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The Clinton Administration's Health Care Reform Plan: A Taxpayer Perspective

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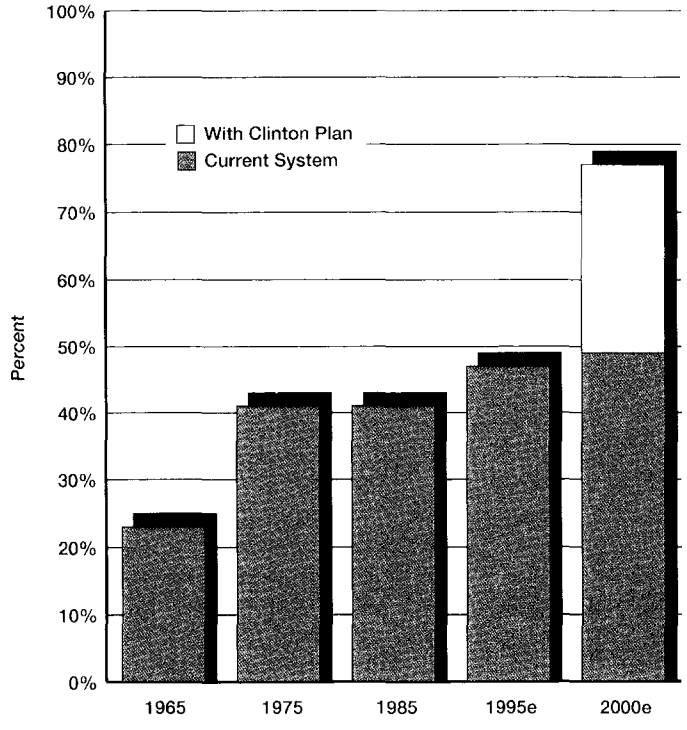
The Clinton administration has presented the American people with a sweeping health care reform plan. However, the general approach and ultimate goals of the plan are not new to the United States.

Serious discussion of compulsory national health insurance began to take place in the second decade of this century. By the end of World War I, suggestions had been made for comprehensive, tax-financed health insurance coverage. The issue was revived during the early 1930s when many people argued that any national health insurance program should be federally-administered and compulsory. The concept was revisited periodically during the administrations of Franklin D. Roosevelt and Harry S. Truman. However, no legislative action was taken.

Nevertheless, for several decades the federal government has conducted a wide variety of programs dealing with specific medical problems and providing health care for certain groups. This role expanded significantly in 1965 when two broadly-based programs—Medicare and Medicaid—were created to assist the aged and the poor. Proponents felt that these two groups had inadequate private health insurance and that out-of-pocket costs deterred them from seeking medical care.

Figure 1
Share of Total U.S. Health-Related Expenditures Paid for through Taxes



Source: Tax Foundation; Health Care Financing Administration; Congressional Budget Office.

The Current Health Care Financing System

In 1965, the year in which Medicare and Medicaid became law, taxes financed about 23 percent of total health care spending in the United States. That figure has escalated to almost 47 percent today. The Clinton administration's health care plan would propel the figure to almost 80 percent by the year 2000. This means that, by the year 2000, only 20 percent of health care financing decisions would remain in private hands. (See *Figure 1.*)

The burden of financing the increased government health care spending, like private health care spending, falls on individual citizens. Tables 1 and 5 show estimates of how Americans finance health care services in

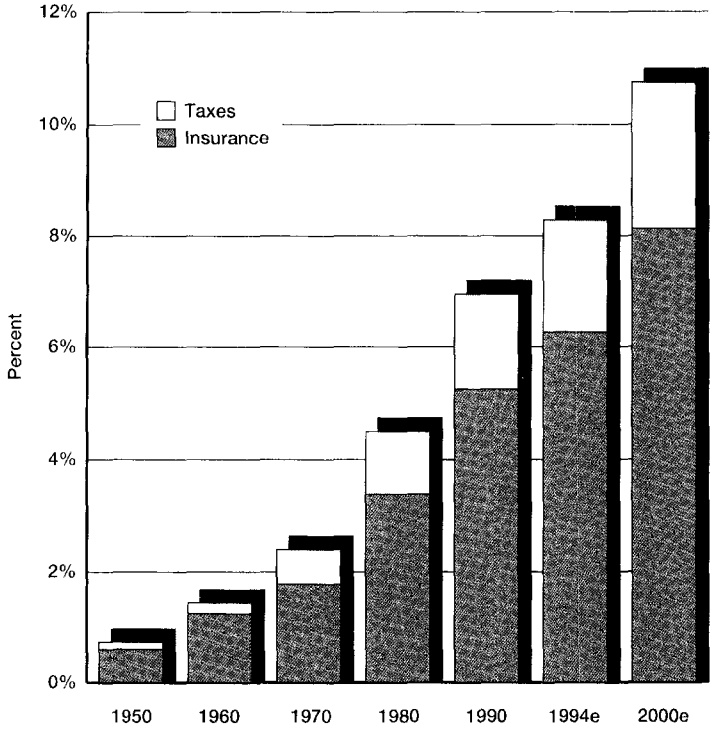
Table 1
Total U.S. Health Care-Related Expenditures by Category and Income Group, 1994 Estimates ($Billions)

