talks, are you going to repropose lifting the arms embargo on the Bosnian Muslims and the air strikes?

THE PRESIDENT: Let me answer the question in two parts, if I might. First of all, they are stalled. I don't believe they are collapsed. The United States will do everything we can in the next few days to get the parties to resume the talks in good faith.

Secondly, if while the talks are in abeyance there is abuse by those who would seek to interfere with the humanitarian aid, attack the protected areas and resume the sustained shelling of Sarajevo, for example, then first I would remind you that the NATO military option is very much alive; and secondly, I would say, as you know, I have always favored lifting the arms embargo. I think the policy of the United Nations as it applies to that government is wrong. But I am in the minority. I don't know that I can prevail, but our allies have said repeatedly that they don't want to totally eliminate the arms embargo if the present state of play is sufficiently abused by other parties.

So, yes, it's still on the table, but I think that the sequence should be let's try to get the peace talks started again. Let's remember that there is a NATO option that is very much alive if there is an interruption of the present state of play that is sufficiently severe.

Q (Asked and answered in Russian.)

Q Mr. President, a Russian journalist.

THE PRESIDENT: A Russian journalist?

Q Yes. When can be expected the lifting of these old restrictions and barriers to the trade and cooperation between Russia and the United States back from the Cold War period?

THE PRESIDENT: When the Congress comes back into town next Tuesday we have a list of approximately 60 pieces of legislation that we would like to see repealed. And we believe there will be broad bipartisan support from both Republicans and Democrats in the Congress for moving this legislation through. So I think you will see quick legislative action on a whole broad range of issues to

recognize the fact that Russia is a democracy, is working with us and that we are moving forward together. And I look forward to pushing that package very aggressively.

Q You mentioned the Bosnia arms embargo. Within the next couple of weeks people expect you to lift the embargo against Vietnam. Have you made a decision, sir, and have you discussed with the Prime Minister -- what have you discussed about the possibility of American POWs in the Soviet Union?

THE PRESIDENT: We're going to go visit. We haven't discussed anything about anything yet. We're just about to start our meeting, and I've reached no further decisions about Vietnam.

I'll take one question on the Middle East. Go ahead.

Q On the Middle East, you will be discussing, I'm sure, that with Russia that played a major role. What is the latest development that you know of? Are you very optimistic on the Middle East?

THE PRESIDENT: I'm still hopeful. The parties have -- I think have been quite candid with the public and the press about some continuing difficulties. But they're really working hard and with great candor, I think, with one another. I'm hopeful. We've been up the hill and down the hill before with the Middle East, but these people are really working at it and I think their hearts as well as their minds are in it. I think we should keep our fingers crossed. The United States will continue to do what we have done.

We're just a sponsor of this process. They will have to make the agreement. And I think there's reason for hope.

Thank you.

END 12:25 P.M. EDT

Clinton's Health Proposal Predicts Quick Deficit Cut

Possible Scenarios All Use Medical Spending Caps, With Savings by 1997

A12

By Rick Wartzman
Staff Reporter of The Wall Street Journal

WASHINGTON – Good health benefits for every American. No new broad-based taxes to pay for them. And deficit reduction beginning in the first years the plan takes effect.

Sound too good to be true? Plenty of experts are certain to think so, but that's just what President Clinton is going to claim that his health-care proposal can achieve when he introduces it next month.

While he's vacationing on Martha's Vineyard this week, aides say, Mr. Clinton is considering several possible scenarios for financing the overhaul of the nation's health-care system. All of them, however, anticipate paying for the plan through caps placed on both private-sector and public health-care spending—including Medicare and Medicaid—rather than through broad-based new taxes.

The options differ, in large part, over how quickly certain aspects of the plan should be phased in and whether to include the one type of levy that is still being contemplated: "sin taxes" on tobacco and possibly alcohol.

But each of the alternatives shares a stunning feature: They show that the plan will help to shrink the federal budget deficit as early as 1996 and 1997, when the new health system is supposed to kick in. The projected reduction in the deficit – although still being refined and subject to change – runs from a couple of billion dollars in the early years to as much as $40 billion annually before the end of the decade, according to senior administration officials. The exact figures will depend on how Mr. Clinton makes certain final trade-offs.

CBO Review

Told of these assumptions, health-care economist Uwe Reinhardt is more than a little incredulous. "At last," says the Princeton University professor, "the proverbial free lunch." Others fear that the Clinton plan, as it's shaping up, could lead to a rationing of medical services. And some analysts worry that the cost-saving measures at the core of the plan could ripple through and harm the economy.

But after months of calculations, Mr. Clinton's advisers are confident that their numbers are solid and their theories are well-grounded. Teams of independent actuaries already have gone through much of the data and signed off on it. What's more, the White House aims to have its assertions backed up by the Congressional Budget Office, which is set to begin reviewing the details over the next couple of weeks.

The CBO will find a plan that promises a lot, and, in an effort to fulfill those promises, demands a lot as well.

The key to financing the Clinton proposal will be the caps placed on both public and private-sector health-care spending. The hope is eventually to be able to limit all health spending growth to the level of inflation plus increases in the population.

The battle over the president's budget "probably forced him to realize that he doesn't have the capacity to ask for new taxes" to fund the health plan, says Brandeis University's Stuart Altman, who served as a Clinton health adviser during the transition. "But if they really put tight controls on spending, I think that could work."

Variety of Caps

Medicare, the federal health program for the elderly and disabled, will be capped under the Clinton plan. So will Medicaid, the state-federal program for the indigent. And so, too, will the growth in the average price of the federally guaranteed benefits package that is provided by private insurers.

The total savings generated, administration officials think, will be enough to bring the 37 million uninsured into the new system, provide all Americans with health benefits that are as good as the ones typically offered by large corporations and give government subsidies to the companies and individuals that can't afford such a package.

The Clinton plan will cover a comprehensive range of medical services, from routine doctor's visits and prescription drugs to hospitalization and post-acute home care. It will also feature better-than-average mental-health and preventive-care coverage. And there is a good likelihood that even dental care will be covered in later years for adults, although children may enjoy dental benefits right away.

