Understanding Clinton's Health Plan: Beyond Political Language

BY JANE H. WHITE

In announcing his health reform plan on September 22, 1993, President Bill Clinton spoke of six overarching principles: security, savings, quality, implicity, choice, and responsibility. You can be sure that all these key words have tested well in polling and focus groups. Throughout the coming months, political language will be critical in shaping the debate. Since healthcare reform is such a complex undertaking, the words used to sell or critique the president's plan become increasingly important.

Critics counter the president's plan with their own key words: bureaucracy, jobs (i.e., loss of jobs if small business is forced to provide health insurance), and, again, choice—in this case, the lack of choice they believe Americans would suffer under the president's plan.

"Choice is one of the most loaded words," said Urban Institute economist Marilyn Moon. "Choice of what? Of insurance plans? What most Americans care about is choice of *providers.*" Moon was the lead speaker at an October 22 Washington, DC, briefing cosponsored by the Alliance for Health Reform, the Catholic Health Association (CHA), and the Henry J. Kaiser Family Foundation.

Another language nuance that has surfaced in the policy debate is "access" versus "coverage" in ensuring the much-vaunted "security" provided by health reform. According to Moon, "Access is insurability. Are you able to purchase insurance? If yes, then you have *access*, even if you can't afford it." *Coverage*, however, is a broader term. "We need to think more about affordability" as a key determinant of universal coverage, continued Moon.

To understand the debate and its effect on providers and the broader healthcare industry, however, it is critical to get beyond the political language and dig deep into the intricacies of the president's proposed plan. It is also critical to understand that Clinton's plan is indeed the focal point of the debate. Although at least half a dozen other health reform plans are floating around Congress—including a Canadian-style plan and several Republican plans—the president is the one with the political power to force the debate on a broad public scale. Thus this column will delve into Clinton's plan, getting beyond the political language and into the goals and framework.

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Goals of Clinton's Plan

The president's plan, the American Health Security Act of 1993, builds on the current American system of employer-provided health insurance. Its theoretical underpinning comes from the managed competition model, and it adds the more regulatory mechanism of insurance premium caps as a backstop for controlling costs. The goals of the Clinton plan, as outlined in the September 7 draft version, include the following.

Security Security is a key selling point of the plan for middle-class Americans. The president drove this point home when he flashed a sample health security card during his September speech to the American people. Clinton envisions providing each eligible person with such a card.

The plan aims to safeguard the health security of the American people in nine ways:

1. All employers would be required to contribute to health coverage for their employees.
2. Everyone would share the responsibility of paying for healthcare coverage.
3. Limits on out-of-pocket payment would protect families from catastrophic costs. Subsidies on insurance would be provided for low-income individuals and small employers.
4. A comprehensive benefit package with no lifetime limits on medical coverage would guarantee access to a full range of medically necessary or appropriate services.
5. Outpatient prescription drugs would be provided to elderly and disabled Americans under Medicare for the first time.
6. Regional health alliances would offer people a choice of approved health plans and providers.

7. No health plan could deny enrollment to any applicant because of health, employment, or financial status. Health plans also could not charge some patients more than others because of age, medical condition, or other factors related to risk.

8. All health plans would have to meet national quality standards and provide consumer information that allows for valid comparisons among plans and providers based on cost and quality.

9. Long-term care coverage would be increased with federal support, and improved quality and reliability standards would be set for private long-term care insurance.

Savings A second goal of the Clinton plan is to bring growth in healthcare costs in line with growth in the gross domestic product (GDP) by 1997. This is a very ambitious savings goal. As a percent of GDP, the United States far outspends other nations on healthcare, at 13.2 percent in 1991.[1] Canada was the next highest spender at 10 percent of GDP. No other country spent more than 10 percent on healthcare. The Clinton plan aims to control rising healthcare costs by increasing competition in healthcare, reducing administrative costs, and imposing budget discipline.

