Health care reform is again under debate and will be one of the most discussed topics in the 1992 presidential election. Before the major proposals for reform are presented, the problems spurring the reform movement will be reviewed. Health care reform is not a new issue. For years the basic debate has centered on the question, "Is health care a right or is it a commodity to be purchased by those who can afford it?" Americans have not taken a stand on this question. Although most Americans might agree that no person should suffer illness or death when treatment is available, they have not committed themselves to fully subsidizing those who cannot pay for care. If Americans were to take a stand that everyone should have full access to high-quality comprehensive health care, the next question would be whether it is economically possible to fulfill that objective within the U.S. free market system.

The United States has a pluralistic system in which employers provide insurance for the general work force and the government provides public financing of care—Medicaid and Medicare—for those who are very poor or elderly. But this approach is not working on either a social level or an economic and political level. The cost of health care continues to climb, and the lack of access to care becomes more critical.

Increasingly, segments of the population are falling between the gaps in the present system largely because the high cost of care diminishes their access to care. The very poor, who presumably have coverage under such publicly funded programs as Medicaid, often find themselves with no real access to care because many physicians and other providers will not accept the Medicaid reimbursement rates (Schwartz, Colby, & Reisinger, 1991). Other segments of the population cannot navigate through the present health care system because of language barriers, differences in social values, or intellectual limitations (Pepper Commission, 1990).

Inadequate access to health care has become a major social problem, but it alone has not been sufficient to stir reform (Fuchs, 1992). A concomitant problem—and one that is the major impetus for reform—is the rapidly escalating cost of care. The cost of health care now consumes approximately 13% of the gross national product and has grown rapidly even after accounting for economy-wide price increases (Levit, Freedland, & Waldo, 1990). As any individual industry, such as health care, takes an increasing share of the nation’s money, there is less to spend on other things, such as roads, defense, housing, and education. This is what generates the greatest concern over the rising cost of health care (Reinhardt, 1989).

As costs have risen, business and the government have been interested in trying to lower costs or at least contain them. Concurrently, there are many players in the health care industry, such as physicians, insurers, pharmaceutical companies, hospitals, and other health care providers, who have every incentive to make substantial profits from this health care system (Bettag & Goodman, 1992). Insurance companies, for example, pay for health care but have the potential to profit from insurance premiums if they can keep their reimbursements for health care claims low.

Studies of health care economics are inconclusive in determining to what extent each part of the industry is responsible for exploiting the market and reaping unreasonably high profits. Each segment of the industry defends its prices and attributes them to its high

Donalda Ellek
Donalda Ellek, PhD, OTR/L, is Manager, Office of Quality Assurance, American Dental Association, 211 East Chicago, Chicago, Illinois 60601.

This article was accepted for publication March 6, 1992.

Those covered through insurance from their employer also experience problems. Insurance companies have numerous exclusions of various services, for example, treatments that are considered experimental and certain preexisting conditions, such as heart disease, cancer, and AIDS. Insurers also require copayments or deductibles that can pose difficult hurdles for low-income workers (Pepper Commission, 1990).

Then there are those who are entirely uninsured. Some employees of small businesses that cannot afford to provide insurance to their employees have incomes that are too high to qualify for Medicaid yet are unable to afford to purchase insurance on an individual basis (Kronick, 1991). In other cases, unemployed persons or those who have exceeded the lifetime payments of their insurance do not qualify for Medicaid because their assets exceed the spartan eligibility requirements (Pepper Commission, 1990).

Other barriers to access, in addition to cost, include the lack of health care services in rural and economically poor areas and the cultural heterogeneity of the American population. Populations living in rural or economically poor areas do not have services readily available. This becomes particularly critical when trauma or emergency care is needed (De Friese & Ricketts, 1989).

Other segments of the population cannot navigate through the present health care system because of language barriers, differences in social values, or intellectual limitations (Pepper Commission, 1990).
The health care market is also unique in that patients cannot gain sufficient knowledge to make independent decisions on the technical aspects of care; they must depend on physicians and others (the suppliers with a profit motive) to tell them what medications, treatments, and services they need. According to some economic theorists, the suppliers of health care control the demand for services. Looking at all of these factors, it is clear that free market principles are not easily applied to health care. The economic circumstances quickly become a political problem as all players in the health care industry seek to promote their own interests. This is where we find ourselves today.

Proposals for Reform

There are many proposals to expand the access to health care and contain its costs. The major proposals for health care reform can be described broadly as falling within three categories: single payer, pay or play, and incremental (American Occupational Therapy Association [AOTA], 1991).

