

Universal Coverage and the American Health Care System in Crisis (Again)

Epilogue to 2nd edition of __*Universal Coverage: The Elusive Quest for National Health Insurance*__ (forthcoming fall 2004, University of Michigan Press)

Rick Mayes, Ph.D.

Assistant Professor of Public Policy
Department of Political Science
28 Westhampton Way
University of Richmond
Richmond, VA 23173

Faculty Research Fellow
Petris Center on Healthcare Markets
& Consumer Welfare
School of Public Health
University of California, Berkeley

Tel: (804) 287-6404
Fax: (804) 287-6833
<http://www.petris.org/>
bmayer@richmond.edu

I wish to thank numerous individuals who critiqued previous versions of this paper, including Cecelia Ackerman, Tom Cosgrove, Abby Emerson, Lindsay Shore, Meredith Stewart, T.R. Straub, and especially Jennifer Mayes. My reexamination of President Clinton's failure at health care reform benefited from personal interviews with numerous individuals who graciously shared their time and recollections with me, including: former Staff Director of the House Ways and Means Health Subcommittee, David Abernethy; President Clinton's Health Care Communications Director, Bob Boorstin; Chief of Staff to former Senate Majority Leader Bob Dole, Sheila Burke; Representative Jim Cooper; initial Senior Advisor to the Health Care Task Force, Alain Enthoven; President and CEO of the National Federation of Independent Businesses, Jack Faris; Director of President Clinton's Health Care Transition Team, Judy Feder; Senior Economist for the Clinton Health Care Task Force, Sherry Glied; former Democratic Senator from Nebraska, Bob Kerrey; former President of the Business Roundtable, John Ong; former Director of OMB and Clinton White House Chief of Staff, Leon Panetta; former Senior Medicare Analyst for the Senate Finance Committee, Lisa Potetz; former CBO Director, Robert Reischauer; former Chairman of the House Ways and Means Committee, Dan Rostenkowski; former Secretary of the Treasury, Robert Rubin; CMS Administrator, Tom Scully; Representative Pete Stark; former Chair of the Council of Economic Advisors, Laura D'Andrea Tyson; former HCFA Administrators, Gail Wilensky, Bruce Vladeck and Nancy-Ann DeParle; Representative Henry Waxman; and former Chairman of Prudential Insurance and Chair of the Business Roundtable's Health Subcommittee, Robert Winters.

EPILOGUE, 2004

One of my administration's top priorities is high quality, affordable health care for all Americans.

—**President George W. Bush**
State of the Union Address, January 2003

I think we're standing on the edge of a cliff... I've become more convinced as time goes by that our health care system is fundamentally broken and needs major surgery; it's collapsing around us.

—**U.S. Senator John Breaux**
March 2003

How long, O Lord, how long?

—**King David**
Psalm 6:3

Another health care crisis has emerged in the United States. It was inevitable. As the previous chapters illustrate, the patchwork quilt of individual government programs and private insurance arrangements that collectively make up the U.S. health care system has numerous structural contradictions, economic inefficiencies, and coverage gaps for millions of Americans. It's no wonder that studying our country's health care system often produces the same reaction one has after studying Italian politics and finance: How does such a Byzantine, sometimes corrupt, and fundamentally illogical structure such as this survive, much less thrive in various areas? It reminds one of the Leaning Tower of Pisa. One marvels at its existence and wonders how much longer it can remain standing. It appears to defy the law of gravity, but everyone talks about it only being a matter of time before the structure comes crumbling down. The mystery is that nobody knows or ever can know exactly when it will happen. Similarly, how many uninsured individuals, medically impoverished patients, disgruntled physicians, burnt-out nurses, and cash-strapped businesses need to exist before a critical mass finally materializes that flushes out the formidable political obstacles to some form of universal coverage in the U.S.? One guess is as good as another. But what is clear is that our country's health care system is experiencing a number of major interrelated problems.

Our Patchwork Health Care System Unraveling?

Ten years after President Clinton's ambitious attempt at comprehensive health care reform died so ignominiously, the same problems—only worse—have returned and some new ones have appeared. The following is a brief overview of just some of the leading ills plaguing many Americans and, more generally, our nation's health care system.

After declining modestly in 1999 and 2000, at the height of the country's economic boom, the number of uninsured Americans rose to 43.6 million (or 15.2 percent of the population in 2002).¹ These figures have likely increased since then. The lack of health insurance coverage has become as much a "working class" and "middle class" phenomenon as it is a "poor" one. Roughly a third of all Americans earning between \$25,000 and \$75,000 (or 21,500,000 individuals) are uninsured.² More than 75 percent of the uninsured work full-time and about a third earn more than \$50,000.³ If you include individuals who have experienced a temporary lack of coverage, the number of Americans without health insurance at some point during the last two years rose to 75 million in 2002, which is nearly one third of all Americans younger than 65.⁴ Even the affluent are not immune. The number of uninsured people with household incomes of \$75,000 or more rose to 7.3 million in 2002, an increase of 633,000 from the year before.⁵

Not only are there millions of Americans without insurance, the costs for those who do have it are increasingly rapidly. Unlike a decade ago, when health care costs and insurance premiums were decreasing, they have been steadily rising and more than the general rate of inflation since 1998.³ Total national spending on health care grew 8.6 percent in 2002, marking the biggest one-year increase since 1993.⁶ Employers' health insurance premiums rose by an average of almost 14 percent in 2003—more than anticipated and the largest increase since 1990.⁷ Small companies of less than ten employees have seen their insurance premiums rise, provided they can still afford them, by as much as 20 percent or more per year since 2001.⁸ And the future does not look better. "The number of uninsured will continue to grow as long as health insurance premiums rise more rapidly than earnings, as they have for a decade," notes Drew E. Altman, president of the Kaiser Family Foundation, which tracks health coverage trends. "Losing health benefits is becoming a middle-class issue. If it had not been for expansions in the child health program and Medicaid, we would have 10 million more uninsured."⁹

One particularly alarming consequence of these worsening trends is that health care problems are by far the single leading cause of personal bankruptcy in the United States. Upwards of 600,000 individual cases in 1999, or nearly 50 percent of the total number of non-business bankruptcy filings, were traceable to one or more of these problems: lack of health insurance, insufficient health insurance, and/or substantial medical bills.¹⁰ Given the recession and sluggish economic growth that have occurred since then, it is certain that these figures have only worsened.

The government's two primary health insurance programs—Medicare for the elderly and disabled and Medicaid for the poor—are experiencing considerable financial strain. As they face their worst fiscal crises in more than fifty years, states are cutting Medicaid benefits and eligibility at the same time that a sputtering economy has boosted demand for the program.¹¹ Meanwhile, Medicare has suffered from two high-profile problems: a failed experiment with enrolling beneficiaries in private managed care plans (Medicare+Choice), and an inability to find a fiscally responsible way to add a prescription drug benefit to the program.¹²

Not only are many of the poor and elderly often inadequately served by our health care system, so too are many children. Despite the progress achieved by SCHIP (the State Children's Health Insurance Program) since 1997, 8.5 million or 12 percent of all youngsters are still uninsured.¹³ What is worse, a combination of factors is expected to reduce enrollment in SCHIP and *increase* the number of uninsured children by 900,000 by 2006.¹⁴ These factors include: pending reductions in federal SCHIP funding, the expected reversion of previously allocated federal SCHIP funds to the U.S. Treasury, and growing state budget crises.

The new health care crisis is affecting doctors as much as patients. Medical malpractice insurance has become an enormous problem for specific specialties: obstetricians, neurosurgeons, radiologists, and emergency room physicians in particular. Many women in Arizona, for instance, now have to drive an hour or more to reach a hospital with a delivery room; the entire state of West Virginia has at times been without the services of a neurosurgeon; and many doctors in West Virginia, New Jersey, Pennsylvania, Florida, Mississippi, Illinois, Texas and Missouri have held or threatened to hold work stoppages to draw attention to the great difficulty they have in obtaining affordable liability insurance.¹⁵ The AMA estimates that medical liability insurance has reached crisis proportions in 18 states (Washington, Oregon, Nevada, Texas, Mississippi, Arkansas, Missouri, Illinois, Georgia, Florida, Ohio, Kentucky, West Virginia, North Carolina, Pennsylvania, New York, New Jersey, and Connecticut) and is nearing crisis proportions in 26 other states. Only six states, it argues, are stable: California, Colorado, Indiana, Louisiana, New Mexico, and Wisconsin.¹⁶ Younger physicians in training have noticed this crisis, along with other problems in our health care system. A quarter of final-year medical students polled said they would not study medicine if they could start their education over again.¹⁷

How has it all come to this? The following sections address each of these problems in greater depth and show how they are often interconnected. Included in this epilogue is a reexamination of President Clinton's epic failure at health care reform based largely on interviews with several key policymakers and staff of that time. Some of those interviewed have only recently granted interviews about why and how everything came to naught in 1993-94. The Epilogue concludes with a brief overview of the leading proposals for solving the problem of the uninsured that have recently emerged. If they seem similar to previous proposals dating back to the early 1970s, it is because they are: hauntingly so. As Yogi Berra once said, "It seems like déjà vu all over again."

