The Health Care Reforms of the 1990s: Failure or Ultimate Triumph?

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With over 45.7 million Americans or 15.3 percent of residents without health insurance, and health care costs projected to comprise 20% of GDP by 2016, access to health care services and reform of the American health care system promises to be one of the key issues for the new Obama administration.\textsuperscript{12} It might even be said that the United States is in the midst of a “health care benefits crisis”; $300 billion is spent annually by employers on health insurance for employees, and overall health care costs continue to increase at a rapid rate.\textsuperscript{3} Employer contributions for health insurance coverage amounted to 24 percent of total spending on health services and supplies in 2005.\textsuperscript{4} It is also worth noting that since 2000, the percentage of employers offering health benefits has declined from 69 percent to 61 percent and the average worker contribution for family coverage has increased by 84 percent.\textsuperscript{5}

Health care reform was an important part of the 2008 presidential campaign and primaries. The saliency of the health care reform issue is also underscored by the very visible attempts by large states such as California, Illinois, and Massachusetts to institute comprehensive health care reform at the state level. The release of the controversial documentary film Sicko in the summer of 2007, which catalogs the “flaws” and “inequalities” of the American health care system also serves to highlight how visible the health care reform issue has become.

\textsuperscript{1} http://www.cbpp.org/4-5-07health.htm
\textsuperscript{2} http://www.kff.org/insurance/snapshot/chcm050206oth2.cfm
\textsuperscript{3} B Net Business Network, “The rising cost of health care: strategic and societal considerations for employers”, http://findarticles.com/p/articles/mi_m3495/is_9_49/ai_n6206615, p. 3
\textsuperscript{5} Nichols and Axeen, p. 6/
The health care reform debate of 2008 is reminiscent of opportunities for reform that have occurred on a cyclical basis throughout American history, most notably in the presidential administrations of Franklin Roosevelt, Harry S. Truman, John F. Kennedy, Lyndon B. Johnson, Richard Nixon, and William Jefferson Clinton with little success.6

The 1990s were one of the most active and engaging health care reform periods in United States history. With health care costs rising sharply and the number of the uninsured growing at a rapid rate, the American health care system was widely considered in “crisis”. Responding to this crisis, many reform plans were proposed during the early to mid 1990s by think tanks, interest groups and political parties. More than 63 reform bills came before the 102nd Congress in 1991.8 During 1993-94, 27 different legislative proposals came out of Congressional debates and discussions on health care reform.9

The Clinton Health Security Act, proposed in 1993, quickly became the center of an intense public debate on “reforming” the American health care system. Both the Republican and Democratic parties proposed reform plans, and a variety of states attempted to adopt more local health care reform efforts. Yet ultimately, no comprehensive health reform plan was passed by Congress during the 1990s reform era, and the success of state reforms was limited.

6 The only exception to this limited success is the 1965 creation of Medicare and Medicaid.
7 JILL QUADAGNO, ONE NATION UNINSURED: WHY THE U.S. HAS NO NATIONAL HEALTH INSURANCE (2005)
9 http://www.upenn.edu/pnc/ptbok.html
It was striking that there seemed to be a public consensus in the late 1980s and early 1990s, related to the problematic nature of rising health care costs and the growing number of uninsured individuals, and that the health care system needed to be reformed. Yet, none of the over 100 proposals introduced in Congress between 1991 and 1994 were enacted. The major stake-holders in the American health care system, providers, consumers, and third-party payers could not agree on what needed to be done. This fact has led many journalists and scholars to conclude that the Clinton initiatives were a colossal “failure” which ultimately led to the Republican victory in the 1994 elections.

In this paper we argue that this characterization of failure is inaccurate and misleading. Not only have many of the components of the Clinton Health Security Act and some of the other reform proposals of that era been incrementally enacted at the federal or state levels of government, but the structure, financing and organization of the American health care in the mid-2000s is radically different from the mid-1990s. This type of change in a relatively short period of time is very significant, and is directly correlated with the health care reform discussions of the 1990s. These discussions created a climate for change which is largely overlooked when scholars and pundits reach the conclusion that health care reform simply failed. The system has been transformed in many of the ways which were foreseen by the authors of the reform proposals which emerged in the 1990s health care reform era.

Ironically, while the health care system of the United States has undergone a transformation from the 1990s to today, the major problems that prompted the
1990s reform effort are still the major problems of the American health care system. The persistence of these problems even after such dramatic changes in health care structure, financing, and delivery accounts for the fact that health care reform continues to be a major priority on the national public policy agenda.

This paper examines the key proposals of the health care reform era in the early to mid 1990s and documents what portions of these “failed” reforms have been enacted into law since 1994. First, we describe the 1990s view of the health care system as in “crisis” and how this view produced optimism about the possibility of reform. We also analyze historical and social barriers to comprehensive health care reform in the United States, and how these barriers impacted the 1990s health care reform debates. Second, we provide a detailed discussion of the health reform proposals in the 1990s, including the existing problems in the health care system and how the reform proposals would attempt to address those problems. Third, we look at how components of those proposals have been enacted at the federal level since 1994. Fourth, we consider how components of those reform proposals have been enacted at the state level. Fifth, we look at the current status of the American health care system, and the revolutionary changes that have taken place in that system since the proposed reforms of the 1990s. Lastly, we provide conclusions on the impact of the 1990s health care reform proposals as well as the political and public policy lessons learned from the 1990s health care reform experience.

Part One: The 1990s as an Era for Health Care Reform

Major Issues in the American Health Care System
The 1990s were believed to be a period with strong political momentum for serious reform of the American health care system. Much of this momentum and initial consensus which followed from it was due to the fact that the American health care system was believed to be in “crisis”. The two major issues of this crisis, identified by politicians, analysts and interest groups, included the number of uninsured, and access to health care for the uninsured and under-insured on the one hand, and the rising costs of health care services on the other. These problems would be the two major areas that all health care reform proposals of this era would attempt to address.

