

PATHS TO UNIVERSAL HEALTH INSURANCE: PROGRESSIVE LESSONS FROM THE PAST FOR THE FUTURE[†]

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Professors Marmor and Oberlander examine the state of health care reform in the United States. The authors briefly discuss the failed Clinton health plan before examining the return of health reform to the political agenda. They then focus on alternatives, such as a federalist option, the pincer movement, and a single-payer system. Finally, the authors highlight the lessons that can be learned from previous attempts to enact comprehensive health reform.

Comprehensive health care reform has once again returned to the American political agenda. In 2003, the media were replete with stories documenting the numerous ills of American medicine: the growing ranks of the uninsured, the rising costs of health insurance and medical care, and the malpractice crisis.¹

This was not, of course, a new story. Similar indictments of American medicine had dominated the first half of the 1990s. The enactment of national health insurance seemed, if only for a fleeting moment, imminent when Bill Clinton won the Presidency in 1992. For the first time since Harry Truman, a president came to the White House with national health insurance as a centerpiece of both his campaign and legislative

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1. For an overview of the contemporary politics of health reform, see Jonathan Oberlander, *The Politics of Health Reform: Why Do Bad Things Happen to Good Plans?*, HEALTH AFF. WEB EXCLUSIVE, Aug. 27, 2003, at W3-391, W3-391-403, at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.391v1.pdf>.

agenda.² Indeed, the chances for President Clinton's success were far better than for Truman. The strength of the "negative consensus"³ in U.S. public opinion that system-wide comprehensive reform was necessary, was both deeper and broader in the 1990s than it was in the late 1940s and early 1950s.⁴ In addition, the American Medical Association (AMA), once viewed as the primary obstacle to national health insurance, had lost much of the political influence—and softened its strident opposition to any government presence in health care—that doomed the Truman plan.⁵

Nevertheless, the Clinton health plan met the same fate as four previous attempts at comprehensive reform of U. S. medical care: legislative failure.⁶ By late 1994, the optimism generated by the election of 1992 had completely evaporated.⁷ In the end, the Clinton administration's carefully constructed plan could not even muster enough support to get out of committee.⁸ Moreover, not only did the Clinton plan fail, but no health reform plan at all emerged from Congress in 1993–1994.⁹ Health reform died from political asphyxiation.

Historically, opportunities for health care reform are few and far between. Therefore, it was no surprise that in the aftermath of the Clinton debacle the issue of major health reform was pronounced dead for the foreseeable future.¹⁰ Controversial changes in the financing and organization of medicine soon replaced governmental reform on the public's agenda.¹¹ A number of health care analysts touted the potential of the private sector—through what came to be called managed care and health insurance competition—to control medical spending, enhance efficiency, and even expand coverage of the uninsured.¹² According to many commentators, the legacy of the Clinton debacle was policy caution.¹³ Health reform, it became conventional to claim, would not reappear anytime soon on the national political agenda, politicians would not

2. See Theodore Marmor & Jonathan Oberlander, *A Citizen's Guide to Healthcare Reform*, 11 YALE J. ON REG. 495, 496 (1994) [hereinafter Marmor & Oberlander, *A Citizen's Guide to Healthcare Reform*].

3. See PAUL STARR, *THE LOGIC OF HEALTH CARE REFORM* 16–24 (1992).

4. Marmor & Oberlander, *A Citizen's Guide to Healthcare Reform*, *supra* note 2, at 500.

5. See THEDA SKOCPOL, *BOOMERANG: CLINTON'S HEALTH SECURITY EFFORT AND THE TURN AGAINST GOVERNMENT IN U.S. POLITICS* 30 (1996).

6. Marmor & Oberlander, *A Citizen's Guide to Healthcare Reform*, *supra* note 2, at 496.

7. *Id.*

8. See SKOCPOL, *supra* note 5, at 74–75.

9. See *id.* at 99–106.

10. Jacob S. Hacker & Theda Skocpol, *The New Politics of U.S. Health Policy*, 22 J. HEALTH POL., POL'Y & L. 315, 316–17 (1997).

11. See Kenneth E. Thorpe, *The Health System in Transition: Care, Cost and Coverage*, 22 J. HEALTH POL., POL'Y & L. 339 (1997).

12. For a critique of the meaning of managed care and its contemporary uses, see Jacob S. Hacker & Theodore R. Marmor, *How Not to Think About "Managed Care,"* 32 U. MICH. J.L. REFORM 661 (1999).

13. Theodore R. Marmor, *Forecasting American Health Care: How We Got Here and Where We Might Be Going*, 23 J. HEALTH POL., POL'Y & L. 551, 568–69 (1998).

consider attempts at system-wide reform, and the public was no longer interested in the plight of the uninsured.¹⁴

Yet a decade later, it is evident that the de facto health care policy of incrementalism and market-based reforms has failed to solve the dilemmas of U.S. medical care. The same pressures of rising costs and the growing ranks of the uninsured that drove the health reform debate in the 1990s are again a force in U.S. politics, and health reform promises to be a prominent issue in the 2004 presidential elections. Now that the debate over health reform has reopened, the question is what can—and should—be done. This article evaluates the prospects for reform, analyzes various reform options, and elaborates a set of principles, goals, and strategies. At the time of this writing, Fall 2003, it is unknown what the precise electoral and economic conditions will look like after the November 2004 elections. Consequently, we conclude the article by examining the feasibility of health reform under different combinations of political and economic circumstances.

I. THE RETURN OF HEALTH REFORM

The reemergence of health care reform as a national issue reflects both troubling trends in U.S. medical care and changing political dynamics. Once again, the public spotlight has focused on the plight of the uninsured. In October 2003, the Census Bureau released a report showing that fifteen percent of Americans (43.6 million) were without any health insurance in 2002, a 2.4 million increase from the previous year.¹⁵ The report underlined a disturbing fact: despite record levels of low unemployment and sustained economic growth from 1992–2000, as well as relatively restrained levels of medical inflation between 1993 and 1998, there was no decline in the number of uninsured Americans.¹⁶ Moreover, the failure to substantially enhance insurance coverage during the 1990s came despite state and federal policy initiatives designed specifically to reduce the number of uninsured, including the enactment of the State Children's Health Insurance Program (S-CHIP).¹⁷ If the number of uninsured did not decline significantly during the best of times, then what would happen under less favorable economic growth and employment

14. This view of the legacy of the Clinton health plan failure was embodied in a series of articles published in 14 *Health Affairs* (Spring 1995) that specifically addressed the past and future of health reform.

15. ROBERT J. MILLS & SHAILESH BHANDARI, U.S. CENSUS BUREAU, HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2002, CURRENT POPULATION REP., Sept. 2003 1 (2003), <http://www.census.gov/prod/2003pubs/p60-223.pdf>.

16. See JOHN HOLAHAN & MARY BETH POHL, THE URBAN INST., HENRY J. KAISER FAMILY FOUND., CHANGES IN INSURANCE COVERAGE: 1994–2000 AND BEYOND, at <http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14140> (last visited Feb. 27, 2004).

