
VIEWS OF A HEALTH POLICY ACTIVIST: A CONVERSATION WITH HENRY WAXMAN

by John K. Iglehart

Prologue: *Representative Henry Waxman (D-CA), chairman of the House Energy and Commerce Subcommittee on Health and the Environment, has emerged as one of the most powerful members of the House. The chairmanship is his most important platform for implementing his views favoring a broadened federal presence in health care. But it is only one source of his power base. Waxman, who represents a Los Angeles district that has concentrations of Jewish and gay constituents, has handily won reelection since 1974. With his own seat assured, Waxman has devoted considerable energy over the years to helping elect like-minded politicians through the entirely legal practice of providing them campaign contributions, generated in part from friendly benefactors within the entertainment industry. Thus, a number of politicians have been helped by Waxman (and another California Democrat, Howard Berman, who together form what is known in their home state as the "Waxman-Berman machine") in their bids for election. Waxman has devoted considerable energies to the accumulation of power for one central purpose: to advance his political agenda. In pursuing this goal, with the assistance of a highly professional and like-minded staff, Waxman has teamed with Sen. Edward Kennedy (D-MA) several times to introduce legislation to create a national health insurance program and, recently, to mandate that employers provide health insurance coverage for their employees. During the stringent 1980s, Waxman has developed a reputation as a practitioner of compromise, having an ultimate policy goal in mind but being willing to accept incremental change when necessary. In pursuit of his agenda, he has clashed with such giants as the automobile industry (over the Clean Air Act) and the pharmaceutical industry (over a Medicare drug benefit). Although his philosophical views hardly reflect the mainline thinking of the hospital industry and the medical profession, he ironically has become one of their better friends on Capitol Hill because of his continued defense of federal health programs and his pursuit of additional health spending.*

The Federal Budget And Administration Policies

Q: The federal budget deficit looms as a major influence on all policy making, as you well know. But specifically, how would you address the problem, if you were in a position to propose a solution? Would you propose a tax increase, reduce programmatic expenses across the board, or seek other remedies?

A: Although there are some differences on the details, I think there is a bipartisan consensus in Congress to reduce the deficit over time by holding in place, if not reducing, military expenditures; making some limited cuts on the domestic side; and generating more revenue. I think the original purpose that many people envisioned for the Gramm-Rudman-Hollings law was to try to force the president into negotiations that would strike that kind of compromise. Obviously, that did not happen.

My own thinking on federal spending priorities would be more resources for some high-priority domestic issues—AIDS (acquired immunodeficiency syndrome), for example—and real reductions in defense expenditures. I think some of them are incredibly wasteful. Some of the large military expenditures are on systems that do not make sense. I would cut back on SDI (strategic defense initiative), the MX missile, and some of the other very costly expenditures. But I do believe the job of government is to determine and then address its priorities. I did not like the Gramm-Rudman approach because it refuses to do that—everything is cut mindlessly and equally. Its defenders say that's the beauty of it. I say it's ridiculous. There are priorities we must meet. In the health area particularly, I think increased spending is called for. The budget deficit has been used as an excuse for renegeing on our promises under Medicare and Medicaid to provide eligible beneficiaries access to mainstream medicine. But even if we lived up to the promises of those two programs, we still have 37 million Americans without any health insurance coverage and an AIDS epidemic, which is already costly and will be even more costly in the future.

Q: Has the budget process that Congress employs to set federal spending priorities been, on the whole, harmful or helpful to the causes that you generally espouse in health and welfare?

A: I think it generally has been more harmful than helpful. Good programs have been frozen or cut over and over. New problems have not been addressed. Initiatives are difficult. But, on the other hand, budget reconciliation has been the only place for us to enact most health legislation. It has been a vehicle for some improvements, but since these legislative changes have come in a revenue-neutral context, progress has been very limited. For every new dollar we authorized, another dollar

would have to be saved—often in another health program. So the reconciliation procedures have kept us from facing up to many of the health problems that loom out there. On the other hand, because the budget bill is a certain legislative vehicle every year, we have had an opportunity to make some important improvements in Medicare and Medicaid. The improvements do not go as far as I would have liked, but they have been important incremental steps.