Health Insurance and the Increasing Numbers of Those Without It

It is hard to grasp the magnitude of the number of uninsured, as Ronald F. Pollack, executive director of Families USA, has observed. It exceeds the aggregate population of 24 states. Nevertheless, in the late 1990s the prospects for reaching universal coverage seemed to be slightly improving. From 1994 to 2000, a period of extraordinary economic prosperity, the rate of the uninsured at least remained steady and even fell a little in 1999 and 2000. This improvement appeared to be the result of two things: an expansion in employer-provided coverage and a decrease in the number of previously uninsured children (thanks to the introduction of SCHIP and changes to Medicaid). This was initially encouraging. The private sector looked as if it was more than matching the public sector's increased generosity (Medicaid and SCHIP's in particular).¹⁸

As it turns out, the primary reason for the overall increase in health insurance coverage during this period (1994-2000) was a large contingent of Americans who moved up the income-ladder. Employers were not beset with a spasmodic burst of generosity as much as a "tight labor market allowed people to take jobs with higher earnings and a higher likelihood of employer coverage."¹⁹ Employers had to either pay more in salary and provide health insurance during this period or lose potential employees to their competitors. That all changed beginning in 2001, when the U.S. economy went into recession and 1.4 million Americans lost their health insurance coverage.²⁰

The most striking lesson from the mid to late 1990s is that prosperity does not solve the problem of the uninsured. The country experienced the longest stretch of uninterrupted economic growth (approximately 118 months) ever recorded, budget surpluses returned after thirty years of continuous and rising deficits, and unemployment levels hit lows not seen since the 1960s. Yet the rate of the uninsured barely budged. The tremendous economic wave of the 1990s that raised just about every "boat" had little to no effect on the 15 percent of Americans without health insurance.

There are three main reasons for the erosion of private health coverage that began in 2001.²¹ First, unemployment has increased. The unemployment rate averaged 4.8 percent at the beginning of 2001, 5.9 percent in 2002, and 6.4 percent by the summer of 2003. Because the majority of American workers and their dependents receive health insurance coverage from their employers, increasing unemployment leads directly to greater numbers of uninsured people.

Second, fewer businesses are offering health coverage.²² A survey by the Kaiser Family Foundation found that premiums for employer-provided insurance have climbed an average of 12.7 percent since 2001. Consequently, more small and medium-size companies can no longer afford to offer coverage. While 67 percent of companies with fewer than 200 employees offered health benefits to their workers in 2000, only 61 percent did so in 2002.²³

Finally, job-based coverage is becoming too expensive for many workers. Employers of all sizes are passing on more of their increasing health care costs to their workers and retirees in the form of larger co-payments, deductibles, and

monthly deductions (particularly for workers' dependents).²⁴ Kate Sullivan, director of health policy at the United States Chamber of Commerce, has noted that "many employers, while continuing to subsidize insurance for workers, have reduced subsidies for dependents. A lot of insurers are dropping out of the small-group market, and customers are balking at what they have to pay."²⁵

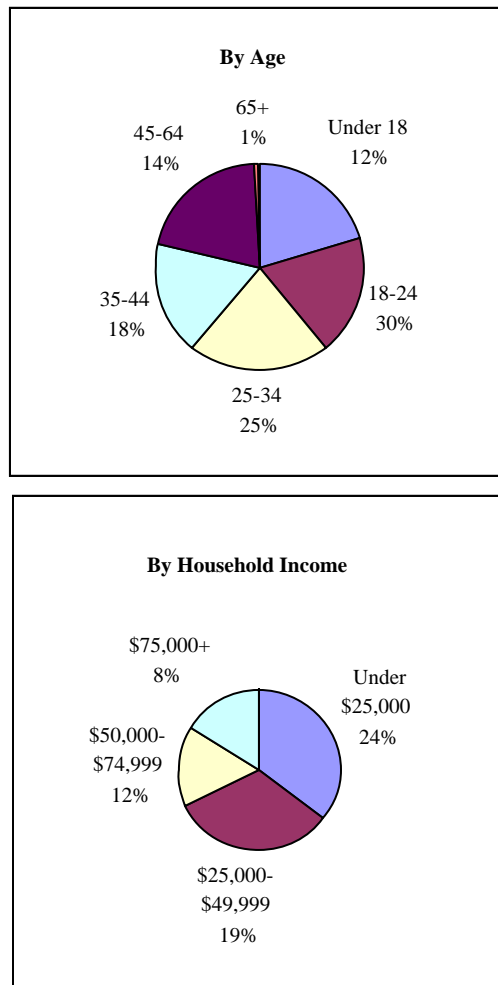
Much of the recent increase in health care costs and insurance premiums can be attributed to the demise of managed care (except for the Medicaid and SCHIP populations) and the reversion to fee-for-service payment. Many of the administrative rules and procedures that made managed care so successful in temporarily containing costs were despised by both patients and medical providers. Hence, over time most were either legislated or litigated out of existence. As Alain Enthoven explains, employers' efforts to control costs through the use of "managed care" were temporarily successful in the 1990s. For a few years they brought the growth of health spending into line with U.S. gross domestic product (GDP), mainly by squeezing provider payments and shortening hospital stays. But these strategies have been played out and they did not bring about a fundamental reform in the way health care is organized and delivered.²⁶

In the meantime, traditional, restrictive managed care has broken down under an onslaught of attacks from trial attorneys, politicians, patients, and providers. Consequently, we are now back to runaway health care inflation, with annual premium increases of 15 to 20 percent or more in some areas. Many physicians are still discouraged to the point of retiring early or switching careers altogether. Meanwhile, health maintenance organizations (HMOs) remain under attack. Patients resent attempts to limit their care, while doctors and hospitals resent and resist attempts to limit their use of resources. Thus, employers have been retreating from managed care constraints while simultaneously reducing coverage and benefits. Enrollment has been shifting from tightly managed HMOs to lightly managed alternatives such as PPOs. And even HMOs are relaxing gatekeeper, utilization review, and other restrictive policies in response to demands from their customers.²⁷

Although the older version of managed care has died a protracted death, one specific event proved symbolic of its burial. Aetna, one of the nation's biggest health insurers, settled a long-running lawsuit with almost all of the approximately 700,000 practicing physicians in the country in late May 2003. Aetna agreed to pay a \$100 million fine (to the doctors), establish a foundation for the improvement of health care (to the tune of \$20 million), and to pay the doctors' lawyers up to \$50 million for their work on the case. The suit alleged that Aetna unlawfully interfered with physicians' medical and billing decisions. In settling the case, Aetna gave up on the classic form of managed care, which was originally designed around so-called "gatekeepers": Aetna administrators "who approved or denied coverage for treatments, often for reasons that were obscure both to doctors and patients."²⁸ The settlement was a victory for physicians and signaled the end of restrictive managed care. Unfortunately, this means that health care costs and rates of the uninsured are likely to increase.²⁹

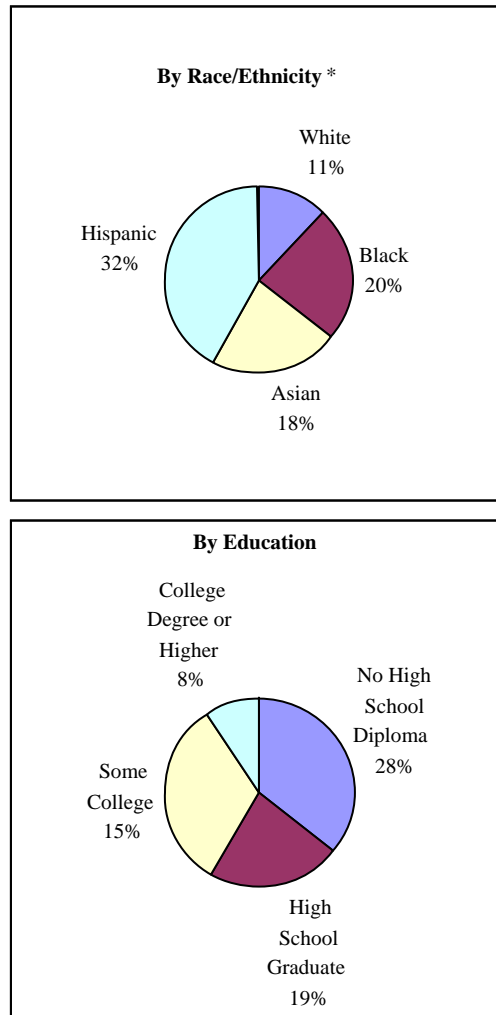
Who are the uninsured? Compared to the general population, the uninsured tend to be younger, have somewhat lower incomes and less education; they are more likely to be members of minority groups, and to work in service industries and for smaller companies (figures E-1, E-2).³⁰ The uninsured population is a dynamic group: individuals often have insurance one year and don't have it the next. People move in and out of coverage depending on their employment status, marital status, income, age, and numerous other factors. The changing nature of the uninsured makes it extremely difficult to fashion a single policy or program to address the problem.

Figure E-1
The Uninsured in America, 2002



Source: U.S. Census Bureau, 2003

Figure E-2
The Uninsured in America, 2002



Source: U.S. Census Bureau, 2003

* Hispanics may be of any race, so figures are rounded.

