Dynamic Chiropractic

CHIROPRACTIC (GENERAL)

What the Clinton Health Reform Plan Means to You

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Wake up doctors, it's here, the 239+ page document that has been referred to as the most complicated plan since the Salt II Treaty (the treaty that resulted in the dismantling of nuclear weapons by the U.S. and the Soviet Union). It combines the complexity of this year's furious deficit reduction fight with the emotional punch of a debate over the issue of life and death. It has such an impact over the life of the American people that the Washington Post recently identified over 1,100 major groups and associations that have an interest in this matter. It is also a proposal which the president's chief public advocate, former Surgeon General C. Everett Koop, has claimed is completely open to change. Everything is on the table and all provisions are negotiable. It is also a proposal that Clinton has staked his entire presidency on. What is it? It's the Clinton health plan (aka the America Health Security Act), whose purpose is to revamp the current health care system. If successful, it will affect the manner in which you and every other health care provider practices in this country. Doctors, this is serious.

General Provisions of the Plan

The Clinton health plan, as generally outlined by the president during his speech to the American people in late September, has two principle objectives: provide comprehensive health care to every American; come to grips with the spiraling cost of health care, which many estimate will represent more than 20 percent of the gross national product (GNP) by the turn of the century. The goal of universal coverage is admirable and necessary, and not subject to debate. The public wants it; the Republicans and Democrats want it. How to pay for this coverage and how the president intends to bring the spiraling cost of health care under control is what makes this effort the most complicated and controversial since the battles fought in Congress in the 1930s over social security, and in the 1950s and 1960s over civil rights. Before discussing how this measure affects this profession, the following is a general overview on how the plan will be implemented.

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The fundamental premise of the Clinton health plan is to develop a structure which will emphasize cost effectiveness. In one fell swoop, Clinton hopes to change a health care system that has been in effect for decades in most sections of the country (less so in California), from the provider having carte blanche (ordering any tests or treatments to cure the condition regardless of the cost of the procedures or necessity), to a system where the cost and necessity of the procedures are almost as important as the success of the procedures.

Under the new system, Americans would obtain health care coverage through state established "health alliances" representing most employers and individuals in a geographic areas. The alliances amount to giant insurance buying pools or purchasing cooperatives, linking large numbers of consumers together, giving them greater clout in the marketplace and spreading their risk widely.

Each year the alliances would collect money from employers and individuals and contract with health care plans (be they HMOs, fee for service plans or hybrids) which meet the standards established by the federal government. Each consumer within the geographic area would have the opportunity to pick from plans offered within the alliance. There is no upward limit on the number of plans an alliance must offer. But every alliance must offer at least three plans, of which one must be a fee-for-service plan. To assist the consumer in making a decision on which plan to choose, the alliance would publish information on the cost of the various plans and list the doctors and hospitals participating in each plan. The alliances would also issue annual "quality performance reports" on each plan.

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Under the plan, both the employer and employee would share in the cost of the coverage. An employer would be required to contribute at least 80 percent of the average premium for the standard benefit package in an alliance. The employee would pay the remainder, the employer could pick up the entire cost (there really is a Santa Claus). If employees choose a plan with a lower than average premium, they pay less than if they choose one with a higher than average premium. Individuals would also be asked to pick up a portion of most doctor and hospital bills, generally 20 percent under a traditional fee-for-service schedule, or $10 per visit if the individual enrolls in a health maintenance organization (HMO) or network. There would also be an annual deductible of $200 for each individual and $400 for each family under the fee-for-service plans. HMO and other networks would generally have no deductible. Each year, out-of-pocket expenses would be limited to $1,500 for individuals and $3,000 for families. In case you haven't noticed, Clinton's health plan discourages the use of fee-for-service plans.

Companies with more than 5,000 employees would be allowed to form their own "corporate alliances," but they would have to provide the same federally guaranteed benefits' package and meet virtually all other government guidelines.

Overseeing the system would be a National Health Board with seven members appointed by the president. The board would have several responsibilities, the most important, and potentially the most explosive, would be setting the budgets in the form of "premium targets" for the regional alliances. The budgets for each alliance would be fixed and not subject to negotiation. The average bid submitted by health plans seeking to do business with an alliance could be no greater than the targets.

Unfortunately, while the concepts sound great, the goblins are found in the details.