Q: Generally speaking, you have been very critical of the health and welfare policies of the Reagan administration over the past seven years. During this period, have you discovered any redeeming qualities about this administration and its health policies?

A: We found the administration to be cooperative in developing and implementing legislation calling for the approval of generic drugs after the patents of brand-name drugs have expired. Because the Food and Drug Administration (FDA) has moved quickly to get generic drugs on the market, many of the top-selling brand-name drugs are now available as generics for prices that are 50 to 80 percent less. Having said that, though, I should point out that we have been disappointed at the FDA's failure to respond more aggressively to the multimillion-dollar anti-generic campaign being waged by the brand-name companies. The FDA's response has allowed some of the pharmaceutical manufacturers to misrepresent generic drugs as somehow different than the original brand-name products. I consider this a reprehensible activity on the part of the brand-name companies. It is to their discredit that they wage such a deceitful campaign and attempt to improve their profits at the expense of the American people. It seems to me that there are ways of competing without claiming that a competitor's product is unsafe and ineffective when they, in fact, know that is not the case.

Q: Are there other activities in which the administration has engaged that you applaud?

A: I give the FDA credit for maintaining the high integrity of the drug approval process. I give the Surgeon General (C. Everett Koop) an enormous amount of credit for his efforts to fight cigarette smoking and his work on behalf of a smoke-free society. I also give him a great deal of personal credit for his outspoken expressions on the public health dimensions of AIDS. He has been a very important figure in alerting the nation to the dangers of AIDS. I also believe that people within the Centers for Disease Control (CDC) and the National Institutes of Health have done outstanding work in fighting AIDS and other diseases. Otherwise, I have been and continue to be critical of the Reagan administration, based on its insensitivity to the needs of the elderly and the poor, on its willingness to see public health programs erode, and on its consistent efforts over the past seven years to cut biomedical research spending and thus retard research that can lead to the prevention, cure,

and control of disease.

Q: Muse for a moment about the post-Reagan years. Do you anticipate that, in terms of your health and welfare priorities, you will face the same budget-making dynamic that you have struggled with during the Reagan years, regardless of who is elected president?

A: I am hopeful, of course, that America will elect a Democratic president who is more sensitive to the social needs of the country. But even if we do not have such a president, I believe major national problems loom ahead that will be impossible for the federal government to ignore. AIDS, for example, is a problem none of us wanted or predicted in 1980 when President Reagan was elected, yet the projections of the toll of this disease are enormous. Federal and state governments are simply going to have to assume most of the responsibility for the fight against AIDS, for seeking a cure through research, for launching a massive educational effort to prevent its spread, and for caring for the people who are afflicted. But there are many other problems, too, that loom ahead, such as providing adequate prenatal care to poor mothers, health insurance for chronic and long-term care, and insurance for those millions who lack it. Whatever administration takes power, it is going to face the reality of spending more for health and medical care.

The Fight Against AIDS

Q: As you point out, the federal and state governments are heavily involved in fighting AIDS. In your view, what should the dynamic be between these several levels of government in relation to fighting the disease?

A: The best illustration of my views on that question can be found in the legislation we recently introduced that addresses testing people for antibodies to the AIDS virus and counseling them, maintaining confidentiality of the information, prohibiting discrimination against those who test positive, and pursuing medical research in relation to AIDS. The legislation establishes a federal framework of policies in these areas, but it provides states considerable latitude within the stipulated requirements. The states of California and New York, areas where the incidence of AIDS is high, have decided that it is neither effective nor affordable for them to record the names of every individual afflicted with the disease. We would not strive through our legislation to change those decisions. Some states may decide that they want to require mandatory testing of individuals seeking a marriage license; other states may decide against that course. We do not decide in our legislation to impose such a requirement. We leave that decision at the state level. The federal government would fund counseling and testing, giving more for counseling than for testing because counseling before and after testing, whatever

the result, is the key to stopping the spread of AIDS and to encouraging people to change behavior that puts them at high risk of either spreading or contracting it. On the research front, I believe the federal government will continue to bear the primary responsibility for providing the resources.

