

HEALTH CARE REFORM: IS 1994 THE YEAR?

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INTRODUCTION

The battle for health care reform has begun in earnest. Last fall, the President addressed a joint session of Congress and outlined his vision of reform. Multiple reform bills are under consideration in Congress.¹ The President and members of Con-

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1. In addition to the Clinton Plan, six major health reform initiatives have been introduced in the 103rd Congress. The Senate Republican Health Care Task Force proposes to require employers with less than 100 employees to participate in a purchasing cooperative, mandate individuals to have health insurance with a penalty for non-compliance, and eliminate pre-existing conditions exclusions. H.R. 3704 & S. 1770, 103d Cong., 1st Sess. (1993) (Chafee/Thomas bill).

The proposed "Managed Competition Act of 1993" would encourage the formation of health plan purchasing cooperatives to negotiate health plans for coverage on behalf of employers with fewer than 100 employees. The bill would also establish a basic benefits package, limit the deductibility of health plans to the least expensive cost of the package, and encourage the formation of accountable health plans. H.R. 3222 & S. 1579, 103d Cong., 1st Sess. (1993) (Cooper/Grandy/Breaux/Durenburger bill) [hereinafter Cooper/Grandy bill].

Incremental reforms are the hallmarks of the "Action Now on Health Care Reform Act of 1993." This bill would implement small group insurance reforms, expand the Medicare program, and provide individuals with tax incentives to save for medical expenses through "medical IRAs." H.R. 3080 & S. 1533, 103d Cong., 1st Sess. (1993) (Michel/Lott bill).

The "American Health Security Act" would establish a single-payer, Canadian-style government system of health care. The bill would replace

gress have held town meetings across the country; newspaper and television advertisements on reform have appeared with increasing frequency; and there have been hundreds of meetings on health care reform in the past year. But despite all of the activity, we remain in the early stages of what will be a difficult and contentious period. The Clinton Administration clearly hopes that the result will be health care legislation in 1994, but that outcome is far from certain. While the President has indicated a willingness to be flexible in negotiating legislative language as long as the resulting bill provides for universal coverage,² the requirement for universal coverage in itself has far-reaching implications.

In order to pass health care legislation, Congress will need to form a majority coalition that, from all indications, does not currently exist. If such a coalition can be built, it is as yet unclear whether the coalition will be to the right of center, as was the case for the recently passed North American Free Trade Agreement (NAFTA),³ or whether it will be to the left of center,

Medicare, Medicaid, and most private health insurance with a government-run system administered at the state level. It would also establish a national health board to set a national health budget based on annual health costs, and be financed through a variety of new taxes. H.R. 1200 & S. 491, 103d Cong., 1st Sess. (1993) (McDermott/Wellstone bill).

The "Health Care Cost Containment and Reform Act" would establish annual budgets based on prior year national health expenditures, with the rate of growth limited to the growth of GDP. The government would establish rates for all personal health services, set national standards for health insurance plans, expand benefits under Medicare and Medicaid, and establish a new federal program to provide health insurance to all children under age 19. H.R. 200, 103d Cong., 1st Sess. (1993) (Stark bill).

Under the "Consumer Choice Health Security Act of 1993," individual medical savings accounts would be funded by current employer and employee contributions for the purchase of a \$3000 deductible catastrophic insurance policy. Pre-existing condition exclusions would be prohibited, but additional charges of up to 150% of the average premium would be permitted. H.R. 3698 & S. 1743, 103d Cong., 1st Sess. (1993) (Nickels/Stearns bill).

2. In his 1994 State of the Union Address, President Clinton stated:

I want to make this very clear. I am open — as I have said repeatedly — to the best ideas of concerned members of both parties. I have no special brief for any specific approach even in our own bill except this: If you send me legislation that does not guarantee every American private health insurance that can never be taken away, you will force me to take this pen, veto the legislation and we'll come back here and start all over again.

State of the Union: Excerpts from President Clinton's Message on State of the Union, N.Y. TIMES, Jan. 26, 1994, at A16. See also Robert Pear, *U.S. Officials Hint at New Flexibility Over Health Plan*, N.Y. TIMES, Jan. 27, 1994, at A1.

3. Pub. L. No. 103-182, 107 Stat. 2057 (1993).

as was true for the Economic Plan passed in August 1993.⁴ In the past, Conservative Democrats have tended to agree more with mainstream Republicans than with their own Democratic leadership. Whether they do so in the future will be a key factor in determining whether a majority coalition can form, and if so, whether it will be right or left of center.

The reason that passage is so uncertain and the direction of a winning coalition unknown is that members of Congress have not yet reached agreements on the most fundamental issues of health care reform. These issues include: whether to moderate spending by market mechanisms or by direct price and spending controls; whether to assure access to coverage or to assure coverage itself; and if the latter, whether to do so by employer mandates, individual mandates, or by government entitlement. Each of these issues is directly affected by the amount of government intervention in the organization and delivery of health insurance and health care.

If the only choice is between "big bang" health care reform,⁵ such as the Clinton Plan, and nothing, it will be nothing. However, legislation is more likely if it is politically possible to fashion a more modest package of reforms that does not involve mandates, spending limits, or big entitlement cuts. Were 1994 not an election year, legislation would be unlikely because of continuing divisions over fundamental issues and vision. Ultimately, the willingness of Congress to pass whatever the majority can agree to, even if it includes less than what appear to be the President's minimum requirements, will determine the fate of health care reform in 1994.