How Does Chiropractic Fare in the Clinton Proposal?

If you listened to the president's speech and read the quotes from unnamed administrative sources in newspaper articles about the role of nonphysican providers, you should feel pretty good. In his speech, the president made a point of saying that the public's ability to select a provider of choice is a fundamental right which will be upheld in the new system. A recent L.A. Times article detailed at length that nontraditional practitioners would be allowed to participate in the plan with the same opportunity as medical practitioners. One unnamed administrative source was quoted as saying, "We have provided a level playing field for all providers" (music to my ears). Even the preamble of the plan contains statements which indicate that the new system would be

nonphysican friendly. Unfortunately, while the concepts sound great, the goblins are found in the details. Following are some of the positive signs:

- The term "choice" is listed in the plan's document as one of the key ethical foundations of the new health care system and includes the following statement: "Each consumer would have the opportunity to exercise effective choice about providers, plans and treatments. Each consumer should be informed about what is known and not known about the risks and benefits of available treatment and be free to choose among them, according to his or her preference."

- The guaranteed benefit package, which must be provided to all Americans, requires that each health plan include, in part, "services of physicians and other health professionals," and "outpatient rehabilitation services." Services of physicians and other health professionals are further explained to include "inpatient and outpatient medial and surgical professional services, including consultations, delivered by a health professional in home, office or other ambulatory care settings and in institutional settings." So far, very encouraging.

- Two important definitions add to our comfort level. Health professionals are defined as "someone who is licensed or otherwise authorized by the state of deliver health services in the state in which the individual delivers services." Covered services are defined as "those services that a health professional is legally authorized to perform in that state." If would have been better if chiropractic services were specifically listed, but this statement isn't bad. We read further, "No state may, through licensure requirements or other restrictions, limit the practice of any class of health professionals, except as justified by the skill or training of each professional."

So far so good. Services included within our scope of practice would be covered by all health plans. The anti-descrimination language prevents states from arbitrarily reducing our scope.

There are other parts of the plan worthy of support, including the introduction of a single insurance claim form which simplifies paperwork and reduce administrative costs; changes to malpractice, although it appears that those changes which do occur are already in effect in California; and favorable comments about contributing more federal dollars to nonphysican schools, although later in the plan only physician assistants and nurse practitioners are specifically mentioned. Lastly, chiropractic is not among those procedures listed under the exclusion section of the plan.

That's the good news. However, there are some real areas of concerns in the proposal.

This is a double whammy. Not only can the plan exclude the chiropractic profession, but if a plan decides to include them, the number of DCs allowed to participate can be limited and patients subjected to the requirement that the treatment be referred by a gatekeeper.

1. Every regional alliance can only contract with health plans which include all the services listed in the guaranteed benefits' package: by inference this includes the services provided by a doctor of chiropractic. Unfortunately, those plans which aren't fee-for-service (i.e., HMOs or networks) have the right to determine which practitioners or group of practitioners may deliver these services. One part of the president's plan states that a plan is "expected to provide a sufficient mix of providers

and specialties and appropriate locations to provide adequate access to professional service." On the other hand, non fee-for-service health plans are authorized to (a) limit the number and type of health providers who participate in the health plan; and (b) require participants to obtain a referral for treatment by a specialized physician or health institution (aka the gatekeeper).

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I think the profession realizes that managed care is here to stay, as long as the public accepts this. But if you have a gatekeeper, which is an integral part of an HMO, allowed to operate without the fear of anti-discrimination statutes, history indicates that under this arrangement, referrals to doctors of chiropractic seldom, if ever, occur.

2. There is an encouraging statement that an alliance must contract with any health plan which meets the requirements of the federal government (cost and minimum benefit package). It further states that an alliance "may not discriminate against health plans or providers on the basis of race, gender, mix of health professional, or organizational arrangements." To most outsiders this would be pointed to as an opportunity for chiropractic plans to be eligible for approval. Unfortunately, since the plans must provide all the services and benefits, including hospitalization and physician services, it would be difficult for a chiropractic plan to provide the full service of benefits necessary to qualify for the plan. Accordingly, they would have to contract with a full-service health plan.

