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**Will Americans Embrace Single-Payer Health Insurance: The Intractable Barriers of Inertia, Free Market, and Culture**

Susan Channick
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Susan Adler Channick

1. Introduction

Lately, I have been having flashes of déjà vu. Here it is, eight years into the new millennium, and it’s the 1990s all over again. There was a Clinton running for president, O.J. Simpson, the media’s darling, is in court and constantly on television news, and health care is America’s number one domestic concern. I feel a little like Rip Van Winkle, having fallen asleep in 1995 and waking up at the end of 2008. What has happened for the past dozen years? While discourse on the first two issues would be fascinating and fun, I do not aspire to it. This article does not theorize about either a Clinton II presidency (no longer a possibility) or an O.J. II felony trial (Simpson was convicted of armed robbery and kidnapping on October 3, 2008, thirteen years to the day that a jury acquitted him of killing Nicole Brown Simpson and Ron Goldman, and sentenced to 15 years in prison.). It does, however, hope to deconstruct salient features of health care in the United States as we approach the second decade of the new millennium.

There is little disagreement that health care in the United States is in or at least heading toward a crisis. At least 46.4 million or approximately 17.9% of Americans under the age of 65 are completely uninsured during an entire calendar year and many more millions are underinsured. Even the approximate 60% of Americans who have health insurance through their employers, or as part of a public program, or individually, are paying significantly more out-of-pocket than ever before. Employers either drop health insurance benefits altogether or shift the cost of health insurance to their employees. The cost of health care is an issue for global companies because the cost of their goods increases with the cost of their employees’ health insurance, making it harder to compete in the global market. Robert Reich, the Secretary of Labor in President

1 Professor of Law, California Western School of Law; B.A., Cornell University; J.D., California Western School of Law; MPH, Harvard University School of Public Health. I would like to thank my extremely able research assistant Richard Vu whose help has been invaluable.
2 The Employee Benefit Research Institute, in a report released on October 5, 2007, found that the number of uninsured U.S. residents younger than 65 rose to 46.4 million or 17.9% of that population. More than 25% of self-employed workers are uninsured, while almost 20% of all workers lacked insurance. Self-employed people and workers at private sector firms with fewer than 100 employees made up 63% of the working uninsured. About 33% of the uninsured were in families with annual incomes less than $20,000, compared with about 7% of people in families with annual incomes of $75,000 or more. California Healthline, Uninsured Nonelderly U.S. Residents Up 17/9% in 2006, Oct. 5, 2007, http://www.californiahealthline.org/articles/2007/10/5/Uninsured-Nonelderly-US-Resident-Up-179-in-2006.aspx.
3 Id.
4 Recently, I heard on two different occasions both President Bill Clinton and Lee Iacocca, the former President of Ford Motors and CEO of Chrysler, talk about how the burden of employer-sponsored health care handicaps US automobile manufacturers in the global market. The CEO of General Motors, Rick
Clinton administration, recently wrote an entire book on the relationship of capitalism and democracy, part of which explores the role of the private market in providing health insurance coverage.\(^5\) Health care is big business. In 2007, the United States spent $2.3 trillion or 16% of gross domestic product on health care, more than it spent in any other sector of the economy.\(^6\) The Congressional Budget Office projects that by 2016, the percentage of GDP consumed by health care will equal 20%.\(^7\)

2008 was the beginning of a national election cycle and each presidential candidate had health care reform on his or her agenda. In addition, many states such as Maine, Massachusetts, and California, in the face of federal inaction, have attempted to fill the vacuum with innovative state health care legislation. All of these proposals, both federal and state, have one main goal in mind: to provide affordable and universal health insurance. The challenge for policy makers is to understand the proposals by unpacking them and looking behind the language to understand the effects that each will really have. Insuring everyone is a laudable goal, and trying to implement universal health coverage without breaking the bank is essential. But in the end, policy and ensuing legislation ultimately have to be palatable to the voters who have the power to change unsatisfactory legislators and the legislators who are more often beholden to the various special interests that make up the players in health care.

In my profession – teaching law to young, bright students – I focus primarily on health care law. My courses tend to focus as much on health policy as health law. Because my interests tend to include accessible health coverage and financing health care, we discuss these issues as social policy. How have we come to accept the twin norms in health care of enormous annual cost, $2 plus trillion, and the exclusion of almost 47 million uninsured Americans under the age of 65? When I put this dilemma to my students, they are universally appalled. But when I posit that the fairest and socially least burdensome solution might be to require the explicit cross-subsidization of the poorest and least healthy sector by the wealthiest and healthiest sector, even the most socially oriented overtly balk. With the notable exception of Medicare, the health insurance program for the elderly, which at least until recently, has been as close to true social insurance as we have, and the State Children’s Health Insurance Program (SCHIP) which insures a relatively large percentage of lower and middle-income children who are not covered by either Medicaid or private insurance, providing even a modicum of health insurance to everyone regardless of ability to pay, is anathema to most Americans.\(^8\) Yet


While that figure may be arguable because it is offset by federal government tax subsidies to employers, it is not without merit. \textit{Id.}

\(^5\) \textit{See generally} Robert B. Reich, SUPERCAPITALISM (Alfred A. Knopf 2007).


in all other first world countries, social solidarity with respect to health care, i.e., the belief that bad health is predominantly outside the individual’s ability to control and therefore the risk of which should fall on society, is a fully integrated value available to all citizens (and indeed non-citizens).

The highly skewed nature of health care costs where a small percentage of the general population accounts for a disproportionately high percentage of costs, often referred to as the “80-20 rule,” further exacerbates the access-financing problem. Insuring large groups has generally been understood to be the solution to the skewing problem. Large group insurance smoothes out the costs of unexpected health risks which, in countries like the United States with ever-increasing costs of medical technology, are expensive. Fee-for-service Medicare is the single best example of social insurance where the federal government is the only payer and the cost of use is delinked from the cost of contribution. So why not expand the social principles of Medicare to everyone? In a country which prides itself on equality of opportunity, why is there so little equality when in comes to healthcare? Why doesn’t the value of equality of opportunity translate into social solidarity?

Seeking answers to these questions is the subject matter of this essay. Risking the possibility of being labeled a socialist or at least a liberal, I posit that the most cost-effective, efficacious and efficient solution to the health care mess that we are in is universal single-payer reform with the federal government as the single-payer. But the probability of single-payer health care reform being adopted in the United States, notwithstanding the real likelihood of its offering the lowest cost solution, is unlikely. The reasons for my conclusion are certainly historical and political, but perhaps more
than that, they are cultural and economic. If some 85% of Americans currently have health insurance and access to health care, what are the incentives to do the same for the remaining 15% of Americans who have been left outside of the system?

Since former President Clinton sought unsuccessfully to bring everyone into a national health care system a decade and one-half ago, there have been virtually no federal attempts to create universal access for all Americans and the health care picture at the beginning of 2009 is significantly worse than it was in 1994, the year that the Clinton Health Security Act was defeated.\(^{15}\) In addition to the general malaise of the past administration and Congress to effectuate reform at the federal level, political and policy momentum seems to be driven by the apparent success of private markets in other sectors. The state-led reform movements as well as the presidential candidates’ health reform proposals rely heavily on the status quo of multiple payers competing in an employer-sponsored health insurance (ESI) environment.\(^{16}\) Employers who, in earlier and less expensive times were satisfied with ESI because of its federal tax subsidy, have grown more dissatisfied as the cost of health care and therefore the cost to them has risen dramatically.\(^{17}\) The growth of the uninsured has been exacerbated by continuous attempts by employers to escape the financial burden of providing health insurance to their employees. But until a good alternative exists, it does not make sense to dismantle the private system that still keeps at least 60% of Americans insured.

Even in the waning days of the Bush administration, in the interregnum before President Obama took office, there is a stirring of interest in a federal solution to the clear failure of the current health care system. The first indication that something was afoot was Senator Ted Kennedy’s caucus with other legislators interested in health care reform. The senator, who is gravely ill, has given up his post on the powerful Senate Judiciary Committee to concentrate on overhauling health care “to guarantee affordable health care, at long last, for every American.”\(^{18}\) In addition, Senator Max Baucus (D-MT), the chair of the Senate Finance Committee, has issued a white paper on health care reform –


\(^{18}\) Senator Kennedy is also chair of the Senate’s health committee said that he was taking advantage of a rare and important opportunity to get 47 million uninsured Americans covered. Posting of Jonathan D. Rockoff to Health Blog, [WSJ](http://blogs.wsj.com/health/category/health-reform/(Dec. 18, 2008)](http://blogs.wsj.com/health/category/health-reform/(Dec. 18, 2008)).
Reforming America’s Health Care System: A Call to Action – which calls for Congress in 2009 to act on meaningful health reform legislation that achieves universal coverage for all Americans while also addressing the underlying problems in our health system.\textsuperscript{19} President Obama himself has made clear the high priority that health reform has for his administration. The President, in a recent press conference, said that health costs are forcing small businesses to lay off employees or close their doors creating a disadvantage for a U.S. auto industry competing against foreign competitors “unburdened by these costs.”\textsuperscript{20} And this statement was made in advance of American businesses shedding jobs literally by the hundreds of thousands.\textsuperscript{21}

In addition to his comments indicating a commitment to health reform, President Obama indicated serious intentions about health care reform by naming former Senate majority leader Tom Daschle as secretary of the Department of Health and Human Services; he was also to get a second charge overseeing a new White House Office of Health Reform.\textsuperscript{22} The deputy director of the latter will be Jeanne Lambrew\textsuperscript{23} who co-authored Daschle’s recent book about health care reform\textsuperscript{24} and is currently a senior fellow at the think tank Center for American Progress\textsuperscript{25} had been tapped as Deputy Director of the White House Office of Health Care Reform. All of the above activity indicates that the President is serious about health care reform at the federal level and, in spite of the state of the economy, wants to be able to hit the ground running to achieve universal access to affordable, high quality health care.\textsuperscript{26}