Everyone Pays Something

The flow of funds into the new system begins with Mr. Clinton's mandate that everyone contribute something. Employers will be asked to pay for 80% of the average price of the health policies offered to their workers by the large regional insurance pools the Clinton plan will set up. Workers, for their part, will have to come up with the other 20%, assuming they buy an average-priced plan. If they buy a cheaper-than-average plan, they'll contribute less. If they buy a more expensive plan, their contribution will increase.

But the mandate is designed to hit only so hard. Sensitive to the potential impact on the business community, the administration will limit contributions to about 3.5% of payroll for the smallest and lowest-wage companies. For larger, better-off companies that are part of the regional insurance-purchasing networks, the limit will be about 7.5%. Administration officials say that many large companies should come in under the limit.

Individuals, whether employed or unemployed, would also have a limit on their contributions – tentatively projected to be 1.9% to 2.4% of their total family income.

The estimated $30 billion to $40 billion gap between what firms and individuals pay into the system and what the basic benefits package costs, meanwhile, is to be made up with federal subsidies.

And that, aides say, is where the spending caps come in. By capping the rate of growth in Medicare and Medicaid, the White House hopes to squeeze tens of billions of dollars a year directly from the system. Billions more should be raised as the government reduces payments to hospitals and doctors that currently treat large numbers of uninsured people.

Shift to Taxable Forms

Still on top of that is another large pot of money. By capping the growth of medical costs, employers will spend less on health care for their employees. They will then presumably take this sum and either give it back to their workers in the form of higher wages or use it to fatten company profits. Health benefits are tax deductible; wages and profits aren't. The end result, the president's advisers say, should be a windfall for the Treasury.

Undergirding the caps will be a host of systemic changes aimed at spurring competition among health-care providers. The sheer size of the regional insurance pools, for example, is supposed to give employers and individuals newfound muscle to buy the best care at the lowest price. Other pieces of the massive Clinton plan – from going to a single insurance claims form to revamping malpractice and antitrust laws – also are intended to bring new efficiencies to the system.

But the focus of the fight ahead is sure to be the caps. Any time an entitlement program like Medicare faces a cutback—as it did in Mr. Clinton's budget plan – it automatically triggers fierce opposition in Congress.

Fear of Rationing

The call for caps on private-sector premium growth also raises concerns. "The biggest hazard of premium controls is the R-word: rationing," says Paul Ellwood, a pediatrician and one of the fathers of "managed competition," the blend of regulation and free-market forces that is at the heart of the Clinton health plan. This doesn't mean that people will be denied medical services, but they might have to wait longer than they want for such services.

James Todd, executive vice president of the American Medical Association, complains that premium caps are "just going to increase the micromanagement that insurance companies put on the providers," undermining quality. And Sylvester Schieber of the consulting firm Wyatt Co. thinks the caps could lead to "fantastic dislocations" in the health-care industry, hurting the overall economy.

For their part, though, Clinton aides argue that there's no reason to have rationing and terrible economic shocks when the current health system has so much waste that can be purged.

"With this much fat in the system, it should be true," says Princeton's Mr. Reinhardt. "The problem is trying to get at it. President after president has tried, and no one has been able to do it."

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Clinton's Rx for Health-Care Overhaul

Key decisions on the Clinton health plan made over the past several months by the president and his top advisers.

	WHAT'S IN	WHAT'S OUT
Benefits	A fee-for-service version of the benefits package with deductibles of $400 for each family and $200 for each individual. There's also a 20% co-payment on each doctor's bill and out-of-pocket maximums of $3,000 for families and $1,500 for individuals. An HMO version features no deductible and a $10 co-payment.	A benefits package that's either bare bones or as generous as the best union plan.
Financing	A mandate for every employer to contribute to employee health coverage. Individuals also will be required to contribute. However, contributions will be capped and federal subsidies given.	A payroll tax. Taken off the table because it would have meant some people have to pay more for the same benefits they get now.
Effect on Large Companies	Large employers—likely those with 5,000 or more employees—will be able to set up their own insurance-purchasing pools but must follow the same rules as the regional health alliances.	Letting big employers opt completely out of the system.
Spending Controls	Caps on the growth of Medicare and Medicaid. Also, caps on the growth of premiums in the regional insurance pools.	A "global budget" that would have limited all health spending.
State Responsibilities	States given extensive flexibility in setting up insurance pools.	Holding the states responsible if the growth in premiums exceeds the targets. Instead, the federal government will enforce the caps.

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Price Cap Regulation:

· Focus on prices rather than on underlying costs.

· Traditional public utility (rate-of-return) regulation involves a cost-plus approach.

  · The regulated firm is permitted to earn amounts necessary to recover all of its costs.

  · This creates disincentives to efficient business behavior -- efficient production by the utility has the anomalous effect of reducing its permissible revenues.

· In recent years in both the U.S. and especially the U.K., regulations have begun to regulate telephone prices without regard to underlying costs.

  · Regulations set a ceiling on the price that can be charged for a single service on the average price of a group of services.

  · In subsequent years, the ceiling is adjusted by a formula -- typically an addition for inflation. (Other factors such as anticipated changes in productivity also can be included in the formula).

  · Price cap regulation thus assures consumers that prices will be controlled.

  · Price cap regulation also gives regulated firms a strong incentive to produce efficiently.

    · Regulated firms get to retain gains from efficiency improvements since lower costs do not result in lower prices.

· One problem: Price cap regulations can lead to reductions in quality.

  · Firms subject to price cap regulation increase or maintain profitability by reducing costs.

  · Firms without significant competition can reduce cost by reducing quality.

  · Government has not yet fully solved this problem.

  · Principal approach to the issue is direct government monitoring of quality.

· If applied to firms in a competitive milieu, however, price cap regulation should not lead to concerns about quality.

· In health care, one might expect less competition, and thus more concern about quality, in rural ares.

· In public utility regulation, comparisons of one utility with another can give regulations a sense of whether a particular firm's performance is adequate -- this is known as yardstick or benchmark competition.

· Performance of firms in a competitive market, e.g. cities can be used to gauge the performance of firms in less competitive markets, e.g. rural areas.

· The price cap does not, however, take cognizance of the utility's underlying costs.

·· Baumol says the President's health plan would make adjustments for inflation every year. He believes this is not adequate because the underlying costs of health care historically appear to have increased faster than the rate of inflation. Therefore, he says that history shows our formula will produce severe unintended consequences. In short, Baumol is concerned about the health plan's measuring devise for the annual budget adjustments.

