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The Clinton Plan: A Salute To American Pluralism
by Uwe E. Reinhardt

Abstract: The strength of President Bill Clinton’s health reform proposal lies in its commitment to universal, portable health insurance. To enhance the political appeal of his plan, however, the president has forged a compromise between two divergent ethical precepts: (1) that health care is a social good to be made available to all Americans, on equal terms, at a financial burden roughly proportional to a household’s income; and (2) that health care is a private good to be financed by households with premiums that may impose a much heavier financial burden on the poor than on the wealthy, even after public subsidies for the poor. The price of that compromise is enormous complexity, which is probably unavoidable in these United States.

As the U.S. Congress contemplated the nation’s moribund health insurance system during the 1980s, its members deplored in unison the absence of “presidential leadership.” If that be the excuse for congressional inaction in the past, that excuse is gone. There is now forceful presidential leadership in health policy, crystallized in the form of President Bill Clinton’s Health Security Act.

This essay examines the president’s plan through the prism of a policy “wonk” who was not part of the proposal’s creation. The natural tendency in such a review is to dwell upon perceived shortcomings, in the hope that constructive criticism might influence Capitol Hill. Unfortunately, such a critique runs the risk of conveying a largely negative message. Therefore, it is worth emphasizing at the outset that I salute Bill and Hillary Rodham Clinton’s great effort on our behalf.

It is hard to quibble with the general thrust of the Clinton proposal: to provide all Americans, rich and poor, with portable health insurance, and to do so without breaking the nation’s bank. Nor do I doubt the Clintons’ deep personal commitment to that goal. That commitment alone is a welcome change from the lethargic management of health policy during the 1980s, a decade whose achievement in this area could not have been more aptly summarized than it was by the Wall Street Journal headline of 28

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The decade of the 1980s, however, does hold at least two lessons for health reform today. First, it appears that regulation is a natural and bipartisan response of government to problems posed by the health care market. Second, the private sector has yet to demonstrate convincingly its ability to manage health care properly, without government’s help.

**Health policy in the 1980s.** In the late 1970s the battle cry of health policy was that government should get off the private sector’s back. Presidents Reagan and Bush sought to comply, but with a quite ironic mix of policies. President Reagan did leave the private sector more or less to its own devices, but he swiftly subjected hospitals serving patients under the federal Medicare program to a system of centrally administered prices. In the late 1980s the Bush administration imposed upon physicians serving Medicare patients a centrally administered fee schedule as well. For good measure, the Bush administration coupled the new fee schedule with an unprecedented demand for a global expenditure cap on Medicare, a cap that subsequently was enacted as the slightly amended volume performance standard (VPS). Finally, in his Comprehensive Health Reform Program announced 6 February 1992, President Bush called for pervasive new regulations on private insurers that would have altered the private insurance industry beyond recognition.

Although Congress was a cooperative and sometimes leading partner in all of these regulatory strictures, much of the initiative emerged directly from the Reagan and Bush administrations. No attempt was made by these Republican administrations to experiment with more market-oriented mechanisms for the Medicare program, as most certainly they could have. It is no small irony that these ostensibly market-oriented administrations, when challenged by our entrepreneurial health system, so quickly and so willingly lapsed into pricing policies resembling the centrally administered price systems favored in the former Soviet bloc.

Equally ironic, however, was the private sector’s response. Throughout the 1970s the leading payers in that sector—the insurance industry and the business community standing behind it—argued that they could control health spending better than the public sector could. As the Reagan and Bush administrations pushed down on Medicare’s regulatory throttles, however, these same private payers began to wail loudly over an alleged “cost shift” from the public to the private health sector, apparently forgetting their earlier braggadocio. This reaction raises two fundamental questions. If these private payers are as adept at cost control as they had claimed earlier, and claim to this day in this volume of Health Affairs, then why did they not display that prowess more forcefully when challenged by the
Medicare cost shift? On the other hand, if these private payers really were the helpless victims of the Medicare cost shift, can they ever be counted on to control their health spending without the guiding and sometimes constraining hand of government? More specifically, does not this open confession of impotence on the part of these private payers require that the by now bipartisan demand for budget caps on Medicare and Medicaid be accompanied by caps on private-sector spending as well? It is a question to which the private sector owes a coherent answer.

My objective is not to make sport of the private sector or to point a finger at Republicans, but to develop a sobering vantage point from which to behold the health reform proposals now before the nation, President Clinton’s among them. If we have learned anything from the 1980s, it is that regulation in health care is not easily eschewed. If a more satisfactory health system could have been constructed without resort to regulation, then more’s the pity that the devotees of such an approach failed to demonstrate it in the 1980s when they had the chance.

