

# Incremental Steps to Reform

BY JANE HIEBERT-WHITE

**W**ith Republicans controlling the Congress, discussions of healthcare reform in Washington have shifted from proposals for sweeping national changes to incremental steps. Said Senate majority leader Robert Dole, R-KS, January 30 at the American Hospital Association (AHA) annual policy conference: "When we talked about incremental healthcare last year . . . it sort of became a dirty word . . . [Now] even the president's offered a new version of reform, which can only be described as limited or incremental. And frankly, it looks a lot like portions of the Dole-Packwood bill we offered last year."

President Bill Clinton, in his January State of the Union address, conceded that "we bit off more than we could chew" on healthcare reform in 1994. His new vision includes such incremental steps as insurance reform, medical savings accounts (MSAs), expanded coverage for children, and allowing tax deduction of health insurance premiums for the self-employed.

This month's column looks at some of the incremental healthcare reform proposals circulating around Washington. I also assess which steps may rate high on the Republican Congress's agenda, now that the first 100 days' obsession with the Contract with America has passed.

## INCREMENTAL STEPS

House Speaker Newt Gingrich, R-GA, spoke to hospital leaders at the AHA meeting about the need for "a genuine transformation and not just . . . incremental change." However, the high-flown rhetoric he used in speaking of an "extraordinary scale of change" has not been echoed at large by other Republican leaders, particularly the chairpersons of the health-related congressional committees. Indeed, although Gingrich spoke of broad healthcare change, his energies have been focused on the Contract with America. Thus the likely scenario for healthcare policy this year is the more incremental approach.

Such incremental steps include malpractice tort



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reform, insurance reforms, MSAs, changes in tax treatment of insurance premiums, opening up the Federal Employees Health Benefits Program to small firms and individuals, and changes to Medicare and Medicaid. Much of the 104th Congress's attention to healthcare will be driven by a desire to control costs and limit government programs that are fueling the federal budget deficit, namely Medicare and Medicaid.

The incremental approach to healthcare reform is not without its problems. Both conservative and liberal health policy analysts acknowledge the pitfalls of this approach. Stuart Butler, of the conservative Heritage Foundation, notes: "Incremental reforms must be framed within the context of an ultimate reform. If Congress does not do this, and the process of incremental reform becomes an end in itself, we will construct a 'reformed' healthcare system that may be worse than the one we have now."<sup>1</sup> Judith Feder and Larry Levitt, both of the Department of Health and Human Services and key members of the president's task force on healthcare reform, warn: "We should not allow a step-by-step approach to reform become an excuse for action that would reduce, rather than improve, health care coverage."<sup>2</sup>

## INSURANCE REFORMS

The one incremental healthcare reform step that many politicians mention is the reform of certain insurance practices. These include preexisting condition limitations, difficulty in carrying insurance from one job to another ("portability"), and "redlining" of certain industries that raise the cost of insurance or make it difficult to obtain.

Yet it is one thing to agree on some of these needed changes; it is another thing to agree on how to make the changes. Feder and Levitt believe apparent agreement on the need for insurance reforms "is more a reflection of the limited policy debate these issues received (relative to employer mandates, for example) than of genuine consensus. The fact is that the specifics of insur-

ance reform are highly controversial." Butler agrees: "Significant insurance reform probably will be almost as divisive an issue this year as it was in 1994, because even small changes in the way the insurance system is structured would cause the health care system to evolve in sharply different ways."

Feder and Levitt explain that most policymakers support the kinds of insurance reforms that nominally increase access to healthcare coverage. Yet, "without the second type of reforms—those that change insurers' rating practices—the promise of greater access is largely an illusion, and there is hardly any consensus around the issue of how to accomplish this type of reform," the HHS analysts note. In addition, there is controversy about what groups of people should benefit from these insurance reforms.

One more likely option is for Congress to encourage the states to experiment with insurance regulation. A key issue here, however, is whether Congress will remove the barriers to insurance reform posed by the Employee Retirement Income Security Act (ERISA). Senators Mark Hatfield, R-OR, and Bob Graham, D-FL, introduced a bill February 1 to set up an ERISA Review Commission.

#### **MSAs AND TAX CREDITS**

MSAs, which have now found favor in the new Republican-controlled Congress, can take several forms. In one form money is set aside, as in an individual retirement account, but for healthcare payments rather than retirement income. Withdrawals for medical purposes could be made without penalty, and money deposited in the accounts would not be taxed.

Another way to structure MSAs is to change the current rules regarding employees' flexible spending accounts ("cafeteria plans") to allow the employee to roll over some of the account money each year, rather than lose any surplus. Money would continue to be contributed tax-free, and could be withdrawn tax-free if used for health-related bills.

