Topic F

Alternative reform proposals
Talking Point 15

Alternative proposals for “universal coverage” (e.g. based on the Federal Employees Health Benefits Program, the old “Clinton health plan” or the recent reform in Massachusetts) do not work. State health reforms over the past two decades have failed to reduce the number of uninsured.
By David U. Himmelstein and Steffie Woolhandler

As the applause fades for President Obama's health reform, David Himmelstein and Steffie Woolhandler fear that the new law will simply pump funds into a dysfunctional, market driven system

It was a stirring scene: President Obama signing the new health reform law before a cheering crowd, and a beaming vice president whispering in his ear, ‘This is a big fucking deal.’ As doctors who have labored for universal health care we’d like to join the celebration, but we can’t. Morphine has been dispensed for the treatment of cancer – the reform may offer a bit of temporary relief, but it is certainly no cure.

The new law will pump additional funds into the currently dysfunctional, market driven system, pushing up health costs that are already twice those in most other wealthy nations. The Medicaid public insurance program for poor people will expand to cover an additional 16 million poor Americans, while a similar number of uninsured people with higher incomes will be forced to buy private policies. For the ‘near poor’ the government will pay part of these private premiums, channeling $447 billion in taxpayer funds to private insurers over the next decade.

Unfortunately, private insurers win in the marketplace not through efficiency or quality but by maximizing revenues from premiums while minimizing outlays. They pursue this goal by avoiding the sick and forcing doctors and patients to navigate a byzantine payment bureaucracy that currently consumes 31 percent of total health spending. The health reform bill’s requirement that uninsured people buy insurers’ defective products will fortify these firms financially and politically.

Meanwhile insurers will exploit loopholes to dodge the law’s restrictions on their misbehaviors.

For instance, the limit on administrative overheads will predictably elicit accounting gimmickry, for example by relabeling some insurance personnel as ‘clinical care managers.’ While insurers are prohibited from ‘cherry picking’ – selectively enrolling healthy, profitable patients – they’ve circumvented similar prohibitions in the Medicare health maintenance organizations (HMOs). The ban on revoking policies after an individual falls ill similarly replicates existing but ineffective state bans.

Sadly, even if the reform works as planned, 23 million people will remain uninsured in 2019. Meanwhile the public and other safety net hospitals that uninsured people rely on will have to endure a $36 billion cut in federal government funding.

Moreover, many Americans will be left with coverage so skimpy that a serious illness could lead to financial ruin. At present, illness and medical bills contribute to 62 percent of all bankruptcies, with three-quarters of the medically bankrupt being insured. The reform does little to upgrade this inadequate coverage; it mandates that private policies need cover only 70 percent of expected medical costs.

The president has often promised that ‘if you like your current coverage you can keep it.’ Yet Americans who now get job based insurance will be required to keep it – whether they like it or not. And many who receive full coverage from an employer will face a steep tax on their health benefits from 2018.

Soaring costs and rising financial strains seem inevitable, despite claims that the reform will ‘bend the cost curve.’ Computer vendors have trumpeted imminent cost savings for half a century (see, for instance, a video made by IBM in the 1960s, available at http://bit.ly/cckdtB). Prevention, though laudable, does not generally reduce costs. Windfalls from prosecuting fraud and abuse have been promised before. The new Medicare advisory board merely
tweaks an existing panel. Without an enforcement mechanism, stepping up comparative effectiveness research cannot overcome drug and equipment makers’ promotion of profligate care. Existing insurance exchanges where patients can compare and shop among private plans haven’t slowed growth in costs for public workers nationally or in California. And the mandated experiments with capitated payment systems are warmed-over versions of President Nixon’s pro-HMO policies and subsequent failed initiatives to fix America’s health cost crisis through managed care.

Experience with reforms in Massachusetts in 2006 – the template for the national bill – is instructive. Our state’s costs, already the highest of any state, grew by 15 percent in the first two years after reform, twice the national rate. Moreover, capitated physician groups had costs at least as high as those who were paid on a fee for service basis. Meanwhile, after initial improvements in the state, access to care has begun to deteriorate, and the state has begun to cut back coverage.

Overall, President Obama’s is a conservative bill, drafted in close consultation with the drug and insurance industries. Its modest salutary provisions – such as an extra $1 billion a year for community health centers and the expansion of Medicaid – mirror measures that have been passed even under Republican regimes. Its central tenet, that the government should force citizens to buy coverage from a for-profit firm, was first proposed by Richard Nixon when faced with the seeming inevitability of national health insurance in 1972. Similarly, Mitt Romney, a favorite of conservatives, embraced the Nixon approach as Massachusetts governor in 2006, a stance he has now abandoned. Democrats, having retreated from their traditional push for national health insurance, freed Republicans to move still further to the right.

Throughout the reform debate we, and the 17 000 others who’ve joined Physicians for a National Health Program, advocated for a far more thoroughgoing reform: a non-profit, single payer national health insurance program. We will continue to do so. Our health care system has not been cured or even stabilized. For now, we will continue to practice under a financing system that obstructs good patient care and squanders vast resources on profit and bureaucracy.

Passage of the health reform law was a major political event. But for most doctors and patients it’s no “big fucking deal.”

David U. Himmelstein, M.D., is associate professor of medicine at Harvard Medical School and Steffie Woolhandler, M.D., M.P.H., is professor of medicine at Harvard Medical School. They are also co-founders of Physicians for a National Health Program.

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Massachusetts’ recent health reform has generated laudatory headlines and a flurry of interest in state-based initiatives to achieve universal health insurance coverage. In 1988, a similar Massachusetts effort was also acclaimed and was imitated by several other states. Unfortunately, none of those efforts can be judged a success. The authors briefly review this earlier experience and caution against premature declaration of victory.

After seeming moribund for a decade, the drive for universal health care coverage shows signs of life. President Bush has proposed federal tax code changes to encourage the purchase of individual private health coverage and discourage very comprehensive, so-called gold-plated, plans. But most legislative activity has taken place at the state level.

Massachusetts’ effort has attracted the most attention. Legislation passed in April 2006 promises near-universal coverage through an “individual mandate” requiring the uninsured to purchase their own coverage, with subsidies for poor and near-poor individuals. After the bill’s passage, then-governor Mitt Romney declared: “Every uninsured citizen in Massachusetts will soon have affordable health insurance and the costs of health care will be reduced” (1).