	Workplace Health Insurance Premums	Workers Comp. & Temp. Disability[a]	Private Health Insurance Premiums[b]	Medicare Payroll Taxes	Out-of-Pocket Medical Expend.	Out-of-Pocket Perscrip. Drugs	Tax-Financed State/Local Health Expend.	Tax-Financed Federal Health Expend.	Total	Per Household
under $15,000	$89.59	$2.83	$19.00	$9.22	$25.96	$10.09	$6.95	$7.82	$171.45	$5,306.37
$15,000 under $22,500	35.53	2.45	16.19	7.98	19.37	7.39	4.74	4.79	98.43	6,111.47
$22,500 under $30,000	47.13	2.80	14.20	9.12	16.04	5.55	6.69	7.17	108.69	8,360.22
$30,000 under $35,000	22.67	1.89	8.05	6.17	11.35	2.33	7.40	8.19	68.06	8,993.28
$35,000 under $45,000	39.26	3.64	7.38	11.86	11.16	2.15	7.79	8.81	92.06	9,781.56
$45,000 under $60,000	26.66	4.64	11.44	15.14	20.74	3.52	16.66	18.81	117.62	11,885.75
$60,000 under $75,000	12.23	2.80	8.32	9.14	13.60	2.52	15.61	17.49	81.73	25,140.64
$75,000 under $115,000	15.60	3.05	9.72	9.94	16.39	2.78	22.84	28.55	108.86	31,081.90
$115,000 under $150,000	3.77	0.95	3.03	3.09	5.29	0.81	9.67	13.01	39.62	39,960.94
$150,000 under $300,000	3.25	1.20	2.40	3.92	4.39	0.59	11.17	16.11	43.02	61,507.27
$300,000 under $750,000	1.05	0.75	0.92	2.43	1.83	0.19	8.47	14.69	30.32	140,535.27
$750,000 or more	0.43	0.71	0.45	2.31	1.05	0.07	12.80	25.06	42.87	616,168.28
Total	$297.15	$27.71	$101.09	$90.33	$147.17	$37.99	$130.80	$170.50	$1,002.74	$10,335.18

[a] Includes industrial in-plant health services estimated at $3.14 billion.
[b] Includes Supplementary Medicare Premiums.

Source: Tax Foundation calculations based on data from the Health Care Financing Administration, Office of Management and Budget, Bureau of Labor Statistics, Bureau of the Census, and Congressional Budget Office.

Figure 2
Health-Related Employer Expenditures as Percent of Total Compensation



Source: Tax Foundation; Health Care Financing Administration.

1994. *Table 1* shows the estimates by income group; *Table 5* the estimates allocated by state and split among their business, individual, and tax-financed shares.

As *Table 1* reveals, workplace-based health insurance is a primary form of health care financing in the United States. According to the Census Bureau, about 64 percent of the non-elderly population (those under 65 years of age) acquires health insurance through workplace-based plans. (About 15 percent of the non-elderly depend upon government programs financed through taxes. Among the elderly, 96 percent receive Medicare coverage, but about 68 percent also have some form of private health insurance coverage.)

The fact that about 86 percent of total workplace-based health insurance premiums are paid by employees—through their employers, in lieu of cash wages or benfits—is an accident of history and an unintended consequence of past government policies.

In the early 1940s, the federal government imposed wage and price controls to limit the effects of its inflationary financing of World War II. The result was widespread shortages of goods and services, including labor. Businesses, in an effort to raise employees' effective compensation rates despite the legal wage controls, received permission to offer employees health benefits in lieu of cash wages. Since the in-kind health benefits were not subject to the relatively new—and

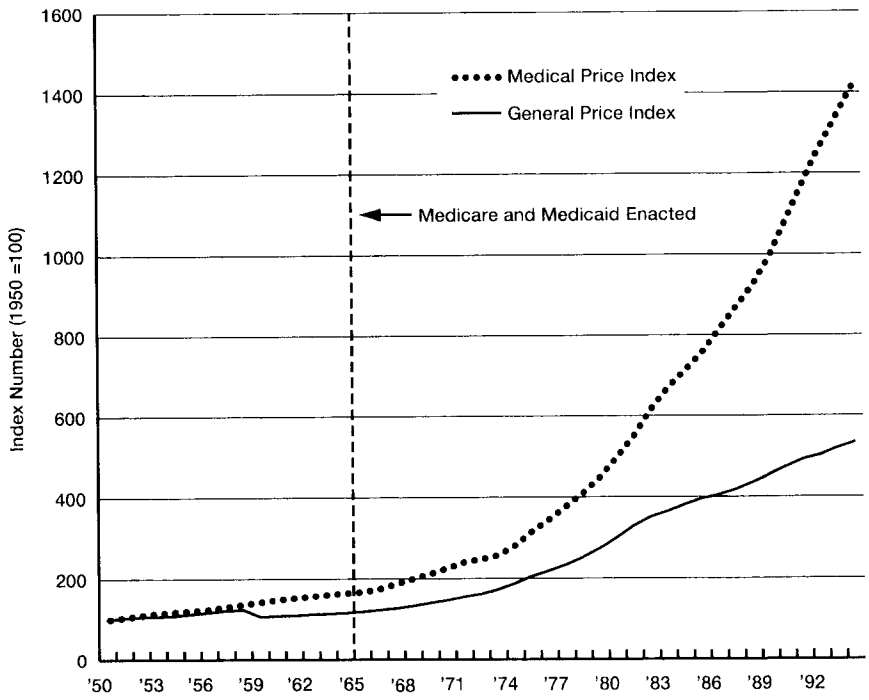
escalating—income tax burden, they became a popular form of remuneration. This popularity led to a 1952 law that codified the tax-exempt status of health benefits.