This is a profound change from the agenda of the previous administration which thoroughly subscribed to President Ronald Reagan’s belief that government is not the solution to the problem but rather that government is the problem.\textsuperscript{27} During a recent prior attempt by Congress to expand the State Children’s Health Insurance Program, former President Bush, who twice vetoed the expanded legislation, said it was unnecessary because emergency rooms are always available to sick children who don’t have health

\begin{footnotesize}
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\item[(19)] Available at \url{http://finance.senate.gov/healthreform2009finalwhitepaper/pdf}.
\item[(20)] Posting of Sara Rubenstein, In Naming Daschle for HHS, Obama Pushes Health Reform to WSJ Health Reform Blog, \url{http://blogs.wsj.com/health/category/health-reform/} (Dec. 11, 2008).
\item[(21)] In December 2008 alone, the nation’s employers shed 524,000 jobs. \url{http://www.nytimes.com/interactive/2009/01/09/business/20080109_jobs_graphic.html} (last visited Mar. 9, 2009)
\item[(22)] Assoc. Press, Daschle Withdraws as Nominee for HHS Secretary, Feb. 3, 2009, \url{http://www.breitbart.com/article.php?id=D964904G0&show_article=1}.
\item[(23)] Jeanne Lambrew, a senior fellow at the Center for American Progress, focuses her research on the uninsured, Medicaid, Medicare and long-term care. She worked on health policy in the Clinton White House and, among other things, focused on the CHIP, the Children’s Health Insurance Program.
\item[(24)] Tom Daschle, Jeanne M. Lambrew & Scott S. Greenberger, CRITICAL: WHAT WE CAN DO ABOUT THE HEALTH-CARE CRISIS (St. Martin’s Press 2008).
\item[(25)] Posting of Sara Rubenstein, Besides HHS, Daschle to Oversee Health Reform Office to WSJ Health Blog, \url{http://blogs.wsj.com/health/category/health-reform/} (Dec. 8, 2008).
\item[(26)] The President intends to move toward universal coverage by building on ESI with an employer pay or play mandate, an expansion of Medicaid and SCHIP, and a choice of competitive private or public plans. \url{WebMD, Obama Wins: What it Means for Health Care} (last visited Mar. 6, 2009)
\item[(27)] Ronald Reagan’s inaugural address as President of the United States, January 20, 1981.
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insurance. “They’re [the Congress] going to increase the number of folks eligible through SCHIP; some want to lower the age for Medicare. And then all of a sudden, you begin to see a – I wouldn’t call it a plot, just a strategy – to get more people to be a part of the federalization of health care.”

Paul Krugman, the Princeton economist and recent recipient of the Nobel Prize in Economics, explained Bush’s veto of the bipartisan SCHIP expansion as an expression of the former President’s fear that if government can be successful at expanding health care access, Americans will be more easily persuaded that government indeed can be the answer. Since the previous administration was opposed to the federal government as the answer to social issues, one could say that Bush’s veto of SCHIP expansion was quite predictable. Before considering the future of federal plans for universal health coverage, it will be illuminating to examine some of the states’ efforts at health care reform. For some time, the popular wisdom has been that solutions to health care access, funding, and cost containment might be more likely to occur in the so-called “laboratories” of the states.

2. State Solutions to Universal Coverage

With a dearth of federal solutions to the problems created by un- and under-insurance, states have stepped into the vacuum with proposals for insuring more of their citizens. Since much of the burden of uninsurance falls on states which often end up being the payers of last resort for a population that is more costly to treat than the insured, they should be incentivized to create new solutions. And indeed at least some appear to be. The newest iteration of universal health insurance, the so-called individual mandate, is the basis for health care reform both in Massachusetts and California. These programs seek to ensure that everyone will have access to health insurance, the financing of which will be the shared responsibility of individuals and employers as well as state and federal government. In California, health care providers are also expected to contribute as a quid pro quo for higher Medi-Cal reimbursement. Each individual is required to acquire and pay for insurance. Low-income individuals in both states can receive premium subsidies to make even lower-cost health insurance policies feasible. Both states plan to modify their Medicaid programs to provide expanded coverage for low-income children and adults.

Ironically, the success of the existing health insurance paradigm – the partnership between the private sector and public health insurance programs such as Medicare and Medicaid which insures some 85% of the population – acts as a barrier to health care

29 Id.
30 The Institute of Medicine (IOM) of the National Academy of Science, has published six reports since 2003 on the effects of uninsurance on personal health, families and communities.
31 Almost one-half, 46.4% of the uninsured reside in just five states – California, Texas, New York, Florida and Illinois; this number represents 36.5% of the nation’s population. Lisa Dubay, et. al., Advancing Toward Universal Coverage: Are States Able to Take the Lead?, 7 J. HEALTH CARE L. & POL’Y 1,18-19 (2004).
32 California’s health reform proposal (ABX1 1) that incorporated individual mandates and was supported by Gov. Schwarzenegger, Speaker Fabian Nunez and Senate President Pro Tem Tom Perata was defeated in early 2008.
reform. Unless we are prepared to spend more GDP to insure the currently uninsured populations, the insured population will inevitably have to give up something to cover the uninsured. “The primary political and policy problems are that it is almost impossible to insure the ‘have-nots’ without in some way disrupting the status quo of the ‘haves.’”

With redistribution always a hard sell and the perception of the “insured haves” that universal health insurance will make them worse off, the probability of the success of explicit social solidarity or cross-subsidization seems dim.

With the resistance of those with insurance in mind, neither the Massachusetts plan nor Governor Schwarzenegger’s individual mandate plan seek to supplant or supersede the private or public programs already in place that insure the lion’s share of their populations. The model with respect to almost all reform plans is to leave the status quo alone, make incremental adjustments to already existing programs such as Medicaid and SCHIP to be more inclusive, and then to add programs to the status quo in order to cover those who still remain uninsured. For example, the federal tax advantage that has traditionally been available to employers who offer and subsidize their employees’ health insurance remains intact and is further incentivized by a possible employer mandate to either play or pay. The argument that it is neither smart, fair, nor efficient for corporate America to subsidize the cost of health care has not been heeded in this round of health care reform either at the state or federal level.

The question of whether states can succeed in improving health care access and health status remains open. On a bright note, the Massachusetts Health Care Reform with an implementation date of July 1, 2007, seems to be gaining approval by state residents according to a poll conducted by the Kaiser Family Foundation, the Harvard School of

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34 John McCain’s health reform plan is an exception to the ESI status quo paradigm. Senator McCain’s health reform plan consists of dismantling tax-subsidized ESI and using the tax savings to give each individual a $2,500 tax credit and each family a $5,000 tax credit with which to shop around and purchase any preferred and affordable health insurance policy. Senator McCain has touted his plan as giving Americans freedom of choice and the financial where-with-all to purchase individual policies that are designed to meet their health care needs. The plan is flawed for a number of reasons, not the least of which is that the average family health insurance policy costs about $12,000 to which the average employer contributes 75%. Senator McCain’s plan would create a much larger liability for many Americans potentially causing them to forego health insurance and increasing the rolls of the uninsured. David Blumenthal, Primum Non Nocere- The McCain Plan for Health Insecurity, 359 NEW ENG. J. MED. 1645-47, Oct. 16, 2008, available at http://content.nejm.org/cgi/content/full/NEJMp0806563.
35 While in Massachusetts, the penalty for failing to pay is $295 per employee, Governor Schwarzenegger’s plan calls for an employer mandate of 4% of payroll. The more aggressive pay-or-play state health insurance reform legislation, A.B. 8, ups the employer mandate ante to 7.5%.
36 Reich, supra note 5. Senator Hillary Clinton, who has scars from her last go-around with health care reform and knows well the pitfalls of threatening the interests of the vested insured population, has come out with a federal version of the individual-employer mandates, an expansion of the existing Medicaid and SCHIP programs, and subsidies for those who are neither covered by public programs nor can afford private insurance. Laura Meckler, Why Clinton Embraced Employer-Based Insurance, WALL ST. J. Sept. 19, 2007, available at http://www.democraticunderground.com/discuss/duboard.php?az=view_all&address=132x3532625. http://online.wsj.com/article/SB1190162345909131867.html?mod-loomia&loomia_si=1
Public Health and the Blue Cross. Of the 1003 Massachusetts residents polled, 67% of state residents who have heard of the law support it. Most interestingly, 90% of supporters believe “it is the right thing to do” and that broader coverage will ultimately keep costs down by providing more incentives for preventive care.  It seems worth the effort to analyze why the Massachusetts plan is currently meeting with approval among residents. How does the fairly broad agreement among Massachusetts residents that providing health care to everyone is “the right thing to do” coincide with the belief that redistributive social solidarity has traditionally been a non-starter in the United States? Is there something unique about Massachusetts that drives this result or can the Massachusetts experience, such as it is, be generalized to other venues?

What, then, accounts for the positive feedback on the individual mandate health insurance legislation in Massachusetts? First, Massachusetts has always been known as a progressive state accustomed to unusually high taxes to fund programs for the poor and underserved as well as what many perceive as overregulation by the state of health insurance. For example, Massachusetts’ uninsured population is 10.3% of the total population compared with 18.4% in California and 15.3% in the United States. Second, the individual mandate model for universal health insurance is much less traditionally progressive than a single-payer universal health insurance model. It was designed and supported by a Republican governor and is not regarded by most as the more typical liberal Massachusetts legislation. As Stuart Altman, the current dean of the Heller School of Social Policy and Management at Brandeis University and a well-respected health care guru puts it, it “is not a typical Massachusetts-Taxachusetts, oh-just crazy-liberal plan . . . [i]t is a pretty moderate approach, and that’s what’s impressive about it. It tried to borrow and blend a lot of different pieces.” However, the plan has been subjected to criticism from both sides of the political aisle and its success still remains to be seen.

Third, Massachusetts is a relatively small state with a population of approximately 6,344,500 of whom 10% or 634,450, were uninsured prior to the effective date of the Massachusetts Health Care Reform Plan. California, another state considering universal health insurance through the individual mandate model, on the other hand, has a population of 35,789,000, and 18% or 6,442,020 of whom are currently uninsured. Fourth, California’s population is significantly more diverse than Massachusetts’ and although I don’t know if I can document this assertion, it seems intuitive that social solidarity is more directly correlated with demographic homogeneity than heterogeneity.

38 KFF State Health Facts- supra
39 Mitt Romney has left the Massachusetts’ governor’s office and was a leading Republican candidate for the presidency in the 2008 elections. His national health reform agenda does not speak to universal health insurance or individual mandates. http://www.mittromney.com/Issue-Watch/Health_Care. – url didn’t work- maybe do a “last visited” in case he took down the cite
Hence, the greater the identification with others, the more likely one would be willing to help those others not as fortunate. This may well be one of the reasons why the social welfare state has succeeded best in the homogeneous societies of Western Europe and Japan.

