Health Care Reform And the Uninsured

Will the November Election Make a Difference?

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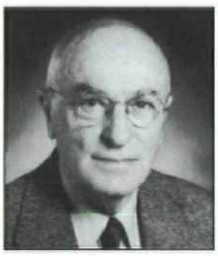

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In the six years since the collapse of President Clinton's health plan, the picture of health care access has darkened for many Americans. In that time, the problem of the uninsured has been addressed in ways that amount to little more than half-measures—what we now call "incrementalism." As the national election approaches, the leading presidential candidates are offering proposals to extend access to health insurance, prop up Medicare, and strengthen relatively new programs such as medical savings accounts (MSAs) and the Children's Health Insurance Program (CHIP).

Although their proposals help to focus awareness, they also remind us that, at the onset of the new millennium, we are presented with two basic reform options. The first option is incremental government-sponsored coverage—largely tax breaks and expansions of existing programs—that extends access to a significant portion of the uninsured (Vice President Al Gore's plan is an example of this, while Gov. George W. Bush's plan is more eclectic). The second option is comprehensive reform that promises universal coverage, with single-payer national health insurance being the most radical option. This article presents a perspective on these options. Beginning with a look at health care reform in America in the 20th century, it considers the condition of the uninsured today as election-year rhetoric once again focuses attention on the need for further reform.

The Long Road to Reform

The idea of comprehensive health insurance for all Americans, a plan that protects each citizen from the financial setback of medical costs, began to emerge in the early years of the last century during a time of intense agitation for social reform.[1] Always just short of a critical threshold of support, the idea remained alive over the years, appearing in cycles.

In the 20th century on at least five occasions at the very least—just prior to World War I, and then in the 1930s, the 1940s, the 1970s, and the early 1990s—government sponsored health insurance was put forward with great fanfare, and in each case was soundly defeated.[2] In most cases the challengers were special interests—powerful conservative groups such as the medical profession, business, and insurance companies—that balked at the specter of "socialized medicine" suggested by compulsory insurance. Ideological divisions, among others, blocked the adoption of a universal health insurance program similar to those implemented by other industrialized nations like England and Germany.

The defeat of President Truman's proposed national health insurance initiative in 1949-1950 was followed by determined efforts to extend the safety net with scaled-down forms of government assistance. In President Eisenhower's administration, for example, legislation added disability insurance to Social Security and extended health care to military dependents. In 1960, the passage of the Kerr-Mills bill provided health care security to the elderly poor; and in 1965, national health insurance laws were passed to cover the elderly and poor. Following this incremental success, the momentum for national health insurance again gathered force, and by 1974 it stood a very good chance of being passed by Congress. However, intransigence on aspects of coverage by certain reform proponents—notably organized labor and liberals, who expected a more reform-friendly Congress following the 1974 elections—eventually killed it. Also, absent committed presidential leadership, none of the bills to emerge from committee stood a chance before the two legislative chambers.[3]

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Similarly, by the late 1970s President Jimmy Carter's campaign promise of universal health insurance appeared within reach. But neither Carter's proposal to phase in a plan gradually nor Sen. Edward Kennedy's proposal for immediate reform of the nation's health care system found sufficient backing among legislators to survive the tumult of debate. Between 1984 and 1990—a period when cost control in health spending was foremost in the minds of legislators—every year saw incremental expansions of Medicaid, while the ranks of the uninsured continued to grow.[4]

In its general pattern, the rise and fall of the Clinton health care reform plan followed the trajectory of past initiatives. As in the past, health system overhaul was for a brief period a hot political issue. The pro-reform momentum of the early 1990s generated campaign promises among the front-running candidates in the 1992 elections; talk of universal health care with cost control enjoyed fairly wide popularity; and public support for reform of the nation's health care system was at a 40-year high.[5] Consequently, when President Clinton began his first term of office, he had both the momentum of an idea whose time had finally come and a political window of opportunity. All the requirements for a national health plan seemed to be in place. Taking a somewhat conservative approach to health reform so as to enlist political support, Clinton eschewed a single-payer plan, proposing expansion of the private market instead.