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Quality A third goal is to enhance the quality of care. The U.S. healthcare system is the best in the world for those who can afford it. To extend this care to all Americans in a more cost-conscious environment, the Clintons want to be sure that quality is enhanced, not sacrificed. To this end, the plan proposes:

- Creating explicit quality goals and standards for healthcare practitioners
- Holding health plans accountable for quality improvement
- Publishing easy-to-understand information for consumers about quality and cost of plans
- Increasing investment in medical research
- Establishing a special funding mechanism to support academic health centers in their role as centers of excellence in research, training, and specialty care
- Promoting training of primary care physicians and broadening roles for nurses and other nonphysicians
- Investing in public health

Access The fourth goal is to expand access to care in areas with limited availability of providers. Strategies to address this goal include giving health alliances responsibility for building health networks in rural and urban areas with inadequate access to care; setting up national loan programs to support the efforts of local health providers in developing community-based plans; investing in alternative sites for delivering healthcare to underserved populations, such as school-based clinics and community clinics; and providing financial incentives to attract health professionals to underserved areas.

Simplicity A fifth goal of Clinton's plan is to reduce bureaucracy in the health system. To achieve administrative savings, the plan relies on several strategies:

- A single, comprehensive benefit package for all Americans to eliminate confusion about coverage
- Standard forms for insurance reimbursement, claims, and clinical encounter records
- Greater economies of scale, thus reducing overhead costs for health coverage purchased by individuals and smaller companies
- Simplified federal regulations for Medicare, Medicaid, and other federal programs
- Merger of workers' compensation and automobile insurance into the new health system to reduce duplication and waste
- Malpractice reform to reduce the incentives in the current system to perform unnecessary tests and procedures

Fraud and Abuse Finally, the sixth goal is to reduce fraud and abuse in the health system by setting tough standards and imposing stiffer penalties. For instance, the president's plan expands the current antikickback statute from just Medicare and Medicaid to cover all health payers. The Clinton plan would end physician self-referrals for any item or service in which the physician has a financial interest.

FRAMEWORK OF THE CLINTON PLAN

The Clinton plan aims to achieve these goals by restructuring the healthcare market to foster competition on price and quality, building on the employer-provided insurance base to cover all Americans. This plan attempts to shift the incentives already in the healthcare system, while also providing some regulatory oversight to achieve the goals of universal coverage and cost containment.

Several structural elements are critical to the plan's framework: a standard benefit package, a National Health Board, increased state responsibility and flexibility, regional health alliances, and approved health plans. Many other key elements in the plan relate to financing and cost control, such as employer mandates and premium caps (which I will discuss in a future column). Following are the plan's structural elements.

Standard Benefit Package By setting a standard benefit package, the Clinton plan acknowledges that,

as a country, we agree some basic level of health coverage should be guaranteed as a right of citizenship. Standardizing the benefit package also allows for more meaningful competition among plans—consumers can compare apples and apples.

Linda Bergthold, who chaired the White House Task Force Working Group on Benefits, explained the importance of true comparability: "Consumers may be reluctant to choose plans with lower prices for fear those plans have hidden exclusions buried in the fine print. Thus the uniform benefit package both clarifies the price differences among the plans and gives consumers greater confidence in picking plans with lower costs."[2] Bergthold is a principal with the benefits consulting firm William M. Mercer.

As defined in the draft plan, the benefit package is quite generous. Once Congress starts tearing it apart, however, the package may be far from its current configuration. The political debate will pit provider interest groups seeking to make sure their services are generously covered against members of Congress who see the rising price tag of such benefits.

Highlights of the benefit package include an emphasis on prevention to improve the nation's health and lower costs over the long term. This inclusion is lauded by many in the health community, but raises concern among some observers regarding cost.

Inclusion of family planning services in the benefit package will bring the controversial issue of abortion coverage to the forefront. Some members of Congress and interest groups have said that their support of the plan hinges on inclusion of abortion coverage in the benefit package. Other groups, such as CHA, oppose this inclusion. Support of Catholic providers will be critical to the Clinton plan. Indeed, CHA's own plan for health reform is similar to the Clinton plan and was commended by Hillary Rodham Clinton in her testimony before the House Ways and Means Committee in late September.