17. See HENRY J. KAISER FAMILY FOUND., HEALTH COVERAGE FOR LOW-INCOME CHILDREN (2002), available at <http://kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14044>.

conditions? The sobering answer, as the 2003 Census Bureau report revealed, is a sizable expansion of the uninsured population. By one estimate, twenty percent of Americans under the age of sixty-five could be uninsured by 2005.¹⁸

Moreover, there is mounting evidence that the already-torn safety net of providers that care for the uninsured—public hospitals, neighborhood health clinics, and others—is stretched to the breaking point.¹⁹ Safety net providers suffering financially, pressured from cutbacks in revenues from both private and public payers.²⁰ As managed care firms have secured contracts to serve Medicaid patients, safety-net insurers have lost not only patients, and thus crucial Medicaid funds to help cover their costs of treating the uninsured, but have been left with an increasingly sicker and more costly clientele, as well.²¹ Finally, the traditional institution of last resort for the uninsured—the hospital emergency room—is becoming endangered in some areas. In the last decade, 400 of the nation's 5000 emergency rooms closed, as for-profit hospitals sought to avoid the costs of uncompensated care by literally closing their doors to the uninsured.²²

The return of high levels of medical inflation has also raised the prominence of health reform. As previously noted, the United States enjoyed a period of relatively stable expenditures on medical care from 1993 to 1998.²³ A slew of analysts interpreted the slowdown in spending as evidence that managed care had solved the problem of medical inflation.²⁴ HMOs and other managed care plans, they argued, had transformed medicine into an efficient model of market competition that was inherently superior to traditional fee-for-service medicine.²⁵ The triumph of managed care over health care inflation, however, has proved to be short-lived. Beginning in 1999, health costs began to rise again sharply.²⁶ By the summer of 2002, medical inflation was rising at twice the rate of the consumer price index.²⁷ According to the Center for Studying Health System Change, per capita spending on medical care rose by 9.6% in 2002—nearly four times faster than the general economy—and by an av-

18. See KENNETH E. THORPE, NAT'L COALITION ON HEALTH CARE, *THE RISING NUMBER OF UNINSURED WORKERS: AN APPROACHING CRISIS IN HEALTH CARE FINANCING* 2 (1997).

19. See David Brown, *Medical Safety Net Seen in Peril*, WASH. POST, Mar. 31, 2000, at A2; Peter T. Kilborn, *The Uninsured Find Fewer Doctors in the House*, N.Y. TIMES, Aug. 30, 1998, § 4, at 14.

20. See Brown, *supra* note 19; Kilborn, *supra* note 19.

21. See Brown, *supra* note 19; Kilborn, *supra* note 19.

22. See Miguel Bustillo, *California and the West Treating an Emergency Care Crisis*, L.A. TIMES, Feb. 15, 2000, at A3.

23. See *supra* note 16 and accompanying text.

24. See, e.g., REGINA E. HERZLINGER, *MARKET-DRIVEN HEALTH CARE* 108–27 (1997).

25. See *id.* at 127. See generally JAMES C. ROBINSON, *THE CORPORATE PRACTICE OF MEDICINE* (1999); Paul Ellwood et al., *The Jackson Hole Initiatives for a Twenty-First Century American Health Care System*, HEALTH ECON. I, 149–68 (1992).

26. CTR. FOR STUDYING HEALTH SYS. CHANGE, DATA BULLETIN NO. 25 TRACKING HEALTH CARE COSTS (June 2003), available at <http://www.hschange.com/CONTENT/564/>.

27. See *id.*

erage of 8.6% from 1999–2002.²⁸ Over time, it has become apparent that the decline in medical inflation between 1993 and 1998 was not a permanent achievement of managed care. Rather, it was a temporary development, attributable in part to marketing strategies and short-term market conditions, as well as to the aggressive use of market power to obtain price discounts.

HMOs, not so long ago viewed as the salvation of public health insurance, have increasingly pulled out of the Medicare and Medicaid programs.²⁹ And employers, who once believed managed care provided the magic bullet to control their health care costs, have become increasingly disillusioned and have sought alternative approaches.³⁰

II. BARRIERS TO NATIONAL HEALTH INSURANCE

Although health care recaptured a salient spot on the national agenda in 2003—and there is every reason to expect that it will be a prominent issue in the 2004 presidential campaign—there is no guarantee that the President and Congress will enact any substantial reform legislation after the 2004 elections. The assumption that attaining a position on the policy agenda and having public majorities—and even presidential support—behind reform guarantees political victory has misled reformers time and again. Indeed, national health insurance would have been enacted five decades ago if those conditions were sufficient to pass such legislation.

The U.S. political system creates many barriers to passing any legislation, let alone a reform as controversial, ideologically divisive, and threatening to powerful interest groups as national health insurance. The political arrangements of U.S. government fragment power. Unlike in a parliamentary system, such as that of Great Britain, the President will not always represent the same party as the majority of Congress. Indeed, divided government has become a regular feature of U.S. government. Moreover, even if the President's own party enjoys majorities in both Houses of Congress, as happened early in the Clinton Administration, reform is not guaranteed to pass. Perhaps the most important lesson for health reform is that partisan congressional majorities are seldom policy majorities. In international terms, U.S. political parties are weak. Members of Congress to a great extent run their own campaigns, raise their own funds, and run independently from—and sometimes opposed to—their parties' platforms. Their first political allegiances are neither to their parties nor the President, but to their congressional districts.

28. See CTR. FOR STUDYING HEALTH SYS. CHANGE, *supra* note 26.

29. See Peter T. Kilborn, *Largest H.M.O.'s Cutting the Poor and Elderly*, N.Y. TIMES, July 6, 1998, at A1.

30. See Robin Toner & Sheryl Gay Stolberg, *Decade After Health Care Crisis, Soaring Costs Bring New Strains*, N.Y. TIMES, Aug. 11, 2002, at 1.

Consequently, presidential sponsorship of major legislation, even with a Congress controlled by the President's own party, does not ensure presidential victory on any given issue—a lesson Bill Clinton learned the hard way.

The internal organization of Congress further complicates the road to reform. Legislation must clear both the House and Senate to reach the President's desk. The labyrinth that must be navigated before that step is daunting. Congress is organized into a series of committees and subcommittees governing various legislative issues. Substantial overlap exists across committees' jurisdictions and one bill is often considered by a multitude of committees. Historically, two key committees—the Ways and Means Committee in the House, and the Finance Committee in the Senate—have been the gateways for health insurance legislation. Failure to get a bill out of these committees dooms it to defeat, even if there are congressional majorities in favor of the legislation. This was the case when Wilbur Mills helped to bottle up Medicare legislation in the early 1960s.³¹

The fragmented structure of Congress and relative weakness of U.S. political parties create another barrier to reform: the difficulty in achieving any consensus on a single piece of legislation. Congress, measured in terms of its independence, administrative capacity, and ability to pursue policies diverging from the executive, is the most powerful legislature in the world. Committee and subcommittee chairpersons have their own platforms to introduce health reform bills, differing from either the President's or their own parties'. As a consequence, any debate over health reform produces numerous bills sponsored by entrepreneurial congressional policymakers. The lesson is a sobering one for reformers. Even if there is a congressional majority in favor of national health insurance, there is not necessarily a majority for any particular plan. The inability of Congressional majorities to coalesce behind one plan arguably doomed national health legislation during the early 1970s, when there was an attainable majority in Congress that could have been mobilized in favor of universal coverage.³²

A second critical barrier to the adoption of national health insurance is the very structure of health politics in the United States. Fundamental reform poses a tremendous threat to those institutions invested in maintaining the medical status quo. This includes a large proportion of U.S. hospitals and physicians. It includes almost all U.S. health insurers, pharmaceutical companies, and suppliers of medical equipment and technology. These groups—what political scientists call “concentrated interests”—have much at stake in any reform that erodes their financial

31. See THEODORE R. MARMOR, *THE POLITICS OF MEDICARE* 40–41 (1973).

32. See generally PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* (1982) (discussing the politics of national health insurance in the 1970s). National health insurance legislation failed in both 1970–1974, *id.* at 381–405, and in 1993–1994, see SKOCPOL, *supra* note 5, at 1–8.

and organizational positions.³³ They are generally well organized, well-funded, and willing and able to take advantage of both the media and fragmented political institutions that provide multiple opportunities to block any legislation deemed as hostile to their interests.

On the other side, however, there are over forty million uninsured Americans and a substantial number of underinsured with a stake in universal health insurance.³⁴ The uninsured and underinsured are, however, a group in statistical terms only. They have little in common—except that they are without health insurance. A diverse group politically, geographically, and ethnically, they have no organization, few financial resources, and little political clout. The textbook view of U.S. democracy is that groups with a common grievance will organize and voice their grievance to a responsive political system. The textbook view of U.S. democracy, as the case of the uninsured illustrates all too well, is often wrong. The uninsured may be large in number, but they are a diffuse interest with tremendous barriers to organization. Thus, it is no accident that while the list of medical lobbying groups and trade associations is endless, there is not a single prominent national group (with the exception of Families USA) whose primary purpose is advocating for the uninsured. Pitted against the organization and influence of the medical industry, the uninsured are no match.

