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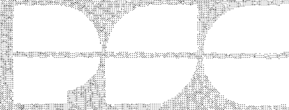

HEALTH POLICY BULLETIN

FOCUS: BILL GRADISON ON HEALTH CARE REFORM

In a speech billed as "Health Care Reform from a HIAA Perspective," Bill Gradison, former congressman (R-Ohio) and current president of the Health Insurance Association of America, covered health care reform broadly. The speech was delivered at an 8:00 am session of the annual meeting of the Association of Health Maintenance Organizations in Michigan at Boyne Highlands on July 27th.

Gradison, who holds an MBA and a doctorate from Harvard and was an investment banker before being elected to Congress in 1974, began by noting that health maintenance organizations (HMOs) are best equipped to cope with the future. In a brief historical review, he observed that President Richard Nixon had sent a health care plan that mandated coverage through employers to Congress in 1974, but that Congress had rejected the plan because it was not comprehensive. During Nixon's tenure the term *health maintenance organization* was coined, replacing the previous *prepaid group health care*, a structure, Gradison noted, that was erroneously labeled *socialized medicine* by the medical establishment. President Jimmy Carter sent a hospital coverage plan to Congress that also was turned down.

Politics, according to Gradison, derailed a comprehensive, incremental health care reform bill in 1992. The plan, endorsed by Rep. Dan Rostenkowski (D-Illinois) and Sens. Lloyd Bentsen (D-Texas) and John Chaffee (R-Rhode Island), provided for full deductibility of insurance premiums, tort reform, and so forth. Why did it fail? "Because," Gradison said, "Democrats did not want to send to Bush a bill that he would sign."

The incident reflects three fundamental problems facing those who want to reform health care in the United States: (1) an unwillingness to compromise, (2) the war between proponents of incremental change and proponents of comprehensive change, and (3) the emergence of health care as a salient issue for the middle class. Gradison said, "Neither Republicans nor Democrats were willing to compromise. The problem in health care is that everybody's second choice [if they cannot have their first choice] is to do nothing on the grounds that when the system collapses, they will be able to get their first choice." This approach also is reflected in what he describes as the war between the proponents of incremental change and comprehensive change. "The opponents of incremental change won't pass it because it then makes it harder to get comprehensive change," he said.

What kind of legislation will emerge in Congress? When will it pass? The interplay among other major issues will affect the outcome for health care reform. Gradison says the basic theme is health security and that there is considerable pressure to delay, that it makes more sense to get the North American Free Trade Agreement and possibly welfare reform out of the way before health care is tackled. "The problem is the trade-offs and needs of Congressmen to vote their districts," he commented. Specific legislation, he thinks, will not be introduced before January 1994. This approach lets the President talk about health care without addressing the details. In the best of all possible worlds—from a congressperson's point of view—Gradison sees legislation passing in 1994 but too late to be implemented before the election. The advantage of this scenario to congresspeople running for reelection is that they can truthfully say they passed health care reform legislation; however, dissatisfaction cannot harm their chances for reelection because the reforms will not have been implemented yet. In short, people will not have been affected yet by the details that arouse anger.

What will the federal legislation look like? There are seven "poison pills"—Gradison's term—in the plan: wage and price controls, applicability to rural areas, a tax cap, income-based premiums, coverage for abortion services, global budgets, and the powers of the purchasing alliances.

Both providers and insurers oppose wage and price controls. Gradison pointed out that controls will not be effective unless ERISA (self-insured) plans and HMOs also are covered by them. The applicability of capitated plans to rural areas where population densities are too low to offer the requisite volume of patients also is a significant problem. In addition, he noted that taxing excess benefits, a move sure to be opposed by labor unions and other recipients of excess benefits, would remedy the perceived failure of market mechanisms.

Income-based premiums are another can of worms. Traditionally, Gradison commented, premiums are computed on a per capita basis. Relating premiums to income eliminates risk as the basis for premiums and converts the premium into a device for introducing subsidies into the system, a strategy that is not likely to sit well with high-income, low users of the health care system. Whether to provide coverage for abortion services also is highly controversial. The degree to which the abortion issue has polarized the country suggests that reasonable compromise on this issue is unlikely.