THE NEW YORK TIMES, SUNDAY, OCTOBER 3, 1993

Viewpoints

Health Plan: Who Will Watch Costs?

By ALAIN C. ENTHOVEN and SARA J. SINGER

ON the surface, the Clinton health reforms seem in tune with the global turn to free markets. Rather than embracing "price controls" and "the heavy hand of Government," the President said last month, he wants "to let market forces enable plans to compete."

Below are the stories of four hypothetical actors in the world after health reform. Their tales show that the President's plan relies less on market forces than he suggests, and thus will require the very things he wants to avoid: price controls and Government regulation.

Joe Wilson. Mr. Wilson, who works at the Stanford Scarf Company, is buying health insurance. He can choose from different plans offered through the Omega Health Alliance, one of reform's huge insurance-purchasing groups.

The cheapest plan costs $100 a month; the most expensive, $150. Whichever plan Mr. Wilson chooses, reform requires his employer to pay a minimum of $110 a month. At the extremes, Mr. Wilson will get a taxable $10 rebate each month or pay a nondeductible $40.

After some thought, Mr. Wilson selects the expensive policy. In his 50 percent tax bracket, the $10 rebate is worth only $5. Plus, his boss is willing to pay the extra $40 for the expensive policy and take it out of Mr. Wilson's wages. That makes the payment tax-free for Mr. Wilson — giving him the $50 more costly plan for only $25.

Like Mr. Wilson, millions of workers will opt for a costly plan for tax reasons. This means that under the Clinton reform, the nation cannot count on them to be sensitive to rising health costs.

Sam Mandel. Mr. Mandel, Mr. Wilson's employer, joined the Omega Health Alliance for its many benefits, including a limit on his premium payments of 7.9 percent of payroll. Under the Clinton reform, the Government pays anything over that for alliance members. So Mr. Mandel is not worried much about costs either.

> To avoid price controls, reform needs a dose of 'cost consciousness.'

Jane Thompson. Meanwhile, Ms. Thompson, head of the Arden Health Company, is setting prices for the policies she sells. Under reform, she must accept all applicants and charge everyone the same rate for the same coverage, allowing only for geographical cost differences.

Ms. Thompson knows one thing for sure. Because Mr. Wilson and Mr. Mandel are somewhat indifferent to cost, she sees little reward in lowering prices. An astute businesswoman, she also knows her competitors feel the same. And she knows her costs are rising 5 percent a year.

So she pressures the alliance to raise its 3 percent ceiling on annual premium increases. (She'd never ask for less than 3 percent; these ceilings always become floors.) Her strategy: predict Arden's insolvency and threaten a lawsuit.

Focused on these tactics, Ms. Thompson will hardly be vigilant about rising costs.

Mary Gardiner. Ms. Gardiner runs the Omega Health Alliance, and she must respond to Ms. Thompson's plea. Given that most employers belong to Omega, it functions like a state health agency. So Ms. Gardiner must think hard about the political fallout if a big health plan fails. And she must listen hard when the governor calls after speaking to his friend and campaign contributor, Ms. Thompson. Despite the 3 percent standard, Omega finds a way to satisfy Arden's demands.

Apparently, the country cannot count on health alliances to slow health-care inflation.

The Clinton proposal has many sound ideas. But — as these stories show — it does not unleash enough market forces to contain costs.

This deficiency must be corrected. For example, President Clinton should tax health benefits beyond the price of the lowest-priced plan, so that individuals like Mr. Wilson will become fully cost-conscious. The President should also take away the regulatory powers of alliances, with their political entanglements, and he should drop the 7.9 percent cap on premium payments that makes Mr. Mandel so indifferent to health costs.

Only through such measures can the President avoid the price controls and Government overregulation that he wishes to avoid. ■

Alain C. Enthoven is a professor of management at Stanford University and a member of the Jackson Hole Group, a health-care policy organization. Sara J. Singer is his special assistant.

Mutual Funds/Carole Gould

Health Care: Loser With a Future?

So far this year, the only losing group among domestic stock funds has been the health-and-biotechnology category.

All the other 15 stock fund categories tracked by Morningstar Inc., a research company in Chicago, have produced positive returns since January. In the latest three months, the average domestic stock fund rose 5.3 percent, yielding a gain of 10.5 percent from January through September.

Gold funds were the biggest winners over the nine months, up 45.3 percent, although gold began losing ground in the third quarter. Following them were the Pacific stock funds (up 36.8 percent since January), foreign stock funds (up 25.7 percent) and natural resource funds (up 23.1 percent).

But health-and-biotechnology funds fell 5.3 percent in the last nine months. Since July, the health-and-biotechnology group rose only 2.6 percent, as investors waited out the uncertainty of the Clinton health care plan.

Health care stocks have been laggards since January 1992, after a stunning run that yielded average returns for health care funds of nearly 45 percent a year from 1989 through 1991.

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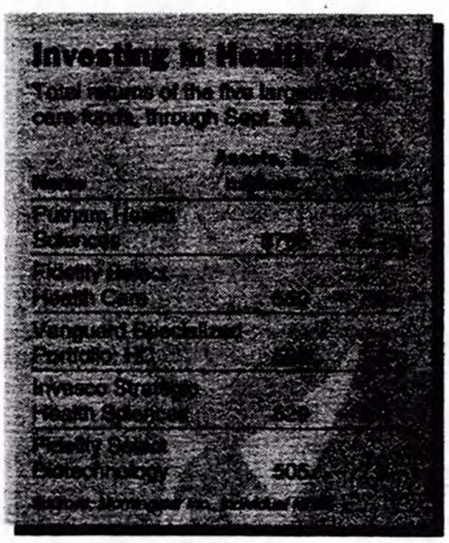
Now the managers say the bad news may be over. "There's a good chance that underperformance has run its course — the economy is not strong and health care is resistant to the economic cycle," said Edward P. Owens, who runs the $540 million Vanguard Specialized Portfolio: Health Care.

Moreover, the Clinton plan "was the event that Wall Street was waiting for," said Joanne Soja, who took over the $765 million Putnam Health Sciences Trust in August. "Now that we know what the worst case is, we can start looking at stocks again."