The resulting imbalance in the arena of health politics is, as the Clinton administration discovered, profound. While the administration found support for its plan from unions and consumer advocacy groups, such as Families USA, the health insurance industry dominated the 1993–1994 debate.³⁵ The Health Insurance Association of America (HIAA) sponsored the infamous “Harry and Louise” ad campaign that helped deflate public support for the Clinton plan by smearing it as a threat to the public.³⁶ Further, congressional Republicans, who at first had considered an alternative to the Clinton plan a political necessity, quickly changed their minds after major business interests made steadfast opposition to any plan clear.³⁷

The third major barrier to health reform is public opinion. To be sure, analysts and politicians alike have vastly exaggerated the role of mass opinion in defeating universal health insurance. An overwhelming number of U.S. residents have consistently supported the idea that health care should be a right in the United States.³⁸ For the past twenty years, a

33. See THEODORE R. MARMOR, *POLITICAL ANALYSIS AND AMERICAN MEDICAL CARE* 6–9 (1983).

34. For estimates of the rate of uninsurance in the United States, see Mills & Bhandari, *supra* note 15.

35. See *infra* text accompanying note 43–44.

36. See SKOCPOL, *supra* note 5, at 137–38.

37. *Id.* at 143–45, 157–58.

38. See Lawrence R. Jacobs, *The Politics of American Ambivalence Toward Government*, in *THE POLITICS OF HEALTH CARE REFORM* 378 (James A. Morone & Gary S. Belkin eds., 1994).

majority of U.S. residents have favored the adoption of universal health insurance.³⁹ There has been, in short, a “permissive consensus”⁴⁰ among the public for universal coverage that would have allowed enactment of national health insurance under favorable political conditions.

Yet the depth and stability of public support for health reform remains suspect. While people favor the idea of a national health program in the abstract, support drops when respondents are asked about any specific plan.⁴¹ Polls also reveal a long-standing reluctance to pay much more in taxes to fund universal coverage.⁴² For all the focus on the moral plight of the uninsured, most Americans, it should be remembered, are insured and any health reform plan that is seen as threatening their medical care arrangements will lose public support from the well-insured middle class.⁴³ At the end of the day, universal health care boils down to a redistributive question: Are the insured willing to pay more taxes to fund medical care for the uninsured? Thus far, the insured public has yet to give an unqualified “yes” to that question.

Perhaps not surprisingly, then, public opinion has proven volatile and subject to the influence of campaigns designed to discredit national health insurance. For example, in 1993 and 1994, the health insurance industry managed to define the Clinton plan to the media on its own terms. Absent any analysis of the clear falsity of these claims by journalists, the industry’s view of the Clinton plan as big government reached the public unfiltered. The result was a striking drop in public support for the Clinton plan that seriously damaged its chances for passage.⁴⁴

Finally, contemporary reformers must confront the prevailing anti-government ideology of U.S. politics. At a time when even Democratic President Clinton declares that the era of big government is over, strong skepticism pervades about the ability of the federal government to solve social problems.⁴⁵ The factual basis for the claim that “government just can’t do anything right” is demonstrably wrong and major public programs such as Social Security and Medicare remain immensely popular. Regardless of the veracity of claims of governmental ineptitude, however, they are politically influential. As segments of the public widely believe these claims, they constitute a barrier to the enactment of any program that substantially increases federal responsibility—both fiscal and administrative—for financing medical care.

39. *Id.*

40. The term “permissive consensus” was first used in the 1960s to describe the type and level of support that was forming among U.S. residents for national health insurance programs such as Medicare and Medicaid. See V.O. KEY, PUBLIC OPINION AND AMERICAN DEMOCRACY 32–35 (1961).

41. See Jacobs, *supra* note 38, at 378–82.

42. *Id.* at 382, 392.

43. Jonathan Oberlander, *The U.S. Health Care System: On a Road to Nowhere*, 167 CANADIAN MED. ASS’N J., 163–68 (2002), <http://www.cmaj.ca/cgi/content/full/167/2/163> (last visited Feb. 29, 2004).

44. See Lawrence R. Jacobs & Robert Shapiro, *Don’t Blame the Public for Failed Health Care Reform*, 20 J. HEALTH POL., POL’Y & L. 411, 412–22 (1995).

45. See Jacobs, *supra* note 38, at 380–83.

The political contest for national health insurance has never been played on a level field, and it never will be. Given the political conditions that existed in 1993—presidential endorsement, public support, and partisan majorities—no parliamentary-style democracy in the industrialized world would have failed to enact universal health coverage. That is the cautionary message of this review of U.S. health care politics. Yet the formidable barriers to enacting national health insurance in the United States should not be taken to mean reform is doomed to fail. Some analysts claim the institutional barriers to comprehensive reform are so strong that achieving universal health insurance is impossible without first enacting constitutional reforms that would radically alter U.S. government.⁴⁶ We reject this analysis. If U.S. political institutions were really an insurmountable barrier to major social reform, then we would not have Social Security or Medicare, both of which were at one time considered politically implausible. Although interest groups representing the medical industry enjoy a considerable political advantage, that too can be overcome. Analysts considered the AMA untouchable until Congress enacted Medicare over the AMA's strident opposition.⁴⁷ Finally, the permissive consensus that has traditionally characterized public attitudes about national health insurance provides reason to believe that antigovernment sentiment can be overcome by persuading the public that public financing of health care is different and necessary. In short, although enacting a system of universal health insurance is very difficult, given the constraints of U.S. politics, it is far from impossible. Given the right circumstances, strategies, and plans, serious, workable reform can succeed.

III. BUSH AND GORE IN THE 2000 ELECTIONS: INCREMENTALISM IN VOGUE

During the last presidential election in 2000, health reform took a halting step back onto the political agenda, emerging as a significant issue during the Democratic primary. Did any of the plans in the 2000 presidential election meet the above criteria? In other words, was there a plan on the table that was both substantively desirable and politically feasible that could surmount the political barriers and provide a workable, effective system of universal health insurance? The answer, sadly, is no. What is most striking is that universal coverage did not become a prominent issue in the 2000 presidential contest despite the forecast of sizable federal budgetary surpluses; evidently the uninsured did not qualify as a political or societal priority. Instead, a significant portion of the

46. See Sven Steinmo & Jon Watts, *It's the Institutions, Stupid! Why Comprehensive National Health Insurance Always Fails in America*, 20 J. HEALTH POL., POL'Y & L. 329 (1995).

47. See MARMOR, *supra* note 31, at 53, 122.

surplus went to tax cuts.⁴⁸ The only major party candidate to even suggest that the surplus should be largely devoted to covering the uninsured was former Senator Bill Bradley, who proposed an ambitious plan of expanded health coverage but ultimately lost the Democratic party nomination to Al Gore.

In the 2000 general election, neither Republican nominee George W. Bush nor Democratic nominee Al Gore aggressively raised the issue of the uninsured and universal coverage. Health care simply was not prominently featured in the early stages of Bush's candidacy. Bush endorsed the conservative incremental reform package of expanding Medical Savings Accounts (MSAs), tax deductions, and transforming Medicare into a premium-support (voucher) system modeled after the plan of the National Bipartisan Commission on Medicare.⁴⁹ Bush, after initially suffering political fallout for ignoring the issue, also eventually promoted a plan for Medicare prescription drug coverage that aimed to cover low-income beneficiaries through private insurance plans.⁵⁰ In terms of expanding insurance coverage, Bush proposed giving states greater flexibility under the S-CHIP program to cover more people and providing a "health credit" of up to \$1000 per individual and \$2000 per family to cover the costs of insurance.⁵¹ He also called for the creation of "Association Health Plans" by the Chamber of Commerce and National Federation of Independent Business that would market new coverage plans to small businesses.⁵²

Bush's package of health measures would hardly have dented the problem of the uninsured. MSAs, most health analysts agree, would disproportionately attract the healthy and wealthy, unraveling already frayed insurance pools and raising costs for sicker enrollees.⁵³ Early experiments with MSAs have fallen far short, in terms of enrollment, of their advocates' expectations.⁵⁴ MSAs require high-deductible, catastrophic insurance that brings with it a level of financial insecurity and exposure to medical bills with which most Americans are not comfortable.⁵⁵ Consequently, not only would MSAs fail to enhance access to medical care, they also would do little, if anything, to control the costs of medical

48. Uwe Reinhardt, *Is There Hope for the Uninsured?*, HEALTH AFF. WEB EXCLUSIVE, Aug. 27, 2003, at W3-376, W3-383-84, at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.376v1.pdf>.

