Will the Opportunity Pass Again?
U.S. Health Care Reform in 1994

Although debate rages in the U.S. over the Clinton Administration's health care reform initiatives, at least one point remains undisputed: the need for reform is more pressing than ever before.

by Kevin G. Volpp

The soaring cost of health care is one of the most pressing issues in America today. Health spending in the United States will total an estimated $1 trillion by the end of 1994, making the American health sector the size of the eighth largest economy in the world, larger than the national economy of Spain. Health expenditures constitute 14 percent of GNP and are projected to grow to 18 percent by the year 2000. Between 1950 and 1990, health expenditures have steadily risen at a rate 3 percent higher than spending for other goods and services, and if this trend continues, a staggering amount of the country's resources will soon be directed to the health sector (as the chart on the next page demonstrates).

Also critical is the need to extend health coverage to 37 million uninsured Americans. The United States and South Africa are the only western, industrialized countries that do not extend health security to all citizens.

Yet another challenge is to improve the quality of health care while controlling its cost. For those with access to it, the United States offers the world's most technologically advanced health care. Molecular, genetic and other research breakthroughs promise further advances in areas once thought untreatable, and pharmaceutical agents have improved quality of life and frequently circumvent the need for surgery. However, quantity of health services does not always mean quality, and the charge is often levied that procedures executed are inappropriate to patients' diagnostic conditions.

These criticisms of the health care industry are not new. Both Richard Nixon and Jimmy Carter predicted disaster unless action was taken to reform health care. Nevertheless, stakeholders in the health system—hospitals, physicians, pharmaceutical and medical equipment manufacturers, insurance companies, the federal government, and patients—have until now preserved the status quo.

With the election of a largely Democratic Congress and a President committed to health care reform in 1992, the issue leapt to prominence on the national scene. The proposed Clinton Health Security Act is the most extensive governmental program since the passage of Social Security in the 1930s, and, though critiqued for its methods, it has been lauded for its goals. In previous attempts at comprehensive reform during this century, interest groups representing the medical profession, insurance companies, and unions, obstructed health reform efforts in response to perceived threats to their own

[Kirk Anderson]

Kevin Volpp is an M.D./Ph.D. student at the University of Pennsylvania, studying at the Department of Public Policy & Management in the Wharton School and at the School of Medicine. *This article was prepared with funding from National Institutes of Health Grant 5-T32 GM-07170s.*

self-interest. Nevertheless, the question remains: will present attempts at reform succeed where others have failed?

Past Failures

Health reform was first attempted in the early 1900s by the Progressives, a political party which sought to reform capitalism and engineer social improvement through government action. In 1912, the Progressives and their presidential candidate Teddy Roosevelt supported social insurance; they believed that national strength must grow from a healthy, prosperous population, and argued that health insurance would relieve poverty caused by sickness and would reduce the costs of illness by providing medical care.

Initially, Progressive reformers had the support of the American Medical Association (AMA), but disagreements arose when the Progressive search for efficiency conflicted with doctors' concerns about their income and autonomy—a conflict which has continued to arise throughout this century. Furthermore, employers and unions alike opposed compulsory governmental health insurance because they feared it would increase worker loyalty to the government, rather than to unions or employers.

Health Care Costs
(as a percentage of GDP)

1940	4.0%
1950	4.5%
1960	5.3%
1970	7.3%
1980	9.1%
1990	12.2%
1991	13.2%
1992	13.9%
1993	14.4%
1995	15.6%
2000	18.1%
2010	22.0%
2020	26.5%
2030	32.0%

Source: "National Health Expenditures Projections through 2030," *Health Care Financing Review,"* 1992, vol. 14, no. 1.

In 1917, the entry of the United States into World War I fueled strong anti-German sentiment, and opponents of health insurance successfully stigmatized this form of insurance as a device for social control with origins in the Prussian Empire. After the war, rising medical costs shifted the emphasis among reformers during the 1920s: while compensation for income losses during sickness had originally been regarded as the primary problem, protection against the costs of medical care now moved to the forefront. The Depression also shifted national concerns away from health coverage and towards unemployment insurance and Social Security. For fear it would jeopardize the passage of Social Security, health insurance was not included in the bill.

Finally, in 1943, universal health insurance was proposed in Congress as part of a new "cradle to grave" social security system. Though this proposal was delayed by the war, only three months after the armistice President Truman proposed a single health coverage system that would include all Americans. He freely acknowledged that the expansion of services would cost more money, but noted that medical services absorbed only four percent of national income. Public funds, he argued, would foot the insurance bill for those too poor to pay themselves.