The plan probably will not have an immediate impact, the managers say, because it takes a broad approach and "the devil is in the details," Mr. Owens said. Also, it's likely that the plan will take the same tortured route through Congress as the Federal budget, yielding to compromises along the way.



Here is what the fund managers have to say about turning their group around:

Given that many large-capitalization health care stocks are near record lows, "I'm relatively sanguine," Mr. Owens said. Still, he finds foreign companies most attractive now. He noted that international stocks have underperformed for the last three years, so their valuations are better. A favorite: Zeneca, a British drug company created when Imperial Chemical Industries split into separate drug and chemical companies in June.

Jordan Schreiber, who manages the $120 million Merrill Lynch Healthcare Fund, has also been moving outside the United States. About 41 percent of the fund is invested overseas; its biggest holding is Roche Holding, the Swiss drug company. In the United States, he said, "large-capitalization drug companies have already been hit, probably more by market forces than the Administration's plan," and the damage is "ongoing and permanent." Some that he feels might survive as industry restructuring are Warner-Lambert, Merck and Carter-Wallace.

Mike Yellen, co-manager of the $4 million Franklin Global Health Care Fund, said he has avoided large-capitalization consumer drug companies because "their pricing flexibility is gone forever." Instead, he buys health maintenance organizations and generic drug companies to benefit from cost-containment trends. He likes Healthsource, a Concord, N.H.-based H.M.O.

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Charles A. Mangum, manager of the $550 million Fidelity Select Health Care fund, compares the health care industry today to "the oil industry of the 1980's, one time perceived as strong growth companies." About half the fund is invested in drug companies; the three largest holdings are Schering-Plough, Warner-Lambert and Imcera. Lately, Mr. Mangum said he has been buying biotech stocks — "which I've avoided for quite some time" — bringing that sector up to 10 percent of the fund. He said he liked Chiron, which is preparing to market a treatment for multiple sclerosis, and Genentech, which has a cystic fibrosis drug up for approval by the Food and Drug Administration.

Ms. Soja, of Putnam, is focusing on companies that have a track record of dealing successfully with intense Government intervention. One favorite is Vivra, a dialysis company that has managed despite declining Government reimbursements. She has increased the fund's H.M.O. position and likes companies that will benefit from the trend to managed care. One favorite: Value Health, a specialty managed care company that helps corporations reduce the drug and mental health portions of their insurance costs.

Louis E. Salemy, who runs the $90 million Fidelity Select Medical Delivery fund, says H.M.O.'s and health insurers are likely to feel the most immediate impact from the Administration's plan. As a result, he is buying shares in companies that dominate local markets "because you have to control the market to maintain pricing power," he said. Hospital companies account for 30 percent of the fund. The biggest are the Hospital Corporation of America, Health Management Associates and Columbia Health Care.

The worst performer in the health-and-biotechnology category, the $529 million Invesco Strategic Health Sciences (down 15.9 percent since the beginning of the year), was hurt this year by a big position in Synergen. Still, fund co-manager John Kaweske is moving slowly back into biotech again, with a position in Creative Bio-Molecules. ■

Health Planners at White House Consider Lid on Medicare Costs

Fierce Debate Erupts on Political Risk of Limits

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By ROBERT PEAR
Special to The New York Times

WASHINGTON, Aug. 29 — Less than a month before President Clinton is to unveil his proposal for a national health insurance program, disputes have broken out among Administration officials over how to finance it and how tightly to limit overall health spending.

Officials said that the White House, seeking to avoid new taxes, was seriously considering a proposal to squeeze more than $100 billion of additional savings from Medicare, the Federal health program for the elderly, by holding down increases in the program through the year 2000. The savings, along with a possible increase in the tax on cigarettes, would help pay for Mr. Clinton's promise of guaranteed coverage for all Americans.

New Agency Envisioned

In addition, some White House officials have proposed setting tight limits on the growth of all health spending, public and private, so that by 1997 it would grow no faster than the economy as a whole. Health spending is now growing more than twice that fast.

Under the Clinton plan, a new Government agency, the National Health Board, would establish a limit on the average yearly health insurance premium to be paid by employers and workers.

The proposals have provoked fierce debate inside the Administration, with some Presidential appointees arguing that the swift imposition of such limits is politically unrealistic and economically unfeasible.

"It's not an ideological argument," one Cabinet officer said. "We agree on Clinton's general approach to health care reform. It's an argument about what is possible — how fast we can pound down the growth of health spending, how tight the caps on such spending should be, how big the cuts in Medicare will be."

Conclusion and Challenge

Ira C. Magaziner, who has coordinated development of the health plan, argues that substantial cutbacks in Medicare and the proposed limits on health spending are feasible and realistic. But several Cabinet officials have challenged that conclusion, including Donna E. Shalala, Secretary of Health and Human Services; Robert E. Rubin, assistant to the President for economic policy; Treasury Secretary Lloyd Bentsen, and Laura D'Andrea Tyson, chairwoman of the Council of Economic Advisers.

Continued on Page A14, Column 1

Will Coverage Hurt Workers?

A problem for the health plan: how to keep requirements that companies insure employees from costing low-wage workers their jobs. Page A14.

Continued From Page A1

Mr. Clinton has promised that his plan will not require any new broad-based tax. This vow has forced him to intensify his search for other ways to pay for his proposals, whose exact cost is not yet known.

Medicare finances health care for 36 million elderly and disabled people. The budget bill signed by Mr. Clinton on Aug. 10 cuts $55.8 billion from the projected growth of Medicare over the next five years, mainly by curbing payments to hospitals and doctors and increasing beneficiaries' premiums. Nevertheless, the cost of Medicare is expected to soar, to $239 billion in 1998 from $129 billion last year.

Fear of Unintended Effects?

Health policy experts warn that further cutbacks could have unintended effects. Doctors and hospitals, they say, would try to offset the loss of Medicare income by raising prices to privately insured patients, thwarting Mr. Clinton's effort to restrain health spending — unless the Government prevents such cost shifting by enforcing limits on all health spending.

Most of Medicaid, the Federal-state program for low-income people, would be folded into the new system under Mr. Clinton's plan.