**Mandate for this paper.** President Clinton’s health reform proposal is far flung and commensurately complex. An illuminating exercise would be to have a dozen health policy experts write brief synopses of the plan just to compare what shines through each beholder’s prism. I forgo that tempting exercise and, instead, comment critically on a select number of the proposal’s facets. I target my remarks on the issues of coverage, financing health care, compensating providers, and, finally, a number of miscellaneous issues that invite at least some comments.

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**Coverage**

In health policy the word coverage has two major dimensions: (1) the set of goods and services whose provision is to be insured, and (2) the percentage of the population guaranteed insurance for that mandated benefit package. Given constrained future health care budgets, policymakers face a troublesome trade-off between these two dimensions of coverage.

**Benefit package.** The new social contract proposed by the president offers Americans a new opportunity, along with a new responsibility. The opportunity consists of guaranteed access to portable, comprehensive insurance coverage, regardless of a household’s health status and more or less regardless of its income. The responsibility lies in the mandate to acquire adequate health insurance coverage.

Just what is “adequate,” however, is a matter on which honorable persons could honorably disagree. One could make the case, for example, that the mandate should embrace only catastrophic coverage, because freeloading in health care occurs mainly for critical episodes of illness that entail high...
costs. To go beyond catastrophic coverage, the case for the mandate must be made more forcefully than it is in the president’s plan.

That case is made most easily in connection with children, say, up to age eighteen or even twenty-one. Children are not sovereign consumers. For most of their wants and needs they depend on the budgets, the managerial acumen, and the benevolence of their parents. A country that regularly deplores widespread parental neglect and abuse of children, as we do, ought not to depend solely on parents to provide adequate health care to their offspring. A safer approach would be, first, to endow every American child with his or her own portable, comprehensive health insurance policy-portable in the sense that it adheres to the child rather than to adults in the child’s household. Second, every child’s use of health services should be externally monitored and, if need be, managed by the state. The school system, for example, could be empowered to act in this matter *in loco parentis*. One could even make the case for efficiently delivering much of routine health care on school premises, permitting parents to opt out of that system only if they can demonstrate adequate alternative care.

Such a proposal is controversial in the United States, for it is at variance with the widely held view that children are in the nature of their parents’ private consumption good and, therefore, their parents’ moral and financial responsibility. The premise embedded in the proposal advanced here reflects the (more European and Canadian) philosophy that children are a precious national resource whose care is merely entrusted by the state to the agency of parents and for whom the state bears primary financial responsibility—certainly in health care. In many instances, of course, Americans too tend toward this view, albeit not consistently, and not in health care.

A mandate upon adults to procure comprehensive health insurance is less easily defended. One could think, however, of several cogent arguments. First, treating noncatastrophic care as a purely private consumption good may lead to the deferral of medical intervention to a point at which illness becomes either contagious or needlessly catastrophic and expensive, in which case it is loaded onto society once again. In this view, insurance coverage of routine health care is akin to an investment whose payoff is lower (socialized) costs for catastrophic care. Second, the very concept of managed competition among “accountable” health plans presupposes coverage for a fully comprehensive benefit package. Without comprehensive coverage, it would be difficult to hold health plans accountable for their members’ health status. Third, one could argue that Americans have demonstrated a preference for comprehensive health insurance, and that all but the poorest households probably would couple mandated catastrophic coverage with voluntary first-dollar coverage.

All of these arguments make valid points, but none of them is totally
compelling. One must expect, therefore, that the nature of the benefit package proposed by the president will become the subject of vigorous debate in the months ahead. The president’s political instinct appears to have dictated a rather broad benefit package at the outset to appeal to the middle class. But a good case can be made for a leaner benefit package up front, to free resources for a speedier move toward universal coverage.

**Universal coverage.** Many of the president’s critics chide him for rushing headlong into universal coverage by 1998, before having wrung out of our health system the enormous existing waste and abuse. These critics talk about phase-ins of up to a decade or more. Ironically, they tend to be well-situated Americans whose own excessive health insurance coverage causes the very waste and abuse they deplore.

I find it ethically more defensible to make the contrary case, namely, that the four-year phase-in called for by the president is longer than should be tolerated in a civilized society. Indeed, I wish that President Clinton had seized the excitement of the beginning of his presidency to announce in his State of the Union address that until Congress has sorted out the politics and technicalities of reforming our entire health system, all uninsured Americans would be swiftly folded into a newly created and temporary Part C of the Medicare program, on a mandatory basis. Financing for such a move could have come from several sources.

