Gerald A. Faverman, Ph.D. • *Chairman of the Board*
Craig Ruff • *President*
William Rustem • *Senior Vice President*
Robert J. Kleine • *Editor*

Public Sector Reports

Michigan **COMMENTARY**

Miles to Go and Promises to Keep: Clinton's Health Care Plan

By Peter Pratt, Ph.D.
Vice President, Health Policy

By the end of President Bill Clinton's impassioned speech to the nation on his health care reform proposal the message was clear: He wants everything—health care coverage for everyone, tight controls on exploding health care costs, and improvements in the quality of care—and he is willing to compromise, which means he will settle for less than everything. Making certain that all of us have health insurance is the only principle that he will not negotiate.

Clinton's contradictory message mirrors the contradictions of our flawed system. On the one hand, most of us revel in luxury: munificent high-tech quality, the utter convenience of it all, and the relatively small dent that it makes in our pocketbooks. This is costly stuff, but not to us. On the other hand, we lament the plight of the 37 million people without health insurance, the difficulty that many of the disadvantaged face trying to get care for which they have coverage, and the struggles that many middle-class families endure because they have lost their health insurance or must pay astronomical premiums for it. Clinton wants it all and will settle for less; in America today, some of us have it all and some of us are forced to settle for less or pay much more than we can afford. The president's challenge is to find a humane and sensible middle ground, and the only meaningful way for this to happen is if those who have it all are willing to take less or pay more.

THE BASICS OF THE PLAN

Make no mistake, in his speech and in his and Hillary's campaign for reform, President Clinton is playing to the public; winning them over is key to successful passage of his plan. When he speaks boldly of security, for example, he is not talking to health providers, health insurers, or even businesses, as there will be tremendous insecurity (with big losers and big winners) among each of these. His plan is designed to create instability, at least for health care providers and health insurers. The president's gamble, his earnest nightly prayer, is that consumers will believe that this instability will create stability for them in the end.

Universal Coverage and the Mandates

All people except illegal aliens will have health insurance that covers a basic benefits package (see below). Clinton estimates that the average individual premium will be $1,800 a year and the average family premium will be $4,200.

Regardless of whether they work, individuals and families will be required to pay a share (on average 20 percent) of their premium unless employers choose to pick up all of it. Employees whose annual household income is at or below 150 percent of the federal poverty level will receive subsidies for their portion of the premium. If individuals or family members are employed, their employer pays on average 80 percent of the premium. Unemployed people are responsible for paying the entire premium, though they are also eligible for government subsidies. Although the plan requires employers to pay a much larger share of the premium than individuals must pay, the Clinton plan is a mandate on individuals as well as businesses.

While many accounts of the plan have stated that the employee pays 20 percent of the premium, this is not completely accurate. Employees—all people, in fact, whether or not they work—will pay more or less than 20 percent of their premium depending on the cost of the health plan premium they choose. If they choose a lower-than-average cost premium, they will pay less than 20 percent; if they choose a higher-than-average cost premium, they will pay more than 20 percent. In other words, Clinton's plan rewards individuals for choosing lower cost plans. Premiums will vary from health plan to health plan

Public Sector Consultants, Inc.
Knapp's Centre • 300 S. Washington Sq. • Suite 401
Lansing, MI 48933-2134 • (517) 484-4954

and depend on which cost-sharing option (see below) a person selects.

Regardless of how much the employee pays, however, employers must pay at least 80 percent of the average premium in the region for the categories (individual, family, and others) into which each of its employees falls. For example, if the employee has a family and the spouse does not work, the employer will pay 80 percent of the average premium for a family in the region. If both spouses work, their employers will (roughly) split the employer share of the average premium. Employers also will be responsible for prorated shares of their part-time workers' premiums. Because the firm's liability is based on regional averages, the premium that its employees choose has no bearing on the amount that the employer pays.

Firms with fewer than 50 employees have their premium contributions capped at between 3.5 percent and 7.9 percent of payroll. The cap depends on the average wage of the firm's full-time workers; businesses whose average wage is more than $24,000 a year can pay no more than 7.9 percent of payroll for health insurance premiums. All firms with more than 50 employees that join regional (as opposed to corporate) alliances also pay no more than 7.9 percent of payroll. Government subsidies fill in the missing premium dollars.