A related concern is the growing number of working Americans who are classified as “covered” by health insurance who really have little to no coverage at all. An estimated 750,000 employees and their dependents have what are known as “limited benefit” plans. The premiums are low (roughly \$7 per week), but they pay only a maximum of \$1,000 a year in medical bills—so little that “some question whether it amounts to health insurance at all,” acknowledged the

Wall Street Journal. “Some in the insurance industry have a hard time taking this coverage seriously. A gathering of 300 insurance agents in Las Vegas erupted into laughter last summer when an insurance-company executive explained a limited-benefit plan offered by Star Human Resources.”³¹ Unfortunately, these policies are among the fastest-growing health insurance offerings in the workplace. Enrollment in the plans has grown about 20 percent in the past two years alone. They are especially popular among low-wage employees at Wal-Mart, McDonalds, and Lowe’s Company.³² Granted, some measure of health coverage is better than none. But these policies are dangerously close to nothing. And what is perhaps most worrying is that more employers are likely to drop their traditional health benefits for these limited benefit plans. As the cost to employers of providing comprehensive health benefits has risen almost 60% in the past five years—to an average of about \$5,700 per employee per year—more service employers might find it irresistible to just offer limited benefit plans that would not cover one full day in the hospital or an MRI.*

Losing health insurance has always registered as a leading neurotic fear among people of all income levels, because it is well known that a prolonged illness or medical emergency can—more than perhaps any other unpredictable calamity—destroy a family’s or an individual’s financial security. If only it were a matter, then, of attaining universal coverage. What was so striking about the widely read April 2000 report by Elizabeth Warren, Teresa Sullivan and Melissa Jacoby, “Medical Problems and Bankruptcy Filings,” was that of the 596,198 families in 1999 that filed bankruptcy due to health care problems, about 80 percent of them had health coverage.³³

The authors also found that nearly half of all bankruptcies involved a medical problem, and certain groups—particularly women heads of households and the elderly—were even more likely to report a health-related bankruptcy. The fact that 80 percent of those who declared bankruptcy had some form of coverage indicates that basic health insurance often does not protect families from financial disaster when they suffer serious medical problems. Families may be left with medical bills that exhaust their health insurance coverage, or they may discover that the income effects, such as lost time from work or a shift to less physically demanding work, impose a financial hardship on a family that basic medical insurance simply does not cover.³⁴

Revisiting the issue in 2002, Warren found that families filing for bankruptcy were a cross section of America. Their educations were slightly better than average in the U.S. More than half were homeowners. Their occupations resembled the range of occupations in the U.S. job market. By most criteria,

* If, for whatever reason, you find yourself worrying about how chief executives have weathered the efforts by companies to pare or eliminate their most expensive benefit, medical insurance, don’t. Roughly one in eight U.S. companies offers what are known as “executive medical-expense reimbursement plans.” These plans pay for chief executives’ deductibles, co-payments, and other out-of-pocket medical expenses—in some cases even as the same companies are cutting back on basic medical coverage for their rank-and-file workers. See Carol Hymowitz and Joann S. Lublin, “Benefits: I’ll Have What He’s Having,” *Wall Street Journal*, May 20, 2003, B1.

about 90 percent of the debtors in bankruptcy would be classified as solidly middle class. But two out of three lost a job at some point shortly before filing, and nearly half had medical problems.³⁵

Invariably, growing numbers of under- and uninsured Americans increases the pressure on the country's public health insurance programs (Medicaid, SCHIP, and Medicare). These programs are already facing serious funding and demographic problems. So it is worth investigating the extent to which they can assume a much greater responsibility for providing health care to individuals who used to have private coverage.

We turn first to Medicaid, the joint federal-state health insurance program for poor women and their children. Or at least that is what most people think Medicaid is for, if they even know of the program at all. But as the record shows, Medicaid is an immense and remarkably flexible program that both state and federal policymakers have continually modified over the past decade and a half to address an array of society's unmet health care needs, including those of the indigent elderly and disabled. In the process, the program relieves the suffering of millions of people who fall through the numerous holes in our country's health care system.

Medicaid: The Ugly, Unloved “Workhorse” of the U.S. Health Care System

This book is an excellent example, unfortunately, of how Medicaid has been largely ignored—relative to Medicare—and labeled a topic for poverty studies and welfare policy. Because much of this book's analysis focuses on Medicare as a seminal achievement in social insurance and its evolution into a major roadblock to universal coverage, Medicaid receives only passing attention. This partly reflects the fact that when Medicaid was enacted in 1965, it was considered “a legislative afterthought to Medicare.”³⁶ Fortunately, this Epilogue provides an opportunity to reexamine a program that, unlike Medicare, bears little resemblance to its original 1966 structure, but which has surpassed Medicare both in numbers of beneficiaries (47 million to Medicare's 42 million) and in terms of total cost (\$259 billion to Medicare's \$257 billion).³⁷

As the nation's largest health insurance program, Medicaid insures 25 percent of the nation's children and, surprisingly, pays for more than one in every three childbirths.³⁸ Although the program's original focus was on poor mothers who received welfare and their children, it has expanded into something of a subsidiary program to Medicare for impoverished senior citizens and the disabled. Medicaid now provides for the care that two-thirds of the nation's nursing home residents receive. It also helps more than 6 million low-income Medicare beneficiaries pay their monthly Medicare Part B premiums and prescription drug costs.³⁹ Medicaid finances the bulk of the care provided to AIDS patients, half of all states' mental health services, and one-sixth of the nation's pharmaceutical drug expenses. The program even provides the financial glue that holds together the nation's “safety net” institutions: most teaching hospitals, community and migrant health centers, psychiatric hospitals, and community-based

facilities which treat persons with mental disorders. These institutions are critical in a nation where, at any given point in time, almost 1 in every 5 individuals does not have the means to pay for substantial medical bills.⁴⁰

As the program “called upon to solve all manner of health-related problems that no other institution or sector of the economy is willing to address,” Alan Weil explains, Medicaid is still “a program loved by few, denigrated by many, and misunderstood by most. It is at least three different programs in one:

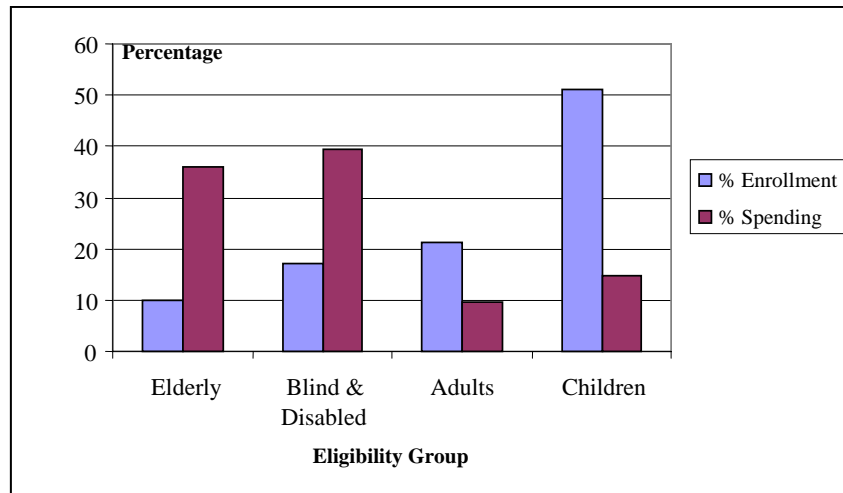
- (1) A source of traditional insurance coverage for poor children and some of their parents;
- (2) A payer for a complex range of acute and long-term care services for the frail elderly and people with physical disabilities and mental illness, many of whom were once middle class; and
- (3) A source of wraparound coverage for low-income elders on Medicare.”⁴¹

Medicaid is frequently ignored, if not disdained, by many Americans because it is a “poor people’s program.” Like any form of means-tested public assistance, beneficiaries have not earned their way into Medicaid (like Medicare and Social Security). Yet this has allowed policymakers to modify the program’s eligibility and benefits over time in response to various unmet health care needs. Responsibility for financing Medicaid is split between the states and the federal government, which pays between 50 and 77 percent depending on each state’s per capita income (wealthier states pay closer to 50 percent, poorer states closer to 23 percent). Last year the federal government paid for 57 percent of the program’s total cost (\$259 billion).⁴²

What surprises many people about Medicaid is the extent to which the program—initially intended for the health care needs of poor single mothers and their children—has expanded to serve as a “safety net” for the elderly and disabled. Women and children represent about 75 percent of the program’s enrollment, but only 25 percent of its spending (see figure E-3). And childless adults are not eligible for Medicaid at all no matter how poor they are. Most of the program’s expenditures go to cover the elderly and disabled who, as a group, are in poorer health compared to single women and children. The single largest category of Medicaid spending is nursing home care. Moreover, “while almost all nursing facility, ICF-MR (intermediate care facilities for the mentally retarded), and home health spending is on behalf of the elderly and disabled,” observes Weil, “this group also accounts for 85 percent of prescription drug costs, more than half of inpatient and outpatient hospital spending, and nearly half of physician services.”⁴³

Medicaid’s growing role as a safety net for these two expensive and growing populations—the disabled and indigent elderly—has prevented it from becoming an even broader “safety net” for the uninsured. This dilemma is exacerbated by the fact that the states, facing their worst fiscal shortfalls in decades, are currently looking for ways to restrain their most expensive program’s costs (after K-12 education), not expand its eligibility.⁴⁴

Figure E-3
Medicaid Enrollment and Spending, By Eligibility Group, 2001



Source: Urban Institute estimates prepared for the Henry J. Kaiser Foundation, "The Medicaid Program at a Glance" (Washington: Kaiser Commission on Medicaid and the Uninsured, January 2001).