Q: You continue to be critical of the Reagan administration's policies on AIDS. What are the key differences between the Republican administration on the one hand and Republican and Democratic legislators on the other?

A: I believe the positions I espouse on AIDS testing policy are the positions of Reagan's health appointees at the Department of Health and Human Services. These are positions advocated by the Public Health Service, including the CDC, the Surgeon General, and the secretary of health and human services. So I do not see AIDS testing policy as a partisan issue. Notwithstanding the fact that its own health appointees have given clear policy recommendations, it is not clear whether the administration is going to follow those recommendations.

Q: Have you attracted Republican cosponsors for your AIDS legislation?

A: We have Republican cosponsors to our AIDS bill, but many legislators are uncertain as to what correct policy options should be adopted. This uncertainty derives in large part from the absence of leadership from the Reagan administration. What we have seen from the president is a balancing out, a compromising of conflicting views he is getting from within his administration. But that is not leadership, that is simply resolving disputes. AIDS is an epidemic that demands leadership, and we simply have not had it. History will judge the Reagan administration badly for this failing. One of the results of that failure has been to leave many members of Congress—members of the President's own party who have not been deeply involved in the issues around AIDS—with great uncertainty, lacking a clear signal of the most effective public health approach to deal with this epidemic.

Catastrophic Health Insurance

Q: Let me turn to the subject of catastrophic health insurance. Are you of the view that Medicare beneficiaries should pay for that new benefit through higher premiums, or should a new catastrophic benefit be financed through general revenues?

A: I have long supported general revenues as a way to finance these benefit increases in Medicare. I think it is unfair to ask the elderly to pay for their benefits entirely by themselves. But the reality is that if we are going to get any of these increased benefits, given the climate in Congress and the weak support Reagan has provided for a catastrophic benefit, even though he first proposed it, beneficiary premiums will have to be increased. I am pleased that the House-passed proposal is financed

primarily by an income-related premium, so that those elderly with larger incomes are required to pay more.

Q: Congress is clearly not prepared to incorporate a long-term care benefit into Medicare at this time, given its price tag, but do you anticipate that the legislation will include provisions relating to chronic or long-term care, such as a mandated study of the possible coverage approaches or a demonstration of innovative approaches?

A: We have been mindful throughout the whole review of catastrophic health insurance that long-term care is potentially the biggest catastrophe of all for elderly people. But we also have recognized that neither the Reagan administration nor Congress will address this question in legislation now. We have made some minor improvements for long-term care in the House bill, such as increased home health support and a respite care benefit, which provide unskilled care to individuals at home as a way to keep them out of nursing homes. We did set up what we call the Pepper commission in the House-passed legislation, named after Rep. Claude Pepper, who urged a study of long-term care issues. The commission would have a responsibility to report back in six months a long-term care proposal. It is our hope that we can move the proposal onto the House floor during the 100th Congress. If we cannot move it forward because President Reagan objects to it, we will use it as an election issue and be in a position to reconsider the legislation in 1989.

Medicare Reform

Q: Your committee's jurisdiction includes Medicare Part B—physician services, home health services, durable medical equipment, and a few other items. As you well know, Part B costs have been rising very rapidly compared with other Medicare costs and other federal health program costs. What proposals do you see in the offing or do you personally embrace that will address the issue of rapidly rising Part B costs?

A: The major policy change will be reforming the way Medicare pays physicians. Congress established a Physician Payment Review Commission last year with the intent that it would give us recommendations for legislation to reform Medicare's payment method. A meaningful reform will perhaps slow down the costs and certainly make the system of physician payment more rational. We anticipate action on this issue in 1988. I think we also will need to develop reasonable methods of looking more closely at utilization and medical review. There is a growing body of research and research tools that I believe we can use effectively to reduce unnecessary services and inappropriate care.

Q: Do you have a preferred policy approach in relation to physician payment reform?

A: I am inclined to support the development of a new relative value scale upon which physician fees would be based. I find this approach more attractive and more realistic than paying physicians on the basis of diagnosis-related groups (DRGs). Physician DRGs are untested, and they could lead to a number of disturbing consequences. The administration advanced such a proposal in its fiscal 1988 budget, but it seems to me what it favors is simply imposing a ceiling on physician payment regardless of what the consequences for quality or access to care may be.