I. THE CLINTON PLAN

The principal forces driving reform are the ballooning costs of health care, the large number of uninsured Americans, and the increasing number of insecure Americans who are insured. Yet enormous changes are proposed in the Clinton Plan that have little directly to do with providing insurance to 37 million uninsured Americans,⁶ or with providing health security to the

4. Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, 107 Stat. 312 (1993).

5. "Big bang" health care reform is characterized by large spending increases or large, painful redistributions of existing spending. See, e.g., Richard L. Berke, *Clinton is Facing State Resistance on Health Plan*, N.Y. TIMES, Aug. 15, 1993, at 1 (citing South Carolina Gov. Campbell's criticism of Clinton Plan as following a "big bang strategy"); William Raspberry, *Health Reform: The Big Bang Theory*, WASH. POST, May 5, 1993, at A21.

6. Emily Friedman, *The Uninsured: From Dilemma to Crisis*, 265 JAMA

remaining 215 million Americans. Rather, the top-down restructuring of the health care system reflects the Clinton Administration's predilection toward an interventionist government, which will reconfigure the way health care is financed, organized, and delivered in the United States. This view is fueled by the belief that such intervention will ultimately result in a better health care system, an opinion not held by this author.

President Clinton's proposed Health Security Act⁷ promises all Americans a generous basic benefits package, comparable to the benefits of Fortune 500 firms. Employed people will have 80 percent of the plan cost funded by their employer⁸ and will be responsible for choosing among a set of government-approved plans;⁹ they must pay for the remaining 20 percent.¹⁰ Small employers with fewer than 75 employees and an average wage of less than \$24,000 will receive subsidies from the government to help finance the employers' share of the costs.¹¹ Self-employed and unemployed individuals, including the cash assistance Medicaid population, will choose from the same set of approved government plans. If these individuals are poor or low income,¹² they will receive sliding scale subsidies from the government;¹³ otherwise, they will be required to pay the full cost of the plan themselves.¹⁴

Major new benefits have been promised to the elderly and early retirees. In addition to maintaining their existing Medicare benefits, the elderly will receive a new prescription drug benefit¹⁵ and a limited home care benefit.¹⁶ Early retirees, those who retire between the ages of 55 and 64, will be able to choose from the same set of plans as employees, with the government financing 80 percent of the cost of the plan.¹⁷

2491, 2491 (1991) (citing estimates of 31-36 million uninsured Americans); Katharine R. Levit et al., *Americans' Health Insurance Coverage, 1980-91*, 14:1 HEALTH CARE FIN. REV. 31, 33 (1992) (estimating 34.7 million uninsured Americans in 1991, or 14% of the U.S. population).

7. H.R. 3600 & S. 1757, 103d Cong., 1st Sess. (1993) [hereinafter Clinton Plan].

8. *Id.* §§ 6121-6122.

9. *Id.* § 1002(a).

10. *Id.* §§ 6101-6103.

11. *Id.* § 6123.

12. Poor and low-income individuals are those with earnings below 150% of the federal poverty line. Clinton Plan, *supra* note 7, § 3172.

13. *Id.* § 6104.

14. *Id.* § 6101.

15. *Id.* §§ 2001-2009.

16. *Id.* §§ 2101-2109.

17. Clinton Plan, *supra* note 7, §§ 6114, 6103.

The health plan is funded by a tobacco tax,¹⁸ a community rating system,¹⁹ highly optimistic spending reductions in Medicare and Medicaid,²⁰ and limits on premium increases in the private sector.²¹ The latter, among other effects, is assumed to lead to increased taxable wages and thus to increased personal income collections.

II. STRENGTHS OF THE CLINTON PLAN

The major strength of the Clinton Plan is a clear commitment to the concept of universal coverage, with a set of policy mechanisms for achieving that coverage. It clearly reflects the Administration's vision of what an improved health care system should look like and provides a set of policies for achieving that vision. This consistency between vision and mechanisms to achieve the vision should be regarded as a strength, even by those who reject the vision being proposed.

The Clinton Plan also contains a set of subsidiary reforms that are both highly desirable and common to most other health care proposals. These include: the elimination of preexisting condition clauses in insurance coverage;²² strategies for reducing paperwork and administrative tasks associated with inconsistent forms and billing;²³ the provision of needed information on outcomes and quality for specific plans and providers;²⁴ limited tort reform;²⁵ and the beginnings of a risk-adjustment process.²⁶ An additional strength is the clear commitment of the Clinton Administration to regard health care reform as a high-priority domestic policy goal. This is reflected in the frequent direct references to health care reform, the appointment of First Lady Hillary Rodham Clinton as the Administration's point person on health care, the Presidential address to a joint session of Congress in September 1993, and the Clintons' personal delivery of legislative language in October 1993.

III. CONCERNS ABOUT THE CLINTON PLAN

Reforming health care is not an easy task. Most Americans like the quality and easy availability associated with the current

18. *Id.* §§ 7111-7113.

19. *Id.* §§ 1384, 1403. The community rating system shifts large amounts of money from younger, healthier workers in lower cost areas to older, sicker workers and retirees in higher cost areas. It accomplishes this by charging the same premium to all people living within a given geographic region.

20. *Id.* at tit. IV, subtit. B.

21. *Id.* § 6011.

22. Clinton Plan, *supra* note 7, § 1402.

23. *Id.* § 5130.