Six weeks later Vermont enacted a plan offering subsidized coverage to poor and near-poor individuals, commencing in October 2007. If more than 4 percent of Vermonters remain uninsured in 2010, the legislature promises to consider making coverage mandatory.

California’s Governor Schwarzenegger, and officials in several other states, have proposed similar mandatory coverage programs. And President Bush lent his imprimatur to experimentation at the state level, proposing to allow states to
shift funds from safety net hospitals to innovative state programs to subsidize private coverage.

Between the late 1980s and the collapse of President Clinton’s plan in 1994, several states passed measures intended to dramatically expand coverage. In this commentary we review the impact of this earlier round of reform on the number of uninsured, using time trend data from the U.S. Census Bureau’s Current Population Surveys. The Census Bureau changed its survey methods in 1999 and produced estimates for that year using both the old and new methods, which differed by 5.5 percent nationwide (2). Hence, to ensure comparability with the post-1999 Census Bureau figures, we adjusted the earlier state estimates by the percentage difference between the Census Bureau’s two 1999 estimates.

**ALTERED STATES**

The last round of reform kicked off in 1988. Like the present one, it started with Massachusetts legislation shepherded by a governor planning a presidential run. On passage of the legislation, then-governor Michael Dukakis announced: “I am very proud of the fact that Massachusetts will be the first state in the country to enact universal health insurance for all its citizens” (3). The *New York Times* editorialized that “Massachusetts last week ventured where no state has gone before: it guaranteed health insurance for every resident” (4). In 1988, 494,000 people were uninsured in Massachusetts. The number of uninsured has remained higher than that ever since (Figure 1A).

A year later Oregon made headlines with “the most far-reaching health care reform plan in the nation” (5), combining universal coverage with explicit rationing of expensive care. When the plan gained the federal waiver needed for full implementation, the governor said: “Today our dreams of providing effective and affordable health care to all Oregonians has come true” (6). The number of uninsured Oregonians did not budge (Figure 1B).

The year 1992 was the high watermark for state health reform; bills passed in Minnesota, Tennessee, and Vermont. According to the *New York Times*, “Minnesota is enacting a program that will be the most sweeping effort yet to provide health insurance to people who lack it. . . . Joy Wilson of the National Conference of State Legislatures described the Minnesota plan as ‘the first complete reform proposal in the United States’” (7). The plan called for universal coverage by July 1, 1997. Between 1992 and 1997 the number of uninsured in the state increased by 88,000 (Figure 1C).

Tennessee’s governor unveiled “the most radical health care plan in America” (8) and declared that “Tennessee will cover at least 95% of its citizens with health insurance by the end of 1994” (9). The number of uninsured dipped for two years, then rose to levels higher than ever (Figure 1D).

Also in 1992, “Governor Howard Dean, the only Governor who is a doctor, signed a law here today that sets in motion a plan to give Vermont universal
healthcare by 1995.” “This is an incredibly exciting moment that should make all
Vermonters proud,” Dean said (10). The number of uninsured in the state has
grown modestly since then (Figure 1E).

The next year Washington State passed “one of the most aggressive health care
experiments in the nation, a program that would extend medical benefits to all 5.1
million residents of the state” (11). The bill called for universal coverage by 1999.
Between 1993 and 1999 the number of uninsured in the state rose from 661,000 to
898,000 (Figure 1F).

By 1995, the New York Times was lamenting that “ambitious state plans to
extend health insurance to more people took on importance as possible models for
the nation. But nearly a year later most of those plans are dead or stalled as the
states turn their attention to cutting budget deficits. Meanwhile the number of
uninsured people is growing fast” (12).

Heralding the new round of health reform, Maine passed its Dirigo Health
Program in 2003. A Boston Globe columnist opined that “Maine has just become
the first state in the union to approve a plan to provide universal access to
affordable health insurance” (13). On signing the legislation, Governor Baldacci
said: “It’s bold and comprehensive, and it is now the law of our state” (14). In 2006
the Associated Press reported that Dirigo “is now providing coverage to about
5,000 people who previously weren’t insured” (15)—about 4 percent of Maine’s
uninsured (Figure 1G).

DOING THE SAME THING AND EXPECTING
DIFFERENT RESULTS

The reforms enacted between 1988 and 2003 differed in detail but shared
common elements. All offered new public subsidies or expanded Medicaid for
poor and near-poor people. All left the bulk of existing private health insurance
arrangements undisturbed, although many included new insurance regulations
or state purchasing pools to help make affordable coverage available to
individuals and small businesses. Dukakis’s Massachusetts legislation, as
well as the reforms in Oregon and Washington State, included “employer
mandates”—requirements that most employers cover their workers. The
Massachusetts and Washington plans also mandated that self-employed
individuals purchase coverage—prefiguring the individual mandates in the
2006 Massachusetts bill.

Why did these plans fail? While they made rhetorical swipes at cost con-
tainment, none included effective cost-control measures. As health costs soared,
legislatures backed off from forcing employers and the self-employed to pay
ever-rising premiums, and the mandates requiring employers and the self-
employed to purchase coverage were repealed.

While Medicaid expansions incorporated in the state bills swelled Medicaid
rolls, the erosion of private coverage continued, offsetting any gains. (Indeed,
Figure 1. Percentage of uninsured in various U.S. states that have attempted state-level health care reforms, 1987–2005.
despite SCHIP—the State Children’s Health Insurance Program—which has added about 5 million children to Medicaid nationally since 1997, the number of uninsured children has fallen by only 2 million, while the number of uninsured adults has risen by nearly 7 million.) Moreover, relying on Medicaid has proved fiscally problematic for the states; when the economy cools, tax revenues fall just as unemployment pushes families out of private coverage.

Like earlier reforms, the recent Massachusetts reform, and those proposed in California, include expansions of Medicaid and requirements that most employers make at least token contributions toward health coverage. While some earlier bills required self-employed individuals to buy coverage, the new ones will impose this mandate on all uninsured people with incomes above poverty. As in several previous reforms, Massachusetts has organized a purchasing pool to help make coverage available to the previously uninsured, lower overhead costs in the individual insurance market, and spread the costs of high-risk individuals over a large risk pool. The new reforms rely on a new funding stream—the premiums (or fines) that the uninsured will be required to pay. But once again, effective cost controls are absent.

