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Abstract: Support for reform is at its highest level, but criticism of president Bill Clinton’s plan is widespread. Nevertheless, the core components of the Clinton plan should be supported. These include (1) building on existing employer-based health insurance with a mandate that employers offer coverage to all workers and pay a substantial portion of the premium; (2) requiring that coverage be universal and benefits comprehensive; and (3) controlling total health care spending via a national expenditure limit. This paper does, however, suggest three changes to strengthen the plan: developing a broader base than Medicare and Medicaid to pay for reform; setting the national health care spending limit at a higher level (gross domestic product plus 1 percent); and strengthening the powers of the regional health alliances.

As early as 1920, while many other European countries were establishing national health programs, the United States began to assess ways to finance health care and improve its delivery system. In 1930 President Franklin D. Roosevelt decided not to include a national health plan with his Social Security program. This lost opportunity resulted in periodic tinkering with the US. health care system, such as the Hill-Burton Hospital Construction Act in 1946, until the passage of Medicare and Medicaid in the mid-1960s. In some cyclical fashion, the United States has revisited health care reform every ten to fifteen years since 1935. This effort has been challenged by one or more of the dominant three issues: the lack of adequate financial coverage, rapidly rising health care costs, or questions about the appropriateness and the quality of care.

The debate in the mid-1960s centered on advancing access for the elderly and disabled. With the leadership of a strong president, the country passed the first significant federal health legislation, which created the Medicare and Medicaid programs. During the 1970s the growing problem of the uninsured among the nation’s working population forced an examination of the private insurance market. President Richard M. Nixon proposed his version of a national health insurance system, which built on the existing private employer-based system and mandated that all employers must offer and help pay for a comprehensive range of health benefits.

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Interestingly, while health care costs had risen dramatically since the passage of Medicare and Medicaid in 1965, Nixon’s Comprehensive Health Insurance Plan (CHIP) included very limited cost containment. Growth in health care costs was not then the compelling issue it was to become in the 1990s.

Further action on this or any other national health insurance proposal was halted by a series of unanticipated events, including the resignations of both President Nixon and Rep. Wilbur Mills (D-AR), then chairman of the powerful House Ways and Means Committee. Not until late in President Jimmy Carter’s term did the reform debate resurface, and even then congressional activity was limited, with no results. Almost a decade later, in the late 1980s, the huge growth in the cost of health care, the realization that millions of Americans lacked health insurance, and a growing fear by millions more that their health insurance coverage would not be available when they needed it made health care reform a major national issue again.

Who are the uninsured? The profile of the uninsured, as traditionally low-income working families, undoubtedly influenced the Clinton administration’s decision to expand the employer-based system as the solution for universal coverage. Linkage to employment makes it easier to track and administer national health care coverage. It also keeps much of the funding for the health care system off the government’s “books.”

Not surprisingly, there is considerable evidence that the uninsured receive less health care than the insured receive.\(^1\) When the uninsured do receive care, they often use the expensive emergency departments of tertiary care hospitals. In addition, delayed treatment adds significantly to the cost of health care today.\(^2\) Thus, even though the uninsured make up 16 percent of our population, it is estimated that their coverage would add only about 5 percent to total health care spending.\(^3\)

Serious as the problems of the uninsured are, this is not the issue driving the current political debate. What is different than in the past is the heightened insecurity of the middle class regarding continuation of their own health insurance plans. The underlying problems are a partial breakdown in the private health insurance market, particularly for small firms and individuals, and the uncontrolled growth in health care costs.

Growing health care costs. The U.S. health care crisis has been exacerbated by health care costs that continue to escalate at twice the rate of general inflation. The United States also spends much more than other industrialized nations for the health care of its citizens. Nevertheless, these other countries—among them Canada, Japan, Germany, and the United Kingdom—provide universal access to a broad range of health services.

