

**UNIVERSAL COVERAGE, HEALTH INEQUALITIES, AND THE  
AMERICAN HEALTH CARE SYSTEM IN CRISIS (AGAIN)**

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*“The system is collapsing around us.”<sup>1</sup> . . . “I’ve become more convinced as time goes by that our health care system is fundamentally broken and needs major surgery; . . . I think we’re standing on the edge of a cliff.”<sup>2</sup>*

—U.S. Senator John Breaux

*“But Thou, O Lord, how long?”*

—King David<sup>3</sup>

Another health care crisis has emerged in the United States. It was inevitable. Ten years after President Clinton’s ambitious attempt at comprehensive health care reform died so ignominiously, the same problems—only worse—have returned, and even some new ones have appeared. The following is a brief overview of just some of the leading problems associated with our nation’s health care system.

After declining slightly in 1999 and 2000, at the height of the country’s economic boom, the number of uninsured Americans rose to 45 million in 2003 (15.6% of the population).<sup>4</sup> The lack of health insurance coverage has become as much a “working class” and “middle class” phenomenon as it is a “poor” one. Roughly one-third of all Americans earning between \$25,000 and \$75,000 (20,110,000 individuals) are uninsured.<sup>5</sup> More than 75% of the uninsured work full-time and about one-third earn more than \$50,000 annually.<sup>6</sup> 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.<sup>7</sup> Even the affluent are not immune. The number of uninsured people with household

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1. Marcia Angell, *The Forgotten Domestic Crisis*, N.Y. TIMES, Oct. 13, 2002, at A13.

2. Gail R. Wilensky, *Interview, Thinking Outside the Box: A Conversation with John Breaux*, HEALTH AFFAIRS WEB EXCLUSIVE, W3-124, W3-124, W3-130 (March 5, 2003), at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.124v1.pdf> (last visited May 28, 2004).

3. *Psalm* 6:3.

4. MILT FREUDENHEIM, *Record Number of Americans Not Insured on Health*, N.Y. TIMES, Aug. 27, 2004, at A1.

5. ROBERT J. MILLS & SHAILESH BHANDARI, U.S. CENSUS BUREAU, CURRENT POPULATION REP. PUB. P60-223, HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2002, *CONSUMER INCOME* 4 (2003), available at <http://www.census.gov/hhes/www/hlthin02.html> (last visited May 30, 2004) [hereinafter HEALTH INSURANCE COVERAGE: 2002].

6. Ceci Connolly & Amy Goldstein, *Health Insurance Back as Key Issue*, WASH. POST, Mar. 16, 2003, at A5.

7. R. Toner, *Study Raises Estimate of the Nation’s Uninsured*, N.Y. TIMES, Mar. 5, 2003, at A19.

incomes of \$75,000 or more rose to 7.3 million in 2002, an increase of 633,000 from the prior year.<sup>8</sup>

Not only are there millions of Americans without insurance, the costs for those who do have insurance are rapidly increasing. Unlike a decade ago, when health care costs and insurance premiums were decreasing, both have been steadily rising at a greater pace than the general rate of inflation since 1998.<sup>9</sup> Total national spending on health care grew 8.6% in 2002, marking the biggest one-year increase since 1993.<sup>10</sup> Employers' health insurance premiums rose by an average of almost 14% in 2003, more than anticipated and the largest increase since 1990.<sup>11</sup> Small companies of less than ten employees have seen their insurance premiums rise—provided they can still afford them—by as much as 20% or more per year since 2001.<sup>12</sup> Unfortunately 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.<sup>13</sup> “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.”<sup>14</sup>

One particularly alarming consequence of these worsening trends is that health care related problems are one of the leading causes of personal bankruptcy in the United States.<sup>15</sup> Upwards of 600,000 individual cases in 1999, or nearly 50% 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.<sup>16</sup> Given the recession and sluggish economic

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8. HEALTH INSURANCE COVERAGE: 2002, *supra* note 4, at 2.

9. Bradley C. Strunk et al., *Tracking Health Care Costs: Growth Accelerates Again in 2001*, HEALTH AFFAIRS WEB EXCLUSIVE, W299, W300-02 (Sept. 25, 2002), at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.299v1> (last visited Apr. 4, 2004).

10. Stephen Heffler et al., *Health Spending Projections for 2002-2012*, HEALTH AFFAIRS WEB EXCLUSIVE, W3-54, W3-56 (Feb. 7, 2003), at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.54v1> (last visited May 30, 2004).

11. *Id.* at W3-55. See also Barbara Martinez, *Rate of Increase for Health Costs May Be Slowing*, WALL ST. J., June 11, 2003 at A1.

12. Len Strazewski, *Benefits Business: Health Plans Stay But Change*, ROUGH NOTES MAGAZINE, Jan. 2004, available at <http://www.roughnotes.com/rnmagazine/2004/january04/01p12.htm> (last visited Apr. 4, 2004).

13. David Broder, *Problem of Lost Health Benefits is Reaching Into the Middle Class*, N.Y. TIMES, Nov. 25, 2002, at A1.

14. *Id.*

15. ELIZABETH WARREN ET AL., HARVARD LAW SCH., WORKING PAPER NO. 008, MEDICAL PROBLEMS AND BANKRUPTCY FILINGS 5-6, (2000), available at <http://ssrn.com/abstractid=224581> (last visited May 30, 2004).

16. *Id.* at 5-6.

growth that have occurred since then, it is certain that these figures have only worsened.<sup>17</sup>

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.<sup>18</sup> Meanwhile, Medicare has suffered from two high-profile problems: a failed experiment with enrolling beneficiaries in private managed care plans (Medicare+Choice),<sup>19</sup> and an inability to find a fiscally responsible way to add a prescription drug benefit to the program. In March 2004 – four months after President Bush signed the Medicare Prescription Drug, Improvement, and Modernization Act (DIMA) into law on December 8, 2003 – a scandal erupted over the disclosure that Medicare's chief actuary, Richard S. Foster, had originally estimated the cost of the new drug benefit plan to be closer to \$550 billion over ten years rather than the \$400 billion figure that lawmakers were led to believe and used in their political deliberations.<sup>20</sup>

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 the State Children's Health Insurance Program (SCHIP)<sup>21</sup> since 1997, 8.5 million or 12% of all youngsters are still uninsured.<sup>22</sup> 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.<sup>23</sup> These factors include: pending reductions in

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17. Press Release, The Access Project, New Report Outlines Far-Reaching Effects of Medical Debt (Mar. 5, 2003), available at [http://www.accessproject.org/downloads/med\\_prenrg.pdf](http://www.accessproject.org/downloads/med_prenrg.pdf) (last visited May 30, 2004).

18. For a discussion of the impact of declining economic conditions on Medicaid see John K. Iglehart, *The Dilemma of Medicaid*, 348 NEW ENG. J. OF MED. 2140 (2003); WHITE HOUSE OFFICE OF MANAGEMENT & BUDGET, A CITIZEN'S GUIDE TO THE FEDERAL BUDGET, FISCAL YEAR 2003 (2002), available at [http://www.house.gov/budget\\_democrats/budget\\_facts/cguide03.pdf](http://www.house.gov/budget_democrats/budget_facts/cguide03.pdf) (last visited May 30, 2004).

19. See Joseph R. Antos, *Medicare+Choice: Where Did the Scorekeepers go Wrong?*, HEALTH AFFAIRS WEB EXCLUSIVE, W83 (Nov. 28, 2001), at the following Internet address: <http://content.healthaffairs.org/cgi/content/full/hlthaff.w1.83v1> (last visited May 30, 2004).

20. For a discussion of the deliberation and passage of Medicare's Prescription Drug Benefit, see John K. Iglehart, *The New Medicare Prescription-Drug Benefit- A Pure Power Play*, 350 NEW ENG. J. MED. 826 (2004). For a discussion of the scandal over the estimated cost of Medicare's new prescription drug benefit, see Sheryl Gay Stolberg & Robert Pear, *Mysterious Fax Adds to Intrigue over Drug Bill*, N.Y. TIMES, Mar. 18, 2004, at A1.

21. See Balanced Budget Act of 1997, 42 U.S.C. § 1397bb (2000 & Supp. 2003).

22. HEALTH INSURANCE COVERAGE: 2002, *supra* note 4, at 8.

23. LEIGHTON KU, CTR. ON BUDGET AND POL'Y PRIORITIES, THE NUMBER OF AMERICANS WITHOUT HEALTH INSURANCE ROSE IN 2001 AND APPEARS TO BE CONTINUING TO RISE IN 2002 2 (Oct. 8, 2002), available at <http://www.cbpp.org/9-30-02health.pdf> (last visited May 30, 2004).

federal SCHIP funding, the expected reversion of previously allocated federal SCHIP funds to the U.S. Treasury, and growing state budget crises.<sup>24</sup>

How has it all come to this? Parts I, II, and III address each of these problems in greater depth and show how they are often interconnected. Part IV reexamines President Clinton's failure at health care reform based largely on interviews with several key policymakers and staff at that time. Some of these individuals have only recently granted interviews about why and how everything came to naught in 1993-94. Part V 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."