Though Truman's plan promised higher incomes to physicians without organizational reform, doctors still supported voluntary, rather than compulsory, insurance and galvanized the support of large businesses, public officials, and community groups. The AMA was able, in a climate of rampant anti-communism, to characterize socialized medicine as a dangerous step towards socialization of other areas of American life. While a compromise—such as a combination of voluntary and compulsory insurance—might have passed, the vehement opposition from the AMA may have intimidated Congress from assembling the necessary support, and ultimately the Truman proposal was killed.

Though World War II postponed discussion of social legislation, one major change in the health insurance landscape did emerge—somewhat accidentally—which continues to influence current debates. In 1942, the War Labor Board decided that though wages were frozen to control inflation, fringe benefits of up to five percent of wages would not be considered inflationary. Therefore, to attract and keep workers, employers began to offer health insurance. This change became more important when unions were granted the right to bargain collectively with management over health care in the late 1940s. Benefits such as health insurance were not considered taxable income, which helped fuel demand for increasingly generous employer-sponsored health plans during the ensuing decades.

In the past, interest groups opposed to national health insurance used ideology as a device to sway the American people. By portraying universal health insurance as first a German device for social engineering and then as a Soviet communist plot, these groups were able to set the tone of public debate. In more recent health reform efforts, political leaders have mitigated interest group opposition by anticipating their positions and incorporating concessions into the design of the legislation. While perhaps necessary for legislative success, such compromises often represented bad policy, and helped fuel the subsequent rise of health care costs.

Short-lived Success in the 1960s

Between 1961 and 1965 the American economy boomed. In 1964, the Democrats gained a voting margin in the House of Representatives not seen since the 1930s. The time was ripe for social legislation, and by July 30, 1965, President Lyndon Johnson had signed three health care bills into law: Medicare Part A, a compulsory hospital insurance program under Social Security; Medicare Part B, a government-subsidized voluntary insurance program to cover physician services; and Medicaid, a state-federal program designed to aid the poor.

The fact that these bills passed through Congress reflected the substantial concessions which had been made to interest groups such as doctors and hospitals. Most significant of these, perhaps, was the decision to administer Medicare payments according to the Blue Cross system of paying hospitals their

reported costs—essentially giving hospitals and physicians a blank check. The initial opposition of hospitals and doctors to the bills was offset by strong grass-roots support for them from the elderly, who by this time had formidable lobbying power.

Since most of the cost of care was covered by health insurance provided through employers, physicians and insured patients demanded the best services regardless of cost. The freer flow of money encouraged the development of expensive new medical technologies, many of which were disbursed before there was proof of their effectiveness or consideration of their cost.

Within a few years, Medicare and Medicaid expenditures had grown far more rapidly than projected. From $2.9 billion in 1966, the programs' expenditures grew to $7.9 billion in 1967. By 1972, the account reached $16.8 billion. In addition, critics lambasted the system for its excessive dependence on specialists rather than general physicians, for too great a focus on hospital-based care, and for being comprised of a patchwork of disparate federal programs rather than a single plan with tough cost controls. Due to its tax exempt status, employer-based health insurance continued to expand. This, along with the increased governmental role in insurance, caused the share of health care expenditures paid by private insurers and the government to increase to 67 percent by 1975. Patients and providers were thus effectively shielded from the true costs of treatments.

The first pronouncement of crisis

Shortly after taking office in 1969, President Nixon announced a major crisis in the nation's health care costs. To address this situation, the Nixon Administration proposed a multistage approach. First, it supported the expansion of Health Maintenance Organizations (HMOs) which integrated financing and delivery systems for health services, providing care for subscribers based on a yearly fee. The logic behind HMOs was to reward care givers for keeping people healthy, rather than paying them more when patients were sick.

Nixon then sponsored a proposal which required employers to provide a minimum package of health insurance benefits to employees, and established a separate government-run program for the rest of the population. Under his plan, patients were required to pay 25 percent of medical bills up to a maximum of $1,500 per year.

