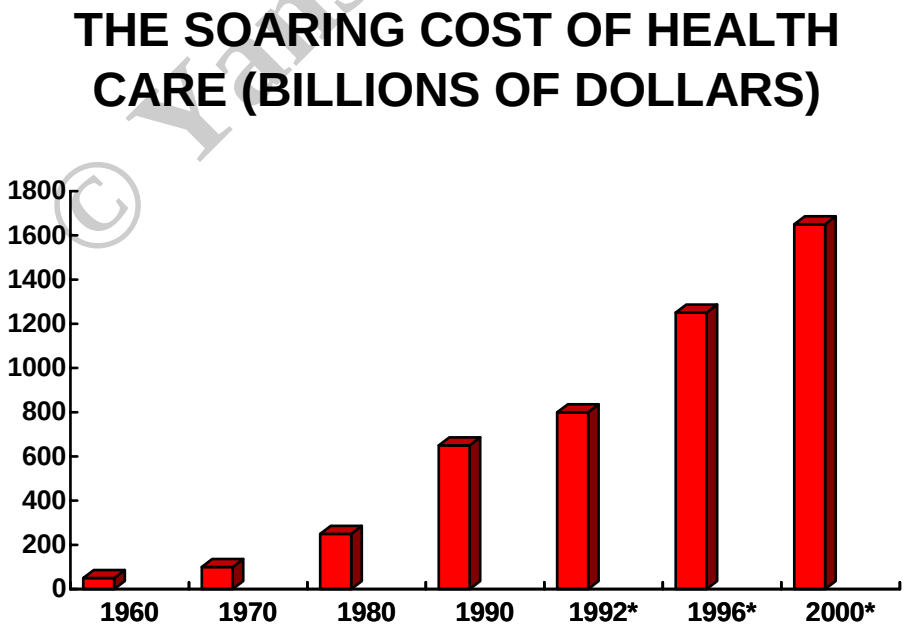
The United States of America. One of the last industrialized countries in the world to adopt a compulsory health care plan. Currently the Clinton administration is trying to provide a new health care system; not since 1949 when President Truman was in office, has this even been attempted.

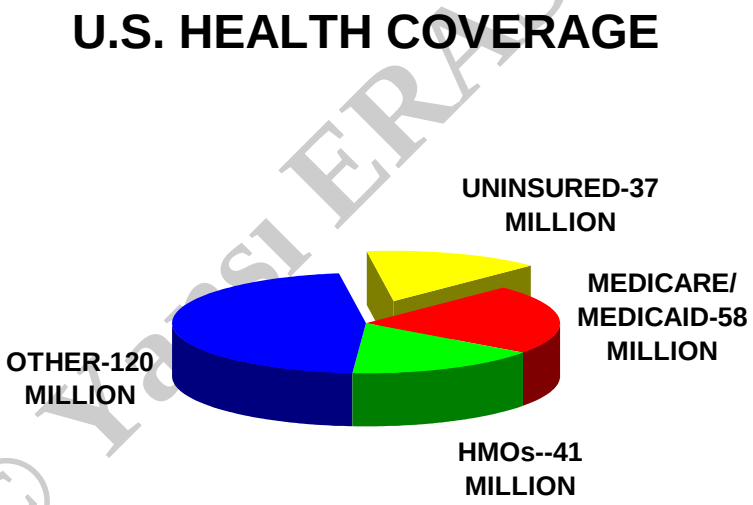
Why is this now being attempted and what are the primary problems of the system currently in place?

One of the primary concerns of the current system is that health care costs are rising faster than any other sector of the economy, as the following chart illustrates (Samuelson 31). Historically, there has been a laissez-faire attitude toward health care. This approach, while helpful for big businesses, has also led to the rising costs of health care in this country. According to the forecasts, by the year 2000, health care costs will be approximately 14% of the gross domestic product (GDP). This percentage is extremely high in comparison with other leading industrialized countries. In other countries such as Japan, Germany and England, the highest percentage of health care costs are only 9% of GDP.



Moreover, bureaucracy continues to overwhelm both consumers and health care providers. For every dollar spent on health care costs, twenty cents goes toward administrative expenses. For example, at Temple University Hospital in Philadelphia, Pennsylvania, over 20,000 paperwork transactions are conducted each day, for a cost of $6,000,000 yearly.

Lack of security is another concern of our current system. One in four people, or 63,000,000 people will lose their health insurance coverage for some period of time between 1993 and 1995. Currently 22,000,000 people lack adequate coverage. The most important point however, is that in the United States today, 37,000,000 million people have no insurance at all, as seen in the following chart (Winslow and Anders A7):



Coverage of long-term health care is also a top concern. The number of elderly people in this country is continually rising; care for these people will become an increasing concern and has the potential to be a huge problem if steps to solve the health care crisis are not taken now (President Clinton's Address to Congress, 9/22/93).