First, the uninsured themselves could have been mandated to pay a tolerable portion of their income toward their coverage. Since about one-third of the uninsured live in households with incomes in excess of 200 percent of the poverty line, that source of financing would have been nontrivial. Second, employer-paid health insurance premiums for employees with incomes above, say, $35,000 per year could have been declared taxable compensation. Taxes on this part of compensation could have been phased so that only employees with incomes above, say, $70,000 a year would have their entire premium added to taxable income. This provision would have stilled the unions’ tenacious objection to this inherently sensible policy. If that policy had been sold to Americans as a moral imperative, they might well have gone along with it. Can well-paid executives really claim to need the tax subsidy granted them now toward health insurance?

If, for political reasons, employer-paid fringe benefits must be treated as sacred cows never to be milked by the tax authorities, then an alternative might have been to include on the 1040 tax form a line labeled “Contribution for Indigent Health Care” or, better yet, “Membership in the Club of Civilized Nations.” On that line one could have levied a small tax of, say, 1 percent of taxable income toward this worthwhile cause. Polls suggest that the nation’s better-off might well go along with such a tax, if it were clearly earmarked for this purpose.
Finally, of course, one could add to the pot sundry sin taxes, and not only on tobacco products (on which such taxes actually are not easily defensible). For instance, alcoholic beverages’ spillover cost to society is arguably much higher than that of tobacco. It is disturbing that political pressure appears to have steered President Clinton away from that potentially rich tax lode in his plan. Congress ought to reconsider it.

It is possible that Congress would have shot down any proposal for a speedier move toward universal coverage. But it would have been useful at least to try, if only to tally naysayers by name. Had it passed, which it might have, we then would have the luxury as a nation to contemplate the much trickier reform of the entire health system at our leisure, without holding America’s hard-pressed, low-income, uninsured families hostage to endless arguments over our ability to hold national health spending to “only” 17 percent by the year 2000. It is an option for which it is not yet too late.

### Financing Health Care

Exhibit 1 presents the distribution of household income in the United States in 1990. Close to 18 percent of American households had an annual

<table>
<thead>
<tr>
<th>More than $100,000</th>
<th>5.4%</th>
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<tr>
<td>$75,000–$99,999</td>
<td>6.9%</td>
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<tr>
<td>$50,000–$74,999</td>
<td>18.2%</td>
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<tr>
<td>$35,000–$49,999</td>
<td>20.1%</td>
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<td>$25,000–$34,999</td>
<td>16.2%</td>
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<tr>
<td>$15,000–$24,999</td>
<td>16.4%</td>
</tr>
<tr>
<td>$10,000–$14,999</td>
<td>7.5%</td>
</tr>
<tr>
<td>$5,000–$9,999</td>
<td>5.8%</td>
</tr>
<tr>
<td>Less than $5,000</td>
<td>3.6%</td>
</tr>
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Note: 50.6 percent of American families have income of $35,000 or more; 49.4 percent have income of less than $35,000.
income of less than $15,000, and almost one-third earned less than $25,000 per year. A reasonably comprehensive health insurance policy for such a family might cost anywhere from $4,000 to $5,000. It follows that if all American families are to have comprehensive health insurance, there must be a major redistribution of purchasing power from the upper half of the American income array to, say, the lower one-third.

Economists advocate that policymakers be absolutely candid with the electorate about the distributive impact of proposed social legislation. Furthermore, economists as professionals must pretend to accept as “proper” whatever verdict a fully informed electorate then renders on that legislation. On these ethical precepts, most economists (this author included) tend to favor a mandate on the individual household to procure adequate health insurance and measures to supplement low-income households with direct subsidies for which government can be held accountable. This approach reveals more clearly than any other the true cost incidence of universal health insurance coverage.

The $64,000 question, however, is whether the American public is willing to let its politicians come so clean on this particular facet of health reform, or whether it prefers to have the redistribution obscured through more roundabout means of financing. Embedded in that query is the further question of whether some social goals—such as universal health insurance coverage—are not sufficiently overarching to justify some deviation from other goals, among them utter candor about ultimate cost incidence. Even economists are not of one mind on this thorny question, for it touches on deeply held ideology.