I do believe that any approach to physician payment reform must redress the historical accident of paying some doctors far more for their services than others are paid, the issue of cognitive versus procedural services. We also must address payment imbalances by geography—the many rural versus urban questions that arise in this context. A realistic way to encourage doctors to practice in underserved areas would be through financial incentives.

Q: Speaking of Medicare, are you satisfied with the effects of its new hospital payment method—prospective payment—in relation to the policy goals you envisioned upon its enactment?

A: Prospective payment clearly has been successful in moving Medicare away from cost-based reimbursement, which fueled ever-increasing hospital costs. I think the DRG system has enabled hospitals to rearrange their priorities so as to constrain cost increases, the primary objective of Congress. On the other hand, the DRG system has shown some undesirable results as well. The reports of elderly people pushed out of hospitals before they are medically ready to leave are of obvious concern to me. The skilled and unskilled services that elderly people need must be available, particularly if hospitals release them early, for the incentives incorporated in prospective payment to work properly.

Q: What is your view on the question of whether the United States has a surplus of physicians, and how might your opinion influence your subcommittee's efforts to extend expiring health manpower authorities in 1988?

A: I think it is accurate to talk about a physician surplus in terms of sheer numbers alone. But it is inaccurate to think that we have a physician surplus in all areas of the country. There are many underserved areas that still do not attract physicians, both in inner cities and in rural places. In many areas, the surplus of physicians is having an impact on the delivery of medical care. Doctors in areas of surplus are finding it attractive to sign up as Medicare participating physicians. Participating physicians who agree to accept assignment (such physicians accept Medicare reimbursement as payment in full and are not allowed to bill beneficiaries directly for additional costs) are paid for their services at rates higher than nonparticipating doctors.

Q: Let me ask about another dimension of Medicare: its aggressive policy of

encouraging elderly beneficiaries to enroll voluntarily in health maintenance organizations (HMOs) for their medical care. This general approach is a policy that you gave leadership to in its enactment in 1982. Are you satisfied with the implementation of this approach by the Health Care Financing Administration (HCFA)?

A: I continue to support voluntary enrollment of Medicare beneficiaries in HMOs. I believe it is important to provide a competitive alternative to the fee-for-service system for Medicare beneficiaries on a voluntary basis. While we have established the legal framework for HMOs to enroll more Medicare patients, we need to be more aware that HMOs have an economic incentive to underserve. We need to monitor more aggressively, through peer review organizations and by HCFA directly, the quality of care delivered by these plans. HCFA favors opening up the enrollment of Medicare beneficiaries into other kinds of medical care organizations that I fear may not meet the strict standards that HMOs must follow. A few of the HMOs that have contracted with Medicare have failed to live up to these agreements. This is not the time to expand the number of eligible organizations, given the possible risk at which it would place beneficiaries and given HCFA's limited capacity to conduct meaningful oversight.

Access To Health Care

Q: You have been a staunch advocate of providing the nation's poor with access to quality medical care. At this point, with some 30 to 37 million people without any health insurance at all, what is your preferred legislative remedy for this problem?

A: A number of approaches may be necessary. First, we ought to expand Medicaid to cover more people, because today only some 40 percent of those individuals with incomes below the poverty level are receiving medical care through this program. We have begun to move in that direction by at least giving states the option to cover low-income women who might not be eligible for public assistance. The poor are not automatically eligible for Medicaid. It is the poorest of the poor within certain distinct categories (recipients of Aid to Families with Dependent Children and Supplemental Security Income, and the medically needy in the twenty-nine states that have opted to provide coverage) that are deemed eligible for Medicaid-financed services.

Second, Congress should enact legislation that I have introduced in the House, and Senator (Edward M.) Kennedy has introduced in the Senate, that would require employers to provide their workers with a minimum level of health coverage as a condition of employment. Almost two-thirds of the 37 million people who lack health insurance are employed people and their families.