In Massachusetts, any savings from reducing the overhead on individual policies are being eaten up by the 4 to 5 percent surcharge that the new purchasing pool will add to premiums in order to fund its own operations (16). The legislature shifted responsibility for additional cost-control measures to a new council charged with setting goals, identifying quality improvement and efficiency measures, and setting up an Internet site to compare providers. Meanwhile, premiums for the new coverage will cost at least $1 billion annually—probably much more. Funds diverted from the state’s existing free-care pool will cover only a fraction of this amount. And employer-provided coverage will predictably shrink as costs continue to rise, leaving the new program with an ever-larger responsibility for coverage.

Meanwhile, few of the near-poor uninsured seem able to afford even the newly subsidized policies (17), and the federal funds providing the bulk of the subsidies are set to expire in 2008. The unsubsidized coverage mandated for middle-income individuals (most of whom have incomes between $30,000 and $50,000) offers a bitter choice between unaffordable premiums (at least $7,200 for comprehensive coverage for a single 56-year-old) or plans so skimpy (e.g., a $2,000 per person deductible with 20% coinsurance for hospital care after that) that they hardly qualify as insurance. The religious coalition that was key to passage of the legislation has already called for a delay in enforcement of the individual mandate, fearing that it will place unbearable financial stress on many of the uninsured (18). In sum, neither government, nor employers, nor the uninsured themselves have pockets deep enough to sustain coverage expansion in the face of rising costs.

We remain convinced that more-radical reforms can simultaneously expand coverage and control costs (19). A shift from our complex and fragmented payment system to a simple single-payer approach could save about 14.3 percent
of total health spending—equivalent to $323 billion in 2007—on reimbursement-driven bureaucracy (20). Such administrative savings are unattainable with lesser reforms. A nonprofit national health insurance system could also curtail wasteful over-investment in medical technology (e.g., the proliferation of new cardiac care hospitals located near existing ones) and attenuate incentives for unnecessary and even harmful care.

Powerful momentum for health reform is building. Previous reform efforts that built on existing but defective insurance arrangements have quickly succumbed to their faulty economic logic. Added coverage meant added expense, on top of already exorbitant costs. It would be shameful to squander the present opportunity on yet another round of reforms that are politically realistic but economically chimerical.

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Direct reprint requests to:
Dr. David U. Himmelstein
Department of Medicine
Cambridge Hospital/Harvard Medical School
1493 Cambridge Street
Cambridge, MA 02139

e-mail: david_himmelstein@hms.harvard.edu
What the Massachusetts experiment teaches us about incremental efforts to increase coverage by expanding private insurance.

Marcia Angell | April 21, 2008

For all their promise of change, Democrats are remarkably timid about changing the health-care system. The system now costs twice as much per person as those of other advanced countries and delivers worse average outcomes. It prices tens of millions of people out of health coverage altogether and limits care for countless others. Yet leading Democrats are clinging to this system, proposing to cover more people but not changing the system itself except at the margins. The timidity extends to choice of words. No one is supposed to say “single-payer” or “national health insurance” anymore, because that is “politically unrealistic”; the most we are allowed is to talk of refining the system incrementally so that someday it will morph into “Medicare for all.”

Thus, the proposals for reform taken most seriously by Democrats — including Barack Obama and Hillary Clinton — would retain the central role of the investor-owned private insurance industry as well as the thousands of for-profit businesses it pays to deliver medical services. This is the industry, mind you, that has brought us to the predicament we’re in now, so let’s take a quick look at it.

The U.S. health system is unique in treating health care as a commodity to be bought and sold in a marketplace. Care is distributed according to the ability to pay, not according to medical need. Private insurers compete by avoiding high-risk individuals, limiting services for those they do cover, and, whenever possible, shifting costs to other payers or to patients in the form of high deductibles and co-payments. We have the only health system in the world based on avoiding sick people. It’s a chaotic and fragmented system that requires mountains of paperwork, which is one reason premiums are so high. Employers who offer health benefits react by capping their contributions, so that workers pay more out of pocket and bear the full brunt of premium increases.

Insurers contract with hospitals, HMOs, and other health facilities to provide the care. They, too, are often for-profit businesses that promote lucrative services for well-insured patients (such as coronary catheterization for Medicare recipients), while giving short shrift to less profitable ones (such as psychiatric services for the indigent). To compete in a market environment, even not-for-profit facilities behave in much the same way as for-profit ones. Doctors often act as entrepreneurs, investing in health facilities to which they refer patients. And because they are usually paid on a fee-for-service basis, they have a strong incentive to overuse tests and procedures that have the greatest profit margins.

All of this drives up costs to the overall system, while yielding profits for the various players within it. In fact, there’s a fundamental illogic to trying to contain costs in a market-based system. Markets are about expanding, not contracting. Like all businesses, hospitals want more, not fewer customers — but only as long as they can pay. Conventional wisdom holds that we need to retain this system because many Americans are satisfied with it. But except for industry spokespeople and politicians whose campaigns they support, I’ve never met anyone who actually is. Many people like their doctors, but that is not the same as liking the system.

The reforms favored by leading Democrats vary somewhat, but all have at their heart expanding insurance coverage through public subsidies for those who can’t afford the premiums or, alternatively, permitting those without access to good, affordable insurance to enroll in a new Medicare-type program that would be set up to provide them with coverage. Some reform proposals include a mandate requiring everyone to be insured.

Many proponents hope that a parallel Medicare-like system would eventually crowd out its less efficient private competitors, that under a play-or-pay requirement, employers would gradually decide to stop providing coverage and just pay into the common pool. However, this wishful thinking overlooks the power of the private health industry, through its huge lobby, to influence the rules so that it continues to profit while the public system is undermined.

All of these variations in the Democrats’ plans run into this intractable dilemma: If the system stays essentially as it is and we try to expand coverage, costs will inevitably rise. On the other hand, attempts to control costs will inevitably reduce coverage. Without fundamental reform, coverage and costs have to move in the same direction. Yet, we don’t have the option of expanding both coverage and costs. At 16 percent of gross domestic product, our health-care system is already unaffordable. In fact, costs are the central problem; universal health care would be easy if money were no object. Furthermore, none of the proposed reforms offers any workable mechanism for controlling the unsustainable inflation in health costs. Attempts to regulate private insurers to prevent the worst abuses would probably do little more than add to the complexi-
ty and administrative costs of the system.

