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The Clinton Plan will push premiums up to allow for the fact that "Americans lack security." (D 3) It is true that 3.5 million workers a month have lost their jobs since the inauguration. And 2 million lost their health insurance. The President has said little about job loss; but has labeled "Health Care...the chief cause of insecurity of families." (8/28) Perhaps because most workers found work within a month. But 95% were again covered by health insurance within a month or so as they found jobs. (9/23)

Clinton's 7 appointees to the National Health Board will limit benefits. But thru obscure tactics. They will limit money for drugs, wage increases for nurses, and shorten hospital stays, etc. They will do so limiting premiums thru "utilization protocols," and "class factors" they themselves improvise. (Secs. 1412, 1502) The Act does not specify the "comprehensive health benefits." These are airily left for the Health Board to define, and (over time) narrow, revise, cancel.

If Congress agrees that health security is the number one problem it need only require today's insurance plans to cover employee families regardless of medical status, or history.

As the President told Congress: there is no "free ride. We have to pay for it. We have to pay for it." Americans may be ready to pay more--lest future illness lock them into a job, or out of one. If so, Congress could amend existing policies long before it ends debate on the Act's 1,342 pages of intricate arrangements.
The Clinton Plan, therefore, hands that health insurance nettle, and many others, to the 50 governors. (They are given the miserable task of choosing which voters go into more costly Regional Health Alliances, and which, into less costly ones. They will also be ultimately blamed for deciding how long patients can stay in the hospital; which new drugs are denied patients; etc.

Thus the Governors will be on camera, not the Oval Office, when reporters ask why Medicaid spending was cut from $4,600 to $2,000 per person—as the Clinton Health Security Plan requires.

3. Health Care Rebates—to American workers

It is time to reduce the government's contribution to higher costs. We tax the dollars used to pay medical bills—directly. And consumers watch those dollars with care. But the IRS does not tax wages that pay medical bills through employer insurance. Such bills, in consequence, are run up less carefully. This tax exemption is a heritage of World War II wage stabilization.

By now it is political hard rock. But that is no reason why Congress should not give workers back some of the money they give to the insurance companies.

Kenneth Arrow, Nobel prize winning economist, has noted that "Insurance against health expenditures creates an incentive to spend more freely than is desirable." Walter Zelman, who helped put together and defend the White House Plan, writes: "After
Congress could specify that part of the year's rebate be paid in cash. Doing so would offer the family immediate and tangible evidence of their wisdom in keeping down their medical spending. The rest would go into an IRA medical account, which earned interest, and was payable on retirement. Neither payment would be taxable. Paperwork? Insurance companies already record every dollar spent, and would do so under the Clinton Alliance scheme. They need only send the worker, and the Treasury, a one line form once a year. (Much like the W-2 already sent for wages.)

Under the Clinton plan, as now, families who restrain their medical spending would continue to hand that saving over to the insurance company. Congress could return it to them, through rebates. Doing so would moderate the increase in health spending. Congress can act promptly, without getting enmeshed in the Clinton plan.

4. WILL CONGRESS REPENT: Section 1886?

Years of Washington health legislation have understandably pushed up medical costs. The forces that did so will remain untouched by the Alliance/Health Board structure of the Clinton Plan.

HHS recently reported that "laparoscopic" surgery for gall bladders etc., reduced patient hospital stays by 40%. And cut the "average charge" by 25%. It saved about $228 million in 80,000 Medicare operations last year.

Did the Government's health planners treat that to be great financial news? Pursuant to Congressional mandate, Medicare
thousands of state Alliances, plus a Health Board to entangle
them in mandates, the Clinton Plan will not change these factors.
Revising Section 1886 (d) (4) (C) (iii) would help.