Yet starting in early 1994, the president's "Health Security" plan began to totter. The pro-marketplace agents, who had been gaining influence for years, got together to attack what had seemed a sure thing only nine months earlier. Conservative interests mounted an anti-Clinton public relations juggernaut that proved critical in turning much of the nation against his plan; ad campaigns cited the restrictions on freedom of choice in managed care and stoked public fears of complexity and "big government" involvement. Business opposition to mandates requiring employers to bear most of the cost of insurance helped to kill the plan, and Republican control of Congress in the midterm elections buried the possibility of any kind of revived federal plan.

Following the defeat of the Clinton plan, political interest in comprehensive reform disappeared, and the market and managed care rushed into the disarray. Since then federal health care initiatives, such as 1996's Health Insurance Portability and Accountability Act (HIPAA) and 1997's CHIP, have appeared as token attempts revive a defeated cause. In sum, this activity calls to mind the aftermath of earlier health reform defeats, such as the demise of the Truman plan in 1950. The private market entered, and government made earnest efforts to cover selected groups of citizens who remained without employer-sponsored or public insurance.

Health Care Reform Today

Still, the achievements of market forces and public initiatives since the death of the Clinton plan may yet constitute solutions of a sort, despite the disdain they arouse in purists of comprehensive reform.

Even piecemeal legislation can comprise a valuable health policy, one that can lead to profound systemic transformations, as we have seen with Medicare and Medicaid. And piecemeal-ism may be inevitable. As Charles E. Lindblom points out in his classic study of public policy formulation, "muddling through" in addressing large public policy issues is unavoidable because perfect comprehensive rationality in decision making is impossible.[6] D. M. Kinzer termed this "disjointed incrementalism . . . the [typical] American political style."[7] In this view, good policy is the path to the best situation we can reach at a cost we think it worthwhile to pay; it does not aim to be perfect in its scope and achievement but merely good in its ends and means.

This inevitability affects the formulation of comprehensive health reform when its proponents attempt to achieve an inclusiveness that may be clear enough in general terms (universal coverage with cost controls) but that introduces particulars whose outcomes cannot be predicted. To appreciate this problem, we need only consider whether Medicare and Medicaid could have been adopted if legislators had thoroughly explored all possible eventualities and foreseen the explosive rises in costs and difficulties that have subsequently occurred. Similarly, it is unlikely that the authors of President Clinton's enormously complex Health Security plan, who tried determinedly to achieve perfection, could ever

BURDENS OF THE UNINSURED

According to the Kaiser/Commonwealth 1997 National Survey of Health Insurance, uninsured Americans are more likely than the insured to:

- Avoid filling prescriptions
- Have difficulty getting needed care (a 1997 study showed that 51 percent of the uninsured had encountered difficulty obtaining care, as against 10 percent of the insured)
- Avoid seeing a physician
- Postpone care because of its costs
- Have a disability or chronic illness limiting daily activities
- Have trouble paying medical bills
- Have to change their lives significantly to cover medical expenses

—National Coalition on Health Care, *Health Care Facts*, March 1998.

have fully realized the success they envisioned, taking into account the task before them: overhauling one-seventh of the economy.[8]

With perfect rationality unattainable according to this theory, we are constrained to use incremental solutions. Examples of "muddling through" to universal coverage have been under way at the state level for years.[9] At the federal level, one of the great appeals of incrementalism is the likelihood of bipartisan support. The decisive importance of political convergence and strong leadership on issues is one of the lessons Flint J. Wainess draws from the failed campaign for national health system reform in 1974. "The heart of incrementalism," he notes, "is the notion that one must start with a politically palatable approach, something that can gain widespread bipartisan support," and then, in theory, the program would be expanded later.[10]

A growing number of workers are foregoing insurance entirely.