An early sign of how the administration may walk the tightrope on the abortion issue cropped up in questions to the First Lady at the Ways and Means hearing. She suggested that it would be possible for certain providers or plans to opt out of providing abortion services under a "conscience clause." However, the regional alliance would have to offer access to abortion services in other plans. Under current constitutional law, states or regions could not prohibit abortions.

Another major and controversial category of benefits is mental health and substance abuse services. Here the advocacy of the vice president's wife, Tipper Gore, is evident. Just over a year ago, at a meeting convened in the Frank Lloyd Wright Wingspread house in Racine, WI, a group of mental health policy leaders were wringing their hands over the fact that their field was so divided. Mental healthcare needed a unified and politically powerful voice at the reform table. They got that voice in the form of Tipper Gore.

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Many mental health leaders contend that the healthcare of the body and mind should be integrated and that current commercial insurance plan limits are often artificial and much more restrictive for mental healthcare than for general healthcare. As more biological links are discovered in mental illnesses, this argument for equal insurance treatment has gained greater credence. The Clinton plan acknowledges this need for integration by eliminating prescribed day limits for mental healthcare and substance abuse treatment by the year 2001.

National Health Board This board is a new, independent entity responsible for setting national standards and overseeing the states in establishing and administering the new health system. The Clinton draft plan proposes giving the president and administration great political power over the board, which is sure to be contested in Congress in the coming months. Some analysts had earlier thought that the board would be modeled after the Federal Reserve Board, whose chair does not serve a concurrent term with the president and is thus somewhat less political.

The functions of the National Health Board would include overseeing the state system to ensure universal access to healthcare, interpreting and updating the guaranteed benefit package, implementing and enforcing a national budget for healthcare spending, and setting quality and reporting standards.

State Responsibility States are pivotal in carrying out the goal that all citizens have access to healthcare. (Key responsibilities were detailed in the November Health Policy column.)

Regional Health Alliances These purchasing alliances serve as the linchpin in the managed competition strategy. In a nutshell, regional alliances pool together many more people than individual health plans, thus achieving economies of scale and more purchasing clout. Alliances do not provide healthcare, nor do they bear insurance risk. Instead, they would serve as a large-scale regional administrator, contracting and negotiating with qualified plans on behalf of individuals and employers, encouraging competition among plans to keep costs down, and ensuring that all

citizens in a region enroll in a health plan. Large corporations with more than 5,000 employees may form their own "corporate health alliance" to purchase health coverage for their workers, rather than use the regional alliance.

The purchasing alliances, whether regional or corporate, must offer at least three choices of health plans. And one of the choices must be a fee-for-service plan. Actually, this would be more of an open-panel plan that accepts any willing provider, according to Kevin Anderson, former White House spokesperson.

Approved Health Plans All health plans offered by the alliances must meet national quality standards and offer the guaranteed benefit package. Health plans would enter into agreements with healthcare providers to deliver services. In these arrangements, the plans may:

- Limit the number and type of participating providers
- Require patients to use participating or authorized providers for nonemergency services
- Require patients to get a referral for treatment by specialist physicians
- Set different payment rates for providers that participate in the plan and those which are outside it
- Create incentives to encourage the use of participating providers
- Use single-source suppliers for pharmacy, medical equipment, and other health products and services

Although the Clinton plan leaves the window open for traditional fee-for-service providers, those who stand to benefit most from the competitive environment are health maintenance organizations (HMOs) or vertically integrated managed care networks. Even before Congress passes reform, insurers, managed care plans, and large providers have begun to team up in integrated delivery networks, such as the new joint venture between Blue Cross/Blue Shield, Henry Ford Hospital, and Mercy Health System in Michigan. Whether these new networks will be driven by the insurers or the providers is a matter of great debate.

Health plans must accept all eligible persons. They cannot terminate, restrict, or limit coverage for the standard benefit package for any reason, including nonpayment of premiums. Health plans cannot exclude people with preexisting conditions and cannot impose waiting periods before coverage begins.