Regional Health Alliances and Corporate Alliances

All firms with fewer than 5,000 employees, all government employees, and Medicaid recipients who do not also receive AFDC and SSI (Aid to Families with Dependent Children and Social Security Income) will be required to join a regional alliance. (Medicaid will continue to pay for coverage for AFDC and SSI recipients.) Once known affectionately as HIPCs, health insurance purchasing cooperatives, these alliances can be either state run or private nonprofit organizations. Among other duties, they will negotiate premiums with the health plans, the large organizations that will deliver health care to most people. After the alliances complete negotiations with each health plan in the region, individuals choose not only a plan but also a cost-sharing option.

Under the Clinton plan, firms belonging to regional alliances will no longer be responsible for collecting money from and choosing health insurance options for their employees. Instead, the regional alliances will collect premium payments from businesses and employees alike, and the employees and their families will select a plan through the alliance. This, Clinton argues, will save many firms money by eliminating the need for health benefits personnel.

By amassing the collective purchasing power of thousands of firms, government, and Medicaid, Clinton believes regional alliances will keep premiums low. If, however, the alliances and the health plans are unsuccessful in keeping premiums from increasing too rapidly, the National Health Board, whose seven members will oversee the new health care system, will set caps on those premiums.

Each state will determine the number and size of its own regional alliances. Regional alliances have no requirements for the minimum number of people they must cover, but they must control enough of the market to negotiate effectively with health plans. The Clinton proposal is no more specific than that. Each region can have no more than one alliance; in other words, alliances cannot compete.

Firms with more than 5,000 employees can join a regional alliance or establish their own corporate alliances. If they form a corporate alliance, they must pay a one percent payroll tax to assist in funding the coverage for the higher-risk patients who are enrolled in the regional alliances. Corporate alliances must still offer the standard benefits package and the same cost-sharing options as regional alliances. Also, the corporate alliances will not be allowed to cap the percentage of their payroll that they contribute to health insurance premiums.

Health Plans

Most people will receive care through health plans. These large organizations can take many shapes (controlled by health maintenance organizations, insurers, physicians, or any combination of the three), but they will all deliver—or contract with others to deliver—the full range of services in the Clinton's comprehensive benefits package through hospitals, doctors' offices, clinics, ambulatory centers, and other sites. The health plans probably will include more than one hospital, numerous ambulatory sites, and hundreds of doctors and other health

care professionals. As creatures that combine financing and delivery of health care, the health plans will establish and negotiate premiums with regional and corporate alliances for the cost of delivering the services in the standard benefits package.

The cornerstone of the Clinton proposal is the competition among health plans. The plans in a region will compete based on the price of their premiums as well as on service and quality. For consumers to assess quality, health plans must publish "report cards" that allow comparison of plans based on a number of indicators, such as immunization rates, breast cancer screening rates, unplanned readmissions to the hospital, and others. These report cards—and the quality indicators—are still being developed.

Health plans cannot turn anyone away for any reason; in fact, they cannot even target their marketing efforts at healthier, higher-income residents. A complex risk-adjustment calculation is intended to prevent health plans that take care of sicker patients from being penalized financially.

Cost Sharing

Health plans also will be required to offer at least three cost-sharing options to prospective enrollees:

- Low cost-sharing option: You receive care through a health maintenance organization (HMO) that restricts access to a network of hospitals, doctors, and other health care providers. The reward is that you pay no deductibles and $10 copays for only a few services, like office visits.

- High cost-sharing option: You receive care from any provider you wish to see, but you pay for that privilege. There is a $200 (individual)/$400 (family) deductible and 20 percent copays on most services, including expensive inpatient hospitalization.

- Medium cost-sharing option: Also known cryptically as a point-of-service (POS) plan, this gives you a choice of seeing network providers and paying the low cost-sharing of the first option or seeing providers outside the network and paying the high cost-sharing of the second option.

All of the options have a $1,500 (individual)/$3,000 (family) maximum annual out-of-pocket payment; that is, no matter what your cost-sharing option, you cannot pay more than $3,000 a year out of your own pocket in copays and deductibles. This $3,000 limit, however, does not include your share of the premium payment.

For most consumers, the crux of the plan lies in premium and cost-sharing options, in part because the two are interdependent. If you choose the low cost-sharing option, your premium *and* your out-of-pocket payments will be lower than if you choose one of the other two cost-sharing options.