Third, the federal government should be more responsible for the health care burden that is now placed upon the counties, particularly local public health systems, in those areas where there are large numbers of illegal immigrants and other indigents. Federal policies or inaction has led to this burden in many instances, and, therefore, support should be borne at the national level, not just simply at local levels.

Q: As you well know, health insurance is regulated at the state level through insurance commissioners. Would the federal government preempt the regulation of insurance in the Kennedy-Waxman mandated health insurance bill, and, more generally, are you an advocate of repealing the McCarran-Ferguson Act, which exempts insurers from the federal antitrust laws?

A: In relation to the Kennedy-Waxman bill, the federal government would be involved to only a limited extent in regulating health insurance. That extent is to make certain that there are a number of insurance companies in geographical areas that are offering coverage to employers for the benefit of their employees. In relation to repeal of the McCarran-Ferguson Act, I do support the federal government's regulating the insurance industry. We are finding more and more issues before us that involve the insurance industry, and we have no ability to find out what is going on within this industry. We have certainly seen this in the medical malpractice area as well as in tort liability overall. Pressures are growing to have the federal government step in and deal with these problems, yet we have limited ways to reach the insurance industry to make sure that their claims are accurate or that the competition is fair.

Medical Malpractice

Q: On the question of medical malpractice, you have a long record on professional liability because, as I recall, you served as chairman of the California State Assembly committee that structured a legislative remedy to that state's malpractice crisis in the mid-1970s. In your view today, how likely is federal action dealing with the problem of medical malpractice?

A: There is a great deal of resistance to having the federal government move in and take over the area of malpractice or professional liability. The licensure of health professionals has always been done at the state level, and, I think, appropriately so. The regulation of hospitals and the insurance industry also has been a state function, as are the tort laws under which all malpractice suits are drawn. If the federal government were to move into this area in a wholesale way, it is not clear exactly what we ought to do. For that reason, I have always supported more initiatives at the state level.

I am pleased to see that many states are examining the reforms that my California committee proposed, which have been law for a decade. On

the other hand, we have taken some federal steps that I believe will be helpful in diminishing malpractice as a problem. For example, Congress enacted last year the Health Care Quality Improvement Act, which provides physicians that engage in peer review broader legal protection against the threat of being sued by doctors who are disciplined as a result of the review process. The law also requires medical societies, health care organizations, state medical boards, and insurance companies to report to a national data bank all disciplinary actions taken against physicians and all payments—both settlements and verdicts—in medical malpractice claims.

I believe we also must get more involved with the insurance industry. The General Accounting Office (GAO) issued a report recently indicating that the insurance industry has not been leveling with us when they tell us companies are losing money on insuring for professional liability for medical personnel. In fact, according to the GAO's report, they make money on premiums that they charge physicians by investing those sums, which are larger than the payouts they make to cover malpractice judgments. This amounted to \$2.2 billion over the 1975–1985 period, just when they were complaining about the unprofitability and high risks of medical malpractice insurance. In a related GAO study of forty-nine property/casualty insurance companies who became insolvent between 1977 and 1986, not a single company had medical malpractice as a primary line of business. So, whatever the reasons are that so many doctors are having trouble finding and affording malpractice insurance, it is not due to an inadequate amount of cash flowing through the insurance companies.

Q. We have talked a lot about health care programs. Your subcommittee also has important environmental responsibilities. What is your involvement in that area?

A. We have responsibilities for clean air, acid rain control, assuring safe drinking water, and—through our food safety jurisdiction—pesticide control. In my view, the distinction between our health responsibilities and our environmental ones is largely a false one. We are talking about protecting the public health in both cases. When we see high incidence of cancer where pesticides are used, when we see people with lung diseases and cancer from exposure to toxic air pollutants, when we realize the health damage done to each of us by polluted air, we need to do more to protect the public health with better environmental programs. It is not an easy task. Very powerful industries are unhappy when they have to spend money to control pollution or when jobs are affected. Their pressure must not stop environmental efforts, however. We are working now on reauthorizing the Clean Air Act. One of my top priorities for 1988 is to take on the problem of pesticide residues in food.

Reproduced with permission of copyright owner. Further reproduction prohibited without permission.