24. *Id.* §§ 5001-5013.

25. *Id.* §§ 5301-5306.

26. *Id.* §§ 1541-1545.

health care system and would like to see everyone with good health care, but they mistrust centralized government services and are reluctant to pay any higher taxes.²⁷ The Clinton Administration has made the difficult task of health care reform even more difficult by promising major new benefits — to the elderly, early retirees, the uninsured, the unemployed, and the poorly insured — at a time when the American public is cynical about its politicians and is in no mood for broad-based tax increases, especially in light of the new economic plan.²⁸ The President has promised too much, too quickly, and to too many, without credible financing. The most serious weaknesses of the plan include: the use of spending limits and premium caps; employer mandates; the administration of health care through a bureaucratic National Health Board and regional alliances; and questionable financing strategies.

A. *Spending Limits and Premium Caps*

The most serious issue that needs to be resolved involves the use of spending limits and premium caps. The Clinton Administration says that its plan uses market forces and relies on market-based incentives, but in fact it uses direct control regulatory mechanisms to control spending. The Administration's actions reflect its fundamental distrust of markets and its greater level of comfort with regulated systems. Although other countries have attempted to control spending by using spending limits and price controls in addition to limiting the use and availability of expensive technologies,²⁹ the use of price controls in the United States has been unsuccessful. Our experience with price controls in World War II, the wage and price controls of the Nixon era, and the Medicare fee freezes of the 1980s were short lived and followed by inflationary surges. The use of price controls (the less polite name for Clinton's premium caps) will

27. See Lawrence R. Jacobs & Robert Y. Shapiro, *Public Opinion's Tilt Against Private Enterprise*, 13:1 HEALTH AFF. 285, 294 (1994).

28. According to a March 1994 poll, approximately 70% of Americans think that the amount they will pay for medical care under the Clinton Plan will increase. George J. Church, *Oh Noooo! The Public Grows Fearful of Clinton's Plan and Shows Little Faith in Alternatives*, TIME, March 14, 1994, at 34-35.

29. For example, in Germany, the increase in expenditures for certain kinds of health care is tied directly to the wages of members of their sickness fund. See generally Klaus-Dirk Henke, *Response*, 11 HEALTH CARE FIN. REV. 93 (1989 Supp.); John K. Iglehart, *Germany's Health Care System*, 324 NEW ENG. J. MED. 503, 503-08 (1991); Deborah A. Stone, *Health Care Cost Containment in West Germany*, 4 J. HEALTH POL., POL'Y & L. 176, 176-99 (1979).

establish prevailing prices rather than serve as a so-called safety net. The use of Medicare diagnosis-related groups (DRGs) and other forms of government-set prices has shown that whenever government sets a maximum allowed price, it becomes the prevailing price even though providers could always compete beneath this established price.³⁰

The use of spending limits and price controls also is an area where conservative Democrats tend to align themselves more with mainstream Republicans than with their own Democratic leadership. While it would be possible to eliminate this aspect of the health care plan, to do so would put several other key elements of the plan at risk. For instance, Democratic support of the sharp reductions in Medicare spending required the use of spending limits in the private sector. Removing the spending limits in the private sector would make the Administration vulnerable to charges of massive cost shifting to the private sector, an issue of particular concern to its congressional supporters. It also would remove the Administration's estimated increase in personal income tax receipts, which is being used to finance some of the benefit expansions. Thus, removing private-sector spending limits would severely jeopardize the plan's funding.

In addition to the practical problems of jettisoning these provisions of the plan, philosophic issues are at stake as well. There are only two ways to get spending "right": reliance on spending limits and price controls, or reliance on market forces. The Administration's dilemma in part reflects a split in the Democratic Party, which is particularly pronounced on health care matters. A sizeable minority distrusts major government intrusions in price setting and spending decisions. However, the majority is uncomfortable with market forces, believing that they have been ineffective at controlling spending in the past and will continue to be ineffective in the future. This has led the Administration to keep a foot in both camps. The political right, however, recognizes premium caps and spending limits as the regulatory mechanisms they are.

B. *Employer Mandates*

The second most serious issue involves the use of employer mandates. The Administration has proposed to guarantee uni-

30. See generally Kathryn Langwell, *Price Controls: On the One Hand . . . And on the Other*, 14:3 HEALTH CARE FIN. REV. 5, 6-9 (1993) (discussing potential impact of health care pricing controls); James A. Morone & Andrew B. Dunham, *Slouching Towards National Health Insurance: The New Health Care Politics*, 2 YALE J. ON REG. 263, 274-80 (1985) (describing history and microeconomic impact of DRGs).

versal coverage by requiring employers to finance eighty percent of the average price of the health care plan in their region³¹ and by requiring employees to purchase a plan and pay the difference.³² Others are assured coverage by selecting a plan from the alliance and receiving various levels of subsidies, depending on their income.³³

This type of employer mandate is very unusual because the employer is not actually required to provide health insurance coverage, but rather to serve as a mandatory financial conduit to the health alliance. As a result, many businesses are objecting that employers are being removed from involvement in negotiating health care networks and prices at a time when they have become most active in this area. Furthermore, employers are being replaced by institutional entities that do not yet exist. Use of the employer mandate also has raised concerns about the future viability of small businesses and the potential impact of the mandate on low-wage employees. An effort to limit these adverse effects led to the proposed use of subsidies to low-wage small businesses.³⁴ As a result, there are growing concerns about the resulting economic distortions as firms attempt to maximize their subsidies.