The Massachusetts and California models count heavily on three basic elements all of which are critical to their success in achieving universal coverage: an individual mandate, an employer mandate (“pay-or-play”), and health insurance policies that are affordable to those who neither qualify for public insurance such as Medicare, Medicaid and SCHIP nor have coverage through private insurance. Each of these elements has its own difficulties. The individual mandate theoretically ensures universal coverage, i.e., that all state residents will have health insurance to enable them to seek care preventively so that disease can be treated less expensively in the early stages rather than when it has developed into an emergency condition. The employer mandate, which in California has been expanded to include providers as well, is a pay-or-play option that requires certain employers to either offer health insurance to their employees or pay a percentage of their payroll toward the cost of employees’ health coverage. Both California and Massachusetts will maintain a state purchasing pool through which those residents who do not have private or public coverage can obtain health insurance and obtain sliding scale subsidies that may apply if eligibility requirements are met.

Even though Massachusetts is the first state to achieve near-universal coverage, there are a number of criticisms of the health reform plan from both sides of the political aisle. One politically neutral observation is the risk of federal preemption of the pay-or-play provision in both plans. If the Employee Retirement Income Security Act (ERISA) is interpreted as it has been in the past, it will bar states from regulating the health benefits of employers who self-fund their health plans. To date, Hawaii is the only state with an employer-mandate that is protected from ERISA preemption by a Congressional exemption. And to date, amending ERISA to permit an employer mandate has been unsuccessful.

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41 In CA, the employer mandate applies to employers with 10 or more employees; in MA, it applies to employers who have 11 or more employees. In both cases, it applies to employers who do not choose to offer insurance options to their employees and make a fair and reasonable contribution to the cost of such insurance.

42 In CA, the minimum health insurance benefit that must be maintained will be a $5,000 deductible plan with maximum out-of-pocket limits of $7,500 per person and $10,000 per family. Governor’s Health Care Proposal. In MA, uninsured residents will purchase health insurance through a the Commonwealth Health Insurance Connector (the “Connector”), a panel of 10 MA residents drawn from business, labor, academia and state government, charged with making the decisions such as how much can low-income families afford for health care, that make all health care reform so difficult. Laura Meckler, How 10 People Reshaped Massachusetts Health Care- The ‘Connector’ Board Makes Tough Choices for Sweeping New Law, WALL ST. J., May 30, 2007, at A1.

43 Those employers who self-insure are protected from state regulation by ERISA and do not fall within any of the ERISA exceptions that would subject them from state regulation.

44 Notwithstanding the employer mandate, Hawaii continues to have a 10% uninsurance rate. Supra, note 40. David A. Hyman, The Massachusetts Health Plan: The Good, the Bad, and the Ugly, CATO INST. POL’Y ANALYSIS, June 28, 2007.

45 However, on September 30, 2008, a three-member panel of judges of the Ninth Circuit court of appeals upheld the San Francisco Health Care Security Ordinance which requires certain covered employers to
Criticisms of the right include inaccurate pricing resulting in an inadequate budget; Massachusetts budgeted $1.4 billion annually for three years and no amounts for the fourth year based on the theory that most of the money would come from diverting old funding such as federal Medicaid payments previously earmarked for safety net providers. Governor Schwarzenegger, on the other hand, received a substantial commitment from the federal government for the increase in cost to California’s Medicaid program, the expansion of which is a critical piece of the governor’s plan to cover the uninsured. In addition, there are the expected criticisms regarding governmental overregulation and the slippery slope from individual mandates toward national health care.

There are criticisms from the left side of the political spectrum as well. The most cogent criticism is that the insurance products available to uninsured populations are subpar and exclude lower income individuals whom simply cannot afford the comprehensive private plans that both Massachusetts and California promise. “[T]hat’s like promising chocolate chip cookies with no fat, sugar or calories. ‘The only way to get cheaper plans is to strip down the coverage – boost copayments, deductibles, uncovered services, etc.”

A second criticism of the individual mandate is that it is administratively expensive compared with single-payer systems. Related to the problem of administrative costs is a third problem endemic to the world of private insurance, even mandated private insurance. For-profit insurers are incentivized and, in the case of publicly-held companies, are required to be profitable for their shareholders. This natural profit motive creates a bias in favor of a relatively low medical loss ratio which is defined as the percentage of the insurance premium dollar spent on member health care versus administration and profit. A single-payer universal health care would not be profit-oriented and therefore would be biased in favor of high medical loss ratios so that the vast majority of the budget would be dedicated to health care costs. Medicare, a single-payer system that pays for health care for the elderly, has administrative costs of 3%, an
argument that proponents of single-payer systems raise frequently in defense of that model.\textsuperscript{53}

3. Federal Health Insurance Initiatives: Can We Get to Universal Coverage?

Notwithstanding credible evidence that a single-payer model could produce a more equitable and more efficient health care system, its absence is notable in the morass of health care plans currently being advanced not only by the states but also by 2008 presidential candidates\textsuperscript{54} who, no doubt, recognize the political barriers to such a wholesale change in health care policy.\textsuperscript{55} Even a single-payer system that would be more universal, equitable, efficient, and perhaps less expensive than any other model is a political non-starter. As early as September, 2007, such diverse groups as political candidates, congressional members, and the administration were beginning to raise the specter of socialized medicine whenever there is talk of increasing the federal government’s role in paying for health care.

While there seems to be agreement on the need for universal coverage, there is little agreement about how to get there. But there does seem to be agreement about one thing: the vehicle will not be universal health insurance provided by a single-payer, the federal government. Republicans generally subscribe to the private market as the solution. There are many who would not dismantle the employer subsidized private market and would ramp up the choice of health savings accounts and high deductible catastrophic coverage policies for employees and individuals.\textsuperscript{56} Most of the proponents of private market solutions recognize the need and indeed the value of premium assistance, either in the form of subsidies or tax credits, for the working poor who are not

\textsuperscript{53} A recent study by The Council for Affordable Health Insurance states that because of the size of Medicare, some of its administrative costs are hidden and that taking those hidden costs into consideration, the administrative costs of the program are more like 5.2%. MERRILL MATTHEWS, MEDICARE’S HIDDEN ADMINISTRATIVE COSTS: A COMPARISON OF MEDICARE AND THE PRIVATE SECTOR (2006), available at http://www.cahi.org/cahi_contents/resources/pdf/CAHI_Medicare_Admin_Final_Publication.pdf.

\textsuperscript{54} In California, Democratic Senator Sheila Kuehl has been sponsoring single payer health care legislation, SB 840, which requires both individuals and employers, ala Social Security and Medicare, to contribute toward funding of health care. The state insurance fund would cover a standard benefits package for all Californians; in addition, Californians would have access to a supplemental insurance private market. http://www.calhealthreform.org/index2.php?option=com_content&task=view&ed=37&pop. (couldn’t access source)

\textsuperscript{55} Having experienced the defeat of the Health Security Act in 1994 of which she was one of the chief architects, Senator Hillary Clinton understands the political resistance to wholesale change. Senator Clinton’s universal health care proposal, like those of her rivals Senator Obama and former senator John Edwards, builds on the existing health care system by expanding it to provide health care coverage to the 47 million Americans who do not already have coverage. http://www.washingtonpost.com/wp-dyn/content/article/2007/09/17/AR2007091701026_p

\textsuperscript{56} The 2003 Medicare Prescription Drug, Improvement and Modernization Act, which literally squeaked through Congress after much arm-twisting by the administration, would probably not have passed but for a provision that authorized HSAs in private plans as well as an option for Medicare beneficiaries. Susan A. Channick, The Medicare Prescription Drug, Improvement, and Modernization Act of 2003: Will It Be Good Medicine For U.S. Health Policy?, 14 ELDER L.J. 237, 264 (2006) [hereinafter Will It Be Good Medicine?]. While HSAs may be an excellent option for the healthier, wealthier and more informed health care consumer, such high deductible insurance does not pencil out for sicker, poorer populations who cannot afford a $5,000 deductible anymore than they can afford expensive premiums. Id. at ?
eligible for public assistance but can ill afford private insurance particularly in the individual market.

For Democrats and moderate Republicans who are willing to concede that the private market has not provided all the answers, the prevailing reform model does not dismantle the current employer subsidy system or the existing public programs like Medicare, Medicaid and SCHIP. Instead, it attempts to close the gaps for the uninsured by expanding existing public coverage and making affordable insurance available to those who remain outside of the system through individual and employer mandates. While acknowledging the drawbacks and problems with the current employer-based health insurance system, all presidential candidates have chosen not to dismantle it because of the political expediency of continuing to support it. As now-Secretary Hillary Clinton has said, one of the lessons she drew from the failure of the Health Security Act was that insured Americans get nervous if they think their coverage will have to change.57 “The trade-off for a political buy-into universal coverage in 2008 may be keeping the current system intact so as to satisfy the 60% of the population that currently have employer-based coverage.” 58 As the employer-based system continues to erode as the cost of health care continues to outstrip the growth of the economy, satisfying the insured population will become politically more expendable and other models may become more attractive. The challenge to this author is to understand why the resistance to a single-payer universal health care system is so great as to preclude it almost entirely from consideration.

If the polls are right and a majority of Americans believe that all Americans are entitled to access to health care, then isn’t the obvious answer a single-payer universal health insurance system with the government as the single-payer? Why retain the current system of which the linchpin has been the employer mandate in light of its diminishing success? The number of Americans insured by their employers continues to decrease both because fewer employers are offering group health insurance as an employment benefit because of its cost, and because of increases in the employee share of cost which has made employer-based health insurance unaffordable to many employees. Will there ever come a point where the majority of Americans will prefer government funded health insurance?

a. Hillarycare Redux

The popular wisdom has been that unless and until the middle-class employed population feels the pain of difficult-to-obtain, expensive health insurance, the health insurance status quo, i.e. employer-sponsored health insurance, will be hard, if not impossible, to change. Whether or not that time has arrived, the conflict that insured Americans are wrestling with, at least when they are made aware of it, is between their desire to retain their vested insured status and their belief, like the residents of

58 Id.
Massachusetts, that broader coverage is the right thing to do.\(^59\) Secretary Clinton’s health insurance proposal as the putative Democratic candidate demonstrated her perfect understanding of this dilemma.\(^60\) She knew, no doubt from past experience with health care reform, that insured Americans would resist change that infringes on their insured status even if that coverage is more expensive to them than ever before. So she attempted to provide universal coverage without disturbing the status quo. And, to a large extent, that is what both the Massachusetts and California individual mandates are seeking to do as well.\(^61\)

Secretary Clinton’s last experience with health reform, the Health Security Act which dissipated under heavy weight of disapproval from a myriad of sources, also sought to provide universal coverage using managed competition.\(^62\) This managed competition system would have supplanted, not supplemented, existing employer-based health insurance to which employers would have been required to contribute and which virtually all Americans would have been required to be insured. Employers with 5000 or more employees could opt out of the scheme and become their own insurer.\(^63\) The HSA envisioned the use of health alliances run by the states as regional purchasing groups that would collect and distribute premiums, certify health plans and offer them to consumers,\(^64\) assure that average premiums grew no faster than federally set limits, and negotiate with doctors and hospitals to set fees for services provided outside of HMOs.