The proposed reforms also make the fundamental mistake of confusing insurance with health care. As many Americans are learning, the two are not the same — not by a long shot. Health insurance can easily be too skimpy or too laden with exceptions and co-charges to be of much use. What people really want when they're sick is medical care, not medical insurance, just as they want education for their children, not the opportunity to buy education insurance.

Despite the Democrats' coalescence around the same approach for achieving universal care, only one such plan has been implemented — the Massachusetts health-reform plan. It is therefore worth looking at in some detail.

**MASSACHUSETTS MIRACLE OR MIRAGE?**

This plan, which was enacted in April 2006 amid extraordinary hoopla, set out to cover the 500,000 to 750,000 uninsured residents of the state, and to see that the coverage for everyone else met a minimum standard. To that end, the state would purchase insurance for everyone with incomes beneath the federal poverty level, and partially subsidize it for those earning up to three times the poverty level (which now comes to $31,200 per year for an individual). Everyone else — roughly 200,000 to 250,000 people — would have to purchase his or her own insurance or face stiff fines. The legislation established a new state agency, the Commonwealth Health Insurance Connector, which would try to make sure insurance was affordable and met the minimum standard and which would also determine the level of subsidies.

Financing the plan was iffy from the outset. When fully implemented, it was projected to cost the state only $125 million in new money the first year — not very much in a state with a $26 billion budget. Mostly it would be financed by diverting existing funds from two sources: Medicaid, under a two-year waiver that would permit federal money to be used for this purpose, and the state's generous "free care pool," which was established to provide direct services to uninsured patients in safety-net facilities and is supported by assessments on hospitals and insurers. There would also be a paltry fine on employers who didn't offer insurance, but no one thought that would be an important source of funding. Success would depend crucially on the individual mandate requiring those with incomes more than three times the poverty level to pay for their own insurance.

What's happened since then? While those beneath the poverty level signed up for free insurance in even greater numbers than anticipated, very few people who were required to pay for their own insurance signed up. Even those eligible for partial subsidies were slow to enroll. The deadline to purchase insurance had to be extended, and 60,000 uninsured people were exempted from the mandate because — yes, that's right — they couldn't afford it (so much for universality). The state modified its requirement that all insurance meet a minimum standard. Jon Kingsdale, the executive director of the Commonwealth Health Insurance Connector, told me that was because the federal Employee Retirement Income Security Act prohibits states from setting standards when employers act as their own insurers (didn't the Massachusetts legislators know that when they crafted the law?), but he said that next year workers will be responsible for somehow upgrading their own policies, or (you guessed it) be fined.

Don't get me wrong. Massachusetts is to be congratulated for seeking to extend health care to everyone in the state. Every decent society should ensure health care, just as it does education, clean water, and police and fire protection. Massachusetts' plan is an ambitious and well-intentioned effort. But unfortunately, it's extremely unlikely to work for three main reasons.

First, the individual mandate is harsh, regressive, and probably unenforceable. It requires the near-poor to pay a much higher percentage of their income on health care than their more affluent neighbors. Although insurers are prohibited from charging more for people with medical conditions, older people have to pay more. The premiums for a 57-year-old are twice as much as for a 27-year-old. According to the Connector's Web site in March of this year, the least expensive plan for a 57-year-old had a premium of $4,700 per year, a $2,000 deductible, and substantial co-pays and co-insurance up to $4,000 per year. (That cap did not include prescription drugs.) So a hypothetical 57-year-old with a $32,000 annual income (just over three times the poverty level) could pay as much as $8,700 out of pocket — or over a quarter of his income. Family plans are, of course, different, but the effect is the same. Next year, those who haven't purchased insurance will be fined half the premium of the lowest-priced plan. Truly this is the Squeeze Blood from a Turnip Plan.

It also lets employers off the hook. They're supposed to pay a $295 per employee fine if they don't provide health benefits, but they're now considered to have met their obligation if they offer benefits to just 25 percent of their employees or contribute 33 percent of the premiums — no matter whether employees accept the offer and no matter how skimpy the coverage. And a $295 fine is no incentive to provide insurance that costs upward of $5,000. So the growing problem of under-insurance will be left to workers themselves to solve.

Second, like all such plans, the Massachusetts strategy pretends that having insurance is the same as having health care. The Connector makes much of the fact that some 300,000 people who were previously uninsured now have insurance, but most of those already had access to health care, either through the free-care pool or Medicaid. So it's something of a shell game, with money that would have been spent directly on health care passed through insurance companies instead (which keep quite a lot of it).

The Connector offers a choice of insurance plans from four different companies for those eligible for state subsidies (called Commonwealth Care), and from six companies for those who have to purchase their own (Commonwealth Choice). There is a trade-off between premiums, on the one hand, and deductibles and other out-of-pocket costs, on the other. The plans with the lowest premiums have the highest deductibles and other costs. But those who select the cheapest plans are likely to be precisely those least able to afford high out-of-pocket costs. So they could end up with health insurance that they can't afford to use but have to pay for anyway. The speaker of the Massachusetts House of Representatives, Salvatore DiMasi, one of the prime movers behind the plan, wasn't worried. He told The Boston Globe last year, "We're moving to
universal insurance and then toward insurance that has substantial benefits. That's the key." Can he really believe that after people have signed up for stripped-down coverage, and costs have continued to climb, there will be the money and political will to add to the benefit package?

Third and most important, there is no effective mechanism for containing costs. Insurance companies can set premiums as high as they like. If they're much higher than the competition, of course, the Connector can choose not to offer those plans. But if all the companies raise their premiums at about the same rate, there's not much the agency can do. And sure enough, premiums have continued to rise faster than the background inflation rate (10 percent for Commonwealth Care next year). The only way to hold them in check is to cut benefits or increase deductibles and co-payments. (The Connector actually favors increasing co-payments to prevent Commonwealth Care from becoming so attractive that employers will drop coverage and send workers to the state plan.) Insurance will quickly become too expensive, as well as increasingly inadequate. The state, which now faces a $1.2 billion budget shortfall and health costs of $147 million more than projected, will not be able to contribute much more from general revenues. Funding depends utterly on the Medicaid waiver being renewed in July, by no means a sure thing.