Problems in this country's health care system are causing a decrease in competition in the health care marketplace. President Clinton has high hopes to dramatically change

the way the United States health care system operates; the main points of the plan and its effects on the marketplace are as follows:

1. Choice: Each consumer will have the opportunity to exercise effective choice about health care providers, plans and treatments. Each and every consumer must be informed about the benefits and risks of available treatments and be free to choose among them according to his or her preferences.

2. Equality: The proposed health care system will avoid the creation of a system providing care based only on differences of need, not differences due to individual or group characteristics.

3. Effectiveness: The new system will deliver care and innovation that works and is what patients want. It will encourage the discovery of better treatments and make it possible for both academicians and health care providers to use their responsibility to evaluate and improve health care.

4. Quality: The proposed system will deliver high quality health care and provide individuals with the information necessary to make informed health care choices.

5. Integrity: The new system will treat the clinical judgments of professionals with respect and protect the integrity of the patient-provider relationship.

6. Responsibility: Each individual and family will assume responsibility for protecting and promoting health and contributing to the cost of care.

Now that Congress attempts to create a national health care system they must try to formulate a program that fits into the Americans ideal health care system. The ideal system would provide three things (Samuelson 31). First, it would provide universal insurance coverage; therefore, no one would be denied essential care.

Secondly, the system would allow absolute freedom of choice. This means that people would be able to choose their doctors and doctors would have the autonomy to select the best treatments for their patients. The growing sophistication in medicine makes the system more costly and bureaucratic. A national health care system will be forced to make the choices for the patients and the doctors. This is discomforting to people because no one wants to face the fact that rationing must be utilized by a national health care policy.

The last point of the system is that it should control health care costs. Therefore, no government, business, or family would face potential bankruptcy by increasing health care costs. Today's system provides no discipline on spending. Doctors can order the most expensive battery of tests because someone else will pay, due to open ended insurance reimbursement. Robert Brook of the Rand Corporation has stated that between one third and one seventh of some types of medical operations are unnecessary (Samuelson 34). Controlling costs will mean rationing care to those who are very sick. The sickest 5% of the population account for 58% of health care costs, whereas the healthiest 50% of Americans account for only 3% of costs (Samuelson 35). Unfortunately, no national health care system can achieve all these goals simultaneously.

The final details of the health care plan will be hammered out in Congress as they build a program from the Clinton blueprint and other proposed plans. The significant aspect of the Clinton blueprint is that it brings health reform to the table. No President has had the courage to attempt this since Harry Truman failed to push national health insurance through Congress in 1949 (A Cure for Health Care 16). Clinton deserves praise for attempting such an immense reform.

Under the Clinton plan everyone will be qualified for coverage even if they become sick, switch or lose their job, or move. All eligible individuals will be guaranteed issuance and renewal. Therefore no one can or will be denied health care coverage based on their medical history, ethical background or any other prejudice.

Eligible individuals covered under Clinton's proposed plan include: American citizens, citizens of other countries legally residing in the United States, nationals, and long term non-immigrants (Clinton Sep 22). These individuals include the 37,000,000 Americans currently uninsured, one fourth of which are children. All of these qualified individuals will be provided with a health insurance card specifying their coverage under the comprehensive benefit package.

Clinton's proposed benefit package is very generous. His package meets many of the benefits packages currently offered by many corporations. With such generous benefits many question if it is financially reasonable. Details of the benefit package were obtained from a Tom Morganthau and Mary Hager article in Newsweek (43).

Routine, professional doctor visits during illness or injury will be covered under Clinton's blueprint. Outpatient hospital care, including emergency room treatment will also be included.

Preventative care will also be embodied under the core benefits. Many question as to how much preventative care is financially feasible. One thing is certain however, the expenses incurred with preventive care are much less than the expenses incurred when curing an illness. Childhood immunizations and prenatal care can save as much as $10.00 for every $1.00 invested. However, some measures of preventive medicine come with enormous price tags for every year of life saved (Apples Come Cheap 33). The government must perform cost benefit analysis on certain measures to determine how to spend the limited resources. Preventive measures will include prenatal and infant care, immunizations, annual physicals, cholesterol screening, and gynecological examinations. Mammograms for women over fifty years old will also be covered. Clinton enforced his

position on mammograms on Monday, October 18th at a White House ceremony when he was presented with a petition of 2,600,000 signatures urging for a strategy to deal with the disease.

A highly regarded benefit is dental care. Initially, only preventative dental care for children under 18 years old will be offered. By the year 2000, however, preventative dental care for adults will be phased into the plan. Some orthodontia will be granted only to avoid reconstructive surgery.