The White House says Mr. Clinton intends to unveil his health plan before a joint session of Congress on Sept. 22 or a few days later. Administration officials have said that under the plan all Americans will be entitled to a comprehensive package of health benefits. To help hold down costs, Mr. Clinton will propose a nationwide system of health insurance purchasing groups to bargain with doctors, hospitals and insurance companies for the best coverage.

The Basic Questions

But interviews with Administration officials suggest that some basic questions remain in dispute.

The President's plan would require employers to pay at least 80 percent of the cost of health premiums for their employees. Workers would generally be expected to pay the remainder, up to 20 percent of the premium; the money would be withheld from their pay. Employers could pay part or all of the employee share. The Government would still incur heavy costs because it would subsidize insurance for low-wage workers and for small businesses that employ such workers.

White House documents show that subsidies would be available to employers with fewer than 50 workers if their average wage was less than than $24,000 a year. Subsidies would also be available to families with incomes up to 50 percent above the official poverty level (up to $21,514 for a family of four) to help pay the patients' share of medical bills, including deductibles.

As a Presidential candidate, Mr. Clinton said he would set "a national health budget" to impose an overall limit on costs. He now proposes to do that by limiting the annual increase in health insurance premiums and health spending by corporations for their employees.

The White House documents say that Mr. Clinton's proposal, the American Health Security Act, would bring "pro-

THE NEW YORK TIMES, MONDAY, AUGUST 30, 1993

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Subsidies for the Uninsured

President Clinton's health plan would provide Government assistance to low-wage workers and to small businesses that employ such workers to help them buy health insurance. Employers would be eligible if they have fewer than 50 employees and if the average wage is less than $24,000 a year. These examples show how it might work.

	Employer's share	Employee's share	TOTAL
INDIVIDUAL POLICY ANNUAL PREMIUM	$1,440	$360	$1,800

Worker's annual wages	Subsidy paid to employer	Subsidy paid to worker	Total subsidy
$ 5,000	$960	$240	$1,200
10,000	480	120	600
15,000 or more	0	0	0

FAMILY POLICY ANNUAL PREMIUM	$3,360	$840	$4,200

Worker's annual wages	Subsidy paid to employer	Subsidy paid to worker	Total subsidy
$ 5,000	$2,880	$720	$3,600
10,000	2,400	600	3,000
15,000	1,920	480	2,400
20,000	1,440	360	1,800
25,000	1,160	240	1,400
30,000	0	120	120
35,000 or more	0	0	0

Source: White House documents

The New York Times

Can a huge program's growth be slowed to avert taxes?

jected growth in health-care costs in line with growth in gross domestic product by 1997." Kevin Anderson, a White House spokesman, said "cost controls will be applied equally" to private health spending and public programs..

Initially, under the Clinton plan, premiums could increase no more than the average of the increase in gross domestic product for the three previous years, White House documents say.

Mr. Clinton would impose stricter limits on medical spending after the first two years of the new health system. "Thereafter," the documents say, "the inflation factor equals the three-year average of the increase in the per capita G.D.P." The increase in the per capita figure is smaller because it takes no account of economic growth attributable to the increase in population.

Over the last four years, health care spending grew an average of 11 percent a year. The gross domestic product grew 5 percent a year, while per capita G.D.P. rose 4 percent a year.

The Administration is shying from explicit price controls on doctors and hospitals. But some Administration officials say the limits on health spending may be so strict that the effect is almost the same.

"Ira would like the caps to be very tight," one Cabinet officer said. "When you go to tight caps, you are going to something like price controls."

The Cabinet officer, a lifelong Democrat, complained: "This plan is heavily regulatory. It smells like big government."

The National Health Board, to be composed of seven Presidential appointees, would compute the cost of the package of health benefits to be guaranteed to all Americans and would calculate the "national per capita premium" needed to cover the cost. Using this number as a reference point and adjusting it for regional variations in health spending, the board would calculate a "per capita premium target" for each of the health insurance purchasing groups set up across the country through which most Americans would get their insurance coverage. In this way, the board would set a yearly budget for each such group.

Here are other details of the Clinton plan, as described in documents from the White House and the National Economic Council:

BIG CORPORATIONS. By Jan. 1, 1996, each state must establish one or more of the large purchasing groups, known as regional health alliances, for its residents. All Federal, state and local government employees must obtain coverage through the purchasing group in the area where they live. People who are self-employed or unemployed will also get coverage through regional alliances unless they qualify for Medicare.

But big corporations with more than 5,000 employees may run their own health plans, serving as their own insurers or buying coverage from a private insurance company. These corporate health plans, to be known as corporate alliances, would have to meet Federal standards regulating the scope of benefits, financial reserves and the prudent use of money held in trust for workers. "Employees in corporate alliances are not eligible for public subsidies," the document said.

Employers operating their own health plans would have to pay "a premium surcharge of 1 percent of payroll" to help cover the cost of the new health-care system. Corporate health plans would have to comply with "cost-containment goals" set by the National Health Board. These limits would be slightly stricter than those for the regional health alliances. Large employers that exceed these spending limits would lose the privilege of running their own health plans and would be "required to purchase coverage through regional alliances."

FEE SCHEDULES. Most consumers would get care from health maintenance organizations and other networks of doctors and hospitals. But each insurance purchasing group would also have to offer a traditional health plan, under which consumers could consult any doctor and doctors could charge a fee for each service.

Each state would establish a fee schedule for doctors serving these patients. A doctor "may not charge or collect from a patient a fee in excess of the rate schedule. Under current law, the Government generally does not regulate doctors' charges to their privately insured patients.

ENFORCEMENT. The Treasury Secretary could impose a monetary penalty on anyone who failed to enroll in a health plan by a specified date. The documents do not say how severe such a penalty would be.

The Federal Government would enforce health-care budgets for three years, from 1996 to 1998. Regional health alliances must submit proposed premiums to the National Health Board for approval. States would be responsible for enforcement after 1998.

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The Outlook

Health-Care Option: Imposing Cost Controls

Al —

WASHINGTON

In the past few months, the president's health-care plan has undergone a quiet but profound transformation. In the spring, Mr. Clinton's advisers were busily sorting through various tax schemes to finance health reform. They looked at taxes on hospitals, on doctors, on insurance companies, and even came surprisingly close to embracing a huge new payroll tax on employers. But now, all the tax talk has stopped.