Most of the specific proposals in each category involve legislation at either the state or federal level. A presentation of all legislative proposals is beyond the scope of this article, but some of the major federal proposals are summarized. At the time of this paper’s publication, some of these proposals will have been withdrawn, some will have been amended, and new proposals will have been presented. However, the proposals discussed below serve as examples of how the general concepts of reform are to be implemented. The details will quickly change, but the basic ideas bear consideration.

Single Payer

Single payer generally refers to a national health insurance system that provides universal coverage for the population. Some examples of national health insurance systems are the Canadian provincial health plans, the British Health Care Service, the French National Health Service and the German national health insurance. National systems are similar in that they provide coverage for all of their citizens, allow patients to select their own physicians, and constrain expenditures at a level that is generally acceptable to the polity (Hurst, 1991). Important differences exist among them in the manner in which they are financed and the level of government that regulates them. For example, the British system is financed from a general tax revenue, whereas the German system depends heavily on employer-based payment (Hurst, 1991). Thus, national health insurance systems are not identical and the United States could create yet another model.

A prominent proposal for a single payer system is H.R. 1300 (AOTA, 1991), introduced on June 25, 1990 by Representative Marty Russo (D-Ill.). Under the Russo proposal, all Americans would have health care coverage without cost sharing, deductibles, or copayments. Federal health care programs such as Medicare, Medicaid and CHAMPUS would be eliminated. Private health insurance would be virtually nonexistent. The program would be financed through a number of tax changes, including a new payroll tax on employers, an increase in the corporate income tax, and increased individual income taxes for the wealthy (AOTA, 1991).

Pay or Play

Under pay or play, employers would be required either to pay most of the cost of private health insurance for their employees or to support public coverage by paying a tax. Pay-or-play proposals usually set a limit on the amount of the premium that the employee must pay (Aaron, 1991).

The Pepper Commission legislation, S. 1177 and H.R. 2535 (AOTA, 1991), is a pay-or-play proposal that would require large employers to provide health insurance for employees and their families or contribute to a public plan for the uninsured that would replace Medicaid. The public plan basic benefit package would be modeled after the Medicare program except that coverage of rehabilitation services would be more limited. Small employers would be encouraged through the use of tax breaks and government subsidies to provide coverage or contributions to the public plan. The bill also includes private insurance market reforms, such as prohibition of preexist-
ing condition exclusions, a return to community rating, and a mandated minimum benefit package (AOTA, 1991).

Another pay-or-play proposal, S. 1227 (AOTA, 1991), was introduced by the Democratic leadership, including Senators George Mitchell (D-Me), Jay Rockefeller (D-W.Va), Don Riegle (D-Mich.), and Edward Kennedy (D-Mass.). The bill would require employers to provide workers and their dependents with basic health care coverage or pay into a newly created public insurance program, AmeriCare. The employer mandates would be phased in over 5 years and would include substantial tax breaks and incentives for businesses with fewer than 100 employees (AOTA, 1991).

The AmeriCare program would replace the Medicaid program, except for long-term care services, and would not affect the current Medicare program. The new public program would be jointly administered and financed by the federal and state governments. Premiums would be based on a sliding fee schedule related to the poverty index. As currently configured, both the AmeriCare program and the employer-mandated coverage would cover rehabilitation services—in particular, occupational therapy services—but only in inpatient and outpatient hospital settings (AOTA, 1991).

Incremental

Incremental proposals start from the premise that the current system is basically sound and that only minor revisions are needed to offset the imperfections of the health care market and to extend subsidized care (Aaron, 1991). Incremental reform focuses on several approaches: insurance reform, refundable tax credits or vouchers, Medicaid extension, and competition (Aaron, 1991).

Insurance reform would include measures such as combining several small companies into one risk pool and eliminating the surcharges that are often placed on small, insured groups. Another possible insurance reform would be to use community rating and to require that all insurance companies accept high-risk persons. Tax credits are the centerpiece of the incremental reform proposed by the Bush administration.

Senator Lloyd Bentsen (D-Tex.) and Representative Dan Rostenkowski (D-Ill.) introduced incremental reform legislation, S. 1872 and H.R. 3626, respectively (AOTA, 1991). The legislation focuses primarily on how to make insurance more affordable for small employers through increased tax deductions. Although S. 1872 and H.R. 3626 are not identical, they both set minimum standards for small employers. Both bills ban medical underwriting and limit pre-existing condition clauses. Both proposals would limit how much insurers could charge employers and would set a range for premiums. In addition, both bills would require that insurers offer a basic benefit package to small employers. The bills differ, however, in that the requirements for the basic benefit package and the federal oversight of the Rostenkowski proposal is modeled after Medicare, whereas the Bentsen package is similar to the basic benefit in S. 1227 (AOTA, 1991).