Not surprisingly, the tax-deductibility of health benefits to businesses and the tax-free nature of health benefits to employees have promoted their growth as a percentage of total employee compensation ever since their inception, as *Figure 2* shows. In 1994, an estimated 6.26 percent of total compensation will take the form of employer-provided health benefits. (Just over two percent will take the form of taxes to finance the government's Medicare and Worker's Compensation programs.) Had the tax exemption for workplace-based health insurance never become law, it is likely the health insurance market would have evolved around individual consumer choices, similar to the market for auto or home owners insurance.

Before 1950, medical inflation tracked closely with, or even lagged, general inflation. As *Figure 3* reveals, however, even prior to adoption of Medicare and Medicaid, medical costs were rising more rapidly than the general price level (perhaps because of the increased demand caused by the tax exemption given to employer-provided health benefits in 1952). Following enactment of Medicare and Medicaid, medical care inflation accelerated.

Some observers hold that the resulting high costs have placed adequate health care beyond the range of many persons, which is a key reason why the Clinton administration and other critics are calling for a further extension of the national government's role in medical and health care.

Figure 3
General Price Inflation vs. Medical Price Inflation, 1950–1994



Source: 1994 Economic Report of the President

The Current System and the Clinton Plan Compared

Tables 2 through *4* and *Figure 4* show estimates of how Americans might finance health care in the year 2000 if the current system remains unchanged and if the Clinton administration's health care plan becomes law. The most fundamental distinction between the current system and the administration plan is one of a primary reliance on voluntary (private) payments versus a primary reliance on mandatory (tax-financed) payments. *Table 6* shows the distribution of the new taxes by state for the years 1996 and 2000.

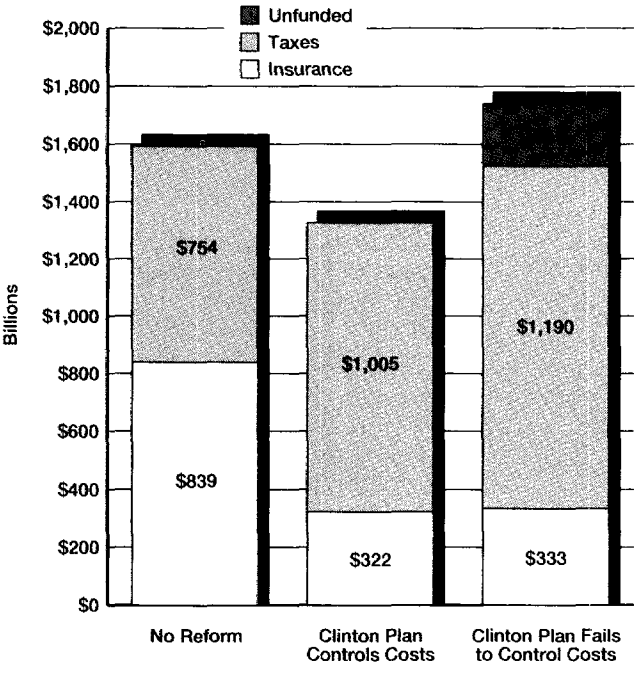
If the Administration Plan Succeeds to Control Costs

The financial and budgetary success of the Clinton administration's health care plan rests entirely on its ability to slow the rate of increase in health care costs, particularly as these costs relate to Medicaid and Medicare. If the plan controls costs as the administration advertises, then Americans' health-related expenditures (from the taxpayers' perspective) will drop almost 17 percent, from an estimated $1.6 trillion to an estimated $1.33 trillion in the year 2000, as a comparison of *Tables 2* and *3* indicates.

In the private sector, the reduced expenditures result primarily from the combination of legal controls the administration's plan places on health insurance premiums and the mandatory participation of everyone in the Regional (or corporate) Health Alliance system. Out-of-pocket prescription drug expenses also drop as a result of the new Medicare-related drug subsidies. In the tax-financed categories, most (86 percent) of the taxpayer savings result from Medicaid spending reductions and assumed reductions in the growth of Medicaid that result from rolling the Medicaid program into the operations of the Regional Health Alliances. The remainder comes from spending reductions in the Medicare program.

A comparison of *Tables 2* and *3* also

Figure 4
A Comparison of Health Care Financing Scenarios in the Year 2000



Source: Tax Foundation; Health Care Financing Administration; Congressional Budget Office; Office of Management and Budget.

shows that the administration's plan shifts the burden of health care expenditures from the lowest income groups toward upper income groups. The primary cause of this shift is the mandatory alliance payments. For example, within the "$15,000 and under" income group, $127.5 billion in workplace health insurance premiums becomes $47.71 billion of mandatory alliance payments. On a per-household basis, the entire burden of the "premium" will drop from an estimated $3,640 to $1,362. (Of course, the same household that would have opted not to purchase health insurance will increase from $0 to $1,362.) The large savings this group of taxpayers achieves via their subsidized Regional Health Alliance payments offsets the strongly regressive distribution of the combined burden of the other new taxes, particularly the cigarette excise.

Those households in the $30,000 to $35,000 income group that would have relied on workplace-based health insurance almost break even under the administration's Regional Health Alliance scheme. However, as one moves up the income scale from the $35,000-income level, households that would have relied on workplace-based insurance will pay substantially more in mandatory alliance payments than they would have paid in workplace-based premiums—employee and employer contributions combined. Any household that would have relied solely upon non-workplace private health insurance will pay much more under the Regional Health Alliance system.