The Vulnerability of the Uninsured

The millions of uninsured Americans who would benefit from these incremental solutions comprise mixed demographic groups according to the most recent findings of the U.S. Census Bureau. Most of this number are children and young and middle-aged adults. Of these, a disproportionate number are minorities; 35 percent of the nation's 32 million Hispanic people have no health insurance as compared with 22 percent of blacks and 15 percent of whites. Comprising only 24 percent of the U.S. population, minorities make up 46 percent of the uninsured.[11]

As one study points out, the greatest increase in the uninsured in the past 10 years has been among young adults aged 18 to 39 years, a generally healthy, low-risk group, many of whose members choose not to insure.[12] With the elderly covered under Medicare and children targeted by CHIP, the most vulnerable group may be the low and middle-income adults in this age range whose employment does not provide insurance, who cannot afford private commercial insurance, and who earn too much to qualify for Medicaid. These are the working poor, a segment that advocates of reform refer to as "the largest and most politically sympathetic uninsured group."[13] Most are employed in service sector jobs in small-sized companies where health insurance is often not an employment benefit (roughly one-half of poor, full-time workers were uninsured in 1998). Many are part-time employees, temporary workers, farm workers, and independent contractors and, therefore, do not qualify for health benefits.[14] Others include the self-employed.

Full-time permanent workers in industry—the middle class—have been affected as well. Although health benefits are usually available here, those benefits have been considerably truncated over the past 10 years. With American businesses experiencing the steepest rise in health insurance prices in a decade, employers are offering health plans with reduced coverage, shifting a larger share of premium costs to employees, and even dropping insurance entirely.[15] According to a recent study, in 1998 workers at small businesses (fewer than 200 employees) paid an average 44 percent of the family coverage premium, up from 34 percent in 1988.[16] Confronted by high out-of-pocket costs for health insurance and other competing expenses, a growing number of workers are electing to forgo it entirely. In 1996, approximately 6 million fewer people enrolled in health insurance through their employers than in 1987.[17]

Many within this growing population of uninsured and underinsured will find charity care increasingly hard to secure. Safety nets are being reduced by cost control measures applied by managed care administrators; cross subsidies that hospitals have traditionally used to finance indigent care are being squeezed. Research has shown that physicians who derived 85 percent or more of their income from managed care in 1996-97 dispensed about half as much charity care as those with no managed care affiliation.[18] Further reducing this traditional source of philanthropy, the Medicare cuts enacted under the 1997 balanced budget act will trim an increasing amount each year through 2002.[19]

For these segments of society, the consequences of being uninsured are far more serious than one might suppose. Living without health insurance means lingering "between denial and fear. It means ignoring the little pains and dealing

with the unmanageable ones in a frantic way."[20] The uninsured are by and large in poorer health than the insured; they typically forgo preventive care and learn to live with serious health problems. According to research conducted in 1999 by the Center for Studying Health System Change, 16.3 percent of uninsured people under 65 were in fair to poor health, compared with 10.6 percent of all people under 65.[21]

Election-Year Scenarios

In its most dire characterization, this problem amounts to a Dickensian picture of an underclass in precarious health, forced to shift for itself in a market where charity is increasingly unavailable. A contrasting picture highlights a minority of Americans who are inconvenienced by sporadic health coverage, but who, nonetheless, are assured of charity care when needed. The truth lies somewhere in the middle.

One hopes that even a divided Congress can find a sufficient consensus to strengthen existing insurance programs, such as Medicare and CHIP, and make the cost of health insurance less burdensome for businesses and individuals. This is the hope reflected in Vice President Gore's program. His proposal for "step-by-step" health care reform includes a stronger, expanded CHIP that covers all children by 2004; a prescription drug program for the elderly and possible expansion of benefits; a patients' Bill of Rights; protection of the Medicare and Social Security programs; a plan to allow individuals between ages 55 and 65 to buy into Medicare; and a pledge to reach universal access (no date specified) through the "step-by-step" method. It would also seek tax credits for the purchase of individual health insurance and tax breaks for small businesses to cover low-income workers.

Gov. Bush's eclectic plan to extend health insurance access to a greater number of Americans is representative of a number of programs proposed in recent years to improve access to health care for those without it. Such programs typically include legislation that encourages insurers to make health coverage more affordable for working class Americans; an expansion of government programs such as Medicaid; federal financial assistance for workers between jobs that would allow them to purchase health insurance; and the creation of medical savings accounts (MSAs).[22] Bush's variation would offer health care insurance tax credits to poor families, make affordable health insurance available to small businesses, and reform health care options such as MSAs.