Standard Benefits Package

All health plans must offer the same benefits package, which the administration argues is as comprehensive as 80 percent of the plans now in force in the country. The benefits include: hospital services, emergency services, physician and other health professional services, clinical preventive services (immunizations, mammography, cholesterol screening, pap smears, physicals, and others in specified intervals), selected mental health and substance abuse services, family planning and pregnancy-related services (although left unmentioned, abortion is presumably covered), hospice, home health care services, ambulance services, laboratory and diagnostic tests, prescription drugs, rehabilitation services, limited extended care services, durable medical equipment and orthotics and prosthetics, vision and hearing services, preventive dentistry for children, and health education classes. Most of these services have limitations—for example, extended care services are limited to 100 days in a nursing home only after an acute illness or injury as an alternative to continued hospitalization. Copayments for services depend on your choice of cost-sharing options.

Supplemental policies can be sold for benefits not covered by the standard package.

Funding and Limits on Growth in Spending

Without question, the funding is the most controversial aspect of President Clinton's plan. Pundits and policymakers across the political spectrum cringe at Clinton's budget legerdemain. The president has said that the new plan will cost $441 billion

over seven years and that he has the money to cover it. Savings will be extracted from Medicaid ($114 billion) and Medicare ($124 billion); it should be understood that these "savings" result from restricting the growth of these programs in the years ahead, not by actually cutting them. Savings in other federal health programs will bring in $47 billion. Added tax revenues as firms deduct fewer health care costs will make $51 billion available. The vaunted cigarette tax and the one percent tax on the payrolls of corporate alliances will raise $105 billion.

Even more irksome to many than the sources of new revenues is the previously mentioned cap on premiums. To keep costs down, the National Health Board will cap premiums if the total increase in premiums across the nation exceeds the rate of inflation (plus an adjustment for population growth) in 1999. In the interim, a cap will be used to diminish the gap between premium inflation and general inflation gradually each year between 1995 and 1999.

Experts and the public alike agree that restraining health care costs is admirable and necessary. Still, President Clinton has been hammered from all sides on his plan to accomplish this. Conservatives and moderates blast the president for failing to let the market do its work without the threat of caps from Big Government. Liberals argue that if you are going to control spending, the best way is with a system in which the government pays all the bills and decides how much it will pay in total for health care.

FAMILIES' HEALTH CARE COSTS AND CHOICE

All of us are asking ourselves if we will be paying more for health care in the future than we are now. President Clinton has said that 63 percent of us will be paying the same or less for the same or better benefits. If this is true, the plan has a good chance of winning over Congress and the public in something resembling its present shape.

The Premium

A recent Michigan public opinion survey on the president's plan performed by Public Sector Consultants, Inc., for the Michigan Hospital Association found that 75 percent of the respondents were willing to pay 20 percent of their health insurance premium; only 17 percent were not. The extent of support is startling until you realize that, according to the Health Insurance Association of America, the average employee in 1991 paid between 25 and 30 percent of the family premium; premium sharing is probably even higher in 1993. Individuals, on average, pay 12–14 percent of their premium. So caught up are we Michiganians in the precedent set for first-dollar coverage (that requires no deductibles or copays) by collective bargaining agreements that we forget that most Americans are paying more of their health insurance premiums every year. For the typical American family with health insurance, then, the plan looks like a reduction in premium sharing.

Cost Sharing (Copays and Deductibles)

Clinton is definitely offering many people, especially employees of small businesses, choices that they have not had before. Everyone will have a choice of health plans, and once a health plan is selected, we will have a choice of cost-sharing options, which are really fundamental choices about how we want health care delivered to us.

The low cost-sharing option is exactly that: no deductible and few copays. It would take an extraordinarily unusual array of health care services for a family to bump up against the $3,000 annual limit on out-of-pocket expenses. But this option also means you must enroll in an HMO, where you will not have your choice of any physician you want. You also will have to get permission from your primary care physician before you can see a specialist. In other words, by *choosing* the least expensive cost-sharing option, you are accepting some restriction on your choice of physicians and other health care providers. You may have greater choice of plans, but you may have less choice of health care providers within the plan you have chosen.

The unanswered question—and nothing less than the nature of our health care system hinges on the answer—is how much HMOs will really restrict our choice of physicians. Doctors will be permitted to sign up with as many health plans as they like, so it is conceivable that your doctor could be available to you in more than one plan. It is also very possible that health plans will sign up most of the physicians in a given region, and chances are pretty good that you will still be able to see your doctor even if you choose an HMO. Some patients will not care if they

cannot stay with their current doctor; the promise of paying less for health care will convince them to select an HMO from which their doctor is excluded. If these three possibilities converge to make choice less restrictive than many experts think, HMOs and other managed care organizations will soon dominate health care. President Clinton has arranged the cost-sharing options to accomplish just that. And remember, even the Senate Republicans in Congress want to encourage managed care.