The failure of the Health Security Act has been attributed to a multitude of factors: its undue complexity, the increase in bureaucracy and government incursion into health care, the perception of a secret process led by the then first Lady, resistance by multiple vested interests such as the health insurance industry (AHIP), and the

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\(^{59}\) See fn supra referencing the poll taken by KFF, HSPH & BCM on the Massachusetts Health Reform Act.


\(^{61}\) Both the MA and CA individual mandates do not disturb employment based insurance and create a pay-or-play employer mandate that requires employers of more than 10 employees either to provide health insurance to their employees or pay a percentage of payroll to a fund through which health insurance could be purchased.

\(^{62}\) Managed competition is a market-based strategy for restructuring the health care industry. It attempts to organize the market for health care finance to make health insurers, managed care plans and health plans to compete with each other for beneficiary enrollment. Managed competition usually requires health plans to sell a uniform product or a manageable number of standardized products to permit price and quality comparisons. Because of the likelihood that health plans will select enrollees who are better risks, explicit risk selection is explicitly forbidden and open enrollment and community rating required. BARRY R. FURROW ET. AL., THE LAW OF HEALTH CARE ORGANIZATION AND FINANCE 150-53 (5th ed. 2004). Medicare Part C, Medicare Advantage, is an attempt to apply a market-based approach to Medicare, our best and last example of social insurance in health care.


\(^{64}\) The available plans, each priced differently depending primarily on the amount of choice given to subscribers, included (1) the Basic plan which would provide health care through an HMO; (2) the Midlevel PPO-type plan; and (3) the Premium which was basically a fee-for-service or indemnity insurance plan. Rob White, The Great Healthcare Debate – President Clinton’s Health Security Act Proposal from a Small-Business Perspective, Watchdog, Jan. 1994, [http://findarticles.com/p/articles/mi_m1563/n1_v12/ai_15035372/print](http://findarticles.com/p/articles/mi_m1563/n1_v12/ai_15035372/print).
association for independent businesses (NFIB), as well as key legislators who were prodded by a strategy document circulated by leading conservative operative William Kristol seeking to kill, not amend, the plan, as well as the much less Machiavellian discomfort of the other health care players. Less overt but equally as important was the resistance of the majority of Americans who were happy enough with the insurance that they had through their employment and feared that the change would somehow diminish their insured status.

While it seems clear that the Bush administration has made serious efforts to privatize government financed health care, I believe that the fear of large government incursions into health care generally cannot be overestimated. When then-Senator Clinton announced her health plan as a presidential candidate, former Mayor Giuliani, the otherwise most moderate of Republicans who were making a run for the 2008 Republican presidential nomination, said that her plan was “essentially the Michael Moore-Hillary Clinton approach which is let’s see if we can build socialized medicine.” And former Massachusetts Governor Mitt Romney, who was also a Republican presidential candidate and the primary architect of the individual mandate plan now in effect in Massachusetts, criticized Senator Clinton’s plan as “government insurance, not private insurance. It’s European-style socialized medicine.” Their comments, it appears, were calculated to appeal not only to a Republican voter constituency, but also to moderate Democrats fearful of socialized medicine. Clearly, in this context, the adjective “socialized” in connection with “medicine” is intended to be an unattractive descriptor of health care reform that is meant to make health care affordable and available to all Americans.

b. SCHIP: The Canary in the Coal Mine

Notwithstanding that Secretary Clinton’s proposed health care reform plan did not make the federal government the single-payer for her Health Choices Plan, it apparently can be criticized as socialized medicine, leading one to ask what exactly the label “socialized medicine” means to Americans. Although Medicare, our clearest example of social insurance has a single public payer – the federal government – it is a partnership of government with private providers. Notwithstanding that Medicare is not socialized

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66 The Medicare Advantage program was added to Medicare in an attempt to shift beneficiaries from fee-for-service Medicare to market-based managed competition. Medicare Part D, which added a prescription drug benefit to Medicare beginning in 2006, requires Medicare beneficiaries to participate in a managed competition stand-alone prescription drug plan or alternatively get prescription drug coverage through a Medicare Advantage health plan. Channick, Will it be Good Medicine? supra, note 28. A current example of the administration’s determination to play a diminished role in the provision and financing of health care is President Bush’s threat to veto expanded SCHIP legislation passed by both the House and Senate; only the Senate vote immunizes the bill from a presidential veto.


medicine but rather a single-payer system that relies on the private sector for the provision of health care, a majority of Americans believe Medicare is socialized medicine but that the Veterans Health Administration (VHA), which is most similar to European socialized medicine, is not. The threat of socialized medicine has been used to block numerous health reform efforts by playing on Americans’ fears of communist or socialist states such as China, Cuba and the former USSR. As a recent example demonstrates, the SCHIP, the joint state/ federal legislation that insures low-income children not eligible for Medicaid, was recently embroiled in a messy conflict between Congress and the President, in which the epithet “socialized medicine” was frequently used. To a large extent, the SCHIP expansion debate put the question of who is entitled to health care in stark relief.

The Balanced Budget Act of 1997 (BBA) originally budgeted $24 billion over ten years in federal funds to subsidize the SCHIP, but the program has instead cost the federal government $40 billion. While there was no explicit eligibility limit in the original legislation, the Department of Health and Human Services’ (DHHS) understanding was that SCHIP would target children at no greater than 200% of poverty level. SCHIP’s original authorization expired on September 30, 2007, and a debate over its reauthorization raged. Both houses of Congress passed their own version of the SCHIP reauthorization legislation that differed in many ways but similarly expanded the reach of the program to greater than 200% of poverty level. Then-President Bush consistently said that he would veto the bicameral legislation. Both bills funded their SCHIP expansion by an additional federal excise tax on cigarettes raising the issue that

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69 According to a recent poll conducted by the Harvard Opinion Research Program at the Harvard School of Public Health and Harris Interactive, although the phrase “socialized medicine” has been used to attack health reform proposals in the U.S., Americans are now split on whether a socialized medical system would be better or worse than the current system. About sixty percent of those surveyed believe that Medicare is socialized medicine. Press Release, Harvard School of Public Health, Poll Finds Americans Split by Political Party Over Whether Socialized Medicine Better or Worse Than Current System (Feb. 14, 2008), available at http://www.hsph.harvard.edu/news/press-releases/2008-releases/poll-americans-split-by-political-party-over-socialized-medicine.html

70 The VHA qualifies as a socialized system of medicine under the strictest definition. The VHA provides medical services to retired, disabled, or recently discharged military personnel who are eligible to receive benefits. VA medical benefits are only redeemable at VA hospitals and medical centers, which are owned and operated by the government; health care providers working within the VHA are government employees. Maria Bizzle, Denise Fraga, Laurie Seremetis, Jeanne Lambrew, The Specter of Socialized Medicine, CENTER FOR AMERICAN PROGRESS, May 14, 2008 http://www.americanprogress.org/issues/2008/05/socialized_medicine.html/print/html.

71 Id.


74 On August 1, 2007, the House of Representatives passed its version of SCHIP reauthorization (HR 3162) by a margin of 225-204. The Senate version of the reauthorization (S. 1893) passed on August 2, 2007, by a vote of 68-31 making it veto-immune.
cigarette taxes, like all so-called sin taxes, are regressive and therefore unfair. However, the bigger issue was the expanded reach of SCHIP which opponents of the legislation said would cost the federal government substantially more than the BBA had estimated and exacerbate the “crowd out” that was already occurring under the originally authorized legislation.

Crowd out occurs when people who have private insurance coverage drop that coverage in favor of getting coverage from a government-run insurance program. A recent study by Professors Jonathan Gruber and Kosali Simon on crowd out in SCHIP found the rate to be 60%, i.e. for every ten new children in SCHIP, private coverage of children declines by six. Predictions by the Congressional Budget Office on crowd out for the reauthorized SCHIP is 42%; of three million children who are predicted to enroll in the SCHIP, 1.4 million will previously have had private insurance that their parents discontinued in favor of public insurance paid for by taxpayers. It is this “free lunch” rationale that the former President objected to.

But perhaps even more philosophically fundamental is what I would call the President’s slippery slope argument: increased crowd out will move more children from private insurance to public insurance, fueling a strategy the President calls “the federalization of health care.” How that argument could literally be true seems improbable given the design of the SCHIP as an insurance program that generally does not create new nor expand existing federal entitlements. In fact, in the large majority of cases, states have chosen to use Children’s Health Insurance Program (CHIP) dollars to subsidize premiums for insurance products privately purchased for CHIP beneficiaries.

75 The SCHIP reauthorization legislation would raise the federal excise tax to as much as $100 per pack under the Senate version. An increase in the federal excise tax could have a negative effect on state revenues that come from state sin taxes. The Center for Tobacco Policy & Organizing, Federal Legislative Update August 8, 2007 at www.Center4TobaccoPolicy.org.

76 If SCHIP funding were to remain at its current level, it would cost about $25 billion over five years and $50 billion over ten. 42 U.S.C.1397 (d)(d), The State Children’s Health Insurance Program: Allotments. According to the CBO, the House bill would cost $47.4 billion over five years and $128.7 billion over ten. Letter from Peter R. Orszag, Director, Cong. Budget Office, to Charles B. Rangel, Chairman, Comm. on Ways and Means, Estimated Effect on Direct Spending and Revenues of H.R. 3162, the Children’s Health and Medicare Prot. Act, for the Rules Comm., July 30, 2007, available at cbo.gov/ftpdocs/85xx/doc8501/hr3162Rangel.pdf.

77 This is a term coined in 1996 by Professors David Cutler and Jonathan Gruber for the same phenomenon in states which expanded their Medicaid coverage. David Cutler & Jonathan Gruber, Does Public Health Insurance Crowdout Private Insurance?,111 Q. J. ECON. 391, (1996).