Conservative health economist Mark Pauly, of the University of Pennsylvania, and long-time

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MSA proponent John Goodman, president of the National Center for Policy Analysis, explain the rationale behind MSAs: "The idea is simple. Instead of buying expensive, full-coverage policies, obtain catastrophic insurance. But instead of incurring the risk of high out-of-pocket payments with no assets to cover them, create a special account with after-tax dollars, earmarked to cover those expenses. The availability of this account will mean that the family will not have to risk incurring bad debts and defaulting on their obligation to pay for the care they receive."<sup>3</sup>

Pauly and Goodman link MSAs to tax credits to avoid creating market-distorting incentives, such as encouraging high-income persons to set up MSAs as tax shelters. The proposal also allows for more competition between different insurance plans and aims to discourage overuse of medical care. The main tenets of the Pauly/Goodman proposal are:

- Fixed-dollar tax credits to reward those who voluntarily purchase insurance
- Basic catastrophic insurance coverage to cover the large medical bills that most families cannot afford
- MSAs to pay small medical bills and to offer rewards for prudent purchasing decisions<sup>4</sup>

Some conservative analysts and Republican policymakers, however, are not enamored of the plan. The "politically volatile employer tax deduction issue" may threaten to split the ranks of MSA proponents.<sup>5</sup>

#### **REVAMPING MEDICARE AND MEDICAID**

Although some action may occur on insurance reforms, MSAs, and other incremental steps, the central focus of health policymaking in this Congress will be on trimming the entitlement programs—Medicare and Medicaid—to reduce federal spending. The relentless rise in costs and drain on the federal budget in the short term and the threatened financial insolvency of the program in the longer term, are key reasons Republicans are looking anew at the Medicare program. The most recent annual report of the Medicare trustees warned that the program may run out of money by 2002, fueling Republican

policymakers' passion for cutting program spending.<sup>6</sup>

Some politicians have proposed cutting \$400 billion from Medicare/Medicaid savings over a period of seven years. However, some Washington analysts say cuts of \$60 billion over five years are more likely.

Gingrich, in his AHA speech, said he wants to "rethink Medicare from the ground up." Yet, as we learned from the passage and quick repeal of the Medicare Catastrophic Care Act in 1989, changes to this program do not come easily. *New York Times* reporter Robin Toner observes: "Medicare is considered the real test for Republicans: unlike the reductions already passed by the House in welfare spending, money that comes out of Medicare will affect, directly or indirectly, a vast and vulnerable middle-class constituency."<sup>7</sup>

President Clinton, in his fiscal year 1996 budget proposal, stepped back from proposing Medicare and Medicaid cuts, as he had done earlier. He proposed funding the Department of Health and Human Services at \$716 billion, a 7.5 percent increase over the previous year. In essence, his budget document turns over the responsibility for controlling federal spending and reforming these health care programs to the Republicans.

One Medicare reform that is moving quickly through Congress is expansion of the Medicare Select demonstration project. This program offers the elderly in 15 states discounts on their supplemental Medigap insurance plans if they use managed care. In early April the House voted to expand the program for five years. President Clinton had sought an 18-month extension of the plan. Policymakers also want to extend the program to all 50 states.

Gail Wilensky, who ran the Medicare program under the Bush administration and currently advises Republican members of Congress, sets Medicare Select at the top of her list of recommended Medicare reforms. Some of her other suggested reforms to increase the use of managed care in Medicare and thus reap more savings are:

- Allow point-of-service plans

*Small steps,  
budget  
cutting, and  
learning from  
the private  
sector's  
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mottoes of  
the day.*

- Allow partial capitation, or risk-based "carve-out" plans

- Refine/revise the capitation rate to break the link to fee-for-service spending

- Move to an annual open enrollment period for all changes in Medicare-related policies; discontinue 30-day disenrollment policy for HMOs

- Allow HMOs to price below the Medicare payment and rebate savings to the elderly (and share savings with the government)<sup>8</sup>

Medicaid reform is tied closely to the debates on welfare reform in Congress. Members are talking about devolving authority for the program back to the states with block grants. In addition, any changes to eligibility for cash assistance welfare will also likely affect eligibility for Medicaid health insurance coverage.

Hospital leaders concerned about how such reform might affect provider payments should pay close attention to the budget reconciliation debate as it unfolds this summer and fall in Congress. Whatever happens on the budgetary and health policy front in 1995, one can be sure that no sweeping government-led healthcare reforms will be part of the package. Small steps, budget cutting, and learning from the private sector's managed care experience are the mottoes of the day. □

#### NOTES

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