What is perhaps most unfortunate about Medicaid's growing status as a "hole-patcher" for Medicare is that, irony of ironies, the past two decades have shown the former to be a much more promising vehicle for reaching universal coverage than the latter. Health reformers have traditionally envisioned it the other way around with Medicare being the vehicle for reaching the goal. But as Lawrence Brown and Michael Sparer point out, Medicare's benefits and beneficiaries have not changed much since the program's passage. Medicaid, on the other hand, has maintained its relatively extensive benefits in the face of economic uncertainty while significantly expanding its eligibility criteria. Moreover, although Medicare has attractive universal coverage for all senior citizens and the disabled, it has forgone the flexibility states have enjoyed with Medicaid in crafting creative structural solutions and implementing reforms such as managed care.⁴⁵

The best example of Medicaid's ability to broaden the level of health insurance coverage—in a way that Medicare never has—is SCHIP (the State Children's Health Insurance Program). SCHIP constitutes the nation's single biggest expansion of public health insurance since Medicare and Medicaid's passage in 1965. Enacted in the Balanced Budget Act of 1997, the program follows the Medicaid model: federal matching funds for programs in which states have wide discretion. SCHIP also allows states to reach the program's target, uninsured children who do not qualify for Medicaid, by making SCHIP an addition to their Medicaid programs.⁴⁶

SCHIP is something of the “Kiddiecare” program that social insurance enthusiasts always envisioned adding to Medicare, but which they never could because of Medicare’s cost explosion.⁴⁷ Consequently, the strategy of incrementalism that stalled in the 1970s was transferred to the welfare path of Medicaid, which policymakers (notably Representative Henry Waxman, D-CA) have cleverly and discreetly expanded by way of the annual budget process. Yet SCHIP, like Medicaid upon which it is modeled, also illustrates the limits and disadvantages of expanding health insurance incrementally via the welfare model. Because, unlike social insurance, what the government giveth in the form of public assistance, it can also taketh away (figure E-4).

SCHIP: Covering the Children of Uninsured, Working Parents

As the largest expansion of government health insurance since Medicare and Medicaid in 1965, policymakers created SCHIP in 1997 to reduce the number of uninsured children (10 million at the time) who were not covered by Medicaid.⁴⁸ The program, Title XXI of the Social Security Act, was a response to a growing economic phenomenon in our country: a family’s household income is too low to afford private health insurance but too high to qualify for existing public health insurance.

Currently, about 70 percent of uninsured children live in a household whose total income is more than \$15,260—the 2003 poverty line for a family of three and the maximum level of income for Medicaid eligibility—but less than \$30,520 (200 percent above the poverty line).⁴⁹ The vast majority of uninsured children have a parent who works full-time (75 percent) or at least part-time (15 percent).⁵⁰ These families, however, are either not offered health insurance by their employers or they cannot afford to purchase it.⁵¹

SCHIP resembles Medicaid’s structure in that the program is jointly financed. The federal government’s share ranges from 65 to 84 percent, depending on each state’s portion of the nation’s total number of uninsured children. The states were given a great deal of discretion in constructing their SCHIP programs, and encouragement to be generous with their eligibility criteria. States could create a new program, expand their Medicaid program to include children eligible under SCHIP, or devise a combination of both. By 2000, every state and U.S. territory had a SCHIP program in place. Currently, 21 states and territories are operating Medicaid expansion programs, 16 have separate SCHIP programs, and 19 are operating combination Medicaid/SCHIP programs.⁵² Similar to Medicaid, most state SCHIP plans rely on—and are the last bastions of—traditional, restrictive managed care to control their costs.⁵³

The states were initially excited about insuring more children, particularly as the robust economy of the late 1990s provided them with surplus funds that were more than matched by the federal government. States took great pride in the new opportunity to develop their SCHIP programs and to reach out to low-income families. According to Jennifer Ryan, they set up marketing campaigns, held outreach events featuring their governors, and came up with catchy

names—such as Healthy Kids, Peach Care, and Hoosier Healthwise—for their new SCHIP programs. Behind the scenes, states also simplified their programs to make them more user friendly. They shortened applications, encouraged families to apply by mail instead of making them come to a welfare office, and removed some of the tedious and burdensome eligibility verification requirements. The federal government did its part to raise awareness of the program. President Clinton and other members of the administration hosted many SCHIP events, including the launch of a nationwide outreach campaign, Insure Kids Now, that includes a toll-free number and Web site where families can call and be linked directly with enrollment information for SCHIP in their state.⁵⁴ As figure E-4 shows, the result of these initial efforts has been encouraging. Enrollment has risen steadily from about 1 million children in 1998 to 5.3 million by 2002.

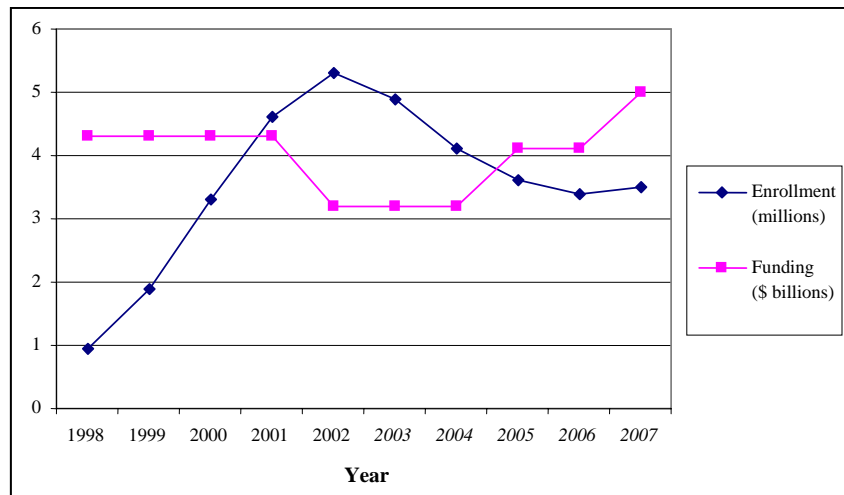
In addition to reaching millions of uninsured children, the most promising SCHIP-related development was the way in which the program made universal coverage more attainable. This new possibility came by way of a number of states expanding their SCHIP coverage to include the uninsured *parents* of eligible children. The theory has been that making the program more generous and available to parents would help states reach more eligible children. Studies of the first four states to cover parents of children enrolled in SCHIP—New Jersey, Minnesota, Rhode Island, and Wisconsin—found that the experiment worked exceedingly well in increasing the numbers of enrolled children and, concurrently, reducing the state's overall rate of uninsured individuals by also insuring more uncovered adults.⁵⁵

But while Medicaid and SCHIP have played innovative roles in keeping millions of working families from bankruptcy, crushing medical debt, and/or ill health, their structure shows the inherent limits of welfare programs that are means-tested and financed by general revenues. First, less than 50 percent of the children covered by SCHIP appear to be retained by the program when their eligibility is redetermined each year.⁵⁶ This is partly explained by children's parents either becoming poorer and, thus, qualifying for Medicaid or wealthier and, thus, ineligible for either program. Neither of these explanations for a child being dropped from the SCHIP program is a reason for concern because they are (hopefully) still covered. But in some states the retention rate is as low as 26 percent and change to parents' income only explains a portion of this very low number. Many of these "lost" children appear to be the result of parents who are confused about the rules and procedures they are to follow to keep their children's coverage up to date.⁵⁷ It is exceedingly discouraging to realize that there are still millions of children without access to regular medical care and insurance protection solely due to bureaucratic misunderstandings and lack of knowledge about their eligibility for SCHIP.

Another major problem with the program is reflected in the "SCHIP Dip." As illustrated in figure E-4, at least 900,000 children are scheduled to *lose* their SCHIP coverage by 2007 due to reductions in federal funding. Because policymakers knew that it would take the states some time to establish their SCHIP programs and as part of their efforts to balance the federal budget, the \$40 bil-

lion they initially allocated to fund SCHIP was not distributed equally over the first 10 years. Instead, Congress allocated \$4.3 billion per year for the first four years of the program (1998-2001), but then reduced it to \$3.15 for the next three years (2002-2004) before having it rise again thereafter. This means that while the number of uninsured children is rising—due to the recession in 2001 and the uneven economic growth the country has experienced thereafter—funding from the federal government is falling. Metaphorically speaking, this resembles the same “Perfect Storm” currently battering Medicaid: growing demand for the program, increasing medical inflation, and declining government revenues.⁵⁸

Figure E-4
The SCHIP Dip: Enrollment and Federal Funding (*Projected*), 1998-2007



Source: Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services; Fiscal Year 2003 Analytical Perspectives, White House Office of Management and Budget.

Recognizing this problem, various members of Congress have introduced legislation intended to address the dip and restore funding for SCHIP to the initial levels. But the bill’s consideration has been prolonged, which has led to a reduction in federal funding in at least 2002. And as long as the economy sputters along, states will fail to receive sufficient levels of revenue needed to maintain current levels of coverage. This is the weakness of any welfare-style program. Social insurance programs, such as Medicare and Social Security, are virtually impervious to fluctuating economic conditions. They are entitlements on which the government cannot default. But SCHIP is a discretionary program. Policymakers can adjust eligibility criteria and benefits in response to larger budgetary pressures (by law states have to balance their budgets annually), even if that means that nearly 1 million children lose their SCHIP coverage over the next three years.

Because of Medicaid and SCHIP's eligibility and financing problems, proponents of universal coverage have traditionally envisioned social insurance (Medicare) to be the optimal vehicle for achieving universal coverage. This enthusiasm for Medicare has persisted despite the fact that the program's managed care experiment in the late 1990s-early 2000s failed, and that it has taken more than a decade of painstaking deliberation and political jockeying just to pass essentially a catastrophic prescription drug plan. But as this book has shown, it's hard to change Medicare. It is a generous, universal, fee-for-service program that—at least from the perspective of its beneficiaries—has been virtually frozen in time from the mid-1960s when there were no “gatekeeping” primary care physicians, prior authorizations, or other restraints from whatever modern medicine had to offer.

