Abstract: The prospects for reforming health care financing revolve around five questions: (1) Will Congress mandate universal coverage? (2) Will Congress require employers to pay most of the cost of employee coverage? (3) Will Congress authorize effective limits on health care spending? (4) What role should regional health alliances play in the reformed system? (5) How much change in health insurance arrangements can be implemented over the remainder of this decade? The author argues that the prospects are slight for quickly implementing reforms as sweeping as those that President Clinton has proposed. But prospects are good for beginning a process that will lead to universal coverage and effective cost controls. The key is the creation of regional alliances.

All too often participants in the health care reform debate present “best” new systems, rather than “best” reforms of the system that exists. Rather than worrying about how to move from where we are now to where they would like us to be, such advocates pretend that it is possible to erase current arrangements and start afresh without cost.

Such immaculately conceived visions fail because they do not recognize the enormous investment that the United States (and every other country) has in its current system. Creating wholly new arrangements entails wholesale changes in methods of paying for care, the relationships between patients and health care providers, and perhaps the organization of the delivery of care itself. In a country such as the United States literally billions of significant contractual and personal relationships would have to be altered as part of a move to a financing system fundamentally different from the one we have. The wrench of change is compounded if, as under the plan advanced by President Bill Clinton, a large cut in the use or price of medical services is the keystone to financing the new system. Such savings require massive income shifts, changes in practice patterns, or both.

Except in cases of economic or military catastrophe, democracies seldom break so much china in the name of reform. Even parliamentary systems seldom make revolutionary changes when the population is sharply divided, although narrow pluralities can and sometimes do effect sweeping changes.

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reforms. Under the U.S. governmental system, in which minority interests can marshall numerous and powerful defenses to block major changes not supported by powerful and well-mobilized majorities, such change is inconceivable.

The structure of U.S. health care problems compounds this political difficulty. Americans recognize the need to assure and extend insurance coverage. This step will cost money. But most reformers say that they also want a drastic slowdown in the growth of health care spending. If both goals are met, reform must inflict losses on some people, businesses, industries, and regions, as the gainers win resources that otherwise would have flowed elsewhere. Such shifts run afoul of the political law, peculiarly apt in this case, that Charles Schultze articulated, “Never be seen to do direct harm.” However, health reform must do some harm. To pay for extending benefits, one must either raise taxes, which is always politically difficult, or cut somebody’s income, which is politically insupportable under Schultze’s law, unless the somebody is shown to be a fool (“we are cutting waste”) or a knave (“we are slashing fraud and abuse”).

I believe that recognition of these underlying forces helps one to interpret the various proposals for reforming the U.S. system of paying for health care and to make sense of the forthcoming debate. I focus here on the proposal President Clinton outlined 22 October 1993, but I comment briefly on other major proposals that will play a meaningful part in the debate.

The President’s Plan

President Clinton’s plan begins with a basically conservative political vision of building on rather than replacing the current system, but deviates substantially from it in execution. This vision recognizes that curbs on premium growth linked to limits on approved cost sharing and prohibition of balance billing can create the budget discipline that is largely missing from the current system.

Unavoidable complexity. Although advocates of the Clinton plan would deny it, the vision behind the plan rests on an acceptance of the complexity of the current system. It does so because it forsakes neat alternative program designs that would scrapp the current system. In fact, the president’s conservative strategy increases complexity because his plan does not rely exclusively on any one of the three possible ways to achieve universal coverage but uses all three—an employer mandate to pay for insurance, an individual mandate to purchase insurance, and government provision of insurance through Medicare.

To make the individual mandate for the self-employed and unemployed
nonelderly affordable, the plan provides subsidies for households including full-time workers and retirees with incomes below 150 percent of official poverty thresholds, a limit covering most of this group. To ease the shock of the employer mandate for companies that do not currently pay for their employees’ insurance, the plan provides explicit government subsidies for some companies with seventy-five or fewer employees in which average earnings of full-time workers are under $24,000 annually. The plan also includes much larger and more extensive implicit subsidies through a cap on employer liability for health insurance costs of 7.9 percent of payroll. All employers whose health insurance costs currently exceed 7.9 percent would be subsidized. These subsidies would be paid for by the government or by payments from companies that do not now pay for employee health plans.