49. See Kenneth Howe, *Health Care Is Candidates' Hot Topic: Parties Differ Widely on Plans for Reform*, S.F. CHRON., Feb. 17, 2000, at A1.

50. JONATHAN OBERLANDER, *THE POLITICAL LIFE OF MEDICARE 190-91* (2003).

51. See Howe, *supra* note 49.

52. See Jonathan Cohn, *W.'s Health Plan Is Conservative, All Right*, NEW REPUBLIC, May 1, 2000, at 15.

53. See Marilyn Moon et al., *Medical Savings Accounts: A Policy Analysis*, URB. INST. REP. Mar. 1996, at 23, available at <http://www.urban.org/UploadedPDF/msa.pdf>; see also JACK A. MEYER & ELIOT K. WICKS, ECON. & SOC. RESEARCH INST., *THE ROLE OF MEDICAL SAVINGS ACCOUNTS IN HEALTH SYSTEM REFORM* (1998), available at <http://web.archive.org/web/19980710024812/http://nchc.org/emerge/medicare2-0698.html> (last visited Feb. 28, 2004).

54. See Moon et al., *supra* note 53, at 2.

55. See *id.* at 4-5.

care (which is one reason the AMA has actively campaigned for their implementation). The \$2000 health credit might help a segment of the uninsured, but it is far too low to help millions of the uninsured⁵⁶ whose premium costs would far exceed the subsidy. Bush's Medicare plan would similarly worsen access to care for program beneficiaries by shifting much of the risk of medical inflation to the elderly and disabled and by creating incentives for chronically ill beneficiaries to join HMOs that studies demonstrate are ill-prepared to care for their medical needs.⁵⁷ Finally, Bush offered few details about how he would expand S-CHIP, other than to promote covering more children as a desirable goal.⁵⁸ Thus, Bush's health proposals did not treat expansion of health insurance coverage as a serious policy goal.

Al Gore, alternatively, proposed a path of centrist incrementalism.⁵⁹ The centerpiece of his plan was an expansion of S-CHIP to include not only more children, but also their parents.⁶⁰ This represented a variation of the "pincer strategy" that we describe later in this article. Gore called for expanding S-CHIP to children up to 250% of the federal poverty level (FPL), allowing children over that threshold to buy into S-CHIP or Medicaid, and opening up S-CHIP to the parents of children already enrolled in the program.⁶¹ He also reiterated the Clinton administration's proposal to allow those aged fifty-five to sixty-four to buy into Medicare.⁶² To be sure, Gore emphasized health reform to a greater extent than George W. Bush. His proposals could have reduced the numbers of uninsured. In particular, his effort to transform S-CHIP into a program for U.S. families, not simply children, represented an important effort to broaden the reach of health reform. It also had the political advantage of attracting the "missing middle" of adults working in low-wage jobs, who

56. See HENRY J. KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, EMPLOYEE HEALTH BENEFITS: 2002 SUMMARY OF FINDINGS, available at <http://www.kff.org/insurance/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14077> (last visited Jan. 23, 2004). According to the Kaiser Family Foundation's estimates, the average health insurance premium in 2002 was approximately \$8000 for a family and \$3000 for an individual. See *id.*

57. See Jonathan Oberlander, *Is Premium Support the Right Medicine for Medicare?*, 19 HEALTH AFF., Sept.-Oct. 2000, at 95 (discussing studies of HMOs and their inability to care for people with chronic illnesses).

58. Jane Cys & Susan J. Landers, Gore, *Bush Give Stances on Medicine: The Presidential Candidates Offer Clear Choices on Issues Affecting Health Care*, AM. MED. NEWS, Oct. 23-30, 2000, available at http://lobby.la.psu.edu/010_Insuring_the_Uninsured/Organizational_Statements/AMA/AMA_102300.htm (last visited Feb. 22, 2004).

59. See generally Kenneth E. Thorpe, Preliminary Estimates of the Federal Costs and Numbers of Newly Insured Persons Under Vice-President Gore's and Senator Bradley's Health Insurance Proposals, at <http://www.sph.emory.edu/hpm/gore-bradley/Gore-Bradley-1.html> (last visited Jan. 23, 2004).

60. *Id.*

61. *Id.*

62. *Id.*

do not qualify for Medicaid and do not receive insurance from their employers.⁶³

Yet Gore's health reforms fell far short of universal coverage. His advisers estimated that, if enacted, Gore's plan would raise the proportion of U.S. residents covered by insurance to only eighty-eight percent—not a substantial leap from the eighty-five percent covered at the time.⁶⁴ In a period of economic and fiscal prosperity, Gore's proposals were hardly bold, contributing to the difficulty his campaign had in distinguishing the proposals from Governor Bush's. Ultimately, both Gore and Bush pursued incrementalism without universal coverage or substantial reform as their ends, leaving the U.S. medical system not far from the status quo.

There is a broader lesson here for the politics of national health insurance. It is relatively inexpensive to finance coverage for the uninsured. After all, eighty-five percent of Americans are insured, and Medicare and Medicaid have already covered the most expensive populations.⁶⁵ We now spend over \$1.6 trillion on medical care. The additional costs of covering the uninsured are in the range of \$100 billion, a modest increase compared to what we are already spending on medical care.⁶⁶ Affordability is not, and never has been, the central barrier to universal coverage. Rather, it is the issues raised to the fore by extending coverage—changing arrangements that threaten insurers and other stakeholders in the current system, and expanding government administrative and budgetary responsibility for medical care—that makes health reform so controversial. The plans offered in 2000—by Bush and Gore—sought to avoid triggering these issues and, consequently, neither offered a compelling vision for the future of U.S. medical care.

IV. ALTERNATIVE PLANS: FEDERALISM, THE PINCER MOVEMENT, AND SINGLE-PAYER

Now that health reform is back on the agenda as the 2004 elections approach, what are the options? This section contains analyses of three options, each of which raises quite different political and administrative issues.

63. "Missing middle" is a phrase coined by Theda Skocpol referring to social policies that target working families. See Theda Skocpol, *A Partnership with American Families*, in *THE NEW MAJORITY* 115 (Stanley B. Greenberg & Theda Skocpol eds., 1997).

64. Paul Starr, *The Defining Issue*, AM. PROSPECT, Feb. 14, 2000, at <http://www.prospect.org/print/V11/7/starr-p.html> (last visited Jan. 23, 2004).

65. Ken Frisof & Ted Steege, *The Universal Health Partnership: A Proposal to Take the Final Step to Universal Coverage*, available at http://www.uhcan.org/files/archive_new/uhp.html (last visited Feb. 28, 2004).

66. See Reinhardt, *supra* note 48, at W3-382.

A. *The Federalist Option*

The first alternative deserving attention from reformers is what we have elsewhere termed the “federalist option.”⁶⁷ This approach, in contrast to previous reform strategies, does not seek to organize a single health plan for the whole nation. Instead, it permits states to choose how to organize their own medical care arrangements, while encouraging them financially to provide universal coverage and broad benefits. Making state choice the core principle of national health reform allows for the decentralized emergence of multiple models of reform. Consequently, the federalist option offers an opportunity to unify advocates of reform who agree on the goal of universal coverage, but disagree on which plan should be adopted to reach that goal.