Many people, but especially Republicans and conservative economists, have questioned whether employer mandates will result in substantial job loss for low-income workers and economic failure for new small businesses. Most economists agree that there will be some job loss, but they disagree on the magnitude. Job loss from mandates has been estimated to be as small as 200,000 and as large as 3 million.³⁵ The latter estimate, however, reflects a mandate that does not provide subsidies to small, low-wage firms and therefore cannot be directly attributable to a proposal such as the Administration's.³⁶ Most economists believe that as long as money wages can adjust demand to reflect the effect of the employer mandate, the amount of job loss will be relatively small. Estimated job losses in the range of 500,000 to 1 million seem most probable. However, substantial economic distortions could occur as small firms attempt to reconfigure themselves to take maximum ad-

31. Clinton Plan, *supra* note 7, §§ 6121-6122.

32. *Id.* § 1002(a), §§ 6101-6103.

33. *Id.* § 6104.

34. *Id.* § 6123.

35. Steven Greenhouse, *Clinton's Health Plan: Job Losses in Health Plan Are Denied*, N.Y. TIMES, Sept. 28, 1993, at B10 (citing government estimates of 200,000 to 700,000 jobs lost, and Employment Policies Institute estimate of 3.1 million jobs lost).

36. *Id.*

vantage of the subsidies being paid to firms with both fewer than 75 employees and an average annual wage of less than \$24,000.³⁷ Alan Krueger has estimated that these distortions could cost upwards of \$10 billion, which is the equivalent of about 1 million jobs lost.³⁸

The various concerns about employer mandates have led to some proposals that rely on individual mandates rather than employer mandates,³⁹ and to other proposals that do not require employers to finance the purchase of insurance but only to make group purchase of insurance available to employees.⁴⁰ Many believe that an individual mandate has certain advantages: it reduces the economic distortions of the Clinton proposal; it allows government to target subsidies more efficiently to individuals who are believed to need subsidization; and it removes the political concerns regarding mandates on employers. On the other hand, there is a fear that reliance on individual mandates would appear harsh, would represent too much change from the current system, and might cost too much money if the middle class demands costly subsidies after realizing that they and not their employers pay for their health care. The lack of a mandate on either the employer or the individual, however, would require some persons to be uninsured, thus violating the Administration's primary requirement for health care reform: universal coverage.

Employer mandates do not represent as fundamental or divisive an issue as that of spending limits and price controls, but resolution of the issue will be contentious nonetheless. The opinion of the business community tends to be split between large employers, which generally provide broad health coverage and have been less concerned about employer mandates, and smaller employers, which tend to be opposed to employer mandates unless they are heavily subsidized. The opposition to the Clinton Plan by the Business Roundtable,⁴¹ the U.S. Chamber of Commerce,⁴² and the National Association of Manufacturers,⁴³ however, indicates that even businesses that may not be

37. Clinton Health Plan, *supra* note 7, § 6123.

38. Interview with Alan B. Krueger, Professor of Economics & Public Affairs, Princeton University (Nov. 10, 1993).

39. H.R. 3704 & S. 1770, 103d Cong., 1st Sess. (1993) (Chafee/Thomas bill); S. 1743, 103d Cong., 1st Sess. (1993) (Nickels bill).

40. H.R. 3222 & S. 1579, 103d Cong., 1st Sess. (1993) (Cooper/Grandy bill).

41. Adam Clymer, *Powerful Business Group Backs Rival to President's Health Plan*, N.Y. TIMES, Feb. 3, 1994, at A1.

42. Robert Pear, *Business Groups and Labor Unions Attack Clinton on Health Plan*, N.Y. TIMES, Feb. 4, 1994, at A19.

43. Louis Uchitelle, *Manufacturers Oppose Clinton Plan*, N.Y. TIMES, Feb. 6, 1994, at A26.

directly impacted by the employer mandate⁴⁴ may be concerned about the amount of government intervention and intrusion represented by the bill. Not surprisingly, the National Federation of Independent Business, which is made up primarily of very small businesses that do not offer insurance, has been opposed to the bill and all forms of employer mandates.⁴⁵ It may be possible to alleviate some of this opposition by requiring businesses to offer access to group insurance and either not specifying the employers' contribution or lowering the required employer contribution. Other options include implementing the requirement gradually over time or limiting it to the larger employers. However, these options will probably not be overwhelmingly appealing either to business or to those members of Congress who staunchly support employer mandates.

Employer mandates are one of many areas where the public has displayed conflicting views. For the past several years, polling data has shown that the public supports the concept of an employer mandate, with approval rates ranging from 52 to 67 percent.⁴⁶ But polling data also has shown that the public withdraws that support if the mandate is assumed to cost jobs (which it will, although the magnitude of job loss is subject to dispute).⁴⁷ Furthermore, an October 1993 poll indicated that a large number of people support the notion of "business encouraging the provision of health insurance," although it is unclear what the public thinks this phrase means.⁴⁸

The rate of change in health care spending will also have an effect on the economy. Many reform proposals seek to reduce spending both by improving incentives for purchasers to be more cost-conscious and by pushing for more efficient provision of services. However, if we are successful in reducing paperwork, in decreasing the number of small insurance companies that have excluded medium- to high-risk persons, or in downsizing the hospital sector, we also will reduce employment in each of these areas. The economic dislocation from such changes will depend in large part on both the speed with which such changes occur and the size of the reduction. If we were to accomplish

44. The vast majority of these organizations' business members already provide health insurance.

45. Steven Greenhouse, *Small-Business Group in No Mood to Relent on Opposition to Health Plan*, N.Y. TIMES, Sept. 17, 1993, at A20.