Outpatient therapy including physical, occupational, and speech therapy will be a core benefit. Therapy will be offered to restore functions lost during illness or injury. Additional therapy will be granted after 60 days if the patients condition is improving.

Long term care and home health care will be covered under Clinton's benefit package as an alternative to hospitalization. Long term care will include nursing homes and rehabilitation centers. Patients will have coverage for a maximum of 100 days per calendar year. This is proposed to be phased in by the year 2000. Home health care will be granted after every 60 days if it is found to prevent institutional care.

Two benefits of the comprehensive package under much debate are prescription drugs and mental health/substance abuse. Prescription drugs as a benefit is needed by many, however it will be a tremendous expense to provide. Coverage could range from $5.00 per prescription to a $250 annual deductible depending on which plan an individual chooses.

Both mental health and substance abuse are under great debate. It is believed that these will be the first benefits to be cut from the package, in order to reduce costs. Coverage under mental health will initially include 30 days of inpatient care per episode of illness, up to a maximum of 60 days per year. Thirty outpatient visits per year to a psychotherapist will also be embodied in the benefit package. By the year 2000, a comprehensive benefits package will be phased into the plan. Substance abuse is under similar guidelines as the mental health coverage. Prevention and treatment of substance

abuse must be a top priority, because unless Americans stop abusing these substances, health costs will be doomed to failure (Substance Abuse is Blamed for 500,000 Deaths 20). Other benefits provided by Clinton's proposed plan are as follows:

- Ambulance service: Auto and air transportation
- Ear and eye care: Routine exams and children's eyeglasses
- Hospice: An inpatient alternative for the terminally ill
- Health Education Classes
- Medical Equipment: Prostheses and braces to improve function or prevent deterioration

Clinton plans to have national medical coverage begin as soon as 1995 with the entire benefit package phased in by the year 1997. More benefits will be added in the year 2000. Rich Thomas states that we should expect to see implementation of a health plan by the year 2000 (48). The delay will result from the debate which is expected to occur in Congress.

Most Americans will obtain their medical coverage with one of the three plans offered by the new regional "alliances". The proposal presents three types of plans: health maintenance organizations (HMOs), preferred provider organizations (PPOs) and fee for service insurance. The health care packages are available to everyone regardless of any preexisting medical conditions. (Clinton's Health Plan 6)

Health maintenance organizations are prepaid plans that sell insurance coverage and also provide health care by hiring or contracting with physicians. Plan members have few out of pocket expenses other then premium payments and the medical coverage is very extensive. Members receive all of their care from the HMOs' physicians and hospitals, therefore losing the option to choose a doctor not employed by the HMO. The approximate cost per office visit is expected to be about $10-15 for the HMO plan (Hager and Morganthau 38).

Preferred Provider Organizations allow members to choose between restricted and unrestricted coverage each time care is needed. Members may use the services of the plans designated group of providers and have full coverage, similar to an HMO, or receive care from providers and hospitals outside the network and pay an additional cost. The cost per office visit is expected to be about $10-25 under the PPO network (Hager and Morganthau 38).

The final option is the fee for service, or traditional indemnity insurance coverage. A fee for service plan allows patients to choose their physicians. Under the fee for service plan there is no inducement to use physicians whose fees are reasonable or whose style of practice is cost-conscious. Patients and physicians have little incentive to save money under this system, so the costs of health care coverage under this plan is extremely high. When coverage and cost are considered under this plan, most fee for service plans offer less protection than HMOs and PPOs. Under Clinton's proposal, a family would have to cover the first $400.00 of its medical expenses every year and individuals the first $200.00. The fee for service plan calls for the patients to be pay 20% of the cost of office visits, tests and hospital stays -- up to a yearly limit of $3000 for families and $1500 for individuals (Luciano 19). This plan is considered to be the most expensive and least comprehensive.

By examining the ways that physicians are paid and by looking at the historic costs associated with each type of plan, it is easy to see some of their respective drawbacks and benefits . Physicians are paid in one of three ways: fee for service, fee for time, and fee per patient.

The fee for service payment is the most well known and widespread method of payment in the United States. Fee for service physicians are paid for each service that they provide. The problem with this type of service is that the physician is allowed to determine the demand for his or her own services. The fee-for service physician makes

the decision to use certain medical services for which he or she will be paid on a piece work basis. The potential for abuse is built-into the system (Relman 7).

The two primary reasons for the excess treatment that runs rampant among fee for service physicians are as follows:

1. Physicians desire to avoid malpractice suits so they order excessive tests and procedures to insulate themselves from liability.
2. The insurance reimbursement system provides for greater rewards to physicians who perform tests and procedures than for those who use their skill to advise patients of less costly types of treatment (Berman and Rose 113).