THE VERDICT: SINGLE-PAYER
Massachusetts is not the first state to come up with a plan to provide near-universal health insurance to its residents, although it is the first to rely on an individual mandate. Maine tried it in 2003, Minnesota and Tennessee in 1992, to name a few. And Massachusetts made an earlier attempt in 1988. All were greeted with great enthusiasm and fanfare in the media. And all failed and died with scarcely a whimper. More recently, California, inspired by Massachusetts, tried to pass similar legislation. Despite Gov. Schwarzenegger's support, it died in the state Senate in January. It didn't have resources anywhere near comparable to those in Massachusetts, mainly the Medicaid funds and free-care pool, and had to rely more on employer contributions. What all the state efforts have had in common is that they left our current dysfunctional system essentially intact and simply tried to expand it around the edges.

The only workable solution is a single-payer system (there, I said it), in which everyone is provided with whatever care he or she needs regardless of age and medical condition. There would no longer be a private insurance industry, which adds little of value yet skims a substantial fraction of the health-care dollar right off the top. Employers, too, would no longer be involved in health care. Care would be provided in nonprofit facilities. The most progressive way to fund such a system would be through an earmarked income tax, which would be more than offset by eliminating premiums and out-of-pocket expenses.

This is not the same as Medicare for all. Medicare is embedded in our market-based entrepreneurial private system, and therefore experiences many of the same inflationary forces, including having to deal with profit-maximizing hospitals and physicians’ groups. Doctors’ fees are skewed to reward highly paid specialists for doing as many expensive tests and procedures as possible. As a result, Medicare inflation is almost as high as inflation in the private sector and similarly unsustainable.

In addition, Medicare is not what it once was. For the past eight years, it has been at the mercy of an administration intent on dismantling and privatizing it. The prescription-drug benefit enacted in 2003 is an example. It’s a bonanza for the pharmaceutical industry because it forbids Medicare from using its purchasing power to get good prices. Medicare recipients have also been encouraged to enroll in private health plans, which are paid on average 12 percent more than it would cost traditional Medicare to care for the same people. Even as public funds are siphoned off to the private sector, premiums and co-payments have been increased, and there are now proposals for means testing — a superficially attractive idea but ultimately a grave threat to any public program.

Over the years there have been many independent analyses of the costs of converting to a single-payer system, either within a state or nationally. They include studies by the General Accounting Office, the Congressional Budget Office, and consulting firms, such as the Lewin group, hired by state governments and, in Massachusetts, the state medical society. Most found that a single-payer system would initially cost roughly the same as the system it replaced, while providing universal coverage, and over time would be much cheaper.

Polls have shown that most people, and most Massachusetts doctors, favor a single-payer system. The Boston Globe called for a national single-payer system last May. In an editorial about the big three automakers’ desire to transfer health costs to the autoworkers’ union, the Globe said, “It would make more sense for the federal government to oversee a national health system financed from taxes. The cost could be spread across the entire population, rather than borne by Chrysler or other companies that no longer enjoy the assured profitability of their best years.”

Nevertheless, the private insurance industry has managed to convince many political leaders, including progressives, that a single-payer system is unrealistic. But what is truly unrealistic is anything else. My greatest concern about the Massachusetts plan is that when it unravels, people will draw the wrong lesson. They will assume that universal care at a cost we can afford is impossible, and give up on it. It’s not impossible; it’s just unlikely to be achievable while leaving our dysfunctional system in place. Can we make it right? I’m tempted to say, “Yes, we can.”
Politicians are fond of saying that everyone should have a health plan as good as the one that Congress has. John Kerry, for instance, says that “all Americans should have access to the same affordable coverage policies that Members of Congress get today,” and he proposes that any individual or business should be able to buy into it. This plan, which is available to Congress and all other employees of the Federal Government, is the Federal Employees Health Benefit Plan (FEHBP). What is FEHBP? Is it as good as these claims suggest? Does the opportunity to buy in to FEHBP provide a model for universal health care?

FEHBP is, in brief, a private insurance program that the Federal government offers to its employees. Just like many other employers, the Federal government makes available a choice of private health insurance plans. Federal employees can choose from among plans offered by Blue Cross/Blue Shield, Aetna, and other such insurers. These include “fee-for-service” plans with “preferred providers” (called PPOs), in which employees can reduce their out-of-pocket expenses by using an “in-network” provider, as well as HMOs offering care primarily through contracted providers.

Thus, FEHBP offers standard private health insurance in the current managed-care mode. As pointed out by the Federal Office of Personnel Management, which runs the program, “You will find managed care features in all the plans…pre-approval of hospital stays, the use of primary care providers as ‘gatekeepers’ to coordinate your medical care, the use of a prescription drug formulary, and networks of physicians and other providers.”

Thus, as in all private insurance plans today, under FEHBP a private, often for-profit, insurance company will decide (i) which physicians you can see, (ii) which drugs your physician can prescribe, (iii) whether you can see a specialist, and (iv) whether and where you can be hospitalized. You can be turned down for treatment. You then can appeal a service denial, but first to the private insurance company before asking the Office of Personnel Management for a second appeal.

Under FEHBP, the Federal Government pays 72% of the average premium for any plan; the employee pays the rest. For example, for the standard Blue Cross/Blue Shield Plan available nationally, the employee’s share of the cost is $1,271 per year for an individual and $2,935 per year for family coverage. Like the corresponding premiums in the private sector, these have been rising rapidly in recent years. For instance, Federal employees’ share of the premium rose more than 7% this year (by $84 for individuals and $199 for families). Premiums have been rising an average of 11 percent per year and have climbed more than 50 percent over the past four years – far above the general cost of living increase of 9 percent over four years.

Then there are deductibles of from $250 to $500 per person (and $500 or more per family). All plans have copays of 10-25% for outpatient care and $10-30 for prescription drugs. There are limits to what it will cost the employee: Most plans provide for maximum out-of-pocket expenses of $4,000 to $6,000 per family. So a family might, under these plans, be paying $6,000 plus the employee’s share of the premium ($2935) or $8,935 per year for

(over)
health care, clearly beyond the reach of many.