46. See Gail R. Wilensky, *Health Reform: What Will It Take to Pass?*, 13:1 HEALTH AFF. 179, 183, 191 n.2 (1994).

47. *Bitter Pill on Health Care*, USA TODAY, Dec. 17, 1992, at 12A (citing Kaiser Family Foundation Poll finding that "[o]nly 30% favor making employers provide health insurance if the added cost would cost jobs.>").

48. Wilensky, *supra* note 46, at 183, 191 n.3.

the spending goals of the Administration, there would be sharp reductions in hospital spending and in the existing administrative structure associated with health care.⁴⁹ Substantial numbers of relatively low-wage, low-skill workers are employed in the health care sector, and absorption of these workers into the economy will take some time. This is not an argument for maintaining the status quo in health care, but rather a recognition that sudden changes in spending can produce local distortions and dislocations that would be difficult to accommodate. In addition, these changes are not easily compensated for by increased spending elsewhere, even in different sectors of the health care industry.

The economic effects of the President's health care reform proposal must be considered in the context of other recently adopted or proposed policies of the Clinton Administration. For example, Labor Secretary Robert Reich recently proposed and subsequently withdrew a fifty-cent-per-hour increase in the minimum wage.⁵⁰ Any increase in the minimum wage, on top of the increased spending implied by an employer mandate, would exacerbate concerns about potential effects on low-wage workers. Furthermore, the increase in marginal tax rates passed in August 1993 will affect some successful small businesses. Approximately forty percent of all U.S. businesses file tax returns as subchapter S corporations⁵¹ — that is, they file as individuals. Those that have been financially successful are at risk of having an increase in their marginal tax rate. When combined with changes resulting from an employer mandate, this could have cumulative effects on the economy.

C. *National Health Board and Regional Alliances*

The Clinton Plan proposes powerful new bureaucracies, while giving new regulatory powers to existing bureaucracies such as the Department of Health and Human Services (DHHS). The new entities include a National Health Board,⁵² with powers to set per capita spending,⁵³ allocate the per capita spending to the

49. It should be noted, however, that sharp reductions in the existing administrative structure could lead to potentially large increases in other administrative costs such as those involved in the bureaucracies of Health Alliances.

50. Michael Arndt, *Clinton Backpedals on Minimum Wage Hike*, CHI. TRIB., Jan. 20, 1994, at 1.

51. In 1990, 3,716,650 corporations filed income tax returns. Of those, 1,575,092, or 42%, were subchapter S corporate returns. INTERNAL REV. SERV., STATISTICS OF INCOME — 1990 CORPORATION INCOME TAX RETURNS 4 (1993).

52. Clinton Plan, *supra* note 7, § 1501.

53. *Id.* § 6002.

states,⁵⁴ review and provide oversight for prices of breakthrough therapeutics,⁵⁵ and assume the functions of health alliances that are not performing in a satisfactory manner.⁵⁶ The proposal also establishes mandatory monopoly purchasing groups: the regional health alliances.⁵⁷

Purchasing groups, which are an important part of almost all health care reform proposals and are used to provide market power to small firms and individuals, are used in the Clinton Plan for purposes that extend far beyond the necessary norms. The Administration's purchasing groups have strong oversight powers to implement the directives of the National Health Board. These directives include: deciding where people will enroll if their health plans are oversubscribed;⁵⁸ setting provider fee schedules for fee-for-service providers;⁵⁹ establishing information requirements for plans that will be allowed to market in their areas;⁶⁰ negotiating and enforcing premium caps;⁶¹ and enforcing the mandatory participation of individuals.⁶²

The problems with use of these highly regulatory entities, however, are not nearly as difficult to resolve as are the problems mentioned above. Most health care reform proposals use the concepts of national health care boards and purchasing groups, even if they do not have the regulatory power that is assumed in the Clinton proposal. If employers and individuals must offer or obtain health insurance, some entity must decide what that health insurance package needs to include. This means that there is a need for a health care board of some sort. In addition, many proposals recognize the value of purchasing groups as a way to give small firms and individuals better market leverage for their health care dollar.

Thus, while the precise functions of a national health care board and health alliances will be subject to negotiation and change, their fundamental concepts are not the subject of controversy as is the case for spending limits, price controls, or employer mandates. Most policy analysts believe that ultimately there will be a national health board of some sort, although one with far less regulatory power than has been envisioned under the Clinton Plan. They also believe that there will be

54. *Id.* § 6003.

55. *Id.* § 1503(i).

56. *Id.* § 1512.

57. Clinton Plan, *supra* note 7, §§ 1301-1303, 1321.

58. *Id.* § 1323(f).

59. *Id.* § 1322(c).

60. *Id.* § 1325.

61. *Id.* § 1321.

62. Clinton Plan, *supra* note 7, § 1323.

health alliances or purchasing groups, although it is unclear whether these will be voluntary or mandatory.