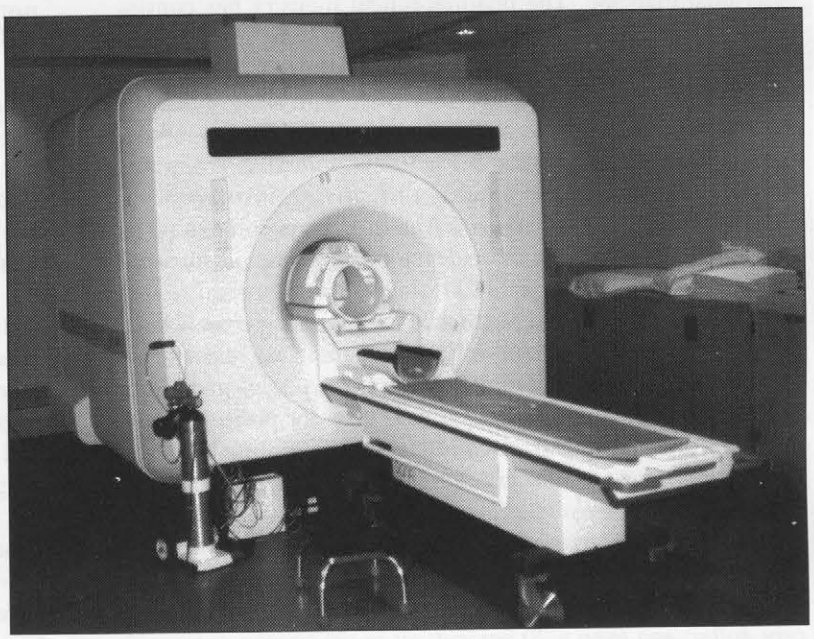
By 1973 and 1974, legislative action on these proposals seemed imminent. However, a combination of political opposition from groups unwilling to compromise their own insurance plans (namely labor unions and liberal Democrats), the effects of Watergate and a severe recession in 1974 and 1975 curtailed any plans to expand social welfare programs in the foreseeable future.

Throughout the 1970s and 1980s, as patients continued to demand the most effective treatments regardless of cost, those who paid for private insurance found that the cost of caring for the uninsured increasingly shifted on to them. This happened as the federal government attempted to hold its expenditures down by paying progressively smaller percentages of the costs of hospitals' bills and physician fees; providers, in turn, charged higher fees to patients with private insurance.

Some states restricted the criteria for Medicaid to make it available only to those with incomes lower than 16% of the poverty line (which for a family of four in the U.S. is now about $13,000). In certain states a family of four with income greater than about $2,100 would not have been eligible for Medicaid.

The working poor—those who earned too much to be eligible for Medicaid in nearly all states—found themselves choosing between health care or food and clothing, as health insurance was rarely provided by their employers. For those who worked independently, for small firms, or who had ongoing illnesses, health insurance coverage was often either unobtainable or unaffordable. Employers, who paid for most private insurance, began to complain that health costs were eroding competitiveness and profits. They therefore increased employees' cost burden by reducing benefits and increasing required co-payments and deductibles.

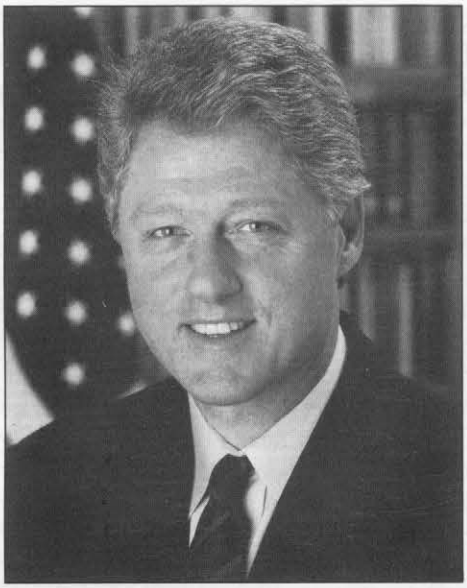
By the 1990s, many workers had been moved into managed care programs which limited patients' choices of physicians, but helped employers control health care costs. Still, an estimated 37 million Americans—mostly workers and their dependents—remain uninsured, and another 40 million have inadequate insurance which would not cover them for catastrophic illnesses. Indicative of the current health care crisis is the fear of middle-class Americans that they will lose health insurance coverage if they get sick or lose their jobs.



Magnetic Resonance Imaging (MRI) machine: wonderful technology, but can the U.S. afford so many? [Schulten]

The Current Debate

Today, the commitment of the White House has ensured that once again health care reform has a chance at success. Most legislators agree that extension of universal health insurance is now just a question of when and how. The current debate, despite what the Clinton Administration had hoped, is one which is heavily influenced by interest groups, though the medical profession no longer has the clout to single-handedly



President Clinton: determined to reform the health care system. [U.S. Embassy, Ottawa]

block reform.