Medicare: This *is* Your (Grand)Father's Health Insurance Program

“I hate this whole G--damn system. I'd blow it up if I could, but I'm stuck with it,” said Tom Scully, Administrator for the Centers for Medicare and Medicaid Services (CMS), which operates both programs. “If it were up to me, I'd buy everybody private insurance and forget about it. Obviously that's what the Republican view is: We ought to do what we do for federal employees—go out and buy every senior citizen a community-rated, structured, and regulated private insurance plan. Let them all go buy an Aetna product, or a Blue Cross product; that's the Republican philosophy. Why should Tom Scully and his staff fix prices for every doctor and hospital in America? Which is what we do.”⁵⁹

Prior to 1994, this view of Medicare was practically non-existent outside of a few ideological purists (such as Newt Gingrich) who were rarely in a position of having to govern. The notion that Medicare should be privatized by changing it from a “defined benefit” to a “defined contribution” plan would have been anathema to the leading policymakers in Washington. There was a political consensus about Medicare, as Jonathan Oberlander has documented, that governed the program for the first three decades of its existence. Policymaking was bipartisan in character, even when it involved extraordinary changes to the program's method of reimbursing hospitals and doctors. Moreover, Republicans and Democrats embraced the idea that Medicare “should be operated as a universal government program, that federal health insurance for the elderly should take the form, in essence, of a single-payer health system.”⁶⁰

The 1994 congressional elections, however, triggered a political earthquake: Republicans gained control of both the House of Representatives and the Senate for the first time since 1954. After being out of power for four decades, they had a number of new political agendas, but none bigger than balancing the federal budget. As Chapter 7 explains, Medicare was already viewed as a perennial “cash cow” that Congress had been accustomed to using to free up spending for other programs and to achieve some measure of deficit control. But to go beyond deficit control to the next level of actually balancing the budget would

have required substantial cuts in Medicare spending that were far beyond the consensus that had existed since the program's beginning.

Conveniently, in 1995 Medicare was predicted to begin running a deficit in 2002 and to be completely insolvent by 2032, when the entire "Baby Boom" generation had reached retirement age (see Figures E-5, E-6).⁶¹ Republicans responded by proposing \$270 billion in Medicare spending reductions over seven years as part of a "Save Medicare" campaign.⁶² President Clinton's veto of this and other critical budget legislation passed by the Republicans triggered the famous government shutdown in late 1995-early 1996. He emerged the political winner from his showdown with House Speaker Newt Gingrich and the House Republicans, and went on to win reelection handily in 1996. In August of 1997, Congress and the President passed the Balanced Budget Act (BBA), which included a number of Medicare reforms and cuts in the program's spending totaling \$112 billion over five years.⁶³

The centerpiece of the 1997 Medicare reforms was policymakers' creation of Medicare+Choice (M+C), which sought to dramatically increase the number of senior citizens in participating managed care plans.⁶⁴ There were already 5 million Medicare beneficiaries enrolled in various managed care plans in 1997 (14 percent of the program's total population), but Republicans had ambitions to significantly increase that number. As Tom Scully previously explained, they wanted to do four things in particular: expand beneficiaries' health care choices; provide additional benefits, such as prescription drug coverage; restrain the growth of federal Medicare spending by encouraging competition among private health plans; and reduce the need for direct government regulation of provider payment policies.⁶⁵ In short, Republicans desired to fundamentally change Medicare to a program that provided beneficiaries with a defined contribution towards the purchase of a private health insurance plan.

When M+C was adopted, the Congressional Budget Office predicted that it would eventually enroll 13-15 million individuals or around 34 percent of the entire Medicare population by 2005.⁶⁶ Instead, enrollment in M+C peaked in 1999, at a little more than 6 million beneficiaries, and has since fallen back to less than 13 percent by 2003.⁶⁷ Furthermore, of the 346 managed care plans that were participating in M+C in 1998, only 156 were still in the program five years later.⁶⁸ The remaining plans have become much less attractive to Medicare beneficiaries, as most have increased premiums and decreased benefits, such as prescription drug coverage.⁶⁹

Ultimately, M+C proved to be an unstable foundation for policymakers to pursue broader reform of the program. Republicans and Democrats disagree over why the M+C initiative failed—the plans were over-regulated and under-paid by the government or the Medicare population is simply unsuited for profit-oriented managed care.⁷⁰ But most would agree that policymakers are left facing a Herculean challenge. They need to find ways to restrain Medicare's costs, while also expanding the program to cover increasingly important but expensive items such as outpatient prescription drugs and nursing home care. And, unfortunately, time is not on their side (figures E-5, E-6).

The risk that a major intergenerational conflict will arise in the future between retirees and workers, who finance retirees' Social Security and Medicare benefits, is considerable. Currently, Medicare takes in increasingly more money by way of the payroll tax than it pays out in benefits, in part because the ratio of workers to retirees is sufficiently high (3.8 to 1) that it generates a surplus of revenue. But this trend will change dramatically beginning in 2011, when the first of the Baby Boomers—the 77 million individuals born between 1946 and 1964—reaches the retirement age of 65. At that point the ratio will have declined to 3.6 workers to each retiree. By 2030, when the last of the Baby Boomers becomes eligible, the ratio will have fallen to 2.3 workers to 1 retiree.⁷¹

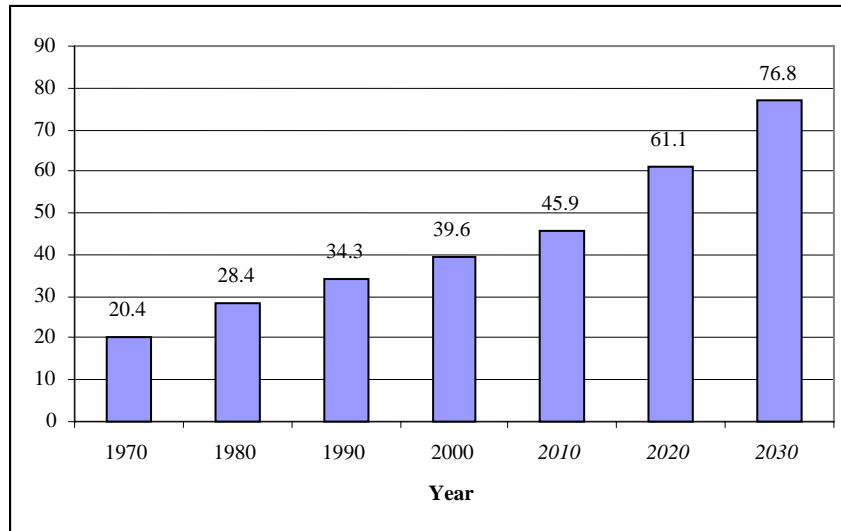
At that point, policymakers will only have three options available to keep Medicare going: increase workers' taxes, decrease beneficiaries' benefits, or some combination of the two. Policymakers could increase the age of eligibility, but it is politically unlikely. This unavoidable future necessity, then, to either increase taxes or decrease Medicare's benefits, makes the recent debate in Congress—over how to *add* an expensive (approximately \$400 billion) prescription drug benefit to the program—border on the surreal.⁷²

Adding drug coverage to Medicare is fiscally irresponsible, but politically attractive because it benefits the largest and most active voting block in the country: retirees. Coverage of outpatient prescription drugs was not included when Medicare passed in 1965, because it was a relatively insignificant part of medical care at the time. The comparatively few drugs in existence were affordable. But since then prescription drugs have become a critical part of modern medicine's armamentarium. They have also become exceedingly expensive, especially for the elderly, most of whom live on fairly modest fixed incomes.

Consequently, there is nearly unanimous agreement among policymakers that some type of drug benefit needs to be added to Medicare. Yet two-thirds of the program's beneficiaries already have some form of prescription drug coverage (through plans they continue to receive from their previous employers, private Medigap policies, Medicaid, or their enrollment in an M+C plan).⁷³ So as with all public health insurance initiatives, the trick for policymakers is how to expand the public safety net for those who desperately need help without encouraging employers to curtail their own retiree drug plans and dump the burden on Medicare, thereby driving up the cost to taxpayers and leaving some of the elderly with worse coverage than they have now. While over 60 percent of U.S. companies provided their retirees with health benefits in 1988, less than 35 percent do so today.⁷⁴ Policymakers do not want to exacerbate this trend.

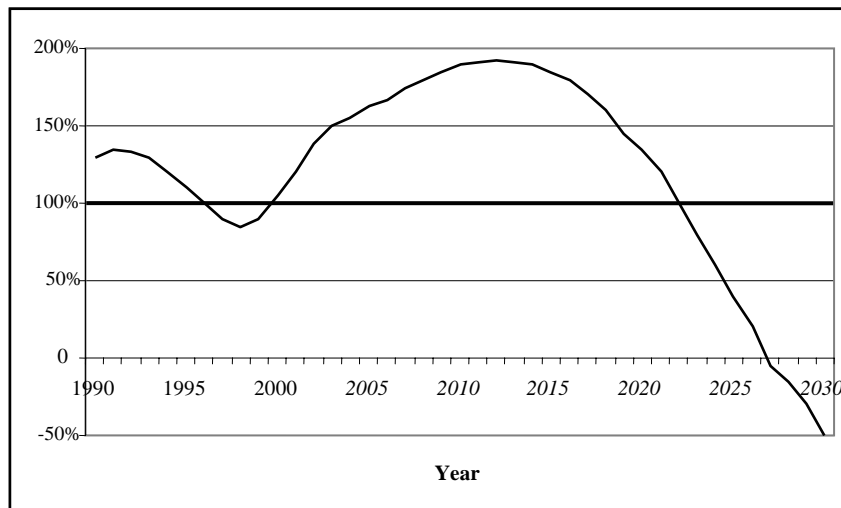
This is arguably *the* dilemma facing our nation's health care system, which is half private, half public and has gaps in-between: How do policymakers wisely and effectively expand the system's public programs without undercutting the private sector's health insurance arrangements? If the government expands the eligibility of existing public health insurance programs, it could provide too many incentives for businesses to stop providing health coverage as a fringe benefit.