For the population as a whole, the per-household figures in *Table 3* drop relative to their counterpart in *Table 2* for two main reasons. First, except for Supplementary Medicare, the administration's plan will largely drive private health insurance out of existence, so those premium payments disappear from the accounting. Second, because of the administration's projected Medicare and Medicaid savings, the tax-financed categories fall by a larger magnitude than the mandatory alliance payments (net of private premiums), and new taxes rise. The drop in the tax-financed categories affects higher-income groups more favorably because of the progressive distribution of state and federal taxes.

If the Administration Plan Fails to Control Costs

Despite the reliance of the Clinton administration's health care plan on slowing the growth of medical-related costs, the economic incentives built into the plan work in the opposite direction. The Congressional Budget Office report on the president's plan states that universal health care coverage combined with the new federal programs and generous benefit package proposed in the plan "would increase the demand for health care services. But the limits on the growth of health insurance premiums and the reductions in the Medicare program would hold down health spending."

Many analysts argue that the cost control mechanisms in the administration's health care plan amount to price controls, while others argue that they are more properly defined as expenditure limitations. Technically, a difference exists between the two terms. But the ultimate effects of price controls or expenditure limitations are the same: They will create a shortage of medical services, reduce the quality of medical services offered, or both. The history of cost control attempts on the Medicare and Medicaid programs offer excellent examples of this fact.

The verdict of history and economic research on price controls is clear: They invariably fail. Consumers will always line up

to buy a good or service with an artificially low price, but few, if any, people will line up to sell it. So, the market adjusts. If the government's enforcement of the price controls is stringent, the good or service being controlled will be in short supply or its quality will decline. If the government's enforcement is lax, the market will work the way it would have worked anyway if left alone.

The record of medical expenditure limitations in the government-run health programs in Australia, Britain, Canada, Germany, Japan, and the Medicare system in the United States all demonstrate outcomes similar to the effects of price controls. When the limitations have been strictly enforced, waiting lines developed or the quality of medical care declined (usually in the form of rushed consultations with physicians or premature discharges from the hospital). When the expenditure limitations have not been strictly enforced, waiting lines did not develop (or were reduced) because the governments increased their budget outlays to meet the demands of their generous medical programs.

The recent experience of Canada is a case in point. While spending controls have created long waiting lists for health care services, throughout the 1980s per capita national spending on medical care has increased about 7 percent faster than in the United States.

The Clinton administration's plan also offers a generous medical program to everyone. But more importantly, health care becomes an entitlement under the administration's plan. So, if the spending controls fail, the potential liability of the federal government—and, therefore, American taxpayers—to pay subsidies for health care is limited only by Congress's and the administration's willingness to further ration health care. Furthermore, state governments have no insulation against paying a greater sum of money to their Regional Health Alliances if the cost controls fail. As the Congressional Budget Office report stated:

> CBO believes . . . that the caps on payments to the alliances [specified in the administration's plan] would not be legally binding. Section 9102 of the proposal attempts to limit federal liability for the subsidy costs of the program, but the limitation does not diminish the federal government's responsibilities under the proposal. The proposal would oblige the government both to make subsidy payments on behalf of employers and families and to ensure health coverage for all eligible people. The proposal contains no provision for limiting those entitlements in the face of a funding gap, ...

So what if the Clinton administration's plan, like the Medicare and Medicaid programs before it, actually works to accelerate the growth rate of health-related spending, as will happen if and when the price control mechanism fails? What if Congress does not have the political will to enforce spending controls in the face of complaints about health care rationing?

Americans will respond to the incentives built into the plan's subsidy arrangements just like they responded to the favorable tax treatment of workplace-based health care benefits. For example, the administration's plan subsidizes employers based on the business's average wage. This formula, as the CBO and Baruch College Professors June and Dave O'Neill have pointed out, allows businesses to reduce their mandatory Regional Health Alliance payments and increase their federal subsidies by grouping or sorting their higher-wage and lower-wage employees into different companies. It will also give lower-wage workers an incentive to "cluster" in certain companies.

Aside from the economic inefficiency of this business reorganization, it indicates just one of many ways that the incentives and promises built into the administration's health care plan make the figures reported in *Table 4*, which assumes the cost controls will fail, the more likely outcome of the plan. Such an outcome will expose taxpayers to a greater tax burden and fewer health care options than they would have had with no health care reform.

Table 4 shows estimates of the costs of financing the administration's reform plan if health care costs grow at accelerated rates because of the universal health care coverage and subsidies in the administration's plan. As in *Table 3*, workplace and other private health insurance expenditures (except for Supplementary Medicare premiums) disappear into the "Mandatory Alliance Payments" column, so private expenditures shrink, and that makes the total bottom line shrink (relative to *Table 2*) from $1.593 trillion to $1.523 trillion. But if the plan works to accelerate health care spending, then unfunded health care costs arise and total health care costs climb 9.2 percent higher in the year 2000, rising from $1.593 trillion without reform to $1.739 trillion with reform.