5. SQUEEZING HEALTH CARE TO INCREASE EXPORTS?

A

The Plan will cancel all health insurance policies and
regulate all medical care. Why? To make sure we spend a
sensible 17.3% of our income for health, not an unreasonable 19%.
(D, Appendix) As the President has stated:

"If we don't change this (medical system) we're going to
go from 14 to 19 percent of our income going to health care
by the end of the decade. It is going to be very difficult
for us to compete and win in a global economy with that sort
of differential." "It is the chief threat to business

Health Planners can apparently distinguish between a
percentage that threatens business growth, and another--2%
smaller--that does not. To achieve their 17.3% goal they will
squeeze the number of specialists in heart disease and cancer--
diseases which together kill over 1 million Americans a year.
They will "redistribute the balance between residency slots" for
primary care and specialist MD's. (HS 68) They do not want to
increase the number of physicians in order to treat 37 million
who are now uninsured. Because doing so would increase medical
spending, not reduce it. And they propose a further $114 billion
cut in the funds Medicaid is scheduled to spend on the poor.
But liberals have long relied on the income tax, which redistributes money from the rich. The Plan makes workers alone subsidize health care for millions of the poor. (Thru an obscure "family collection shortfall add-on" in Secs 6107, 6104). Payroll taxation may be approved by Nixon. But perhaps a stronger reason for adopting it is that it frees the President from having to ask Congress to raise the income tax to finance "health security."

Clinton's Health Security report describes how an "average-price benefits package" is paid for by seven families. The Sands earn "almost $90,000 a year," will pay no more than the Rutherfords with their "income of $21,200." For the Clinton payroll tax does not tax income from capital. Nor does it tax "upper income people" more, unless they are old.

B

The sting is not taken away because "employers pay 80% of the cost." When workers get more in insurance premiums they get less in cash. Moreover, employers only pay 80% as grocers "pay 100%" when they hand their customers' money over for sales taxes. The 80% comes not from profits, but from what the worker produces. (In boom times cartels can hope to pass some costs along to workers in other firms (i.e. consumers) by raising prices. But today they have few opportunities. And imports already compete, via lower prices, as the NAFTA debate reminds us.) Employees receive few gifts from their employers. If they get more in insurance premiums they get less in cash—and vice versa.
Premiums charged by Alliances must differ from area to area. For health risks differ, and salaries of nurses, kitchen workers, etc.

Suppose Utah's abstemious Mormons were forced into a high cost "Regional" Alliance with Nevada's two pack-a-day lung cancers, cirrhoses of the liver, and AIDS cases? (Nevada's death rate is 45% greater than Utah's.) Even good church going voters would revolt.

Governors will find it a thorny task to define "regions," even within their states. Yet the Plan requires them to specify the area each Alliance will cover. And thereby decide which voters pay more for health insurance, which will pay less. But upstate New York may object to subsidizing downstate. (Over 90% of the State's AIDS cases appear in one down state city.) Staten Island may even object to subsidizing the Bronx. Nor does the rift between East and West Texas, or North and South California, give governors an easy political solution.

But suppose all Governors are as astute as Ann Richards or Mario Cuomo. They could minimize such problems by setting up one Alliance for every county. True, three thousand additional insurance bureaucracies hardly simplify health delivery, even when called Alliances. Nor will the 3,000 cut health costs, unless their directors and employees work for free. But why should the governors take the political heat more heroically than their betters by setting up only a few Alliances to save costs?

Yet the Governor's problems only begin with the Plan's geography lesson. For they must "ensure that every Alliance has
(4) How would Governors even solve the easiest problem handed them by the Clinton Plan? How will they "ensure"—an elegant, if ominous, verb—that Christian Scientists and Jehovah's Witnesses join an Alliance? Some politicians might give the back of their hand to Civil Liberties protests. But what then? Send out the State Troopers? Tell the Attorney General to sue bikers claiming exemption as Scientologists? Planners can ignore such questions. What Governor would?

George Washington's warning against entangling foreign alliances may apply to entangling domestic Alliances as well.

8. CUTTING WASTE AND INEFFICIENCY

Planners differ from the way other Americans define "the waste, inefficiency...that bloats our system." Clinton's cuts in Federal spending this year give the most direct clue as to where the Administration has found obvious waste and inefficiency.

1. MEDICAID. Poor mothers and children will have their Medicaid health care cut. Those "eligible" for a Clinton Alliance can expect $121 billion less during 1994-2000. (D: App) Those who remain on Medicaid will get less than half the $4,600 a year now spent for them. The President's Report to the American People describes what an "average-price (comprehensive) benefits package" would cost seven families. That cost is less than half the present Medicaid level for six families. It is also far less for the seventh.