Figure E-5
 Medicare's Enrollment in Millions (*Projected*), 1970-2030



Source: Program Information on Medicare, Medicaid, SCHIP and Other Programs, CMS, 2002.

Figure E-6
 Medicare's Trust Fund Balance as % of Annual Costs (*Projected*), 1990-2030



Source: 2003 Trustees' Report; see <http://cms.hhs.gov/publications/trusteesreport/2003/figif2.asp>

The Medical Malpractice Crisis: Litigation Nation

The previous sections might leave the impression that the only insurance crisis in the U.S. health care system involves the 41.2 million individuals who don't have coverage. But the nation is currently experiencing another significant insurance problem, which affects physicians and institutional health care providers: professional liability protection (more commonly known as medical malpractice insurance). Its affordability has become an extremely difficult proposition in many parts of the country for physicians in high-risk specialties such as obstetrics, emergency medicine, general surgery, surgical subspecialties (e.g., neurosurgery), and radiology.⁷⁵ The crisis has become so bad in some states that thousands of doctors have gone on strike, several hospitals have temporarily closed or threatened to close emergency room, obstetrical or other services, and pregnant women in states such as Washington and Nevada have had to drive as far as seventy miles to find a physician who still delivers babies.⁷⁶

This is actually the country's third medical malpractice crisis. The first, in the early to mid-1970s, was primarily a crisis of insurance availability. As Michelle Mello explains, its distinguishing features were the departure of many major malpractice insurers from the market, which made insurance virtually impossible for many physicians to purchase at any price. This situation led to the formation in many states of insurance companies owned and operated by physicians ("bedpan mutuals") and state-sponsored joint underwriting associations, many of which are still in operation.⁷⁷ The second crisis, in the early to mid-1980s, was more a crisis of affordability. Insurers did not pull out of the market, but they began charging premiums that many physicians simply could not afford to pay.⁷⁸ Both crises began in much the same way. Physicians in a handful of states experienced a sudden spike in their medical malpractice insurance premiums, which triggered a domino-effect whereby physicians in more and more states found it increasingly difficult to obtain affordable coverage.

The current malpractice insurance crisis is something of a combination of both availability and affordability problems. In 2002, the second largest malpractice carrier in the country, St. Paul Companies, pulled out of the market, partly because of a \$940 million underwriting loss in 2001. Several other insurers have subsequently followed its lead. Consequently, many states have witnessed the exiting of insurance companies that held a significant share of the market, which has left thousands of doctors with fewer and much more expensive options for obtaining liability coverage.⁷⁹ In some of the hardest hit states such as West Virginia, Pennsylvania, Florida, Nevada and Washington, many physicians have been left without any options whatsoever. No insurance carrier will offer them a policy. Therefore, physicians have had to turn to their states' joint underwriting associations as the "insurer of last resort." Although the purpose of these organizations is to guarantee that all physicians are able to obtain coverage, the rates they charge can and often have been prohibitively high, especially for doctors who have been sued before. In states such as Florida, which do not require that doctors have malpractice insurance, increasing numbers of them are "going bare" and working without coverage. Not surpris-

ingly, “asset protection” is a growing industry in these states, as doctors endeavor to protect their personal property.⁸⁰

The three parties involved—physicians, attorneys, and insurance carriers—all point to each other as the cause of the crisis. Physicians blame “ambulance chasing” attorneys for flooding the courts with frivolous claims that physicians have to either settle prior to going to trial (at the average cost of \$30,000) or contest in court (win and still pay on average \$95,000). Obviously, both options are money-losers for doctors, even though they win most cases (70 percent are closed without payment).⁸¹ Physicians also blame “out of control” juries who do not understand the realities of medicine, the cumulative effect of multimillion-dollar awards on the cost of health care, and the fact that not all “bad” outcomes are the result of malpractice.⁸² The quantity and quality of empirical data on either of these claims is thin. What is clear, though, is that while the number of both claims and awards against doctors has remained relatively steady, the average size of awards has increased substantially.⁸³

Insurers concur with physicians in pointing the finger of blame at attorneys. They claim that the large increases in premiums are due to the growing number of “\$1 million+” awards, as well as the increases in both the median settlement amount and the average administrative costs associated with defending malpractice claims.⁸⁴ Therefore, insurers have joined with physicians in advocating federal legislation, similar to California’s law, that limits awards for non-economic damages or “pain and suffering.”⁸⁵

Attorneys have responded, perhaps predictably, by blaming both physicians and insurers. They claim that lawsuits are a necessary means of providing victims with the financial support they need to pay for damages inflicted by negligent physicians. When the medical error rate goes down, they argue, so will the rate of litigation.⁸⁶ Moreover, attorneys point to insurers’ financial practices as the real culprit for skyrocketing premiums. They maintain that insurers underpriced their products in the early 1990s to gain market share against their competitors and in order to invest the premiums they received in the stock market, which annually was producing double-digit returns. But when insurers suffered three straight years of investment losses beginning in 2001, attorneys argue, they had no choice but to substantially increase their premiums to compensate for the effects of a bear market and low bond yields.⁸⁷ In other words, attorneys argue, relax. When stocks and bonds recover and new insurers reenter the market to undercut insurance policies that have become too expensive, the “insurance cycle” will repeat itself and today’s medical malpractice crisis will disappear just as it did in the 1970s and 1980s.

It is very difficult to empirically test this theory or insurers’ and physicians’ claims about the causal relationship between lawsuits and premiums. But most observers would agree that our current tort system is not well designed to significantly reduce injuries due to medical errors or to compensate the majority of injured patients in a timely and appropriate way. And because all proposals for tort reform invariably reflect the interests of the three groups that propose them, it is unlikely that meaningful change will occur anytime soon. But what makes

the current tort system and its malpractice insurance crisis an impediment to universal coverage is that they both encourage physicians to practice more “defensive medicine,” which includes additional and often unnecessary tests to protect them from future lawsuits. Defensive medicine adds billions of dollars to the nation’s health expenditures and fuels medical inflation, which only makes health insurance more expensive and increases the number of uninsured.⁸⁸

With so many festering problems in our health care system, perhaps we are approaching another period of serious political deliberation over comprehensive reform. If so, it is critical that policymakers take a moment and learn from previous failures, especially President Clinton’s.

Learning From Clinton’s Failure: A Decade Later

In the spring of 1993, one year before he died, former President Richard Nixon visited the White House at the invitation of President Clinton. Shortly after he arrived, he pulled Hillary aside and said, “You know, I tried to fix the health care system more than twenty years ago. It has to be done sometime.” She replied, “I know, and we’d be better off today if your proposal had succeeded.”⁸⁹ Ironically, she crafted a plan that closely resembled Nixon’s proposal and which ultimately met the same fate: defeat. Reflecting on the outcome ten years later she concluded: “Someday we will fix the system. When we do it, it will be the result of more than fifty years of efforts by Harry Truman, Richard Nixon, Jimmy Carter and Bill and me. Yes, I’m still glad we tried.”⁹⁰

Given both the forests of trees and vats of ink that have been consumed analyzing the defeat of health care reform in 1993-94, one pauses before consuming any more (particularly given the attention this book has already paid to it in Chapter 7). The only worthwhile purpose this author can see in revisiting Clinton’s failure is to relearn some important lessons about the politics of health care reform. Because hope springs eternal and significant problems with our health care system continue to fester, it is likely that there will be another major push for health care reform in the future. Unfortunately, the Clinton effort provides several object lessons in how not to go about it.

Before being critical, though, the Clintons are to be applauded for having even tried, despite the fact that the likelihood of success was low from the outset. President Clinton was narrowly elected in 1992 in a three-way race in which he ultimately received less than 50 percent of the popular vote. Once in office, his administration had to face an economy in recovery and enormous annual budget deficits “as far as the eye could see.” Hence, there was little to no room for error and no unused money lying around for major new policy initiatives. Moreover, opting for comprehensive reform—rather than the incremental variety—reduced his administration’s chances for success even further.

Nevertheless, the Clintons chose a plan modeled on Republican President Richard Nixon’s 1974 health care proposal and built on the same market-oriented strategies that Republicans today desire to impose on Medicare. So there was a chance, however remote, that the Clintons’ efforts could have succeeded politically. As Robert Winters, Chairman of Prudential Insurance and Head of

the Business Roundtable's Health Care Task Force (which became one of the leading groups opposed to President Clinton's efforts), said: "Were there days when we thought the Clinton plan was going to go through and pass? Oh, yes, absolutely!"⁹¹ The Democrats controlled the Presidency and both houses of Congress. The media was largely sympathetic to the goal of comprehensive reform. Millions of working- and middle-class Americans were without health insurance and millions more lived in daily fear that they could soon join them. There were many large businesses saddled with enormous health care costs for their workers, and especially their retirees, that desperately wanted major change to the country's health care system. Thus, there was good reason for the abundance of optimism that surrounded the issue of health care reform in 1993.