### I. HEALTH INSURANCE AND THE INCREASING NUMBERS OF THOSE WITHOUT IT

It is hard to grasp the magnitude of the number of uninsured, as Ron Pollack, executive director of Families USA, has observed.<sup>25</sup> It exceeds the aggregate population of twenty-four states.<sup>26</sup> Ironically, in the late 1990s the prospects for reaching universal coverage seemed to be improving largely due to two factors: 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).<sup>27</sup> This was initially encouraging. The private sector looked as if it was more than matching the public sector's increased generosity (Medicaid's and SCHIP's in particular).<sup>28</sup>

As it turned out, the primary reason for the overall increase in health insurance coverage during the latter half of the 1990s was a large contingent of Americans who moved up the income-ladder.<sup>29</sup> 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."<sup>30</sup> During

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24. *Id.* at 6-7.

25. Press Release, Ron Pollack, Families USA, Census Bureau's Uninsured Number is Largest Increase in Past Decade (Sept. 30, 2003), available at [http://www.familiesusa.org/site/PageServer?pagename=Media\\_Statement\\_Census\\_Bureau](http://www.familiesusa.org/site/PageServer?pagename=Media_Statement_Census_Bureau) (last visited May 30, 2004).

26. *Id.*

27. See John Holohan & Mary Beth Pohl, *Changes in Insurance Coverage: 1994-2000 and Beyond*, HEALTH AFFAIRS WEB EXCLUSIVE, W162, W162 (Apr. 3, 2002), at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.162v1> (last visited May 30, 2004).

28. ROBERT J. MILLS, U.S. CENSUS BUREAU, CURRENT POPULATION REP. PUB. P60-215, HEALTH INSURANCE COVERAGE: 2000, *CONSUMER INCOME* 2 (2001), available at <http://www.census.gov/prod/2001pubs/p60-215.pdf> (last visited May 30, 2004)[hereinafter HEALTH INSURANCE COVERAGE: 2000]; Robert Pear, *Number of Uninsured Drops for Second Year*, N.Y. TIMES, Sept. 28, 2001, at A20.

29. Holohan & Pohl, *supra* note 28, at W162-63.

30. Holohan & Pohl, *supra* note 28, at W163.

this period, employers had to either pay higher salaries and provide health insurance or lose potential employees to their competitors. That changed beginning in 2001, when the U.S. economy went into recession and 1.4 million Americans lost their health insurance coverage.<sup>31</sup>

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 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.<sup>32</sup> The tremendous economic wave of the 1990s that raised just about every “boat” in society had little to no effect on the 15% of Americans without health insurance.

There are three main reasons for the erosion of private health coverage that began in 2001.<sup>33</sup> First, unemployment increased. The unemployment rate averaged 4.8% at the beginning of 2001, 5.9% in 2002, and 6.4% by the summer of 2003.<sup>34</sup> 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 individuals.

Second, fewer and fewer businesses are offering health coverage.<sup>35</sup> A survey by the Kaiser Family Foundation found that premiums for employer-provided insurance have climbed an average of 12.7% since 2001.<sup>36</sup> Consequently, more small and medium-size companies can no longer afford to offer coverage. While 67% of companies with fewer than 200 employees offered health benefits to their workers in 2000, only 61% did so in 2002.<sup>37</sup>

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 premiums (particularly for workers’ dependents).<sup>38</sup> Kate Sullivan, director

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31. HEALTH INSURANCE COVERAGE: 2002, *supra* note 4, at 3; KU, *supra* note 24, at 1.

32. Holohan & Pohl, *supra* note 28, at W162--63.

33. KU, *supra* note 24, at 1.

34. KU, *supra* note 24, at 1.

35. KU, *supra* note 24, at 1.

36. THE KAISER FAMILY FOUND., DAILY HEALTH POLICY REPORT (Sept. 6, 2002), *available at* [http://www.kaisernetwork.org/daily\\_reports/rep\\_index.cfm?hint=3&DR\\_ID=13307](http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID=13307) (last visited May 30, 2004); THE KAISER FAMILY FOUND. & HEALTH RESEARCH AND EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2002 ANNUAL SURVEY 1 (2002), *available at* <http://www.kff.org/insurance/3252-index.cfm> (last visited May 30, 2004)..

37. KU, *supra* note 24, at 3; David Cho, *Feeling Uninsured About the Future*, WASH. POST, May 16, 2003, at B1.

38. See JENNIFER N. EDWARDS ET AL., THE COMMONWEALTH FUND, ISSUE BRIEF, THE EROSION OF EMPLOYER-BASED HEALTH COVERAGE AND THE THREAT TO WORKER’S HEALTH CARE: FINDINGS FROM THE COMMONWEALTH FUND 2002 WORKPLACE HEALTH INSURANCE SURVEY (2002), *available at* [http://www.cmwf.org/programs/insurance/edwards\\_Erosion\\_ib\\_559.pdf](http://www.cmwf.org/programs/insurance/edwards_Erosion_ib_559.pdf) (last visited Apr. 7, 2004).

of health policy at the United States Chamber of Commerce, noted that many employers continue to subsidize insurance for workers, but have reduced such subsidies for dependents. Sullivan further notes, "A lot of insurers are dropping out of the small-group market, and customers are balking at what they have to pay."<sup>39</sup> 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.<sup>40</sup> Both patients and medical providers despised many of the administrative rules and procedures that made managed care so successful in temporarily containing costs.<sup>41</sup> Hence, over time most of these rules and procedures were either legislated or litigated out of existence. Employers' transition to managed care effectively controlled costs for a period in the 1990s, largely because they were able to squeeze payments to physicians and shorten the average length of most hospital stays.<sup>42</sup> In short, there was a lot of "fat" in the health care system that could be eliminated through annual, competitive negotiations between insurers or managed care organizations and medical providers. After much of the "fat" was removed, however, these cost cutting strategies proved to be short-lived and unsustainable.<sup>43</sup>

In time, as Alain Enthoven explains, "traditional, restrictive managed care has broken down under an onslaught of attacks from trial attorneys,<sup>44</sup> politicians, patients, and providers.<sup>45</sup> Consequently, we are now back to runaway health care inflation, with annual premium increases of 15 to 20% or more in some areas."<sup>46</sup> Meanwhile, health maintenance organizations (HMOs) remain deeply unpopular.<sup>47</sup> Patients resent administrative restrictions to medical care just as much as (if not more than) providers resent restrictions to providing it.<sup>48</sup> Thus many employers have moved away from rigid, cost-conscious managed care plans to more lightly

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39. Robert Pear, *After Decline, The Number of Uninsured Rose in 2001*, N.Y. TIMES, Sept. 30, 2002, at A22.

40. Alain C. Enthoven, *Employment-Based Health Insurance is Failing: Now What?*, HEALTH AFF. WEB EXCLUSIVE (May 28, 2003), at <http://content.healthaffairs.org/cgi/content/full/hlthaff.w3.237v1> (last visited Apr. 6, 2004).

41. *See id.*

42. *Id.*

43. *Id.*

44. *See* Gregg Bloche & David M. Studdert, *A Quiet Revolution: Law As An Agent of Health System Change*, 23 HEALTH AFF 29, 29 (2004).

45. Enthoven, *supra* note 41.

46. Enthoven, *supra* note 41.

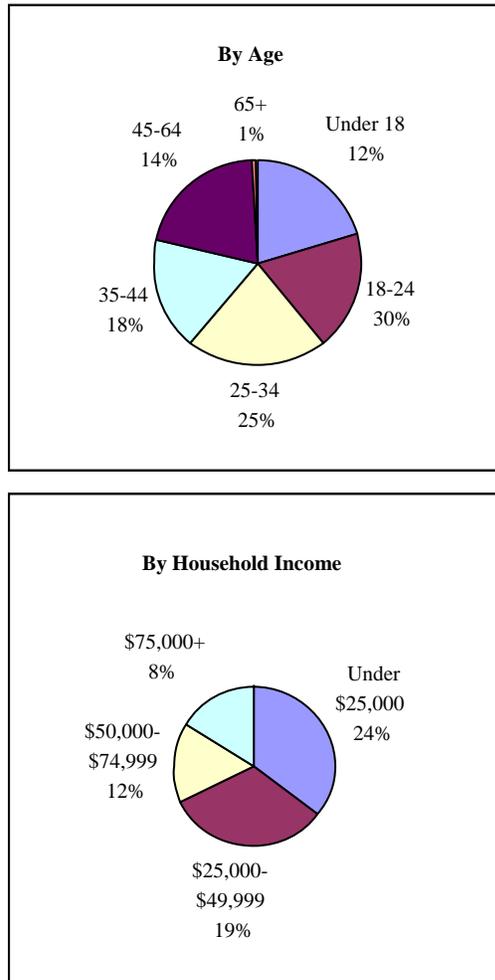
47. *See* Issue Brief: Findings from HSC, Center for Studying Health System Change, *Wall Street Comes to Washington: Where is Health Care Headed?* No. 67 (Wash. D.C., August 2003), available at <http://www.hschange.org/CONTENT/597/597.pdf> (last visited May 28, 2004).