Another scenario, comprehensive health system reform, is rarely mentioned today as a serious option, in part because of the fate of the Clinton health plan. Many observers believe that national health insurance, the most radical expression of this scenario, is political poison. They see a single-payer, federally financed plan—the "Canadian system"—as much too extreme for the times. Still, even taking into account the considerable negative baggage involved in this approach (e.g., the alleged inefficiency of "big government"), a single-payer plan becomes less and less inconceivable as the dissatisfaction over market-driven managed care continues to grow. As the authors of an article on the topic point out, we are witnessing one of the Clinton era's "main event[s]," a scenario in which the "business ethic gains ascendancy, and the market wrings the last vestige of charity and compassion from our health care system." It is time, they argue, "for Congress and the states to abandon their failed pro-competition strategies and embrace a more fiscally conservative single-payer national health program similar to Canada's. Such a system could cover all Americans, cut costs, and decrease bureaucracy."[23]

The first scenario, incrementalism made up of cobbled-together programs, is perhaps the more realistic option, offering an alternative to the unpalatable choices of doing nothing and attempting to restart national health insurance. Lindblom would likely advise health reformers to consider the first of these scenarios, to seize the day in significant increments, because attempting to take it in one fell swoop is politically impossible in America.

Of course, nothing will be politically out of reach if a galvanizing social crisis occurs. We believe that federally sponsored comprehensive reform is possible given sufficiently dire conditions, such as the proportion of uninsured Americans reaching a much higher figure (D. Blumenthal puts the crisis point at 25 to 30 percent)[24] or a new round of rapidly mushrooming health care costs, coupled with an upwelling of grassroots support, determined political leadership, and political majorities that are keen for reform. To skeptics who point to America's historical ideological resistance to "socialized medicine," we would reply that the combined federal, state, and local government share of the national health bill was 47 percent in 1998. Moreover, since it insures 35 percent of America's population, government is far and away the nation's largest insurer.[25]

"Muddling through" to Universal Coverage

Inevitably, the problem of the uninsured will reemerge as a major national social issue.[26] Judging by the growing frequency of its appearance in the news, the problem may already have begun announcing itself. A poll conducted in July indicates that health care issues will have an important impact on the November election.[27] In the

view of Arthur Caplan of the Center for Bioethics at the University of Pennsylvania, the absence of a more substantial safety net "is the most complacent acceptance of the unacceptable that I've seen in a long time."[28] Henry Simmons of the National Coalition on Health Care goes further, terming this complacency a "national disgrace."[29]

Debate of health care reform in response to this problem is likely to occur in terms of incrementalism. Although the various concerns include cost control, the erosion of coverage, and the constraints imposed by managed care, the heart of health care reform remains universal coverage, a fact that seemed lost amid the recent congressional debates over the Patients' Bill of Rights. Most Americans have long favored this, but have balked at paying more in taxes for universal coverage.

The issue is not just where to go, but how to get there. For now, little substantive debate occurs on the means to universal coverage, even as many observers sustain hope that new life may yet return to it. If reformers are to frame a new debate, they must avoid the miscalculations of the past, concentrate on sound fundamentals, and rethink political strategies. Any new program must address coverage and cost in the same proposal. It must be conceptually simple and easily understood by ordinary citizens. The president must be a strong supporter. It must be bipartisan. And its supporters must give special attention to a strategy to promote it both in Congress and on Main Street.

Sooner or later, the nation will again need to address comprehensive health care reform. This eventuality is obvious as we look back at the rise and fall of health reform in the 20th century, from the Progressive era to the Clinton era, and then look ahead at the potentially disastrous social problem that awaits us if we fail to "muddle through" more expeditiously. In health care reform, an enlightened incrementalism may be the best course at the present time. Yet, for politicians who are faithful to their humanitarian principles, the goal of this gradualism should be a safety net that extends to all Americans. □

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