The federalist option also directly addresses the diversity of U.S. medical care. States vary widely in their political cultures, wealth, medical care delivery systems, and experiences of health reform.⁶⁸ Instead of enacting a single system for the entire country, the federalist option would allow states to choose how to reform U.S. medicine within the context of federal guidelines. In recent years, the federalist option has gained some political support, as demonstrated by the introduction of legislation by the late Senator Paul Wellstone and endorsements of the Universal Health Care Access Network and the Services Employees International Union of the American Federation of Labor-Congress of Industrial Organizations (AFL-CIO).⁶⁹

The starting point for the federalist option is the historical record of stalemate in U.S. health reform. While efforts to enact national health insurance have been stymied five times in the past, it is striking that the episodes of stalemate have not been of the same character. What made the complete failure of the Clinton plan so frustrating was precisely that there was, at least early in the process, a realizable majority in Congress for national health reform that was not converted into a programmatic legislative majority for *any* reform bill. The same can be said of reform efforts in the early 1970s, when other congressional majorities favored reform that did not produce any legislative breakthroughs.⁷⁰

The lack of consensus over which model of national health insurance the United States should adopt and the accompanying failure to enact legislation have obscured the extent to which reformers of different stripes favor the same goals: universal coverage, cost containment, and

67. See Theodore Marmor, Jerry Mashaw, & Jon Oberlander, *National Health Reform: Where Do We Go from Here?*, in HEALTH POLICY, FEDERALISM AND THE AMERICAN STATES 277, 280–82 (Robert F. Rich & William D. White eds., 1996). See generally Jerry L. Mashaw & Theodore R. Marmor, *The Case for Federalism and Health Care Reform*, 28 CONN. L. REV. 115, 115–26 (1995) (describing how federalism can make health reform “viable, successful, and acceptable to most citizens”).

68. See Marmor, Mashaw, & Oberlander, *supra* note 67, at 116.

69. See Frisof & Steege, *supra* note 65.

70. See Steinmo & Watts, *supra* note 46, at 350.

reform of private health insurance practices. Although no single proposal for health reform has attracted a legislative majority, during both the early 1970s and the early 1990s, public and congressional majorities arguably supported these fundamental principles.⁷¹ National health reform, then, has been deadlocked recently more by disagreement over means than ends. As explained earlier, the conditions of U.S. political life—particularly the fragmentation of Congress and weakness of political parties—reinforce these tendencies of those favoring health reform to dissipate into multiple camps advancing competing proposals.⁷²

The federalist option seeks to address the problem of forming a legislative majority among reformers who disagree on the appropriate model for reform. Under the federalist option, national legislation would be passed that encourages the states to enact universal coverage, insurance reform, and cost control measures, but gives the states flexibility to choose what types of reform they wish to implement. Congress would enact legislation offering federal financial support to all states establishing health plans that meet federally-established standards of national health reform. To receive federal money for health expenditures, states would be required to enact health reforms guaranteeing universal coverage, comprehensive benefits, administrative accountability, fiscal viability (including cost control measures), and portability (recognition of other state's coverage). Although the majority of government expenditures would come from federal sources, states would choose how to finance their portions of the health plan budget. States would also choose whether and how to restructure health care delivery. As long as a state's plan met federal standards, it could choose to implement any one of a variety of systems ranging from a single-payer to competition among privately administered HMOs.

The federalist option tries to address the puzzle of how to translate a majority favoring health reform into legislation when that majority cannot agree on the precise shape of reform. Substantively, the plan recognizes the variation in state health systems and reform preferences. Politically, it taps into the rhetoric of devolution, states rights, and choice, while putting opponents of reform on the defensive by changing the debate from focusing on the particular details of any one plan to the fundamental question of whether legislators support universal coverage.

This is not to suggest that the federalist strategy is without problems. The first, and largest, barrier to surmount is that the federalist option represents a new alternative in the U.S. health reform debate, one that lacks the familiarity of, for example, single-payer insurance. It is politically difficult to build legislative and public constituencies—whatever their substantive and political strengths—that have no prior history of support from legislators or consumer groups active in health policy. A

71. *See id.*; *see also* Frisof & Steege, *supra* note 65.

72. *See supra* note 32 and accompanying text.

second objection likely to be raised is that the state-by-state variation permitted by a federalist health system is inequitable. Such a system is alleged to be unfair because citizens' access to medical care services will be a function of the health system chosen by their states. A third objection is that the federalist strategy circumvents national gridlock, only to invite political deadlock at the state level, instead. While some legislatures may simply replicate federal congressional failure to enact reform, other states may resist the imposition of a federal mandate for health reform that they do not welcome for either ideological or financial reasons. In addition, while the federalist plan mandates a state plan for cost control, in the absence of a national budget for health care, its hold on medical care spending is less certain than the single-payer model.

B. The Pincer Strategy

While the federalist option for health reform in the United States represents one path of reform, it is only one of the many possible roads a nation can take to produce, over time, a health care system with expanded coverage, a workable administrative design, and political feasibility. One of the other alternative roads is what we term the pincer strategy of health reform: expanding Medicaid, S-CHIP, and other existing insurance sources for both children and working adults. Such a plan could move to universal coverage by guaranteeing health insurance for all children, while expanding access to insurance for adults. This strategy is also compatible with efforts to expand Medicare by lowering the program's age for eligibility.

The pincer strategy is more incremental than either the federalist or single-payer approaches. Rather than creating a new medical care system, it seeks to build on existing institutions in order to move the United States closer to universal coverage. Families USA has, in the recent past, proposed an exemplar of the pincer strategy.⁷³ Under its plan, the eligibility age for Medicare coverage would be lowered from sixty-five to fifty-five. The Medicaid program would also be extended to cover everyone whose individual or family incomes were at or below 133% of the federal poverty level. It would also provide federal matching funds to cover both children and adults in families with incomes up to 200% of the federal poverty level. Coverage could be received through expanding Medicaid S-CHIP, or the Federal Employees Health Benefits Program; creating a new program, or, under some plans, by subsidizing private insurance premiums through refundable tax credits. Federal transfers to states would exceed current matches, with the goal of ensur-

73. See Families USA, *The Building Blocks of Universal Coverage: Families USA's Proposal for Expanding Health Care Coverage* (paper presented at the National Conference on Health Coverage 2000 in Washington, D.C.), available at <http://web.archive.org/web/20030410134140/www.rwjf.org/news/eventshc2000/familiesusa.htm> (last visited Feb. 28, 2004).

ing that a higher proportion of the uninsured who are eligible for public coverage enroll in these plans than do currently.

Such a proposal has three dominant sources of appeal. First, it has the potential for substantial progress in reducing the number of uninsured. Over 60% of the uninsured live in families with household incomes below 200% of the poverty level.⁷⁴ Consequently, the uninsured rate could theoretically be cut to about 6% and over time, the income threshold could be raised (e.g., to 300%) to move even closer to universal coverage. Second, the pincer strategy incorporates the uninsured into existing programs that require nothing substantial in the way of administrative innovation to finance the medical care of newly-covered groups. Nor does this route of health reform alter the medical care arrangements of the currently insured. Building on the established state-federal partnership model embodied by S-CHIP is also likely to have political appeal. Third, as noted earlier, the pincer strategy moves health insurance reform beyond the traditional categories of the aged and children to target working adults. Both a substantive and political rationale support this approach. Politically, there may be untapped appeal in providing subsidies to workers and their families who “play by the rules” and yet are left behind in the insurance market because they are not poor enough to qualify for Medicaid and not wealthy enough to afford their own insurance. Next, since the uninsured are concentrated in low-wage working families, any serious attempt to improve substantive coverage must target this group. Moreover, the extension of Medicare eligibility reaches a population whose coverage difficulties, particularly with the accelerating erosion of private coverage for early retirees, also command attention. The fifty-five to sixty-five decade is one where health insurance under private coverage is expensive, where retirement threatens coverage, and when medical bills, on average, mount.⁷⁵

Advantages, however, have the vices of their virtues. The pincer strategy simplifies administrative concerns by building on existing programs. It is reasonable, however, to wonder how effective Medicaid and S-CHIP can be as building blocks to universal coverage. Millions of persons eligible for Medicaid do not actually sign up for coverage due to administrative hurdles⁷⁶ and, in some cases, states purposefully keep enrollment down by limiting outreach campaigns.⁷⁷ To be sure, reforms have been proposed—such as the higher federal match rates to states and penalties to ameliorate this problem—but the lesson is clear: eligibility is

74. HENRY J. KAISER FAMILY FOUND., *THE UNINSURED AND THEIR ACCESS TO HEALTH CARE* (2002), available at <http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14102> (last visited Feb. 28, 2004).