80 See generally Sara Rosenbaum, SCHIP Reconsidered: Reauthorization of SCIP Offers an Opportunity to Consider the Program with a Fresh Eye and to View this Modest Program in the Broader Context of Recent Changes in Medicaid, 26 HEALTH AFF., Aug. 14, 2007, available at http://content.healthaffairs.org/cgi/reprint/hlthaff.26.5.w608v1

Nonetheless, the ideological debate about the expansion of SCHIP and universal health care has begun. A recent editorial in the Wall Street Journal called Congressional plans to expand SCHIP a dress rehearsal for the health-care fight in 2008 and a Democratic effort to “expand government control of health care and undermine private insurance . . . Democrats think they have a political winner in the guise of helping ‘children,’ but the House bill shows that their higher priority is expanding government.”82 As political journalist Paul Krugman noted in a recent op-ed piece in the New York Times, wanting the public to believe that the government is always the problem, never the solution, is at the core of the President’s philosophy. “It’s not because he thinks the plans wouldn’t work. It’s because he’s afraid that they would. That is, he fears that voters, having seen how the government can help children, would ask why it can’t do the same for adults.”83

c. What We Know About the High Cost of Health Care:

The problem of providing universal health care is confounded by many factors including policy, politics, economics, and philosophy. There seems to be little doubt that individuals and populations are healthier with affordable access to regular health care that seeks to prevent disease, promote wellness, and detect and treat disease in the earliest possible stage.84 If this premise is correct, the cost of health care in the United States, currently at $2 trillion with annual growth well in excess of the growth of the economy,85 should start to flatten out. There is little question that the distribution of health care costs is highly skewed with a small percentage, 5%, of the population accounting for a disproportionately large percentage, 49% or almost half, of total health care expenditures.86 On the flip side, the 50% of the population with the lowest health care expenditures account for only 3% of total health care spending with high-cost users spending 17 times as much as low-cost users.87

1) High Cost Users

Who are these high-cost users? They are primarily people with multiple chronic conditions who are elderly and may have had little or no access to health care prior to

85 Health Care Spending to Double by 2016, 12 BNA 24 (Feb. 21, 2007).
87 Id.
their eligibility at age 65 for Medicare. As discussed earlier in this paper, health care expenditures tend to be highly skewed; small percentages of the population account for a disproportionately higher share of costs with the converse being true as well. The question is whether the focus of health care cost reduction research should be spent on identifying both high-cost populations and interventions that mitigate expenditures rather than on techniques to reduce expenditures in the general population. The latter are the mitigating techniques that have been identified as those that tend to discourage health care use in the general populations such as high deductibles and co-payments, and systems of managed care.

Assuming high-cost populations could accurately be identified, what kinds of strategies could be successful in reducing their cost of care? One possibility that has had extremely limited success is the Oregon Medicaid initiative which prioritized the expenditures that the state would reimburse under the state Medicaid program. The approach taken by Oregon did not reimburse certain high-cost procedures such as heart, liver, pancreas or bone marrow transplants. Notably, Oregon’s explicit approach to the allocation of Medicaid resources has not been adopted by any other jurisdiction and it seems impossible to this author that Medicare could or would take this approach, at least explicitly.

A second possibility for cost reduction is disease management programs which attempt to identify beneficiaries with specific chronic conditions and then provide care designed to produce better outcomes and save money. These disease management programs may vary widely in the techniques used but share certain goals to achieve higher quality lower cost care: patient buy-in through education of how to use medication properly; regular monitoring of clinical symptoms and treatment plans using evidence-based standards; and coordination of care among providers including physicians, hospitals, laboratories, and pharmacies. A third possible way to reduce costs would be to put someone in the system in charge of managing the care of patients, particularly patients with multiple chronic disease or elderly frail patients, perhaps a primary care physician who would provide a so-called “medical home” that would include case and disease management. In the United Kingdom, where such a system exists, primary care physicians are able to earn bonuses for keeping their patients healthy.

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88 CONG. BUDGET OFFICE, HIGH COST MEDICARE BENEFICIARIES (2005) [hereinafter HIGH COST BENEFICIARIES]
89 See supra notes 59-60 and accompanying text.
91 HIGH COST BENEFICIARIES, supra note 88.
92 Concentration of Expenditures, supra note 90.
94 Concentration of Expenditures, supra note 90.
States, the medical home model has been endorsed by the major primary care specialists to more effectively support the core functions of primary care and the management of chronic diseases.  

2) Reimbursement Incentives: Treatment vs. Prevention

Related to the impact of reducing the cost burden of chronic disease is the equally compelling issue of disease prevention and the role of lifestyle choices. A recent study researching sources of the U.S.-European health spending gap found significant differences in disease prevalence and rates of medication treatment in the older adult populations of the United States and Europe. The study showed that the prevalence of some chronic diseases in the United States’ older adult population was twice that in similar European populations. According to lead study author Kenneth Thorpe, chair of the Health Policy and Management Department at Emory University’s Rollins School of Public Health, “[w]e expected to see differences between disease prevalence in the United States and Europe, but the extent of the differences is surprising . . . [i]t is possible that we spend more on health care because we are, indeed, less healthy.” The study demonstrated that the prevalence of both obesity and tobacco use was significantly higher among older adults in the United States than in Europe although the connection between these life-style choices and the prevalence of chronic disease was not established.

The recommendation of the study group was that reducing chronic disease should be a key policy goal in the United States. In an interview with the Los Angeles Times, Professor Thorpe noted that the U.S. health care system is neither preventive nor proactive. “We wait for people to get sick. They show up. We treat them. And doctors and hospitals get paid. That’s not a very good way for managing diseases.” A second recent report on the economic burden of chronic disease by the Milken Institute, a private economic think tank based in Santa Monica, California, states that much of chronic disease is preventable and that a reorientation toward prevention could avert 40 million cases of seven chronic diseases by the year 2023. “That would reduce anticipated treatment expenses associated with the seven diseases and improve productivity by $1.1 trillion that year.” Both studies pointed to reimbursement practices of both Medicare and private plans that incentivize treatment rather than prevention. Professor Thorpe said he hoped his comparative study would “help to shift the focus of the debate over

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99 Id.
healthcare reform away from arguing about who pays for what to a focus on preventing disease that affect the quality of life and run up costs.”  

3) What We Know Matters: Comparative Effectiveness Research

So if we believe and can prove to some extent that universal affordable access, prevention, early diagnosis and disease management all lead to more effective, less-costly health care, why are we so resistant? First, we have not spent the money necessary to have really good empirical data about what works and what doesn’t. We have some data from which we can infer conclusions but not many. Robert Reischauer, President of the Urban Institute, believes that until we have really good research on what works most effectively and efficiently, we are condemned to a cycle of failure. We need “information on the comparative performance of alternative health delivery systems in a way that we can convince the American people that integrated health care systems that use resources parsimoniously have as good or better outcomes than the a la carte, uncoordinated systems we have, so that health reform to them does not mean that we are taking something away.”

Paul Farmer, the physician/anthropologist who believes and lives the credo that the best can sometimes be the enemy of the good, provides extremely effective but quite inexpensive health care to very poor, very sick populations in Haiti. The message that Reischauer echoes is that very expensive health care modalities are often not more efficacious than less expensive ones. However, without empirical evidence of that fact, it is impossible to make such assertions. As has been discussed, Americans generally oppose policy changes that might threaten their insured status and, as we know, in the United States, policy and politics are inextricably intertwined.

Until the recent discussion about comparative effectiveness, the current research has been focused on determining whether or not technologies are effective, i.e. the outcomes of research. But as the many constituencies who are supporting comparative effectiveness point out, such a center would go a long way toward improving health care as well as containing costs in a rational way. Gail Wilensky, an economist, a senior fellow at Project Hope and a former administrator of Health Care Financing Administration, the precursor of Centers for Medicare and Medicaid Services, who

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103 Europe Healthier Than U.S., supra note 101.
recently wrote a comparative effectiveness piece for *Health Affairs*\textsuperscript{107}, says, “[w]e need to find ways to spend smarter,”\textsuperscript{108} regarding the future of health care.

d. **Health Care Cost Containment**

Dr. Wilensky’s words echo universally. Whatever process for universal health care coverage that is adopted, keeping health care costs in check must be part of the plan. According to Henry Aaron and Joseph Newhouse, two prominent health economists,

\[\text{t}\]he stakes in achieving such control are enormous. If health care spending outpaces income growth by 2 ½ percentage points a year – a bit less than the historical average of the past four decades – and if economic growth proceeds at the rate projected by the CBO, per capita income available for purposes other than health care will still grow strongly for the next decade, but then will stagnate and eventually fall. Simply put, the United States faces a *health care financing challenge – public and private* - that it cannot ignore.\textsuperscript{109}

Aaron and Newhouse make clear that the problem isn’t simply that we are drowning in general entitlement costs – Medicare, Medicaid, and Social Security – but that the more pressing problem is the out-of-control health care costs in both the public and private sectors where the same financing and delivery issues exist.\textsuperscript{110}

Health care reform faces a number of challenges, at least two of which this piece addresses. One is universality and that every American should be able to afford access to meaningful health care. Currently, at least 45 million Americans are uninsured. The other challenge is cost containment, that ever-increasing health care costs must be addressed. Currently, the United States spends in excess of $2 trillion annually, more than $7000 for each man, woman and child, and more than we spend on any other sector of the economy. While the clarion call is usually universal coverage, it is now cost containment without which universal access may be unfeasible. The irony of course is that cost containment will not be achieved without universal access. Overuse of hospital emergency departments, too much uncompensated care, unnecessary or non-efficacious treatments, continuous improvements in expensive technology, uncoordinated care, coverage and reimbursement administrative costs, the heavy presence of the for-profit


\textsuperscript{110} Henry Aaron, health economics at the Brookings Institute, argues that the real problem is health care spending in both the private and public sectors, not the sheer cost of public entitlements. He argues that if we can get control over health care spending, we will solve the entitlement crisis. Henry J. Aaron, *Budget Crisis, Entitlement Crisis, Health Care Financing Problem – Which Is It?*, 26 *Health Aff.*, (2007_), available at http://content.healthaffairs.org/cgi/content/abstract/26/6/1622.
sector, grossly disproportionate compensation arrangements in not only the for-profit sector but also the not-for-profit sector, insufficient preventive care – all of these drive health care costs in both the public and the private sector.

4. The Universal Single-Payer Option: The Barriers of Inertia, Free Market, and Culture

There are many other reasons why health care reform does not and will not include a shift from a multiple-payer private market model to a public single-payer model. Though I will present the reasons in what seems to me to be a logical order, the order is not intended to be one of descending importance to the outcome. Some of these reasons have already been articulated and others not; some reasons are apparent and others more hidden. Taken together, they represent the overwhelming odds against the adoption of tax-financed national health insurance.