3. Every alliance must include at least one fee-for-service health plan, and if individuals enroll in such a plan, they have direct access to any health care provider, including a doctor of chiropractic, without a gatekeeper referral. That's the good news. The bad news is that Clinton's intention is to move away from a fee-for-service to a capitated system. He has intentionally made fee-for-service substantially more expensive for the employee than the HMO or network plans. (You will recall earlier in this article, I discussed the deductibles and other costs for those enrolled in the fee-for-service plan).

4. More discouraging news is that the plan allows workers' compensation benefits to be folded into the system. This is may be one of the most dangerous provisions. A health plan approved by the alliance may qualify to be certified by an individual state to provide workers' compensation services. Injured workers enrolled in such a plan could only receive care from providers within the plan. In other words, the federal benefit package would supersede the state's workers' compensation benefits, which for California is a serious erosion of chiropractic access. The plan states: "State laws regarding choice of provider for workers' compensation cases are overridden with respect to individuals covered through health alliances." If a health plan fails to include doctors of chiropractic, which non fee-for-service plans are permitted to do, and said plan is certified to provide workers' compensation, an injured worker would be denied chiropractic care. Where is the choice?

5. Lastly, there is a provision calling for folding in auto insurance. However, the same kind of exemption on freedom of choice isn't included under this provision. The plan isn't clear on how auto insurance will be implemented. We need to watch this closely as clarification in this matter unfolds.

Overall Evaluations

It needs to be repeated that the proposal is just that, a proposal, subject to change. Additionally, once approved, it will first be tested in nine states, with the most optimistic date of 1995 for the start of the pilot project. That aside, this plan needs to be taken seriously.

First, after reviewing the concerns outlined above, you are probably asking yourself was the administration serious when an unnamed White House source was quoted as saying "nonproviders were being given a level playing field?" Frankly, I believe the plan contains many positive statements about nonphysican providers which a few years ago or under a different administration would not have been possible. I think the administration is serious and feels that they have gone a long way in addressing the concerns of nonphysican providers. They believe that market forces will convince the HMOs to utilize chiropractic care. And with the tight fiscal control which states and their appointed regional alliances will have over health plans, this profession could possibly do better than in today's managed care environment. With ERISA laws being preempted for those businesses which employ less than 5000 employees, the opportunity for new markets for this profession are present, at least on paper. However, I think we can all agree that without anti-discrimination language, most medical gatekeepers will revert to their old ways and ignore the pleas of their plan's administrators to refer patients to chiropractic doctors, maybe not as often as occurs today but enough to hurt our participation.

Unless the administration assures provider choice under workers' compensation, injured workers will lose their fundamental right to choose a doctor of chiropractic. Much needs to be done with this plan before it gives this profession and other health providers a "level playing field."

Does the President's Plan Have a Chance to Pass Congress and Be Signed into Law?

The text books say that in a democracy public opinion determines the course that government takes. Political insiders however know that on most issues this does not occur: partly because the majority of the public doesn't feel a personal enough interest in the issue to voice their opinion to their legislative representatives. In this environment, special interest groups with their PACs and prestige are able to impact the direction legislation will take.

But health care is a different issue. It has the interest of the public. Over the last couple of years, the public has listed health care as second only to the economy in terms of concerns. As health care costs continued to increase, with the consumer having to pay more for less, and many fearful of losing their insurance coverage, Americans have increased their interest in seeking health care reform. On the eve of the president's speech, 78 percent of those interviewed felt that the current health care system does not meet the needs of most Americans. That is a tremendous margin and any congressional representative who will be seeking reelection in 1994, which is the entire congressional delegation and one third of the Senate, will be looking to meet the needs of the voters in this regard. While the voters need for reform is clear, it is very unclear what the voters believe to be the "right" health care system to be implemented. While they don't like the current system, they are fearful of the cost and potential coverage of any future program. This is what modern day democracy is all about, and while the environment is ripe for reform, whether it will happen in the next couple of years isn't certain.

Let's review the players involved in seeking reform and the goblins waiting in the weeds to stop such an effort. The Democratic party, and more specifically, President Clinton, begin with a distinct advantage in getting the Clinton health care bill passed and signed into law. For only the fourth time in the last 50 years, the individual occupying the White House comes from the same political party that controls both the U.S. Senate and the House of Representatives. In the 1930s, President

Roosevelt used this advantage along with an ability to communicate with the public, to radically change the direction and role of government by passing significant social legislation, including social security. In 1965, President Johnson had the same advantage and through legislative skill and scare tactics passed controversial legislation, including civil rights and Medicare, which for years and years had languished in Congress. In 1976, President Carter had the advantage, but was never able to rally the Congress and the American people behind his program. The question is, does Clinton have the ability, like Johnson and Roosevelt, to mobilize the American people and Congress behind his proposals, or will he become the butt of a new generation of Carter jokes?