The president’s plan also will redistribute insurance costs among companies. Companies whose employees are now covered by the plans of relatives employed by other companies will have to shoulder those costs directly. The shift from experience rating to community rating for all companies with more than fifty but fewer than 5,000 employees will cause even larger intercompany shifts in health care costs. Companies with above-average current costs will receive subsidies paid for, at least at first, by increased charges on companies with below-average costs. If growth of spending is slowed, most companies will have lower insurance costs after a few years. Reportedly, at the last minute a provision crept into the plan to relieve companies of costs of retiree health benefits for people under age sixty-five. This provision, a massive gift mostly to the shareholders of a few large, old corporations, should be subject to the political equivalent of LIFO accounting—last in, first out.

Each of these steps is costly initially. Exactly how costly is determined by the comprehensiveness of coverage provided under the plan, the generosity of new benefits for the elderly, and the depth of subsidies. Estimates for the plan submitted to Congress put these costs at approximately $107 billion in 1998, the first year in which the plan would be fully operational and four years after presumed enactment.

Paying the bill. The next step is to decide how to pay the added costs of new and extended services. The problem for government payers is quite different from that of private payers. Governments have four options. Two-deficit financing and cutting nonhealth programs can be disregarded. The deficit is already too high, and elected officials have paid in political blood with program cuts to bring it down; further politically acceptable spending cuts in nonhealth programs are decidedly scarce. The fallout from the deficit reduction debate seems also to preclude more than token use of the third instrument, tax increases. The added federal costs of the president’s health plan therefore are financed largely from cuts in
current health programs, notably Medicare and Medicaid.

The added private costs are met initially by public subsidies and by cost shifting among private payers. The magnitude of intercompany shifts has not been measured systematically, but such shifts are likely to be quite large as the cost differences among plans are now frequently on the order of two or three to one. Moreover, these variations arise primarily from variations in local prices, differences in delivery patterns, and work-force characteristics. While the president’s plan would perpetuate some of these differences, most would be leveled out by proposed community rating within each regional alliance.

Over the longer run, both private and public payers are projected by the administration to benefit from a sharp slowdown in the growth of health care spending. Real growth of Medicare and Medicaid, projected to grow under current policy at an annual rate of 8 percent from 1995 to 2000, would be slashed to 1.4 percent in 2000. The ferocity of the implied cost containment is indicated by comparison with the 1980s, when the number of hospital days per person was slashed 30 percent and when Medicare and Medicaid payments to providers were reduced, but Medicare expenditures rose an average of 7.7 percent annually, Medicaid expenditures rose 6.5 percent annually, and all other health care spending rose 5.3 percent annually, all after adjustment for inflation.

Administration. President Clinton’s plan also would massively change the administration and politics of health insurance. Employers with fewer than 5,000 employees and all individuals would be prohibited from dealing directly with insurers or at-risk providers such as prepaid group practices. Each state would be required to establish one or more nonoverlapping regional health alliances that would jointly cover the whole state. These alliances would be required to accept applications from entities wishing to sell health insurance and to approve those plans that meet certain conditions, some of which are outlined in the draft plan. The alliances would be the conduit for subsidies paid to small businesses, and they would administer risk-rated payments to health plans.

Serious technical and political issues surround these new entities. How would the alliances prevent cream-skimming by health plans? Are available techniques of risk-rating adequate to squeeze the profit out of cream-skimming? If states tried to gerrymander health alliances, are there objective and legally defensible techniques for identifying when such practices are improper? How would the provision be enforced that prohibits alliances that span two or more states from favoring local providers over providers located in neighboring alliances? If political differences regarding administration of the plan arise between the president and Congress, on the one hand, and governors and state legislatures, on the other, are enforcement
techniques politically feasible? No reliable answers exist because these questions have never been put into practice.