D. *Questionable Financing Strategies*

The final set of concerns relate to the proposed financing and the accuracy of the spending and savings estimates. By promising major new benefits to both the uninsured and the insured, the Administration has put itself under enormous fiscal pressure. Its response has been to propose historic reductions in Medicare and Medicaid, and to couple these reductions in public programs with a very tight premium cap for the private sector. Ultimately, savings can only come from: (1) paying providers less; (2) providing less in the way of quantity or quality of services; or (3) finding ways to increase the efficiency with which health care is provided. Although the Administration nominally invokes the third option, most of the savings under the Clinton Plan would come from paying various providers less.

The largest source of funds to finance the Clinton Plan comes from reductions in Medicare and Medicaid spending. The Administration proposes a reduction of \$118 billion in Medicare program spending over the next five years. This amount is in addition to the \$56 billion in reductions that was included in the economic plan passed by Congress in 1993.⁶³ Thus, the Administration is proposing a \$174 billion reduction in Medicare by reducing payments to providers.

The Medicare reductions involve approximately twenty-eight specific payment changes that range from reductions in hospital update factor⁶⁴ and reductions in payments for capital⁶⁵ to changes in hospital outpatient department payments⁶⁶ and in physician reimbursement.⁶⁷ While a few changes could be viewed as attempts to produce savings by affecting use,⁶⁸ the vast majority of savings occur because of reductions in provider payments. These reductions will affect the availability of services to the elderly as providers respond to reductions in funding and restructure how they provide services. In addition, these reductions will further exacerbate the schism between a price-con-

63. Wilensky, *supra* note 46, at 185.

64. Clinton Plan, *supra* note 7, § 4101.

65. Clinton Plan, *supra* note 7, § 4103. The reductions account for approximately \$28 billion in savings. Wilensky, *supra* note 46, at 186.

66. Clinton Plan, *supra* note 7, § 4116.

67. *E.g.*, *id.* §§ 4113-4114. The changes will result in an additional \$25 billion in savings. Wilensky, *supra* note 46, at 186.

68. Examples of savings produced by affecting use include changing the coinsurance rate for home health agencies, Clinton Plan, *supra* note 7, §§ 4133-4134, and establishing coinsurance for laboratory services, *id.* § 4117.

trolled Medicare system⁶⁹ and a managed care-oriented system for the non-elderly.⁷⁰

The heavy reliance on reductions in provider payments — both in the financing of the Clinton health care reform package and in the changes included in the economic plan — makes these Medicare reductions both politically unlikely and substantively questionable. The Administration had a difficult time convincing a majority in Congress to agree to the \$56 billion reduction in August 1993. The likelihood of persuading an uneasy Congress to add \$124 billion of Medicare reductions in an election year seems remote.⁷¹

The Administration also proposes several changes to the Medicaid program. The disproportionate-share payment program,⁷² which has been a major source of Medicaid spending growth, would be eliminated.⁷³ In its place, the Clinton Plan would reserve a small amount of funding for hospitals treating large numbers of low-income persons.⁷⁴ This is a reasonable proposal because the justification for the disproportionate-share program was to finance the costs of treating large numbers of low-income uninsured persons, which will no longer be an issue under the Clinton proposal. Eliminating disproportionate-share payments or making this amount of money available to the states under flexible guidelines are elements of many other health care reform proposals.

The remaining Medicaid reductions are more problematic. The Administration assumes that health alliances will be able to provide Medicaid services at ninety-five percent of what would have been paid if the cash-eligible beneficiaries were still on

69. In a price-controlled Medicare system, providers can attempt to compensate for low payments by increasing volume.

70. In a managed care-oriented system, providers respond to funding reductions by limiting non-essential services. See generally Alain C. Enthoven, *The History and Principles of Management Competition*, 12 HEALTH AFF. 24 (Supp. 1993); ALAIN C. ENTHOVEN, THEORY AND PRACTICE OF MANAGED COMPETITION IN HEALTH CARE FINANCE (1988).

71. There certainly is potential for reducing Medicare spending. However, removing \$174 billion of projected spending over a five-year period, while promising the same service level, would be a serious mistake unless the elderly understand how it will affect the level and availability of their health care. Furthermore, financing new benefits for the elderly in light of the proposed reductions will only exacerbate Medicare's current fiscal fragility.

72. 42 U.S.C. §§ 1395ww(d)(5)(F), 1396a(h) (1988 & Supp. IV 1992). Under the disproportionate share program, hospitals serving a disproportionate number of uninsured, poor individuals who are ineligible for Medicaid will receive federally-funded state Medicaid dollars.

73. Clinton Plan, *supra* note 7, § 4231.

74. *Id.* § 4104.

Medicaid.⁷⁵ In addition, those who have been on Medicaid will be subject to a stringent cap placed on their spending growth, as these persons will now be part of the health alliance and thus subject to the Consumer Price Index (CPI) cap on payments.⁷⁶ Federal savings of \$85 billion are also assumed as a result of the shift to employer-mandated Medicaid coverage, with the states being required to continue their current financial efforts on behalf of the noncash Medicaid population.⁷⁷ These savings seem unreasonably high, but it is difficult to criticize these estimates until more information is known as to how precisely these calculations were made.

The adequacy of the Administration's financing estimates and the issue of whether the financing is adequate to support the promised benefits is a matter to be resolved by the Congressional Budget Office (CBO). Under existing budget rules, new benefits can be enacted only if new funding sources are identified or existing spending levels reduced, and these spending and financing estimates are approved by the CBO. But if history is any guide, these estimates will be wrong, and they will be wrong in one direction: government spending will be underestimated and government savings will be overestimated.

