

# Policymakers Must Be Candid About the Costs of Reform

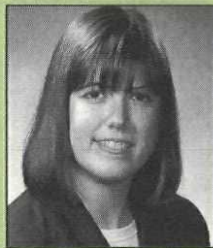
BY JANE H. WHITE

**I**f this nation is ever to achieve meaningful healthcare reform, policymakers must help the public understand the cost issues leading to reform and how the various reform proposals will affect them.

Although President Bill Clinton has touted universal coverage as his top goal of health reform, in many ways it is healthcare's rising costs that have put reform on the political agenda. State and federal governments see an ever-rising share of their budgets devoted to healthcare; businesses and consumers face double-digit increases in insurance premiums, leaving less and less for wage raises.

To be sure, many Americans are concerned about the 37 to 39 million citizens who are uninsured. But what makes reform infinitely more difficult is figuring out how to pay the tab for covering the millions of uninsured and underinsured Americans and how to keep the cost of the healthcare system from careening out of sight.

Among the main goals of healthcare reform, 72 percent of Americans believe providing coverage for the uninsured is a "very important" goal, according to a 1993 survey conducted by Harvard University's Robert J. Blendon and the Boston-based polling firm Marttila and Kiley, on behalf of the Robert Wood Johnson (RWJ) Foundation.<sup>1</sup> Note Blendon and colleagues, "Our survey shows that moral concern for the uninsured is a strong public value. This value alone, however, is not enough to generate popular support for a national health care program." Other goals ranking as high or higher than covering the uninsured in the poll include reducing waste and inefficiency (86 percent), providing coverage between jobs (82 percent), halting cost increases (77 percent), emphasizing preventive care (73 percent), reducing malpractice suits (73 percent), and improving overall quality (72 percent). "This relative lack of differentiation indicates that Americans are still making up their minds about what they want health care reform to accomplish," explain Blendon et al.



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## WHO REALLY PAYS?

The average 1993 health insurance premium cost for a family ranged from \$4,980 for a health maintenance organization (HMO) to \$5,784 for a point-of-service plan.<sup>2</sup> But most Americans do not know the true cost of their healthcare because much of the cost is paid directly by employers. Furthermore, most Americans do not realize that the employer rarely "pays" for this insurance. The cost of the health insurance is passed through to the employee in the form of lower wage raises or to consumers via higher prices.

If Americans do not realize how much they are "paying" for their healthcare coverage, they also do not realize how much the amount increases each year. Their employers may switch from a fee-for-service plan to a managed care plan to hold down costs, may cut back on benefits, or may increase the deductible. A recent survey of insurers by KPMG-Peat Marwick and Wayne State University, Detroit, found that the percentage of Americans who had the option of choosing conventional health insurance over a managed care plan offered by their employer fell drastically from 90 percent in 1988 to 65 percent in 1993.<sup>3</sup> The survey also found that employee cost sharing increased in all types of plans, deductibles were higher, and lifetime maximum benefits were cut back between 1988 and 1993.

## CANDOR ON HEALTHCARE COSTS

So how can healthcare leaders and policymakers clarify the debate for the American public and move toward meaningful healthcare reform? In a satellite-linked speech to a group of congressional and White House staff, health policy analysts, and economists gathered at Princeton University in late January, Victor Fuchs offered his solution: "Be candid, be creative, and be courageous."

**Be Candid on Costs** Fuchs, considered by many the elder statesman of healthcare economics, urged the audience of top policymakers to first be candid on who bears the cost of healthcare and what

that cost would be under a reformed system. Only after policymakers and the public agree to an open, candid discussion of healthcare costs and trade-offs inherent in reforming the U.S. healthcare system, can we effectively move on to developing creative solutions and building up our courage to implement them.

Fuchs's entreaty for candor came just days before the Congressional Budget Office (CBO) unveiled its cost estimates of the Clinton administration's Health Security Act at 15 percent higher than what the White House predicted.<sup>4</sup> The release of CBO's report touched off a debate in Washington about what the "true" costs would be under the Clinton plan, charges of "smoke and mirror" estimates, and claims that the president's plan was dead.

CBO Director Robert Reischauer, anticipating this response, testified before the House Ways and Means Committee February 8 that he feared the information contained in the CBO report "might be used to undercut a serious discussion of health reform alternatives or to gain some short-term partisan political advantage." Reischauer added, "We should be designing health care reform according to what makes sense for healthcare policy, not according to how it's going to show up in the budget."

**Be Candid on Cost Estimates** The subject of projecting healthcare costs under various reform plans is fraught with problems. First, many analysts—both inside and outside of government—acknowledge that the data bases they use to make their estimates are far from ideal. Some of the data are old; there are gaps and comparability problems. Many variables and differing assumptions can lead to a high level of uncertainty in these estimates. Indeed, in the White House's own cost estimates of insurance premiums under the Clinton plan, a 15 percent cushion was added to account for "potential behavioral responses that are difficult to model."<sup>5</sup>

A private, independent estimate of the Clinton plan premium costs ran 15 percent to 20 percent higher than the administration's estimate because of the varying assumptions used.<sup>6</sup> These estimates by the Fairfax, VA-based consulting firm Lewin-VHI suggest that employer spending on healthcare by 1998 would rise \$29.8 billion, instead of falling as the White House forecasts. In addition, the plan's long-term impact would still reduce the deficit by the year 2000, but by \$25 billion, rather than the \$58 billion savings the administration predicted. These estimates differ for several reasons:

- Different accounting for the aging of the "baby boom" generation by 1998 (15 percent of the difference)

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- Differing premiums in HMOs (40 percent of difference)
- Differences in the offset for uncompensated care (20 percent of difference)
- Methods used to estimate the unit cost of care (3 percent of difference)
- Ways of adjusting data from the National Health Accounts, on which both estimates were based (22 percent of difference)

Yet despite the problems inherent in these estimates, policymakers use these flawed numbers as the foundation on which to build major legislative proposals. This can lead to big surprises down the road. Take Medicare, for example. When passed back in 1965, it was estimated to cost \$9 billion by 1990; in reality it cost \$67 billion that year.<sup>7</sup>

Such figures strike fear in many a legislator's heart and have led some, such as Sen. John Chafee, R-RI, to propose "pay-as-you-save" provisions in their health reform proposals to limit the government's exposure to cost overruns. Under such provisions, healthcare coverage would be extended gradually toward universality as savings are achieved in the health system. The big unresolved question is, How do we get those savings?

### **TOUGH CHOICES AHEAD**

As members of Congress struggle with how to control healthcare costs with candor, they face some tough choices in the months ahead. One option, of course, is to stick to political gaming and not achieve real reform.

The president's plan pins its cost control strategy on reorganizing the health insurance market to encourage "value-based" or managed competition among healthcare plans and providers. According to administration economists, the plan "creates bargaining power for small groups; gives consumers better information about health plans and a direct financial stake in choosing lower-cost plans; replaces experience rating and risk selection with community rating and open enrollment; and provides financial incentive for providers to form networks that deliver cost-effective care."<sup>8</sup>

**Regulatory Controls** Although a number of plans in Congress rely on various forms of managed competition similar to that in the Clinton plan, the president adds a backstop mechanism of premium caps and budget limits to control rising costs. The Clinton plan limits the growth rate in the healthcare system to the rate of increase in a regional alliance's weighted average premium. In 1996 insurance premium increases would also be capped at 1.5 percentage points over the current inflation rate. This limit is lowered further in subsequent years.

These premium limits have raised a red flag in the debate over healthcare costs. Many economists, politicians, and private-sector business leaders have argued against such regulatory limits. Princeton economist Uwe Reinhardt, for instance, explains that "over time, the successive application of premium caps could convert a system of managed competition among essentially commercial health plans into something resembling a rate-regulated public utility."<sup>9</sup> He argues that while such limits were probably put into the plan for CBO "scoring" purposes, problems with this mechanism include perverse financial incentives for efficient plans that started out with lower premiums, risk adjustment difficulties, and the possibility that too tight a cap may limit medical innovation.

Reinhardt suggests that President Clinton start out by imposing "strict budgetary discipline on the public-sector health programs under his purview, leaving the private sector to cope with the fiscal fallout from his policies as best it can." A number of business groups, such as the Business Roundtable and the U.S. Chamber of Commerce, have argued that they can achieve savings on their own, without government regulation, and should be given a chance to prove themselves before the heavy hand of government is imposed.

University of Pennsylvania economist Mark Pauly notes "the spending caps in the administration's proposal represent quite a drastic departure from trends that have persisted for decades."<sup>10</sup> Pauly asks, "If the budget is cut, all activities—not just those judged wasteful—will be reduced in volume. Then we are left to ponder the trade-off: Is the money saved, or more precisely, are the alternative nonmedical outputs, worth more than the foregone quantity and quality of medical care services?"

Economist Henry Aaron of the Brookings Institution, on the other hand, believes "national spending limits are essential for sustained control of growth of spending."<sup>11</sup> However, he too predicts that the limits set in the president's plan are too stringent and will probably fail to win support in Congress. Aaron argues that it is not practicable to "wring so much out of health care spending as quickly as he proposes" and that such a level of cuts may deny some people beneficial healthcare.

### A CRITICAL STEP

As the various House and Senate committees begin to negotiate the fine points of healthcare reform and look at alternative plans such as the Cooper-Grandy and the Chafee bills, the same tough cost control questions must be asked. Many policy analysts in Washington have noted that the primary reason congressional plans such

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as Cooper-Grandy have not received the same scrutiny on cost to date as the Clinton plan is that the president's plan is more candid on the details, thus allowing for more serious debate of the cost estimates.

Although people may not agree on the details and assumptions about how we achieve cost savings, the alternatives must be debated with the same level of openness and candor. If premium caps and budget limits are deemed too regulatory and inappropriate for an American healthcare system, then what other cost control strategies will we pursue? Where will we look for savings besides the popular and overestimated target of waste and abuse? How will we pay for extending coverage to the uninsured? If we do not address these questions soon, healthcare costs will rise to a point where we may be forced into more drastic control measures down the road.

This debate on who pays, how much is really saved, and how we can realistically achieve our goals is a critical step toward the candor that Fuchs has asked of healthcare reformers. Having cracked open the door on candor toward healthcare costs with the recent CBO report and other independent assessments, we must now push it wide open. Then Congress—and the healthcare community that is presenting its case to Congress—need to be creative and courageous if we are to achieve the goal of meaningful healthcare reform. □

### NOTES

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