Box **A-Summary of Major Approaches to** Health Care Reform

Current health care reform proposals attempt to address simultaneously three major issues: cost, quality, and access. Depending on a variety of factors (e.g., philosophy of goverment, belief in the wisdom of market forces), the proposals deal with these issues in somewhat different ways and can be categorized in diverse ways depending on the criterion of interest (e.g., whether and how the plan provided for Universal coverage, whether it provides for a global budget).[11] Typically, however, the three major approaches are characterized based on their approach to how they would arrange for the financing of he@ care; they have been termed "play or pay, " "single payer, " and "market reform. " These three major approaches are described briefly below, along with selected variations within the three major approaches. Also described are two other approaches that do not quite fit into these three main categories.

"Play or pay": "Play or pay" approaches were at one time called "public-private combination" approaches (e. g., U.S. Congress, Congressional Research Service, 1990). Essentially, "play or pay" proposals would require that all employers either provide health insurance coverage for their employees ("play") or contribute a specified amount (e. g., 7 percent of total payroll) to a public fund that would provide coverage to all uninsured workers. Some observers fear that "play or pay" would eventually become a "single payer" approach (see below) because employers would (eventually) find paying into a public fund more attractive than arranging for health insurance coverage for their own employees (e.g., President, 1992; Vagelos, 1992).

"Single payer": Single payer is shorthand for a universal access program financed with taxes, and is also known as the "Canadian model." In the version of this approach closest to the Canadian model, States would approve and administer federally qualified health plans to cover all permanent residents of the United States (e.g. S. 1446 and H.R. 8, the Comprehensive Health Care for All Americans Act./Claude Pepper Comprehensive Health Care Act, introduced by Sen. Kerrey and Congresswoman Oakar, respectively, in the 102nd Congress). Individuals would have a choice of competing private and public health plans in which to enroll, and health expenditures would be controlled through a system of budgeting and all-payer reimbursement systems for physicians and hospitals.

"Market reform": The category "market reform bills" encompasses a wide range of proposals, from tax credits for individual consumers (e. g., The Heritage Foundation Butler, 1992]), to "small group reform" (e.g., **S. 1872 in** the 102d Congress) to "managed competition" (e.g., Jackson Hole Group [Ellwood and Etheredge, 1991]) affecting potentially all citizens. "Market reform" proposals do not necessarily provide universal health insurance coverage but aim at alleviating problem areas in the private insurance marketplace--for example, by requiring insurers to provide or offer coverage for specified health services, by requiring insurers to determine health insurance premiums through community rating methods, by preventing insurers from excluding coverage for any pre-existing health condition, by introducing "managed competition" concepts, or by individualizing insurance coverage by instituting individual refundable tax credits in place of the current tax advantages accorded to employer group plans.

The Bush plan would use the tax system to "encourage and 'empower'" **individuals to** buy health insurance, and would enact insurance market reforms that make it possible for everyone--even if they have pre-existing health problems--to get insurance (Murray, 1992). The Bush plan **also aims** to create a health insurance market in which competition would keep costs down. Thus, under one of the bills intended to implement the Bush plan, small employers would benefit from managed competition through the formation of health insurance

networks (HINs)]) (“ Compmhensive Health Reform Act of 1992”). HINs would arrange for the purchase of health insurance and could also negotiate payment rates and selective contracts with health care providers “for the purpose of obtaining favorable health insurance rates for its members. “[12] The Bush plan hopes to achieve universal coverage by mandating the purchase of at least a basic benefit plan, to be specified by Congress.

S. 1872 (Bentsen), the Better Access to Affordable Health Care Act of 1991 is an example of “small **group reform.” S.** 1872 would expand insurance coverage by increasing self-employed individuals’ tax deduction for health insurance expense to 100 percent and through small employer health insurance reform. The bill provides for grants to help States develop health insurance group purchasing arrangement for small employers (i. e., employers with 50 employees or fewer), and begin the process of developing and enforcing standards for guaranteed eligibility, renewability, limits on pm-existing condition exclusions, and preemption of State mandates by a Federal package of basic benefits. Among other things, the Bentscn bill specifies **two** packages--a “basic” (bare bones) and a “standard” benefit package-f minimum benefits that insurers offering health insurance plans to small employers in a State must offer (sec. 21 13).