75. See Lisa J. Andeen, *Improving Health Care for Uninsured Children in the Wake of the State Children's Health Insurance Program (CHIP)*, 27 J. LEGIS. 299, 320 (2001).

76. See Health Res. & Servs. Admin, *Barriers to Medicaid Enrollment*, at <http://bphc.hrsa.gov/OSNP/Medicaid.htm> (last modified Oct. 16, 2001).

77. HENRY J. KAISER FAMILY FOUND., *supra* note 17.

not enough. Medicaid's problems—including administrative inefficiency, access problems, and underfunding have been well documented.⁷⁸ The key question, then, is whether changing policies and adding new populations to Medicaid would improve recipients' medical care experiences or would instead expand on a program that already has tremendous problems. Finally, the pincer strategy focuses on incremental coverage additions, but has little to say about cost control.

C. *Single-Payer Plans*

Another major option is what has been conventionally termed “single-payer” plans. Single-payer has been the model of choice for many reformers since the early 1980s. In fact, Medicare itself is a single-payer in the sense that the insurance funds that pay for Medicare's benefits are in a single program. The trouble with the term, however, is that it inadequately describes what most people want who call for such reform. The dominant model of a single-payer, comprehensive public health insurance program is Canada's Medicare.⁷⁹ In Canada, the governing legislation prescribes broad physician and hospital coverage (comprehensive), accessible terms (that is, no deductibles or coinsurance as financial barriers), public administration (for accountability), and portability (that is, coverage that protects Canadians whether in their home provinces or not).⁸⁰ There are numerous administrative details that make this simple characterization only the briefest guide to Canada's model.⁸¹ Universal health insurance has been for most Canadians the country's postwar public triumph. It has brought a decent level of care to the country's citizens and at an economic price that consumes forty percent less of Canada's national income than does medical care in the United States.⁸² The necessary consequence of Canada's method of financing and cost-control—paying for medical care from each provincial budget, setting budgets for hospitals, and limiting what doctors and drug firms can charge—is regular controversy.⁸³ That controversy is about how much money to spend and on what, for whom, and under what rules of fairness of access or fi-

78. See generally LAURA KAYE ABRAHAM, *MAMA MIGHT BE BETTER OFF DEAD: THE FAILURE OF URBAN HEALTHCARE IN AMERICA* (1993).

79. THEODORE R. MARMOR, *UNDERSTANDING HEALTH CARE REFORM* 11 (1994).

80. *Id.* at 126; see also The Commonwealth Fund, Total Health Care Spending, at http://www.cmwf.org/programs/international/anderson_multicomp2002_ii_582.pdf (last visited Jan. 23, 2004); OECD Wash. Ctr, Total Expenditures on Health, at <http://www.oecdwash.org/DATA/STATS/healthexp60-2000.pdf> (last visited Jan. 23, 2004).

81. For a more elaborate analysis of Canadian medical care, see MARMOR, *supra* note 79, at 186–89.

82. *Id.* at 79, 184; see also The Commonwealth Fund, *supra* note 80, at http://www.cmwf.org/programs/international/anderson_multicomp2002_ii_582.pdf; OECD Wash. Ctr., *supra* note 80, at <http://www.oecdwash.org/DATA/STATS/healthexp60-2000.pdf>.

83. See MARMOR, *supra* note 79, at 184.

nancing the money will be spent.⁸⁴ There is a democratic accountability that is truly astonishing when compared to the enormously fragmented, and hence less accountable, decision making in the United States. A necessary consequence of such accountability is constant media attention. Canada's single-payer program gets this publicity and, in turn, Canada's doctors and members of other medical occupations constantly claim that "crises" are imminent or in full bloom.⁸⁵

A program like Canada's Medicare is administratively cheaper than other options, is more easily understood, and involves far fewer constraints on professional autonomy and patient choice than is the case in the United States. Indeed, the U.S. has the most intrusive regulation of medical care practice of any Organization of Economic Co-Operation and Development (OECD) nation, though the bulk of that intrusiveness arises from private regulation.⁸⁶ Such comparisons highlight the reasons Canada's model has had such appeal for U.S. reformers over the past quarter century. At the same time, Canada's model has awakened the intense opposition of those groups whose incomes and ideological sensibilities would be threatened by such a reform. So, it is no surprise that the HIAA, the AMA, the trade association of the drug industry, and the managed care trade association have treated the Canadian model as a serious problem, instead of as a policy solution.⁸⁷ Indeed, in the spring of 2000, a newly formed group, disingenuously described as "Citizens for a Better Medicare," launched a multimedia campaign "urging American seniors to reject the Canadian model of health insurance and coverage of prescription drugs."⁸⁸ The forty groups sponsoring the campaign included such traditional opponents of government health insurance as the Chamber of Commerce, the National Association of Manufacturers, and the pharmaceutical trade association. In short, the problem with the Canadian model is not an absence of substantive merit, but the intensity of opposition to it by financially interested and ideologically opposed parties.⁸⁹ Knowledge of such forces need not counsel abandoning such a model, but it demonstrates the powerful opposition single-payer reformers confront and points to the need for a strategic argument about what

84. See Theodore R. Marmor, *Lessons from the Frozen North*, in *THE POLITICS OF HEALTH CARE REFORM*, *supra* note 38, at 487, 493-94.

85. In the period 2000-2002, another round of Canadian fretting about Medicare took shape. It culminated in the creation of a one person royal commission, with former Saskatchewan Premier Roy Romanow presiding over an extensive series of background research efforts and public hearings. For more information on Romanow's findings, see ROY J. ROMANOW, Q.C., *BUILDING ON VALUES: THE FUTURE OF HEALTH CARE IN CANADA* (2002), available at http://www.hc-sc.gc.ca/english/pdf/care/romanow_e.pdf.

86. *Rx for the Health Care System*, WALL ST. J., Oct. 18, 1998, at A18.

87. See Gary Lee, *Health Insurance Lobby Mounts Effort Against Adoption of Canadian System*, WASH. POST., Mar. 16, 1992, at A15.

88. Theodore R. Marmor & Kip Sullivan, *Canada's Burning!*, WASH. MONTHLY, July/Aug. 2000, at 15, 19.

89. See *id.* at 15-20; see also T. R. Marmor, *Medicare: Suspect Messages*, GLOBE & MAIL, Feb. 12, 2002.

is gained by holding onto the single-payer strategy when other options are available.

In sum, none of the above plans offers an easy path to universal coverage. They all contain different mixtures of strengths and weaknesses; however, they also provide legitimate alternatives that would be more or less feasible and desirable under varying conditions. The question is how to move the debate in a direction where substantial health reform can command serious attention. We thus turn now to the lessons and strategies that should guide health reformers in 2004 and beyond.

V. LESSONS AND STRATEGIES FOR 21ST CENTURY HEALTH CARE REFORM

A. *Lesson One: If You Lose, Lose the Right Way*

As our overview of the politics of national health insurance tries to make clear, the obstacles to enactment of substantial reform are formidable. While winning must be the aim, it is hard to ignore the numerous failures of the past century. Reformers must confront the reality that political setbacks and more legislative defeats are not only possible, but probable. Although it is important to shape the terms of victory, it is equally critical to influence the terms on which one loses. In 1948, President Truman's national health insurance plan went down to defeat. Truman used that defeat as a key element in his presidential campaign against the infamous "do-nothing" Congress.⁹⁰ In contrast, in 1994, the Clinton health plan politically imploded.⁹¹ By the end of the debate, even the administration had abandoned its own plan. The administration had no end-game strategy as legislative support for its health reform failed to materialize, and the blame for the failure of health reform was laid as much on President Clinton as it was on its congressional opponents. The lesson for reformers is this: if legislation cannot pass, then there still may be political benefit to extract if responsibility for blocking expanded health insurance coverage can be clearly pinned on the opposition. In that respect, even unsuccessful legislative efforts may keep health reform on the agenda and, in some circumstances, help expand support for it.

