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WHAT THE LEWIN-VHI ANALYSIS OF THE CLINTON HEALTH PLAN REALLY SHOWS

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After Congress adjourned last year and lawmakers left Washington, the Clinton Administration waited anxiously for the results of a major analysis of its health plan being prepared by Lewin-VHI, one of the country's leading health care accounting and econometrics firms. Lewin-VHI, based in Virginia, has conducted analyses of several leading health care proposals and is often viewed as the private sector equivalent of the Congressional Budget Office.

When the Lewin-VHI report was issued to the press, on December 8, 1993, White House officials quickly dubbed it a vindication of the Administration's own cost estimates.[1] This is curious, for the report shows little of the kind. To be sure, the overall budget impact calculated by Lewin-VHI does not depart widely from White House figures. But this is only because the firm took as its basic assumption that the Clinton plan's price controls and expenditure limits would operate exactly as the Administration predicts, and thus health expenditures would be curbed by law. Even then, the financial reserves in the plan completely evaporate and the predicted deficit reduction shrinks by half. But more disturbing for most Americans, the fine print in the report reveals many unpleasant and very costly surprises for businesses and families.

Specifically, the Lewin-VHI report finds:

- **Price controls and forced cut-backs in spending, not managed care or paperwork reduction, is how the Administration will reduce health costs.** If the Administration's plan works exactly as planned, which is Lewin-VHI's crucial benchmark assumption, total health care spending in America will be cut by less than $1 billion in 1998, the first year of full operation. In the year 2000, Lewin-VHI estimates the plan will reduce America's health care spending by $57.2 billion over current projections (from $1,631.0 billion to $1,573.8 billion). But significantly, these reductions are not achieved primarily by pushing Americans into managed care networks or by administrative savings in the insurance industry, as the Administration has been

1 Lewin-VHI, *The Financial Impact of the Health Security Act* (Fairfax, VA: Lewin-VHI, 1993). Copies of the full report may be obtained from Lewin-VHI Inc., 9302 Lee Highway, Suite 500, Fairfax, Virginia 22031. Tel.: 703-218-5500.

claiming. According to Lewin-VHI's detailed analysis of spending, managed care in 1998 will yield only $14.9 billion in savings, and administrative savings by providers and insurers just $1.9 billion. The bulk of the savings ($60.4 billion in 1998 alone) comes from cutting both Medicare spending and reimbursements by health insurance companies, the latter achieved by stringent controls on what can be spent by Americans on medical care ($13.1 billion from Medicare spending limits and $47.3 billion from insurance spending limits).[2] As Lewin-VHI puts it, "Although managed care savings are intended to be the primary source of savings under the Act, the premium caps will provide a backstop measure to limit the growth in health spending."[3] It turns out, as Lewin-VHI shows, that direct controls on spending, leading inevitably to rationing, will in fact be the primary way the Administration holds down costs.

This $60.4 billion cut in expenditures in 1998 would be a 4.3 percent reduction from projected health care spending under current law. (Most of these savings would go to a new long-term care program and to extra services for the currently uninsured.) To appreciate the implications of such a cut, consider the effect of a recent 3.5 percent health budget cut imposed in Ontario, home to one-third of all Canadians. Hospitals in that province had to shut down many beds and operating rooms for two to three weeks over Christmas to comply with the cut. Many non-emergency patients were sent home from specialist centers, or transferred to other facilities to await treatment in January. "If you said to an American patient, 'We're going to delay your surgery for two weeks because costs are involved,' they would never accept it," said one orthopedic surgeon forced to delay operations. Hospitals required staff (other than doctors) to take twelve days unpaid leave.[4]

☞ **Firms not now providing insurance face over $100 billion in additional costs.** Despite premium subsidies to employers of $142.9 billion from 1996 through 2000 (and subsidies to individuals of $168.4 billion), employers not now providing insurance will face insurance costs (even after their subsidies) of $29.3 billion in 1998, and a total added cost of $107.4 billion from 1996 through 2000. Firms currently providing insurance will see their total insurance costs during the period fall by a mere $0.3 billion. (Lewin-VHI estimates that costs for these firms will be $293.2 billion in the year 2000.)

☞ **Some 67 percent of firms not now providing insurance will have to pay at least $1,000 per year extra per employee.** Despite the subsidies available to small business and to other firms in low-wage industries, many firms not now providing insurance will see large increases in their labor costs. Lewin-VHI calculates that, in 1998, 19.9 percent of firms not now providing coverage will see costs per employee rising $500-$1,000, 51.6 percent will face a cost rise per employee of $1,000-$2,500, while another 15.2 percent will see cost increases of over $2,500.[5] And even among firms currently providing insurance, 21 percent will experience an increase in costs per employee of

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2 *Financial Impact*, Appendix A-3. The net impact of the spending cap in 1998 is actually $56.6 billion, because changes in Medicaid administrative costs, payment lags and changes in reserves add $3.8 billion in costs that year. Lewin-VHI also projects an additional $32.5 billion in savings in 1998 by recovering "windfall" benefits to insurance companies because of the reduction on uncompensated care costs now borne in part by private insurers.