In the 1990s, health care costs were on a dramatic rise. Health care spending rose at an annual rate of 11.6% between 1970 and 1990, while national income rose only 8.8%.\textsuperscript{10} Health care was also consuming a growing portion of federal expenditures; in 1970, 7.1% of the federal budget was spent on health care, in 1996, 13.4% of the federal budget was spent on health care.\textsuperscript{11} The average cost of health insurance rose by about 53 per cent in the 1990s or over $800 in inflation adjusted dollars.\textsuperscript{12} It is important to note that the increases in the 1990s was not as significant as the increases experienced in the 1980s: Per capita health care spending increased by 156% from 1980 to 1990 and it increased by 71% from 1990 to 2000.\textsuperscript{13} Increasing use of medical technologies, excess capacity and productivity,

\textsuperscript{10} Lee at 577.
\textsuperscript{11} Lee at 578
\textsuperscript{12} University of Michigan, “Research Highlight”, Number 10, December, 2005, p. 1
\textsuperscript{13} BNET Business Network, p. 4
defensive medicine, administrative costs, and market failure were believed to be the major factors influencing rising costs.\textsuperscript{14}

The rapid increase in the number of Americans without health insurance was the second chief concern of the 1990s health care debate. The number of uninsured Americans increased from 28.8 million in 1979 to 37.3 million in 1984. The 1987 National Medical Care Expenditure Survey found that 18.5\% of the population lacked health insurance for all or part of 1987.

The increasing number of the uninsured was directly related to the increasing costs of health insurance and health care. Employer contributions to private health insurance went up significantly and fairly continuously from 1980 to 2005, Thr result of this trend is that employers are dropping health insurance plans; employers are doing this because they are unable to shift costs to employees and are ,otherwise, not able to afford the premium increases.\textsuperscript{15} The private employer share of premium contributions declined from 77 percent to 73 percent between 1987 and 2005 \textsuperscript{16}

Prohibitively high costs for care led to employers no longer providing health insurance as a benefit of employment. It also led to employers shifting substantial increases in costs to employees thru deductibles and co-payments. In other words, employers felt that they were in a position where, in order to remain competitive, they had to reduce health insurance and health care benefit generosity and their

\textsuperscript{14} Lee at 579.
share of premiums. 17 High costs also made it difficult for uninsured Americans to purchase individual health insurance.

One of the reasons for the “health care crisis’ was that health care expenditures were increasing and the number of uninsured was continuing to grow despite the fact that the 1990s were considered to be a time of “economic boom”; the United States Gross Domestic Product increased by between 3 and 5 percent each year during the 1990s, real wages increased by 20 per cent and rates of unemployment reached new lows.18

Public Opinion on Health Care Reform: Historical Context, The “Crisis of Expectations” and American Exceptionalism

The combination of these two factors, an increasing price for health care services on an individual and system-wide level, and growing number of Americans unable to afford or have access to increasingly expensive health care led to public frustration and dissatisfaction with the existing health care system. Louis Harris and Associates in 1988 found that 89% of Americans wanted to see a dramatic change in the health care system: 29% thought that the health care system needs to be completely rebuilt, and an additional 60% thought that the system needed fundamental changes.19 A 1991 poll by Time and CNN found that 91% of

18 University of Michigan, “Research Highlight”, Number 10, December, 2005, p. 1
19 Lee at 575
Americans thought that the health care system needed fundamental changes and that 75% said that the costs were much higher than they should be. Such widespread public dissatisfaction naturally made health care reform a salient political issue. Politicians viewed public frustration with the health care system as a foundation to form a broad public consensus for health care reform in the United States, and pundits declared “a new consensus has emerged” for health care reform. Optimism was also present in Congressional leadership. Senate Majority Leader George Mitchell after the election of the 103rd Congress stated: “I believe that we will in this Congress enact comprehensive health care reform.” The health care reforms of the 1990s were believed to be taking place within a “window of opportunity” for dramatic reform.

Along with this widespread public interest in health care reform was the mobilization of a variety of health care interest groups, each advocating for their own reform package. More than 500 interest groups approached President Clinton’s Health Care Reform Task Force in November of 1992, including Families USA, the American Association of Retired Persons, Public Citizen, Consumer’s Union. The involvement of interest groups fueled optimism that reform would become a reality. An editorial published by the Journal of the American Medical Association in 1992 declared that “the reality of reform seems assured. The only

20 Lee at 576
21 Hackey at 233
22 Hackey at 239
23 Hacky at 235
question now are what, how much, how soon, how incremental, how complete, how
effective, and how long lasting.”

Proposals for Health Care Reform in the 1990s

Financing and Organization: Managed Care and Managed Competition

The public discussion and concern over problems in the American health care
system in the early 1990s naturally led to many proposals for reform. In 1992,
more than 40 health care reform bills were considered by the 102nd congress. Reform proposals were enacted in Oregon, Washington, Minnesota, Vermont, and Florida.

There were four major options for structuring the American health care system
that were proposed in reform plans. The first option was individual based health
insurance with voluntary enrollment, which is based upon the fee-for-service,
private health insurance and private health service market. This option was based
upon the traditional model of health insurance and medical service delivery in the
United States, with patients or insurance companies reimbursing physicians on a
fee-for-service basis. The second option was employer based health insurance with
voluntary enrollment. This second option represents how the American health care
system is financed and organized, with the majority of Americans receiving health
care as a benefit of employment. The third option provided for employment-based
health insurance with mandatory enrollment, which was best illustrated in the “play
or pay” plans where employers were required to provide insurance or, if they did

24 Hackey at 241
25 Soffel at 494.
26 Soffel at 494.
not provide insurance, pay into a fund for the uninsured. The fourth option was mandatory health insurance funded by tax dollars. This was commonly known as national health insurance or single-payor health insurance.\(^{27}\)

The majority of reform proposals preserved the traditional structure of health care as a benefit of employment, and considered health care a privilege rather than a right. Only nationalized health care financed through tax revenues, such as the “single payor” plan modeled after the Canadian health care system, considered health care a right of citizenship. Even health care reform proposals that considered health care a right struggled to fit this right into the American health care marketplace. For example, the Clinton Health Security Act explicitly stated that health care was a fundamental right, but still maintained strong links with employment based health insurance.

Key to the reform of the American health care system was the suggestion that cost-controls should be implemented to limit rising health care costs. One of the most important cost controlling mechanisms used by the health care reform proposals in the 1990s was managed care. Managed care is a health care delivery system structured to control costs, and is a dramatic departure from the traditional fee-for-service model.