The substantially higher expenditures in the United States are related to several factor—in particular, our lack of a national system that limits total
health care spending, such as exists in these other countries. These coun-
tries also have enacted government policies and regulations that control
the number of medical specialists and actively promote the use of primary
care providers as the basis of their health care delivery systems. In addition,
European health systems use global budgeting, which places controls on the
development and diffusion of high-cost new technologies and restricts the
growth of hospital budgets and physician fees. These European global
budgeting systems, which rely on sector-specific budgets—that is, a separate
hospital budget and a separate budget for outpatient and physician serv-
ices—differ from the budgeting system proposed in the Clinton plan. The
Clinton plan instead would use controls on the rate of growth in spending,
leaving to each health care plan the decision on how to allocate its funds.

**Business response.** Variation among payers for health care services
allows providers to obtain additional revenue from some payers to offset
losses from other payers, or to shift costs. This cost shifting to well-insured
private patients translates into health insurance companies paying 30 per-
cent more than the actual costs of the care received. As a result, many
health care providers have not had to directly confront the financial
pressures imposed by governmental payment and coverage restrictions.

Increasingly, businesses that are faced with high and rising health insur-
ance premiums and that lack the same bargaining power as government are
being forced to reduce the health care benefit package provided through
insurance, limit coverage for nonworker family members, or shift a larger
portion of the insurance bill onto workers. Thus, while it might appear that
employers are paying more of the bill, it is actually workers themselves who
are paying more. Of course, most economists believe that it is workers who
pay for the coverage even when it is “paid” by the employer. Psychologi-
cally, however, workers resent the high costs more when they pay directly
for insurance.

**Medicare spending.** Legislated in 1983, the Medicare hospital prospec-
tive payment system (PPS), and more recently, the Medicare fee schedule
for physicians (resource-based relative value scale, or RBRVS), have re-
duced the rate of growth in spending by the federal government. By the
end of the 1980s the rate of Medicare spending growth was below that of
growth in national health spending. Preliminary data from the Health Care
Financing Administration (HCFA) on Medicare outlays for physician serv-
ices show an increase of only 5.6 percent for the first ten months of 1993,
compared with 9.5 percent for the same period in 1992. The private rate of
growth was significantly higher.

Because PPS affects only the payment rate for Medicare, hospitals have
managed to increase their costs beyond the Medicare limits and to maintain
profit margins by charging more to other payers. Hospitals also have sought
to recoup lost revenues by providing services that pay higher Medicare rates, such as open-heart surgery, and by providing services not controlled by PPS payments, such as expanded outpatient services.\(^7\)

The ability of the Medicare program to control its payments to hospitals while total hospital expenses continued to rise at pre-PPS levels strongly suggests that, to be truly effective, cost controls must be comprehensive and must apply to all payers of the service, public and private. Should the Clinton plan be enacted as proposed, it will be complicated but necessary that the same level of control be developed with the two separate spending control systems, one for Medicare and one for private health plans.

**Analysis Of The Clinton Plan**

Given the complexity of designing any comprehensive national health insurance plan, including offering a realistic financing system, one can easily find aspects of the plan to criticize. I, too, have several concerns. But in basic design the Clinton plan does address the major problems of our health care system. By building on rather than destroying our current financing system, it minimizes the disruptions that would be caused if we went to a completely governmental, tax-based system. Most importantly, the Clinton plan incorporates three key components that should be strongly supported by all: universal and comprehensive coverage, a mandated employer-based financing system, and a national expenditure limit.

**Universal and comprehensive coverage.** First and foremost, the Clinton plan provides universal coverage with health care benefits that are broad-based and comprehensive. Some have criticized the benefits as being too comprehensive (and therefore too expensive). Such criticisms come from a mind-set that is focused on designing a benefit package for low-income populations that is paid for by someone else and that leaves the general population either to receive different benefits or to supplement the core benefits. This is the wrong way to think about a true national health insurance plan. Using the political process to decide what level of benefits the average American wants and is willing to pay for (either through a community-rated premium or from taxes) may not be perfect, but it does bring into play all of the forces for expanding and contracting the benefits offered. The president or Congress cannot, as some contend, simply add benefits without balancing value with cost, since they must develop the means to pay for the added coverage or face the added political pressure from those who would be required to pay for it.