H.R. 5936 (Cooper and Andrews), The Managed Competition Act of 1992, is **a far-reaching example** of a **“managed competition”** approach to health care reform. The bill uses strong tax incentives to encourage providers and insurance companies to form health partnerships which will be publicly accountable for costs and quality. Large regional purchasing cooperatives (Health Plan Purchasing Cooperatives [HPPs]) would give individuals and small businesses the benefits of greater buying power. A national health board will establish a “uniform set of effective health benefits”; in order to have tax-favored status, health plans will be required to offer those standard benefits, comply with insurance reforms, and disclose information on medical outcomes, cost-effectiveness, and consumer satisfaction (Conservative Democratic Forum Task Force on Health Care Reform, ‘[The Managed Competition Act of 1992: Highlights, ” Washington, DC, September 1992).

Other managed competition plans that would apply to the nation as a whole as a whole include "The 21st Century American Health System" (the Jackson Hole Group's plan [Ellwood and Etheredge, 1991], which provided much of the basis for H.R. 5936) and the Clinton/Gore Health Plan (Clinton/Gore Campaign, October 1992). The Clinton/Gore Health Plan differs from H.R. 5936 in that, in addition to the use of managed competition, Clinton/Gore propose: a national health budget; some price controls (e. g., on prescription drugs and on fee-for-service care) [13]; and universal coverage (through mandatory coverage of employees and their families through employer-based health plans, and a public plan for unemployed people).

Other proposals. Some proposals introduced in the 102nd Congress do not easily fit into any of the categories named above. These include:

- H.R. 3229, the U.S. Health Services Act, introduced by Congressman Dellums in the 102nd Congress, would set up a single delivery system to provide a full range of mental and other health services through the facilities of the U.S. Health Service. There would be no charges for services.

- H. R. 5502 was intended to "establish the framework for a health care system that will bring about universal access to affordable, quality health care by containing the growth in health care costs, by improving access to and simplifying the administration of health insurance, by deterring and prosecuting health care fraud and abuse, by expanding benefits under the Medicare program, by expanding eligibility and increasing payment levels under the Medicaid program, and by making health insurance available to all children. "[14] Some of the Medicaid and Medicare amendments of H.R. 5502 were folded into a combination tax and urban aid package passed at the end of the 102nd Congress; at the time this background paper was being prepared, it was unclear whether this measure would be vetoed by the President (Pianin, 1992).

11 As an example of a different strategy for categorizing reform **approaches,** Henry Aaron of the Brookings Institution addressed two objectives of health care reform and analyzed three different approaches to achieving each of the objectives: Aaron compared "national health insurance, " "tax credits, " and an "employment-based, public backup" system as approaches to achieving universal coverage, and "competition, managed competition, " and "budget limits" as approaches to controlling the growth of health care costs (Aaron, 1992). According to Aaron, "No necessary connection exists between cost control and extension of coverage, but most who advocate national health insurance espouse budget limits to control costs, and most who advocate tax credits support market competition to control costs. Advocates of extending employment-based insurance support managed competition or budget limits" (Aaron, 1992).

12 HINs as defined in H.R. 5919 are similar to HPPCS as defined in H.R. 5936.

13 However, according to Clinton/Gore, "managed competition, not price controls, will make the budget work" (Clinton/Gore Campaign, October 1992).

14 To help contain costs, Title I of H.R. 5502 sets a national health budget **for total public and** private sector health care expenditures and establishes maximum payment rates to **providers; it also provides incentives** for expansion of qualified HMOs. Title II sets health benefit plan *standards (e.g.,* plans may not deny, limit or condition coverage based on the health status of an individual), mandates procedures for administrative simplification (e. g., uniform claims requirements, uniform hospital reporting), establish= procedures for dealing with fraud and abuse by health benefit plans, and has provisions for malpractice reform and uniform reporting of patient outcomes information. Title III expands Medicaid eligibility and sets a floor on Medicaid payment levels for inpatient hospital services and physicians' services; expands Medicare benefits to include well-child care for children under age 7 and prescription drugs; increases and makes permanent the deduction of health insurance costs of self-employed individuals; and establishes a program of health insurance for children under age 19 by adding a new title to the Social Security Act.