48. *See* Clark C. Havighurst, *The Backlash Against Managed Health Care: Hard Politics Made Bad Policy*, 34 IND. L. REV. 395 (2001).

managed preferred provider models (PPOs) and, in some cases, even reverted entirely to traditional fee-for-service insurance arrangements.<sup>49</sup>

**Figure 1**

The Uninsured in America, 2002

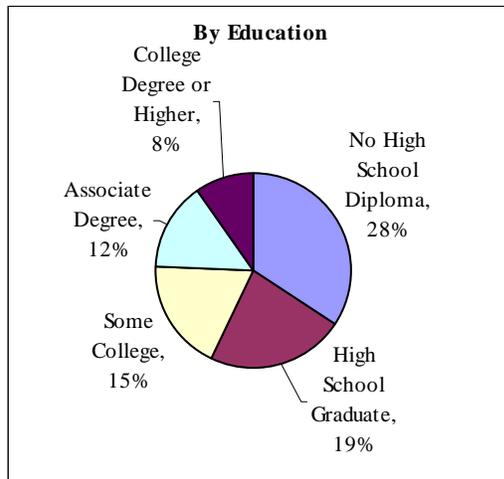
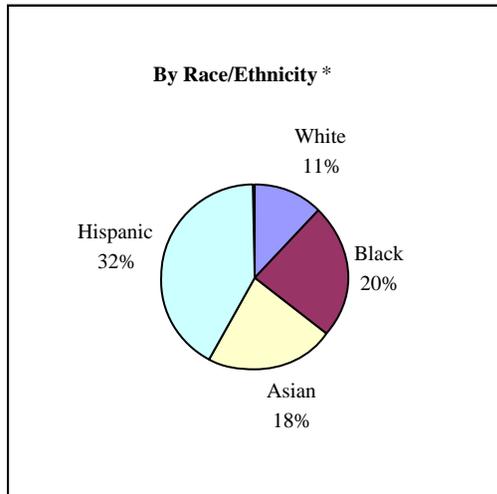


Source: ROBERT J. MILLS & SHAILESH BHANDARI, U.S. CENSUS BUREAU, CURRENT POPULATION REP. PUB. P60-223, HEALTH INSURANCE COVERAGE: 2002, *CONSUMER INCOME* (2003).

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49. Issue Brief: Findings from HSC, *supra* note 48, at 1; James C. Robinson, *The End of Managed Care*, 285 JAMA 2622, 2623 (2001).

**Figure 2**  
The Uninsured in America, 2002



Source: ROBERT J. MILLS & SHAILESH BHANDARI, U.S. CENSUS BUREAU, CURRENT POPULATION REP. PUB. P60-223, HEALTH INSURANCE COVERAGE: 2002, *CONSUMER INCOME* (2003).

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

Who are the uninsured? Compared to the general population, the uninsured tend to be younger, have somewhat lower incomes and less education;<sup>50</sup> they are more likely to be members of minority groups, and to work in service industries and for smaller companies (figures 1, 2).<sup>51</sup> The uninsured population is a dynamic group: individuals often have insurance one year and don't have it the next.<sup>52</sup> People move in and out of coverage depending on their employment status, marital status, income, age, and numerous other factors.<sup>53</sup> The changing nature of the uninsured makes it extremely difficult to fashion a single policy or program to address the problem.

Losing health insurance has always registered as a leading 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.<sup>54</sup> 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 that filed for bankruptcy in 1999 due at least in part to a "medical reason," about 80% of them had health coverage.<sup>55</sup>

The authors also found that nearly half of all bankruptcies involved a medical expense problem, and certain groups—particularly women heads of households and the elderly—were even more likely to report a health-related bankruptcy.<sup>56</sup> The fact that 80% 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.<sup>57</sup> 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

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50. For a discussion of the heterogeneity of the uninsured, see Uwe E. Reinhardt, *Is There Hope for the Uninsured*, HEALTH AFF. WEB EXCLUSIVE, W3-376, W3-378-81 (2003), at <http://content.healthaffairs.org/cgi/content/full/hlthaff.w3.376v1> (last visited May 30, 2004).

51. See HEALTH INSURANCE COVERAGE: 2002, *supra* note 4, at 2 tbl.1, 6 fig.2.

52. See PAMELA FARLEY SHORT ET AL., THE COMMONWEALTH FUND, CHURN, CHURN, CHURN: HOW INSTABILITY OF HEALTH INSURANCE SHAPES AMERICA'S UNINSURED PROBLEM (Nov. 2003), available at [http://www.cmwf.org/programs/insurance/short\\_churn\\_ib\\_688.pdf](http://www.cmwf.org/programs/insurance/short_churn_ib_688.pdf) (last visited May 30, 2004).

53. See generally HEALTH INSURANCE COVERAGE: 2002, *supra* note 4.

54. See WARREN ET AL, *supra* note 16; see also TERESA A. SULLIVAN ET AL., THE FRAGILE MIDDLE CLASS: AMERICANS IN DEBT 141-70 (2000).

55. See WARREN ET AL., *supra* note 16, at 4-7 (noting that only 20.9% of debtors filing for bankruptcy did not have health insurance). However, this survey category of "medical reasons" may understate the actual number of medical reasons as a contributing factor. Other survey categories, such as "birth of a baby" or "death in the family" also most likely encompass financial difficulties as a result of medical spending. WARREN ET AL., *supra* note 16, at 5-6.

56. WARREN ET AL., *supra* note 16, at 4-5, 9-12.

57. WARREN ET AL., *supra* note 16, at 7.

demanding work, impose a financial hardship on a family that basic medical insurance simply does not cover.”<sup>58</sup>

Revisiting the issue in 2002, Professor Warren indicated that families filing for bankruptcy represented a cross-section of America.<sup>59</sup> For instance, she discovered that their educations were slightly better than the U.S. average, over half were homeowners, and their occupations were typical of the range of occupations in the U.S. job market.<sup>60</sup> By most criteria, about 90% of the debtors in bankruptcy are classified as solidly middle class, however two out of three lost a job shortly before filing, and nearly half had medical problems.<sup>61</sup>

Invariably, growing numbers of under-insured 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, and it is therefore 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.

Turning first to Medicaid, the program most people view as the joint federal-state health insurance program for poor women and their children. In actuality, 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.

## II. MEDICAID: THE UGLY, UNLOVED “WORKHORSE” OF THE U.S. HEALTH CARE SYSTEM

Unfortunately, Medicaid has been largely ignored—relative to Medicare—by many health policy enthusiasts and labeled a topic for poverty studies and welfare policy. This partly reflects the fact that when Medicaid was enacted in 1965, it was considered “a legislative afterthought to Medicare.”<sup>62</sup> Unlike Medicare, however, Medicaid bears little resemblance to its original 1966 structure, and according to 2002 data, has surpassed Medicare in numbers of

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58. Melissa B. Jacoby et al., *Rethinking the Debates Over Health Care Financing: Evidence from the Bankruptcy Courts*, 76 N.Y.U. L. REV. 375, 377-78 (2001).

59. *Discussion with Elizabeth Warren*, HARV. L. TODAY (March 2002), available at <http://www.law.harvard.edu/news/today/2002/03/5warren.php> (last visited May 30, 2004).

60. *Id.*

61. *Id.*

62. Sara Rosenbaum, *Medicaid*, 346 N. ENG. J. MED. 635, 635 (2002).

beneficiaries (51 million to Medicare's 41 million) while almost equaling it in terms of total spending (roughly \$250 billion).<sup>63</sup>

As the nation's largest health insurance program, Medicaid insures 20% of the nation's children and, surprisingly, pays for more than one in every three childbirths.<sup>64</sup> 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.<sup>65</sup> Medicaid now provides coverage for an estimated two-thirds of the nation's nursing home residents.<sup>66</sup> It also helps more than 6 million low-income Medicare beneficiaries pay their monthly Medicare Part B premiums and prescription drug costs.<sup>67</sup> 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.<sup>68</sup> 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.<sup>69</sup> These institutions are critical in a nation where, at any given point in time, almost one in every seven individuals does not have the means to pay for substantial medical bills.<sup>70</sup>

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: a source of traditional insurance coverage for poor children and some of their parents; a payer for a complex range of acute and long-term care services for the frail elderly and people with physical disabilities and

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63. John K. Iglehart, *The Dilemma of Medicaid*, 348 N. ENG. J. MED. 2140, 2140 (2003); Alan Weil, *There's Something About Medicaid*, 22 HEALTH AFF. 13, 17 (2003). THE HENRY J. KAISER FAMILY FOUND., MEDICARE FACT SHEET: MEDICARE AT A GLANCE (2004), available at <http://www.kff.org/medicare/1066-07.cfm> (last visited May 28, 2004); THE HENRY J. KAISER FAMILY FOUND., MEDICAID AND THE UNINSURED: THE MEDICAID PROGRAM AT A GLANCE (2004) available at <http://www.kff.org/medicaid/2004-04.cfm> (last visited May 28, 2004) [hereinafter MEDICAID PROGRAM AT A GLANCE].