The only proposal still on the table is a cigarette tax, valued more for its health effects than its revenue effects.

It isn't surprising that the administration is abandoning its tax proposals, given the bruising Mr. Clinton suffered in his budget battle. And the change in the health plan brings it into line with Mr. Clinton's own rhetoric. Health-care reform, he has told the nation repeatedly, is the key to conquering the budget deficit. If that is the case, why do we need new taxes to pay for it?

But the Clinton line has always been misleading. Health care may be the cause of the budget problem, but it isn't necessarily the solution – at least in the near term. Many experts believe the nation can't control health-care costs until it first provides coverage to the estimated 37 million people without it. That costs money—lots of it.

Even congressional conservatives like Democratic Rep. Jim Cooper of Tennessee, who champions a market-oriented "managed competition" health plan, believe the government will have to pay $30 billion to $40 billion a year in the first few years to make reform work. "As far as we know, that's the cheapest plan there is," he says.

But the president's chief health-care guru, Ira Magaziner, believes a hat trick is possible. He is working on a plan that aims to provide coverage to the uninsured, avoid tax hikes and reduce the deficit, all at the same time. It would require businesses to buy their employees health-care coverage—a requirement some businesses may view as no better than a tax. And to raise the tens of billions of dollars needed to cover the unemployed and subsidize hard-hit small businesses, it would squeeze out "waste and inefficiency" by imposing sharp controls on health-care costs.

Asked about the cost controls, White House spokesman Kevin Anderson said that "no final decisions have been made," but the options before the president "contemplate varying degrees of savings, ultimately as a result of how hard and how quickly we step on the brake of runaway health spending."

Clinton's aides bristle whenever they are compared with the Reagan administration, but there is a similarity here. In 1981, Mr. Reagan claimed he could cut taxes, increase defense spending and reduce the deficit all at the same time. And the key to doing it was eliminating waste, fraud and abuse. If it relies too heavily on cost controls, Mr. Clinton's health-care plan could be heading in a similar direction. "Any administration has a tendency to use smoke and mirrors to achieve its goals," worries Mr. Cooper.

To be sure, Mr. Clinton is in a tough spot. A big tax increase would endanger the health-care plan's chances for garnering bipartisan support on Capitol Hill. And while some of Mr. Clinton's economic advisers argue he should hold down the plan's cost by phasing in universal coverage more slowly, that has pitfalls, too. Health-care experts say if you put cost controls on providers before you provide health-care coverage to all, then the uninsured may have an even harder time getting needed care.

Moreover, it is difficult to argue with Mr. Magaziner's notion that there is waste and inefficiency that can be squeezed out of the health system. The U.S. spends 12% of its output on health care, while other industrialized nations spend only 8% or 9% – and their citizens remain relatively healthy and happy. "If they can do it, you have to ask, why the hell can't we?" says Henry Aaron of the Brookings Institution.

The problem comes in figuring how long it takes to get from here to there. It could take years, if not decades, to convert the nation's convoluted and wasteful health-care system into a more sensible, and less costly, one. The fear is that in the desire to provide universal coverage without raising taxes, the Clinton plan may impose cost controls that force change too quickly.

There are dangers in this approach. One is it would stifle Mr. Clinton's stated desire of creating a system of "managed competition." Alain Enthoven, the Stanford University economist who fathered the idea of managed competition, wrote in an op-ed piece in the Los Angeles Daily News last week that Mr. Clinton's plan for tough cost controls may actually "make a bad situation worse" by "freezing the inefficiencies of today's system into place."

Another concern is that such an abrupt, government-dictated change could cause painful dislocations and unintended consequences. Hospitals with excess beds might be forced to go under; those that have invested in expensive technology might find their equipment standing idle. Rationing of health care would rise, and horror stories about people who died because they were denied tests by bean-counting health-care accountants are certain to proliferate.

When those horror stories start flowing in, will Congress enforce the controls? "I doubt it," says Mr. Cooper. "We're not going to curtail health care just because some bureaucrat guessed wrong on the cap." The result could be more health-care spending, no means of paying for it, and another promised free lunch that ends up fattening the federal budget deficit.

—ALAN MURRAY

What's News—

Business and Finance

NATIONAL MEDICAL'S policies and directives are being examined by federal agents, who are seeking evidence linking suspected criminal misconduct by many of the firm's hospitals with its top executives. Meanwhile, the company acted to try to restore confidence following Thursday's raid by U.S. agents of more than 20 of its facilities. On Friday, its stock plunged $3.375, or 30%, to $7.75.

(Article on Page A3)

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GPA Group is expected to sign financial-rescue packages with GE's financial subsidiary and a bank syndicate this week, 14 months after a failed stock offering plunged the giant Irish aircraft-leasing firm into crisis.

(Article on Page A3)

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McDonnell Douglas's planned sale to the U.S. of 120 C-17 transports could be reduced to half that amount, with the military still able to deploy forces effectively, a Pentagon study says.

(Article on Page A3)

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Banks' lending terms seem to be easing, according to a Fed survey. Equally important, the lenders found businesses and households increasingly willing to borrow money.

Mortgage lending to minorities improved last year at many of the nation's biggest banks. However, the disparity between minority and white applicants is still significant.

(Articles on Page A2)

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Stocks fell amid declining bond prices. The Dow Jones industrials lost 7.55 points to 3640.63 as the benchmark 30-year Treasury bond's price slid ¾ point and its yield rose to 6.14%.

(Articles on Page C1)

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Novell's Roel Pieper is leaving the software maker, only two months after its purchase of Unix Systems, of which Pieper had been chairman and CEO.

(Article on Page B6)

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Alyeska Pipeline's safety and environmental practices along the Trans-Alaska pipeline will be audited by a team of independent engineers dispatched by the Interior Department.

(Article on Page B3)

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Machine-tool orders fell 20% in July from June as seasonal plant closings slowed activity, but orders stayed well above the year-earlier level.

(Article on Page A2)

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Chrysler asked for health-care concessions and lower starting wages for new hires in its opening offer to the UAW, which criticized the proposal.

(Article on Page A4)

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World-Wide

ISRAEL'S CABINET PLANNED to review an accord on Palestinian autonomy.

