A Postelection Look At Healthcare Reform

BY JANE H. WHITE

With the election of Bill Clinton as president, Americans have asked for renewed attention to domestic and economic policies. A critical part of the U.S. domestic front demanding attention is healthcare reform. However, the message voters sent Clinton on healthcare reform is far from clear. Several postelection public opinion surveys show that, although voters believed healthcare reform was a key issue, their views are complex and full of contradictions.

For example, an election-night survey of California voters offered insights into the defeat of Proposition 166, a ballot initiative that would have required employers to provide basic healthcare coverage for employees who work more than 17.5 hours a week and for their dependents. The Kaiser Family Foundation–Louis Harris and Associates poll revealed that the main reason for the proposition's 68 percent to 32 percent defeat was that 50 percent of voters believed it would put many small employers out of business. In a related economic concern, 14 percent of voters said it would cause a loss of jobs or cut in wages. Others believed the measure did not go far enough to reform healthcare in the state: 17 percent said it was inadequate and that more sweeping changes were needed; 10 percent were concerned that it would not control healthcare costs; and 6 percent thought it would not cover all uninsured Californians.

Nationwide postelection surveys also show that, although healthcare was the third most important issue to voters in their choice of president (ranking higher than in the previous presidential election), voters are split on how to reform the system. Results of another election-night survey conducted by Louis Harris and Associates on behalf of the Kaiser Family Foundation and the Harvard School of Public Health were released December 16, and an analysis was published in *JAMA* (Robert J. Blendon et al., "The Implications of the 1992 Presidential Election for Health Care Reform," December 16, 1992). The survey also found that voters see healthcare reform as the third most important issue for Clinton to address in his first 100 days, behind the economy/jobs and the deficit.

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Fifty-eight percent of voters surveyed chose cost-related concerns as the most important change needed in the healthcare system. However, voters are split on how to control costs, with 52 percent favoring regulation ("government controls on how much doctors and hospitals are paid") and 41 percent favoring managed competition ("having employers and employees choose between competing health insurance plans, each of which offers a limited choice of doctors and hospitals"). Voters are also split on Clinton's proposed idea of a global budget cap, with 43 percent for and 48 percent against. When voters were told that such a cap could cause longer waits for care or travel for some nonemergency care, support dropped to 23 percent.

When three types of reform plans were described without attribution, only 28 percent of voters favored Clinton's employer mandate-type proposal, while former-President George Bush's tax credit plan attracted 33 percent of the voters, and a single-payer national health insurance plan was favored by 32 percent. When the option of the single-payer plan was removed, voters favored Clinton's plan over Bush's by 52 percent to 41 percent.

To finance healthcare reform, half the surveyed voters were willing to pay an additional $20 a month. This dropped to 24 percent when the price tag rose to $50 a month. The type of taxes favored by a majority of the voters to finance healthcare reform include liquor and cigarette taxes (76 percent); income tax increase for those earning over $50,000 (61 percent); taxes on hospital charges, physician fees, and insurers (55 percent); and a tax on health insurance benefits (52 percent).

These statistics point to the divisions of opinion on healthcare reform among Americans, the

serious concern about reform's effect on small business, and the fear of rising costs. "The message nationally is that health reform will not sell without aggressive cost containment," said Kaiser Family Foundation President Drew Altman in a press statement.

Timing of Reform

During the campaign, Clinton promised action on healthcare in the first 100 days of his administration. This fast-track timetable had the health policy community in a flurry of activity during the normally slow winter months of congressional recess.

Some analysts believe the combination of one-party control of both the Congress and the administration and the high profile of healthcare as a campaign issue could lead to significant reform during the 103d Congress. But amid this optimism lurks the realization that healthcare reform is complex, full of competing interests, and expensive. This tension is leading to some backpedaling on the time frame for reform. Many analysts with whom I spoke seem to believe that in the 100 days after the inauguration, Clinton should be able to produce a blueprint for reform and get a bill before Congress for debate. Gathering the consensus needed for passage, on the other hand, will take longer.

Analysts also believe a reform proposal should be comprehensive and well-planned, even if it takes somewhat longer. In a November 9, 1992, letter, a coalition of healthcare groups urged Clinton "to avoid a quick fix approach that merely alters a severely flawed payment system." The groups signing the letter included the Catholic Health Association (CHA), American Hospital Association (AHA), American Nurses Association, Blue Cross/Blue Shield Association of America, Washington Business Group on Health, and Congress of Hospital Trustees.