Table 2
Total Health Care-Related Expenditures by Category and Income Group, Projected Year 2000 ($Billions)
(Current Law)

	Workplace Health Insurance Premums	Workers Comp. & Temp. Disability[a]	Private Health Insurance Premiums[b]	Medicare Payroll Taxes	Out-of-Pocket Medical Expend.	Out-of-Pocket Perscrip. Drugs	Tax-Financed State/Local Health Expend.	Tax-Financed Federal Health Expend.	Total	Per Household
under $15,000	$127.50	$6.36	$26.77	$16.25	$42.69	$15.22	$12.44	$15.34	$262.57	$7,497.21
$15,000 under $22,500	48.85	5.70	22.81	14.57	31.85	11.16	8.48	9.38	152.80	8,752.53
$22,500 under $30,000	64.64	6.32	20.00	16.15	26.39	8.38	11.97	14.05	167.89	11,913.96
$30,000 under $35,000	31.60	4.26	11.34	10.89	18.66	3.52	13.25	16.06	109.59	13,360.25
$35,000 under $45,000	52.28	7.81	10.40	19.95	18.36	3.24	13.94	17.28	143.25	14,043.16
$45,000 under $60,000	28.92	8.15	16.12	20.81	34.12	5.32	29.82	36.87	180.13	16,792.01
$60,000 under $75,000	14.64	5.18	11.72	13.24	22.37	3.81	27.94	34.29	133.20	37,798.87
$75.000 under $115,000	14.48	4.50	13.69	11.50	26.95	4.19	40.87	55.97	172.17	45,348.87
$115,000 under $150,000	3.42	1.39	4.26	3.56	8.71	1.22	17.31	25.50	65.38	60,832.92
$150,000 under $300,000	3.57	1.96	3.38	5.01	7.22	0.89	19.99	31.57	73.59	97,063.12
$300,000 under $750,000	1.14	1.19	1.29	3.03	3.00	0.29	15.17	28.79	53.91	230,534.04
$750,000 or more	0.39	0.96	0.63	2.46	1.72	0.11	22.91	49.13	78.30	1,038,293.70
Total	$391.43	$53.79	$142.42	$137.42	$242.05	$57.34	$234.09	$334.23	$1,592.78	$15,145.49

[a] Includes industrial in-plant health services estimated at $5.35 billion.
[b] Includes premiums paid by individuals to Medicare Supplementary Insurance Trust Fund.

Source: Tax Foundation computations using data from the Health Care Financing Administration, Office of Management and Budget, Bureau of Labor Statistics, Bureau of the Census, and Congressional Budget Office.

Table 3
Total Health Care-Related Expenditures by Category and Income Group, Projected Year 2000 ($Billions)
(With Clinton Health Care Reform-Price Controls Succeed)

	Mandatory Alliance Payments	Workers Comp. & Temp. Disability[a]	Medicare Payroll Taxes	New Taxes[b]	Supplementary Medicare Insurance Premiums[c]	Out-of-Pocket Medical. Expend.	Out-of-Pocket Perscrip. Drugs	Tax-Financed State/Local Health Expend.	Tax-Financed Federal Health Expend.	Total	Per Household
under $15,000	$47.71	$6.36	$16.50	$5.52	$9.51	$42.69	$10.18	$9.67	$9.24	$157.39	$4,493.91
$15,000 under $22,500	42.98	5.70	14.79	4.39	8.62	31.85	7.46	6.59	5.65	128.04	7,334.55
$22,500 under $30,000	47.43	6.32	16.39	4.43	5.50	26.39	5.60	9.31	8.46	129.84	9,213.75
$30,000 under $35,000	31.99	4.26	11.06	2.91	2.22	18.66	2.35	10.30	9.68	93.43	11,390.43
$35,000 under $45,000	58.14	7.81	20.25	4.38	2.03	18.36	2.17	10.84	10.41	134.39	13,173.95
$45,000 under $60,000	58.55	8.15	21.13	5.13	2.89	34.12	3.55	23.19	22.21	178.92	16,679.32
$60,000 under $75,000	37.63	5.18	13.44	3.26	2.09	22.37	2.55	21.73	20.66	128.90	36,578.62
$75.000 under $115,000	31.16	4.50	11.67	3.21	2.25	26.95	2.80	31.78	33.72	148.06	38,998.17
$115,000 under $150,000	9.62	1.39	3.61	1.63	0.64	8.71	0.82	13.46	15.37	55.24	51,399.39
$150,000 under $300,000	13.89	1.96	5.09	2.05	0.45	7.22	0.59	15.55	19.02	65.82	86,812.66
$300,000 under $750,000	8.37	1.19	3.08	1.34	0.14	3.00	0.19	11.79	17.35	46.45	198,642.69
$750,000 or more	6.52	0.96	2.50	1.71	0.05	1.72	0.07	17.81	29.60	60.94	808,103.84
Total	$394.00	$53.79	$139.50	$40.00	$36.39	$242.05	$38.34	$182.02	$201.36	$1,327.46	$12,622.60

[a] Includes industrial in-plant health services estimated at $5.35 billion.
[b] Except for $1.4 billion in new Medicare payroll taxes, includes medical education assessments and all other levies associated with the plan.
[c] Includes premiums paid by individuals to Medicare Supplementary Insurance Trust Fund, the new Medicare premium increases, new co-payments, and new co-insurance provisions.

Source: Tax Foundation computations using data from the Health Care Financing Administration, Office of Management and Budget, Bureau of Labor Statistics, Bureau of the Census, and Congressional Budget Office.

