THE POLITICS OF HEALTH REFORM Rx

No one in Washington nowadays, except for an occasional AMA lobbyist, worries about Federal intrusions into our private health care system. It is at least eight years and $80 billion too late for such misgivings. What many people do worry about, and endlessly debate, is the precise nature of future Federal involvement: How much will it cost, who will pay for it and what groups, ultimately, will benefit?

In addition, there is much fretting over the question of *control*, because everybody in Washington knows that having a hand on the administrative steering wheel often entitles one to have the other hand in the Federal pocketbook. Thus, the desks of our Congressmen, and maybe their wastebaskets as well, are overflowing with measures that purport to have the right answers. Most of these schemes will die in committee; a privileged few, though not invariably the worthiest, will reach the floor of Congress.

What is a good, comprehensive health care proposal? No one is certain—at least no one ought to be—but there is little mystery about the goals toward which any sensible bill should point. These include: (1) full insurance coverage opportunities for every American; (2) a reasonable price tag, equitably shared; (3) more primary care physicians and fewer surgeons; (4) guarantees of health care *when* and *where* the patient needs it—at night and on weekends, in ghettos and in rural areas; (5) a shift of emphasis from hospital-sponsored crisis medicine to preventive medicine; and (6) a strong, continuing consumer voice in health care arrangements and policies.

Self-evident as such goals may be, not all the principal disputants can agree even on these; and when the debate shifts from goals to ways and means, the citizen's ear is assailed by a Babel of tongues. Every bill has its lobby, and every major lobby has its pet bill.

There now are about 600 registered health care lobbyists in Washington, more than half of whom work for the insurance industry. The growth of the insurance presence since Truman's time is proof of the proposition that today's vested interests are the products of yesterday's inadequate reforms. Unlike the AMA, which is forever emoting and verging on tantrum politics, the insurance lobby keeps a low profile. "They're very smooth, and they have a lot of money," says Allen Zach of the AFL-CIO. "It was mainly the insurance people and not the AMA who won all those concessions in Medicare and Medicaid. They've also got a lot of clout at HEW and the White House."

Insurance companies and their executives have been big Nixon contributors. Clement Stone, president of Combined Insurance, topped the list in 1972 with a $2 million gift to the Committee to Reelect the President. Nixon has shown his appreciation in the kinds of health reforms he has proposed to Congress and in the way his HEW administrators have conducted their end of the health care business. HEW, as we demonstrated earlier, has suppressed its own auditors' reports of Medicare and Medicaid abuses by "fiscal intermediaries." It has also displayed a reluctance to air data that might make the commercial insurance industry look bad.

Not long ago Blue Cross sent out a news release based on an HEW research study showing how its customers got back in benefits a higher percentage of their premiums than did commercial insurance customers (*Social Security Bulletin*, February 1973). The very next day Blue Cross' information director, Joseph S. Nagelschmidt, received a call from an HEW official asking him to withdraw the release. According to Nagelschmidt, the official claimed to be acting on instructions from the White House. "They got a complaint from Clement Stone," Nagelschmidt says he was told. The release was withdrawn.

The nation's second most effective health care lobby is the AMA. Its political arm, the American Medical Political Action Committee (AMPAC), spent more than $3 million on Congressional elections in 1972, distributing largesse to all candidates willing to sponsor

"Medicredit," the AMA-backed bill that was submitted to Congress in 1970. The measure at present has more than 180 sponsors, including a sprinkling of northern Democrats.

Money accounts for much but not all of the AMA's political effectiveness. The association enjoys an inner strength as well because it believes its own mythology. While the rest of us despair of discovering a sensible path through the health care maze, the AMA remains serenely certain it knows the right answers. Yet it is risky to present an AMA official with a fact; you may put him out of sorts.

At a hearing before Senator Edward M. Kennedy's subcommittee two years ago, four AMA spokesmen denied there was a health care crisis. Even the President had said there was a "crisis," responded Kennedy, who went on to point out that the number of tonsillectomies in California was four times the national rate, suggesting that the distribution of surgeons around the country might be uneven. "Where does that statistic come from?" asked Harry Peterson, the AMA's chief lobbyist. The Senator replied that the figure was part of the Nixon health message. He then asked about the high rate of infant mortality in the U.S. Weren't there a dozen or so nations with lower rates? "Those figures are wrong!", cried Dr. Max Parrott, chairman of the AMA Board of Trustees. "They are absolutely wrong. They are used dishonestly." The statistics came from the United Nations.