64. Iglehart, *supra* note 64, at 2140; Weil, *supra* note 64, at 13, 17, 21.

65. Iglehart, *supra* note 64, at 2140.

66. U.S. GENERAL ACCOUNTING OFFICE, GAO-04-143, MEDICAID NURSING HOME PAYMENTS: STATES' PAYMENT RATES LARGELY UNAFFECTED BY RECENT FISCAL PRESSURES 5 (October 2003).

67. See Iglehart, *supra* note 64, at 2141.

68. Iglehart, *supra* note 64, at 2141; Weil, *supra* note 64, at 22; MEDICAID PROGRAM AT A GLANCE, *supra* note 64.

69. Iglehart, *supra* note 64, at 2141.

70. See Iglehart, *supra* note 64, at 2140 (noting that one in seven Americans, or 51 million people, are eligible for Medicaid).

mental illness, many of whom were once middle class; and a source of wraparound coverage for low-income elders on Medicare.<sup>71</sup>

Medicaid is frequently ignored, if not disdained, by many Americans because it is a “poor people’s program.”<sup>72</sup> 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.<sup>73</sup> Responsibility for financing Medicaid is split between the states and the federal government, which pays between 50 and 77% depending on each state’s per capita income (wealthier states pay closer to 50%, poorer states closer to 23%).<sup>74</sup> Last year the federal government paid for 57% of the program’s total cost (\$259 billion).<sup>75</sup>

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% of the program’s enrollment, but only 25% of its spending (see figure 3).<sup>76</sup> Able-bodied, childless adults are not eligible for Medicaid regardless of income level.<sup>77</sup> 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.<sup>78</sup> The single largest category of Medicaid spending is nursing home care.<sup>79</sup> 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.”<sup>80</sup>

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71. Weil, *supra* note 64, at 13, 15

72. Weil, *supra* note 64, at 13.

73. Diane Rowland and James R. Tallon, *Medicaid: Lessons from a Decade*, 22 HEALTH AFF. 138, 139-40 (2003).

74. Iglehart, *supra* note 64 at 2142.

75. Iglehart, *supra* note 64 at 2140.

76. See Fig. 3.

77. See 42 U.S.C. § 1396d (2000 & Supp. 2003) (excluding from definition of eligible persons any childless adults under age 65 who are not disabled).

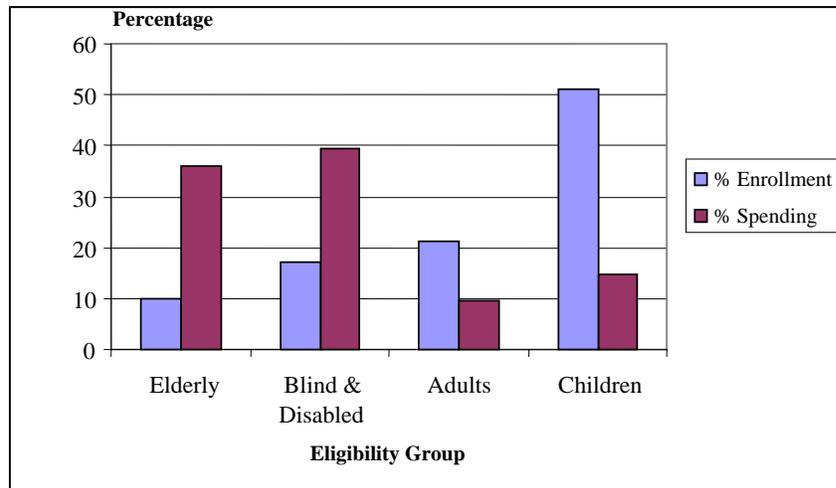
78. MEDICAID PROGRAM AT A GLANCE, *supra* note 64.

79. MEDICAID PROGRAM AT A GLANCE, *supra* note 64.

80. Weil, *supra* note 64 at 17; see also BRIAN K. BRUEN & JOHN HOLAHAN, THE HENRY J. KAISER FAMILY FOUND., MEDICAID AND THE UNINSURED: ACCELERATION OF MEDICAID SPENDING REFLECTS MOUNTING PRESSURES (2002), available at <http://www.kff.org/medicaid/4056-index.cfm> (last visited May 30, 2004).

**Figure 3**

Medicaid Enrollment and Spending, By Eligibility Group, 2001



Source: THE HENRY J. KAISER FAMILY FOUNDATION, *MEDICAID AND THE UNINSURED: THE MEDICAID PROGRAM AT A GLANCE* (2004).

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.<sup>81</sup>

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.<sup>82</sup> Health reformers have traditionally envisioned it the other way around with Medicare being the vehicle for reaching the goal.<sup>83</sup> But as Lawrence Brown and Michael Sparer point out, Medicare's benefits and beneficiaries have not changed much since the program's passage.<sup>84</sup> Medicaid, on

81. See Donald J. Boyd, *The Bursting State Fiscal Bubble and State Medicaid Budgets*, 22 HEALTH AFF. 46, 46 (2003); see also NAT'L GOVERNORS' ASS'N AND THE NAT'L ASS'N OF STATE BUDGET OFFICERS, *THE FISCAL SURVEY OF STATES*, 4-5 (Nov. 2002), available at <http://www.nga.org/cda/files/NOV2002FISCALSURVEY.pdf> (last visited May 30, 2004).

82. See generally, Lawrence D. Brown & Michael S. Sparer, *Poor Program's Progress: The Unanticipated Politics of Medicaid Policy*, 22 HEALTH AFF. 31 (2003) (offering a comparison of the political philosophies and end result of Medicaid and Medicare).

83. *Id.* at 31.

84. *Id.* at 32, 34.

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 that states enjoy with Medicaid to craft creative structural solutions and implement reforms such as managed care.<sup>85</sup>

The best example of Medicaid's ability to broaden the level of health insurance coverage—in a way that Medicare never has—is SCHIP. SCHIP constitutes the nation's single largest expansion of public health insurance since Medicare and Medicaid's passage in 1965. Enacted in the Balanced Budget Act of 1997,<sup>86</sup> the program follows the Medicaid model: federal matching funds for programs in which states have wide discretion.<sup>87</sup> 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.<sup>88</sup>

SCHIP is something of the "Kiddiecare" program that social insurance enthusiasts always envisioned adding to Medicare, but which could not be done because of Medicare's cost explosion.<sup>89</sup> 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 federal government's annual budget process.<sup>90</sup> Yet SCHIP, like Medicaid upon which SCHIP is modeled, also illustrates the limits and disadvantages of expanding health insurance incrementally via the welfare model. Unlike social insurance, what the government giveth in the form of public assistance, it can also taketh away (figure 4).<sup>91</sup>

### III. 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 (approximately 10 million at the time) who were not covered

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85. *Id.* at 34, 39-41.