Under a traditional Health Maintenance Organization (HMO) model—one form of managed care---patients are restricted in their choice of physician and medical procedures are pre-authorized and controlled for cost. Primary care physicians serve as “gatekeepers” through which patients can be referred for

\(^{27}\) Zelizer at 520.
specialty care. HMOs rose to prominence during the Nixon Administration with the passage of the HMO Act of 1973. Only 15 million Americans were insured by managed care organizations in 1984, but by 1991 the shift from traditional indemnity insurance and a fee for service model was well underway, with nearly 40 million Americans enrolled in five hundred HMOs. By 1996, nearly 50 millions Americans were enrolled in some type of managed care plan.

Preferred provider organizations (PPOs) and point-of-service plans (POS) were also managed care models prevalent in the early 1990s and included in reform plans such as the Clinton Health Security Act. PPOs and POS plans were introduced to allow patients slightly more patient choice, allowing patients choose doctors from within a more loosely associated preferred provider organizations as opposed to the tightly controlled HMOs. Due to this increased freedom of choice, PPOs and POS plans do not reduce health care costs as drastically as HMOs. By 1991, about one quarter of American workers who received health care insurance as an employment benefit were insured by PPOs or POS plans.

“Managed competition” emerged as one key proposal in the 1990s which coupled cost controlling mechanisms of managed care with preservation of competition in the health care market place.” Managed competition is a government regulated system of purchasing alliances that contract with the most

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28 http://www.ahrq.gov/research/managed.htm  
29 http://www.ahrq.gov/research/managed.htm  
30 http://www.ahrq.gov/research/managed.htm  
31 http://www.ahrq.gov/research/managed.htm  
32 http://www.ahrq.gov/research/managed.htm  
34 Zeilizer at 521-522.
efficient managed care providers such as HMOs and PPOs.\textsuperscript{35} Citizens receive a fixed contribution from either their employers or the government that would cover the basic premium of the most efficient managed care provider.\textsuperscript{36} Individuals or families who wished to purchase insurance from a different provider could use their fixed contribution towards the premium of that provider, but any additional costs would need to be paid out-of-pocket.\textsuperscript{37} Providers, therefore, have an incentive to provide the least expensive, most cost-efficient plan; citizens have an incentive to purchase the least expensive plan.

The idea of managed competition did not originate during the 1990s health care reform discussions, but was first developed by the Federal Health Benefits Program of 1959. This program allowed federal employees to choose from a variety of health plans. The federal government made a fixed contribution to each worker to pay for health care services, so the employee had an incentive to choose the cheapest plan that met their needs. Managed competition was also central to the same national health program proposed by the Nixon Administration in 1973 that introduced the concept of managed care.\textsuperscript{38}

Managed competition was a key component of the “Clinton Health Security Act. Other health care reform proposals such as those from the Jackson Hole Group, a collaboration between conservative policy experts and business leaders, included managed competition components.\textsuperscript{39} Senator Bob Kerrey proposed “Health USA”

\textsuperscript{35} Zeilizer at 521-522.
\textsuperscript{36} Zeilizer at 521-522.
\textsuperscript{37} Zeilizer at 521-522.
\textsuperscript{38} Zeilizer at 521-522.
\textsuperscript{39} Zeilizer at 522.
which was a single payer and managed competition reform plan. Sociologist Paul Starr’s and Garmendi’s plan both incorporated elements of managed competition. Political analysts who would look at the Clinton Health Care proposal in the years after its “failure” believe that Clinton chose managed competition because it was more politically pragmatic than single payer or the “play or pay” alternative proposed by the Democratic leadership, and provided a balance between the market and universal coverage.

Specific Reform Proposals

The most well known health care reform plan was the 1993 Health Security Act proposed by President Clinton. The plan was a political failure, and was believed to be at least partially responsible for the Democratic loss of the House and Senate in 1994, and the over a decade of Republican leadership that followed. Most analysis of health care reform in the early 1990s has focused on the immense variety of political factors that led to the bill’s failure. Few have looked closely at the great impact the Clinton health care plan has had on the American dialogue about health care reform, and how many central components of the Clinton Health Security Act have been gradually enacted by the federal, state and local governments. Most importantly, however, is that the health care system of the United States is dramatically different from the health care system of the early 1990s, largely due to the wide acceptance of managed care, a central cost control mechanism included in the Clinton Plan. The system of today is organized and delivered differently from the past, and this reorganization is due directly to the health care reform dialogue that took place in the 1990s.
It should be noted that the Clinton’s health reform proposal, while revolutionary in the concept of health care as a “right,” was largely a carefully packaged political compromise. Under the Clinton plan, health care was a “legal right” organized into a national system that relied upon employer mandates and government financed programs; this system would have required every person to have a basic form of health insurance. Coverage was financed through tax revenues, and care was delivered through a managed care model.

Under the Clinton plan, all “American citizens, nationals, citizens of other countries legally residing in the United States and long-term non-immigrants” would be eligible for a national, comprehensive benefit package that would be funded through a national health budget. A National Health Board would set standards and oversee plan administration in conjunction with Regional Health Alliances.

Although health care would be considered a right, health insurance was still a benefit of employment, and employers would be required to pay 80% of their employee’s health costs. To contain costs, health plans themselves relied heavily on managed care, with mandated minimum coverage, and the ability for consumers to choose between PPO, HMO and fee-for-service plans.

The use of managed care was, as previously mentioned, a huge shift from the previous model of health care delivery in the United States, where patients and insurers would reimburse physicians on a fee-for-service basis. Cost controls were similar to those used by the managed care industry, with the addition of national standards set by the National Board of Health.
The HSA is considered to represent “the last serious effort to craft a comprehensive approach to reforming our complex health care delivery system, and its content and its failure are still relevant.”

Contemporaneous with Clinton proposal were numerous proposals that incorporated a variety of financing and delivery structures. Many of these proposals influenced the development of the Clinton plan, or were formulated as political compromises in reaction to the Health Security Act. Physicians for a National Health Program proposed a tax-based, fee for service system. Enthoven and Kronick and the Jackson Hole Group proposed a mandatory, employment-based, managed competition scenario, the managed competition aspect which was adopted by the Clinton plan. John Garamendi, Insurance Commissioner for the State of California proposed tax based managed competition under a national health budget. Garmendi’s proposal was another key influence in the development of the Health Security Act.