Certainly, many people will choose the medium and high cost-sharing options, at least initially, to guarantee that they will be able to see the physician of their choice. They will pay a higher premium for that complete freedom, and one can only speculate as to whether the difference between high and low premiums will deter many from this choice. If you or a family member has to have surgery or spend much time in a hospital, however, the 20-percent cost-sharing of the high-cost option will quickly drive your share of the bill toward the $3,000 out-of-pocket limit. The risk of paying that much money for health care—over and above the premium—may be enough to make HMOs very attractive to patients.

QUALITY AND HEALTH PROFESSIONAL AUTONOMY

In the end, the choice of cost-sharing options cannot simply be a question of which plan will save you more money. A new system will fail if the quality of competing health plans does not also enter into the consumers' decision about the plan and cost-sharing option they choose. The danger is that price will have too big a hand in driving consumers' choice of plan in the time before good information on quality is available to them.

Yet again Clinton is playing to consumer—and not health care provider and health insurance company—needs. He believes that, with the proper information properly presented, consumers will flock to health plans that offer better quality care. But making this information available to consumers will require unprecedented data collection on the ways in which physicians, hospitals, nurses, and other health professionals deliver care and the ultimate result of that care. Clinton may be simplifying the insurance claims form for providers' benefit, but he is asking for much more paperwork than the current system now requires of providers.

In an even more dramatic change, health plans will be forced to scrutinize the work of their own health professionals if they are to coordinate care in ways that improve quality while keeping down costs. This *internal* oversight will limit physician and other health professional autonomy much more than any existing external oversight agency does today. From Clinton's perspective, this external and internal *management* of health providers is necessary if we are to deliver information to consumers that will allow *competition* to work in health care.

MANAGING CARE: HOSPITALS, PHYSICIANS, NURSES, AND INSURERS

Hospitals, hospital systems, physicians, and insurers are scrambling in Michigan to establish formidable health plans. The rash of agreements, joint ventures, and mergers masks extraordinary tension between insurers and health care providers, hospitals and physicians, primary care physicians and specialists, and physicians and nonphysician health care professionals.

All are vying for control of or a major role in managed care, as no one dares to assume that something akin to Clinton's plan will not pass Congress. Even if a plan does not pass, some experts reason justifiably, payers will insist on slower growth in health care premiums. The Clinton plan begs for an answer to the question: What mix of health professionals—primary care physicians, nurses, physician assistants, specialists, and others—does a health plan need to take good care of a large number of patients at a reasonable cost? There is no easy answer, and even if there were, the proper mix most certainly does not exist in many markets today. Can nurse practitioners take better care of certain patients than doctors? How aggressively should we move to create a physician corps composed mostly of primary care physicians? These and other questions will rankle and even divide the health professions. The answers, which will come sooner rather than later, will mean that some hospitals and health professionals will flourish and others will suffer. The shake out will be dramatic.

SPENDING CAPS AND RATIONING

There are two schools of thought, generally speaking, in health care: (a) those who believe that by cutting all the waste and inefficiency from the

system, we can afford all the health care we truly need, and (b) those who believe that cutting the waste and inefficiency is not enough to make affordable all the health care we need. President Clinton belongs squarely in the first camp. He believes that strict limits on the growth of Medicare, Medicaid, and private health insurance premiums will not force us to cut *necessary* care from the system.

Most health policy makers disagree with Clinton. Uwe Reinhardt, a prominent health care economist at Princeton University, stakes out a compelling middle ground: Even if there is enough waste in the system to fund all the care we need, he contends, we cannot possibly find it all and cut only the fat. Our budget-cutting lasers are simply not sharp enough.

By taking the tack that he has, President Clinton is avoiding the issue of rationing. He fails to acknowledge explicitly even the possibility that health plans will not be able to deliver all the quality care everyone needs for the price of a capped premium. By inference, he leaves it to the health plans to cut corners as they see fit and to ask the question: How can the necessary compromises in quality be undertaken so that they harm us least when report cards on quality reach the consumers? Clinton fails to confront explicitly the complex issues surrounding assisted suicide and the use of extraordinary measures to prolong life.

This is not to argue necessarily against caps on health care costs. Rather, it is to argue that no discussion of comprehensive reform should occur without facing up to the *possibility* that we cannot pay for everything that might benefit patients. If we must make decisions to ration care, they must involve the public and health professionals in explicit debate. President Clinton will not be able to evade this essential debate for long.