The president proposes to funnel the financial lifeblood for health care through a novel administrative infrastructure. At the center of the new system stands a large, state-chartered brokerage agency known as a health alliance. This brokerage somehow pumps money from private households into its own insurance fund. The alliance then distributes that fund to providers through a mechanism known as “managed competition” or, more aptly, as “regulated competition.” In the remainder of this section I focus strictly on the “cash-intake” facet. I then turn to the “cash-output” facet. As I have argued in an earlier volume of this journal, these two facets are quite independent of one another and should be so treated.6

**Employer mandate.** All monies going into a health insurance fund ultimately must originate from the purses of private households. Government participates in this flow of funds only as an intermediary pumping station, by taxing households and conveying the money into the insurance fund. Employers who purchase health insurance for their employees also act as pumping stations, for they replenish their coffers either by cutting their employees’ take-home pay or by raising prices for their clients, or both.7
Finally, households may put money into the insurance fund directly by purchasing insurance themselves.

Although the president’s plan activates all three methods of funneling money from households into the alliance’s insurance fund, the chief pumping stations are to be employers. The individual mandate—the default system in this scheme—would be used by households headed by non-working adults. For the poorest among these, the government would act as a pumping station, supplementing whatever funds are gathered through the individual mandate. This system is rather complex by international standards. One should remember, however, that it is much less bewildering and much more reliable than the haphazard, brittle patchwork of capillaries through which American health care currently is financed.

The president’s approach to health care financing offers several advantages, most of them administrative or political. First, relative to an individual mandate, an employer mandate is likely to enhance the degree of compliance with universal coverage. Second, the president can justly claim to be building upon an American tradition, the existing system of employment-based health insurance. Third, the employer mandate will reduce the payroll costs of those firms that now insure their employees, since they in effect now pay for the care of uninsured Americans through higher health insurance premiums. Economic theory suggests that the employer mandate should increase employment in such firms, as a result of the reduced payroll costs. Finally, no one knows who ultimately pays how much for an employee benefit mandated on employers. Therein, one suspects, lies a major political attraction of employer mandates, and of corporate taxation in general, but therein also lies a major time bomb.

The requirement that employers pay at least 80 percent of the weighted average premium bid received by an alliance from the competing health plans makes universal health insurance look artificially inexpensive to the average employed American. It perpetuates the harmful myth that someone else—namely, “the company”—pays for the bulk of health care. It also obscures from view the fact that financing human services through mandates on employers tends to be regressive in the ultimate incidence of the associated costs. Unfortunately, the Clinton plan is no exception.

Both standard economic theory and empirical research suggest that the bulk (probably as much as 80 percent) of employer-mandated benefits tend to be shifted back to the employee in the form of lower take-home pay. Union leaders have long appreciated this fact, although the rank and file probably have not. A case can be made for letting the rank and file in on that secret. Germany, for example, officially splits the payroll-based health insurance premium fifty-fifty between employer and employee.

Second, the employer mandate almost surely will have a negative impact
on employment among those firms that do not now offer their employees health insurance—particularly in low-wage firms subject to minimum wage constraints. Just how severe that impact may be, however, is a matter of wide disagreement, even among economists. It can be shown with appeal to standard economic theory that the wage and employment effects of a mandate are not independent of one another but are inversely related.

Broadly speaking, the more wage sensitivity one posits for the demand for and supply of labor in a particular industry, the larger will be the predicted reduction in employment triggered by the employer mandate and the smaller will be the predicted reduction in the take-home pay of those who remain employed. Wage sensitivity in the demand for labor, in turn, depends on the market for a firm’s products and on the technology of producing them. Other things being equal, the more price-sensitive the market demand for the product sold by the firm, the more wage-sensitive the firm’s demand for the type of labor that produces that product will be. Furthermore, the easier it is to substitute capital equipment for labor in the production of the firm’s product, the more wage-sensitive its demand for that type of labor will be. Finally, on the supply side, the more readily the labor employed by an industry can find employment or other desirable activities elsewhere, the more wage-sensitive the supply of that type of labor to a particular industry will be.

The existing empirical literature offers a wide range of the relevant wage elasticities, which permits analysts considerable latitude in estimating the employment and wage effects of the employer mandate. This in turn permits economic analysis to be driven by the analyst’s own ideological predilection, or by that of the client for whom the analysis is produced. Economists who seek to demonstrate a large negative employment effect tend to draw on literature pointing to a high wage sensitivity. Economists seeking to minimize the employment effect draw their inspiration from the lower end of estimated wage sensitivities.

In a recent, thorough review of the issue, economist Alan Krueger concluded that the supply of labor is relatively insensitive to the wage rate. This implies that job loss triggered by the employer mandate would be relatively modest and that the financial burden of the mandate would be shifted primarily to the employees—themselves. In an earlier review of the matter, the Congressional Budget Office (CBO) also concluded that the cost of the mandate will be shifted primarily to workers.