86. Balanced Budget Act of 1997, § 4901, 42 U.S.C. §§ 1397aa – 1397jj (2000 & Supp. 2003).

87. Brown & Sparer, *supra* note 83, at 36.

88. Brown & Sparer, *supra* note 83, at 36.

89. See Robert M. Ball, *Perspectives on Medicare: What Medicare's Architects Had in Mind*, 14 HEALTH AFF. 62 (1995).

90. See Dan Morgan, *How Medicaid Grew: The Unmet Needs of the Poor*, WASH. POST, Feb. 2, 1994, at A8.

91. See Fig. 4 (illustrating the SCHIP dip).

by Medicaid.<sup>92</sup> The program, Title XXI of the Social Security Act,<sup>93</sup> was enacted in response to a growing economic phenomenon: the single family's household income was too low to afford private health insurance but too high to qualify for existing public health insurance.<sup>94</sup>

Currently, about 70% of uninsured children live in a household whose total income is more than \$15,670—the 2004 poverty line for a family of three and the maximum level of income for Medicaid eligibility—but less than \$31,340 (200% above the poverty line).<sup>95</sup> The vast majority of uninsured children have a parent who works full-time (75%) or at least part-time (10%).<sup>96</sup> These families, however, are either not offered health insurance by their employers or they cannot afford to purchase it.<sup>97</sup>

SCHIP resembles Medicaid's structure in that the program is jointly financed. The federal government's share ranges from 65 to 84%, depending on each state's portion of the nation's total number of uninsured children.<sup>98</sup> The states were given a great deal of discretion in constructing their SCHIP programs, and were encouraged to be generous with their eligibility criteria.<sup>99</sup> States could create a new program, expand their Medicaid program to include children eligible under SCHIP, or devise a combination of both.<sup>100</sup> By 2000, every state and U.S. territory had an SCHIP program in place. Currently, twenty-one states and territories are operating Medicaid expansion programs, sixteen have separate SCHIP programs, and nineteen are operating combination Medicaid/SCHIP programs.<sup>101</sup> Similar to

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92. NATIONAL CENTER FOR HEALTH STATISTICS, CDC, EARLY RELEASE OF SELECTED ESTIMATES BASED ON DATA FROM THE 2001 NHIS, TABLE 1.1 NUMBER AND PERCENT OF PERSONS WITHOUT HEALTH INSURANCE COVERAGE, BY AGE GROUP: UNITED STATES, 1997-2001 *available at* [http://www.cdc.gov/nchs/about/major/nhis/released200207/table01\\_1.htm](http://www.cdc.gov/nchs/about/major/nhis/released200207/table01_1.htm) (last updated July 15, 2002).

93. Social Security Act, Subchapter XXI, 42 U.S.C. §§ 1397aa – 1397jj (2000 & Supp. 2003).

94. See Cynthia R. Mabry, *Second Chances: Insuring That Poor Families Remain Intact By Minimizing Socioeconomic Ramifications of Poverty* 102 W. VA. L. REV. 607, 643 (2000).

95. ROBIN A. COHEN ET AL., NATIONAL CTR. FOR HEALTH STATISTICS, CDC, HEALTH INSURANCE COVERAGE: ESTIMATES FROM THE NATIONAL HEALTH INTERVIEW SURVEY 8 tbl.4 (JAN. – SEPT. 2003), *available at* <http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur200403.pdf> (last visited May 30, 2004); Annual Update of the HHS Poverty Guidelines, 69 Fed. Reg. 7336 (Feb. 13, 2004).

96. OFFICE OF HEALTH POLICY, U.S. DEP'T. OF HEALTH AND HUMAN SERVS., CHARTBOOK ON CHILDREN'S INSURANCE STATUS: TABULATIONS OF THE MARCH 1997 CURRENT POPULATION SURVEY 5 (1997), *available at* <http://aspe.hhs.gov/health/97chartbk/97chrt05.htm> (last visited Apr. 8, 2004).

97. JAMES D. RESCHOVSKY & PETER J. CUNNINGHAM, CTR. FOR STUDYING HEALTH SYS. CHANGE, ISSUE BRIEF 14: CHIPING AWAY AT THE PROBLEM OF UNINSURED CHILDREN 1 (1998), *available at* <http://www.hschange.org/CONTENT/45/45.pdf> (last visited May 30, 2004).

98. ALLIANCE FOR HEALTH REFORM, COVERING HEALTH ISSUES: A SOURCEBOOK FOR JOURNALISTS, CH. 2 (2003), *available at* [http://www.allhealth.org/sourcebook2002/ch2\\_2.html](http://www.allhealth.org/sourcebook2002/ch2_2.html) (last visited Apr. 8, 2004)[hereinafter ALLIANCE FOR HEALTH REFORM].

99. *Id.*

100. *Id.*

101. *Id.*; see also CTRS. FOR MEDICARE AND MEDICAID SERVS., STATE CHILDREN'S HEALTH INSURANCE PROGRAM PLAN ACTIVITY, *available at* <http://www.cms.hhs.gov/schip/chip-map.pdf> (last

Medicaid, most state SCHIP plans rely on—and are the last bastions of—traditional, restrictive managed care to control their costs.<sup>102</sup>

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.<sup>103</sup> 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, states set up marketing campaigns, held outreach events featuring their governors, and came up with catchy names—such as Healthy Kids (Florida), Peach Care (Georgia), and Hoosier Healthwise (Indiana)—for their new SCHIP programs.<sup>104</sup> The states also simplified their new programs. For example, they shortened applications, encouraged families to apply by mail instead of requiring them to come to a welfare office in person, and removed some of the onerous and rigid requirements for individuals to verify their eligibility for the program.<sup>105</sup> The federal government, notably President Clinton and other members of his administration, did its part to raise awareness of the program by encouraging potential beneficiaries to use toll-free numbers and the Internet to learn more about how to enroll.<sup>106</sup> As Figure 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.<sup>107</sup> The theory was that making the program more generous and available to parents would help states reach more eligible children.<sup>108</sup> 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

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updated Mar. 11, 2004) (noting that CMS has approved 18 Separate State Child Health Plans; 19 Medicaid Expansions; and 19 Combination Plans).

102. See Marsha Gold et al., *Participation of Plans and Providers in Medicaid and SCHIP Managed Care*, 22 HEALTH AFF. 230, 230 (2003).

103. See JENNIFER RYAN, NAT'L HEALTH POLICY FORUM, ISSUE BRIEF NO. 781, SCHIP TURNS FIVE: TAKING STOCK, MOVING AHEAD 1-3 (2002), available at [http://www.nhpf.org/pdfs\\_ib/IB781\\_SCHIP5\\_8-15-02.pdf](http://www.nhpf.org/pdfs_ib/IB781_SCHIP5_8-15-02.pdf) (last visited May 30, 2004).

104. *Id.* at 2.

105. *Id.*

106. *Id.*

107. Embry Howell et al., *Early Experience with Covering Uninsured Parents Under SCHIP*, in ASSESSING THE NEW FEDERALISM: ISSUES AND OPTIONS FOR STATES, SERIES 1 (Urb. Inst., Series A, No. A-51, Wash., D.C.) (2002) (discussing the implantation of section 1115 waivers to cover parents under SCHIP).

108. *Id.*

state's overall rate of uninsured individuals by also insuring more uncovered adults.<sup>109</sup>

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% of the children covered by SCHIP appear to be retained by the program when their eligibility is redetermined each year.<sup>110</sup> This is partly explained by the parents of eligible children either becoming poorer and, thus qualifying for Medicaid, or wealthier and ineligible for either program.<sup>111</sup> Neither of these explanations for a child being dropped from the SCHIP program is a reason for concern because they are (hopefully) still covered. However, in some states the retention rate is as low as 26%<sup>112</sup> and a change in 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.<sup>113</sup> 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 or their parent's lack of knowledge about their eligibility for SCHIP.

Another major problem with the program is reflected in the "SCHIP Dip."<sup>114</sup> It is estimated that at least 900,000 children are scheduled to *lose* their SCHIP coverage by 2006 due to reductions in federal funding.<sup>115</sup> Because policy-makers 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 billion they initially allocated to fund SCHIP was not distributed equally over the first ten years.<sup>116</sup> Instead, Congress allocated \$4.3 billion per year for the first four years of the program (1998-2001), but then reduced it to \$3.1 for the next three years (2002-2004) before having it rise again thereafter.<sup>117</sup> 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

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109. *Id.* at 3-5.

110. Ian Hill & Amy Westpfahl Lutzky, *Is There a Hole in the Bucket? Understanding SCHIP Retention* 18 (Urb. Inst., Occasional Paper No. 67, Wash., D.C.) (2003).

111. *Id.*

112. *Id.*

113. *Id.* at 16-17.

114. See RYAN, *supra* note 104, at 4-6.

115. EDWIN PARK ET AL., CTR. ON BUDGET AND POLICY PRIORITIES, OMB ESTIMATES INDICATE THAT 900,000 CHILDREN WILL LOSE HEALTH INSURANCE DUE TO REDUCTIONS IN FEDERAL SCHIP FUNDING (2002), available at <http://www.cbpp.org/7-15-02health.pdf> (last visited May 28, 2004).