In contrast with the past, almost all interest groups have now voiced the need for universal health insurance and tougher cost controls. Big business has helped lead the push towards reform, though many businesses (both large and small) still oppose required employer provision of health insurance. The AMA has firmly supported universal coverage, whether through an employer or individual mandate. The pharmaceutical industry has consistently favored extending health insurance (and prescription drug) coverage to the entire population, though it does fear possible governmental price controls, which would stifle research and innovation. In this round of health care reform negotiations, the principle obstructionist lobbying group has been the major trade association of private insurers—the Health Insurance Association of America. Though claiming to support universal access, it has developed a television advertising campaign highly critical of President Clinton's plan.

The key issue is how to finance the extension of new benefits. In the interest of controlling the deficit, current budget rules forbid Congress from approving any new programs unless they are paid for through new taxes or projected savings. Unfortunately, though predictably, the current political debate is laden with misconceptions about how reform could be financed.

For example, many argue that physicians' salaries and pharmaceutical profits are the source of excessive costs. Yet, physicians' salaries constitute only 19 cents of every health care dollar, and even a 20 percent cut in net physician income would reduce total health spending by only two percent. Similarly, spending on pharmaceuticals constitutes only seven percent of health care spending, and even a 50 percent cut in drug company profits would save less than one percent of health care expenditures.

Perhaps the most insidious myth espoused by politicians is the notion that employers "give" health insurance to their employees. Union leaders have long understood, though the rank-and-file may not, that employers view cash wages and fringe benefits as a total compensation package. To remain competitive, firms which pay more for benefits pay less in cash wages.

One of the main reasons for the rising cost of health care has been the increase in the number and type of services performed, especially as new technology is rapidly dispersed. For example, there are more Magnetic Resonance Imaging machines (MRIs) in Philadelphia alone than in all of Canada. While MRIs represent a fantastic technological advance, can the United States really afford to support the distribution of such technology without considering the costs?

Likely Outcomes: The Three C's

Within the myriad of plans proposed by Congress, there are three which will likely represent the basis for an eventual compromise. Tennessee Democrat Jim Cooper's proposal is the most market-oriented, President Clinton's the most regulatory, and Senator John Chafee's (R.—R.I.) somewhere in between. All three agree on many fundamental principles.

First, they concur there has been a breakdown in the insurance market—particularly for small insurers and individuals—and they support insurance reforms. Second, they support the use of a regulated marketplace as a means of controlling health care costs. Third, they suggest standardized benefit packages as a way to facilitate competition. Fourth, they support quality report cards to drive internal improvements and competition among health plans. Fifth, they seek to simplify health care delivery by reducing paperwork and red tape. And finally, they agree that broad-based taxes would be unpalatable to the American public, and rely instead on other financing mechanisms.

All the plans are rooted in the concept of managed competition, a system in which a sponsor acts on behalf of a large group of subscribers. That way, attempts by insurers to avoid price competition by selecting patients who are poorer health risks can be overcome. To be fair to insurers who end up with a pool of older or sicker patients, risk-adjustments are included to ensure higher premiums for populations which are expected to have more illnesses.

Managed competition is based on annual contracts that include comprehensive health services, such as managed care organizations or HMOs. The goal of these organizations is to promote efficiency by two means: first, through the integration of payment and care systems into one organization, and second, by encouraging comprehensive health care that focuses on keeping patients healthy.

One of the inequities managed competition was designed to address is the provision of employer-based health insurance to workers as a tax-exempt benefit, which, because such insurance is not received by the less well-off, represents a redistribution of funds from the less wealthy to the more wealthy. This use of tax dollars as a subsidy for higher priced plans should be eliminated. Ideally, health insurance would be paid for with after-tax dollars, with appropriate subsidies to those who need them on the basis of income.

The role of tax dollars in health insurance plans is, in fact, one of the central differences between the approaches of Clinton, Cooper and Chafee. Cooper and Chafee limit tax deductions for premiums above a certain level, while Clinton does not meaningfully do so. The other differences center around the role of health purchasing cooperatives, price controls, and mandatory coverage.

In all three plans, health insurance purchasing cooperatives are created to assemble small groups of consumers into larger entities for the purchase of insurance. The size and regulatory authority of these groups differs markedly, however. Cooper and Chafee both suggest alliances for employers with

fewer than 100 employees or individual purchasers. These alliances would serve as health benefits departments for individuals or small businesses who do not have the resources to create such departments for their employees.