The cost per employee of an employer mandate is independent of the employee’s wage. If the cost of the mandate is shifted substantially back to the employee, then this form of financing becomes highly regressive. To mitigate this regressivity and any negative employment effect, the president proposes to limit a firm’s outlays on premiums for firms with seventy-five or
fewer employees by a progressive step function that starts at 3.5 percent of total payroll for the smallest firms with the lowest average wages and rises to 7.9 percent of payroll for firms with an average wage of $24,000 per full-time-equivalent (FTE) employee. No firm in the regional alliance, regardless of size, is to pay premiums in excess of 7.9 percent of payroll.

While I would not quarrel with the underlying motive for these caps, the nature of this provision strikes me as needlessly complex and potentially inequitable. First, it is not clear why the size of the firm should be made a relevant parameter at all in the step function. Would not fairness dictate that assistance be offered to low-wage firms of any size? Second, the caps on contributions are pegged to the firm’s total payroll, rather than to the wages of the individual employee. Therefore, the policy creates the unintended incentive to split companies into high-wage and low-wage components, to minimize the entities’ total outlay for health care. To avoid these unintended distortions and to simplify the provision, Congress should insist on pegging the caps to the individual worker’s wage, as is customary in other countries using payroll-based health care financing (such as Germany).

Finally, policymakers should remember that the economic damage an employer mandate might visit upon segments of the economy not only stems from the monetary contributions extracted at the payroll, but also consists of the administrative hassle to the nation’s entrepreneurs. The mandate should be expressed so that it cannot easily be gamed and can easily be obeyed, without the help of high-price consultants.

Is the employer mandate a tax? Suppose one accepts the president’s complicated employer mandate as the only politically feasible means of financing universal health care in the United States at this time, and suppose one shares the economist’s conviction that in the long run, the cost of the mandate will be shifted mainly to employees. Would it then be proper to call that mandate a bona fide income or payroll tax?

I would take a bona fide tax to be a payment made to a government without an identifiable, personalized benefit in return. The employer mandate does not quite fit this definition, for in return for a loss in take-home pay, the employee would receive a clearly identifiable, personalized benefit, namely, comprehensive health insurance coverage for that employee’s own family. Thus, if one wishes to oppose the employer mandate, one should do so with appeal to reasons other than the dreaded T-word. More legitimate reasons are enumerated above. On the other hand, if one insists on labeling the employer mandate a tax, then that label must be extended also to the individual mandate proposed in the Chafee-Thomas bill and, indeed, to any government-mandated purchase, such as seat belts and vaccinations. In my view, that broad application would be a debasement of the word tax.

Tax treatment of premiums. The tax treatment of premiums is at
variance with the purist’s conception of managed competition. In the
president’s proposal, every extra dollar an employee spends on even very
expensive health plans comes out of pretax income, while rebates earned by
selecting plans costing less than those offered by an employer are treated as
taxable income. That asymmetry is curious. If consumers are to be steered
toward low-cost plans, then the cost of their more expensive choices should
come substantially out of after-tax income. If health insurance premiums
are to come out of pretax income at all, then that tax preference should be
confined to the average premium bid by the competing plans in the health
alliance.

This is the purist’s case. Frankly, although I am a card-carrying econo-
mist, I have always wondered whether the average American consumer’s
choice of a health plan really would be driven by such small tax differentials. Unfortunately, there is little hard empirical evidence on how changes
in the tax code or tax differentials of any sort affect the choice of health
insurance.

Whatever the case may be, there remains the curious fact of a remarkably
tenacious political resistance to the economist’s bright ideas on this point.
Actually, the case for exempting any form of employer-paid fringe benefits
from taxable income is extremely weak-on both economic and ethical
grounds-particularly when the benefit is mandated and no one needs to be
enticed through tax preferences to partake of these benefits. At progressive
marginal tax rates, that tax preference heaps most of the tax dollars saved
onto the upper reaches of the income distribution. It puzzles economists
that union leaders have always defended that distribution of economic
privilege, but that is, of course, these leaders’ privilege in our democracy.

Paying Providers

The president’s proposal seeks to combine two distinct forms of compen-
sating the providers of health care: regulated piece-rate compensation and
regulated capitation. This is achieved by permitting health plans that pay
providers by budgets, diagnosis-related groups (DRGs), salaries, or capita-
tion payments to compete head-on with plans that compensate providers
by the traditional fee-for-service mode, albeit at common fee schedules.
The entire process, however, is to be subjected to powerful regulation from
the top. Regulation of this sort always rings alarm bells among economists
and politicians. One wonders whether much of that regulation could not be
deferred, until the case for it becomes more compelling. It might not.