Table 4
Total Health Care-Related Expenditures by Category and Income Group, Projected Year 2000 ($Billions)
(With Clinton Health Care Reform—Price Controls Fail)

	Mandatory Alliance Payments	Workers Comp. & Temp. Disability[a]	Medicare Payroll Taxes	New Taxes[b]	Supplementary Medicare Insurance Premiums[c]	Out-of-Pocket Medical. Expend.	Out-of-Pocket Perscrip. Drugs	Tax-Financed State/Local Health Expend.	Tax-Financed Federal Health Expend.	Total	Per Household
under $15,000	$47.71	$6.36	$16.50	$5.52	$9.51	$44.63	$10.18	$12.44	$15.34	$168.19	$4,802.25
$15,000 under $22,500	42.98	5.70	14.79	4.39	8.62	33.30	7.46	8.48	9.38	135.10	7,738.90
$22,500 under $30,000	47.43	6.32	16.39	4.43	5.50	27.58	5.60	11.97	14.05	139.28	9,883.90
$30,000 under $35,000	31.99	4.26	11.06	2.91	2.22	19.51	2.35	13.25	16.06	103.61	12,631.32
$35,000 under $45,000	58.14	7.81	20.25	4.38	2.03	19.19	2.17	13.94	17.28	145.19	14,232.70
$45,000 under $60,000	58.55	8.15	21.13	5.13	2.89	35.66	3.55	29.82	36.87	201.75	18,808.25
$60,000 under $75,000	37.63	5.18	13.44	3.26	2.09	23.39	2.55	27.94	34.29	149.75	42,498.13
$75,000 under $115,000	31.16	4.50	11.67	3.21	2.25	28.17	2.80	40.87	55.97	180.62	47,575.59
$115,000 under $150,000	9.62	1.39	3.61	1.63	0.64	9.10	0.82	17.31	25.50	69.62	64,783.98
$150,000 under $300,000	13.89	1.96	5.09	2.05	0.45	7.54	0.59	19.99	31.57	83.15	109,664.42
$300,000 under $750,000	8.37	1.19	3.08	1.34	0.14	3.14	0.19	15.17	28.79	61.41	262,593.63
$750,000 or more	6.52	0.96	2.50	1.71	0.05	1.80	0.07	22.91	49.13	85.65	1,135,678.07
Total	$394.00	$53.79	$139.50	$40.00	$36.39	$253.02	$38.34	$234.09	$334.23	$1,523.33	$14,485.10
								Unfunded (New Taxes Required):		26.38	189.47	215.85	
								Totals with Unfunded Portion Included:		$260.47	$523.7	$1,739.18	$16,537.59

[a] Includes industrial in-plant health services estimated at $5.35 billion.
[b] Except for $1.4 billion in new Medicare payroll taxes, includes medical education assessments and all other levies associated with the plan.
[c] Includes premiums paid by individuals to Medicare Supplementary Insurance Trust Fund, the new Medicare premium increases, new co-payments, and new co-insurance provisions.

Source: Tax Foundation computations using data from the Health Care Financing Administration, Office of Management and Budget, Bureau of Labor Statistics, Bureau of the Census, and Congressional Budget Office.

In that case, reform will add about $1,392 in health-related taxes to the average American household's budget.

The increase in total spending shown in Table 4 relative to Table 2 results from two factors. First, the administration's health care plan proposes $94.6 billion in net new federal spending in the year 2000. Second, the health plan will significantly increase the demand for health care services. Table 4 assumes a $132.22 billion increase in demand by the year 2000. This estimate was derived from a study of the administration's health care plan conducted by the economic consulting firm of DRI/McGraw-Hill. DRI estimated that the plan would increase health care consumption by 8.3 percent over what it would have been in the year 2000 without the plan. Since DRI's estimates used data based on the National Income and Product Accounts instead of the National Health Expenditure Accounts used by the government and this study, the 8.3 percent figure estimated by DRI was applied to the spending total in Table 2.

The increased demand for health care increases out-of-pocket medical expenditures by $10.97 billion, accounts for the $26.38 billion unfunded liability in the state and local tax-financed category, and accounts for $94.87 billion of the $189.47 billion unfunded liability in the federal category seen in Table 4. These unfunded liabilities will require either new taxes or a severe rationing of health care services.

The new entitlement of universal health care coverage at the core of the Clinton administration's health care plan suggests why taxpayers may have to finance additional government spending if the plan's cost controls fail. The frequent expansion of the benefits offered by the Medicare and Medicaid entitlement programs throughout their brief history indicates that the federal government has a propensity to spend the money necessary to meet the American people's health care demands when those demands are met through federal government programs. And, as the Congressional Budget Office and others have argued, the administration's health care plan will substantially increase the demand for—and, therefore, the price of—health care.

Table 5
Estimated Total 1994 Health-Related Expenditures by State and Category ($Billions)