B. *Lesson Two: Don't Forget the Long Term*

A related lesson is that while responding to short-term political and economic constraints may be necessary, it would be foolish to focus on these strategies to the point of abandoning long-term aims. The debate

90. DAVID McCULLOUGH, TRUMAN 642 (1992).

91. See SKOCPOL, *supra* note 5, at 133–72; see also JACOB S. HACKER, THE ROAD TO NOWHERE: THE GENESIS OF PRESIDENT CLINTON'S PLAN FOR HEALTH SECURITY 171–80 (1999).

over Medicare is instructive.⁹² From the time the idea was first conceived, it took thirty years of political struggle before Congress adopted federal health insurance for the elderly.⁹³ While Medicare's political sponsors accepted incremental steps they believed would not detract from their ultimate goal, they never abandoned the campaign for the basic Medicare model. Indeed, Medicare reformers used opposition to that model as grounds for defeating congressional critics where that was promising. Over time, public support for the Medicare strategy increased the number of congressional backers and sharply constrained the reactions of opponents, as the battle in 1965 showed.⁹⁴ The U.S. political system, with its individualistic focus and shifting coalitions, tends to prompt short-term visions and encourage impatience. Yet one clear option for reformers is to first reject these pressures by agreeing on one health plan as a programmatic model and legislative goal, and then to begin a long-term political campaign to secure its enactment. As with Medicare, this requires patience, time to build and maintain a coalition, and the commitment to absorb defeats, while punishing opponents. In the short run, this may be a painful route; over the long haul it may prove the most rewarding.

C. Lesson Three: Don't Let the Perfect Be the Enemy of the Good (or Why Canadian Single-Payer Insurance Is Not the Only Answer)

Perhaps one of the most serious barriers to adopting a national health system is the widespread perception that the United States has only two choices in health care. One is to maintain the status quo system of for-profit private insurance, along with Medicare and Medicaid, that leaves forty-four million people uninsured without controlling costs. The other option is to embrace the Canadian model of single-payer national health insurance. This strategy would replace current arrangements with public insurance and eliminate the role of private insurers in U.S. medical care (with the exception of insuring services not covered by the public system). This dichotomy in the U.S. health debate is one that does not serve reformers well. It leaves the mistaken impression that the Canadian program is the only available model of universal health coverage. It ignores the comparably-successful experiences of universal health insurance in Western Europe, Japan, and Australia.⁹⁵ Unfortunately, the reform community itself has contributed to this misperception by focusing single-mindedly on Canada and, in some cases, misconstruing its lessons.⁹⁶ The exclusive focus is unfortunate, from a political perspective.

92. See generally MARMOR, *supra* note 31; JONATHAN OBERLANDER, *supra* note 50.

93. See MARMOR, *supra* note 31, at 1, 10.

94. *Id.* at 59.

95. See JOSEPH WHITE, *COMPETING SOLUTIONS* 91–127 (1995).

96. See MARMOR, *supra* note 79, at 11–12.

Internationally, the Canadian system is unusual in the extent to which it embraces a one-tier conception of public insurance that bans private coverage for services covered by the government.⁹⁷ Single-payer “purists” have implied that copying these features of the Canadian system are necessary to achieve cost-effective, universal coverage in the United States. They are wrong. The real lessons of Canada are these: universal coverage is conducive to cost containment; slowing the growth of medical expenditures requires the concentration of financial responsibility and budgeting; enforcing a uniform set of rules for health insurance achieves administrative as well as economic efficiencies; and enforcing one set of rules for medical care payment and enrollment is critical to controlling medical inflation.⁹⁸

Other countries have embodied the lessons in systems that are structurally different from the Canadian model and contain less centralization and a larger role for private insurers. For example, we know from the German experience that it is possible to have multiple payers and still control costs if all the payers play by the same set of rules.⁹⁹ We also know from Germany and Australia, among others, that it is not actually essential to have everyone in one public insurance system, as Canada does.¹⁰⁰ These nations have a safety valve of private insurance that offers wealthier citizens an alternative to public insurance. Neither the quality of care nor the capacity to control costs has been obviously compromised in these nations’ public insurance systems. What matters is that most people are in the public system to ensure that it has both a broad-based political coalition and strong economic influence over purchasing medical services. What is not necessary is for *everyone* to be in a single system.

The point is not that the Canadian system is unworthy of emulation. Indeed, we have written of its long record of success and of how it might be adapted to the U.S. political circumstances.¹⁰¹ Moreover, the recent revival of stories in the U.S. media suggesting that Canadian health care is in crisis and unraveling are misleading and simply untrue.¹⁰² Such stories unfortunately maintain a long-established trend of U.S. distortion of the Canadian experience. Single-payer advocates have also played a crucial role in arguing both for reform and that public insurance alternatives to the U.S. system are both available and desirable.

The Canadian model is not the only one available to U.S. health reformers, and indeed, it carries a number of features that make it difficult to import to the United States. If universal coverage is to be politically viable in the United States, then pragmatic universalism, rather than

97. WHITE, *supra* note 95, at 65–66.

98. *See id.* at 65–72.

99. *Id.* at 84–89.

100. *Id.* at 75–78, 91–96.

101. *See* MARMOR, *supra* note 79, at 186–94.

102. *Id.* at 164–67.

ideological purity, must be the cornerstone of any successful campaign. Pursuit of a “perfect” health system at the cost of ignoring good alternatives attaining the same goals makes neither intellectual nor political sense. Nor does it do much good for forty-four million uninsured U.S. residents. The case must be made that a pure single-payer system is not the only option for universal coverage in the United States.¹⁰³

D. Lesson Four: Look for New Allies

The events since the Clinton debacle provide new opportunities to expand the coalition for health reform. The transformation of the medical system through various managed care practices has created deep discontent among physicians with the current arrangements. Already, consumer groups and physicians’ associations have subdued their traditional enmity to work together to pass both state and federal laws regulating HMOs and other managed care plans.¹⁰⁴ That alliance could potentially be taken another step. Given doctors’ discontent with their growing lack of clinical authority, and their unhappiness with the corporatization of U.S. medical care, it is not difficult to envision an alliance for national health insurance that incorporates large segments of the medical community. Physicians may be increasingly persuaded that they will fare better under a public system that could reinstate their clinical autonomy than under the corporate control of private health plans. Historically, physicians have been a substantial obstacle to large-scale reform. In the future, they may prove a key catalyst to its enactment.

E. Lesson Five: Controversy Is Inevitable

The failure of the Clinton plan has given rise to an industry of commentary on its lessons. One set of lessons proffered is that for reform to succeed, it must be bipartisan and encompass a coalition that includes health care reform’s strongest opponents, the health insurance industry. These lessons purport to provide a political rationale for the incremental reforms discussed earlier. As the previous section makes clear, it is sensible for reformers to look for new allies and that the medical profession offers an intriguing potential for alliance. As we have argued, there may be plans that preserve a role for private insurance while achieving universal coverage. Any campaign for health reform that has as its main objectives avoiding controversy and bipartisanship will produce one of two results: political failure or adoption of anemic reform. By its nature, health reform will inevitably be controversial in the United

103. See Oberlander, *supra* note 1, at W3-401.

104. In the 1990s, legislators in California and New Jersey passed bills opposed by managed care companies and backed by physician and consumer groups. *Govs. Whitman and Wilson Weigh Legislation HMOs Don’t Like*, MANAGED CARE MAG., Aug. 1997, available at <http://www.managedcaremag.com/archives/9708/9708.states.shtml>.

States. The ideological, economic, and political stakes, as well as its impact on powerful interests, make avoiding controversy a fool's errand. Reform is also quite unlikely to be bipartisan. As already noted, it took fifteen years of deep ideological and political struggle to enact sixty days of hospitalization insurance for elderly Social Security recipients.¹⁰⁵ Bipartisan support for Medicare came only in the end, when passage was already assured. Pursuing reform far greater in scope than federal health insurance for the aged will hardly deaden partisan battles. The aim should be to build a majority coalition for health reform, not universal agreement or national consensus on a new system. Such a consensus, whether among the public or stakeholders, is not only impossible, but it is not a necessary condition for enacting major social changes in the United States.