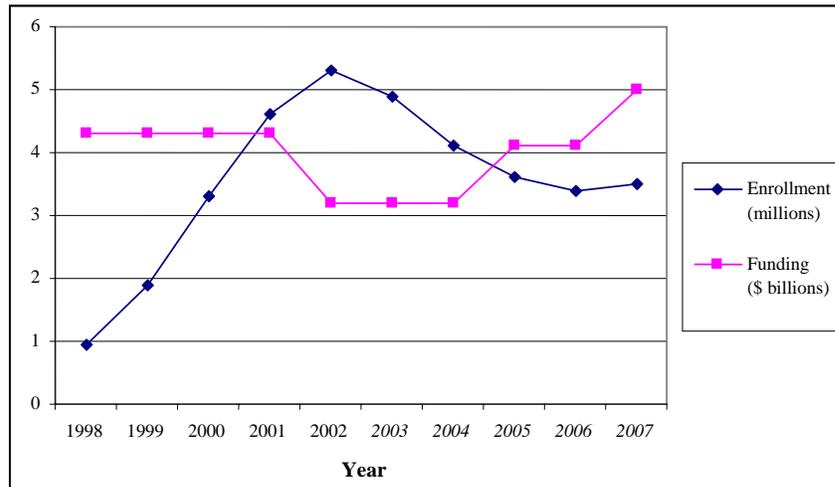
116. ALLIANCE FOR HEALTH REFORM, *supra* note 99, at Chap. 2.

117. ALLIANCE FOR HEALTH REFORM, *supra* note 99, at Chap. 2.

“Perfect Storm” currently battering Medicaid: growing demand for the program, increasing medical inflation, and declining government revenues.<sup>118</sup>

**Figure 4**

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



Source: CINDY MANN ET AL., THE FUTURE OF CHILDREN, HISTORICAL OVERVIEW OF CHILDREN'S HEALTH CARE COVERAGE (2003), available at [http://www.futureofchildren.org/usr\\_doc/tfoc13-1c.pdf](http://www.futureofchildren.org/usr_doc/tfoc13-1c.pdf) (last visited Apr. 20, 2004).

Recognizing this problem, various members of Congress have introduced legislation intended to address the dip and restore funding for SCHIP to the initial levels.<sup>119</sup> But consideration of the bills has been prolonged, which has led to a reduction in federal funding at least in 2002. 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 because they are entitlements on which the government cannot default. SCHIP, however, is a discretionary program and policymakers can adjust eligibility criteria and benefits in response to larger budgetary pressures (by law states have to balance their budgets annually),<sup>120</sup> even

118. See Weil, *supra* note 64, at 18-19.

119. See e.g., S. 138, 108<sup>th</sup> Cong. (2003); Children's Health Equity Act of 2003 S. 621, 108<sup>th</sup> Cong. (2003).

120. CAROL S. WEISSERT & WILLIAM G. WEISSERT, GOVERNING HEALTH: THE POLITICS OF HEALTH POLICY 208 (2d ed. 2002).

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.<sup>121</sup> This enthusiasm for Medicare has persisted despite the fact that the program's managed care experiment in the late 1990s-early 2000s failed,<sup>122</sup> and that it has taken more than a decade of painstaking deliberation and political jockeying to pass a catastrophic prescription drug plan.<sup>123</sup> But it is 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.

#### IV. 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,” exclaimed Tom Scully, former Administrator for the Centers for Medicare and Medicaid Services (CMS), which operates both programs.<sup>124</sup>

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, a structured, regulated private insurance plan. Let them all go buy an Aetna product, or Blue Cross products; 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.<sup>125</sup>

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

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121. See Brown & Sparer, *supra* note 83, at 31.

122. See *supra* text accompanying notes 29-36.

123. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108-173, 117 Stat. 2066 (2003) (to be codified in various sections of 42 U.S.C.)

124. Telephone Interview with Tom Scully, Former Administrator, Ctrs. for Medicare & Medicaid Services, 2001-2003 (Oct. 24, 2002).

125. *Id.*

from a “defined benefit” to a “defined contribution” plan would have been anathema to the leading policymakers in Washington.<sup>126</sup> There was a political consensus about Medicare, as Jonathan Oberlander has documented, that governed the program for the first three decades of its existence.<sup>127</sup> Policymaking was bipartisan in character, even when it involved extraordinary changes to the program’s method of reimbursing hospitals and doctors.<sup>128</sup> 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.”<sup>129</sup>

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.<sup>130</sup> After being out of power for four decades, they had a number of new political agendas, but none bigger than balancing the federal budget.<sup>131</sup> Medicare had already been viewed for years 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.<sup>132</sup> 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 for Republicans, 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 5, 6).<sup>133</sup> Republicans responded by proposing \$270 billion in Medicare spending reductions over seven years as part of a “Save Medicare” campaign.<sup>134</sup> 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.<sup>135</sup> President Clinton 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.<sup>136</sup> In August of 1997, Congress and the President passed the Balanced

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126. JONATHAN OBERLANDER, *THE POLITICAL LIFE OF MEDICARE* 157 (2003).

127. *See generally id.*, for a detailed analysis of the history and politics of Medicare.

128. *Id.* at 157–96.

129. *Id.* at 157.

130. *Id.* at 159–60.

131. *Id.* at 161.

132. *Id.* at 163–76.

133. *Id.* at 172–73.

134. *Id.* at 172; *see also* George Hager, *Medicare is Targeted for Large Cuts*, CONG. Q., Apr. 8, 1995, at 1013; Charles N. Kahn III & Hanns Kuttner, *Budget Bills and Medicare Policy: The Politics of the BBA*, 18 HEALTH AFF. 37, 39–40 (1999).

135. Kahn & Kuttner, *supra* note 135, at 42.

136. *See* Kahn & Kuttner, *supra* note 135, at 41, 42.

Budget Act (BBA), which included a number of Medicare reforms and cuts in the program's spending totaling \$115 billion over five years.<sup>137</sup>

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.<sup>138</sup> There were already 5 million Medicare beneficiaries enrolled in various managed care plans in 1997 (14% of the program's total population),<sup>139</sup> but Republicans had ambitions to significantly increase that number. As Tom Scully previously explained, they wanted to do four things in particular: (1) expand beneficiaries' health care choices; (2) provide additional benefits, such as prescription drug coverage; (3) restrain the growth of federal Medicare spending by encouraging competition among private health plans; and, (4) reduce the need for direct government regulation of provider payment policies.<sup>140</sup> 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% of the entire Medicare population by 2005.<sup>141</sup> Instead, enrollment in M+C peaked in 1999, at 17% of beneficiaries, and has since fallen back to less than 12% in 2003.<sup>142</sup> 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.<sup>143</sup> The remaining plans have become much less attractive to Medicare beneficiaries, as most have increased premiums and decreased benefits, such as prescription drug coverage.<sup>144</sup>

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—either the plans were over-regulated and underpaid by the government or the Medicare population is simply unsuited for profit-

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137. Kahn & Kuttner, *supra* note 135, at 42-43.

138. BRIAN BILES ET AL., THE COMMONWEALTH FUND, MEDICARE + CHOICE AFTER FIVE YEARS: LESSONS FOR MEDICARE'S FUTURE FINDINGS FROM SEVEN MAJOR CITIES 1 (2002).

139. *Id.* at vii, 21 app. A.

140. *Id.* at 1.

141. Sandra Christensen, *Medicare+Choice Provisions in the Balanced Budget Act of 1997*, 17 HEALTH AFF. 224, 228 (1998).

142. Marsha Gold, *Can Managed Care and Competition Control Medicare Costs?*, HEALTH AFF. WEB EXCLUSIVE, W3-176, W3-177 (Apr. 2, 2003), at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.176v1> (last visited May 30, 2004); MARSHA GOLD & LORI ACHMAN, MATHEMATICA POLICY RESEARCH, INC., SHIFTING MEDICARE CHOICES: 1999-2003, No. 8 (2003), available at <http://www.mathematica-mpr.com/publications/PDFs/fastfacts8.pdf> (last visited May 28, 2004).

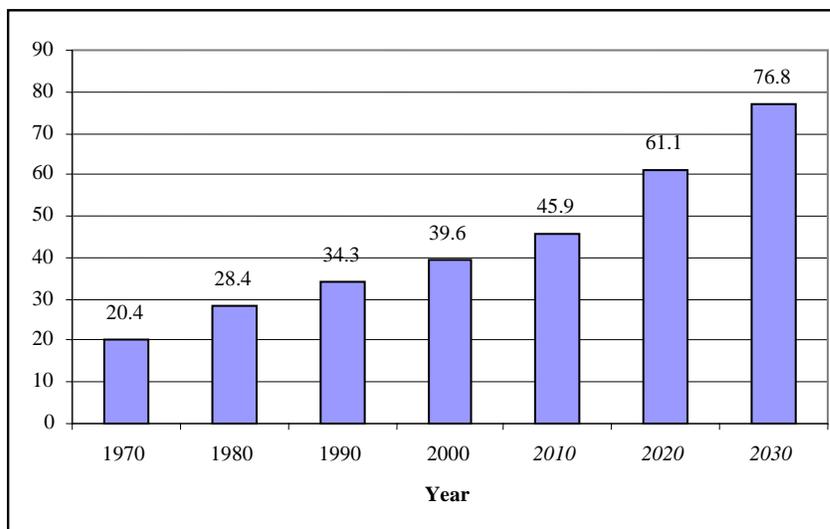
143. *Id.*

144. LORI ACHMAN & MARSHA GOLD, THE COMMONWEALTH FUND, TRENDS IN MEDICARE+CHOICE BENEFITS AND PREMIUMS, 1999-2002, vii - viii (2002), available at [http://www.cmwf.org/programs/medfutur/achman\\_trendsM+C\\_580.pdf](http://www.cmwf.org/programs/medfutur/achman_trendsM+C_580.pdf) (last visited Apr. 15, 2004).

oriented managed care.<sup>145</sup> However, 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. Unfortunately, time is not on their side (figures 5, 6).

