

VISIONS AND REVISIONS: VIEWPOINTS ON NUCLEAR MEDICINE AND HEALTH CARE REFORM

ALL DISCUSSION OF HOW PRACTICE guidelines, outcomes research, and the changing physician workforce will affect and fare for medical specialties after health care reform is moot until specific legislation is enacted. Certainly, practitioners are trying to anticipate how any reform measure will affect them and steer political forces in the direction that will most benefit them and quality care. But many sources have cited that the current health care political process has generated some of the most intense debate in legislative history (for 1994, advertising expenditures on the topic will exceed \$60 million, more than advertising dollars for the combined 1992 Bush and Clinton campaigns); the amount and minutiae of the proposals can only confound the average person. Five Congressional committees proposed major bills, and there was an assortment of miscellaneous health care amendments, besides the several moderate and conservative proposals by several Congressional members, such as Sen. Robert Dole, and the compromise bill from either chamber of Congress, and the final compromise between the two houses—and of course, the Clinton Plan at the center of it all. But along a certain line of logic, some sense emerges through the chaos, along with nuclear medicine's part in it all.

From Clinton to Nuclear Medicine

The thread of logic begins with President Clinton's health care proposal and continues with the responses of individuals and factions in Congress to particular points within the plan. The central tenet of Clinton's plan was universal health care (see *Newsline*, November, 1993, p. 32N), meaning that everyone, including the estimated 15% uninsured portion of the population, would always be insured, no matter if unemployed, between jobs, or possessing a costly medical history. Although a July CBS/*New York Times* poll showed that 79% of Americans favored universal care, and most liberal, moderate, and some conservative camps have acknowledged the need for it (or its approximation), the major political disagreements have arisen over the timetable and the financing. In the medical community, the concern has been that some proposed means of obtaining universal care could affect the patient's choice of physician, and possibly quality of care, particularly if health maintenance organizations

(HMO's) become the primary means of providing universal care and cutting costs. Nuclear medicine and other specialties have been concerned that the proposal to attain universal care by increasing the percentage of primary care physicians may affect graduate medical education, and how much latitude a patient may be allowed to go outside his or her health plan to obtain specialty services. General and specialist medical societies make up only a fraction of the forces attempting to influence legislation; insurance and pharmaceutical companies, labor unions, disabilities organizations, and consumer advocates also seek to assure that their own, sometimes conflicting needs are met.

"From a policy viewpoint, we have determined that we would not spin our wheels like [some generalist societies] to address general issues," said SNM President James J. Conway, MD. "We would address those specific issues that would affect nuclear medicine, like manpower."

Although SNM has not endorsed particular legislation or general platforms such as universal care, it has taken specific steps in response to health care reform. The history of the health care reform legislation can put the response on SNM and other medical societies into perspective.

The Congressional Proposals

August is the month—before the Labor Day recess—that Congressional leaders slated to complete both chambers' reform proposals. With elections coming in November, Congress members may be feeling the pressure to show action on this major issue.

Two Senate and three House committees proposed health reform bills after the beginning of the year. The House Energy and Commerce Committee reached a deadlock on the issue this spring and relinquished its effort. Due to Congress' power structures, Capitol Hill observers noted that the House Education and Labor Committee's proposal would



Capitol Hill debates on health care reform could eventually influence the direction of nuclear medicine.

SNM has yet to endorse a general reform measure, but many medical societies have backed consumer choice.

likely exert the least influence on the final bill, whereas the Senate Finance Committee, which guides how funds in general are to be spent, is highly influential. The Senate Labor and Human Resources Committee, chaired by Sen. Edward Kennedy (D-MA), devised a bill that closely resembled the Clinton plan, with some changes in requirements for workplace insurance coverage to protect companies with five or fewer employees, and with extra support for women, children, the disabled, and the mentally ill. Another bill similar to the Clinton plan, from the House Education and Labor Committee (perhaps the least influential of the five committee's that drew up bills), offered the President's major points: universal coverage, choice of health plans, private insurance for most workers, subsidies for small business, and cost controls. Revealing the divisiveness of the whole issue, this bill passed the committee 17-10, split straight down party lines.