The problem of global budget caps. President Clinton would subject
the competitive process among the health plans to a global budget cap
imposed by the federal government on the health alliance with a view of
constraining total national health spending on a desired growth path. Over time, the successive application of such premium caps could convert a system of managed competition among essentially commercial health plans into something resembling a rate-regulated public utility. That much should be acknowledged at the outset.

Pragmatic considerations aside, it might have been better not to burden the health reform freight train with this particular load, for a number of reasons. For one, the proposal sets in concrete the premiums of competing health plans as of 1996. It seeks to punish those plans with higher subsequent growth rates in their premiums. That approach may inadvertently punish lean and efficient plans with a low absolute initial premium but a relatively high growth rate, and it may leave unscathed relatively fat and inefficient high-cost plans that can afford to come in under the wire with premium growth just below the alliance’s target. The arguments and the litigation around such an outcome could quickly degenerate into an administrative nightmare.

The system of budget caps proposed by the president also assumes that the alliance will be able to adjust the various plans’ premiums correctly for differential growth in the plans’ actuarial risk. If not, a plan may be subjected to a punitive assessment simply because it was the host for relatively sicker new enrollees. Until appropriate risk adjusters exist, if they ever will, it would be best not to impose upon the competing health plans the punitive assessments now proposed in the Clinton plan.

The problem of risk adjustment also would arise if the punitive assessments were put on plans with relatively high absolute premium levels (rather than relatively high growth rates). Furthermore, that approach might trigger a dynamic in which an externally set ceiling on health insurance premiums becomes a floor in the minds of the bidding plans. Unless consumers show themselves extremely price-sensitive in their choice of health plan, a plan’s manager may find it hard to convince his or her board why they should price below the government-sanctioned ceiling.

Finally, there is the possibility that too tight a cap might make it difficult for health plans to accumulate capital and to innovate. As the Medicaid program has amply demonstrated, there is always the danger that such a cap may not be used responsibly by government. The budget may be set below the level that would be desired by the general public were it properly informed of the opportunity cost of the budget ceiling.

The budget caps are a red flag in the current debate on health policy. What, one may ask, makes them so compelling? Probably the chief reason is that the president must get his plan past that “mother of all tollgates,” the skeptical and highly independent analysts of the CBO. If the CBO is to be persuaded that we can reach universal coverage without new broad-based
taxes, it must be convinced that the Medicare and Medicaid budgets can be very tightly constrained without triggering the usual laments over the cost shift among private payers. That perennial gnashing of teeth among private payers must have left an indelible mark on the president’s mind. It entitles him to think that without the help of external budget caps, the private sector will never get its act together on cost containment, will continue to shed bitter tears before Congress, and will frighten Congress into backing off of the proposed constraints on the Medicare/Medicaid budgets.

If these private payers have become reborn cost containers in the meantime—as recent data suggest—then now would be a good time to convince the president and the CBO of that reformation along with a promise, however, henceforth to abstain from whining over the fiscal fallout from the Medicare/Medicaid budgets. Perhaps, like President Reagan, President Clinton then would be content to impose strict budgetary discipline on the public-sector health programs under his purview, leaving the private sector to cope with the fiscal fallout from his policies as best it can. I would deem that a preferred strategy, for starters. But the ball in this game is in the court of the private payers. How will they testify before Congress on the proposed Medicare and Medicaid budgets in the months ahead? Will they whine, as is their usual wont, or will they support the president’s budget “cuts” (really, “somewhat more constrained budget increases”)?

Controls on fees. Under the president’s plan, each health alliance would negotiate fee schedules with providers for the fee-for-service plans on its menu. These fee schedules would be binding on the individual provider, as such schedules usually are in most other countries using fee-for-service compensation. In effect, in its fee-for-service component (which may remain quite large) the health sector would become an “all-payer” system.

An alternative to this swift imposition of outright price control would have been merely to mandate better price transparency, at least in the early stages of health reform. For example, one could mandate all physicians to use Medicare’s resource-based relative value scale (RBRVS) and all hospitals to write their bills on the relative value scale implicit in Medicare’s DRGs, but allow each provider to announce, for non-Medicare patients, its own monetary conversion factor for these schedules. The federal government or its local agent in these matters, the health alliance, then could stipulate that to have its premium fully tax-deductible, a fee-for-service plan may not pay providers at a conversion factor in excess of $X (set with an eye to meeting whatever budget caps there may be on premiums). Providers, however, could bill their private patients at a higher conversion factor, as long as all of their patients were billed the same factor and that factor was made known to the patient ahead of treatment. Price discrimination among patients would not be permitted, because that could be an
endless source of mischief. Any extra-billing in excess of the conversion factor $X$, of course, ought not to be a tax-deductible medical expense.