These factors increase the cost of health care greatly due to the wasting of the health care system's resources. However, the flaws in this payment system do not negatively impact on the quality of care provided; no one is really hurt by extra tests in a medical sense. Rather, these factors just misdirect the system's energy and money.

Other ways that physicians are paid are fee for time and fee per patient. These are used mostly by HMOs and PPOs to keep the cost of health care down. Fee for time physicians agree to work a certain number of hours per week in exchange for a steady salary. Their earnings are not affected by the number of patients they see or how many tests and procedures they order. Fee per patient physicians are paid an amount based upon how many people they have signed up to receive treatment from them when it is needed. The doctors receive a set payment regardless of the amount of medical services their HMO or PPO patients use.

The physicians in an HMO or PPO generally have a financial stake in their organization's performance. This stake allows for the possible development of abuses. It is an exchange of quality care for doctor profits. Some common profit maximization methods commonly employed are as follows:

1. Physicians try to keep the number of office visits to a minimum while still providing effective care.

2. Physicians may only order those tests that are proven to be useful.

3. Physicians may only refer patients for consultations when they believe they are medically necessary.

4. Physicians may only admit patients to hospital care when there is no safe alternative (Berman and Rose 123).

These factors can impact negatively on the quality of service provided by the managed care organizations. Physicians skimp on the quantity of care provided because they have a financial incentive to keep costs down so that they can make a higher profit.

Managed care organizations are plagued by other related problems regarding the quality of the care that they provide. According to a Sept. 22, 1993 USA Today survey of 17,000 people, "the more costs are reduced, the more dissatisfied consumers" seem to become regarding the quality of the service provided to them. In "large HMOs 65% of people had to wait a week or more for an appointment verses only 25%" in fee for service plans. In addition HMO customers had to call repeatedly or wait a long time on hold to get to speak with someone (Cauchon and Stone 2).

Even with service abuses and slower care, HMOs and PPOs have been flourishing. The following charts from the September 29, 1993 USA Today shows the current enrollment under each type of plan:

Comparing approximate current enrollment by plan:

Fee for service	49%
HMOs	26%
PPOs	20%
Other	5%
	100%

The general costs associated with these plans explain the growing popularity of HMOs and PPOs. They are as follows:

Average per employee cost in 1992 by plan:

Fee for service	$4,080
PPOs	$3,708
HMOs	$3,313
Other	$3,566

Health Maintenance Organizations and PPOs provide the least expensive care. They should continue to get less expensive due to the increased consolidation in the industry. Recently, there has been a number of mergers and acquisitions among health care providers. On October 2, 1993, Hospital Corporation of America agreed to merge with Columbia Healthcare Corporation in a $5.7 billion stock swap. This turns Columbia into a 190 hospital operation that gives the company even greater economies of size to reduce costs (Schiller 36). On October 18, 1993, WellPoint Health Networks, a health care provider, announced that it is acquiring UniCARE Financial Corporation, a workers' compensation company, for about $154,000,000 in cash. This will put WellPoint in a strong position to benefit from managed care growth in workers compensation (WellPoint Health Networks). Mergers like these will continue in the future as health care competition increases. Increasing a managed care organizations size is one of the easiest ways to lower and control costs.

Overall, the Clinton proposal encourages consumers to choose managed care plans due to the lower cost of this type of coverage for both the provider and the consumer. The fee for service plans higher cost of care, co-payment and deductible make the plan too costly for most individuals. Therefore, it is expected that fee for service health care will end up being used only by wealthier individuals and most others will use managed care plans.

Clinton's plan poses several concerns to the business community. For most Americans, the plan will permanently change how health care is provided and paid for.

The President's goal is to provide health care to all Americans. Consequently, the plan requires employers to provide health insurance for all workers.

The effects of the plan on business will vary significantly with the nature of the firm. Large companies who mainly employ full-time, high-wage workers will enjoy cost savings when the proposal is implemented. Small businesses and employers of low-wage workers seldom provide health care under the present system. For these individuals, mandatory health insurance requirements pose a new threat to their financial well-being in already tough economic times.

Presently, large employers' average health care costs are 9.9 % of their total payroll costs. Small businesses that offer health care coverage pay an average of 13.5% of their total payroll cost for premiums (Garland and McNamee 31). These Labor Department statistics present a picture President Clinton hopes to change. His goal is to reduce the cost of health care insurance to below 8% of payroll costs for all employers. In fact, the President claims that many businesses will pay much less than that.