The three proposals that had received the most attention prior to the Clinton proposal were the concept of a “Single Payer” system, the Democratic reform proposal, and the competing Republican proposal. Under a “Single Payer Plan” health care providers were on a salaried system funded by a national health budget. This was similar in structure to the Canadian national health system. The Democratic proposal was termed “Pay or Play” and required employers to provide their workers health insurance as an employment benefit or pay into a national pool for the uninsured, thereby subsidizing care for those who were unemployed or did

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40 Budetti at 2000.  
41 Zelizer at 520.
not receive health care as a benefit of employment. The Republican plan was based largely on tax credits, and gave individuals and corporations tax credits to purchase private health insurance.

Key to the Congressional discussions about health care reforms were the Republican sponsored proposal championed by Senator John Chaffee and Senator Robert Dole. The Chafee plan sought to provide a fiscally conservative, market-based solution to the health care crisis while still containing some of the idealism that made the Clinton plan so popularly attractive.\[42\] The plan had voluntary, not mandatory, purchasing alliances and medical savings. Universal Coverage would only be attained by 2005, as savings from the plan made expansion of coverage possible.\[43\]

The major bi-partisan proposal was a "managed competition" plan sponsored by Representatives Jim Cooper, a Democratic, and Fred Grandy, a Republican. The Cooper-Grandy proposal had many similarities with the Clinton plan, but attempted to limit government influence in the health care marketplace, and placed must less stringent requirements on insurance providers and businesses. The Cooper-Grandy proposal created a national commission to specify the uniform benefits package that must be offered by all insurers to qualify for federal tax

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\[42\] The Chafee plan was initially called “Clinton lite” by critics. Initially, the Chafee plan did not have employer mandates or price controls, but did have the central features of the Clinton plan, such as: purchasing alliances, a National Health Board, and universal coverage with a comprehensive benefits package. The plan was soon amended to be more fiscally conservative, a halfway point between the conservative proposal by Senator Don Nickles and the Clinton Plan.

\[43\] Rich Lowry, Chafee's political prescriptions - Republican Senator John Chaffee has his own proposals for health care reform, National Review, Jan 24, 1994
exemption. In the Clinton plan, the uniform benefits package was mandatory for all insurance providers, and was not linked to federal tax status.

Additionally, the Cooper-Grandy plan did not mandate that employers pay the bulk of health insurance costs. The plan would repeal Medicaid and instead and provide federal subsides for low income health care consumers.\textsuperscript{44} The organization, financing, and delivery mechanisms of the congressional proposals were therefore distinct from the Clinton Plan. Organization was much more along the lines of the employer-based system, with limited federal involvement through subsidies. Financing mechanisms relied upon the private market rather than tax revenues. Delivery mechanisms were similar to the Clinton plan, with the use the managed care model to streamline health care delivery and also contain costs.

The health care reform proposals of the 1990s can therefore be summarized as, with the exception of the national health insurance or single payor plans, as careful political compromises. The proposals sought to expand coverage and lower costs while still maintaining the traditional mindset that health care was not a right, but a commodity dictated by market forces. The vast majority of plans embraced the cost-cutting effectiveness of managed care and the free market nature of managed competition. This reinforcement of health care as a free market commodity and the promotion of managed care would greatly shape the evolution of the American health care system in the fourteen years after the rejection of Clinton’s health care reform proposal.

\textsuperscript{44} John Hood, \textit{Clinton lite: why would big business, in rejecting the Clinton health-care plan, go for one with many of the same features? - Bill Clinton's managed care reforms} National Review, March 7, 1994
Outcome From Health Care Reform Proposals

Yet, as already noted, these reform proposals based on a wide-spread public optimism did not translate into the enactment of specific comprehensive reform proposals. This is due to the on-going “crisis of expectations” and the widely held belief in “American Exceptionalism”.

First, and most importantly, the health care reform debates are affected by a “crisis of expectations” Put simply, the American public wants the highest levels of health care services and they want the services delivered “immediately” and certainly without any significant waiting period. But, they are unwilling to pay the higher taxes and other costs necessary to support government involvement in a national health program, nor are they supportive of governmental mandates that would make health insurance, much like mandates for automobile insurance, required by law. In other words, the American public was ultimately unwilling to accept the political and social changes that would result from comprehensive reforms. This mentality is still very present in American attitudes about health care and health care reform.

The crisis of expectations is evidenced in the 1990s health care reform debate by conflicting public opinion, from both individual Americans and the business community, between apparent broad support for national health insurance and a lack of support for the higher taxation that such a program may require. Poll results from the early 1990s showed that more than 50 percent of individual Americans supported universal health insurance, even if it required higher taxes. In universal health insurance, coverage is financed for all citizens through tax
revenues. Yet when asked specifically about support for higher tax rates and how much they would be willing to pay, support for universal health insurance declined significantly.  

This conflict between desires for reform but disinclination towards new revenue raising options was also prominent in the business community in the early 1990s, just prior to extensive political discussion on health care reform. Many pundits believed that the rising costs of health care would cause businesses to embrace new mechanisms for cost control, even if such cost controls came from the government. A 1991 Gallup survey of corporate executives’ opinion on health care reform illustrates a deep concern among business leaders about the health care system: 60% of those surveyed listed the cost of health care as “major concern” for their firms, and more than 80% agreed that “fundamental changes” were needed to make the U.S. health care system “work better.” Yet only 8.8% of the CEOs polled endorsed the creation of public, national health insurance, indicating that the crisis of expectations was prominent not only among individual Americans, but also the corporate leadership of the United States. 

Second, the health care reform debate of the 1990s was affected by what can be labeled as “American exceptionalism.” American exceptionalism is a general way of thinking that influences much of American political and social structures. According to this perspective, Americans generally believe in the virtues of self-reliance and hard work and are therefore mistrustful of government entitlement

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45 Hackey at 244.  
46 Hacey at 246  
47 Hackey at 234
programs, or reliance on social welfare system. Unlike their European counterparts who, for the most part, have a highly integrated and extensive social welfare system, American political culture is “highly individualized.” American exceptionalism has led to the evolution of the predominantly private-market health care system, health care insurance as a “privilege” tied to employment rather than a “right” tied to citizenship, and stymied previous efforts for government led health care reform.