AHA's Executive Vice President Richard Pollack elaborated on the question of timing. Clinton "may get one big shot [at healthcare reform], and we'll see an effort to do something comprehensive," he said. However, to push a reform plan in 100 days "is more than ambitious and may be too hasty." Pollack predicts that action on healthcare will occur "before the 1994 midterm congressional elections. That's the true political timetable that's out there." In addition to Clinton, many members of Congress put healthcare reform high on their campaign platforms and will need to show some action on the healthcare front when they run for reelection.

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Robert Berenson, MD, said that relatively quick movement on healthcare reform was possible because it "will be one of the two or three major items on [Clinton's] agenda—unlike the Carter days when there were ten or so" early agenda items. Berenson was a member of the health policy advisory group for the Clinton campaign and was an informal adviser to the transition team. He also served in President Jimmy Carter's administration on the White House domestic policy staff.

Elements of the Clinton Plan

The plan Clinton proposed on the campaign trail, although not fully fleshed out, does offer some insight into the type of healthcare reform package he may pull together. Key elements include the following:

- Universal access would be achieved by requiring employers to offer basic healthcare coverage. This would be phased in over time to ease the effect on small business. Persons not covered by employers would participate in public insurance alternatives.
- A core benefit package would be set for both private and public plans. It would cover ambulatory care, inpatient hospital care, prescription drugs, basic mental healthcare, and key preventive care.
- A national health board would define the core benefit package and would set a national healthcare budget (also known as a "global budget"). The board would also set a budget target for each state.
- Local managed care networks would include coalitions of insurers, physicians, and healthcare facilities. These networks would negotiate fees with participating providers and compete for patients on the basis of cost and quality.
- Reform of the insurance system would require insurers to eliminate preexisting condition restrictions and change underwriting practices back to "community rating," which bases premiums on expected costs for the broader group covered, not on the "experience" of particular smaller groups.
- Malpractice reform and the development of practice guidelines to improve quality of care are proposed.
- Administrative simplification would help cut wasteful spending. Such reforms include a stan-

dardized claim form for all private and public insurance plans, a "smart card" that contains each person's medical history, and a simplified billing system.

- To protect small businesses from high insurance costs and increase their market clout, Clinton proposes developing large purchasing groups called health insurance purchasing cooperatives (HIPCs).
- Other reform elements include expanding Medicare to cover long-term care, providing incentives for primary and preventive care, slowing the rising cost of prescription drugs, and controlling the growth of duplicative technology.

Clinton draws on the "managed competition" proposal of the 65-member Conservative Democratic Forum (CDF). This group of conservative Democrats in the House and Senate, led by Reps. Jim Cooper, TN, and Charlie Stenholm, TX, put forth their plan in April 1992 and then introduced it in the House in September as the "Managed Competition Act of 1992" (HR 5936).

The CDF plan, in turn, draws on the managed competition ideas developed by a group of policy analysts known as the Jackson Hole Group. This group, which includes Stanford University economist Alain Enthoven and policy consultant Lynn Etheredge, has met in the Wyoming resort town for more than a decade. It was the brainchild of Paul Ellwood, an early proponent of health maintenance organizations.

Clinton's campaign proposal called for using elements of managed competition along with the more regulatory strategy of imposing global budget targets to control cost increases. In addition, Clinton has called for universal access to healthcare, something not included in the CDF plan. Clinton reconciled the paradox between promoting both competition and regulation this way:

> Many suggest that we must choose between two extremes in reforming the healthcare system: we can have either a government-run regulatory system or a private, market-based, competitive system. Although that may be traditional and politically convenient rhetoric, it is the type of thinking that has resulted in gridlock in the nation's entire domestic-policy agenda. . . . [We must] combine an appropriate and revised governmental role with a reliance on the private sector to provide care and to compete to serve every person in this country. But that competition must take place under a restructured set of ground rules that foster competition to provide the best care at the best price, not to avoid covering the less healthy and to raise prices fastest for the sickest. (Bill Clinton, "The Clinton Health Care Plan," *New England Journal of Medicine*, September 10, 1992, pp. 804-807)

"We must 'combine an appropriate and revised governmental role with a reliance on the private sector to provide care and to compete to serve every person in this country,' Clinton said.

In many ways, the elements of Clinton's early plan parallel the CHA and the AHA reform proposals. Similarities include (1) universal access, (2) restructuring of the healthcare delivery system with local managed care networks, (3) establishment of a national health board, (4) a commitment to increase incentives for primary and preventive healthcare, and (5) an emphasis on streamlining administrative aspects of healthcare.

Issues to Resolve

In putting together a workable, comprehensive healthcare reform plan, policymakers must resolve many critical issues. Number one on the list will be the cost of such reform and how to pay for it. To date, Clinton has been rather murky on the financial details.