The President has two main tools for cost control: health alliances and subsidies. Under the new plan, health alliances replace health insurance purchasing cooperatives (HIPCs). The idea is to pool together a large number of persons needing insurance to attain more bargaining power for small groups, and reduce insurance costs for the individuals. The President has proposed two types of alliances under his plan: corporate and regional alliances.

Clinton's proposal allows companies with 5,000 or more employees to form their own corporate alliances. A corporate alliance allows companies to directly purchase their own insurance, or administer their own health care program. Companies that choose to form a corporate alliance do not benefit from any subsidies for low wage workers or premium caps they would have received in a regional alliance.

Employees of smaller companies, as well as self-employed persons and other persons will join regional alliances. Regional alliances will be run at the state level with

federal money. The President aims to enroll three out of every four Americans in a regional alliance. If most people enroll in regional alliances the cost of insurance to individuals will decrease even further.

The President's second tool for cost reduction are subsidies. The proposal calls for the subsidization of small businesses and low-wage workers. For companies with fewer than 50 employees, government subsidies will cap their health care costs at a low of 3.5% of total payroll for workers earning $12,000 per year or less. For workers earning $24,000 per year or more, government subsidies will cap premium costs no higher than 7.9% of payroll (Bowers B2). The administration has not been specific in defining exactly how subsidies will affect individual businesses. However, the variables for determining the amount of subsidies will be average wages, and the number of workers.

Unemployed workers, and persons 150% below the poverty level will also receive subsidized health care. Initially, the subsidies will come from Medicare or Medicaid. In fact, Clinton has tentatively decided to use price ceilings on the total amount of subsidies available to small businesses and low-income people (Stout A2). In the future, however, the government will provide direct subsidies for these groups (Morganthau, 35).

The proposal will have several effects on who pays for insurance premiums. The most significant is that employers will pay 80% of insurance premiums while workers pay 20%. This applies to both large and small businesses. Any government subsidies will go directly toward the employers' portion of the insurance premium where they are applicable. Self-employed persons will pay the entire amount of their premium, however the full amount will be tax deductible.

While the administration has been vague on what the new insurance will cost the consumer, they have made some preliminary estimates. The President's health care experts estimate premiums at $1800 per year for individuals and $4200 per year for families. For workers, this translates into a cost of $360 per year, and $840 per year

respectively (Bowers B2). This will only provide basic coverage; extended coverage will translate into higher deductibles.

The majority of media coverage regarding the effects of the Clinton health plan on business focuses on the speculation of the business community. Both large and small businesses have serious concerns about what the actual effects of the proposal will be on their profitability. The most frequently discussed concern is that of job loss. Even the most conservative estimates are that 500,000 jobs will be lost as a direct result of the proposed health plan. (Garland and McNamee 31) Small businesses claim that they will be responsible for much of those losses; even with subsidies they feel that the additional burden of health care insurance will force them to lay off workers to stay afloat.

Businesses that do offer health care insurance are also uneasy about the proposal. Large businesses with efficient health care programs do not want to be forced into untested government programs. A study in the October 18, 1993 issue of Business Week found that, in a survey of 370 employers, 54% said they were "very likely" to form their own corporate alliances. They are willing to forego potential subsidies for two main reasons. First, these corporations lack confidence in the governments ability to control the bureaucracy and cost of health care in the future. Secondly, once a company allows their employees to go to regional alliances, they cannot later form a corporate alliance if they are dissatisfied. The administration wants as many Americans as possible in regional alliances.

Small businesses are also following this trend. Voices on capital hill are now becoming louder, arguing that companies with as few as 500 employees should be allowed to form their own corporate alliances. (McNamee 92)

The planned action by these two groups reflects the concern most Americans, not just the business community, have about the feasibility of President Clinton's plan. The job of running regional alliances, which should be run as non-profit agencies overseen by boards of large companies, could be passed on to state officials. The power would then

be in the hands of politicians, while the purchasers and consumers of health care insurance lose their collective voice. For 35 states, the money allotted to health care premiums through the regional alliances could actually exceed the states' budgets (McNamee 92). In the October 9, 1993 issue of The Economist, a study found that the estimate for the total cost of subsidizing premium costs for small businesses and low wage workers will probably be raised an additional $16 million (The Naked Truth 22). It is clear that once the plan reaches Congress, President Clinton will receive many suggestions regarding the businesses' power under the new health care plan. The entire business community will be watching closely for more detailed information regarding how alliances and subsidies will affect their bottom line.

One of the biggest questions being asked is how much will Clinton's healthcare reform cost and where will the money come from. As it stands now, Medicare and Medicaid account for the greatest amount of savings, totaling $238 billion, followed by sin taxes, $105 billion, revenue gains, $51 billion, and lastly, other federal program savings, $47 billion. The greatest cost is expected to be subsidies for low-income firms and workers -- totaling $169 billion, followed by healthcare funds that will be applied to deficit reduction, $91 billion, long-term care, $80 billion, Medicare drug benefits, $72 billion, and public health and administration, $29 billion (Clinton Blueprint 6). As a financial document, the Clinton plan is erroneous. "A Fantasy," was the description given by Senator Daniel Patrick Moynihan.