The debate surrounding the benefits included in the plan will go on throughout the reform process, and some changes no doubt will occur. Such changes, however, will be marginal and will not affect the ultimate likeli-
hood of passage of the plan. What is critical to the Clinton plan and to whether this country does create a universal health insurance system is the requirement that all employers offer the agreed-upon benefits to all workers and pay a substantial proportion of the premiums.

The employer mandate. The Clinton plan requires that employers pay 80 percent of the average premium for mandated benefits offered by health plans in their region. Interestingly, this is the same percentage required under President Nixon’s CHIP. There is nothing magical or crucial in the percentage selected, other than that it should be a substantial proportion of the total premium. Perhaps this proportion will be one of the compromise items during the legislative process.

Much of the criticism of the Clinton plan comes from representatives of small businesses and some economists who believe that the employer mandate would destroy hundreds of thousands or even millions of jobs. In response to these dire predictions, several alternative proposals have been introduced, which, while still relying on an employer-based insurance system, drop the requirement that employers pay a major proportion of the premium. I believe that these predictions seriously distort what would happen to the employment market under the Clinton plan. Recent testimony by the chair of the Council of Economic Advisors and economists of the RAND Corporation supports this conclusion. Further, it should be clearly understood that the alternative plans are neither universal nor comprehensive.

While these alternative plans would provide subsidies to help low-income uninsured populations purchase coverage, and most of the plans attempt to reform the health insurance market for small businesses and individuals, all of these proposals would still leave millions of Americans without coverage. To me, the employer mandate is critical to any proposal that seeks to provide universal coverage and still retain an employment-based insurance system.

Ironically, the uninsured are disproportionately represented in just those small businesses the alternative proposals would free from the mandate. The uninsurance rate is almost 34 percent in firms with fewer than twenty-five employees and 26 percent in firms with twenty-five to ninety-nine employees. This uninsurance rate would be much larger were it not for the fact that for many of these workers, other family members receive insurance from their employers. Thus, the health care expenses of workers whose firms do not provide coverage are added to the insurance costs of the employers that do provide coverage.

Given the market assumption that requiring firms that do not offer health insurance to do so leads to a loss in jobs, it also should hold that reducing employment costs to firms that now insure their workers will
increase employment in those firms. In addition, one must consider the employment effects on firms that now pay for the cost of care used by the uninsured. The Prospective Payment Assessment Commission (ProPAC) estimated that for 1991 the uninsured generated unreimbursed expenses of $10.8 billion for hospital inpatient care alone.\(^\text{11}\) To this amount must be added billions of dollars for unreimbursed expenses incurred for outpatient care, particularly emergency room services, as well as for physician services and other types of health care. These expenses are added to the bills of those who are privately insured. If everyone were insured, this hidden tax would be eliminated, thereby further reducing the cost for those firms that now provide insurance—perhaps adding jobs as well.

There is no model at this time that reflects all of the expected gains and losses that would result from the Clinton plan, or any other plan. But, given the likelihood that the increase in total health care spending from the reform plan will be small—or as under the Clinton plan, negative—once the cost containment features are factored in, I postulate a positive net employment effect for the nonhealth sector and a negative impact on health care employment. In total, the net employment results are likely to be small in either direction or could completely offset each other.