For example, suppose that the National Health Board allocates to a given state a share of national health spending well below the level that the governor or the state legislature deems appropriate or acceptable. Suppose further that that state responds by refusing to enforce such limits on local health plans. Is it plausible that the federal government will take over operation of these alliances, as called for in President Clinton’s plan? Would it not be preferable to place the states at financial risk, as is done in Canadian province—a measure that the administration is reported to have considered and rejected?

Major Alternative Approaches To Reform

Plans that claim to achieve universal insurance coverage without an employer mandate contain either of two options—mandatory individual and family purchase of insurance or tax-financed government insurance—or a blend of the two.

The Chafee plan. The proposal advanced by Sen. John H. Chafee (R-RI) and cosponsored by other Senate Republicans (the Health Equity and Access Reform Today Act, S. 1770) relies on a mandate that employers make group insurance available to all employees without regard for preexisting conditions or certain other limitations currently common in the group insurance market. But employers would not be required to pay any of the cost of such insurance. Current tax advantages would be extended to the unemployed, but these advantages would be capped in amount for all individual income-tax payers.

Individuals and families would be required to purchase insurance to achieve universal coverage but not until 2005. Unfortunately, however, low-income households cannot afford insurance without subsidy. How the Chafee mandate would deal with this problem is unclear. It would provide some subsidies to low-income households but limit the subsidies initially to households with incomes below 90 percent of official poverty thresholds. The subsidies would be broadened gradually, extending to families with incomes up to 240 percent of official poverty thresholds by the year 2000. The subsidies would be financed out of savings from shaving two percentage points annually from the growth of Medicare and Medicaid spending.

The Chafee proposal leaves fundamental questions about the subsidy and the mandate for universal coverage unanswered. The subsidy would be reduced if savings from program cuts were below expectations, but this provision raises the question of whether the mandate could be sustained in the face of larger-than-anticipated outlays. Would the mandate apply im-
mediately to those who will never be eligible for subsidies? Or would it be introduced in some other pattern? The plan does not say, and the absence of evidence that these issues and others have been thought through (together with the delay in universal coverage until 2005) raises doubts about whether the sponsors are genuinely serious about universal coverage.

Like President Clinton’s plan, the Chafee plan would create regional health alliances, although their powers would pale beside those of the Clinton alliances. The Chafee alliances would be responsible for creating an insurance pool for employers with fewer than 100 employees and for individual purchasers but would not be empowered to approve health plans or to enforce fee schedules.

Also like the president’s proposal, the Chafee plan would rely on reductions in the growth of Medicare and Medicaid spending to pay for the federal costs of subsidies to low-income households. Unlike the president’s plan, however, the Chafee proposal calls for no additional revenues and contains no controls to discourage providers from shifting additional costs to private payers, as they have done over the past decade. In contrast to President Clinton’s plan, which unambiguously promises universal coverage and a genuine budget constraint in the form of limits on the growth of premiums, the Chafee plan contains no credible assurance of universal coverage and relies upon the rosy claims for cost containment of the more euphoric proponents of managed competition.

**Full national health insurance.** Several plans calling for the government to directly provide universal health insurance have been put forward. All contain broad benefit packages, include some form of budget control or fee regulation for physicians and hospitals, and depend on new taxes along with savings from reduced growth of current programs to pay for the new program. Long advocated by a solid core of liberal Democrats, this approach credibly promises universal coverage and would create powerful regulatory instruments to control the growth of spending. But its even more credible promise to move health care spending from private to public budgets has effectively discouraged support among centrist and conservative members of both parties. Nothing in the current debate so far has suggested that the fate of full national health insurance as the perennial bridesmaid will change soon.

**Conservative options.** While all of the preceding options promise universal coverage, proposals for reform advanced by conservative House Democrats led by Rep. Jim Cooper (D-TN) and by House Republicans and Sen. Phil Gramm (R-TX) make no such claim. These plans would mandate that employers make group insurance available to employees but not pay for it. These plans would prohibit underwriting practices that bar new employees or those with preexisting medical conditions from eligibility. The Re-
A publican proposal would expand tax-sheltered savings for medical expenses. The plan advanced by Representative Cooper would establish the framework of managed competition but would not force any employer to pay for insurance. Subsidies to aid low-income households would be expanded little if at all. No limits would be placed on the growth of medical expenses except for those arising from the incentives created by tax-sheltered savings for upper-income households to buy plans with high cost sharing.