A few examples of our inability to accurately forecast expenditures associated with new benefits illustrate this point.

The most glaring underestimation concerns Medicare itself. Passed in 1965, the Hospital Insurance component was estimated to cost \$9 billion by 1990; actual costs were \$67 billion.⁷⁸ More recent underestimations are exemplified by the Medicare Catastrophic Legislation savings attributed to the 1990 Budget Act.⁷⁹ Most of the Catastrophic program was never in place long enough to assess the accuracy of the projections, but one part that was assessed concerned the removal of a three-day hospital stay requirement before Medicare would pay for nursing home care. The cost of this change was independently estimated by

75. Wilensky, *supra* note 46, at 187.

76. *Id.*

77. *Id.*

78. Estimated amount is from Committee on Ways and Means, *Actuarial Cost Estimates and Summary of Provisions of the Old-Age, Survivors, and Disability Insurance System as Modified by the Social Security Amendments of 1965 and Actuarial Cost Estimates and Summary of Provisions of the Hospital Insurance and Supplementary Medical Insurance Systems as Established by Such Act*, Pub. L. No. 89-97. The actual amount is from the 1993 *Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund*. It should be noted that no long-term estimates were made for the Supplemental Medical Insurance component.

79. Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, 104 Stat. 1388 (1990).

the Health Care Financing Administration (HCFA) and the CBO at \$150 million per year.⁸⁰ During the one year that the change was in effect, the provision was estimated to have cost \$1.4 billion.⁸¹ This means that both HCFA and the CBO were off by a factor of nine in a program change for which adequate information was believed to exist for an accurate prediction.

The 1990 budget deal was expected to reduce Medicare and Medicaid spending by about \$40 billion. Within months of the agreement, however, it was clear that rather than a reduction, there would be a net increase in spending of at least \$60 billion within the relevant time frame of the budget deal. In fact, technical revisions to the 1990 Budget Act have now added about \$190 billion of spending to that agreement.⁸² This history, combined with specific concerns about the Medicare and Medicaid reductions, has led to overwhelming skepticism about the claims of conservative estimates of funding health care reform.

As a result of the concern over the financing estimates, a number of proposals involve a "spend-as-you-save" or "pay-as-you-save" provision.⁸³ This is an attempt to recognize that despite the best efforts at projecting expenditures or savings in policy changes, only after changes are implemented will it be known how much has been spent or saved. Given the size of the health care sector, such a provision has been suggested as a way to limit the damage that major changes otherwise could impose on the federal deficit. If not a "pay-as-you-save" provision, some attempt to limit future government financial exposure may be needed if the legislation is to be supported by the more conservative members of Congress.

IV. THE POLITICS OF HEALTH CARE REFORM

In assessing the politics of health care reform, the usual approach is to outline areas with the greatest differences between the Democrats and the Republicans. While this remains important, the more significant split is within the Democratic Party itself. Conservative Democrats and mainstream Republicans tend to agree on some of the most fundamental issues: opposing spending limits, price controls, employer mandates, and sharing

80. Original estimates were contained in the 1989 Mid-Session Review budget documentation. Actual outlays were contained in the unpublished budget documentation for the fiscal year 1994 President's Budget.

81. *Id.*

82. Telephone interview with Timothy Muris, former Associate Director, Office of Management and Budget (Sept. 1993).

83. *See, e.g.*, H.R. 3704 & S. 1770, 103d Cong., 1st Sess. (1993) (Chafee/Thomas bill).

a distrust of government intrusion in the marketplace. Of course, significant splits exist within the Republican ranks as well.

A. *Democratic Divisions*

To understand the magnitude of the divisions within the Democratic Party, it is instructive to recall the summer of 1992. This was a time when partisan Democrats would have dearly loved to embarrass a weakened Republican president by passing health care reform legislation that they knew he would be forced to veto. Senate Majority Leader George J. Mitchell (D-Me.) was advocating Health America,⁸⁴ a bill that incorporated spending limits, price controls, and employer mandates; it was cosponsored in the Senate by Edward M. Kennedy (D-Mass.), Jay Rockefeller (D-W.Va.), and Donald W. Riegle, Jr. (D-Mich.). But Health America never went to the floor of the Senate because it was clear that it did not have the fifty-one votes required for passage. In the House, the Health Cost Containment and Reform Act of 1992,⁸⁵ cosponsored by Fortney (Pete) Stark (D-Cal.) and Richard A. Gephardt (D-Mo.), also contained spending limits, price controls, and employer mandates. It too was never brought to the House floor, for while substantial efforts were made to garner the 218 votes needed for passage, it was clear that it would not pass. This was a time when there were ten more Democrats in the House and one more Democrat in the Senate than in 1994. Thus, even when the legislation would have been "for show" in that the President would have vetoed it, there was enough division within the Democratic Party to prevent passage of the legislation containing the most critical elements of the Clinton Administration's health care plan.