Clinton's plan, by far the most regulatory of the three, forces all employers with fewer than 5000 employees to join these alliances, and taxes larger employers if they choose not to join. In addition, the Administration's plan grants these alliances greater authority to regulate and administer health plans, and also creates a National Health Board to monitor the changing needs and prices charged for these plans. A big reason for the increased regulatory authority of the alliances and National Health Board is Clinton's decision to use price controls and an annual cap on health-care spending "in case" market forces do not keep cost increases in check. Neither Cooper nor Chafee employ price controls or spending limits.

Whether or not price controls will work is a key issue. In the past, attempts to regulate premiums have failed to eliminate inefficient, high-cost producers. Price controls may also create the wrong incentives, as providers and health plans will be more concerned with convincing regulators they need more money than with improving efficiency.

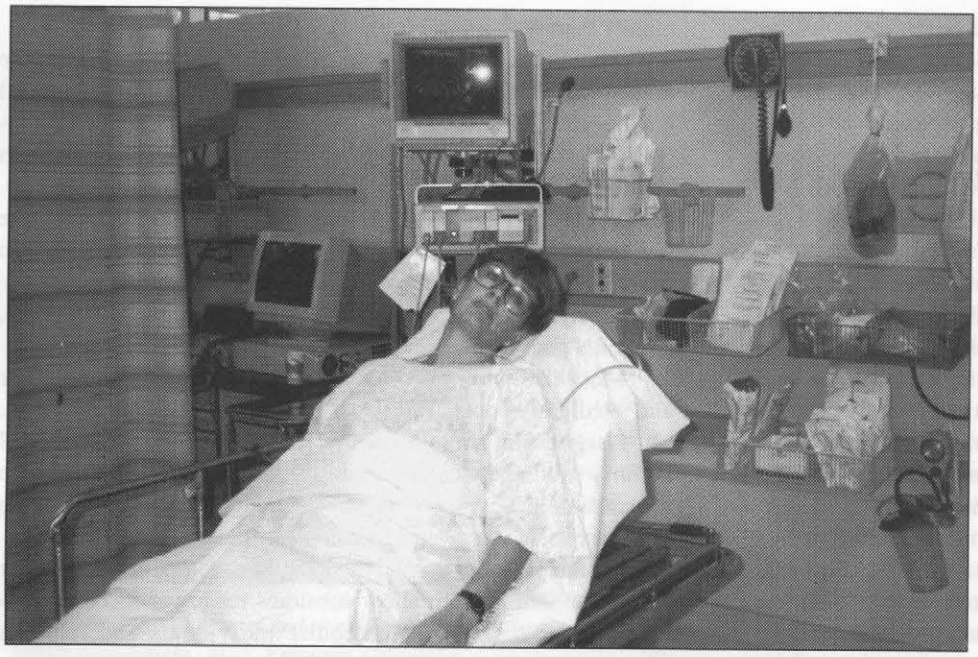
All three plans require employers to make group insurance available to employees without regard for pre-existing medical conditions or similar limitations. A big part of the complexity—and controversy—of the Clinton plan is its use of an employer mandate. Employers will be required to pay 80 percent of the cost of health insurance premiums (divided by the number of workers in the family), while workers will pay the other 20 percent. Government subsidies will limit the percentage of payroll firms will have to pay dependent on firm size. Clinton's goal is universal coverage by 1998.

Most economists decry the employer mandate as an unfair and needlessly complicated way to achieve universal coverage. They argue that the tax exempt status of such benefits will unfairly privilege wealthier families, and the incentives of such a plan would adversely affect the labor market by inducing practices such as not hiring workers with dependents.

Neither Cooper nor Chafee require employers to pay for insurance, though both allow subsidies for lower-income families. Chafee's plan would require individuals and families whose employers do not provide insurance to do so them-