First, approximately 84% of Americans currently have health insurance that they probably are happy enough with and fear losing. That includes employer-sponsored, both private and public, insurance that comes from public programs like Medicare, Medicaid, and SCHIP that are not employment-related, and individual policies. The majority of the insured perversely wait to get old enough to be eligible for Medicare, an almost incomprehensible perspective in an otherwise youth-oriented society. Just as Social Security and Medicare are considered the third-rail of politics, so too is a large percentage of the current system by which Americans have access to health insurance. However fragmented, inequitable, unfair, impermanent, and regressive it is, having health insurance calms people’s fears of the catastrophic financial consequences of noninsurance. The current entrenched system survives in spite of altruistic instincts to the contrary, i.e., that the system is unfair to the uninsured outsiders. This is part of the inertia barrier.

Another part of the inertia barrier is what social scientists call “path dependence,” i.e. the evolution of institutions based on past experience. As Robert Putnam has observed, “what comes first, even if it was ‘accidental,’ conditions what comes later.” This theory is easily demonstrated by the health care system that we have in the United States and that we seem wedded to notwithstanding its acknowledged failures or the fact that we might indeed do better if we could do it again. Our system with its multiple

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112 Insurance premium costs are usually distributed equally across all of the insured in the pool making them regressive with respect to their effect on low and high earners. Jonathan Oberlander, *The Political Economy of Unfairness in U.S. Health Policy*, 69 LAW & CONTEMP. PROBS. 245, 250 - 51 (2006); Clark Havighurst and Barak Richman call attention to other distributional unfairness such as the so-called “head tax” that insurers pass on to insureds to cover the cross-subsidization costs imposed by monopolistic providers. Clark C. Havighurst & Barak D. Richman, *Who Pays? Who Benefits? Distributional Injustices in Health Care*, 69 LAW & CONTEMP. PROBS. 7 (2006).

113 Oberlander, supra note 112, at

114 See fns and accompanying text (on the poll taken of MA residents by Kaiser and HSPH on residents’ satisfaction with reform plan)


payers from both the private and public sectors is the result of an historical accident of
WWII wage freezes and the persuasiveness of President Lyndon Johnson in convincing
Congress to enact Medicare, our only true social insurance program.\(^{117}\) Because of the
current system’s sunk costs and entrenched players, it would be enormously difficult to
adopt a universal single-payer system. And so the momentum for change is heavily
weighted in the direction of existing institutions rather than in the direction of an entirely
new system. This phenomenon of accident as opposed to planning is not unique to the
United States; the health care paths taken in the both the UK and France were extensions
of systems that already existed rather than the products of analysis and planning.\(^{118}\) And
they both seem to work well for the citizens of their respective countries.\(^{119}\)

How our health care system – mostly its access and financing – became linked to
employment rather than to Social Security is a story well and completely told by many
others. After WWII, with much of the workforce returning from war and seeking
employment, President Roosevelt was concerned about wage inflation because of the
competition among employers to attract employees. The result was a freeze on wages so
that employers, who were foreclosed from attracting employees with higher salaries,
began to use employment benefits such as health insurance for that purpose. The linking
of employment and health insurance was facilitated by companies that might not have
been trying to attract better employees but instead were trying to resist unionization of
their shops.\(^{120}\) The linkage between employment and health insurance was solidified by
its favorable tax treatment – a deduction to the employer and non-inclusion of the health
insurance benefit in the employee’s income – that was intended to incentivize employers
to provide health insurance.\(^{121}\) Today, the favorable tax treatment of ESI has been
estimated to equal foregone revenue of $225 billion annually, which if eliminated, would
be a good down-payment on the adoption of a universal single-payer system.\(^{122}\)

The adoption of Medicare, the social health insurance system for the elderly, in
1965, was intended by its proponents to be the first step toward embracing a universal
single-payer system. As Robert Ball, Social Security’s commissioner from 1962-1973,
later admitted, incrementalism was the covert strategy for achieving universal health
insurance coverage.\(^{123}\) “We saw insurance for the elderly as a fall back position, which
we advocated solely because it seemed to have the best chance politically. [W]e
expected Medicare to be a first step toward universal health insurance, perhaps with
‘Kiddiecare’ as another step.”\(^{124}\) Part of the reason that this strategy has mainly failed is

\(^{117}\) See generally RICK MAYES, UNIVERSAL COVERAGE: THE ELUSIVE QUEST FOR NATIONAL HEALTH

\(^{118}\) Gawande, supra note 115.

\(^{119}\) In 200, the World Health Organization ranked the French system the best health care system in the
world with the United States coming in at 37\(^{th}\). Id.

\(^{120}\) THE ELUSIVE QUEST, supra note 117, at 45-46

\(^{121}\) Statement of Professor Jonathan Gruber For Health Reform Summit 2008 (July 16, 2008), available at

\(^{122}\) Id.

\(^{123}\) THE ELUSIVE QUEST supra note 117, at 81

\(^{124}\) Robert Ball, Medicare’s Roots: What Medicare’s Architects Had in Mind. Generations 20 (Summer
1996): 13. Ironically, although a universal single-payer system has never been adopted, the next population
to achieve near universal coverage is children through the now-expanded SCHIP.
because of the high costs of Medicare which emerged as problematic very early on. That Medicare Part A funded by the same type of payroll tax as Social Security is perpetually on the verge of insolvency makes a universal social insurance system predictably frightening to legislators and voters alike. But as Henry Aaron points out, it isn’t the high costs of public entitlements that we should fear; it’s the high and uncontrolled costs of health care whether in the public or private sector.\footnote{125}

As Rick Mayes explains, part of the reason for Medicare’s profligacy was Congress’ fear of alienating providers, what others have called the “politics of accommodation.”\footnote{126} Both physicians and hospitals were initially given a license to spend in an effort to cement the attractiveness of the program. This complete lack of fiscal restraint resulted in an astonishing growth not only in Medicare expenditures but also health care expenditures in general, with general health care expenditures totaling $38.9 billion or 5.9 GDP in 1965 and $247.2 billion or 9 GDP by 1980.\footnote{127} On the one hand, this spike in health care costs has soured Medicare’s reputation and diminished the political viability of Medicare as a model for national health insurance.\footnote{128} On the other hand, the enormous stakes in the fragmented system that we do have – private multipayer employer-based insurance as the centerpiece with public programs such as Medicare, Medicaid, SCHIP, and the VA for select populations – make it seemingly impossible to move in another direction. So the great likelihood is that we will continue to build on what we have toward the goal of universality.

Second, the belief that the private sector can better solve problems, even social problems, than government - the free market barrier - is also entrenched and difficult to dislodge.\footnote{129} This is true in spite of the forty or so years of Medicare success, which is a federal social insurance program that not only provides fee-for-service insurance for seniors using a prospective payment system but also acts as the policy-making body.\footnote{130} Notwithstanding its limited beneficiary pool, i.e. approximately 44 million individuals 65 and older or disabled, and its cost of $374 billion in 2006,\footnote{131} a Republican administration and Republican controlled legislature added an expensive benefit to the Medicare program to provide outpatient prescription drug coverage for Medicare beneficiaries.\footnote{132}

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\footnote{125}{Henry J. Aaron, Budget Crisis, Entitlement Crisis, Health Care Financing Problem – Which Is It?, 26(8) \textit{Health Aff.} 1623, Nov/Dec 2007.}

\footnote{126}{\textit{The Elusive Quest}, supra note 117, at 84-85 (citing Medicare experts Theodore Marmor and Paul Starr).}

\footnote{127}{\textit{Id.} at 87. Today the United States spends $2.2 trillion or 16% of GDP on health care expenditures.}


\footnote{130}{CMS is the federal government agency charged with not only administering the Medicare program but also with making policy such as the scope of covered services, reimbursement to providers, and regulation of Medicare supplemental insurance.}

\footnote{131}{2006 was the first year that Part D of Medicare, which provides an outpatient prescription drug benefit, was available to Medicare beneficiaries. In 2006, nine percent of the $374 billion Medicare price tag was attributable to outpatient prescription drugs. Kaiser Family Found., Medicare Spending and Financing, Fact Sheets, June 2007, \url{http://www.kff.org/medicare/upload/7305-02.pdf}.}

\footnote{132}{See generally \textit{Will it be Good Medicine}, supra note 56.}
Medicare Part D is estimated to cost the federal government and taxpayers at least an additional $500,000 billion over the next eight years. While its passage was, in the vernacular, a squeaker, a Republican administration and legislature added appreciably to a high-cost, albeit popular entitlement program. How this seeming conflict can be explained is the story behind the story of the Medicare Modernization Act (MMA).133

Why historically small government Republicans could be pressured into agreeing to add an expensive prescription drug benefit to an already expensive entitlement program is, to a large extent, due to the program’s design. Unlike Parts A and B of Medicare where the federal government is the insurer, Part D coverage can only be purchased through so-called private drug plans that compete with each other to provide prescription drug benefits at competitive prices.134 The MMA, while touted as the first meaningful expansion of the Medicare benefit structure in almost 40 years, became law because the administration was able to convince reluctant legislators that it represented the beginning of the privatization of Medicare. For a President who promoted the notion of an “ownership society” from the beginning of his first term by putting the privatization of Social Security at the top of his domestic agenda, privatizing health care was not a surprising or unexpected move. As Rashi Fein, Emeritus Professor of Medical Economics at Harvard Medical School, says, “[t]he administration believes we are millions and millions of individuals not bound together into a society… [and] medical care is just another good or service that we purchase as we will in the marketplace subject to normal market forces.”135 As Professor Fein notes, this is the antithesis of the belief that we are a society of individuals who assist each other through an instrument called government.136

The view that the private sector is better positioned to solve our social problems than the government is not unique to the former administration although it is far more pervasive. But when the leadership of the country so publicly dismisses the ability of government to solve important social problems like public education and health care while promoting instead self-reliance represented by the privatization of Social Security, it cannot be surprising that a significant portion of the population shares that view.137 Retaining the social safety net is expensive and will no doubt require an increase in direct taxation as well as indirect cross-subsidization of the poorer by the wealthier. This seems a very unlikely scenario in a time when spending has exceeded taxing. In the past seven years, federal government expenses, particularly the cost of an expensive war in Iraq, have increased while revenues have decreased.138 One way to balance a budget short on

133 Id.
134 This experiment with managed competition in the prescription drug arena is one that failed in managed care part of Medicare, Part C or Medicare Advantage. Marsha Gold, “Medicare’s Private Plans: A Report Card on Medicare Advantage,” 28(1) HEALTH AFF 2009.
136 Id.
138 The cost of the war in Iraq to date is cost to $500 billion while taxes on earned income, capital gains, and transfers have decreased. These tax cuts which have all taken effect during the Bush administration are
tax revenues is to make programmatic cuts particularly for the benefit of relatively powerless groups. Former President Bush’s vetoes of an expanded CHIP program citing the specter of government-sponsored health insurance as the reason is such a tactic.  As Professor Rashi Fein observed, the Bush administration will be remembered as the administration that has systematically tried to disassemble the social safety net erected by earlier administrations and respected by Presidents of both parties.