But the House committee bill that formed a large part of that chamber's final bill on July 29 came from the House Ways and Means Committee, based in turn on the plan from the Subcommittee on Health. To achieve universal coverage, this proposal evolved from a single-payer system. Subcommittee chair Pete Stark's (D-CA) plan expands Medicare by creating a new category for which companies employing fewer than 100 workers would qualify if they had no private coverage. Compared with the system proposed by Rep. Jim McDermott (D-WA), a former Seattle psychiatrist and de facto leader of the House's single-payer faction, Stark's bill was a very diluted version of "single-payer." Closer to the Canadian system, McDermott's faction would rather not allow exemptions for any size company while giving every state the option for a single-payer system. All citizens would be automatically enrolled in a national insurance program administered by the states and paid for by payroll taxes, a 2.1 percent tax on individuals' taxable income, a \$2 cigarette tax, and excise tax on handguns and ammunition. The single-payer faction is about 90 strong in the House, and their platform is generally viewed by the rest of the House as too radical to pass, but they do not promise to place their votes with a moderate package, and could possibly ally themselves with conservatives in a "nay" vote. House majority leader Richard Gephardt promised to include this factions' leaders in the final bill-drafting meetings.

As stated in his November 18, 1993 letter to the Ways and Means chair (then Dan Rostenkowski), Stark's plan began as a single-payer proposal. Sam Gibbons' (D-FL), current Ways and Means chair, has said that he personally favors a single-payer system, but in deference to the Administration has acknowledged that he would have com-

promise his personal views to obtain universal coverage. Thus, in full committee, the Stark plan evolved, until the plan passed by Ways and Means on June 30 offered to create the new Medicare category to cover individuals not covered elsewhere, and to allow states the option of forming mandatory alliances. As with the Clinton plan, it retained the requirement, unpopular with conservatives and some moderates, that employers pay up to 80% of their employees' premiums, with tax credits and varying percentages of premium payments for smaller firms. Compromises with the many representatives from tobacco farm states lowered the cigarette tax from \$2 to 45¢; the bill also included a two percent tax on health insurance premiums.

The Senate Finance Committee's bill received a great amount of attention from commentators and media, as the committee originates congressional financing, which health care reform likely will require. It also represented a significant compromise between Clinton's universal coverage and conservative calls for, at best, gradualism: it gave employers and states a chance to voluntarily bring insurance coverage up to 95 percent of the population by the year 2002, when a national commission would determine how to bring about universal coverage. The bill had no mandate for employers and created voluntary insurance pools for individuals and small businesses. To reach many uninsured, it also established a standard benefits package similar to that for federal workers. Besides a cigarette tax, it raised money by taxing expensive insurance plans and charging affluent Medicare recipients higher premiums.

A report by the Congressional Budget Office in late July found that the Finance Committee bill would not only insure 20 of the 39 million uninsured but would save the federal government money. The bill had a built-in fiscal-responsibility mechanism that automatically reduced subsidies and thus insurance coverage if expenditures were about to exceed receipts. The Administration, intent on universal coverage, remained unimpressed with such savings. "We doubt that leaving tens of millions of hard-working Americans without real health security will be acceptable to the public," White House spokesperson for health told the *New York Times*, hinting of the compromise hurdles ahead.

The Medical Community Response

Prominent physician groups, like the American Medical Association (AMA) have generally supported consumer choice, whatever the reform measure that arises from the battles. Earlier in the year, when the legislative process was just taking off, the role of health maintenance organizations (HMO's)

was prominent in reform discussions, and HMO lobbies were working Capitol Hill. Although the Clinton plan used the concept of "managed competition," readily lending itself to HMO-type service, the bills that emerged from Congress tended more toward the "any willing provider" or fee-for-service concept.

An AMA poll released in April showed that about three-quarters of Americans would prefer to pay more and select their physician and hospital and get immediate care than to pay less and lose the flexibility. Beginning soon after the Clinton plan's release last fall, the AMA, without particularly backing or completely lambasting any plan, has been campaigning for freedom of choice. Its December 1993 publication, "Preserving Choice in Medicare for the American People," while condoning President Clinton's proposal for universal coverage and for controlling health care costs by "putting consumers in the driver's seat," took issue with managed competition: "the range of choice would ultimately be limited... The AMA feels that the President's plan can be enhanced and strengthened by *expanding* the fee-for-service health plan choices that his plan gives consumers."