The Three C's: A Comparative Look

Sponsor	President Clinton	Sen. John Chafee (R., RI)	Rep. Jim Cooper (D., TN)
Coverage	All Americans, mostly through employers. Regional health alliances available to facilitate purchase for individuals and small groups.	All Americans required to buy insurance if not provided by employers. Health insurance purchasing cooperatives for uncovered workers and unemployed. Government subsidies for low-income people.	Coverage not required. Small employers, employees, non-workers can buy through health alliances. Government subsidies for low-income people.
Financing	Large employers pay 80% of workers' premiums; workers pay the rest. Government costs financed by Medicare and Medicaid cuts, cigarette tax, 1% payroll tax on large employers not in alliances.	Tax deductions limited for premiums above certain level. Medicare and Medicaid would be cut. Employers have option of contributing to premiums.	Limits imposed on tax deductions by employers for premiums above a certain level. Medicare cuts.
Benefits	Standard benefit package includes hospital, doctor, primary care, preventive services, prescription drugs, dental , mental health, in-home care.	Insurers required to offer package of medical, surgical, preventive care, prescription drugs, rehabilitation services, severe mental problems, substance abuse treatment.	Standard acute-care benefit package to be offered. May include more benefits later.
Cost Control	Government would set annual cap on health care spending; by 1999, growth to be limited to inflation rate. Administrative savings, malpractice reform.	No budgets would be set. Enhanced competition among insurers and providers expected to hold down costs, along with administrative savings and malpractice reform.	No budget would be set. Cost cuts from enhanced competition among insurers and health care providers, administrative savings and malpractice reform.



How will she pay for her care? [Schulten]

selves, though only by 2005. While there is no employer or individual mandate under Cooper's plan, his supporters claim that 80 percent of uninsured Americans will purchase insurance if market failures are corrected.

Compromises and Concessions

All the plans, of course, carry a hefty load of political concessions. Clinton's is particularly laden with fat. To appease the elderly, Medicare is maintained as a separate program and sweeteners are added in the form of a new prescription drug benefit and long-term care. Unions will be able to keep the existing tax subsidies of more expensive plans. And most significantly, rather than forcing Americans to face up to the cost of the care they consume by financing the entire system with a payroll tax or individual mandate, his plan uses the camouflage of an employer mandate.

To appease employers, the plan includes an extensive array of subsidies to shield smaller employers (inappropriately, without regard to the wage level of their employees) and large employers from the cost of the employer mandate. In addition, the Clinton plan removes the burden of health insurance coverage for 55- to 64-year-old retirees from the backs of large corporations.

Clinton's goals are laudable, but critics are wary of the highly regulatory aspect of the plan, which to them smacks of bureaucracy. Cooper's plan is regarded by many as closer to the original concept of managed competition. As a concession to the elderly (and their clout as a lobbying group), both his and Chafee's plan, like Clinton's, leave Medicare as is. There is concern, however, that neither Cooper nor Chafee is serious about achieving universal coverage.

What to Expect

Supporters of the three centrist plans are now making the compromises necessary to create the bipartisan coalition all believe is required if there is to be success. Much of the battle will focus on the extension of an employer mandate, the extent of the regulatory oversight of the National Health Board and alliances, and the appropriateness of price controls and spending limits.

The Administration's plan would be greatly simplified without the intricacies of rules governing the employer mandate. However, due to the fact that most Americans believe that employers "pay" for health care, it is hard to imagine that this politically attractive feature will be left out of the final bill.

Conservative Democrats and some Republicans might agree to support a plan which includes an employer mandate if price controls and spending limits are deleted from the bill. In such a scenario, the regulatory power of the alliances and National Health Board would be reduced. It is likely that the generous benefits offered by the Clinton plan will shrink as cost projections are more closely scrutinized.

History tells us that we should not necessarily expect Congress to pass meaningful legislation before this opportunity disappears, which perhaps it will as soon as November and the mid-term elections. But the fact that major interest groups back—at least in principle—broad reform distinguishes this reform attempt from past failures. And there is also a groundswell of support from the general public, albeit with a limited willingness to make sacrifices.

Only an eternal optimist would expect that good policy will triumph over politics in this round of health care reform battling, but almost any change is likely to represent an improvement over the status quo. There is, however, a danger in having consensus behind the idea of reform but not behind any particular plan: if compromises cannot be reached in sufficient time, the window of opportunity may close once more. ●

Suggestions for Further Reading

Henry Aaron and William B. Schwartz, *The Painful Prescription: Rationing Hospital Care*. (The Brookings Institution, Washington D.C., 1984).

Frank Campion, *The AMA and U.S. health policy since 1940*. (Chicago Review Press, 1984)

Rashi Fein, *Medical Care, Medical Costs*. (Harvard University Press, 1989).

Victor Fuchs, *Who Shall Live? Health, economics and social choice*. (Basic Books, 1975)

Health Affairs, Spring 1994 special issue "The Clinton Plan: Pro and Con."

Paul Starr, *The Social Transformation of American Medicine*. (Basic Books, 1982).

Kevin Volpp and J.S. Schwartz, "Myths and Realities of Health Reform," in *Journal of the American Medical Association*. (May 4, 1994).