**Defining Questions For The Health Reform Debate**

The course of the health care reform debate will be determined by how Congress responds to five fundamental questions. While members of Congress clearly are responsive to their constituents’ views and President Clinton and other members of the administration will try hard to shape these views, I believe that the positions of members of Congress are sufficiently set on the first four questions so that one can predict the opening and middle games of the great chess match now beginning. The final moments of this contest, which is likely to enliven late summer 1994, hinge on answers to the fifth question and still hold important mysteries.

(1) *Do participants in the debate embrace the principle that government should assure essentially all Americans health insurance coverage?* Support for this guarantee clearly has grown. The ranks of supporters have long included most Democrats in both houses and now include many Senate Republicans who have endorsed the Chafee plan. Whether a clear majority in the House endorses this proposition remains unclear, but whatever the count may be on the principle of universal coverage, what matters is agreement on timing and method, which together strongly influence cost. The critical but still unresolved question is whether the president can mobilize the growing and well-founded middle-class fear of curtailment or loss of health insurance coverage into an irresistible force in support of his approach and timetable.

(2) *Should universal coverage be achieved by requiring employers to sponsor, and pay most of the cost for, insurance for their employees?* The fate of President Clinton’s approach to health care reform hinges on the answer to this question. In the Senate nearly all Republicans and a few Democrats, constituting (at least) a filibuster-sustaining minority, oppose such a mandate. Nearly all House Republicans and a solid bloc of conservative House Democrats, who together form a majority, also now oppose a mandate as extensive as that proposed by the president.

The outcome of the health care reform debate may well depend on whether the president and his administration can persuade enough opponents of a full-blown mandate to accept a limited mandate that initially
would force relatively few businesses to change their practices. Opponents of a sweeping mandate would claim that they had won in practice, while proponents would claim that they had won in principle.

(3) Should the United States impose an effective budget constraint on the growth of health care spending? If this question refers to a nationally legislated limit on the annual growth of health spending, whether translated into caps on health insurance premiums or imposed through fee controls and hospital budget caps, the lineup in both the House and the Senate closely resembles that on forcing employers to pay for health insurance for their workers.

The important difference, as far as President Clinton’s proposal is concerned, is that no obvious compromise exists. The administration could easily accept less stringent limits on premium growth than it proposes. But opponents cannot agree to any such limit without capitulating, in flagrante delicto, on the fundamental principle of disagreement with the president’s approach to cost control. Furthermore, many opponents to a legislated cap on spending hold fast to the faith (I believe to an illusion) that their method of controlling costs is “not only lighter but tastes better.” They believe that various measures to promote price-sensitivity among insurance purchasers and to standardize the health insurance product will suffice to produce a sustained slowdown in the growth of health care spending, while the president’s approach will fail through bureaucratic elephantiasis.

President Clinton no doubt will continue to try to persuade the public that national spending goals can be met, at least through the year 2000, by eliminating medical waste, fraud, and abuse. In so doing, I believe that he will be making a serious blunder. First, trying to wring so much out of health care spending as quickly as he proposes is not practicable. Cuts of this magnitude—one-sixth of baseline acute care spending by 2000—would require radical changes in the behavior of providers or large cuts in their incomes. But while many providers acknowledge instances of waste, most believe that they are now doing the right thing most of the time. And large cuts in provider incomes are likely to provoke guerrilla warfare by the groups whose complicity in, if not actual support for, reform is essential for its success. Those who note that citizens of countries that spend far less than the United States does are more satisfied with their health financing systems (than are Americans) should acknowledge that large savings eventually will be possible. But they still can insist that such savings will take more time than the four years the president allows for their achievement.

Second, large, sustained reductions in the growth of health care spending eventually must force the denial of some beneficial care to some people. Despite the palpable truth of this assertion, it is more effective in emptying a room of elected officials than shouting “fire.”
officials to avoid it are understandable, as the choices that rationing will impose are ethically and politically distressing. But health care reformers who insist on claiming that enormous savings can be quickly achieved complicate the task of politicians bent on fuzzing this truth.