As I write this, we have just experienced an historic presidential election where the same electorate that gave the Republican George W. Bush two terms as President has elected a young energetic progressive Democratic. It is clear that if Senator John McCain had been elected on November 4, 2008, his administration would have continued the Bush administration’s pursuit of a relatively unregulated free market and private market solutions to large social issues such as the financing of health care. Because Barack Obama was elected instead, and particularly with a Democratic Congress, there is likely to be significantly less antipathy to government solutions to social problems. Although the goal of President Obama’s plan is universal or near-universal coverage, he certainly has not proposed a single-payer solution to replace the current multi-payer system. Instead, he proposes, as did Senator Clinton in her recent run for the Democratic presidential nomination, to build on existing ESI which would require employers to

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140 See Fein, supra note 135.
141 See Fein, supra note 135.
142 The deep recession that we find ourselves in that is, at least to some significant degree, the result of the free market gone wild with no or little regulation, has resulted in an unprecedented federal bailout of a number of traditionally private sectors such as the banking and auto industries. Hearing former Federal Reserve Chairman Alan Greenspan and other free market proponents talking about the wisdom of nationalizing the banks is so anomalous it barely can be believed. Greg Brown, Greenspan Suggests Bank Nationalization and other free market proponents talking about the wisdom of nationalizing the banks is so anomalous it barely can be believed. Greg Brown, Greenspan Suggests Bank Nationalization, Feb. 18, 2009, http://moneynews.newsmax.com/streettalk/greenspan_nationalization/2009/02/18/182900.html.
143 The employer-mandate is an important part of the universal health insurance plan currently in effect in Massachusetts and part of what was proposed but recently failed in California. See Susan A. Channick, “Can State Health Reform Initiatives Achieve Universal Coverage: Lessons from California’s Recent Failed Experiment,” 17 S. Cal Interdisciplinary LJ (forthcoming 2009)
make a meaningful contribution to the cost of their employees’ health plan or pay a tax that would help pay for a new public health insurance plan.  

While many consider it fair for employers to contribute to the health care of their employees, this contribution has generally taken the form of a voluntary rather than mandatory subsidy. When employers are mandated to subsidize their employees’ health insurance, they often shift the burden of health insurance to their employees in the form of decreased wages or other benefits. Employers are particularly induced to shift cost for employee health insurance when the supply of the unemployed increases, making it more difficult for employees to demand increased benefits and easier for the employer to pare its benefits package without jeopardizing its attractiveness to new employees. Certainly the prediction of the national unemployment rate increasing in the next year to as high as 10% in conjunction with an employer mandate for health care is likely to result in fewer hires as well as lower compensation packages. If this outcome is predictable, it does not enhance the economic position of the employed except to guarantee them access to hopefully affordable health insurance in the same way that mandated employer contributions to Social Security guarantees workers an income-replacement floor.

Third is the fear of a bigger government with a mandate to tax and spend. Although the fear of increased spending and taxing has generally been more closely associated with Democratic administrations, the Bush administration managed to hold up its end of the spending phenomenon as well and even better than previous Democratic administrations. At the state level, the spending barrier is even greater since states have much more limited revenue options, mandatory spending requirements, and generally a requirement to balance their budgets. In California, Republican Governor Schwarzenegger faced opposition to his individual mandate universal health insurance proposal from legislative Democrats fearful of the fiscal impact of health reform. Don Perata (D-Oakland) who was then the President Pro Tempore of the California Senate slowed the momentum of the Governor’s $14 billion proposed plan by asking the state’s legislative analyst to determine how the overhaul plan could affect the state’s projected budget shortfall of $10 - $14 billion over the next two years.

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146 During decades when the cost of health insurance to the employer was relatively low and it was in the self-interest of employers to attract employees with decent employment benefits, the employer contribution was accomplished through the free market rather than regulated.
147 The same phenomenon is true of the mandatory Social Security contribution made by employers on behalf of employees; the effect of the mandatory employer tax is a shift to the employee in the form of decreased compensation. Antos, supra note 145, at

(D-San Diego) also withheld her approval of the legislation pending more examination. In defense of these tactics, unlike the federal government, state governments including California are constitutionally required to balance their budgets. The governor’s plan would have required substantially all California residents, including some six million uninsured, to obtain health insurance which would be funded through employer contributions, a hospital tax, a tobacco tax increase, and an expansion of federal funds. In the end, the money was simply not there.\footnote{Given the events that actually transpired leaving California with a $42 billion budget gap and no budget, the decision not to take on health care reform was probably wise. On February 19, 2009, the California legislature passed a budget that closes the $42 billion deficit with a combination of increased taxes, cuts in programming and assistance from the federal government economic stimulus package available at http://www.cnbc.com/id/29279663?__source=RSS*tag*=&par=RSS.}

Although the governor’s health reform bill passed the State Assembly, it did not pass the Senate. In addition to the fiscal opposition of then Senate President Pro Tempore Don Perata, Senator Denise Ducheny, and Senator Sheila Kuehl, the chairperson of the Senate Health Committee and sponsor of SB 840, a bill introduced in February 2007 that would create universal single-payer health insurance in California, was able to prevent the governor’s health reform bill from even getting out of the Senate health committee and on to the Senate floor for a full vote of the Senate. SB 840 would achieve an overall savings of more than $29 billion dollars, most of which would be used toward covering the uninsured and providing financial savings to employers and families. According to an economic impacts analysis by the Lewin Group, SB 840 would achieve universal coverage with broad benefits while actually reducing total health spending for California by about $8 billion in the first year alone.\footnote{LEWIN GROUP REPORT RELEASE OF THE HEALTH CARE FOR ALL CALIFORNIANS ACT: COST AND ECONOMIC IMPACTS ANALYSIS, FACT SHEET (2007), available at https://www.cta.org/NR/rdonlyres/A8B22AA9-FC6B-4D07-93D2-2D846C23C965/574/LewinGroupReportFactSheet2.pdf.} Unlike either Massachusetts or California health reform, or health reform as proposed by President Obama, Kuehl’s universal single-payer proposal does not rely on an employer mandate.\footnote{SB 840, the California Health Insurance Reliability Act, which at one point had passed both the CA Assembly and the CA Senate but was vetoed by Gov. Schwarzenegger, would be funded by employer and employee contributions. Metroactive, California Senate Bill 840, available at http://www.metroactive.com/metro/04.18.07/senate-bill-840-0716.html.}

Since the November 2008 election, the shape that health reform is likely to take has become more predictable. As noted above, President Obama supports universal coverage incrementally with immediate universal coverage of children, a population remarkably inexpensive to insure.\footnote{The goal of universal coverage for children could be accomplished by reactivating the CHIP expansion legislation that President Bush twice vetoed in 2007. Since CHIP relies on both federal and state funds, the burden of covering children would be shared. .} While popularity of universal health care for children hasn’t always been the norm, recent bipartisan Congressional support for expanding SCHIP seems to prove its current cache.\footnote{See “The Long Road,” supra note 139.} Obama’s plan would also include expanding Medicaid to include more low-income Americans. The retention of employer-
sponsored health insurance as part of the President-elect’s health reform model demonstrates a pragmatic policy orientation. Barack Obama is both an idealist and a pragmatist and the pragmatist Obama knows that retaining ESI will be much more palatable to Americans than converting to a single-payer model with the federal government as the payer. The President’s plan also includes a national health plan for employees of small employers and those without ESI. It would offer a choice of plans ostensibly on the order of the Federal Employees Health Benefits Program (FEHBP) which offers a range of health insurance products from expensive plans with rich benefits to plans with skimpier benefits for lower premiums or higher out-of-pocket costs.\textsuperscript{155}

It seems clear that the Obama administration, while committed to health care reform, is also practically and perhaps philosophically committed to incrementalism as opposed to a systematic overhaul of the current health care system. The next administration’s reasoning is no doubt dictated by what it perceives to be the political will with respect to health reform. For example, in a recent survey of employers by the International Foundation of Employee Benefit Plans (IFEBP), a majority polled believe the employer-based system should continue to be the primary mechanism for benefits delivery.\textsuperscript{156} A second survey conducted by the Washington Post-ABC News also had strong support for health system reforms but with concerns that sweeping reforms would replicate the Health Security Act fiasco at the beginning of the first Clinton administration.\textsuperscript{157} Even former Senate Majority Leader Tom Daschle whom the President had named as Secretary of Health and Human Services and head of a new health reform task force prior to his recent withdrawal from consideration and who had signaled his intention to make more systemic changes to health reform including a new federal agency, which he calls a Federal Health Board with authority to set guidelines for what treatments and procedures are most cost-effective, was not proposing a single-payer system.\textsuperscript{158} Mr. Daschle made it clear that he would indeed learn from history and steer clear of the missteps made by the Clinton administration such as excluding key players including health insurers, providers, and even congressional leaders.\textsuperscript{159}

Even before the appointment of replacements for Tom Daschle as Secretary of HHS and health reform czar,\textsuperscript{160} the President is going forward with plans for health care

\textsuperscript{155} Antos, supra note 145.
\textsuperscript{156} This is notwithstanding the fact that 71\% of those polled said the U.S. health care system needs a complete overhaul. BNA Health Care Daily Report, Most Employers Favor Health System Reform That Keeps Job-Based System, Survey Shows, Nov. 17, 2008 available at http://news.bna.com/hdln/display/batch_print_display.adp.
\textsuperscript{157} The Health Security Act, the Clintons’ health reform legislation that would have supplanted an employer-sponsored insurance system with a managed competition system, was defeated in 1994 before even getting to the floor of Congress. Although then Senate Majority Leader George Mitchell introduced a compromise bill on the floor of the Senate, the compromise bill was defeated in August 1994, a defeat that weakened the Clinton administration. Wikipedia, 1993 Clinton Health Care Plan, http://en.wikipedia.org/wiki/Clinton_health_care_plan (last visted Mar. 6, 2009).
\textsuperscript{159} Id.
\textsuperscript{160} The President announced on March 2, 2009, Nancy-Ann DeParle, a former administrator of HCFA (the predecessor to the Centers for Medicare and Medicaid Services) during the Clinton administration, as his
reform announcing that he has budgeted $630 billion over ten years as a down payment.\textsuperscript{161} As part of a $3.6 trillion 2010 budget, this is a big additional commitment over and above the $700 billion TARP legislation and $787 billion economic stimulus package which itself contains a large fiscal commitment to health care.\textsuperscript{162} The money to support the health reform plan will be paid in part by reductions over 10 years in Medicare and Medicaid spending and in part from increasing taxes for Americans in the highest tax brackets.\textsuperscript{163} In addition, the President’s plan includes reductions in spending in Medicare payments to private health plans which exceed by about 14% the amount paid by Medicare for its fee-for-service beneficiaries.\textsuperscript{164} As previously noted, President Obama has expressed his intention of retaining ESI with an employer pay-or-play mandate as the centerpiece of health reform and choices of FEHBP-type private plans or a Medicare-like public plan for those who either have no insurance through employment or are dissatisfied with such insurance. However, the President has made it equally clear that he is planning on working closely with Congress in the design of health reform.\textsuperscript{165}