Other variants of this relatively more market-oriented approach might be tried as well. In any event, it is not clear to me why an immediate move to single fee schedules is necessary now.

**Miscellaneous Points**

The president's proposal is extensive and rich in detail. Within a single paper, one's commentary on the entire plan must necessarily remain rather superficial. With that disclaimer, I comment briefly on a few other issues raised in or by the plan.

**Potential for a tiered health system.** Over time, managed competition would permit the emergence of multiple tiers, especially if the public subsidies to low-income households were capped or otherwise constrained through the political process. Some may view this as a shortcoming, as it violates truly egalitarian precepts. It is my impression, however, that in the United States tiering by income may be an advantage. As I have argued on other occasions, opposition to universal health insurance in this country could be explained by the fear among the moneyed elite that it would have to finance for the poor the same luxurious and expensive health care that this elite wishes to secure for itself. A system that grants the elite what it wishes but limits its obligation to the poor may be just what the doctor ordered. In the eyes of an economist it would be proper to debate this issue openly. But that may be politically naive.

**Early retirees.** The president would permit early retirees ages fifty-five to sixty-five to procure coverage through the health alliance at highly subsidized rates. Although the section of the Health Security Act that deals with this matter is cryptic and under review, one gains the impression that these retirees would pay into the alliance only 20 percent of the community-rated weighted average premium, although the cost of coverage may be much in excess of the community rate. The remainder of the cost of caring for these early retirees presumably would be loaded onto the average premiums collected from employers and other individuals paying premiums into the alliance. Companies that had promised early retirees comprehensive insurance coverage apparently would be able to buy out of that obligation by contributing to the alliance only the retirees’ 20 percent share.

Whatever the particulars of this provision were meant to be-and turn out to be in the final draft, their intent seems clear: to give substantial economic relief to the early retirees themselves, as well as to the shareholders of their current and former companies, at the expense of other members of the health alliances. Among the latter will be low-income workers and...
near-poor mothers and their children who had hitherto been fully covered by special Medicaid programs but henceforth will have to make some out-of-pocket contribution for their health insurance coverage. The provision may make perfect political sense; it is tailor-made to appease big business, whose support for the plan may be sorely needed in the months ahead. Fair enough. But one is nevertheless entitled to question the provision on both economic and moral grounds.

On economic grounds, one may ask whether this nation really wishes to provide added economic incentives for early retirement. The argument that new jobs thus will be created for younger people is too specious to warrant further comment. On moral grounds, one may question the regressive nature of the income redistribution implied by the measure. The provision redistributes income from hard-working Main Street America to the shareholders of giant corporations whose management had earlier paid labor with “funny money,” that is, with promised retiree health benefits that were neither booked as a current payroll expense nor recorded as a future liability, let alone properly funded. Limitation of space does not permit elaboration on this point. Suffice it to recommend that the firms that engaged in this scam should be made to contribute to the regional health alliance the full actuarial cost of the benefits promised any early retiree. The magnitude of the liability now must be reported under the mandatory candor imposed upon corporate America by Financial Accounting Standards Board (FASB) Brief 106. It is, therefore, easy to identify.

The president’s cost estimates. Exhibit 2 speaks to the cost estimates in the president’s proposal. The bottom line represents the path health spending would take in the 1990s, if it followed the traditional growth path of gross domestic product (GDP) growth plus three percentage points. The upper curve depicts the most recent baseline forecast by the CBO. It implies a growth rate of GDP plus 4.25 percentage points. Finally, the president’s proposed trajectory ends up with health spending at 16.9 percent of GDP by the year 2000. That ratio is far higher than what any other industrialized nation would be likely to tolerate.

It is a remarkable comment on our health system—and on our political system as well—that this rather modest program of cost containment is decried as sheer fantasy. One wonders whether the heated debate over these cost estimates is not once again our time-worn habit of deflecting the debate from the vexing moral issues before us to more neutral ground. We ought to debate whether a civilized society can sit by idly while working mothers are left the task of raising their offspring without the financial protection of health insurance. We choose to debate instead variables on whose numerical values seven years hence we can all honorably disagree. I rate it a rather sad commentary on late-twentieth-century America.
Exhibit 2
National Health spending Under Three Scenarios, 1990-2005

<table>
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<th>Billions of dollars</th>
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</table>

Sources: Estimates from the draft Clinton plan (September 1993); and Congressional Budget Office estimates.