Subsequent State and Federal and State Health Care Reforms

With the two major problems of the health care system left unaddressed after the attempted reforms of the early 1990s, states and the federal government introduced smaller scale reforms attempting to expand health care coverage for the uninsured and address rising costs. The enacted reforms between 1994 and 2008 followed a policy of careful incrementalism focusing on smaller scale reforms that did not address the fundamental issue of health care as a “right” and accepted that it was a benefit or privilege associated with employment. After the “failure” of the Clinton era health care reform proposals, comprehensive government intervention in the health care market was treated with great political caution.

Health care reforms since the 1990s have gradually been enacted at both the state and federal levels, and many of these reforms contain similar policy concepts or mechanisms as proposed in the Health Security Act and contemporaneous proposals. Notable reforms at the federal level that have followed both the policy of incrementalism and enacted previously proposed portions of the Health Security

\[48\] Hackey at 234
Act are the Health Insurance Portability and Accountability Act of 1996 (HIPAA),
the Medicare Prescription Drug Benefit Plan, and the State Children’s Health
Insurance Program (SCHIP).

State reforms also proposed state-wide health reform programs such as in
the states of Wisconsin, Massachusetts and Oregon. Besides direct state and federal
programs that have directly incorporated portions of 1990s reform proposals,
another important occurrence in the American health care system has been the
public embrace of managed care organizations followed closely by public
disenchantment with managed care organizations. This disenchantment has led to
legislation that has re-shaped how managed care organizations operate.

In short, these reforms looked to improve the financing and delivery of
health care services. (i.e., making the system more efficient, effective, and
competitive) Reforms also sought to address the two major issues that continue to
be problematic in the American health care system: rising costs and access to health
care for the growing number of the uninsured. Overall, a variety of the “failed”
reforms of the 1990s have been incorporated at both the state and federal level.
These reforms have increased the complexity of the American health care system
while not fully addressing the issue of rising costs and access for the uninsured.

Federal Reforms

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA)
was directly based upon the Clinton Health Security Act sections “dealing with
information systems, privacy, and administrative simplification.” HIPAA sought to increase patient privacy, and protect patients against discrimination for pre-existing medical conditions.\textsuperscript{49} HIPPA regulations cover all health plans and health service providers such as doctors and pharmacists.\textsuperscript{50}

HIPAA had two major impacts: increased mobility of workers, and increased privacy protections for medical records. Mobility was increased because HIPAA greatly reduced the ability of health insurers to discriminate on the basis of pre-existing conditions, allowing individuals with serious medical conditions or concerns over their medical coverage to more easily switch jobs or insurance plans without worrying that they would lose health care coverage. Now, under the requirements of HIPAA, an health insurance plan provided by an employer can only deny coverage based upon a preexisting condition “if the employee or dependent is diagnosed, receives care or treatment, or has care or treatment recommended in the 6 months before the enrollment date.”\textsuperscript{51} Coverage can only be denied for a pre-existing condition for no longer than 12 months, 18 months for late enrollees into health insurance plans. Late enrollees are those who do not sign up for a new plan as soon as they become eligible, or those who experience a significant break in “creditable coverage” of 63 days or more.

\textsuperscript{49} PUBLIC LAW 104-191, HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AUG. 21, 1996.
Privacy of medical records was increased through a number of HIPAA provisions designed to protect patient privacy, including “provisions designed to encourage electronic transactions” and “new safeguards to protect the security and confidentiality of health information.”  52 HIPAA places privacy protections on the confidential health information that would be given to a patient by physicians and other health care providers, including the information placed into a patient’s medical record, conversations between a doctor/health care provider and a patient, information held about the patient by the patient’s health insurance company, and billing information held by clinics, hospitals and medical offices.  53 The privacy components of HIPPA were a component of the Health Security Act, and the provisions regarding health care portability and discrimination on the basis of pre-existing conditions sought to provide additional coverage to Americans who might otherwise be uninsured.

State Children’s Health Insurance Program (SCHIP)

Another reform that has attempted to address the uninsured, specifically the high risk population of low-income children is the State Children’s Health Insurance Program (SCHIP). SCHIP is a federal program that covers families who cannot afford to purchase private insurance, but are ineligible to receive Medicaid benefits. SCHIP was enacted in 1997 to deal with one of the key problems with the


53 HIPAA Privacy Factsheet
health care system in the 1990s, the growing number of the uninsured, and specifically, the growing number of children without health insurance.\textsuperscript{54}

SCHIP provided health insurance to over 6 million children in 2005. The state and federal governments jointly fund SCHIP, and every state has an approved state plan. The plans themselves are administered by the states within broad federal guidelines, with the state’s themselves determining the administration, eligibility and mechanisms to deliver benefits.

Medicare Prescription Drug Improvement and Modernization Act of 2003

The Medicare Prescription Drug Improvement, and Modernization Act of 2003 is another reform that was enacted from the legacy of the 1990s reform effort. The Medicare Prescription Drug Improvement, and Modernization Act of 2003 enacted Medicare Part D, the controversial prescription drug benefit plan.\textsuperscript{55} The addition of a prescription drug benefit to Medicare was one of the major reforms of Medicare proposed by Clinton’s Health Security Act.

Medicare Part D, illustrates how the proposed reforms of the 1990s have been enacted in an incrementalist fashion. Additionally, Medicare Part D demonstrates how health reforms, after the political failure of the Clinton plan, have sought to rely upon free market philosophy and private health insurance as it currently exists.