This spectacle of a temperamental giant flailing in the dark would merely be funny if the AMA was not so adept at keeping the rest of us in the dark, too. Each week, for example, about 40 million Americans watch the television series, *Marcus Welby, M.D.*, a portrayal of fee-for-service Nirvana whose wise, kind and handsome protagonist is the very model of a modern general practitioner. The AMA serves as a technical consultant to the program, and last fall reporters learned that it was instrumental in having two scenes from a single show left on the cutting room floor.

In the expurgated scenes a surgeon, Dr. Jeliff, remarked to Welby that 80 per cent of the cost of an operation he had scheduled the next day would be paid by the patient's group medical insurance. Welby asked if that "isn't true in most of your cases?" Jeliff replied, "No. I'm sorry to say many of those who need insurance the most don't have it." Questioned about the cuts, the producers conceded that certain changes had been made "during editing."

Besides the AMA and the private insurance industry, lobbies like Blue Cross and the American Hospital Association (AHA) carry some weight on the Hill, though Blue Cross observes a nominal neutrality toward bills under consideration. ("We support certain principles," says George Kelley, its chief lobbyist, "but we don't take stands on legislation.") Since the health care community is a loose coalition of interest groups, each scrambling for the dollar, the lobbying organizations do not always agree. For instance, during last fall's Congressional debate over the Emergency Medical Service bill, a measure that would have pumped Federal funds into hospital emergency units if the President had not vetoed it, the AHA found itself arrayed against the AMA. (The AMA won when the House, by four votes, failed to override the veto.)

Nevertheless, at this stage of the game the private lobbies recognize that they have much in common and frequently they synchronize their ad hoc campaigns. Late last year, all the big-letter lobbies—AMA, HIAA and AHA—got together in strategy sessions intended to make the impending HMO bill conform more nearly to their interests. Among other things, they agreed to press for "dual choice," a provision putting private insurance plans on at least an equal competitive footing with HMOs (at the same time, they opposed requiring employers to include HMOs in the choice of insurance packages offered to employes). Blue Cross representatives attended some of these sessions, despite their insistence that they could take no position on proposed legislation.

The Liberal Lobby

The lobbying scales are thus tipped heavily on the side of private interest groups. The only counterweight of any note is the AFL-CIO and its embattled offspring, the Committee for National Health Insurance (CNHI), which is also called "The Committee of 100." On its roster can be found such distinguished names as Arthur Goldberg, John Kenneth Galbraith, Dr. Charles H. Mayo II, and Mrs. Martin Luther King Jr., plus a curious trio of former Senators—Paul H. Douglas, Ralph W. Yarborough and William B. Saxbe. In philosophy and spirit the committee is the natural descendant of two organizations mentioned earlier for their attempts to bring about enactment of universal national health insurance, the American Association of Labor Legislation (1912) and the Committee on the Costs of Medical Care (1927-32). The continuity is more than symbolic: Among the "100" is I. S. Falk, a CCMC founder who sought to get national health insurance written into the New Deal's Social Security Act.

CNHI is working in support of the "Health Security" program, S.3, introduced four years ago by Senator Kennedy and Congresswoman Martha W. Griffiths (D.-Mich.). Although Kennedy on April 2 announced he was joining in a substitute bill, S.3 remains a touchstone for all those who view themselves as keepers of the 60-year-old dream of universal health insurance.

Most of the other bills are narrow-gauge proposals calling for new institutional subsidies, while permitting the overall system to lurch forward unattended and unaltered. To begin with, there is Medicredit, a gimmick the AMA whipped up in 1968 and has wistfully promoted ever since, with the help of that tireless champion of social reform, Senator Vance Hartke (D.-Ind.). It would leave fee-for-service practice unscathed, and provide every possible incentive for doctors, hospitals and insurers to raise their rates.

In brief, Medicredit would dis-

tribute health insurance vouchers to all citizens, in amounts varying in inverse proportion to the size of their income tax bills—the less one pays, the more vouchers one receives. Theoretically, the poor would gain the most from this arrangement, but it would also reward millionaires like J. Paul Getty who by slipping through loopholes each year manage to pay little or no taxes. More important, the plan would be virtually useless to a majority of middle-income Americans, because their tax bracket would render them ineligible for more than a token quantity of vouchers.

Few people in Washington take this proposal seriously. One must wonder whether many of the Congressmen who signed this bill did so out of conviction or out of gratitude to AMPAC. Even the commercial insurers, who stand to benefit from the measure—in effect, it would convert Federal agents into insurance salesmen and underwriters—prefer to ignore Medicredit and concentrate instead on the industry's own entry, the "National Health Care Act," introduced a year ago by Senator Thomas J. McIntyre (D.-N.H.).