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Finally, the two thorniest issues are likely to be global budgets and the powers of the purchasing alliances. Gradison observed that the first question about budgets is, How to define *health care expenses*? Once they have been defined a second question arises, How does one set the budget? For example, he noted, New York and Massachusetts have the highest costs while Mississippi and Arkansas spend the least. Does a policymaker choose the high number, the low number, or one in the middle? What is the relationship of the global budget to the health status of the state's residents? Are the states that spend the least frozen into that spending arrangement even if it does not meet the needs of the people of the state?

Governors, he noted, do not like the provisions for cost overruns. A state that spent more than its global budget would have to pay the excess amount itself. To governors, already complaining about the effect on their budgets of federal mandates for Medicaid, such a provision sounds like more of the same. President Clinton, he observed, is "close to the governors. The only bipartisan group on the Health Care Reform Task Force was the NGA [National Governors Association] staff."

The purchasing alliances (formerly called *health insurance purchasing cooperatives* (HIPCs) and now called *health alliances*), according to Gradison, could have immense power. Gradison notes that current plans call for the alliances to be state-created entities. As such, they could have the power to regulate prices, who would be required to purchase insurance from them, and determine the number of plans available.[1] Purchasing alliances with broad regulatory powers, according to Gradison, are known as "muscular HIPCs" and are opposed by Blue Cross and Blue Shield, commercial insurers, and employers.

On the financing end, the state will probably receive money for developing comprehensive, portable plans that cover everyone. Gradison commented that Canada took this approach—the central government gave the provinces money and the provinces designed their plans, a situation that has led to considerable variations among the provinces in terms of the coverages available to residents. Medicare beneficiaries could be included or left out; either way, the same benefits would have to be available to them as to those people covered by the plan because it would be politically unrealistic and untenable to have different benefits.

FOCUS: A DIFFERENT VIEW OF HEALTH CARE COSTS

A recent publication by the federal Agency for Health Care Policy and Research, *Annual Expenses and Sources of Payment for Health Care Services*, has just come to our attention. Although the report presents data from 1987, it offers a picture of health care use rarely considered in public policy discussions. The uniqueness of this report lies in its analysis of the percentage of people who use various health care services (inpatient hospitalization, inpatient physician services, outpatient prescriptions, and others). The demographic breakdowns—age, race, income, insurance status, and others—provide comparative data that should be valuable for evaluating any health care reform proposal.

The report is loaded with fascinating information, such as the following:

- In 1987, 84 percent of the population used a health care service.
- In 1987, 88 percent of females and 80 percent of males used at least one health care service.
- In 1987, 87 percent of whites, 74 percent of African-Americans, and 71 percent of Hispanics used a health care service.
- Of all people under age 65, 86 percent of those with private health insurance used a service in 1987; 81 percent with some form of public insurance received health care, at almost twice the per capita total cost of people with private insurance. Only 62 percent of people under age 65 who were uninsured all year received health care, and their average expenditure was 70 percent of those with private insurance.
- The higher one's family income, the more s/he is likely to use health care services.
- Nine percent of the total population was hospitalized in 1987—20 percent of people 65 years of age and older were hospitalized. Ten percent of African-Americans spent at least one day in the hospital, compared to 9 percent of whites and 7 percent of Hispanics. Rural residents are more likely to be admitted to a hospital than their suburban and urban counterparts.

OF INTEREST

In the next 30 days, look for

- the Senate Health Policy Committee to hold three hearings—August 17, 24, and 31—in Lansing on educating consumers about healthy lifestyles and the likely changes to the health care system and
- conference committees to resolve differences on departments' budgets.

1 Michigan State Rep. Michael Bennane's HB 4741, discussed in the May *Health Policy Bulletin*, does allow the alliances to determine prices in each region and does specify who is required to purchase insurance through them.

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