Not every medical professional society took up the AMA's position. The National Medical Society and the American Medical Women's Association endorsed Rep. McDermott's plan, and the American College of Surgeons (ACS) stated that a single-payer system appeared to be the best method to preserve consumer choice. "Moreover, single-payer approached can probably be made more simple and more workable administratively," ACS board of regents chair David G. Murray, MD, testified before the House Committee on Education and Labor. (The AMA has strongly opposed single-payer systems.) The American Urological Association endorsed Rep. Stark's bill. And even a controversial JAMA editorial by editor George D. Lundberg, MD, using "expert assessments" to grade the Congressional health reform proposals, using an 11-item evaluation ("Provide access for all to basic care? Produce real cost control? Promote continuing quality?"), found that Rep Stark's proposal scored the highest.

The AMA's single-minded and persistent lobbying may have affected the direction Congressional bills have taken through this summer. "It's clear that forces like the AMA must be glad that HMO's have not come out well in the Congressional proposals," said Henry N. Wagner, MD, chair of SNM's Health Care Reform Committee. "The AMA has done a thorough job and has managed to have a significant impact on Congress."

Where Nuclear Medicine Fits In

Ever since President Clinton's September 22 presentation, the SNM has been investigating what role it may play in health care reform and how may best assert its interests (see *Newsline*, November 1993, p. 32N). J. Michael Hall, director of legislative affairs at the SNM/ACNP Joint Government Relations Office, said that the two issues that his office has been working for in legislation, in the interests of nuclear medicine, have been: "the Graduate Medical Education issue—[and thus] how many nuclear medicine physicians are trained; and point-of-service, to permit the patient to go out-of-plan for specialty care,

Reform in the States: The Hawaiian Example

Whatever Federal bill is finally worked out, much of its execution will happen—as with Medicare and Medicaid—at the state level. But many states have already enacted some form of health care reform, and one in particular, Hawaii, has adopted many of the measures that appear in several Federal reform proposals: the goal of universal health insurance coverage, employer mandate, subsidies for low-income residents, and reductions in cost-shifting. Some proponents of similar, Federal measures have proffered the Hawaii example, but critics point out that Hawaii is a special case that the rest of the country cannot emulate and besides the system is not working as well as proponents contend.

A February 1994 General Accounting Office report, "Health Care in Hawaii: Implications for National Reform," laid out the pros and cons. Uninsured Hawaiians number 3.75-7.0%, the lowest of any state in the union. Yet the states' government insurance programs still do not ensure universal coverage, and some insured citizens, particularly Medicaid patients, do not have access to all health services. Two unique factors laid the groundwork for Hawaii's health program: a history of "plantation medicine," in which a plantation employed doctors to provide free care for its workers; this led to a tradition of employer-provided health benefits. Also, Hawaii's special exemption from the 1974 federal Employee Retirement Income Act allowed the state authority to regulate employer health plans. In 1974, Hawaii extended health insurance coverage with the Prepared Health Care Act, the "employer mandate," under which employers and employees share premium payments. Residents without such insurance may qualify for Medicaid or for the State Health Insurance Program, established in 1989 to cover the "gap group."

Despite the mandate, certain kinds of workers—part-timers, government employees, the self-employed—who are given the option, may choose not to purchase insurance. Also, due to waiting periods, or to an individual's recent unemployment, some Hawaii residents go without coverage. Others who are covered may not have access to certain treatments, like that from comprehensive trauma facilities, because of the remoteness of some islands and the difficulty of travel between them. Although the state has a higher than average per capita physician ratio, some private care providers limit the number of Medicaid patients because of Medicaid's low reimbursement rates. On the other hand, Hawaii has lower insurance premiums than other states, although per capita health care expenditures are average.

Critics are not satisfied by even other gaps in coverage. "The state of Hawaii is under a U.S. Department of Justice injunction to comply with national standards relative to the care of children and adolescents.... Hawaii's mental health system is rated last in the nation," write one physician, Alfred M. Arensdorf, MD, of Hawaii, to JAMA. Another physician wrote to the same journal, "The assumption that the Hawaiian program has led to better health indexes is not documented."

Still, supporters of the Hawaiian system contend that the state's experience provides a model or forum for anyone developing federal health care reform policy.

—Lantz Miller