	Employer			Self-Employed	
	Workplace Health Insurance Premums[a]	Workers Comp. & Temp. Disability[b]	Medicare Payroll Taxes	Workplace Health Insurance Premum	Medicare Payroll Taxes[c]
Alabama	$3.46	$0.36	$0.53	$0.57	$0.65
Alaska	0.76	0.08	0.12	0.13	0.14
Arizona	1.89	0.36	0.53	0.30	0.65
Arkansas	1.79	0.18	0.27	0.29	0.33
California	34.05	3.78	5.52	5.84	6.81
Colorado	3.54	0.39	0.57	0.60	0.70
Connecticut	4.52	0.50	0.73	0.76	0.90
Delaware	0.87	0.09	0.14	0.14	0.17
Dist. of Col.	2.16	0.25	0.37	0.39	0.45
Florida	10.73	1.32	1.93	1.90	2.37
Georgia	6.63	0.74	1.08	1.10	1.33
Hawaii	1.22	0.16	0.23	0.22	0.28
Idaho	0.81	0.08	0.12	0.14	0.15
Illinois	12.89	1.37	2.00	2.16	2.46
Indiana	5.46	0.55	0.81	0.87	1.00
Iowa	2.41	0.24	0.34	0.40	0.42
Kansas	2.28	0.24	0.34	0.38	0.42
Kentucky	3.04	0.31	0.45	0.50	0.55
Louisiana	3.28	0.33	0.49	0.55	0.60
Maine	1.09	0.11	0.17	0.18	0.20
Maryland	5.07	0.59	0.86	0.89	1.06
Massachusetts	7.22	0.82	1.19	1.24	1.47
Michigan	9.69	0.99	1.44	1.57	1.78
Minnesota	4.84	0.52	0.76	0.80	0.93
Mississippi	1.78	0.17	0.25	0.29	0.31
Missouri	4.99	0.52	0.76	0.82	0.94
Montana	0.56	0.06	0.08	0.10	0.10
Nebraska	1.42	0.15	0.22	0.24	0.27
Nevada	1.27	0.17	0.24	0.23	0.30
New Hampshire	1.13	0.12	0.17	0.19	0.22
New Jersey	9.78	1.08	1.58	1.63	1.94
New Mexico	1.18	0.13	0.19	0.21	0.23
New York	22.21	2.43	3.55	3.90	4.38
North Carolina	6.54	0.70	1.02	1.06	1.26
North Dakota	0.45	0.05	0.07	0.08	0.09
Ohio	10.59	1.10	1.61	1.73	1.98
Oklahoma	2.51	0.25	0.36	0.42	0.44
Oregon	2.73	0.28	0.41	0.45	0.50
Pennsylvania	11.62	1.22	1.78	1.94	2.19
Rhode Island	0.92	0.10	0.15	0.16	0.18
South Carolina	3.06	0.33	0.49	0.50	0.60
South Dakota	0.49	0.05	0.08	0.09	0.09
Tennessee	4.67	0.48	0.71	0.77	0.87
Texas	16.68	1.76	2.56	2.79	3.16
Utah	1.50	0.16	0.24	0.25	0.29
Vermont	0.52	0.06	0.08	0.09	0.10
Virginia	6.41	0.76	1.11	1.09	1.37
Washington	5.10	0.57	0.84	0.86	1.03
West Virginia	1.29	0.12	0.18	0.21	0.22
Wisconsin	4.81	0.49	0.72	0.78	0.89
Wyoming	0.41	0.04	0.06	0.07	0.07
United States	$254.31	$27.71	$40.47	$42.84	$49.86

[a] Includes all government contributions to private health insurance premiums: Federal share about 4.5% of total; state/local share about 20% of total.
[b] Includes industrial in-plant health services estimated at $3.14 billion.
[c] Self-employed individuals pay the employer and employee share.
[d] Includes premiums paid by individuals to Medicare Supplementary Insurance Trust Fund.

Source: Tax Foundation computations using data from the Health Care Financing Administration, Office of Management and Budget, Bureau of Labor Statistics, Bureau of the Census, and Congressional Budget Office.

Individual			Tax-Financed		
Private Health Insurance Premums[d]	Out-of-Pocket Medical Expend.	Out-of-Pocket Prescription Drug Expend.	State/Local Government	Federal Government	Total
$1.41	$2.35	$0.61	$1.49	$2.03	$13.45
0.25	0.35	0.09	0.36	0.49	2.77
0.83	2.32	0.60	1.28	2.09	10.86
0.75	1.36	0.35	0.58	1.04	6.93
13.23	18.40	4.75	16.16	22.77	131.31
1.31	1.99	0.51	1.24	2.31	13.15
1.78	1.89	0.49	2.73	3.51	17.81
0.33	0.40	0.10	0.32	0.52	3.08
0.50	0.33	0.09	0.99	9.69	15.21
5.01	8.14	2.10	5.68	3.90	43.08
2.54	3.95	1.02	2.72	0.89	22.01
0.45	0.67	0.17	0.62	0.50	4.51
0.31	0.60	0.16	0.23	8.98	11.58
5.05	6.55	1.69	5.51	3.32	43.00
2.10	3.20	0.83	1.86	1.59	18.27
0.98	1.56	0.40	0.90	1.58	9.25
0.90	1.43	0.37	0.95	1.83	9.14
1.25	2.11	0.54	1.17	2.07	11.99
1.44	2.40	0.62	2.27	0.66	12.64
0.43	0.72	0.19	0.62	3.91	7.61
1.95	2.86	0.74	2.47	4.90	21.40
2.95	3.44	0.89	4.91	6.05	30.17
3.83	5.33	1.38	5.26	2.92	34.18
1.81	2.57	0.66	2.47	1.00	16.35
0.74	1.48	0.38	0.65	3.12	9.17
1.97	2.96	0.76	2.19	0.41	16.33
0.23	0.46	0.12	0.28	0.95	2.94
0.56	0.90	0.23	0.41	1.03	5.44
0.52	0.82	0.21	0.46	0.84	5.07
0.40	0.66	0.17	0.97	7.44	11.46
3.80	4.46	1.15	4.87	0.73	31.01
0.46	0.92	0.24	0.53	14.81	18.89
9.28	10.31	2.66	22.75	3.69	85.17
2.51	3.96	1.02	2.73	0.33	21.12
0.19	0.36	0.09	0.20	6.66	8.22
4.33	6.22	1.61	5.09	1.65	35.92
1.02	1.81	0.47	0.89	1.75	9.93
1.04	1.70	0.44	1.03	8.05	16.63
4.96	6.79	1.75	6.09	0.66	39.00
0.38	0.58	0.15	0.83	1.72	5.17
1.17	2.09	0.54	1.50	0.37	10.65
0.20	0.40	0.10	0.22	2.75	4.47
1.87	2.86	0.74	1.75	11.01	25.73
6.48	10.32	2.66	6.44	0.83	53.67
0.54	1.05	0.27	0.40	0.34	5.05
0.20	0.33	0.09	0.23	4.42	6.11
2.33	3.72	0.96	2.36	3.77	23.88
1.94	2.99	0.77	2.47	0.80	17.37
0.56	1.00	0.26	0.55	3.02	7.40
1.86	2.85	0.73	1.94	0.29	15.37
0.16	0.26	0.07	0.17	0.53	1.83
$101.09	$147.17	$37.99	$130.80	$170.50	$1,002.74