"Healthcare," rhapsodizes a recent Health Insurance Association of America pamphlet, "seeks to contain health costs, improve organization and delivery of health services, and make comprehensive health insurance—including a $250,000 catastrophe benefit—available to all. Under Healthcare no family need ever impoverish itself because of ill health." All this is to be accomplished through a complex system of state and Federal subsidies to insurance companies (HIAA graciously includes the "Blues" in its patronage plans) that would enable insurers to offer more benefits to more Americans, even the "high risks." This is the industry's latest attempt to persuade taxpayers to underwrite "clunkers."

In fairness, Healthcare does make a casual stab at revising the system, and that puts it light years ahead of Medicredit. For example, the plan would set up minimum Federal standards for benefits, which might widen coverage beyond hospitalization and raise the ceiling on "catastrophic" insurance, but it lacks specific machinery to enforce these guidelines. Healthcare does recommend machinery to review charges submitted by health care providers under Federal programs, yet the review powers are to be vested not in Washington but in 50 separate "State Healthcare Institutions Cost Commissions" to be appointed by the governors. Both the notion and the name are so awkward that a hospital might double its charges before anyone in a state capitol could find tongue or title.

The AHA favorite—the National Health Care Services Reorganization and Financing Act (H.R. 1)—is not thought to have much chance of passing either. The bill, introduced by Congressman Al Ullman (D.-Ore.), is better than most, albeit Byzantine in structure. It mandates creation of a network of local health care corporations to which citizens may subscribe in advance for services. "All persons," Ullman has said, ". . . would be entitled to the same broad package of benefits," with employers paying three-fourths of the cost for their workers, and the Federal government picking up the tab for the poor and the elderly.

Apparently these corporations could function as HMOs, though the wording on that score is not entirely clear. What is clear is that hospitals would play a central role in this system, since in most places they are the only institutions capable of administering so complicated a plan. The hospitals, in turn, would be regulated by state health commissions appointed by the governors—an unpromising arrangement, to judge from the Medicaid experience, where so many states have failed to enforce sensible standards of quality and cost.

The strength of Ullman's bill lies in its attempt to "rationalize" the health care system rather than merely subsidize it, and in its provision for a new Cabinet-level Department of Health to preside over the entire mélange. Yet for all its detailed exegesis—the measure, in close type, fills 34 pages of the *Congressional Record*—H.R. 1 remains distressingly vague about who will control what. One is left with the impression that the hospitals will be in charge, and that these state health commissions will represent institutions instead of consumers.

'Viable Proposals'

Perhaps what weighs most heavily against Medicredit, Healthcare and H.R. 1 is that none is a "politically viable proposal." A politically viable proposal is one made by the President, or else sponsored by somebody on the Hill capable of getting it on the agenda of an appropriate committee. In the Senate, the man to watch is Russell B. Long (D.-La.), chairman of the Finance Committee. And sure enough, his committee is slated to consider a new health bill—drawn up in collaboration with former HEW Secretary Abraham Ribicoff (D.-Conn.)—the Long-Ribicoff Catastrophic Health Insurance and Medical Assistance Reform Act.

Before Nixon introduced his latest health plan, the Long-Ribicoff bill enjoyed considerable support among reformers on the Hill. The names of its sponsors—such lustrous liberals as Senators Gaylord Nelson (D.-Wis.), James Abourezk (D.-S.D.), George McGovern (D.-S.D.), and Quentin Burdick (D.-N.D.)—remain on the measure, but their ardor has cooled somewhat in the face of the President's program. For to the embarrassment of these Senators, the Administration's proposal actually offers more health insurance coverage to the public than does the "liberal" Long-Ribicoff package. As a result, Chairman Long will probably feel compelled to hold hearings later this spring that will also take up the President's bill, sponsored by Senator Robert Packwood (R.-Ore.) and Congressman Herman Schneebeli (R.-Pa.).

In the House, the man who counts most is Wilbur D. Mills (D.-Ark.), chairman of the Ways and Means Committee. And sure enough, he has in hand a freshly minted bill sponsored by himself and Senator Kennedy for which he

has scheduled hearings to begin after the Easter recess. "I think the bill has a good chance of passing this year," Mills said at a recent press conference.

The Kennedy-Griffiths proposal, therefore, remains just a gleam in the CNHI. Since it has been abandoned by one of its authors, what little chance it had of passing this year is completely gone. For liberals, this raises difficult tactical questions: Should they, like Kennedy, give up on S.3 and settle for half a loaf from Mills, Nixon, or Long? Or should they hold out for their own full loaf and thereby risk —indeed, guarantee—getting nothing this session? Before exploring this dilemma, we ought first to compare the three competing bills in the light of those six basic goals listed earlier.