If the FEHBP were to be offered through private employers, would they be willing to pick up the same nearly three-quarter share of the insurance premium as the Federal government’s does for its employees? If they did not, or if a self-employed (or unemployed!) individual were to buy into this plan, the annual premium for the standard Blue Cross/Blue Shield plan alone — without any out-of-pocket medical costs — would be $4,539 for an individual and $10,482 for a family. Kerry has suggested tax subsidies to help pay these costs; they would have to be quite substantial to make this truly affordable for low-income individuals and employees of small businesses.

But this is not the worst of it: Those who advocate an “FEHBP solution” assume that the private insurers who participate in FEHBP would be willing to offer the same plan that is offered to Federal employees, at the same cost, to anyone wishing to purchase it. However, Federal government employees are healthier, more securely employed, and more “middle-class” than the average person in the population. It is highly unlikely that private insurers would be willing to offer the same deal to any small business or individual. We know that insurance premiums for small businesses and individuals are much higher than for large employers, where the risk is spread far wider. If FEBHP were to be offered to the general population, either the premiums would be substantially higher, or fewer insurance companies would choose to join, or, more likely, both.

Finally, there is the vaunted “consumer choice” that a program such a FEHBP would offer. Over time there have been fewer and fewer choices offered in FEHBP. The number of participating plans has dropped by 50 percent in the past five years. In the New York City area, for instance, employees have the choice of just four major insurers — Aetna, Blue Cross, GHI, or HIP — along with several firms set up originally to serve postal workers but now offered to any Federal employee. Other areas of the country have even fewer.

FEHBP requires that all plans cover the same medical services. In spite of this, some plans offer more dental and vision coverage than others. However, the primary “choice” is whether to pay now or pay later. Those who choose plans with lower premiums (taken out of biweekly or monthly paychecks) face higher deductibles and co-payments when they actually need medical care. Often this results in higher overall cost to those who choose what looks like a less-expensive plan. Seeing physicians “out of network” costs more in a “basic” plan than in a “standard” or “high option” plan. We know from many studies that higher co-payments lead low- and even middle-income people to postpone needed medical care. Since FEHBP premiums are independent of the employee’s income, lower-wage workers are likely to choose a “basic” plan and thus face the barrier of higher costs when they have to seek care. And many, of course, will not be able to afford to pay for any plan.

This is not universal health care. It is simply the clearest example of the excessively expensive way we finance health care today, with millions still left out completely. Funnelling billions of additional dollars into the wasteful and intrusive private insurance system would not move us toward the kind of humane, inclusive, and efficient health care system we need and deserve. We would simply be pouring more money into the coffers of the for-profit insurance industry, which is the central problem with American health care, not its solution. We know, for instance, that the complexity and wastefulness of the insurance industry alone is responsible for 1 out of every 6 dollars we spend on health care today. Studies by a variety of analysts show that, compared with countries with simpler national systems, our use of multiple private insurance companies costs our country hundreds of billions of dollars each year in funds that could be better spent actually providing health care to those who don’t have it and improving the health care for those who do have it.

The only solution is to move to a single payer national health insurance system which would eliminate the duplication of multiple billing and reimbursement systems, the eligibility determinations, the corporate intrusion into medical practice, the massive expenses on marketing and other administrative waste, and the deeply offensive attempt to collect thousands of dollars from ill and dying patients. We need Expanded and Improved Medicare for All, as embodied in the Conyers Bill, HR 676, if we are truly to make health care accessible and affordable for all Americans.
GETTING THE FACTS RIGHT: WHY HILLARYCARE FAILED

By VICENTE NAVARRO

Professor of Health and Public Policy - The Johns Hopkins University

In his article “The Hillarycare Mythology” (The American Prospect, October 2007, pp. 12-18), Paul Starr, a senior health policy advisor to President Bill Clinton and a leading figure in Hillary Rodham Clinton’s White House task force on health care reform, analyzes the origins, development, and final outcome of the Clinton administration’s health care reform – referred to by Republicans as “Hillarycare.”

Starr dates the origins of Bill Clinton’s commitment to health care reform to the special congressional election held in Pennsylvania in November 1991, when Harris Wofford won against all odds by making reform of the health care sector a major campaign issue. According to Starr, this event triggered a great deal of interest in health care reform; even the American Medical Association (AMA) and the Health Insurance Association of America (HIAA) supported some types of reform such as an employer mandate to provide health benefits coverage. As noted by the editor of JAMA, “there was an air of inevitability about health care reform.” It was this surge of interest that candidate, and later President, Clinton tried to capitalize on by developing a proposal to provide universal health care coverage for all Americans (meaning all U.S. citizens and residents).

Once elected, Bill Clinton established the 500 member White House task force, led by Mrs. Clinton, to work on the details of a proposal developed within a framework defined by the President. According to Starr, the proposal failed when President Clinton presented it to the U.S. Senate after completion of, rather than before, the budget discussions. The Senate did not support the proposal, because it would require extra revenues (making senators susceptible to Republican charges of fiscal irresponsibility) and particularly because – again, according to Star – the proposed benefits coverage was too extensive and too large for many senators to swallow. The final message of Starr’s article is that it was President Clinton’s fault, rather than Hillary’s, that the reform proposal failed.

Starr reproduces a widely held interpretation of the failure of the Clinton health care reform that (limiting the analysis to the relationship between the President and Congress) attributes this failure to a calendar error – bad timing – and to the excessive generosity of the proposed health care benefits. I believe there is a need to correct such an interpretation of the events that led to the death of the reform proposal and to challenge the assumptions behind the interpretation. This is important because we might face a similar situation very soon. The majority of the U.S. population is dissatisfied with the funding and organization of the health care sector, and this dissatisfaction has reached unprecedented levels. Once again, all indicators show that people want change. But we could face another failure unless some major changes take place in the U.S. – changes that, I admit, are unlikely to occur with the current correlation of forces in the country and in the Democratic Party.