Some analysts question the extent to which Clinton's plan will control costs. "There are a couple of linchpins on which managed competition is based: that people will buy cheaper policies when they have a nonsubsidized choice, and that insurance companies can successfully pressure providers" to hold down costs, explained University of California–Los Angeles associate professor Thomas Rice in an interview. "We don't know if people will buy less comprehensive policies; we don't know the extent to which providers will compete to keep prices down; and we don't have experience with HIPCs," Rice continued. He is concerned that this type of managed competition would further entrench a two-tier system of healthcare where only the poor will be in the cheapest plan, which "will be less comprehensive, possibly with a limited provider panel, possibly not the best providers, and may have an incentive to underprovide."

On the issue of universal coverage, some policy analysts question how and when this will be achieved. "My impression is that they are backing off on universal coverage" for the near term, said Allen Dobson, a vice president at the Fairfax, VA–based Lewin-VHI. He sees the Clinton team

gearing up for a "first punch with cost control and then a second punch with universal coverage. If you don't have cost control, you can't do universal" coverage. He points to small business as "one of the most serious groups blocking universal coverage. They are very powerful and very much opposed to universal coverage, especially if done through an employer mandate or tax."

CHA's vice president for government services, William J. Cox, echoed the concern about universal access as one of several main reform issues that need to be addressed. The debate has "three main flash points," he said: How do you combine managed competition with global budgets? How and when do you achieve universal access? And what is the definition of managed competition? (See Cox's article on p. 16 for further discussion on Clinton's proposal and how it will affect CHA members.)

Working with Congress and the States

In working out the many details of a healthcare reform plan that can be enacted, Clinton will need the backing of a broad coalition of Congress and healthcare leaders. "My Republican friends tell me that the Clinton people underestimate how difficult Congress will be to deal with," noted Dobson. In addition, Clinton "will have enough trouble putting his own troops in order," he continued. Since Clinton's early plan combines features of both competition and regulation, he may have to work to bring in the more conservative Democrats opposed to his global budget regulatory strategy and emphasis on universal coverage, as well as to woo the more liberal faction to accept the market-driven competition portions of the plan.

A number of key Republican healthcare leaders have expressed a willingness to work with the president, however. Sen. David Durenberger, R-MN, for instance, has participated in the Jackson Hole Group and delivered a white paper to Clinton on November 4, 1992, that sets out his commitment to bipartisan action on healthcare reform ("Designing an Infrastructure for Health Reform").

Building a bipartisan coalition will be critical for such a complex piece of legislation. An early sign of Clinton's appreciation of this fact was his appointment of bipartisan "Pepper Commission" Staff Director Judith Feder as his transition team healthcare director, as well as his appointment of Stuart Altman, who served in both the Nixon and Ford administrations. Altman is dean of Brandeis University's Heller Graduate School and chairperson of the Prospective Payment Assessment Commission. Feder is codirector of Georgetown University's Center for Health Policy Studies.

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In addition, Clinton is seeking to improve relations between the congressional and executive branches in general. "Early in his transition period, Clinton made both rhetorical and actual moves toward reestablishing cooperation between the White House and Congress," wrote Lawrence Brown, a political scientist at Columbia University ("Political Evolution of Federal Health Care Regulation," *Health Affairs*, Winter 1992, pp. 17-37).

Even though Bill Clinton's party controls Congress, coalition building is still critical and must extend outside the Beltway. "The major party in Congress is not the Democratic or Republican party; it is the 'Reelect Me' party. For guidance on reform, members of the House will look to their districts, not just the House leaders or the president," explained Cox.

The role of states in carrying out healthcare reform raises some interesting issues. "On the one hand, states won't want to do things that are inconsistent with a national plan," notes AHA's Pollack. "But with Clinton, an ex-governor relying on advice from other influential governors, there will still be opportunities for states to do creative things."

A number of policy analysts have questioned the varying capacity of states to carry out the reforms, collect the necessary data, and meet the budgetary caps of a managed competition plan. "The administration is going to come in bright-eyed and bushy-tailed and want to change the system quickly; [however,] we're talking a 5- to 10-year transition to make it happen. The states will change at their own pace," said Dobson.

As the debate moves forward, it is imperative that hospitals and other healthcare leaders get involved and work at meaningful reform and coalition building. The election of Bill Clinton has stepped up the pace and heightened the reform debate. It is now important to work together toward comprehensive reform that does not tinker with the easy surface issues, but that sets out to control the rising healthcare costs that threaten the economy; that finally makes access to healthcare a right, not a privilege; and that does not threaten the quality of healthcare for the most vulnerable citizens. □