It is difficult to condense the different explanations for the Clintons' failure into a single coherent argument, but *alienation* is a theme that runs through most of them. In brief, the self-imposed alienation of key policymakers in the Clinton administration (Hillary Clinton and Ira Magaziner, in particular) and the extent to which they subsequently alienated key policymakers both in Congress and in the larger health care community led to a health care plan—and a strategy for passing it—that was critically lacking in political feasibility. Hillary Clinton has admitted as much: "After twenty months, we conceded defeat. We knew we had alienated a wide assortment of health care industry experts and professionals, as well as some of our own legislative allies."⁹² This alienation, which made passing any kind of reform impossible, unfolded and intensified over time.

The alienation began with the 500+member President's Task Force on National Health Care Reform that the Clinton administration created in early 1993 for the purposes of drafting a proposal. Walter Zelman, a key health policy advisor to the Clintons and a senior member of the Task Force, explains why it was such a mistake: "There are all kinds of ways to make policy. One is to put a small number of people into a back room and have them thrash it out. Another is to have a large, slow, public, participatory effort that builds, you hope, to consensus and public support. We picked the worst of both models, secret and huge... The public—and worse, all kinds of interest groups—saw 500 people behind closed doors, with themselves on the outside."⁹³ Bob Boorstin, Communications Director for the Task Force, puts it more bluntly:

What happened with the Health Care Task Force was that it did three things. One, it pissed off the journalists, so they were looking for anything and everything they could find that reflected badly on the process... The second group that it pissed off was the Republican staffers who had burrowed in at HCFA [the Health Care Financing Administration] and OMB [the Office of Management & Budget], particularly at OMB. These people, I mean, the minute they saw an option paper would leak it. So you've got all these headlines in the *Post* and the *Times* and the *Journal* totally based on leaks from Republicans who were holdovers from President Bush and had burrowed into the bureaucracy in order to save their butts, their jobs, their pensions, whatever. So there's a pretty devastating combination. The third group that was really pissed off was the lobbyists. They had no way in. And closing the door in the face of a lobbyist is going to piss them off.⁹⁴

In retrospect, Hillary Clinton agreed that the Task Force was the wrong way to start the policymaking process: “The group was so large that some members concluded they were not at the center of the action where the real work was getting done. Some got frustrated and stopped coming to meetings. Others became narrowly interested in their own piece of the agenda, rather than invested in the outcome of the overall plan. In short, the attempt to include as many people and viewpoints as possible—a good idea in principle—ended up weakening rather than strengthening our position.”⁹⁵

The second stage of alienation involved the exclusion of President Clinton’s key budget and economic advisors, who would have advocated a less ambitious and more politically feasible proposal for health care reform. Leon Panetta (Director of OMB), Laura D’Andrea Tyson (Chair of the Council of Economic Advisors), Robert Rubin (Chair of the National Economic Council), Lloyd Bentsen (Secretary of the Treasury), and Alice Rivlin (Deputy Director of OMB) had just helped Clinton pass his first budget in August 1993. It proved to be the single biggest and most important accomplishment of the President’s first term. The plan required extensive negotiating with numerous members of Congress and difficult political choices, including raising taxes. It passed by one vote in the House and by the tie-breaking vote of Vice President Gore in the Senate. Based on this experience and their professional backgrounds, Clinton’s budget and economic advisors were far more knowledgeable than Hillary, Ira Magaziner, or any member of the Health Care Task Force about what was and was not politically feasible. But probably because of the tough questions they would have asked (and later did ask) about the health reform plan, Rivlin claims, they were largely excluded from the Task Force’s drafting process.⁹⁶ Their lack of input, in Panetta’s opinion, damaged the plan’s political prospects:

Instead of the careful work that went into developing the budget, the health care thing became part of a political strategy... The President’s plan was designed by a smaller group of individuals. Once it was done, it was very difficult to try to change it. A lot of us indicated our concerns with what would take place. I had kind of a double concern, which was not only the nature of what was being proposed, because it was so hard to understand, but, secondly, I said that the problem is that Congress is not going to be able to understand the implications here. It cannot digest this big a piece of legislation in one bite. I asked, “Who’s going to be for this proposal when it goes to Congress?”

In the end, the plan didn’t have a lot of useful politics. So the problem is that they lost sight of the fact that without being able to sell it politically, it wasn’t going to happen. Unfortunately, of all the battles we’d been through to try to get the budget put in place, all of those lessons just went out the window with the rest of health care reform.⁹⁷

Without the involvement of the administration’s key budget and economic advisors, the plan’s ambitions were never cross-checked against what realistically could be passed in Congress. The end result, as Robert Rubin points out, was a politically impossible situation: “I think that partly it’s because the process led into something that was too large to accomplish at one time... The

reform of the health care system in one fell swoop was more than anybody could expect to accomplish.”⁹⁸

The last stage of alienation involved key members of Congress and their staff. It was not only senior Republicans, such as Representative Newt Gingrich and Senator Phil Gramm, who were logically and by necessity excluded because of their bitter opposition to any reform whatsoever. Moderate and conservative Democrats, many of whom had extensive backgrounds in health policy, were also ignored. In addition to Hillary and Ira Magaziner’s naiveté and hubris, perhaps part of this exclusion can be attributed to the less than helpful advice Hillary claims she received from key senior Democratic members of Congress early in the process:

We had originally envisioned presenting Congress with an outline of principles that would shape the health care reform legislation. But we subsequently learned that Congressman Dan Rostenkowski expected us to produce a detailed bill, complete with legislative language. Giving Congress a comprehensive bill at the outset turned out to be a tremendous challenge and a tactical mistake for us. We thought it would be 250 pages at most, but as drafting continued, it became clear that the bill needed to be much longer, in part because the plan was complex and in part because we acquiesced to some specific requests from interested groups... The Health Security Act delivered by the White House to Congress on October 27 was 1,342 pages long.⁹⁹

But David Abernethy, Staff Director of the House Ways and Means Committee at the time, denies this claim and points to the Clinton administration’s lack of Washington experience as a major weakness in moving health care reform along in a timely manner:

Health care was already receding as a political issue in late ‘93, in part because the Clinton administration took nine months to get a proposal up to Congress. Mrs. Clinton used to love to say, “Well, your boss, Mr. Rostenkowski, said that we had to send up a bill.” The third time she said that to me, I finally said, “Mrs. Clinton, there’s a bill and then there’s a *bill*.” Mr. Rostenkowski did not mean 1,000+ pages of finely dense type. What he meant was that you had to have a reasonably fully fledged-out proposal, so that it was clear what you wanted.” I went on to say, “You and I, with all due respect Mrs. Clinton, could have knocked that out in a weekend.”

But they didn’t know any better. They were new to Washington. This is a problem with electing a governor and particularly a governor of a small state. A governor of California might be better positioned to understand what it takes to survive in Washington. But they really didn’t know. The first meetings with them were painful, just painful.¹⁰⁰

The Clinton administration and its Democratic allies in Congress did not need—and never would have received—help from most Republican members. But they did need a few, key moderate Republicans for health care reform to be politically feasible. Other than the late Senator John Chafee of Rhode Island, the

Clinton team chose not to seriously engage any Republicans. According to Sheila Burke (Chief of Staff for Republican Senator and Majority Leader Bob Dole), this partisan alienation was a crucial mistake, but also a function of the bitter politics that existed then:

I think the politics of the time didn't permit it. I think there were a series of decisions that were made that almost precluded ... our coming to what would have normally been a compromise. I think the decision to exclude the Republicans from the outset was a huge mistake on the part of the White House... Mr. Rostenkowski tried to warn them; Senator Moynihan tried to warn them. But the Democrats had problems on their own side, so that all the pieces that could have been put into place for a compromise had no opportunity. And then it just became too late and too close to the '94 elections....

But at the end of the day you want to solve a problem. There was a history between the House Ways and Means and Senate Finance Committees, where we would often be at opposite ends but there was a commitment—whether it was Dole as Chairman or Packwood, or Bentsen, or Rostenkowski—to come to closure. And we weren't permitted to do that. It was terrible. In the 20 years I've served as a staff member on the Hill, it was by far the worst experience I ever had and I had some horrific experiences. It was *the* worst. It is the period of time I look back on with the greatest regret.¹⁰¹

Once the sense of alienation had reached such a high level and affected so many leading representatives of the health care system, comprehensive health reform was effectively dead. Worst of all, making a mid-course correction sometime in 1994—in order for a compromise to be reached over a more modest, incremental reform plan—became politically infeasible as well.

Even millions of middle class Americans came to feel alienated by the manner in which the Clintons tried to sell their reform plan. “We kept trying to link middle-class concerns to lower-income concerns, knowing that we had an opportunity to piggyback the universal coverage issue onto middle-class insecurities regarding the potential loss of health insurance. But it was a tough sell,” argues Zelman. “What the middle class needed was the opportunity to buy health insurance at a reasonable price and then keep it. That could be achieved without universal coverage and without subsidizing insurance for lower-income persons. We kept trying to make a case that anything less than universal coverage would hurt the middle class. But that argument had its limits. It just wasn't true. Every time we made it, we were burning our bridges—there would be no ground left on which to compromise.”¹⁰²

Ironically, after the tremendous disappointment over the defeat of health care reform faded over time and the managed care revolution took off with a vengeance in the mid-1990s, many high ranking Clinton administration officials felt a sense of having been spared politically. They came to believe that if the Clinton health care plan had passed, it would probably have been next to impossible to actually implement and then President Clinton would have been blamed for the hugely unpopular managed care revolution. According to one senior

Clinton administration official, “Implementing the plan would have been a mess. And, so, two things: I think he would have been thrown out [in the ’96 election] and his health plan would have been repealed.” Laura D’Andrea Tyson, President Clinton’s Chair of the Council of Economic Advisors, disagrees with this argument only in that she is skeptical that the plan could ever have been implemented, much less by 1996:

I don’t think the health plan would have been implemented by 1996, so I don’t agree with the notion that he would have gotten the blame... I think from the time it would have passed in ’94 to the time that the ’96 election came around not that much could possibly have been done that would have politically affected him... The plan was really complicated. You were going to have to set up all these HIPCs [Health Insurance Purchasing Cooperatives] all over the country. You were going to have to come up with price caps. You were going to have to get the Medicare population enrolled in new plans. When you actually think about doing something that big....