Let’s start with some corrections to Starr’s assumptions. The commitment of the Democratic Party and candidate Bill Clinton to universal health care coverage for all citizens and residents started much earlier than Starr suggests. It began in the presidential primary campaigns of 1988, when Jesse Jackson (for whom I was senior health advisor), running for the Democratic nomination, made a commitment to universal, comprehensive health care benefits coverage a central component of his platform. This proposal was dismissed by the Democratic Party establishment as “too radical,” but it had already mobilized large sectors of the party’s grassroots (especially labor unions and social movements) to support Jackson, with more than 40% of the delegates at the Democratic Party Convention in Atlanta. This shook the Democratic establishment and stimulated responses from Governor Clinton, Senator Al Gore, and Congressman Richard Gephardt to block this rise of the left in the Democratic Party, which they did by establishing the Democratic Leadership Council, among other interventions. (Gore and Gephardt have changed since then; Bill Clinton hasn’t.) I describe these effects of Jackson’s health proposals on the Democratic Party in “The 1988 Presidential Election,” in The Politics of Health Policy: The U.S. Reforms 1980–1998, Blackwell, 1994. pp. 99-110.) To control this growth of the left, something had to be done. And as liberals always have done when faced with the left, they recycled its progressive proposals, adopting much of their narrative but emptying them of their content. This is what Clinton did in his 1992 campaign. He used the title, narrative, and symbols of Jesse Jackson’s campaign, calling his platform “Putting People First” (the title used by Jackson in 1988) and including the call for universal health care benefits. As the perceptive Financial Times wrote, “Clinton [has borrowed] extensively from Jesse Jackson 1988. He sounds like a Swedish social democrat.” While borrowing the language and the symbols, however, Clinton changed the content dramatically.

Whereas Jackson had called for a single-payer program similar to that in Canada, Clinton chose the opposite pole of the political spectrum: managed care competition. Managed care competition basically meant the insurance companies exercised full control over health care providers, with doctors working in group practices called Health Maintenance Organizations (HMOs). As
stated by Paul Elwood, a leading member of the White House task force, “insurers-controlled HMOs, under managed care competition will stimulate a course of change in the health care industry that would have some of the classical aspects of the industrial revolution – conversion to larger units of production, technological innovation, division of labor, substitution of capital for labor, vigorous competition and profitability as the mandatory condition of survival” (“Heath Maintenance Strategy,” Medical Care, 9 (1971), p. 291). This industrial revolution in medical care would indeed have revolutionized the practice of medicine.

It is important to note that the idea of managed care competition was first proposed as a solution to the irrationality of the U.S. health care sector by Alain Enthoven, personal advisor to U.S. Secretary of Defense Robert McNamara during the Vietnam War. Enthoven was in charge of developing the “body count” as an indicator of military efficiency. After the Vietnam fiasco, Enthoven retired to the Rand Corporation, choosing to focus his intellectual efforts on the reform of U.S. health care. A strong ideologue and market fundamentalist, and completely ignorant of the mechanics of the medical care sector, Enthoven thought the best way to control out-of-control costs in the health sector was to increase competition in the sector, letting health insurance companies compete for consumers – meaning patients – based on the price of services. The problems with such a naïve and unrealistic scenario are many. First, patients do not determine the cost or price of medical care services. Second, patients have very little choice in the U.S. health care sector: employers choose which plans are available to employees. Third, the market does not exist in the health care sector. Fourth, the insurance industry’s financial viability depends on its ability to discriminate against heavy care-users. I could go on and on detailing just how wrong Enthoven’s proposals were.

Not surprisingly, managed care was the proposal chosen by the insurance industry and by employers. As Bill Link, Executive Vice President of Prudential and one of the highest-paid CEOs in the country, stated: “for Prudential, the best scenario for reform – preferably even to the status quo – would be enactment of a managed competition proposal.” Link envisioned the corporatization of U.S. medicine, breaking the long dominance of health care providers in the medical care sector. As Enthoven wrote in an article co-authored with Richard Kronick, another leader of the White House health care reform, “what about traditional fee-for-services individual and single specialty group practices? We doubt that they should generally be compatible with economic efficiency. . . . Some would survive in private solo practice without health plan contracts, serving the well-to-do.” It could not have been put more clearly: managed care competition was corporate assembly-line capitalism for the masses and their health care providers, with free choice and fee-for-service medicine for the elites.

This proposal was actively promoted in the White House task force by the staff of Democratic Representative Cooper and members of the so-called Jackson Hole Group, who even distributed the group’s manuals on implementing managed care competition to task force members. They were particularly active in the Governance of the Health System (chaired by Richard Curtis, who had been an official of the HIAA) and Global Budgeting working groups. Outside the task force, managed care competition was actively promoted by the insurance companies. Mr. Weinstein, a disciple of Enthoven and a member of the editorial board of the New York Times (a third of the Times board members then had connections with insurance companies), wrote nine editorials in support of managed care competition.

Paul Starr sold managed care to candidate Bill Clinton. Of course, Starr and another leader of the White House task force, Walter Zelman, were aware of some drawbacks of this scheme, and they modified it to allow for some form of regulation of the ill-defined market forces – without specifying, however, who would do the regulating. They spoke of Health Alliances that would regulate the rate of growth of premiums and would allow, in theory, for consumer choice of health plans, with large employers operating on their own outside the regulatory process but still within the framework of managed care competition (with budget constraints); health insurers and health care providers could be integrated in the same organization, or Health Plans. While managed care competition was the proposal favored by insurers and large employers, it was not favored by health care providers. Providers had already had enough experience with insurance companies to know that they could be more intrusive, abusive, and nasty than government. And managed care was certainly not the choice of the grassroots of the Democratic Party – labor unions and social movements.

Concerned that managed care was not backed by the majority of the progressive base of the Democratic Party, Jesse Jackson, Dennis Rivera (then president of Local 1199, the foremost health care workers union), and I went to see Hillary Clinton. We complained about the commitment to managed care competition without due consideration of a single-payer proposal supported by large sectors of the left in the Democratic Party. We emphasized the need to include this proposal among those to be considered by the task force. Mrs. Clinton responded by asking Jackson and the Rainbow Coalition to appoint someone to the task force with that point of view. And this is how I became a member of the White House task force. I later found out that there was considerable opposition from senior health advisors, including Starr and Zelman, to my becoming part of the task force. According to a memo later made public and published in David Brock’s nasty book The Seduction of Hillary Clinton, Starr and Zelman disapproved of my appointment “because Navarro is a real left-winger and has extreme distaste for the approach we are pursuing” – which was fairly accurate about my feelings, but I must stress that my disdain for managed competition and the intellectuals who supported it did not interfere with my primary objective: to make sure that the views of the single-payer community would be heard in the task force. They were heard, but not heeded. I was ostracized, and I had the feeling I was in the White House as a token – although whether as a token left-winger, token radical, token Hispanic, or token single-payer advocate, I cannot say. But I definitely had the feeling I was a token something.