For all of these reasons, I believe that President Clinton’s proposed national health budget and limits on premium increases will fail to win majority support. The limited chances for acceptance of the principle of a national health budget have been doomed by the high cost of the plan developed by his advisers. The atmosphere created by the 1993 budget debate made politically unthinkable advocacy of increased taxes on anything but the voluntary inhalation of poison. This situation is highly regrettable, in my view, because President Clinton’s repeated insistence that national spending limits are essential for the sustained control of growth of spending is correct. Spending limits also are necessary to create incentives for efficient resource allocation and even to enable managed competition to achieve its full potential.6

President Clinton’s health proposal also embraces price regulation of physicians and hospitals that continue fee-for-service medicine. But it is not clear how this mandatory extension to the private sector of current practice under Medicare and Medicaid could win approval outside of the general framework of the president’s plan.

(4) What role, if any, should mandatory associations of insurance buyers play in mediating the purchase of insurance by private businesses and individuals? Something called “health alliances” is likely to win congressional approval, given their inclusion in both the president’s plan and that of Senate Republicans. But the role and powers of the alliances remain in doubt. At a minimum the alliances would assemble small purchasers into large groups for the purchase of insurance. The larger question is whether the alliances will be vested with regulatory power to approve health plans, to regulate fees, to pay subsidies to businesses (if an employer mandate survives), and to pay subsidies to households.

For reasons set forth above and elaborated below, I think that Congress is not likely to approve powers for health alliances as extensive as those proposed by President Clinton. The incentives are great for health alliances in states politically in the control of a party different from that in control in Washington (even assuming that one party is in control) to pursue policies that are intolerable to Congress or to the president. The regulatory demands on the National Health Board or other federal agencies to police the health alliances will be enormous and probably unmanageable.

Despite these difficulties, however, the infinite variations in the design and possible powers of health alliances make this the most negotiable element of the reform debate. A broad consensus has developed on the
failures of the small-group market. Health alliances are a natural vehicle for effectuating limitations on permitted practices. The case for insisting that health plans all quote prices for a standard plan to help purchasers compare prices also is powerful. This requirement is an element of both the president’s and Senator Chafee’s plans. It could be accepted easily by all participants in the debate other than those who have never met a government function they did not dislike. Alliances could become the agency for administering Medicaid and for offering coverage to any Medicare beneficiaries who wish to switch from the Health Care Financing Administration.

Any compromise is likely to invest health alliances with powers well short of those proposed in the Clinton plan. A process of gradual evolution then would commence, as Congress added, subtracted, and modified alliance powers. The eventual character of the alliances would be influenced by their initial design, but it would be determined largely by future decisions. The creation of health alliances would be a watershed event, bringing into existence entities that in the future could become enforcers of managed competition, managers of an employer mandate, or administrators of government-sponsored health insurance.

(5) How much change in health insurance arrangements can be implemented over the remainder of this decade? No hard analysis can answer this question. How much can be done and how fast depend on political leadership and will. In fact, U.S. history presents no example of legislation that remotely resembles the president’s proposal for reforming health insurance in the depth and pervasiveness of institutional change. It has become commonplace to compare reform of health care financing to enactment of the Social Security Act in 1935. This analogy is faulty but instructive. On a scale of complexity starting at zero, if the Social Security Act rates a 10, President Clinton’s health reform plan rates a 200.

The Social Security Act was passed during a time of great economic distress, an era of chaos in the American capitalist system that more closely resembles the current conditions of Russia or the near-collapse of Britain after World War II than the slowly emerging and comparatively minor chronic difficulties that the United States is now experiencing. Nevertheless, the largest element of that landmark legislation, old age insurance, was financed by taxes that did not start until 1937, nearly two years after enactment, to pay for benefits that did not start until 1940, more than four years after enactment. Survivors insurance was enacted only in 1939. These programs began with a delay and grew slowly. More fundamentally, they replaced essentially nothing and required virtually no one to rewrite existing contracts or to change existing pension arrangements.