2. MEDICARE. The Plan will cut $124 billion by its "cap" on physician and hospital services, but add $72 billion in "drug benefit." That $72 billion in drugs would surely improve health.
American's "comprehensive package of health benefits." Which areas of waste, or excessive generosity, account for that difference? Until the Administration explains its cuts in Medicaid and Medicare will appear oriented to deficit reduction rather than to improving health.

9. HEALTH CARE WHOLESALE: BARGAINS FROM ALLIANCES

To cut medical costs by 3%, or even 5%, is it worth ending all health insurance contracts; reducing the specialists in complicated diseases; forcing vast change in the way we see doctors and get medical care?

The Clinton planners promise to save billions by "consolidated purchasing power." But an extensive record exists for how both the Federal government and private industry "buy health care wholesale." And that record promises few bargains.

A. Giant hospital chains have bought in wholesale quantities for years. (Hospital Corporation of America, Humana, etc.) How much did they save? These corporations surely sought maximum profits. To do so they paid the lowest prices they could wring out for drugs and bandages, and the lowest wages that could get quality nurses, orderlies etc. They then transferred the savings to the profit account.

How great was their net income over the past decade? About 6% of "total sales" for the group. Enormous "consolidated purchasing power" had cut their costs less than 6%. (Their investors cared about profits per dollar invested not per dollar of sales.) Hence their savings from "delivering care efficiently" came to 6% of the bills patients paid, or less.
10. What's in the Package?

The National Health (Cutting) Board

What's in the "comprehensive package of health benefits?"
The President decided to answer that question in "a magic
moment," as he termed it, by appointing seven wise men and/or
women.

For they will "determine...total payments for items and
services included in the comprehensive package." Benefits the
Board considers "not...payable" thus become so much pie in the
sky, even if they had been negotiated by the Alliances. (Secs
6002, 6001)

How will the Board "enforce the budget?" (D 42)

Should "too many" Americans seek health care the Alliances
must cut treatment costs, lest spending "exceed the budget."
(Sec 1322) How will they do it? By turning away every tenth
patient? Or prescribing wage cuts for nurses? Or firing
janitors? Or becoming magically efficient in ways that evaded
state legislatures and Congresses for the last ten years under
the Medicare and Medicaid programs? They must somehow conform to
the Board's budget hammer.

The Board itself is free to decide a new drug was not
"medically necessary or appropriate," or a CAT scan, or an extra
nurse in surgery. (Sec 1141) Even if the services were in the
package of benefits bargained by an Alliance. After all, ? of
these seven fine minds will have "expertise in...business,
law...financing health care." (Sec 1502) They are charged not
to go "over budget, certainly not to increase premiums more than
the "inflation factor." (However the Board is free to add
1. The BLS index of medical costs is generally used to describe how medical costs have risen. But that index rises even when a new surgical procedure cuts hospital days, and costs. The index did not fall when Medicare saved $228 million because laparoscopy substituted for a more expensive surgical treatment (of gall bladder problems etc). For the index does not even purport to measure the changing costs of illness. It measures the price of two hospital items—"one hospital day" and "one hospital admission kit."

What follows? If patients with surgery for gall bladder, stomach etc spent fewer days in the hospital (at $750 a day) the official index did not decline. (Because the price of "one hospital day" didn't decline.) Worse still, the cost of the admission kit automatically rose--for the index makers divide its $13 cost by 6.4 days (now required for laparoscopy) instead of by 10.2 days (required by the previous procedure).

The result? The index reported total medical costs rose BECAUSE a far less costly procedure was introduced. No wonder the red curve of medical costs has kept "ever increasing."

2. A similar oddity helps explain why pharmaceutical costs "increase so spectacularly." Millions of Americans now survive thanks to penicillin, erythromycin, coumadin. These drugs substituted for much more expensive surgery and hospital stays. And cut the real cost, as the President has recognized. ("If someone with a $5,000 annual drug bill stopped taking those drugs he might be in the hospital two weeks a year immediately, which would cost a whole lot more than $5,000.") (Sept. 26)