Health plans must use community rating to determine premiums. With community rating, insurers need to pool a larger number of people to remain commercially viable than they do with experience rating. This shift alone will probably lead to fewer insurance plans in the market. These larger insurance plans may also be able to increase their influence over healthcare provider behavior. To confirm the trend to fewer, larger insurers, Bill Gradison, president of the Health Insurance Association of America, noted, "Of the 1,200 to 1,500 health insurers in this country, 275 underwrite 94 percent of the policies." Gradison shared his views at an October Washington forum sponsored by the Employee Benefit Research Institute (EBRI).

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The health alliance *will*, however, adjust its payment to the health plan to account for the level of risk associated with its enrollees. The National Health Board will determine this risk-adjustment formula. The discussion around risk-adjustment is also likely to be contentious in Congress.

Health plans may offer consumers one of three standardized levels of cost-sharing: low, high, and combination. In a combination plan, users would pay no deductible and only a $10 per visit copayment for in-network care. If a patient opts for care outside the plan's network, deductibles and higher copayments would be imposed. Supplemental insurance would be allowed under Clinton's proposal to cover benefits over and above those in the guaranteed national package or to pick up the out-of-pocket costs entailed by the cost-sharing requirement.

EFFECT OF CLINTON PLAN ON DELIVERY SYSTEM

With the creation of health alliances, health plans must compete on the basis of cost and standardized quality measures. According to EBRI's Bill Custer, this may lead to increased market power for insurance plans that would "force providers to attract patients on both the cost and quality dimensions."[3] One result of these pressures will likely be lower real physician incomes for some specialists. Custer continued:

> The net effect on the healthcare delivery system will depend on the measures of quality used to evaluate plans and on relative values consumers place on those measures. If consumers value unlimited choice of providers, the ability of insurers to affect the healthcare services market may be constrained. . . . However, the growth of HMOs and managed care networks implies that consumers are willing to make some tradeoff between costs and choice.

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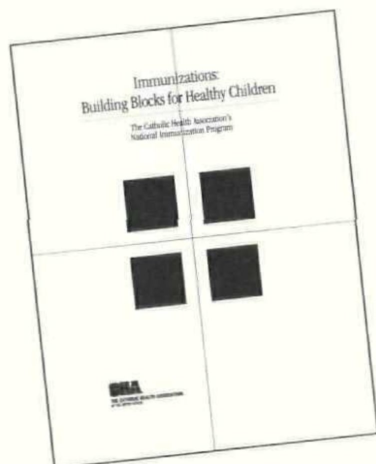

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This growth signals that reform of the healthcare delivery system is not waiting for Washington. Vertical integration is already happening. In many ways, the healthcare reform debate in Washington is not the instigator of change in the health system, but the accelerator.

Both the administration and members of Congress say the pressure on the accelerator could push reform legislation through Congress by next year. "I think next year is *the* year," said Sen. John Danforth, R-MO, at the October 22 briefing. At the same meeting, Sen. Jay Rockefeller, D-WV, forecast that legislation "will be passed sometime before the coming election."

White House Senior Adviser Ira Magaziner, in a voice worn rough by hours of late legislation drafting, appealed to the Hill staff at the October briefing to work together toward passage. "We don't have any hubris that we have all the right answers. We won't view it as a defeat or retreat if someone comes up with a better idea on how to achieve the goals" set out by the president, he said.

The White House has now laid out its hand. And as Rockefeller remarked, "We're finally at the beginning of the process. It seems like we've been at this forever. Now it gets really serious." □

NOTES

1. George J. Schieber, Jean-Pierre Poullier, and Leslie M. Greenwald, "Health Spending, Delivery, and Outcomes in OECD Countries," *Health Affairs*, Summer 1993, pp. 120-129.
2. Linda A. Bergthold, "Benefit Design Choices under Managed Competition," *Health Affairs*, Supplement 1993, pp. 99-109.
3. William S. Custer, "Reforming the Health Care Delivery System," paper presented at EBRI policy forum, "The Changing Health Care Delivery System," October 6, 1993, Washington, DC.