The proposal, which would give Palestinians authority over the Gaza Strip and the West Bank city of Jericho, was to be discussed at a cabinet meeting today. The self-rule plan also will head the agenda when Mideast talks resume in Washington tomorrow. Israeli radio said Israel and the PLO were considering mutual recognition as part of the package. Gaps remain between the Israeli and Palestinian positions on the accord, which reportedly was reached during talks between Foreign Minister Peres and a PLO official. (Article on Page A6)

The Israeli right wing is gearing up to oppose any agreement; the opposition Likud party is sponsoring a no-confidence motion in parliament today.

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BOSNIA'S FACTIONS PREPARED to set conditions for accepting a peace plan.

The rival groups were expected to return to Geneva to present their official responses to a proposal for partitioning Bosnia into three ethnic states. Mediators have set today as the deadline for approving the proposal. The parliament of the self-proclaimed Bosnian Serb republic approved the plan Saturday but will press for the lifting of U.N. sanctions against Belgrade. Meanwhile, Bosnia's Muslim-led government and the Croat assembly called for amendments to the proposed territorial borders.

In southwestern Bosnia, U.N. officials were negotiating to arrange an exit for 53 U.N. peacekeepers trapped in Mostar by Muslim civilians.

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Elite U.S. troops raided a building in Mogadishu, Somalia's capital, before dawn Monday, in an apparent operation against fugitive warlord Mohamed Farrah Aidid. Witnesses said about 40 American attack helicopters participated in the assault and fired at several targets in southern Mogadishu. Aidid is wanted by the U.N. in the killings of peacekeepers in Somalia.

Defense Secretary Aspin said U.S. forces won't pull out of Somalia anytime soon. Before there is an American withdrawal, he said Friday, heavy weapons must be taken out of the hands of Somali clan leaders, credible police forces must begin patrolling the major cities, and security problems in southern Mogadishu must be settled.

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The Security Council suspended a crippling 2½-month-old oil embargo and other economic sanctions against Haiti on Friday as a democratic government prepared to take office there by Oct. 30. The unanimous decision to suspend the sanctions was effective immediately. Oil shipments are expected to begin arriving this week.

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Senate Republican leader Dole said his party is ready to work with Clinton on a compromise health-care reform package, but he predicted that the legislation won't be approved this year. The Kansas lawmaker said several GOP health proposals are expected to be introduced as alternatives to the president's plan.

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Unita rebels attacked a U.N. food convoy in central Angola over the weekend, killing two relief workers and destroying two vehicles, according to news reports. There was no official confirmation of the guerrilla assault on the World Food Program trucks in coastal Benguela province.

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Nigeria's interim government ordered the release of three pro-democracy leaders detained since July. Meanwhile, unions staged a strike over the military's installation of interim leader Ernest Shonekan. The release of the activists was Shonekan's first major action since he succeeded former military leader Babangida last week.

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Mexican lawmakers approved constitutional reforms over the weekend that are designed to reduce election fraud. The administration of President Salinas also issued rules requiring that government officials be audited to determine their net worth and income. (Article on Page A6)

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A dam burst in China's remote western Qinghai province, flooding numerous villages and killing at least 223 people, officials said. Thousands of people were injured and many were still missing after Friday's accident at the Gouhou reservoir.

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Ong Teng Cheong won Singapore's first presidential election on Saturday, as expected. Ong, a former deputy prime minister and labor leader, took 59% of the votes cast in the two-way race. His opponent, a former bank executive, won 41%, though he didn't wage a formal campaign and had said Ong was the superior candidate.

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Central & South West's proposal to purchase El Paso Electric was accepted by a bankruptcy judge, moving the Dallas utility closer to victory in its bitter fight with Southwestern Public Service to acquire El Paso.

(Article on Page A4)

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Hormel's Richard Knowlton plans to step down as chief executive of the food processor but will remain chairman. He intends to recommend that President Joel Johnson succeed him.

(Article on Page B6)

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VW demanded an explanation from German prosecutors for what it says were unusual actions surrounding last week's police search of company offices and top managers' homes.

(Article on Page A6)

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Markets—

Stocks: Volume 194,790,720 shares. Dow Jones industrials 3640.63, off 7.55; transportation 1655.06, up 3.64; utilities 254.09, off 0.66.

Bonds: Lehman Brothers Treasury index 5557.64, off 15.04.

Commodities: Oil $19.75 a barrel, up 28 cents. Dow Jones futures index 127.78, up 1.24; spot index 123.12, up 0.57.

Dollar: 103.75 yen, off 0.60; 1.6644 marks, off 0.0031.

WILL CLINTON'S HEALTH CARE COST CONTROL PLAN WORK?

Draft of Oped Article

Stephen Zuckerman, The Urban Institute, and Jack Hadley, Georgetown University

Controlling medical care spending is "Job One" for the Clinton Administration's health care reform plan. System savings from successful cost control will help pay for extending insurance to the 37 million Americans who don't have it, for making sure that those who have it can't lose it, and for guaranteeing that every insurance plan includes a comprehensive benefit package.

Not surprisingly, critics from both the left and right are concentrating their fire power on the administration's cost control plan. The criticisms can be roughly divided into two camps. One is that the plan's cost control features won't work. The other, oddly enough, is that they will work too well and lead to massive disruption in the provider system and the rationing of care.

What is the administration's cost control plan? Although often ridiculed as being of, by, and for policy wonks, the basic strategy is quite simple. It has two lines of attack. The first is to promote competition among insurance plans under a cap on the average premium charged across all insurance plans in an area. The second is to limit the amount of money flowing into the system by capping the rate at which insurance premiums are allowed to increase.

Currently, state insurance regulation requires little more than that a company be financially solvent. The Clinton proposal requires insurance plans to meet stricter standards before they can be offered for sale. All plans must offer a comprehensive package of benefits, comparable to what many large group plans currently offer. A plan must be sold at the same premium to all comers, regardless of age, health history, or employment situation. Plans cannot cancel policies

or increase premiums selectively for people who turn out to be bad risks. Finally, once every year, people will have the option to switch plans during an open season.