**Figure 5**

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



Source: CTRS. FOR MEDICARE AND MEDICAID SERVS., PROGRAM INFORMATION ON MEDICARE, MEDICAID, SCHIP AND OTHER PROGRAMS, Section III.B.1 at 4 (JUNE 2002).

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 (nearly four to one) that it generates a surplus of revenue.<sup>146</sup> This trend is expected to 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 sixty-five.<sup>147</sup> At that point

145. See Marcia Angell, *Dr. Frist to the Rescue*, AM. PROSPECT, Feb. 1, 2003, at 14.

146. THE BDS. OF TRS. OF THE FED. HOSP. INS. AND SUPPLEMENTARY MED. INS. TRUST FUNDS, THE 2003 ANNUAL REPORT, H.R. DOC. NO. 108-48, at 13, 49-50, fig.II.B.5 (2003).

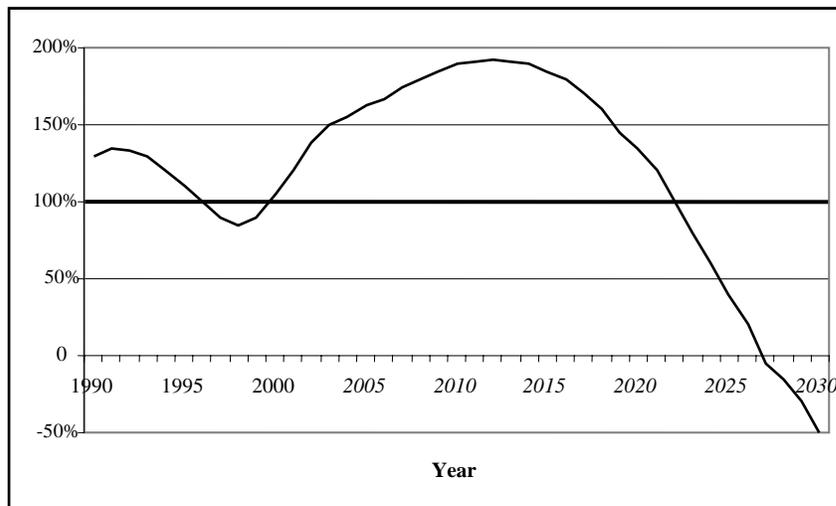
147. *Id.*

the ratio will have declined to approximately 3.6 workers to each retiree.<sup>148</sup> By 2030, when the last of the Baby Boomers becomes eligible, the ratio will have fallen to 2.4 workers to 1 retiree.<sup>149</sup>

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.<sup>150</sup> Policymakers could increase the age of eligibility, but it is politically unlikely. The 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 \$500 billion) prescription drug benefit to the program—border on the surreal.<sup>151</sup>

**Figure 6**

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



Source: THE BDS. OF TRS. OF THE FED. HOSP. INS. AND SUPPLEMENTARY MED. INS. TRUST FUNDS, 2003 ANNUAL REPORT, fig.I.F2 (2003), available at <http://cms.hhs.gov/publications/trusteesreport/2003/figif2.asp> (last visited Apr. 9, 2004).

148. *Id.*; PAUL J. FELDSTEIN, HEALTH POLICY ISSUES: AN ECONOMIC PERSPECTIVE ON HEALTH REFORM, 89-91 (3rd ed 2003).

149. FELDSTEIN, *supra* note 149, at 91.

150. See generally FELDSTEIN, *supra* note 149, at 92-95 (detailing several proposed approaches for reforming medicare).

151. Robert Pear & Robin Toner, *House Committee Approves Drug Benefits for Medicare*, N.Y. TIMES, June 18, 2003, at A19.

Adding drug coverage to Medicare was 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.<sup>152</sup> The comparatively few drugs in existence were affordable. However, 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 was nearly unanimous agreement among policymakers that some type of drug benefit needed 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).<sup>153</sup> So as with all public health insurance initiatives, the trick for policymakers has been 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% of U.S. companies provided their retirees with health benefits in 1988, less than 35% do so today.<sup>154</sup> 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.

## V. 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

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152. Nancy-Ann DeParle, *Medicare at 40: A Mid-Life Crisis?*, 7 J. HEALTH CARE L. & POL'Y 70, 87 (2004).

153. Oberlander, *supra* note 127, at 192.

154. Bruce Stuart et al., *Employer-Sponsored Health Insurance and Prescription Drug Coverage for New Retirees: Dramatic Declines in Five Years*, HEALTH AFF. WEB EXCLUSIVE, W3-334 (July 2003), available at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.334v1> (last visited May 28, 2004); See also Editorial, *The Medicare Momentum*, N. Y. TIMES, June 16, 2003, at A22; Milt Freudenheim, *Employers Seek To Shift Costs of Drugs to U.S.*, N. Y. TIMES, July 2, 2003, at A1.

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.”<sup>155</sup> 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.”<sup>156</sup>

Given both the forests of trees and vats of ink consumed while analyzing the defeat of health care reform in 1993-94, one pauses before consuming any more. 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 taking a more critical look at the Clintons’ health care reform efforts, they 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% of the popular vote.<sup>157</sup> Once in office, his administration had to face an economy in recovery and enormous annual budget deficits of \$200 billion a year “as far as the eye could see.”<sup>158</sup> 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!”<sup>159</sup> At the time, the Democrats controlled the Presidency and both

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155. HILLARY CLINTON, *LIVING HISTORY* 226 (2003).

156. *Id.* at 249.

157. John M. Rushing, *Vote Swapping and Free Speech: Voice, Politics, and Choice*, 7 TEX. F. ON C.L. & C.R. 73, 73-74 (2002).

158. PBS FRONTLINE & ABC NEWS NIGHTLINE, *THE CLINTON YEARS*, CH. 2 (2001), available at <http://www.pbs.org/wgbh/pages/frontline/shows/clinton/chapters/2.html#3> (last visited May 30, 2004).

159. Telephone Interview with Robert Winters, Head of the Business Roundtables Health Task Force, 1988-1994; Chairman, Prudential Ins. Co., 1986-1994 (August 28, 2002).

houses of Congress, the media was largely sympathetic to the goal of comprehensive reform, and millions of working- and middle-class Americans were without health insurance and millions more lived in daily fear that they could soon join them.<sup>160</sup> In addition, 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.<sup>161</sup> 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 (particularly Hillary Clinton and Ira Magaziner) 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.”<sup>162</sup> 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 health care reform proposal.<sup>163</sup> 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. . . . [T]he public—and worse, all kinds of interest groups—saw 500 people behind closed doors, with themselves on the outside.<sup>164</sup>

Bob Boorstin, Communications Director for the Task Force, puts it more bluntly:

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160. CLINTON, *supra* note 156, at 144.

161. CLINTON, *supra* note 156, at 145.

162. CLINTON, *supra* note 156, at 247.

163. CLINTON, *supra* note 156, at 148.

164. Walter Zelman & Lawrence D. Brown, *Looking Back on Health Care Reform: 'No Easy Choices'*, 17 HEALTH AFF. 61, 62 (1998).

[W]hat happened with the Health Care Task Force was that it did three things. One, it pissed off the journalists. So the journalists were looking for everything and anything they could find that reflected badly on the process. . . . [T]he second group that it pissed off was all the Republicans who had burrowed in at HCFA [the Health Care Financing Administration] and OMB [the Office of Management & Budget], particularly at OMB and these people where the minute they saw an option paper would leak it. So you've got all these headlines and stuff in the *Post* and the *Times* and the [*Journal*] and everywhere totally based on leaks from Republicans who were hold-overs from Bush who had burrowed into the bureaucracy in order to save their butts, their jobs, their pensions, whatever. So there's a pretty devastating combination. And then you had the third group that was really pissed off were the lobbyists. Because they had no way in. And closing the door in the face of a lobbyist is going to piss them off.<sup>165</sup>

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.”<sup>166</sup>

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.<sup>167</sup> The plan required extensive negotiating with numerous members of Con-

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165. Telephone Interview with Bob Boorstin, Communications Director for President Clinton's Task Force on Nat'l Health Care Reform (Jan. 5, 2003).