Clinton hopes to create savings under Medicare and Medicaid by reducing their combined growth rate of about 13% to under 5% by the year 2000. Under the President's plan, the rate of growth of Medicare would be slowed in a variety of ways detailed as follows (Thomas 36):

1. Limiting the updates to hospital and physician rates and home health agency cost limits.

2. Reducing indirect medical education, capital, and disproportionate share hospital payments.

3. Instituting a prospective payment system for hospital outpatient services.

4. Competitive contracting for clinical labs.

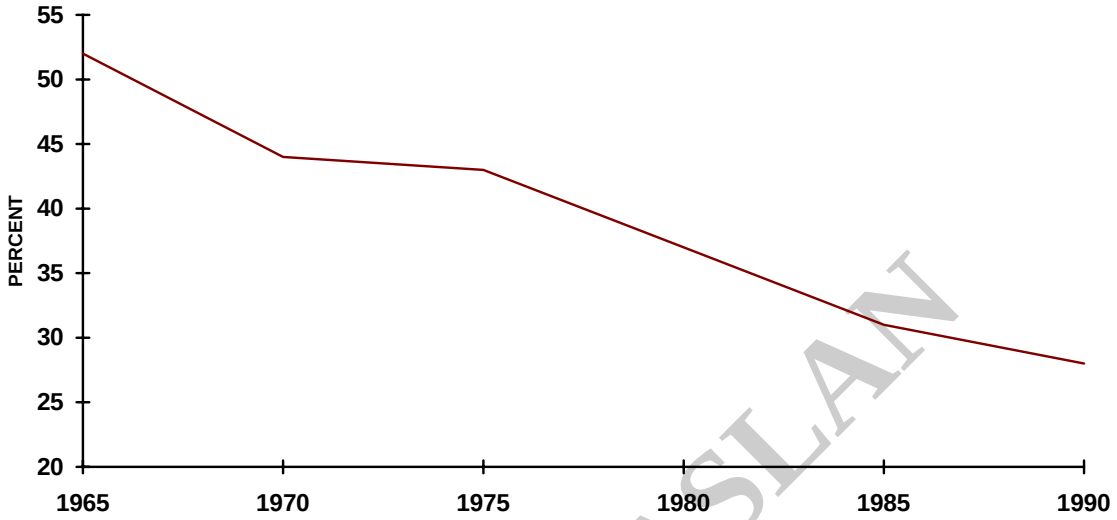
5. Extended Medicare Secondary Payer policies.

6. Requiring a means-tested Part B premium.

Clinton plans to achieve savings under the Medicaid program through a cap on Medicaid spending (Poor 31), with the ultimate goal of transferring everyone currently covered under Medicaid over to the health alliances, essentially reserving Medicaid only for undocumented persons (A Reader's Guide 35).

Another highly debatable source of revenue under Clinton's plan is the proposed sin tax on cigarettes. This tax will be 75 cents on each pack of cigarettes sold in the United States (Pear 18). What Clinton has failed to take into account is that given the drastic decline in the number of smokers in the last few decades, a tax of this magnitude will most likely drive cigarette consumption down at a quicker pace than normal. Washington has allowed for some drop in consumption in its calculations, but the estimates tend to be conservative. Washington should concentrate on a more stable source of revenue. The reduction in the percentage of smokers can be seen in the following chart:

DOWN BUT NOT OUT-SMOKERS AS A % OF TOTAL POPULATION



The President has deftly avoided sin taxes on wine, beer and hard liquor. California, which has a large number of electoral votes that Clinton needs to win a second term, is a major wine producing state. Anheuser Busch, who produces 44% of all the beer sold in the United States just happens to be located in the House Majority Leader's district. Hard liquor is also unlikely to be taxed. The Senate Majority Leader, known as a good judge of what will and won't fly on Capital Hill, informed Clinton that Congress would never go for a tax on just one type of alcohol. Clinton appears to have taken his advice, for the moment at least (Cohn 51).

Under the new reforms, another $41 billion is expected to be saved through other federal programs such as:

1. New fraud and abuse restrictions that will be extended to all payers.

2. Malpractice reforms -- under which Clinton is talking about ideas such as alternative mechanisms for dispute resolution (Kill or Cure 33).