Already the president has sent signals over his willingness to compromise over health reform. His chief spokesperson within the medical community, Dr. C. Everett Koop, said recently that nothing in the proposal was sacred; everything is on the table.

If you analyze the first nine months of the Clinton presidency, you would have to conclude that he will end up like Carter, mistake-prone and unable to pass significant legislation. However, we would be mistaken to take too much comfort from this possibility since he has shown in recent months the ability and desire to compromise, something Carter was never willing to do. The recent battle over the budget was a case in point. This is a president with no strong ideological bent. The budget which was signed by the president looked nothing like the one introduced by him initially or for that matter, the type that was passed by the House of Representatives.

Already the president has sent signals over his willingness to compromise over health reform. His chief spokesperson within the medical community, Dr. C. Everett Koop, said recently that nothing in the proposal was sacred; everything is on the table. Clinton already let it be known that if the issue of paying for abortion, a strong part of his presidential platform, was holding up the passage of his health plan, then he is willing to discard it. This is a guy focused on winning who will push any kind of comprehensive program which is able to gain the support of the majority of the public and Congress.

Clinton starts off with some clear advantages that he didn't have with the budget. First, the Republicans are no longer a solid block of opposition against reform as they were with the budget. A significant group of Republicans, mostly moderate, led by Senators Dole and Chafee have introduced a health plan with features strikingly similar to Clinton. While issues like how the plan is to be paid for are different, the Republican plan acknowledges the need for universal health care for all and emphasizes that government must play a role in determining the minimum benefits package. These are conciliatory positions of some significance. Some can argue that the Republicans have introduced this conciliatory measure because they read the polls and don't want to be accused of being obstructionists over this issue. Maybe so, but it's better for Clinton's purposes in winning the hearts and minds of the American people to be able to point to some Republican support for the basic parts of his plan. The White House is clearly pleased with this development.

There are other positive signs for Clinton. Two powerful groups have lined up behind the plan: the 32 million members of the American Association of Retired Person (AARP), and the fourteen million members of the American Federation of Labor and Congress of Industrial Organizations (AFL-CIO). So far, with the exception of small business and the insurance community, groups like the American Medical Association (AMA) have been cautious about their opposition. Frankly, they are afraid that if they come out too early against the measure, they won't be at the table 12 months from now when the deals are cut and a compromise bill is enacted.

So the Clinton plan appears to have a lot of things going for it: public support for health care reform, a president willing to compromise, a Congress dominated by the same party, and many of the potential opposition members fearful of retaliation. Yet there is much out there that indicates the passage of this measure will be very difficult and maybe impossible.

First of all, the sheer number of groups that are affected by this measure will mean that it faces a rocky future. Over 1,100 associations with 1,100 political action committees, 1,100 lobbying groups, and 1,100 separate public relations' programs. Those involved in the delivery of health care, including this profession, will weigh in with all of their respective resources to affect the outcome.

The insurance industry has a particular stake in the outcome and will be particularly active. Under the president's plan, hundreds of health insurers will be forced out of their services, pushed aside in the name of HMOs and networks. Of the current 500 or more health insurance companies, it is estimated that only five or six major ones will survive.

Likewise, there is no role for insurance agents and brokers as "alliances" will fulfill their role in this system. Attorneys will also have a stake in the outcome of this measure, because of the proposed changes in malpractice. Small business obviously suffers in the current proposal with the requirement that they pay 80 percent of every employee's health care. Faced with this new requirement, it is estimated that many small businesses will not survive.

But the issue which may eventually doom this proposal is how the entire plan will be funded. You might have noticed that the president didn't discuss this issue when he talked to the Congress and the American people. That is probably because the administration hasn't come to any absolute conclusion. Even the cost of the program is subject to controversy. The administration has projected that the plan would cost $100 billion, but this is based on significant savings in the Medicare and Medicaid programs which many prominent Democrats, in and outside the administration, are already criticizing.