In contrast, the president’s health care reform plan would transform the financing and organization of the delivery of roughly 11 percent of gross
domestic product (GDP). It would bring into existence a wholly new type of agency, the regional alliances, with sweeping regulatory powers and would do so in the space of less than two years. Quite apart from the huge administrative task this represents, the successful operation of these alliances depends on the successful execution of difficult technical tasks, such as risk rating, that have never been carried out in practice before and whose feasibility remains in doubt, even among experts sympathetic to an employer mandate.

The practical questions facing Congress are how much change to ask the American people to accept during a peacetime of relative prosperity, and how fast to ask them to accept it. In making this decision, Congress and the federal agencies that will have to administer the new legislation will not be able to draw on the good will, patriotic fervor, and sense of shared sacrifice that united the nation after Pearl Harbor. They will not even be able to count on the toleration of experimentation born of economic desperation that smoothed the way for the untried and often unsuccessful innovations of the New Deal. Instead, they will confront a public that is suspicious of government and elected officials, that is mostly satisfied with the access to health care it now enjoys but is worried about losing, and that is bombarded by information and disinformation provided by groups with huge economic stakes. Against this background, I believe that the plan advanced by President Clinton asks more of the political system than it can or will deliver.

The mystery that will not be solved until late 1994 is whether the administration can keep alive in the public the recognition that reform is necessary and that its plan has many good ideas that should survive in any compromise. Can those committed to reform prove sufficiently flexible to start down a road to reform, the end of which cannot be seen and will not be reached within their own political lives?

**Achievable Triumph On Health Care Reform**

Reform of health care financing will not be achieved by one grand new law enacted in 1994. It will emerge from a succession of laws enacted over many years. The current debate is extremely important, however, because it will determine whether the process of reform begins in 1994 or is delayed indefinitely.

I have argued that no proposal now on the table is likely to win majority support in both houses of Congress. However, compromise could be fashioned from these proposals that would initiate a process leading eventually to universal coverage and to the creation of institutions capable of controlling the growth of health care spending. A successful compromise must be fashioned principally of elements drawn from the proposals of President...
Clinton and Senator Chafee. Particular elements of other proposals may be included if support from the left or right hinges on them.

The Clinton and Chafee proposals have important elements in common. Both call for malpractice reform and for limitations on the underwriting practices of insurance companies. Both include an individual mandate to buy insurance, although the mandate is quite limited in the president’s plan and long delayed in Senator Chafee’s. Both call for the creation of regional health alliances, although the powers accorded the alliances differ radically between the two plans. Both call for subsidies to help low-income households buy insurance. Both embrace the principle of managed competition. Both advocate large cuts in payments to Medicare and Medicaid providers. Most importantly, both declare an unhedged commitment to universal coverage.

Building a compromise on these common elements that is acceptable to a majority of both houses of Congress will be technically and politically difficult and may prove impossible. The principal value of such a compromise will lie in its capacity to serve as the seed from which real reform can grow. The vital core of this compromise is the creation of regional health alliances. While regional health alliances fully empowered to administer universal coverage and cost controls are unlikely to emerge from Congress in 1994, creation of alliances could evolve through later legislation. To create organizations capable of growing into these powers would represent a historic achievement.

NOTES


2. The plan also provides subsidies to individuals and families with incomes up to 250 percent of official poverty thresholds if the family includes one or more part-time workers but no full-time worker. The incentives of the varied thresholds are quite odd.

3. The consensus among economists is that most health insurance costs, before and after reform, are borne by workers through reduced wages. For a thorough review of these issues, see A.B. Krueger, “Observations on Employment-Based Government Mandates, with Particular Reference to Health Insurance” (Mimeo, 15 October 1993). Few people other than economists believe in this offset, and economists acknowledge that the adjustment process may be slow and painful.

4. As noted in Note 3, what appear as intercompany shifts in the short run can be expected over time to become shifts in the composition of workers’ compensation.

5. Part of this Medicaid increase was attributable to extension of eligibility. In the latter years part of the increase occurred as states exploited a loophole in federal legislation that permitted them the increased federal payments by an accounting gimmick.