Medicare Part D benefits started on January 1, 2006, and is a program through which the federal government provides a subsidy for prescription drugs for

\textsuperscript{54} Centers for Medicare and Medicaid Services, Low Cost Insurance for Families and Children, available at http://www.cms.hhs.gov/LowCostHealthInsFamChild/

\textsuperscript{55} Medicare Prescription Drug Improvement, and Modernization Act of 2003
Medicare beneficiaries. The actual drug benefits are overseen by private insurance companies, and these companies are reimbursed by the federal government. There are two private plans that offer the Medicare prescription drug benefit, a Prescription Drug Benefit Plan that offers insurance coverage only for the prescription drug, and a Medicare Advantage plan that provides prescription drug benefits as a component of an HMO or PPO insurance plan. Insurance companies are able to offer the drugs at lower prices by using pooled purchasing, and formularies, which use a tiered system, in which low tier and low cost drugs are easiest for doctors to prescribe. There are currently 34 Prescription Drug Benefit Plan regions in the United States and 26 Medicare Advantage regions.56

State Reforms

In addition to the incremental reforms which have been enacted at the federal level, several states (Massachusetts, Oregon, Illinois, and California) have introduced more comprehensive reforms which incorporate elements from the Clinton health care reform proposals as well as other plans proposed in the 1990s. Massachusetts

As evidenced by SCHIP and Medicare Part D, reform plans heavily rely upon states for regional organization and enactment of federal-level health reform proposals. Such regionalization was a key component of the Clinton Health Security Act, which used regional alliances and state-organized reform plans to supplement, support, and coordinate federal reforms. Although none of the proposed plans from

the 1990s have been fully and comprehensively enacted on a national level, many states have developed programs to address major problems with their health care systems.

Massachusetts’s Health Care Reform Law was signed into law on April 12, 2006, and was touted not only as an effective solution to many of the health care problems of Massachusetts, but also as a model to which other states and even the federal government could look.” Chief goals of the plan include a fully integrated universal health care system for all citizens of Massachusetts by July of 2007.57 The plan projects that by expanding coverage and bringing more healthy people into the market, overall costs can be reduced and stabilized.58 Mandating the purchasing of health care will allow individuals and families who would previously not have easy access to primary care, access to this prevent the more costly effects of an untreated diagnosis.59

The Massachusetts Health Care Reform Law splits responsibility for financing and coverage between individuals, employers, the state of Massachusetts, and the federal government. Individuals are responsible for coverage under a method similar to “play or pay”; all individuals who can afford healthcare are required to purchase it or pay a penalty of up to 50% of the potential cost. Discounted plans are available for individuals and families who are under 300% the

57 Id.
58 Id.
59 Id.
Federal Poverty Line.\textsuperscript{60} State funds that subsidize hospital care for the uninsured will be shifted to funding programs that will provide low cost health insurance to low-income families.\textsuperscript{61} The program will provide health care plans to small-group and non-group markets like small businesses, the self-employed, and younger individuals just entering the work force.\textsuperscript{62}

The Massachusetts plan has several aspects that were present in the Health Security Act. The Clinton plan proposed a plan to extend health insurance coverage that would have been implemented through individual mandates. The Massachusetts plan also would require all residents to have health insurance. People who do not have health insurance would be penalized, although low-income residents would get premium support on a sliding scale. In the Massachusetts plan, residents would be required to provide details regarding their health insurance policies on their state income tax returns. Residents who cannot afford to pay for their health insurance would be able to have their policies subsidized; this is a feature that was also a part of the Clinton plan.

A second component of the Clinton plan that is also present in Massachusetts plan deals with employer mandates. In the Health Security Act insurance would have been provided through employers. Similarly, in the Massachusetts plan, employers would be required to provide health coverage for their employees. Employers who did not provide insurance would have to pay an annual fee per

\textsuperscript{61} The Significance of Massachusetts Health Reform. http://www.heartland.org/Article.cfm?artId=20094
\textsuperscript{62} Id.
employee. Employer mandates are not a new idea. Even before the Clinton proposal Hawaii had employer mandates. The Hawaii’s Prepaid Health Care Act of 1974 was the first plan of its type in the United States. It requires “all employers to provide health insurance to their employees who worked 20 hours or more a week for four consecutive weeks.” The act also sets standards for benefits which employers must provide. Under this act employers are required to pay at least 50% of the premium.

One other component that is similar in the Clinton plan as well as the Massachusetts plan is the creation of regional offices to help operate the new health care system. In the Clinton plan there were proposed regional alliances. The alliances would enroll consumers, negotiate with health care plans, and offer consumer health plans. Although not called regional alliances, the Massachusetts plan has proposed a new state agency that would “serve as a liaison between the government, policy holders and private insures”. Both of these agencies would have served to help connect residents and the government to necessary information regarding health insurance. Managed competition is also used by the government of Massachusetts to negotiate prices and services between health service providers.

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Oregon

A state-wide initiative that mirrored many of the policy proposals found in the Clinton health plan was attempted by the state of Oregon in 2002. The proposal was called Measure 23 and aimed to provide universal coverage to all residents. The main goal of Measure 23 which was on the ballot in November 2002 election was to provide universal coverage without discrimination. Under Measure 23 all residents would receive medically necessary health care benefits.\textsuperscript{66}

Benefits would include services such as inpatient care, prenatal care, immunizations, outpatient services, emergency care, long term care, prescription drugs, as well as many other benefits.\textsuperscript{67} Under the Measure residents could receive care from any physician they wished to see. A proposed “Comprehensive Health Finance Board” would be established. The Board’s responsibilities would include providing information about treatments, establishing utilization guidelines, as well as monitor physicians, suppliers, and participants.\textsuperscript{68} Measure 23 would be a type of single-payer system in which the Financing board would act as a single purchasing authority for all health services. The Oregon plan included many aspects of the Clinton health reform proposals, as well as incorporating financing models from the single-payer health care plan instead of the managed competition plan. Although this plan was ultimately unsuccessful, it was a serious public dialogue on reforms that followed much of the Clinton model.

\begin{itemize}
\item \textsuperscript{66} Health Care for all Oregon available at http://www.healthcareforalloregon.org/documents/initiative.pdf at 1
\item \textsuperscript{67} Health Care for all Oregon at 1-2
\item \textsuperscript{68} Health Care for all Oregon at 3-5
\end{itemize}
Illinois

Another state that has successfully worked on the issue of health care reform has been Illinois. The state of Illinois has also provided major health care reforms to citizens of the state, also addressing the two key problems of the health care system: rising costs and the growing number of the uninsured. Much of these programs have focused on expanding health care coverage to lower income families and children.

For example, KidsCare, the predecessor to the full coverage of all children in IL, All Kids, had been adjusted to include those who fall under the 200% Federal Poverty Level from its original 185% marker. The closely related FamilyCare was also expanded several times to benefit those falling in the range from 133% below the Federal Poverty Level to 185% below the Federal Poverty Level.

Rising health care costs for small businesses has been addressed by the creation of a small business insurance pool. In this pool, so employers with as many as 50 employees can join together and save 10-15% of costs through negotiation rates, administrative costs, and broker fees.