Mindful of the criticisms by those opposed to an employer mandate, the Clinton plan includes a series of subsidies for firms most likely to be affected. Not only would firms with fewer than seventy-five employees and an average annual payroll of less than $24,000 per worker have a limit on the percentage of payroll required for health insurance (between 3.5 percent and 7.9 percent), but all firms whose employees receive health insurance coverage through a regional alliance would have the percentage of payroll for such coverage limited to 7.9 percent. This includes firms with more than 5,000 employees who choose to use the regional alliance. Employees who work for firms using the regional alliance also can receive a subsidy to assist them in paying their share of the coverage if their family income is below 150 percent of the federal poverty level. Such employees are entitled to this subsidy even if they work for a firm whose average payroll is in excess of the subsidy limit, regardless of the firm’s profitability. Such a provision is certainly justified on equity grounds for such low-income employees relative to others with comparable income, but this subsidy is in effect a hidden wage increase paid for by the government. It may be that the designers of the Clinton plan overreacted to critics of the employer mandate and provided too many subsidies to private companies and their workers. This concern is heightened when the subsidy for early retirees is added.

**National health expenditure limits.** There has been much criticism about the size, scope, and power of the regional alliances, particularly about
their control over health plan premiums. Many of the alternative reform proposals, while requiring regional purchasing associations to help small firms and individuals to buy insurance economically, stop well short of giving these regional entities any influence over the health care system, including how much is spent. This, I believe, is a mistake.

To control future growth in health care spending, this country has three choices: (1) rely completely on market forces, (2) use tight price controls and supply constraints, or (3) limit the total flow of funds going for health services and leave allocation of these funds to market forces.

The administration is correct in relying on indirect spending controls rather than direct price controls. Price controls can be effective for limited time periods when excessive spending results from price increases that have been bid up by rapid and artificial increases in demand or drastic reductions in supply as, for example, in wartime or during panic buying. Today's increase in medical spending, however, has resulted from an uncontrolled flow of funds into the health care system, leading to excess capacity for many types of expensive services. Having health plans responsible for their own allocation decisions within externally generated budgets is likely to be the best way of both reducing total spending and increasing the efficiency of the health care system. Other countries that use sector-specific budgets have been successful in reducing total spending but have less-efficient health care systems. These sector-specific budgets impede the transfer of services across sectors as, for example, from inpatient to outpatient care.

Without an external spending limit, competition among managed health care plans alone cannot generate sufficient savings to bring total health care spending down to levels that are in line with the growth in the nation’s income or inflation rates. Experience with managed care plans indicates that savings of at most 10 to 20 percent can occur. For the most part, these are one-time savings with yearly increases similar to those in traditional fee-for-service systems. The president’s plan, however, would require reductions in the annual growth in private spending of closer to 50 percent. Such savings cannot be generated without an external budget constraint. Without such savings, this country faces the real prospect that its spending for health care will still reach 20 percent of gross domestic product (GDP), despite expanded market competition to slow the growth rate. As we approach this rate of spending, serious dislocations in other sectors of the economy surely will occur.

Concerns About The Clinton Plan

Among my concerns about the Clinton plan are the following: (1) It relies too heavily on savings from Medicare and Medicaid to fund the new
Medicare benefits and broader health reform; (2) it may bring total health spending down to almost no real per capita growth; and (3) it limits the responsibilities of the regional alliances over the shape and size of the delivery system. Let me state at the outset that I believe it is appropriate to look to expected savings to help pay for reform. My problems are with focusing primarily on savings from Medicare and Medicaid, the expected magnitude of these savings, and the ceiling level for private spending.

**Do not rely on savings from only Medicare and Medicaid.** The major beneficiaries of health care reform, in addition to newly insured persons, would be currently well insured Americans, including those associated with our largest and most profitable corporations. Well-insured companies and their employees now pay extra premiums in three ways: They pay for employees’ noninsured family members; they pay for the health care costs incurred by the uninsured; and they pay when government forces providers to accept payments that are lower than the cost of the medical care used by government beneficiaries. Covering all Americans and including Medicaid recipients in private health care plans would help to reduce these add-on costs. In addition, if the Clinton plan is successful in reducing the rate of growth of all health care spending, those who are currently well insured by private plans will see additional savings.