Another incremental proposal is S. 1956 (AOTA, 1991), which was introduced by Senator Chafee (R-R.I.). The bill represents the Senate Republican leadership package and is similar to the Bentsen and Rostenkowski proposals. It focuses on small market reform initiatives, including tax incentives and deductions for small employers. Some expansions of current health care systems, such as community health centers, are included as an attempt to provide more preventive services. It would also allow states to expand health care coverage for persons with low incomes with a federal match based on the current Medicaid match (AOTA, 1991).

Conclusion

The objectives of health care reform are to provide comprehensive, full access to care for all Americans and to contain the escalation of health care costs. The American public, as well as those who constitute the health care industry, seem to agree on the objectives, but the shape of reform is controversial. The economic interests of each participant within the health care industry is at stake in any reform, which adds to the politics of any proposed solution.

Every segment of the health care industry is currently reacting to legislative proposals and promoting their interests in reform. It appears that most players in the health care industry favor some type of incremental reform combined with a few elements from the pay-or-play idea. The following synopsis of organizational positions is not exhaustive but does provide an overview of the stance that some participants in the health care industry are taking.

The insurance companies, represented by the Health Insurance Association of America (HIAA), are opposed to federal reforms, want to maintain regulation of insurance companies at the state level, and want to make health insurance more affordable to small businesses. HIAA is opposed to community rating but is in favor of guaranteed availability of insurance, whole group coverage, premium pricing limits, and a reinsurance mechanism that would enable firms to cover the cost of insuring high-risk persons ("Insurers Seek," 1991).

The Blue Cross and Blue Shield Association, which is the trade association for all the Blue Cross and Blue Shield plans nationwide, is in favor of preserving private insurers and providing tax incentives for small businesses to buy insurance coverage. Under the Blue Cross and Blue Shield Association's proposal, insurers would become qualified carriers designated by each state to contract with health maintenance organizations (HMOs) and preferred provider organizations (PPOs). Purchasers would be given incentives to choose those carriers. The Blue Cross and Blue Shield Association also believes that insurance companies should desist from skimming the best risks and that community rating should be used ("Blues Floats Insurance," 1991).

The American Hospital Association supports the use of managed care and cost sharing. They believe that the cost of insurance coverage could be lowered by waiving state mandates for coverage, improving the rates of Medicare and Medicaid reimbursement, federally financing and expanding Medicaid, and providing public subsidies and tax credits to small businesses and financially vulnerable employers and employees (Pharmaceutical Manufacturers Association, 1990).

The American Medical Association supports Medicare eligibility and an increase in Medicaid reimbursement rates to bring these rates to the
level of Medicare care. They also support tax deductions for the self-employed and others who purchase coverage and limits on the amount of employer-provided insurance that is tax-free to the employee. Regarding health care insurance, they support federal minimum employer benefit standards, not-for-profit state-level private risk pools for the uninsured and medically uninsurable, and larger risk spreading for insured groups (Pharmaceutical Manufacturers Association, 1990).

AOTA, as a member of the National Rehabilitation Caucus, promotes the inclusion of rehabilitation services and occupational therapy as part of a basic benefit of any health care reform package. In its Statement on Health Care Reform, the National Rehabilitation Caucus (1991) believed that a balanced health care system demands that emphasis and resources be distributed along a continuum of care, beginning with preventive services and including acute care, rehabilitation, and continuing long-term care services.

As can be seen from these brief summaries of legislative proposals and the positions taken by health care organizations, the issues in reform are unevenly addressed. Financing is a major issue, but some proposals address it more specifically than others. Generally, the proposals focus on acute services. Long-term care, which continues to be a growing issue in health care, is not accounted for in many of the proposals.

Each participant in the system opposes reforms that would diminish its profit or professional autonomy or encumber its business with regulation. However, the urgent need for health care reform might force the industry into devising a balancing-act proposal in which no one segment sacrifices their substantial economic advantages or autonomy too greatly. But this kind of compromise approach generally leads to incremental piecemeal changes, in which each participant is asked to concede only minor interests, with its economic interests and autonomy remaining intact. It is questionable whether piecemeal changes can be effective in meeting the objectives of cost containment and full access to care. The United States has a history of piecemeal changes in the structure and provision of health care, and the outcome has always been sorely lacking in providing access to care for the entire population.

It is unlikely that any reform legislation enacted by the current Congress will be the final word on the subject. It is more likely that reform will be debated throughout the 1990s, with a series of incremental changes being made. More time will be needed for the United States to construct a health care structure and provision system that is congruent with the American value of maintaining a primarily private, for-profit system, but one that also provides full, comprehensive access to care for all Americans at a reasonable cost.

References