The largest reform has been the creation of the All Kids program, which was created to provide health care coverage to all children of Illinois. All Kids provides

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69 Gov. Blagojevich signs “No Senior Left Behind” law New law fills gaps created by federal drug benefits program.
http://www.illinois.gov/PressReleases/ShowPressRelease.cfm?SubjectID=1&RecNum=4107

70 Id.

71 Gov. Blagojevich reaches out to Illinois’ Congressional Delegation urging them to help with federal SCHIP funding to Illinois.
http://www.illinois.gov/PressReleases/PressReleasesListShow.cfm?RecNum=5638
health care benefits to all the children under the age of 18 that reside in the state of Illinois whether they were a part of KidsCare, or Medicaid, and have not been insured for at least one year.\textsuperscript{72} There is no limitation to All Kids based on income. Instead a tiering system is used, where those of higher income families pay a higher premium and co-pay.\textsuperscript{73} As of December 2006, 300,000 children were enrolled in the All Kids program.\textsuperscript{74}

All Kids covers a wide range of medical necessities and can also act as a supplemental form of insurance. Doctor visits, hospital stays, prescription drugs, vision care, dental care, eyeglasses, check-ups, immunizations, medical equipment, speech therapy, and physical therapy are all covered by All Kids for those who need the appropriate services.\textsuperscript{75} Children with pre-existing medical conditions, have parents receiving health care through COBRA, have insurance that only covers a single medical condition or service are also eligible for All Kids.\textsuperscript{76}

Illinois has also been active in attempting to lower the cost of prescription drugs. Legislation in Illinois has attempted to maintain the cost of prescription drugs at a stable level prior to the implementation of Medicaid Part D, which was widely projected to raise prescription drug costs for many seniors.\textsuperscript{77}

\begin{footnotes}
\item[73]Id.
\item[74]Gov. Blagojevich sworn in for second term at Inauguration Ceremony in Springfield People mandate action, Governor intends to act; Lieutenant Governor, Attorney General, Secretary of State, Comptroller and Treasurer also take Oaths of Office. http://www.illinois.gov/PressReleases/ShowPressRelease.cfm?SubjectID=3&RecNum=5629
\item[75]Id.
\item[76]Id.
\item[77]Id.
\end{footnotes}
California

California has also proposed an ambitious health care reform plan that aims for universal health care coverage for citizens of the state of California. A major champion of the plan is Governor Arnold Schwarzenegger, who touts a health care reform vision that is “accessible, efficient, and affordable” and “promotes a healthier California through prevention and wellness and universality of coverage.”

The proposal relies up a three-part “systems approach” which includes “1) Prevention, health promotion, and wellness; 2) Coverage for all Californians; and 3) Affordability and cost containment.”

The first prong of the plan, “Prevention, health promotion, and wellness” is centered upon health lifestyle changes and public education. Education of youth and children is key, and may provide huge financial benefits by creating a healthier population. Coupled with public education are seemingly simple reforms that include bans on junk food and carbonated beverages from school vending machines. California also hopes to increase health education by bringing back the physical education departments and teachers that were reduced during the 1990’s.

The second prong of the plan, “Coverage for all Californians” is the most ambitious portion of the plan, and will likely provide a valuable model and source of information for future state and federal reforms. California is a large state with a diverse population; California makes up 12% of the United States population, and

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79 Id.
has 6.5 million people who are uninsured and many more that are underinsured.\textsuperscript{81} The new reform proposals would require that every individual would have some form of health insurance.

The third prong of the plan focuses on making the purchasing of health care insurance affordable. is central to the success of the universal nature of the plan, and is addressed in the third prong of the plan, “Affordability and cost containment.” Tax deductions will be used by small businesses who are purchasing health care coverage for themselves and their employees.\textsuperscript{82} The new proposal there will require that insurance companies put at least 85\% of their revenue into patient’s care and keep administrative costs and profits to 15\%. To reduce the cost of prescription drugs, California has passed legislation that enables the state to actually negotiate prices through Medi-Cal for those who are uninsured.\textsuperscript{83}

Similarities to the Clinton plan can also be found in recent proposals by other states. In 2005 Maryland also drafted a bill that is similar to the proposed employee mandates featured in the Clinton plan. The Maryland bill would require employers with more than 10,000 employees to spend 8\% of their payroll on health benefits.\textsuperscript{84} This mandate only involves large companies but the concept of requiring

\textsuperscript{81} Business Eyes the California Health Reform Debate. http://smallbusinessreview.com/for_the_boss/california-health-reform-debate-business/
\textsuperscript{82} Comparing the President’s Plan to Governor Schwarzenegger’s Comprehensive Health Care Reforms. http://gov.ca.gov/index.php?/fact-sheet/5296/
\textsuperscript{83} Prescription Drug Information Project. http://www.chcf.org/topics/chronicdisease/index.cfm?itemID=103138
employers to provide health benefits to employees is the common idea in the two plans.

Contrasting the American Health Care System of 1993-94 with the American Health Care System of 2007

The incremental introduction of health care reforms at the federal and state levels is one measure of the impact of the Clinton-era health care reform discussions and debates. Another key measure is: how has the structure and financing of the American health care system changed since the “failure” the health care reform proposals of the early 1990s

From the 1990s to 2007 there has been a major shift in how the American health care is financed and organized. This has taken place in two major ways. First, there has been a significant decrease in the number of individuals that are provided health care as a benefit of employment. Second, the vast majority of health care is now provided in a managed care model, as opposed to the fee-for service model that was the dominant model of the early and mid-1990s.

In the early 1990s, just prior to the health care reform debates, 140 million Americans, two-thirds of Americans under the age of 65, received health care as a benefit of employment. Overall, the percentage of workers and dependents with employment-based health insurance has fallen from 70 percent in 1987 to 59.5 percent in 2005. This percentage marks the lowest level of employment-based insurance coverage in more than a decade. The lack of health insurance benefits

85 MARILYN JANE FIELD & HAROLD T. SHAPIRO, EMPLOYMENT AND HEALTH BENEFITS: A CONNECTION AT RISK (1993), 1
adds many individuals to the ranks of the uninsured: in 2005 27.4 million workers were uninsured. These workers were uninsured because health benefits were not offered, they did not qualify for coverage, or they could not afford to pay for available coverage.  

