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November 1993

# HEALTH POLICY BULLETIN

## FOCUS: THE REVISED CLINTON PLAN

The version of the Clinton plan for health care reform submitted to Congress in October differs in some respects from the draft that circulated in August. Space restrictions do not allow detailed discussion here of all of the changes that were made to the August draft; these changes are incorporated in the 1,342-page version awaiting introduction in the U.S. House of Representatives.

**Global budgeting** as originally proposed is gone, but what might be called "Son of Global Budgeting" survives in the form of insurance premium targets. In the revised plan, each regional alliance has a per capita premium target that will be established by a National Health Board. If an alliance has a weighted average accepted bid from all the health plans in the region that exceeds its per capita target, the alliance will be considered noncomplying. When an alliance is noncomplying, each noncomplying plan within it is subject to a percentage reduction in the premium payments the plan receives from the alliance. This reduction is computed by a complex formula. Forcing noncomplying health plans to accept lower premium payments than those they originally negotiated with the alliance is, essentially, global budgeting at the regional level. These provisions apply to both regional and corporate alliances.

**Corporate alliances** that cannot limit their spending to the premium target level plus the general inflation factor for two consecutive years will be dissolved by the Secretary of Labor, and their employees will be required to purchase insurance through the regional alliances.

Congress would be required to decide annually how much money to appropriate for the **subsidies** to small businesses, low-income individuals, retirees under the age of 65, and businesses whose health care costs exceed 7.9 percent of payroll. Unlike Medicaid and Medicare, which are uncapped entitlement programs that must cover everyone who is eligible, the subsidies would be capped. A capped program has the advantage of setting finite limits, but it also has the disadvantage of leaving some people out in the cold. Some observers have asked, What happens when the money runs out? Will people who are eligible for subsidies be told they cannot have subsidies because the money has run out? Will they be told they can have coverage but will have to pay for it? Will the health plans be told they will have to cover these people and absorb the loss? Do the regional alliances have to share the loss? All of these questions are unanswered.

The August draft estimated subsidies at $30 billion; the October version estimates the subsidies at $45 billion. The stress on the subsidies will be relieved somewhat by a provision requiring companies that currently provide health benefits to retirees under the age of 65 to pay an assessment for three years beginning in 1998. The assessment would be 50 percent of (1) the company's health **costs for retirees under the age of 65** or (2) the amount by which the company's health costs were reduced, whichever is greater.

Revising the definition of small **businesses that are eligible for subsidies** to include companies with as many as 75 employees may overcome some objections from those businesses, but it raises some serious questions. For example, it is entirely possible that groups such as holders of fast-food franchises could opt to reorganize so that no part would have more than 75 employees. Consequently, a business that previously employed 300 people could become five firms each employing 60 people, with each firm eligible for a subsidy to which the original entity would not have had access. Almost any service business entity could reorganize itself around functions performed by employees and qualify for subsidies by judiciously mixing high- and low-wage employees to create an average low wage that would entitle the business to a subsidy. The current draft has no provisions that prohibit or inhibit such behaviors.

Dropping the restrictions on the number of **fee-for-service plans** that the alliances—both corporate and regional—can offer encourages competition and reflects the clout that health care providers still carry. Alliances can reject a fee-for-service plan if (1) the plan's budget exceeds the average of the plan budgets in the region by more than 20 percent or (2) the plan does not meet the state's quality standards. Health maintenance organizations will be required to cover treatment when patients go outside the network or the staff for care. In such instances, the subscriber will incur cost-sharing requirements typical of the high cost-sharing option allowed in the Clinton plan.

Of great interest to hospitals are **disproportionate share payments** for certain populations. There will be a five-year transition period before such payments are elimi-

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nated for the Medicaid program. Payments for hospitals with specified percentages of supplemental security income (SSI) patients will be reduced through the use of a formula that takes into account the number of hospital beds, the number of days of admissions for such patients, and other factors. Although how these payments will be financed is unclear, it is likely that savings from other parts of the Medicare and Medicaid programs will be used.

Two developments will affect **medical education**. The National Council on Graduate Medical Education will control access to specialty training so that by the year 2002, 55 percent of the nation's training slots will be in primary care medicine. The addition of obstetrics and gynecology to general internal medicine, family medicine, and general pediatrics simply reflects the fact that an ob-gyn specialist is really the primary care physician for most women for at least a third of their lives. It is likely that residency training in overcrowded specialties such as general surgery, neurosurgery, and ophthalmology and the internal medicine subspecialties of cardiology and nephrology will be concentrated even more heavily in academic medical centers. Residency programs in community hospitals will probably be forced to concentrate on primary care medicine. Graduate medical education will be funded through the Medicare program and assessments on regional and corporate alliances.

Much has been written about the enormous bureaucracy that the Clinton plan proposes. The relationship between the federal agency and the regional alliances deserves special consideration. On the federal level, the plan proposes to create a **National Health Board** (NHB) that would be part of the executive branch and directly responsible to the president, rather than a freestanding agency similar to the Federal Trade Commission or the Federal Reserve Board.

In addition, the revised plan calls for the creation of **regional professional foundations (RPFs)**. RPFs may be multistate agencies composed of academic health centers, schools of public health and allied health professions, health plans, regional and corporate alliances, and health care providers. The service areas (geographic) of the RPFs will be established by the NHB in consultation with the National Quality Consortium, an agency to be established under the NHB.

The revised plan requires the RPFs to develop continuing education programs for health professionals; foster cooperation and collaboration among health plans and providers; disseminate information about quality improvement programs, practice guidelines, and research findings; develop innovative patient education systems that support patient decision making in health care; conduct research on health care quality; and provide information about the innovative use of health care professionals. The RPFs distribute the results of their efforts to the regional alliances and provide the alliances with technical assistance in quality assurance matters as the alliances need help.

Critics have said that RPFs are too out of touch with actual clinical practice and that giving RPFs certain responsibilities infringes on the ability of the states to oversee the quality of health care services that are delivered to residents. Under the revision, the alliances are responsible for disseminating information to consumers about quality and access, the quality of health plans, conducting patient education programs to aid consumers in choosing health care plans, and ensuring that performance and quality standards are continually improved. The RPFs, federal creations, are linked to the alliances, state creations, and essentially oversee the alliances.

Other changes include the following:

- The date of implementation has been pushed back to January 1, 1998
- Insurers lose their exemption from federal anti-trust regulation
- The proposed $12,000 disregard of assets for unmarried people living in a nursing home is made a state option
- Children who receive services from the Medicaid program because of their poverty will continue to receive services such as transportation

## OF INTEREST

Both the House and the Senate have adjourned until November 30. Representative Bennane, Democratic co-chair of the House Committee on Public Health, has announced that the committee may report out HBs 4740 and 4741, bills that provide a single-payer alternative (HB 4740) and a managed competition alternative (HB 4741).