Note: Following the traditional baseline, health spending is at 16.2 percent of gross domestic product (GDP) by the year 2000. Following the president’s plan, health spending is 16.9 percent of GDP by 2000. Following the Congressional Budget Office (CBO) baseline, health spending is 18.2 percent of GDP by 2000.

To be sure, the president’s plan has needlessly frightened the public by suggesting that the growth in health spending is to be permanently equated to the growth in GDP. That is surely not the Clintons’ intention. A differential growth of 1 to 1.5 percent above GDP probably would be sustainable for at least several decades into the twenty-first century. But to get to that lower growth path, it seems perfectly plausible to have a transition period during which the differential would be zero or even slightly negative. If the health sector were given ample warning—three years is ample warning—then such a plan is not unrealistic. One can quibble over the particular methods by which such a descent is being sought and suggest alternatives, but one can hardly take issue with the still quite generous end point: 17 percent of GDP.

Concluding Remarks

The president’s proposal is not a clean, simple design tailored to a single dominant philosophy as are, for example, the Canadian and German health systems. True to American tradition, it is a complex compromise that has been bent and twisted onto the Procrustean bed of a pluralistic set of ethical precepts and of an equally pluralistic set of narrow economic interests pursued by politically powerful groups.

The great strength of the plan lies in its unwavering commitment to universal portable insurance coverage for comprehensive health benefits. It is easy to pay facile lip service to that goal, and many an insincere legislative
proposal has. President Clinton’s proposal leaves no doubt that universal coverage would be achieved, probably by the target date.

The plan also conveys, however, the painful image of a well-meaning president and First Lady who would very much love to see well-to-do Americans be their poor brethren’s and sisters’ keepers in matters of health care and who would prefer to come clean on the distributive impact of that scheme but who are convinced that the well-to-do will balk at the very thought of redistributing downward along the income scale. The result is a blend of an individual mandate and an employer mandate, each shored up with a complex mixture of subsidies and taxes that might become a bureaucratic nightmare. I rate that complexity the plan’s major shortcoming.

Managed competition arguably will give this nation health care of the highest clinical quality and with the greatest amenities available in the world. But the price of that achievement will be a health system in perpetual motion, most probably foisting more information, more choice, and more change upon the average American patient and physician than either will appreciate. The more pastoral systems of Canada and Germany may lack this dynamism and also our exuberant drive toward external quality monitoring. But chances are that the average American actually would be more satisfied with such a system.

I am reasonably certain of this assessment, but I do not think it matters in thinking about American health policy. No health reform plan passed by the U.S. Congress will ever be simpler than Congress’s ironically titled Tax Simplification Act of 1986, which few Americans could understand, even if they tried. The Clinton health plan merely recognizes this fact preemptively. After all, everyone seems to agree that simpler and philosophically cleaner versions of health reform that can achieve universal coverage would be dead on arrival on Capitol Hill. President Clinton’s plan, tempered somewhat by constructive Republicans, is probably the best deal around at this time. We should take it while the taking is good,
NOTES

1. I am speaking here of diagnosis-related group (DRG) prices Medicare imposed upon the hospital sector as early as 1983, of the series of price freezes imposed on physicians throughout the 1980s, and of the establishment of the Medicare physician fee schedule toward the end of the decade.

2. For example, one could have constructed a relative value scale from the DRGs now used for hospital compensation. Individual hospitals could have been invited to bid their own conversion factor for that schedule. The elderly then could have been offered a choice of 100 percent coverage at hospitals whose conversion factor fell within a certain threshold, but only partial or no coverage for any excess billing above that threshold. One could have engaged a similar mechanism for physicians.

3. It is one of this nation’s charms that immigrants need not shed their earlier philosophies.


5. Because smokers have significantly shorter life expectancy, the present value of their lifecycle expenditures on health care is, on average, lower than those of nonsmokers.


7. In a competitive global economy, the idea that much of the money could come from the owners of private enterprise can be dismissed.


10. Ibid. Krueger estimates the probable job loss from the employer mandate at between 200,000 to 500,000 jobs (out of a total civilian labor force of 120 million), with higher likelihoods at the lower end of this range.


12. Even after these “cuts,” the president proposes to let the Medicare budget increase from $128 billion in 1993 to $208 billion only seven years later.


14. By their deceptive tactic on retiree health benefits, the auto companies had stealthily promised away substantially all of the owners’ net worth that these owners were told by management to be theirs.

15. A useful exercise in this connection would be to reread The President’s Comprehensive Health Reform Program presented by former President Bush to the nation 6 February 1992. That plan endorsed the notion of universal coverage but offered only halting, incremental steps toward that goal.