1. *Full insurance coverage opportunities for every American.* Under Kennedy-Griffiths everyone is eligible for benefits that cover the entire range of health services. There are no means tests and no strings—no deductibles, no coinsurance clauses, no limits on preventive care.

The other three bills offer protection to nearly every American, too, but the extent depends upon age and income. They would keep Medicare, replace Medicaid and introduce plans for the heretofore neglected middle class. In general, they would pay some benefits to some of the people some of the time. Long-Ribicoff emphasizes catastrophic insurance, for which 95 per cent of the population is eligible, and a Federal subsidy system for the poor; Kennedy-Mills and Nixon both propose benefits for the middle class—the former through a compulsory Federal plan, the latter through voluntary private insurance plans.

The President's employe group package carries a $150 deductible on out-patient drugs. Further, a family must pay one-fourth of *all* charges, up to $1,500 each year. Such "copayments" are also a feature of Long-Ribicoff and Kennedy-Mills. Long-Ribicoff would charge a middle-income patient $17.50 for each day of hospitalization and 20 per cent of all medical bills (up to $1,000)—*after* the patient has absorbed the first $2,000 of medical expenses and 60 days' worth of hospital costs. Under Kennedy-Mills, the patient would pay a $150 deductible and then one-fourth of the total medical bill up to $1,000 per family per year. However, preventive care like prenatal examinations and family planning would get "first-dollar coverage" (no deductibles or copayments).

2. *A reasonable price tag, equitably shared.* S.3 is the most expensive—$67 billion. The program envisions a Health Security Trust Fund fed by a Social Security tax of 3.5 per cent on employers, and 1 per cent on the first $15,000 of a worker's annual wages. This money would be supplemented by Federal general revenues.

Kennedy-Mills supporters say their measure would cost $40 billion a year, the funds to be raised along S.3 lines. The slight difference is that a minimum of 3 per cent would be charged to employers and a maximum of 1 per cent to workers.

A similar price of $40 billion is estimated for the Nixon proposal, though the Administration claims it would require only $13 billion a year from the Federal treasury. That is because the White House is relying largely on private insurance coverage privately financed—by employers and employees—and as the New York *Times* has observed, "Mr. Nixon's premiums must be paid just as if they were called taxes." Worse, it treats as taxable income for individuals the premium contributions made by employers, and then turns around and treats employe contributions as *nondeductible* expenses. The tax-paying worker is thus put in double jeopardy.

By contrast, Long-Ribicoff backers claim their bill would cost about $10 billion. It adds only 0.3 per cent to the Social Security tax, the burden to be shared by employers and employes, yet its system of copayments and deductibles constitutes cruel (though not unusual) punishment of the poor, and in effect forces low-income families to subsidize the Federal program. Under its replacement for Medicaid, a family of four earning $6,000 a year would have to spend $1,200 on health care before becoming eligible for spotty and incomplete Long-Ribicoff assistance.

The real dollar difference between Kennedy-Griffiths and the other three proposals can be found not in their total cost estimates, which are in any case likely to change as the debate progresses, but in their varying approaches to cost control. There is nothing in the other programs to suggest that the upward spiral of health care prices will be checked. All three plans retain Medicare, the chief inflationary villain of the past decade. Kennedy-Mills further repeats the Medicare mistake of designating insurance companies "fiscal intermediaries," thus virtually guaranteeing an open season on prices.

Kennedy-Griffiths, on the other hand, has provisions for long-range budgeting procedures, region by region, that may compel hospitals and physicians to set their prices in advance and stick to them. Only institutions meeting Federal standards of cost and quality will be allowed to participate in the program, and wasteful duplication of services is gradually to be eliminated through threatened withdrawal of Federal funding. Such measures, it is true, hardly guarantee effective cost controls, but they point in the right direction, while the other three bills simply feed the inflationary monster.

3,4,5. *More "primary care" physicians and fewer surgeons; guarantees of health care when and where the patient needs it; and a shift of emphasis from hospital-sponsored crisis medicine to preventive medicine.* Long-Ribicoff and Nixon are silent on all these issues. The Kennedy-Mills bill calls for planning grants that may help small towns to attract medical workers and facilities, and it gives financing preference to HMOs as well as to other forms of group medicine. None of its provisions, though, measures up to those in Kennedy-Griffiths. That includes a "manpower support" program for the training of primary care physicians and of other types of health care generalists (public health nurses, community health workers, etc.). It also offers

financial incentives to doctors and health workers prepared to work in ghettos and rural areas, and imposes "disincentives" for the disproportionate clustering of doctors in affluent neighborhoods.