Plans will be allowed to offer additional benefits and to differ in the range of provider choices and the amount of cost sharing. Plans that offer unlimited choice of provider and little cost sharing will charge higher-than-average premiums, some of which may not be tax deductible. Plans that limit choices, like closed-panel HMOs, or require extensive patient cost sharing will undoubtedly charge lower premiums. The Clinton proposal will not lead to a "one size fits all" health care system. Many people will have more choices than they do now, and no one will be locked into their current coverage.

According to the theory of managed competition, with the product standardized and insurance companies unable to compete by rejecting or avoiding high risks, competition will have to take the form of price competition. Insurance plans will attract customers and prosper by providing value for money.

In spite of the promise of managed competition, it largely remains a theory. To put teeth into it, the Clinton plan will impose a financial penalty on any insurance plan that tries to increase its premium more than the cap allows. There is little doubt that if faced with constrained revenues, insurance plans will limit their expenses. Each plan will decide the best way to do this, including constraining the overuse of services and limiting what they pay doctors, hospitals, and other health care providers. However, they will have every incentive to do it in a way that doesn't drive away subscribers. One critic characterized this approach as "getting the

insurance plans to do the government's dirty work." However, it seems far preferable that insurance companies that are responsible to their subscribers make these decisions than having the Federal government involved in detailed price negotiations and utilization review procedures with individual hospitals and physicians. As another critic put it, "That's like bombing from 30,000 feet. You can't see whom you kill."

The Administration's target for health care spending growth is 4 percent in the year 2000, roughly half the projected growth rate. Can this proposed target be attained by then, as the plan assumes? Will the system be able to respond to a rate of growth well below the historical trend?

In reality, the administration's cost containment goal is extremely modest, almost to a fault we believe. It estimates an annual savings of $136 billion after 5 years. That's a lot of money to anyone. But let's put it into perspective. CBO currently projects that health care will absorb 18.9% of GDP by the year 2000. The Clinton plan would bring that down to 17.3%. We currently spend 14.9% of GDP on health care while no other industrialized country spends more than 10%. Thus, the Clinton plan's "draconian" cost containment combination of more competition and caps on premium growth permits a more than 2% increase in the share of GDP going to health. This plan does not try to shrink health spending relative to where we are now. No health care jobs will be lost, though fewer new jobs may be added in the future.

How will the system respond to these constraints? The specter of sick patients being unable to receive care is completely farfetched. The U.S. health system is fraught with inefficiencies and excesses that have no measurable health benefits. The constraints on spending

growth will, for example, force more acceptable triaging that reduces the estimated 15-30 percent of diagnostic tests and surgeries that may be unnecessary. Private insurers will no longer be willing to pay providers prices that are 20-30 percent above Medicare, nor should they. Providers will be able to survive with lower prices for private patients, because universal coverage will mean an end to uncompensated care.

Studies of the present system have shown that hospital costs are 10-15 percent higher than they would be if all facilities produced services more efficiently, and this excludes savings that would accrue from not producing unnecessary services. Imposing financial pressure through caps on premiums means some hospitals will scale back their investments in buildings and equipment--that are often under utilized--and reorganize their staffs. In the longer-run, some services now provided by hospitals may be provided in less costly settings, while others will provided less often because their current rates of use are not cost-effective.

Our own current research suggests that hospitals respond to financial pressure by controlling costs without adverse consequences for patients. The 25% of hospitals with the lowest profits in 1987 experienced cost increases of 13.3% between 1987 and 1989 compared to an average of 27.6% for hospitals with the highest profits. Total revenues grew at virtually the same rate in both sets of hospitals, about 21% over the three years.

Patients will also need to change. They may need to accept some increases in waiting times for non-emergency care. They may also need to consider whether their current health plan, if it is high cost, is worth the extra money. If it is not, consumers will be put in the position of

choosing a different health plan that they do feel comfortable with. However, they will no longer fear losing their coverage if they become very sick or lose their job.

We agree with critics who argue that reducing administrative waste, controlling fraud and abuse, and eliminating defensive medicine do not represent strategies for changing incentives. These are, at best, one-time savings that do nothing to alter the underlying rate of growth. However, any short-term savings from these areas will be gravy on top of the savings generated from meaningful reforms of the system's incentives.

If the proposed caps on spending and the change in incentives they imply are to reduce the growth in health care costs, all participants in the health care system will have to change. Everyone needs to be willing to seek out the efficiencies that can be achieved. Fewer tests will be ordered that have limited diagnostic value and little effect on a patient's course of treatment. An unwillingness to move from the status quo in terms of how the system is organized or the volume of services that are produced, while at the same time expanding coverage, will lead to increases in spending. Nobody wants this.

How fast would spending growth begin to subside? If the speed with which hospitals have responded to Medicare's Prospective Payment System, other state-level rate-setting systems, and low profits is a guide, the answer is almost immediately. When providers are paid less, they move quickly to cut their expenses and organize service delivery more efficiently. When Medicare phased in its Prospective Payment System between 1982 and 1984, hospitals that faced the greatest potential financial loss held their expense growth to one-third that of hospitals facing

prospects of financial gain, 3.2% compared to 10.2%. Hospitals in California that faced strong competitive pressures as well as prospective losses from PPS actually cut their costs by 4.3 percent between 1983 and 1985. The annual increase in the volume of so-called "overpriced procedures" provided to Medicare beneficiaries by physicians fell from 9.3% in 1986-87 to 2.4% in 1988-89 in response to a 2.4% cut in average fees. Starting in 1996, the Clinton plan assumes spending growth approximately in line with GDP until the year 2000. If this is an achievable target--as most regulatory- and market-oriented reformers believe--and Congress acts within the next year, the system will have enough time to adjust.

The Clinton proposal aims to alter incentives by a combination of regulatory and market forces. Some critics would rather see much greater reliance on changes in the tax treatment of health insurance premiums as the way to change incentives. Despite its intellectual appeal to some, there is little evidence to show that this approach would succeed. On th eother hand, even though strict systems of regulated spending and price controls have good track records of controlling costs, they do not have widespread political support. Many people view such systems as administratively burdensome, inflexible, and likely to lead to explicit rationing. The Clinton proposal relies on competition among plans, but limits the amount of tax-subsidized dollars than can flow into the system and requires the development of a potentially regulatory framework for limiting total spending. This is a compromise. But, its acceptability and likely success may be greater than either pure alternative.