It was at a later date, when some trade unions and Citizens Action mobilized to get more than 200,000 signatures in support of a single-payer system, that President Clinton instructed the task force to do something about single-payer. From then on the battle centered on including a sentence in the proposed law that would allow states to choose single-payer as an alternative if they so wished. In Canada, after all, single-payer started in one province (Saskatchewan) and later spread to the whole nation. I have to admit that I made that proposal with considerable misgivings, since the insurance companies can also be extremely influential at the state level. For example, Governor Schaeffer
(a Democrat) of Maryland had asked insurance companies to interview the various candidates for state insurance commissioner. Still, including this proposal was a step toward giving single-payer a chance in the U.S.

It is interesting that in my debates with Alain Enthoven, he dismissed my proposals with the comment that “the U.S. Political System is incapable of forcing changes in such powerful constituencies as the insurance industry.” Such candid admission of the profoundly undemocratic nature of the U.S. political system was refreshing. The splendid opening of the U.S. Constitution, “We the people . . .,” should be amended with a footnote reading “and the insurance companies.” Actually, Enthoven’s statement came very close to Marx and Engels’ Communist Manifesto, which defines democracy as a class dictatorship in which the corporate class controls the state. Empirical support in the U.S. for that statement is strong. But the statement is not 100% accurate. I lived under a dictatorship in my youth (in Franco’s Spain) and I recognize a dictatorship when I see one. The U.S. is not a dictatorship. People in the U.S. do have a voice. Marx and Engels (and Enthoven) were not completely right: U.S. history shows that people’s mobilizations can win the day. But, while not a dictatorship, U.S. democracy is profoundly undermined by the enormous influence of the economic and corporate lobbies, components of the corporate class. I documented this in Medicine Under Capitalism, published in the 1970s. And things have become much worse during the Reagan–Bush Sr.–Clinton–Bush Jr. era. The huge limitations of U.S. democracy are evident in the difficulty with which the importance of people’s voice gets noticed. And this is why the Clinton proposal failed. He did not include in his plans any effort to mobilize people in support of the reform. Quite to the contrary. He allied himself with the major forces responsible for the sorry state of the U.S. medical care sector – the health insurance industry. The insurance companies ultimately opposed the final proposal because of its regulatory components, added by Starr and Zelman. But, apart from these components, the insurance companies would have continued to manage the health care system.

Starr’s explanation of why the reform failed is dramatically insufficient. The failure had little to do with timing, with when and where President Clinton presented the proposal. It had to do with how the Clintons related to the progressive constituencies, including labor and social movements. No universal, comprehensive coverage will ever be achieved in the U.S. without an active mobilization of the population (especially progressive forces) so as to balance and neutralize the enormous resistance from some of the most important financial lobbies in the nation. Starr’s social engineering approach, lacking any understanding of the dynamics of power, explains failure as a consequence of problems of the electoral calendar or the types of benefits offered.

In reality, the Clinton administration ignored the majority of the country’s progressive forces from the very beginning of its mandate. President Clinton made his first priority a reduction of the federal deficit (a policy not even included in his program), approved NAFTA (against the opposition of the AFL-CIO, the social movements, and even the majority of the Democratic Party), and committed himself to perpetuation of the for-profit health insurance system — the primary cause of the country’s inhumane medical care system. When NAFTA was approved, Clinton signed the death certificate for the health care plan, and for the Democratic majority in Congress. The number of people who voted Republican in 1994 was no larger than in 1990 (the previous non-presidential congressional election year). The big difference was in the Democratic vote. Abstention by working-class voters increased dramatically in 1994 and was the primary reason why Democrats lost their majority in Congress. This is a point that Starr ignores. The Gingrich Revolution of 1994 was an outcome of voter abstention, particularly among the working class, who were fed up with President Clinton. But NAFTA was also the death knell for health care reform. One could see this in the White House task force. NAFTA empowered the right, and weakened and demoralized the left.

A continuing shift to the right (erroneously called the center) has been the Democratic Party’s strategy for the past 30 years, abandoning any commitment to the New Deal and the establishment of universal entitlements that make social rights a part of citizenship. David Brock writes in his book “that Navarro had told Mrs. Clinton that if the President went ahead with a managed care competition plan, it would cost the election to the Democratic Party.” Brock’s credibility as a reporter is extremely limited, but on that point he was right. I told Mrs. Clinton that the only way of winning, and of neutralizing the enormous power of the insurance industry and large employers, was for the President and the Democratic Party leadership to make the issue one of the people against the establishment. It was a class war strategy that the Republicans most feared. My good friend David Himmelstein, a founder of Physicians for a National Health Program, told Mrs. Clinton the same thing. And as I judged by her response, she seemed to think we did not understand how politics works in the U.S. The problem is, we understood only too well how power operates.

This, then, is why the Clintons failed. And unfortunately, Hillary Clinton will fail again if she lacks the courage to confront those responsible for the predicament in the nation’s health care system. The insurance-controlled system imposes enormous pain on the population. It is not just that 46 million people are now without health insurance, but the system also fails the huge numbers of people who have insufficient coverage and don’t discover this until they need it. This cruel system has been supported by large employers because it gives them oppressive control of the labor force. When workers lose their job, they lose not only their income but also health benefits coverage – for themselves and their families. The alliance of two of the most powerful forces in this country — insurance and large employers — is at the root of the problem.

A final observation. Love of country is measured by the extent to which one promotes policies that support the well-being and quality of life of the population and, most particularly, the working and middle classes that make up the vast majority of the population. Judged by this standard, most super-patriotic, right-wing forces fail miserably on the love-of-country front. People in this nation die due to lack of health care. The estimates vary from 18,000 to 100,000 a year, depending on how you measure preventable deaths. But even based on the most conservative number of 18,000 (from the conservative Institute of Medicine), this is six times the number of people killed on September 11, 2001, by Al Qaeda. And these deaths continue year after year. The deaths on 9/11 are rightly seen as the result of enemy action. But why do the 18,000 deaths each year go unnoticed? Why aren’t they seen as the outcome of hostile forces, whose love for their country is clearly nil? Mark Twain said, “You cannot love people and then go to bed with those who oppressed them.” Why is it so difficult to understand such a basic truth?