3. Rate caps for health insurance premiums for everyone. The President hopes to reduce the current growth rate of 7.4% to 4.1% by the year 2000, by instituting a per capita premium constraint that would be tied to the consumer price index (Clinton Blueprint 6).
4. Reduction of the current 20 cents of every dollar spent on healthcare paperwork by instituting a single-form system (Cohn 6).

An additional $51 billion is expected to be saved through revenue gains. The rationale here is that as employers begin saving money under the healthcare system, they will need less tax allowances and will plow the money they have saved back into wages and jobs, thereby resulting in additional income tax revenue (Kill or Cure 31). Some other revenue--generating ideas have been discussed such as:

1. A 1% payroll tax on large corporations that have opted out of joining an alliance.
2. A value-added tax (VAT tax) has also been discussed - resulting in little enthusiasm for the idea (Simon 125).

The promise of improved long term care and drug benefits have managed to sway lobbyists representing older Americans to Clinton's side (Hey 12). The Federal funding per state would be capped based on the number of eligible patients and per capita spending. Subsidies for low-income firms and workers account for the majority of the spending. This is expected to provide $160 billion in subsidies to small businesses and the working poor and $9 billion in subsidies to the self-employed (Kill or Cure 32). Clinton's healthcare plan also includes the $91 billion that's been allocated to deficit reduction.

Criticisms of President Clinton's health care plan are varied. They are all equally important, as many critics are trying to influence both the public and Congress on how the plan needs to be reformed. The greatest critics of the plan are Republicans, doctors, insurance companies, pharmaceutical companies and large retailers.

Republicans are opposed to a great deal of Clinton's plan. They believe the proposed comprehensive benefits package is too generous; while they favor a

comprehensive package, they believe it should be less generous and provide uniform benefits. The 80% of health insurance premiums that employers will be required to pay are much too high by Republican standards. They believe individuals must be required to obtain their own health insurance coverage. Further, Republicans do not believe that government subsidies are the correct way to bring poor into the system. Clinton's proposed plan will give federal subsidies to small, low-wage firms and for individuals with incomes 150% below the poverty level. The Republicans would rather provide federal assistance to individuals with incomes 240% below the poverty level. Clinton's plan proposes a "sin" tax on tobacco, and possibly alcohol; Republicans want no new taxes. Under the President's plan insurance-buying "health alliances" will be formed and all companies with fewer than 5,000 workers will be required to join. Republicans prefer optional insurance-buying pools for firms with less than 100 workers, in order to foster competition as a way to promote economic growth. Lastly, while the plan proposes government set limits on any increases in insurance premiums, the Republicans are against government price controls, instead favoring competition to promote growth (Two Plans and Where They Might Lead A8).

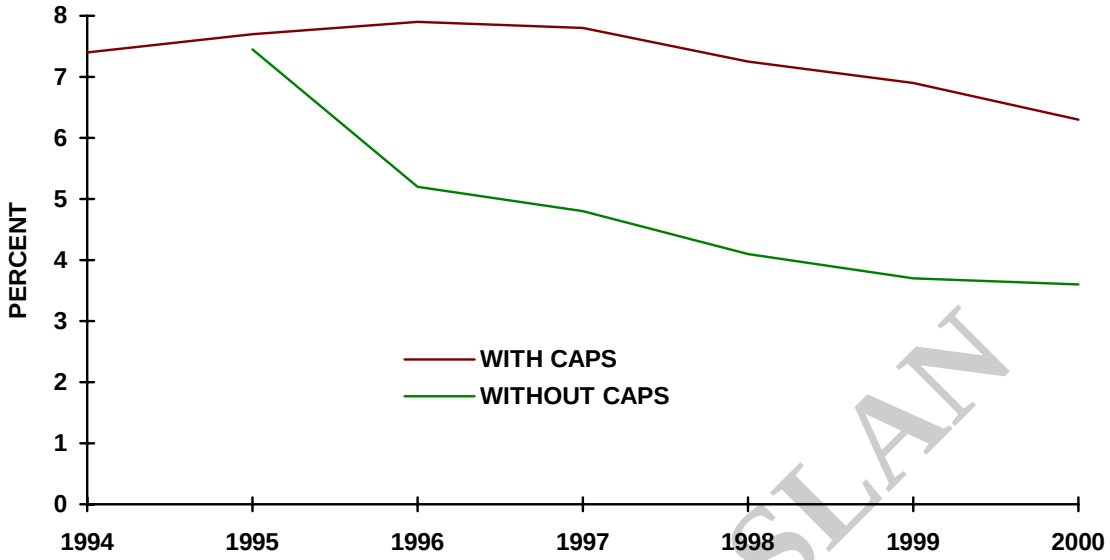
The American Medical Association (AMA) agrees with the broad aspects of the plan, yet disagrees with a few of the smaller points that, in turn, have big implications. The AMA is worried about the rationing of health care. With the proposed price ceilings that the insurance industry is facing, insurance companies will be forced to cut costs without raising insurance premium prices. The AMA fears this will equate to the rationing of health care; because insurance companies will not be able to pay for as many expensive health tests that are currently conducted. The AMA also believes that the reductions and reimbursements in store for Medicare will limit patient and doctor choice and lead the way to more and more federal controls in the future (Anders and Stout A10).