In the early 1990s, the dominant model for health insurance financing and delivery was the fee for service system. Managed care was beginning to grow in importance, but still had a smaller market share. In 1994 50.5 million Americans were enrolled in HMOs, and in 1993, PPOs had approximately 60 million enrollees. By 2006, over 70 million Americans have been enrolled in HMOs and almost 90 million have been part of PPOs.

Not only has the model of managed care moved to become the predominate mode of health insurance in the United States, but early on in the transition, traditional fee-for-service insurance plans began to use cost cutting techniques central to managed care. These techniques included utilization review and pre authorization prior to hospitalization or major medical procedures. In 1987, 40 percent of employee health insurance plans did not use utilization review, by 1991, only 5 percent of employee health insurance plans did not use utilization review.

The restrictive nature of managed care led to widespread complaints from patients and physicians, and led to a public backlash against techniques such as utilization review. Congress enacted federal requirements for requiring a minimum

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86 http://www.nchc.org/facts/coverage.shtml
87 Managed care has become the dominant mode of health care delivery in the United States, and providers must deliver not only on price, but also on value, quality, and performance” - special edition: The State of Health Care in America 1995 Business & Health, Annual, 1995 by Barbara Sande Dimmitt
88 Id. 16-17
for maternity length of stay, and requiring managed care organization to provide coverage for medical procedures such as mastectomies and lumpectomies. The Balanced Budget Act placed federal controls on the managed care organizations used by Medicare and Medicaid. In 1997, the Consumer Bill of Rights and Responsibilities Report was released. During the period of 1997-1998, more than 170 patients’ rights and managed care reform proposals were before Congress.\(^{89}\)

Restrictions that have been placed on the traditional HMO model as well as public dissatisfaction with HMOs have led to a rise in the number of PPOs and POSs, and a corresponding decrease in HMO enrollment. This, in turn, has impacted the cost-cutting techniques that can be used by managed care organizations, rendering them slightly less effective. In 2005, PPO enrollment was at 61\%, but HMO enrollment was only 21\%, decreasing from a 1996 high of 31\%. By 2005, only 3\% of employee health insurance plans were enrolled in traditional fee-for-service plans.\(^{90}\)

Despite the legal constraints on many of the practices central to managed care, the model has continued to be a dominant force in the American health insurance market, demonstrating that perhaps the greatest component of the 1990s health care reform proposals has been enacted on a wide-spread level. Generally, managed care enrollment, including HMOs, PPOs and POS plans has continued to increase from 1990s levels, with 97\% of all employer health insurance plans in 2005 structured in some type of managed care model.

\(^{89}\) Bundetti at 2003  
\(^{90}\) http://www.kff.org/insurance/7031/print-sec2.cfm
An area where this shift to managed care has been particularly influential has been in Medicaid. In 1991, 2.7 million Medicaid beneficiaries were enrolled in some form of managed care; by 2004, 27 million Medicare beneficiaries were enrolled in managed care. Sixty-three percent of all Medicaid beneficiaries were enrolled in managed care in 2005.

Although there has thus been a substantial shift in how the American health care system is financed and organized, the two major problems that the reforms of the 1990s attempted to address: the uninsured and rising cost of health care still exist. Not only do these problems exist, but they also have been growing increasingly serious. At the time of the debate over the Clinton Health Plan, 35 million Americans were uninsured. The most recent figures suggest that nearly 47 millions Americans were without health insurance in 2005.\(^91\) Health care costs now comprise 16% of the GNP, the highest proportion ever.\(^92\)

Conclusion

This paper shows how the failure to enact any of the Clinton-era health care reform proposals should not be considered as a “failure” to bring about significant reform of the American health care system. Indeed, the structure and financing of the health care system is significantly different in 2008 than it was in the early 1990s. These differences reflect the substance of the reform deliberations of the 1990s. Moreover, some of the specific proposals of the 1990s been enacted in an incremental fashion at the federal and state levels of government.

\(^91\) http://www.nche.org/facts/coverage.shtml
\(^92\) http://www.washingtonpost.com/wp-dyn/content/article/2006/01/09/AR2006010901932.html
It is important to distinguish between political and substantive failures. Politically, neither President Clinton nor any of the other Republican or Democratic sponsors of health care reform proposals of the 1990s were successfully in building a political coalition with enough votes to pass national legislation.

The deliberations surrounding health care reform in the 1990s, the failure to enact any national legislation, and subsequent “incrementalist” initiatives at the national and state levels has important implications for how change is introduced in the health care policy arena. Gradual reform from 1994 thru 2008 has created a fragmented and patchwork health care delivery system. What is missing is a unified or comprehensive health care reform strategy which would integrate the disparate or diverse components.

The ‘failure’ of the comprehensive or overarching plans of the 1990s and the subsequent enactment of select pieces of the reform proposals can be attributed to the “crisis of expectations” present in the American public’s mindset about health care reform. Americans want specific facets or components of problems (e.g., requirements of managed care organizations or lowering employee contributions to health insurance premiums) addressed “now” without increasing taxes, introducing mandates, and changing the basic structure of the American health care system (i.e., health care is an employee benefit or privilege and not a legal right) or introducing a formal “rationing” scheme.

The elections of 1992 and 2008 seem to indicate that the American public wants health care reform, but there is not sufficient support among consumers, business leaders, and government officials to make the policy leap to define health
care as a legal right or to introduce truly comprehensive or dramatic reform that would create a national system and/or break the traditional employment-health insurance link.

The discourse in the 2008 election continued the trajectory set out after the 1994 mid-term elections: introduce smaller-scale reforms without introducing fundamental or comprehensive change.

The primary lesson of the early 1990s is NOT that health care reform failed. The health care system has changed significantly and from this perspective the reformers were successful. However, the outcome is ironic: the organization and financing of the American health care system has changed significantly, but we have not altered the basic ideology which is at the foundation of this system. The United States continues to be the only advanced industrial society in the world where health care is not a legal right and we have not broken the traditional link between employment status and access to health insurance. Moreover, despite making major changes in the structure and financing of the American health care system, the dual problems of rapidly rising costs and access to high quality health care for the uninsured and under-insured have not been solved.