TAKING CARE OF THE POOR

The Clinton plan will cover everyone in the country, but universal coverage should not be confused with universal access to care. Having health insurance does not necessarily mean that a person has a physician near by or has the means to get to the physician's office. People living in poverty will continue to struggle to receive the care that they need, and to get care of lesser quality than their better-off counterparts if safeguards are not in place that reward health plans financially for taking good care of them. Without these incentives, low-income people, who tend to be sicker than their wealthier counterparts, are likely to flock to low-cost plans. Health plans that wish to avoid treating sicker patients will have an incentive to raise their premiums, a prospect that will not only preserve our two-tier system of health care but defeat competition.

Mainstreaming Medicaid recipients through the health alliances is a promising start, as is the promise to offer financial incentives for health professionals to locate in underserved areas. A tremendous commitment of resources, however, will be needed to attract adequate numbers of doctors and nurses to central cities and isolated rural areas.

Health plans must be given the means—adequate Medicaid funding, for example (Medicaid will still pay for AFDC and SSI recipients)—and the incentives to work closely with clinics, community health centers, substance abuse programs, and other places beside the hospital emergency room where people living in poverty will want to receive care. It is doubtful that the Clinton plan adequately encourages health plans to strengthen outreach programs and care for disadvantaged populations.

BATTLES AMONG BUSINESSES

In 1991, 95 percent of large firms—those with more than 100 employees—offered health insurance to their employees. Most of these firms offered a rich benefits package with low premium sharing and low copays and deductibles. As larger firms tend to have better benefits than smaller firms, spouses working in smaller firms are likely to choose the larger firm's coverage. This is especially true of firms that collectively bargain.

The Clinton plan will not allow workers to ride along on a spouse's richer plan. All families with two working spouses will have to be covered by their respective employers. As a result, in general, the richer the current benefits plan, the better off the employer will be under the Clinton plan. Smaller firms with less generous packages will have to cover employees who had been getting coverage through their spouse's company. While this will encumber many small businesses that currently offer health insurance, it could be offset by lower premiums that result from regional alliances' greater bargaining power.

Many large firms have argued for years that an employer mandate is necessary to eradicate the cost shift that occurs when firms that do not offer health insurance have employees who require health care. Hospitals deliver the care and then shift those costs onto paying customers, that is, the large firms.

In fact, however, it is the small businesses that do offer health insurance to their workers that are hardest hit by this cost shift. Unable because of their size to influence the cost of their health insurance, they end up paying much more of the cost shift than the disgruntled big businesses.

This fact will not be lost on Clinton. Look for his administration to attempt to split the small business community on the employer mandate. In an effort to gain the support of small businesses that now offer health insurance the president will argue that they are paying outrageous premiums because they must pay for the health care of the employees of small businesses that do not offer health insurance. This may not be a fruitful effort for Clinton, as only 32 percent of firms with fewer than 25 employees offered health insurance in 1991.

CONCLUSION

It is easy to say that the Clinton plan will fall short of its goals. Of course it will. That, however, is not the point. The point is to come up with the best possible plan, one that is a good sight better than the system we now have. The compromises will come: Benefits will be cut, most likely in mental health; the premium caps will disappear, only to reappear in an intense national discussion on rationing in the waning days of this century; the employer mandate will survive but it will be phased in over seven or eight years. Big business will benefit less than it does in the Clinton plan, small business will fare better. This list of compromises will expand. With divisions within almost every interest group and with everyone finding fault with some little or big piece of the plan, consensus will be very difficult to build.

In the end, however, after public support has waxed and then waned, we will have moved from today's hasty opinions to considered judgment about a version of reform that reflects a much deeper understanding of the health care system and the shared responsibility it demands of all of us, not just the sedentary smokers. Education and deliberation will take time. In the meantime, a new delivery and finance system remarkably like the one Clinton proposed is under construction in every state in the union.

PUBLIC SECTOR CONSULTANTS publishes **Public Sector Reports** and the **Health Legislation Analysis Service**, which includes the ***Health Policy Bulletin*** and the ***Health Care Legislation Abstracts***; offers strategic and tactical counsel and issue management for retainer clients; undertakes specialized research studies; provides public relations and meeting and conference planning services; and, through its textbook division, produces research and reference works, including ***Michigan in Brief: An Issues Handbook*** and the ***Michigan Insurance Handbook***.