166. CLINTON, *supra* note 156, at 153.

167. *See* CLINTON, *supra* note 156, at 179.

gress and difficult political choices, including raising taxes.<sup>168</sup> It passed by one vote in the House and by the tie-breaking vote of Vice President Gore in the Senate.<sup>169</sup> 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.<sup>170</sup> Their lack of input, in Panetta's opinion, damaged the plan's political prospects:

[I]nstead of the careful work that went into developing the budget. . . [t]he health care thing became part of a political strategy. . . . The President's plan was designed by a smaller group of individuals. . . [and] [o]nce it was done, it was very difficult to try to change it. And a lot of us . . . indicated our concerns with what would take place. I mean, 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. Congress cannot digest this big a piece of legislation in one bite. . . . It 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, you know, all of those lessons just went out the window with the rest of health care reform.<sup>171</sup>

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 it [the process] led into something that was too large to accomplish at one time. . . . [T]he reform of

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168. CLINTON, *supra* note 156, at 179.

169. CLINTON, *supra* note 156, at 179.

170. Telephone Interview with Alice Rivlin, Founding Director, Congressional Budget Office [CBO], 1975-1983; Director, Economic Studies Program at the Brookings Institution, 1983-1992; Deputy Director, White House Office of Management & Budget [OMB], 1993-1994; Director, Office of Management & Budget, 1994-1996 (August 12, 2002).

171. Telephone Interview with Leon Panetta, U.S. Representative, CA, 1977-1993; Chairman, House Budget Committee, 1989-1993; Director, White House Office of Management & Budget [OMB], 1993-1995; White House Chief of Staff for President Clinton, 1995-1997 (August 13, 2002).

the health care system in one fell swoop was more than anybody could expect to accomplish.”<sup>172</sup>

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.<sup>173</sup> Moderate and conservative Democrats, many of whom had extensive backgrounds in health policy, were also ignored.<sup>174</sup> 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.<sup>175</sup>

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:

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172. Telephone Interview with Robert Rubin, Secretary of the Treasury, 1995-1999; Director, National Economic Council, 1993-1995; Director and Chairman of the Executive Committee, Citigroup, 1999-present (Nov. 12, 2002).

173. See CLINTON, *supra* note 156, at 247.

174. See generally Telephone Interview with David Abernethy, Staff Member with responsibility for Medicare Part A Hospital Reimbursement, House Ways & Means Subcommittee on Health, 1987-1992; Staff Director of the Ways & Means Health Subcommittee, 1992-1996 (June 19, 2002). Telephone Interview with Sheila Burke, Chief of Staff, Senate Majority Leader, Bob Dole, 1985-1996; Deputy Staff Director, Senate Finance Committee, 1982-1985; Professional Staff Member, Senate Finance Committee, 1979-1982; Executive Dean, John F. Kennedy School of Government, Harvard University, 1996-2000; Under Secretary for American Museums and National Programs for the Smithsonian Institution, 2000-present (Oct. 2, 2002).

175. CLINTON, *supra* note 156, at 191.

[H]ealth care was already receding as an issue, because the Clinton administration took nine months to get a proposal up to the Hill. . . . [Mrs. Clinton] use to love to say, “Well, you know your boss,” in other words Rostenkowski, “said that we had to send up a bill.” And I finally one time, the third time she said that to me, I looked at her and said “Look, there’s a bill and then there’s a *bill*.” 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.” As I said, “You know what, 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.<sup>176</sup>

The Clinton administration and its Democratic allies in Congress did not need—and never would have received—help from most Republican members. However, the administration 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.<sup>177</sup> 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, too close to the [‘94] elections....

[B]ut at the end of the day you want to solve a problem. It was the 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. . . . [I]n the 20 years I’ve served as a

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176. Telephone Interview with David Abernethy, *supra* note 175.

177. CLINTON, *supra* note 156, at 247.

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.<sup>178</sup>

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.<sup>179</sup>

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.<sup>180</sup> 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.<sup>181</sup> 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.”<sup>182</sup> Laura D’Andrea Tyson, President

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178. Telephone Interview with Sheila Burke, *supra* note 175.

179. Zelman & Brown, *supra* note 165, at 63.

180. This is an opinion rendered anonymously by a high-ranking Clinton administration official.

181. *Id.*

182. The source of this quotation, the same high-ranking Clinton administration official, insisted on absolute anonymity.

Clinton's Chair of the Council of Economic Advisors, on the other hand, is skeptical that the plan could ever have been implemented, much less by 1996:

I don't think the health plan would have been enacted 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 1994] 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. [Y]ou were going to have to come up with price caps. [Y]ou 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 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 would have been [a political disaster because t]here were some real managed care elements to the Clinton health care reform. But . . . my [personal] view is that it wouldn't have been feasible [to actually implement the plan.]<sup>183</sup>

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, 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 require[d] the disruption of all existing health insurance arrangements. And that is what the Republicans exploited ruthlessly.*<sup>184</sup>

That leaves 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.

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183. Telephone Interview with Laura D' Andrea Tyson, Chair of the Council of Economic Advisors under President Clinton (Sep. 30, 2002).

184. Telephone Interview with David Abernethy, *supra* note 175. italics added

## VI: 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 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.<sup>185</sup> Each proposal has its own strengths and weaknesses. Not surprisingly, one proposal's weakness is often another one's strength and vice versa. To varying degrees they all reflect the limitations highlighted by the Clinton debacle. Structurally, as Abernethy argues, you cannot radically disrupt existing health insurance arrangements. 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."<sup>186</sup>

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.<sup>187</sup> 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.<sup>188</sup> Since 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, the average family would still have to pay about \$3,700 out-of-pocket.<sup>189</sup> Given that most of the uninsured are working- to middle-class, this amount would be prohibitively expensive. In addition, the cost of

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185. Karen Davis & Cathy Schoen, *Creating Consensus on Coverage Choices*, HEALTH AFF. WEB EXCLUSIVE, W3-199, W3-199 (2003), at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.199v1> (last visited May 30, 2004).

186. Zelman & Brown, *supra* note 165, at 67.

187. U.S. DEP'T OF TREASURY, GENERAL EXPLANATIONS OF THE ADMINISTRATION'S FISCAL YEAR 2004 REVENUE PROPOSALS 46 (2003), available at <http://www.ustreas.gov/press/releases/reports/bluebook2003.pdf> (last visited Apr. 15, 2004).

188. Marcia Angell, *Insufficient Credits*, AM. PROSPECT Sept. 10, 2001, at 12, available at <http://www.prospect.org/web/page.wv?section=root&name=ViewPrint&article ID =5580> (last visited May 30, 2004).

189. *Id.*

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.<sup>190</sup> 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.<sup>191</sup> In effect, this would be the equivalent of extending Medicare to the entire population. As Angell notes:

[M]edicare is, after all, a government-financed single-payer system embedded within our private, market-based system. 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.<sup>192</sup>

If President Bush's tax-credit proposal is too timid or insufficient 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, when the House Ways and Means Committee passed "Medicare Part C."<sup>193</sup> The plan became the leading House alternative to the Clinton plan. However, 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.

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190. JOHN CONYERS, MAJOR ISSUES: HEALTH CARE, at [http://www.house.gov/conyers/news\\_health\\_care.htm](http://www.house.gov/conyers/news_health_care.htm) (last visited May 30, 2004).

191. Marcia Angell, *The Forgotten Domestic Crisis*, N.Y. TIMES, Oct. 13, 2002, at A.13.

192. *Id.*

193. See H.R. 3704, 103rd Cong. (1993).

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.<sup>194</sup>

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 thirty-five.<sup>195</sup> 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.<sup>196</sup>

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.<sup>197</sup>

According to Ted Halstead, President of the New America Foundation,

The new system would also 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

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194. Wilensky, *supra* note 2, at W3-124.

195. T. Halstead, *To Guarantee Universal Coverage, Require It*, NY TIMES, Jan. 31, 2003, at A.29.

196. *Id.*

197. Wilensky, *supra* note 2, at W3-125.

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 now, and there is little reason to believe that employers would suddenly stop providing it.<sup>198</sup>

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. 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. Two-thirds of the uninsured would need substantial government subsidies to be able to afford an individual health insurance policy, thus the government would have to provide upwards of \$60-90 billion per year.<sup>199</sup> Moreover, as Jonathan Oberlander points out, an individual mandate plan has no cost-control mechanisms.<sup>200</sup> 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.<sup>201</sup>

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198. Halstead, *supra* note 196.

199. These figures are 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.

200. Jonathan Oberlander, *One Dimensional*, AM. PROSPECT, Web Feature (2003), at <http://www.prospect.org/web/page.wv?section=root&name=ViewWeb&articleID=1016> (last visited May 30, 2004).

201. *Id.*

## VII. CONCLUSION

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, however, to accurately predict 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 King David's memorable lament: "But thou, O Lord, how long?"<sup>202</sup>

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202. *Psalm* 6:3.