We should not, therefore, rely exclusively on the savings from government programs, particularly programs that already have in place much stronger financial control systems than is the case in the private sector. Instead, we should ask all who are now well insured to invest some of the savings they will realize under total health care reform. Some will call this a tax increase (and I know there is political reluctance to raise taxes), but this is not a normal tax increase. It is a form of shared savings or an investment. Such shared savings could come in various forms: an earmarked add-on in all provider rates, a set-aside or add-on fee to private health plan premiums, or some form of a broad-based health tax. Most surveys suggest that Americans would be willing to pay a small amount to see health care reform become a reality.

You may ask, Why not accept the political reality that it is much easier to get through Congress a payment system that relies only on savings from government programs? The answer is that we are not likely to see the savings that are required from only these two programs without opposition from providers of these services and their patients. Opposition to cuts in the growth rate in Medicare spending for hospital care and outpatient services will not be eliminated because these savings will be used in part to finance the new Medicare prescription drug and community long-term care benefit programs. Some of these savings will be used to fund broader health reform. Concerns also will be raised about the negative impact of these cuts on the
quality and availability of services whose payments have been reduced. Some of these concerns may be real, for several reasons.

First, Medicare payments for inpatient care and for physician services already have been cut back significantly below provider costs and private payment rates. Even before the reductions legislated in the Omnibus Budget Reconciliation Act (OBRA) of 1993, Medicare hospital payments were estimated to equal only 88 percent of provider costs. For physician services, Medicare payments are now on average 30 percent below private rates, and for several services they are 50 percent or more below private rates. Volume growth in these large spending items also has slowed and has even declined in the case of hospital care. Further spending cuts in these two programs may therefore require reductions in Medicare services.

Second, Medicare thus far has been able to reduce growth in payment rates to providers without seeing a backlash from providers or a cutback in services to beneficiaries. This is due to the ability of most providers to find other patients whom they can charge higher rates. Under the Clinton plan such extra revenue generation or cost shifting would become very difficult, as tight limits would be placed on private spending rates. With no place to add extra revenues, hospitals and doctors would be forced to make major cuts in costs. Given that the cuts will be real and are likely to require significant and noticeable reductions in services to beneficiaries and in health care workers’ incomes, providers and their patients are likely to mount extensive lobbying campaigns on state legislatures and Congress to provide new funds for Medicare.

Third, the major growth areas in spending under the two government programs in recent years have been in outpatient testing and procedures, home health care, and other noninstitutional care. There are no provisions in the Clinton plan to significantly change Medicare’s utilization controls. Even if the plan wanted to, there are no good programs for controlling services in these areas without questions about restricting needed care. The one mechanism that does exist is to cut provider payment rates. To make the kind of cuts needed, however, would require sizable reductions in the payment rates for these services.13

Finally, the payment rates for most Medicaid programs are lower than for Medicare and much lower than private rates. Therefore, health plans covering Medicaid individuals under the reform plan would have to produce sizable utilization reductions. If they did not, substantial amounts of cross-subsidization would be needed in regions with extensive Medicaid populations. These subsidies would be more extensive because each state’s payment rate would be capped at 95 percent of its current level.

**Set lowest spending control levels at rate of GDP growth.** The Clinton plan expects that within two years of enactment, the growth rate
in total private health care spending will fall 2.5 percentage points below the baseline (a reduction in the expected growth in spending of 30 percent). Within four years spending growth would be required to fall still further to only the overall per capita growth in the Consumer Price Index (CPI) (in essence, no real growth in spending). Hence, the expected rate of growth of private spending would be expected to fall by more than 30 percent between 1995 and 2000. Thereafter, the plan leaves control of the level of spending to Congress or, if by default, to the National Health Board. The board would be required to set the ceiling at the rate of per capita growth in GDP. For Medicare the long-term growth rate is expected to fall by somewhat less than private spending, or about 30 percent, from a baseline of 11.1 percent to 7.8 percent. This is before the additional spending for the two new high-demand and high-growth services of outpatient prescription drugs and community-based long-term care are added. Therefore, it is not that the cuts in growth in Medicare spending are too large relative to expected reductions in private spending, but that combined reductions in the rate of growth of total spending may be too large.