The biggest objection that insurance companies have to the proposed plan is the government price controls, namely price ceilings on health insurance premiums.

Insurance companies are successful when they provide the best doctors, the quickest referrals and provide the best customer service. If the price ceilings go into effect as planned, insurance companies will be in a dilemma between cutting costs and upgrading quality and service. The long run potential of a forced reduction in health care and restricted access to new technology is quite substantial (Steinmetz B1).

The Health Insurance Association of America (HIAA), has recently started a television advertising campaign attacking Clinton's plan, specifically focusing on the dangers of price controls to the insurance industry (Wartzman B3). Interestingly enough, this countries top five insurers, Aetna, Cigna, MetLife, Prudential and Travelers, have not joined HIAA in its direct criticism of Clinton's plan. Instead, they have formed their own conservative group, and so far, have not publicly criticized the plan (Wartzman A16). The following graph (Wessel and Wartzman A12) illustrates the projected growth potential of insurance rates in The United States through the year 2000. It becomes clear that with or without a price ceiling, insurance growth will decline, from approximately 8% to 6%. With a price ceiling however, projected growth declines even more, with a drop from 8% to 4%.

INSURANCE GROWTH RATE



If Congress passes the plan as it is proposed, it is evident that insurance companies have a long, hard road ahead of them. Many insurance companies are already preparing for bad times ahead. Cigna plans to cut approximately 1,000 jobs through attrition and layoffs by the end of this year and Travelers has plans to cut 5,000 jobs company wide. While the consolidation of insurance companies has been occurring for the past few years, the prospect of national health care reform has greatly accelerated the process (Levick A1).

Pharmaceutical companies are faced with a similar dilemma. Harsh price controls will force companies to discount drug prices to Medicare recipients by 15%. Further, Health and Human Services will have the power to negotiate the price of any drug they deem too expensive. Drugs that go to Medicare recipients account for about 25% of a typical pharmaceutical companies revenue. When this core base of revenue is altered the effects on a company become quite substantial. One of the major concerns of drug companies is that of limited research and development. With harsh price controls, many drug companies will hesitate continuing or starting expensive research on diseases such as

Alzheimer's or cancer if they cannot be sure they would even recoup their investment (Waldholz A6).

Similar to the insurance industry, many pharmaceutical companies have been consolidating operations over the last few years and have accelerated consolidation when the prospect of national health care reform became evident. American Cyanamid, Pfizer and Upjohn plan to eliminate a combined total of 7,000 jobs in the near future. As said by Cyanamid chairman and CEO Albert Costello, "...intense health-care cost-containment world-wide and the prospect of health-care reform in the U.S. require that we restructure our operations to be as efficient and productive as possible." (Tanouye, Mitchell and Miller A3).

For big retailers the primary concern of Clinton's proposal is the 80% of health insurance premiums that employers will be required to pay for both full and part-time employees. For companies that employ a large number of part-time employees, the potential costs are monumental. In a company such as Kmart for example, 40% of the workforce are part-time employees. The most recent estimate of how much it would cost to pay 80% of these employees premiums, as stated by Mr. Joseph Antonini, Kmart's chairman and CEO, is $300 million. The question remains, where is this money going to come from? Large retailers, such as Kmart, have very low profit margins, usually 5% or less. This means that monumental costs cannot be passed along to the consumer, nor can they be absorbed by the company. The only answer Kmart and other retailers have at this time is potential layoffs. This alternative will obviously not be a popular one (Stout A2).

In every presumably good or bad event there are winners and losers. As Clinton's plan stands now, it appears that the losers outnumber the winners. When all is said and done, the winners of the proposed health care plan will be low cost providers of health care that are an alternative to traditional hospital care. Mobile ambulatory clinics that travel within a city providing health screening and testing will be successful. Sub-acute care facilities, such as drug rehabilitation centers, where patients need beds and certain

services, but not all the services that a traditional hospital would provide will be successful. And lastly, companies that provide home nursing for the elderly or terminally ill who wish to live at home will be successful (Gupta B2).

As President Clinton's Health Care Plan heads toward Congress this week, rest assured the debate will be lengthy and changes to the plan will be made. It remains to be seen if Health Care Reform is truly a cure to the American Health System or just a band aid waiting to fall off again.