Congressman Waxman, the very powerful chairperson of the Committee on Health, has been sharply critical of this projection. Senator Patrick Monihan, chairman of the Senate Finance Committee, and the principle architect and proponent of the Clinton budget, has stated publicly that there is no way he will allow such cuts to occur in the Medicare system. Whether the cost is $100 billion or $150 billion, the contributions by employers and employees will not be sufficient to cover the cost of the plan. Right now the only thing that is fairly certain is the imposition of a "sin tax" on cigarettes and even that isn't a certainty, since in a close vote, Clinton may have to compromise with senators and members of the House of Representatives from states where tobacco is the major economy.

So the bottom line question remains: Who will pay for this program, and how much more will the employees who already have to pay 20 percent of their health care have to contribute so that everyone has health care? There is already talk about a tax on providers, a "value added" tax. The question of payment, how the public thinks it will adjust to a managed care environment, and whether they feel they will still get the same level of service will be the determining factors in whether there is health reform and in what form.

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Even now, the polls are subject to flux. While everyone supports health reform and the need for

change, that support begins to erode substantially when the consumer's right of choice is brought into question or the consumer is asked to pay a higher price for the service. This issue may take on the same pattern of public opinion that occurred during the battle for the budget. When asked during the budget battles whether the American people were concerned about the tremendous deficit and whether they would support steps to correct it, there was overwhelming support for reform. However, when the solutions to these problems surfaced, including higher gas and personal taxes, the support eroded tremendously. Undoubtedly, this will happen with health reform, particularly when so many powerful interest groups are willing to spend their resources to point out all of the flaws in the plan. I think it can be assumed that what the president has proposed will not be the final document. It's possible that the issues are so controversial that a consensus will never be found. But I wouldn't bet the mortgage on it. And if you don't get involved, that is exactly what you may be doing.

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What Can You Do As a Doctor and As an Association Member?

This measure's fate depends on public opinion. Any vote that a member of Congress is going take on this issue will hurt his position with one or more powerful interest groups. Naturally, the majority of Congress will base their votes on where the majority of the public in their community is going on the issue. You need to get yourself and your patients involved in informing your representative about the down sides of the proposal and keep up the pressure.

There is something else of equal importance that every doctor and state association must keep in mind. Their state, regardless of whether this plan is adopted, will play an active role in any health care plan. If the Clinton proposal gets bogged down in Congress and is overwhelmed by the smoke and power of the opposition, there will be public clamor for individual states to develop their own comprehensive plans as Florida, Vermont, Minnesota, Hawaii, and Oregon have done.

If the Clinton plan is adopted, individual states will have tremendous clout in its implementation. First a state has the option to impose a single-payer system where state government contracts directly with the providers for services, thereby scrapping the Clinton plan. I really don't see this happening in California but in smaller states it is a possibility. If the state adopts the Clinton plan, their power will remain substantial. An individual state has the authority to not only approve and certify regional alliances but also determine their size and make up. The biggest battle in the state legislature could evolve around what these alliances are to look like. There could be just one alliance in a state or many. They could be run by the governor, the department of insurance, some other governmental entity or a private, non-profit corporation. The states will have to monitor closely the alliances and make certain they really do bargain for good health care and that good health care is provided to all citizens. The information distributed by the alliances to the consumers about the various health plans available will also be closely scrutinized by the state.

The states will also be responsible for establishing the criteria for health plans to be certified to provide workers' compensation and auto accident services as well as establishing a fee schedule for both. It will be politics as usual on the state level and every association needs to be prepared.

The question is do you take the threat against your profession seriously enough?

How many times have you heard it said that for your sake and the sake of the profession you need to get involved? You need to join an association? Most of you have ignored the warning and allowed others to carry the water and, in the end, you survived. This time however, you better "read the tea leaves." What is happening in Washington, D.C. hasn't happened before in the area of health care. Either you help this profession by getting involved and supporting the efforts of your state or national organization or you may find yourself someday looking at a different career. It has been reported that the administration acknowledges that over the next five years over 200,000 Americans will lose their jobs as this new system is implemented. The administration has already earmarked money for retraining some of these individuals. They are serious about making change, regardless of the costs. The question is do you take the threat against your profession seriously enough?

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