In addition, by spreading and in some measure equalizing purchasing power for health care, Kennedy-Griffiths gives Harlem and Appalachia a chance to compete for doctors with Scarsdale and Gramercy Park. Finally, the Health Security bill is the only one of the three to offer special subsidies to HMOs, encouraging the practice of preventive medicine and of comprehensive, 24-hour health care.

6. *A strong, continuing consumer voice in health care arrangements and policies.* This is another area where Nixon, Long-Ribicoff and Kennedy-Mills are largely silent. The groups that would oversee the Kennedy-Mills planning grants, it is true, are to have a majority of consumer members; but the make-up of the three-man "Social Security Board" that would run the national program is not specified, and a spokesman for the bill has said off the record that it is not likely to include consumers.

The Kennedy-Griffiths measure does pay lip service to consumer participation, but nothing in the proposal spells out how the consumer's voice is to be heard over the institutional chorus. The faint hope here is something called a "National Advisory Council," which is to have a majority of consumer representatives.

In sum, then, while Kennedy-Griffiths is less than perfect, it outscores the others on nearly all counts. In a single administrative package it offers universal coverage, full benefits, sensible cost controls and a variety of devices designed gradually to reshape our health care system—to redistribute manpower, establish more HMOs and encourage preventive medicine. It is therefore the only measure now in the hopper that begins to correct the historic despoliations of fee-for-service medicine and to break up the thriving but unwholesome trade triangle of physicians, hospitals and insurers.

Prospects

CNHI officials, in pondering whether to "go for broke" this year with Kennedy-Griffiths or to support the passage of one or another weaker measure, would like most of all to delay a decision on this question. "We don't have enough votes in this Congress," explains Max Fine, the CNHI's director. "So we're hoping there'll be no action in '74. Then we can make health reform an issue in the November campaigns and come back with a Medicare-type mandate"—that is, with an overwhelmingly liberal majority of the kind that rammed home Medicare in 1965. The strategy will strike some as cynical. After all, even Nixon's program would afford at least some succor to millions of Americans not now protected. Surely any plan that reduces the incidence of family bankruptcies can't be all bad.

And yet, as we have seen, the history of health care reform is strewn with compromises that have tended to shore up the system without necessarily making things easier for the patient; and each new compromise has spawned new lobbies determined to delay fundamental reform. Are we, then, in retribution for past failures and current casuistries, condemned to play Sisyphus forever? Or can we find a way to break the old pattern—those long uphill struggles, those painful downhill slides—and at last attain the top (or at least a reasonable height)? The question will doubtless be answered by the American voter, a frequently confused citizen, careless of distinctions and neglectful of his own interests.

At bottom, the prospects for health care reform depend upon our ability to mobilize the democratic process in the service of institutional change. That is an old challenge in America, going back at least as far as Andrew Jackson, who regretted "that the rich and powerful too often bend the acts of government to their selfish purposes." But it has a particular urgency today in Washington, where private lobbies make public policy, and where government is more than ever an instrument of corporate plunder. Some of the signs suggest that the American voter may be prepared to act, if he can find a leader. Never before have so many citizens mistrusted the health care system and its friends; never before have the lobbies been forced to run so hard simply to stay in one place; and never before has there been such broad agreement on the need for strenuous Federal action.

When word filtered back to North Dakota that Senator Burdick had affixed his name to the Long-Ribicoff bill, the Farmers' Union sent him 5,000 protesting telegrams. The Senator was stunned. "I didn't know they cared," he is reported to have said. Quite a few organizations are beginning to care. In recent months the CNHI has put together a coalition that embraces such groups as the National Education Association and the American Federation of Teachers, the United Methodist Church, the National Council of Senior Citizens, the Urban League, Common Cause, the National Jewish Welfare Association, and the Mennonite Central Committee. Even the League of Women Voters is sending a representative to the meetings. "It's a massive lobbying effort," says a spokesman for the coalition. "We're telling our friends on the Hill that we'd rather have nothing than have a weak bill."

The coalition, informal and disorganized as it is, represents an entirely new stage in the country's long struggle for reform of the health care system. It is precisely what was missing in those earlier battles of 1912, 1934 and 1947. Curiously, in its efforts to put together a grass-roots health lobby the CNHI is being unwittingly assisted by Nixon, who for obvious political reasons of his own is now diligently pushing a health program in Congress. "Health reform," notes Susan Stoiber of CNHI, "is usually everybody's fourth or fifth concern. This year it may be number two."

For the public, the challenge is plain enough: There is the goal and there is the stone; it is everyone's turn to push.