I support aggressive controls on health spending. However, the reductions suggested by the Clinton plan seem unrealistically tough. To succeed, they would shift the United States from being among the fastest-growing health-spending countries to one of the slowest. The average real growth in health expenditures per capita in Organization for Economic Cooperation and Development (OEDC) countries during 1986-1991 was 3.4 percent. The U.S. rate was 5.3 percent. The Clinton plan would bring the per capita U.S. growth rate down to slightly above 2 percent by the year 2000. Thereafter, it will be up to Congress to decide the tightness of the limits.

If spending growth is not brought down to these tight limits, then several components of the plan would begin to add significantly to the cost of reform, or Congress will be forced to reduce subsidies for low-income persons or low-wage firms or to scale back the new Medicare benefits. By relying so heavily on Medicare savings to finance health reform and to keep Medicare payments in line with private payments, the private premium growth limits must be kept very tight. Thus, these limits should not be thought of as benign targets or a “backup” system; rather, they are critical to the success of the Clinton plan. This could spell trouble in the years after passage if these tight spending caps are not met. I suggest instead that the spending growth rate and subsidy rates be revised to reflect a higher ceiling for health care spending, such as real per capita GDP plus 1 percent. Such a growth rate is more in line with the controls used by other major industrial countries. These reductions still would generate substantial savings from the baseline growth rate.

To compensate for lower Medicare/Medicaid savings, President Clinton
and Congress should build upon the fact that most Americans will benefit from health care reform and should help pay for it. This would not be in the classic form of a tax increase, but rather a reduction in the savings rate. If we do not move in this direction, we face the real possibility that those who oppose comprehensive reform will use the tightness of the premium limits as a justification to sabotage the entire package. Or, if the Clinton reform plan does pass, financing problems will occur very quickly as we find that the spending limitations are unattainable.

**Strengthen, not weaken, the regional alliance.** If we are serious about making the national health care budgeting system work, then it is likely that the regional alliances will need more authority to affect the size and shape of the health care system. As envisioned under the Clinton plan, the powers of a regional alliance are limited to only indirect controls over the administrative and financial aspects of the health plans in its region, not the health care delivery system itself. While over time tough price negotiating between plans and providers could “wring” some redundancies and inefficiencies from the system, this is likely to be a very long and cumbersome process. Furthermore, there is no evidence that market forces alone will ever achieve the level of constraints necessary.

The Clinton plan requires substantial savings very quickly. Regional authorities should have the power to assist in reducing the excess capacities of high-cost services in the region and even to force the system to cut back to the point that some waiting for nonemergency care might occur. This is how other countries have kept their spending rates below U.S. rates.

We also should not eliminate most of the business community as allies in controlling costs. There is little to be gained in administrative savings by requiring employers with more than 500 workers to join a regional alliance. To assist the regions in controlling spending, therefore, I recommend that firms of 500 workers or above be required to operate their own corporate alliance. Their premiums would be affected by how well they control their expenditures. But they would not be allowed to violate the reform rules concerning no coverage restrictions based on health status, and all workers would have to be covered with the firm paying 80 percent of the premium. This would keep these powerful community interests involved in controlling the health care costs of their region. If we do not strengthen the cost containment powers in the community, we cannot then expect the health care system to bring spending down close to GDP growth. Easy savings from administrative inefficiencies or “fat” in the system will not do it.

**Summary**

A true national health insurance system has been long in coming to the
United States. If we let this opportunity for reform pass without making some significant changes, the problems will be much more serious a decade from now. I therefore applaud the Clinton administration for pushing this issue to the top of our domestic agenda and strongly support the basic approach it has taken to solve our health system’s interrelated problems. The changes I have recommended, while important, are small in comparison to the many areas with which there is agreement. I also believe that these changes can be added without doing serious harm to the plan’s overall structure. What is most important is that we enact a reform plan that will solve the pressing problems of our current health care system.

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NOTES

2. Ibid.