F. Lesson Six: Time Is on Our Side

Throughout the past decade, opponents of reform have raised the specter of the coming retirement of the baby boomers as a demographic "tidal-wave" that threatens the U.S. economy, political system, and inter-generational relations.¹⁰⁶ In health care, the fear mongering has been particularly acute. Images of a growing elderly population devouring scarce medical resources—most of which are incorrectly portrayed as useless expenditures on dying seniors—are juxtaposed with the growing ranks of the uninsured. The doubling of Medicare enrollment over the next four decades, a number of analysts contend, means that the program will face "crisis"—and that the only way out is radical reforms that voucherize Medicare and shift costs or cut coverage for the elderly.¹⁰⁷ Moreover, the argument goes, if the government cannot afford the growing population in Medicare, then how can we possibly afford to guarantee insurance for the entire population? The argument that demographic trends and Medicare commitments preclude universal coverage appeared in 1991–1992, and they are once again surfacing in current health care debates.

Claims of demographic apocalypse, popularized by commentators such as former Secretary of Commerce Peter Peterson¹⁰⁸ and the Cato Institute,¹⁰⁹ are misleading and based on little or no understanding of international trends in population aging. They are designed to scare the public sufficiently to prompt passage of legislation on the conservative agenda: privatizing both Medicare and Social Security. Demography, as

105. See MARMOR, *supra* note 31, at 56; OBERLANDER, *supra* note 50, at 40.

106. See PETER G. PETERSON, GRAY DAWN 5–7 (1999).

107. See *id.* at 121–25.

108. See, e.g., PETERSON, *supra* note 106.

109. See, e.g., MILTON FRIEDMAN, SPEAKING THE TRUTH ABOUT SOCIAL SECURITY REFORM (1999), available at <http://www.socialsecurity.org/pubs/articles/bp-046es.html>.

we have argued elsewhere, is not destiny.¹¹⁰ The United States can afford the baby boomers, and their retirement in itself does not threaten the national economy or the health care system. The fact that Medicare's enrollment will grow as the population ages is not a crisis. We should be thankful that we have a government program as effective as Medicare to finance the medical costs of an aging population. The real crisis would be if we did *not* have a public program that protected seniors and their families from the financial burden of medical costs.

Clearly, defending Medicare from attacks should be the first order of business for reformers. Demographic trends can be an argument *against*, and not for, risky and untested schemes such as vouchers. Reformers can go even further in turning the demographic argument on its head. Empirical studies have shown that there is no relationship between the age structure of a country and its spending on health care, measured both historically and in contemporary terms.¹¹¹ Many of the industrialized democracies have populations far older than the United States, yet they spend far less on health care. If demography were destiny, then northern Europe would already have had to jettison its health programs. After all, those nations have substantially older populations than the United States.¹¹² What do all these nations have that the United States does not? National health insurance. In the context of systems that provide public control over medical spending and universal coverage, it is easier for countries to manage the costs of aging populations and to make decisions on where—and on whom—health care resources should be used. Indeed, reformers should argue that the best way to moderate the medical care costs of the baby boom generation is to enact a national health insurance program that gives the United States the same tools that other nations have available to absorb aging populations into their medical care systems.

VI. CONCLUSION: HEALTH REFORM AND VARYING POLITICAL CONTEXTS

Health reform, we have argued, is not and never will be a dispassionate matter of selecting policy instruments from some menu of idealized options. The stakes of the contending parties foreclose such possibilities, as the history of U.S. health politics amply illustrates. Thus, taking into account the political context in reform thought is a necessary feature of an enlightened progressive strategy in health care. That, in turn, requires considering the different environments that are obvious possibilities for the next decade and beyond the 2004 elections.

110. See Theodore Marmor & Jonathan Oberlander, *Rethinking Medicare Reform*, 17 HEALTH AFF., Jan.–Feb. 1998, at 52.

111. *Id.* at 55.

112. See *id.* at 55.

The first requirement is to imagine what those multiple futures might be. One can think of six possible futures by varying both the political composition of the national government and economic circumstances in the following way. Imagine, for example, either rapid economic growth of the kind experienced in the second half of the 1990s or, on the other hand, recession circumstances of the sort experienced at the opening of the 1990s and during 2001–2002. Imagine, further, three political contexts, one involving unified government at the federal level where Democrats prevail, one where Republicans dominate both the Congress and the Executive, and a situation of divided government. That produces a six-fold set of possible futures, each of which has somewhat different implications for a reform strategy.

The next task is to sort out more clearly what these possible futures imply for the reform strategies discussed above. A moment's reflection suggests that only under circumstances of flush economic times and Democratic Party domination would the single-payer option represent a live possibility (since single-payer would require an expansion of federal taxes and public financing). Even under those conditions, however, it would confront tremendous opposition and would face an uphill battle for enactment. Incremental expansion, including universal coverage of children and expanding uninsured adults' access to public insurance programs, would of course, also attract support under such circumstances. Introducing economic and fiscal austerity would suggest a more defensive posture, protection of Medicare and Medicaid rather than substantial expansion. Were Republican rule dominant amidst favorable economic circumstances, one could imagine incremental reform along the lines of tax credits as one option. Were recession to be the context, Republican leaders would in all likelihood seek further restraints on Medicare outlays through vouchers and oppose any substantial measures that would expand coverage. Under that scenario, there still may be political value in pushing for an agenda that seeks to expand coverage.

There is, we have argued, no single magic bullet that can ease the United States's path to universal coverage. Perhaps the most attractive option for health reformers at this time, and for the next decade, is to build support for the federal option. The federalist strategy, referred to by others as a state-federal partnership,¹¹³ offers the prospect of genuine health reform and the advantages of political flexibility. The federalist option can be altered according to the various political-economic scenarios outlined above. For example, a pincer strategy of narrowing the number of uninsured in the short run could serve as a prelude to the long-run campaign for adoption of federalist health legislation. Similarly, under circumstances less favorable to reform, advocates could propose incremental versions of the federalist strategy that emphasize fed-

113. See Frisof & Steege, *supra* note 65.

eral funding of optional state programs. Finally, under a political-economic scenario favorable to reform, the federalist strategy offers the best hope for building a legislative majority for comprehensive reform. We recognize that embracing the federalist option would mean altering the past emphasis of U.S. reformers on enacting the Canadian single-payer model. The federalist option is by no means an easy transformation or compromise to make. Ultimately, it is a bold move that would increase the chances for achieving universal coverage in the United States more than most alternatives.

In the end, the picture of the politics of health reform entering 2004 is a familiar one. There is, as there was in the early 1990s, growing dissatisfaction with rising medical care costs and escalating rates of uninsurance. As a result, the incrementalist focus of health policy since the failure of the Clinton plan is now giving way to a debate on more comprehensive reforms. The Democratic candidates running for their party's presidential nomination in 2003–2004 thus all offered plans to expand insurance coverage that were significantly more ambitious than Al Gore had in 2000. These plans were, for the most part, variants of the pincer strategy that proposed combinations of public insurance expansions and tax credits to move toward universal coverage.¹¹⁴

Yet the question remains: Will this time be any different for health reform than its past failures?

Dramatic, transformative shifts in U.S. health care policy, history shows, are less likely than marginal adjustments and incremental reforms. There is, of course, no denying the possibility of situational factors — of leadership, context, and happenstance — that could end up causing large programmatic changes. The challenge for reformers is to take advantage of those contexts. Ultimately, the character, as well as desirability, of changes in national health policy will be shaped in no small part by the choices that reformers themselves make about the goals and strategies that should guide U.S. health reform.

114. Sara R. Collins et al., *The Commonwealth Fund, Health Care Reform Returns to the National Agenda: The 2004 Presidential Candidates' Proposals* (Jan. 22, 2004), at http://www.cmf.org/programs/insurance/collins_reformagenda_671.pdf.