What I would say is that if the average American had ever actually been forced to choose among a limited number of health care plans run by regional HIPCs and if their range of medical services had been in any way limited, then, yes, I think it could have been a political disaster because there were some real managed care elements to the Clinton health care plan. But my personal view is that it wouldn’t have been feasible to actually implement the plan.¹⁰³

In the end, the failure of health care reform in 1993-94, Abernethy argues, “can be summarized in one sentence: You have to leave the health insurance that most people have alone. You can’t come up with a system that requires you to disrupt the existing insurance arrangements that most people have. Even if they aren’t very happy with them, they’re not going to let you mess with them. The problem with the Clintons’ ‘managed competition’ proposal is that it required the disruption of all existing health insurance arrangements. And that is what the Republicans exploited ruthlessly.”¹⁰⁴

This leaves us with an obvious question: What can be done to reach some form of universal coverage and, in the process, improve our current health care system? The final section briefly examines three competing solutions that have recently risen to prominence.

Conclusion: Possible Solutions to the Problem of the Uninsured

Three of the leading proposals for addressing the problem of the uninsured run the gamut from conservative to liberal, modest to ambitious, and Republican to Democratic. The major disagreements between them, Karen Davis and Cathy Schoen explain, are over the role of private insurance in covering the uninsured, whether public programs should be expanded to include additional groups, and the commitment of adequate budgetary resources required to assist those who are unable to afford the full cost of health coverage.¹⁰⁵ Each proposal has its own strengths and weaknesses. Not surprisingly, one proposal’s weakness is often

another one's strength and vice versa. But to varying degrees they all reflect the limitations highlighted by the Clinton debacle. Structurally, as Abernethy argues, you cannot disrupt the existing health insurance arrangements that most people currently have. And politically, Zelman notes, discretion is the better part of valor: "More than anything else, you have to understand the limitations and restraints—all of them, institutional, political, policy and educational. The opposition will always have more levers, the public can be moved only so much, and you've almost certainly got less power than you think you have."¹⁰⁶

One option advocated by President George W. Bush calls for tax credits of up to \$1,000 for individuals earning below \$45,000 a year and \$2,000 for families earning below \$60,000 a year.¹⁰⁷ Uninsured individuals would use these tax credits to purchase a private health insurance policy. The proposal's primary strength is that it does not call for any new government program or organization, nor does it threaten any existing health insurance arrangements. Therefore, it is the most feasible, modest and least controversial option. However, the proposal has several weaknesses. First, the amount of the tax credits is not enough to purchase an adequate policy, especially given that they would be individual/non-group policies. The average cost of a non-group health insurance plan for a family of four is roughly \$7,300 per year. Even if the tax credit was increased to \$3,600, the most generous proposed, that would leave the average family with about \$3,700 to pay out-of-pocket.¹⁰⁸ Given that most of the uninsured are working- to middle-class, this amount would be prohibitively expensive. In addition, the cost of private, individual health insurance policies could increase significantly; employers could use the new policy as an excuse to cease providing health insurance as a fringe benefit; and the credits would have to be paid for by either increased government revenues (more taxes now) or increased government debt (more taxes later).

Another option, advocated by Democratic Representative John Conyers and others, involves significantly expanding Medicare. Citing the high proportion (upwards of 50 percent) of each private health insurance dollar that is diverted to overhead and profits—and, thus, not to cover actual physician and hospital expenses—Marcia Angell, former Editor of the *New England Journal of Medicine*, argues that what we need is a national single-payer system that would eliminate unnecessary administrative costs, duplication and profits. In effect, this would be the equivalent of extending Medicare to the entire population. "Medicare is, after all, a government-financed single-payer system embedded within our private, market-based system," notes Angell. "It's by far the most efficient part of our health-care system, with overhead costs of less than 3 percent, and it covers virtually everyone over the age of 65. Medicare is not perfect, but it's the most popular part of the American health-care system."¹⁰⁹ If President Bush's tax-credit proposal is too timid and unlikely to help many uninsured, then the idea of extending Medicare to all suffers from a serious lack of political feasibility. This option was actually considered by Congress in 1994 (see pages 125-127), when the House Ways and Means Committee passed "Medicare Part C." The plan became the leading House alternative to the

Clinton plan. But congressional leaders could not even get it to the floor of the House of Representatives for a vote due to its political impracticality. The extent of the disruption it would cause to existing health insurance institutions and arrangements precludes this option from being seriously considered any time soon. The health care system would have to deteriorate further by several orders of magnitude before a massive expansion of Medicare (“Medicare for All” or “Universal Medicare”) would have any chance at passing.

The last, and perhaps most popular, option is something of a middle-ground approach that combines individual obligations and government subsidies. Using the example of automobile insurance, Senator John Breaux (D-LA) and others argue that health insurance should simply be mandatory. According to Senator Breaux, “I’d like to see a nationwide federal mandate that every U.S. citizen purchase a private health insurance policy. There would be a basic plan, that the government would help fund for low-income people who cannot afford it. The government’s subsidy would be graduated according to income, to the point where you would ultimately be responsible for paying for it all yourself when you can afford to. People could buy more than the basic plan if they wanted to, but it would be at their expense.”¹¹⁰ One of the keys to this option working is that it would enroll tens of millions of uninsured Americans who are below the age of 35. Mandating that this massive demographic group of young and mostly healthy Americans join the insurance risk pool would drive down the costs for everyone, because they would pay a lot more money into the system in the form of premiums than they would consume in the form of medical care.¹¹¹

Senator Breaux and others ultimately see this option replacing employer-provided insurance over time, which is radical. But as Senator Breaux argues, “Look at the problems we’ve got in this country right now with employer-sponsored health insurance. Health benefits are among the fastest-growing costs employers face now, and some can’t afford to pay for health care any more—many, particularly small businesses, are dropping it entirely. Of course, a lot of people like their employer plan and would want to stay in it. We want to make sure that we don’t discourage those who are providing coverage from continuing to do so, if it works for them.”¹¹² According to Ted Halstead, President of the New America Foundation, “The new system would be an improvement for Americans who receive their health insurance from their employers. They would be able to select their own insurance policy and level of coverage from among private providers, instead of being limited to the one selected by their employer. They would also be able to keep the policy and doctors of their choice as they move from job to job. Employers, meanwhile, would not stop paying for coverage—they would simply contribute to the policy of their employee’s choosing. After all, employer-subsidized health insurance is voluntary right now, and there is little reason to believe that employers would suddenly stop providing it.”¹¹³

A government mandate for people to purchase their own insurance is an innovative concept, but not a new one. It was part of the Senate Finance Committee’s alternative to the Clinton plan in 1994 (see page 127). Similar to the first option of tax credits, an individual mandate does not significantly expand

current government programs nor does it create new ones. This feature makes it less threatening to the status quo and, hence, more politically feasible. But an individual mandate has problems of its own. First, it would be enormously expensive. Because two-thirds of the uninsured would need substantial government subsidies to be able to afford an individual health insurance policy, the government would have to provide upwards of \$69-\$90 billion per year (based on the calculation that 30 million uninsured individuals would need, on average, between \$2,000 and \$3,000 in government subsidies to help them purchase their insurance policies; in reality, some would need less or none, while others would need a lot more). Moreover, as Jonathan Oberlander points out, an individual mandate plan has no cost-control mechanisms. It relies instead “on the vague hope that competition between private insurers will lower health-care costs. Yet the American experience with competition in medical care provides no basis for relying on a private system—the most expensive in the world, incidentally—to slow health spending. Without government regulation and freed from the negotiating leverage that big companies now exert for premium discounts, there would be no constraints on private insurers who wanted to raise prices. Under an individual mandate program, health-care spending and insurance premiums would continue to escalate, necessitating sizable increases in public subsidies—and likely generating political pressure to retreat from universal coverage.”¹¹⁴

* * * *

In conclusion, it does not seem likely that universal coverage, the Mount Everest of public policy in the United States, will be conquered any time soon. Maybe individual states, such as Maine and Oregon, will lead the way in innovative policymaking. Maybe it will take a Republican president, willing to risk political martyrdom, to reach across the political aisle and work with Democrats in Congress for comprehensive health care reform to ever pass. Maybe politics will change substantially when the majority of Baby Boomers have retired in the next twenty years and demand the best that modern medicine has to offer. Maybe health care costs, insurance premiums, and the number of uninsured will eventually increase to some critical point (yet to be reached) where sufficient numbers of middle class voters will finally demand that government do something on their behalf. There is no way to accurately predict, however, what straw will finally break the system’s back. But the history of health reform is clear about one thing: despite its numerous shortcomings and failures, which cause immense amounts of suffering for millions of people, our health care system has shown an extraordinary ability to muddle through one crisis after another. In the process, it has successfully repelled every attempt at comprehensive reform. Invariably, then, we are left with the quote from King David that began this Epilogue: “How long, O Lord, how long?”

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