Table 6
State-by-State Tax Burden of Clinton Health Plan ($Millions)

	Share of Mandatory Health Alliance Payments		Other New Taxes		Total	
	1996	2000	1996	2000	1996	2000
Alabama	$518.3	$5,012.1	$251.2	$574.6	$769.4	$5,586.6
Alaska	112.7	1,063.2	34.7	104.7	147.4	1,167.9
Arizona	540.1	5,539.4	188.2	603.5	728.2	6,142.8
Arkansas	263.0	2,541.0	141.1	321.6	404.0	2,862.5
California	5,577.1	56,469.8	1,321.0	5,264.7	6,898.1	61,734.4
Colorado	562.3	5,469.4	178.3	558.6	740.6	6,028.1
Connecticut	731.7	7,353.7	183.4	692.5	915.0	8,046.2
Delaware	136.3	1,367.4	51.7	148.2	188.0	1,515.6
Dist. of Col.	361.3	3,515.1	630.7	759.4	992.0	4,274.5
Florida	1,984.5	20,948.7	517.5	2,225.3	2,501.9	23,174.0
Georgia	1,105.0	11,439.1	87.6	864.8	1,192.6	12,303.9
Hawaii	229.8	2,334.4	55.2	205.7	285.0	2,540.1
Idaho	117.0	1,108.6	519.2	556.6	636.1	1,665.1
Illinois	1,947.7	18,352.6	465.4	1,771.5	2,413.0	20,124.1
Indiana	786.5	7,388.5	166.7	678.7	953.1	8,067.3
Iowa	329.3	2,981.3	130.8	347.1	460.0	3,328.4
Kansas	334.5	3,140.3	312.4	522.5	646.9	3,662.8
Kentucky	436.9	4,129.9	245.7	533.0	682.6	4,663.0
Louisiana	457.1	4,020.0	92.9	400.0	550.0	4,420.0
Maine	165.1	1,638.1	209.4	312.3	374.5	1,950.4
Maryland	872.7	8,856.2	303.1	909.7	1,175.8	9,766.0
Massachusetts	1,192.6	11,881.2	559.0	1,323.4	1,751.6	13,204.6
Michigan	1,394.4	12,961.3	260.1	1,187.3	1,654.5	14,148.5
Minnesota	751.5	7,360.9	172.6	672.3	924.1	8,033.2
Mississippi	247.0	2,307.9	310.4	460.2	557.4	2,768.0
Missouri	746.5	7,106.2	78.4	598.9	824.9	7,705.1
Montana	76.9	680.9	75.4	128.5	152.3	809.3
Nebraska	212.8	1,999.0	81.1	220.2	294.0	2,219.2
Nevada	251.5	2,652.1	96.1	277.4	347.6	2,929.5
New Hampshire	178.0	1,834.2	328.9	434.3	506.9	2,268.5
New Jersey	1,586.1	15,958.2	163.5	1,279.6	1,749.6	17,237.8
New Mexico	182.9	1,760.5	715.2	783.9	898.1	2,544.5
New York	3,535.1	34,769.3	704.8	3,105.7	4,239.9	37,875.0
North Carolina	1,030.0	10,416.1	84.1	806.3	1,114.1	11,222.4
North Dakota	67.4	605.3	573.6	564.6	641.0	1,169.9
Ohio	1,549.5	14,284.5	227.8	1,267.3	1,777.2	15,551.8
Oklahoma	342.4	3,059.6	162.3	390.3	504.7	3,449.9
Oregon	397.3	3,755.7	586.6	821.3	983.9	4,577.0
Pennsylvania	1,726.2	16,137.9	161.9	1,388.7	1,888.1	17,526.7
Rhode Island	145.2	1,395.4	206.3	291.0	351.5	1,686.4
South Carolina	487.3	4,851.6	58.7	399.6	546.0	5,251.2
South Dakota	74.3	705.8	288.9	316.2	363.2	1,022.0
Tennessee	703.4	6,921.9	729.4	1,139.0	1,432.8	8,061.0
Texas	2,529.0	24,425.2	199.0	2,007.2	2,728.0	26,432.3
Utah	238.2	2,359.7	44.2	212.3	282.4	2,571.9
Vermont	81.5	822.4	324.1	356.2	405.6	1,178.5
Virginia	1,131.0	11,591.2	257.4	1,051.8	1,388.4	12,643.1
Washington	833.3	8,237.7	152.6	741.0	985.9	8,978.6
West Virginia	164.7	1,409.3	468.4	770.0	633.1	2,179.3
Wisconsin	704.3	6,666.8	69.7	557.7	774.0	7,224.5
Wyoming	50.7	414.1	25.6	60.3	76.3	474.4
United States	40,000.0	394,000.0	14,000.0	41,400.0	54,000.0	435,400.0

Note: Includes medical education assessments.

Source: Tax Foundation; Congressional Budget Office; Joint Committee on Taxation.

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