3 *Financial Impact*, Appendix A-5.

4 Anne Swarden, "Ontario Hospitals Save With Holiday Shutdowns," *The Washington Post*, December 25, 1993, p. A33.

5 *Financial Impact*, p. 79.

at least $1,000, with another 12.5 percent facing a rise of $500-$1,000.[6]

- **Neither the Administration nor Lewin-VHI takes into account wage reductions resulting from mandates on employers.** In calculating the impact of all the changes on families (see below), Lewin-VHI does not calculate any effect on wages or employment of the insurance mandate on employers not now providing insurance. Lewin-VHI notes that it is estimating only the impact on family health spending, not family income. Thus although a family might be "better off" in terms of health spending under the Clinton plan, the extra cost borne by an employer may lead to a reduction in the wages paid to the family of more than the family's health savings. Or the worker in the family may receive a pink slip. Economists generally assume that about 88 percent of the cost of an employer mandate is recovered by the employer by reducing wages. So an additional cost of, say, $2,500 for an employer normally would mean a wage cut of $2,200 for the employee. The Administration has, so far, failed to include this effect when describing the financial impact on families.

- **Workers and their families will lose $34 billion in tax benefits because health care "cafeteria plans" or "flexible spending plans" are eliminated.** Millions of workers today elect to place pre-tax income into special employer-administered accounts which are used to pay for out-of-pocket medical costs or other services, such as extra life insurance, nursing home insurance, or disability benefits. The Clinton plan does not allow these accounts to be used for health expenses in the future, and so families now using the tax-free accounts to pay for deductibles and co-payments—or for hospital and physician charges not covered by insurance—will have to pay for these services in after-tax dollars. Lewin-VHI calculates that this change will lead to $34 billion in extra taxes from 1996 though 2000, although the firm assumes that workers will respond by spending more through the accounts on non-medical services, leaving a net increase in taxation of $17 billion.[7] It should be noted, however, that many experts on fringe benefits believe that if cafeteria accounts cannot be used for health care, a high proportion of employers would end them completely for any purpose, in which case the tax increase for employees not only would be greater than $17 billion, but could rise well above $34 billion.[8]

- **Half of all working-age households will pay more for their health care.** Examining health care costs of households headed by an individual under 65, Lewin-VHI calculates that 49.5 of such households will pay more (i.e., at least $20 more per year) for their health care than today. Some 61 percent of these families will see their costs rising by more than $500 per year.[9] In the Lewin-VHI analysis, as noted above, there is no estimate of the wage effect of the new health insurance mandate, and so many households enjoying lower health costs may well see their wages cut by more than their health savings. Of those working-age households facing an increase in health costs, 43 percent will experience no improvement in coverage. And many of those classified by Lewin-VHI as receiving "improved coverage" may not actually feel better off, because they may have to pay extra for coverage they do not want, while losing benefits they value. For example, with the Clinton plan in place, if a family

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6 *Financial Impact*, p. 77.
7 *Financial Impact*, p. 49.
8 See Albert Crenshaw, "Health Reform Targets a Flexible Flyer," *The Washington Post*, January 1, 1994, p. B1.
9 *Financial Impact*, p. 90.

had to pay more for generous mandatory psychiatric and abortion services they did not want, but had to join a managed care network which did not include the pediatrician they had always used, the Lewin-VHI analysis would say they now had "improved coverage." The family doubtless would disagree.

- **The cost of the standard benefits package in the Clinton plan is about 17 percent more than the White House estimated.** This price means higher costs for families and employers. Lewin-VHI puts the price tag at $5,975 for two-parent families ($2,732 for individuals) in 1998, although it will vary from an average of $5,591 in the South to $6,513 in Midwest states.[10]

- **New requirements for insurance companies will increase premiums for average workers and their families, as well as their employers.** Because the Administration intends to introduce "community rating" for insurance premiums, meaning rates must be set without regard to age and health status, there will be large new cross-subsidies in health insurance. Lewin-VHI estimates that community rating will push up the insurance cost for workers and dependents to about 14 percent above the actual cost of covering them. "Thus, in general," concludes the report, "employers will cross-subsidize the cost of covering the highest cost non-working population."[11]

- **The budget "cushion" is used up.** The Administration's "contingency cushion" of $45 billion for 1995-2000, the reserve fund to compensate for any errors in Administration projections, must be used up entirely to pay for the basic program—leaving no further margin of error.

- **The promised deficit reduction is more than halved.** The Administration's estimate that its plan would cut the deficit by $58 billion between 1995 and 2000—a figure already reduced from $90 billion earlier in the year—should be trimmed to just $25 billion.

- **Cities and other units of local government will experience a $17.9 billion increase in their health costs through 2000.** The main reason for this is that although the costs cities bear today for indigent care in public hospitals will be cut substantially, federal payments they now receive to help pay for those hospitals would be reduced by a larger amount.[12] Spending by states, on the other hand, will decline by $61.9 billion through 2000.[13]

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10 *Financial Impact*, p. 25.
11 *Financial Impact*, p. 27.
12 *Financial Impact*, p. 62.
13 *Financial Impact*, p. 60.