This division between conservative Democrats and party leadership is complicated by the existence of a third group — the single-payer group. This group is led by Rep. Jim McDermott (D-Wash.) and has almost 90 members in the House, but only 2 or 3 supporters in the Senate. The Democratic leadership group, which wants universal coverage through an employer mandate and spending limits with price controls, includes about 110 supporters in the House and about 40 in the Senate. The conservative Democratic forum in the House is more easily identified and has 60 to 70 members. The conservative Democrats in the Senate are a less identifiable group made up of 8 to 10 senators. These conservative Democrats do not want employer mandates, may or may not support individual man-

84. S. 1227, 102d Cong., 1st Sess. (1992).

85. H.R. 5502, 102d Cong., 2d Sess. (1992).

dates, want reliance on market forces, and are against total private-sector spending limits.

B. *Republican Divisions*

Within the Republican Party there are three identifiable groups. One group, which includes the House leadership and a majority of House Republicans, favors incremental changes such as insurance reform; administrative simplification; tort reform; more flexibility for the states regarding Medicaid; full tax-deductibility of premiums for the self-employed; the option of a medical savings account instead of the tax exclusion of employer-provided insurance; and small additional investments in community health centers and rural health centers. A second group, including 25 House Republicans and 20-25 Senate Republicans, wants a less regulatory type of managed competition, involving individual mandates or no mandates rather than employer mandates, no overall spending limits or price controls, and either voluntary purchasing groups or mandatory purchasing groups that are limited to small firms. A third set of Republicans wants individual vouchers or tax deductions with medical spending accounts, either with the incremental reform that the first group of Republicans favors or otherwise strong encouragement to have some type of insurance. There is a substantial amount of diversity within this third group, but they number 25 to 30 in the Senate (some of whom also sponsored the less regulatory managed care legislation) and at least 25 in the House.

C. *Forging Alliances*

The big unknown is what it would take to bring these camps together and whether it will occur in time for passage of some legislation in the 103rd Congress. At the moment, the dynamic appears to be moving toward the more moderate group of Democrats and Republicans. This group's preference is embodied in both the Cooper/Grandy bill⁸⁶ and the Chafee bill.⁸⁷ The former has neither a mandate on employers or employees nor spending limits, but is otherwise a managed competition structure. The Chafee bill has an individual mandate, steep Medicare cuts, voluntary purchasing groups, and no spending limits. Both bills include a tax cap, however, which will be a significant impediment to their passage. Unions hate such caps, and because

86. H.R. 3222 & S. 1579, 103d Cong., 1st Sess. (1993) (Cooper/Grandy bill).

87. H.R. 3704 & S. 1770, 103d Cong., 1st Sess. (1993) (Chafee/Thomas bill).

President Clinton has already alienated labor with NAFTA, he may be loath to do it again. Most economists believe that a tax cap or the substitution of a refundable tax credit for the current tax exclusion of employer-provided insurance makes eminent policy sense because it makes purchasers more cost conscious and is therefore an important element in market-oriented reform. But a tax cap also translates into a middle-class tax increase or benefit loss, which causes politicians political heartburn. Because a tax cap produces tax revenue, there also would be a severe shortfall if the cap was excluded from legislation. Thus, while including a tax cap brings a political and financial problem, not including it does the same.

In addition, guaranteed universal coverage — the repeated prerequisite for presidential support of any health care reform plan — requires an individual mandate, an employer mandate, or universal provision by the government. But employer mandates raise concerns, which have already been discussed, about economic growth and the employment of low-wage workers. Individual mandates are also of concern because they depart from current practice and because they sound harsh to individuals.

It is possible that enough conservative Democrats and/or Republicans could yield in their opposition to employer mandates, particularly if the mandates were triggered over time or phased in so as to impact only large employers in the beginning. However, this type of accommodation is unlikely to occur in 1994. Alternatively, the Administration may yield on its universal coverage requirement and support the Cooper/Grandy bill, which provides universal access to coverage but not necessarily universal coverage. This also seems unlikely given the harsh attacks on this plan by the Administration and its congressional supporters. When more attention is given to the financing strategies supporting the Cooper/Grandy bill and the cost estimates have been subjected to CBO scrutiny, it will be more difficult rather than less difficult to build a majority consensus around this bill. At present, no such majority support exists.

Were 1994 not an off-year election, there would be little chance of passing health care reform. However, many members of Congress have promised health care reform and 435 members of the House and one-third of the Senate need to return to their constituents for support and re-election. This may provide a sufficiently powerful incentive to forge the alliance necessary to pass some legislation.

The chance of passing legislation would be better if it were possible to vote on whatever package of reforms can gain majority support, even if it does not contain universal coverage or other key components of the Administration's bill. Unfor-

unately, the Democratic leadership's prior reluctance to allow a vote on an incremental reform package will most likely continue in 1994. Despite the repeated statements by the Administration and congressional leadership urging health care reform in 1994, it may well be that they would prefer no vote if it would mean voting on a package that deviates in too many ways from the principles espoused by the Democratic leadership: universal coverage with a comprehensive package of benefits and "meaningful" (*i.e.*, direct controlled) cost containment. If this is true, it is easy to imagine the Democrats' clarion call to battle for the 1994 election: "Send us more Democrats and we will give you health care reform." Of course, this would put tremendous pressure on Democrats to pass something in 1995. As the party in power most frequently loses seats in an off-year election, the Democrats may have to accomplish this task with fewer members than in 1994.

To pass a health care reform bill this session, there will need to be movement toward a majority consensus no later than the summer of 1994. The absence of a majority consensus will mean a stalemate during this session of Congress. In light of the current situation on Capitol Hill, this is the most likely outcome for 1994. Although the interest in health care reform is strong, the near-term passage of legislation is by no means inevitable.