Even without single-payer government-run health care, there are still major objections to budgeting an unprecedented amount to government interventions into the private sector. As House Minority Leader John Boehner (R-OH) told his colleagues at a recent gathering of the Conservative Political Action Committee: “The stimulus, the omnibus, the budget – it’s all one big down payment on a new American socialist experiment.”\textsuperscript{166} While the view that a shift from a private market to a public government model is seismic and dangerous may held only by the most conservative of politicians, it appears that many Americans may agree.\textsuperscript{167} This fear of government interference in the traditionally private market is notwithstanding the fact that there seemed to be relatively little resistance to the infusion of TARP money into the capital markets, a move that has


\textsuperscript{162} The predicted budget deficit for 2009 alone is predicted to be a staggering $1.75 trillion dollars.


\textsuperscript{164} In response to the cut in payments to Medicare Advantage private plans, the stock of these Medicare contractors like Aetna, Humana, and United Health Group tumbled by double digits on Friday, February 27, 2009, one day after the budget was announced.

\textsuperscript{165} President Obama is exquisitely aware that one of the factors that defeated the Clinton Health Security Act was the exclusion of Congress from the design and drafting of the plan until it had been completed by the White House.


euphemistically been called “recapitalization via public capital injections.”\textsuperscript{168} The TARP legislation does not explicitly allow for this recapitalization and both the U.S. Treasury and the banking industry were opposed to the idea of the government taking equity positions in financial institutions.\textsuperscript{169} But, notwithstanding the absence of explicit authorization, infusing large amounts of public capital into financial institutions is what Treasury has been doing in hopes of attracting private capital back into the finance sector which has been called a pipe dream for institutions with tens of billions of dollars of risky assets.\textsuperscript{170}

If the federal government is willing to spend literally billions and perhaps trillions of dollars bailing out banks by means of capital infusions of public money - partial nationalization – what remains of public and governmental objections to nationalizing health care? Clearly the problem of a frozen credit market was impossible for the private sector to solve and rather than risk greater financial disaster, the private sector looked to the only feasible solution – a federal government infusion of public money. Just this past week, in spite of Congress’ refusal to use TARP funds for an automakers’ bailout, the White House agreed to a $17.4 billion infusion of public money to bail out Chrysler and General Motors\textsuperscript{171} rather than allow the companies to reorganize under bankruptcy protection.\textsuperscript{172} So why not save health care through a federal government single-payer system? President Obama successfully endorsed a large economic stimulus package, the American Recovery and Reinvestment Act,\textsuperscript{173} which includes a significant subsidy\textsuperscript{174} for health care.\textsuperscript{175} Health care information technology would presumably get a bump if providers – physicians and hospitals – were required to use such technology as electronic health records as a condition for participation in Medicare.\textsuperscript{176} In addition, the plan calls for additional federal money to go to the states to for Medicaid assistance and a proposal to allow U.S. residents between the ages of 62-64 to pay to enroll in Medicare.\textsuperscript{177}

\textsuperscript{168} Nouriel Roubini, \textit{How authorization to recapitalize banks via public capital injections ("partial nationalization") was introduced – indirectly through the back door – into the TARP legislation, GLOBAL Economonitor, Oct. 9, 2008.  
\textsuperscript{169} Id.  
\textsuperscript{172} In order to receive the loans, GM and Chrysler were required to demonstrate their continued viability by March 2009 or be required to pay back the loans. \textit{White House Green Lights Automaker Bailout}, CBS News, Dec. 19, 2008 available at http://www.cbsnews.com/stories/2008/12/19/business/printable4676962.shtml.  
\textsuperscript{177} Id.
While a good deal of “reform” to health care has already been proposed, all of it involves incremental changes to an existing system that are aimed at decreasing the number of uninsured and controlling the currently out-of-control costs of health care in both the public and private sectors.\(^{178}\) There are very few experts who are advocating a single-payer system to replace the complex, expensive multi-payer system that we currently have. As some advocates of a single-payer system opine, we should say yes to a Medicare-for-All option, not “yes but.” The “yes but” contingent who include such health economics luminaries as Henry Aaron, Rashi Fein, and Paul Krugman believe that a single-payer system modeled on Medicare would not have political legs. On the other side of the policy debate are Merton Bernstein and Ted Marmor, two experts in welfare state policy, who argue for answering “yes” not “yes but” to Medicare-for-All because it is simpler, cheaper, more efficient, and more practical than other more complex, more incremental and less well-tested paradigms.\(^{179}\) Jacob Hacker, a professor of political science, has suggested a compromise between single-payer Medicare-for-All and the incremental approach favored by the Obama administration: universal health coverage that combines employer-sponsored insurance with an employer mandate and an expansion of Medicare for Americans without ESI.\(^{180}\) The Lewin Group has estimated that “Health Care for America” would cost the federal government an additional $50 billion per year, a relatively modest sum, by capitalizing on the Medicare’s simplicity and lower pricing.\(^{181}\)

Hacker envisions his plan working because, while it is initially incremental, i.e. it builds on an already existing employer-sponsored system where the employer can elect to play or pay, he believes that this model will inevitably achieve universal single-payer insurance. Although most employers who currently provide health insurance coverage will continue to do so initially, many may elect the pay option of their pay-or-play mandate particularly if the federal government is able to more successfully control the costs of providing care than the private sector.\(^{182}\) A plan that would incrementally get the United States to universal single-payer health care might satisfy the need to reform the system without unnecessarily disturbing the status quo. While I admire this stealth approach to universal single-payer health coverage, at the same time I wonder why it is necessary. In other words, why can’t Americans accept express single-payer government health insurance without obfuscation? Is there something about the model that is deficient or is there something about Americans that makes a government solution to a huge and ongoing societal problem – the guarantee of decent, affordable health care for

\(^{178}\) Cost savings proposals that have been floated include health care IT, requiring pharmaceutical companies to give the federal government a discount or rebate on prescription drugs used in Medicare Part D, and various pay-for-performance reimbursement schemes. In addition, the President-elect’s health reform plan includes an employer mandate that the Congressional Budget Office says would raise $47 billion in additional revenue over 10 years. CBO Reports Analyze Major Health Insurance, supra note 175.


\(^{180}\) Posting of Jacob S. Hacker, Putting Politics First, Health Aff. May/June 2008, http://content.healthaffairs.org/cgi/content/abstract/27/3/718


\(^{182}\) Id.
all – impossible? Ingrained cultural beliefs are a fourth reason why single-payer universal government health insurance will not work in the United States.

Since every other democracy except the United States views sickness as a relatively random risk to everyone and health care as a human right to which none should be excluded for lack of ability to pay, it would be reasonable to suppose that there is something unique about the United States that makes a social solidarity model for health care impossible even as we move from a conservative, antigovernment, market-oriented regime to a one that seems to believe in the power of government to solve social problems. Until now, health care has been inextricably tied to individual success. Those who succeeded in obtaining employment that included health care as a benefit were safe from the economic vagaries of illness but those who were unsuccessful were unprotected and consigned to bad default positions. Only the elderly, certain populations of the very poor, and now children, none of whom could get coverage through employment, were exempted from this model. Whether Americans would politically and financially support a system delinked from employment, delinked from wealth status, founded instead only on membership in society and the random need for health care, is a question that politicians and policy makers have generally believed is no.

Here, at the beginning of 2009, almost the end of the first decade of the millennium, Americans are facing an economic crisis that is predicted to result not only in much higher unemployment, but also a significant decrease in personal wealth. Large corporations as well as small businesses are shedding employees in order to survive. As we well know from the recent sorry sight of CEOs of the big three automobile companies coming hat in hand to plead with Congress for a bailout, the cost of health care as well as other employment benefits is part of the reason that Americans companies are not only unprofitable and uncompetitive, but perhaps also unsustainable. As the saying goes, we are all feeling the pain. The question is whether the pain is sufficiently universal to create empathy for the less fortunate by the more fortunate, the kind of empathy that might support a redistribution of wealth. With the health care system an acknowledged mess, the economic system shaky enough to scare even those who currently have affordable health insurance, a terrible economy, and a new administration that believes in the power of government to solve problems, is the time right for systemic health care reform? In other words, has the policy window for health reform opened?

John W. Kingdon, a political scientist at the University of Michigan, explores the important question of why legislators pay attention to some ideas and not to others. In Kingdon’s words, what makes an idea’s time come so that it appears to catapult to the top of the political agenda? Even when an idea’s time seems to have come, there is no guarantee that it will succeed. Professor Kingdon uses health care reform as one of the

185 John W. Kingdon, AGENDAS, ALTERNATIVES AND PUBLIC POLICIES 165 (HarperCollins, 2d ed.)
186 Id. at 1.
areas of public policy that he studies for his book with national health insurance proposals as an example of how what seems a good idea can perennially fail. A more recent example occurred in 2007 in California when it appeared that state health reform was an idea whose time had come. Both Governor Schwarzenegger and Kim Belshe, Secretary of California’s Health and Human Services agency, vigorously supported health care reform but by the end of 2007, it was defeated by a reluctant state senate and enormous looming budget gap with little or no change to the status quo.

Currently there are many reasons to believe that federal health care reform is an idea whose time has come. The President supports it, a number of important legislators including Senator Ted Kennedy who has made universal health care a life-long project support it, and Tom Daschle, the former Senate Majority leader who was President Obama’s initial choice for Secretary of Health and Human Services, supports it. Congress and the President are both Democrats. But, as we all learned from former President Bill Clinton’s ill-fated health reform, none of these agenda predicates guarantee a successful implementation. A recent Gallup poll on Americans’ perception of the health care system versus their own health care demonstrates what seems to be an inexplicable attitude: while 73% of respondents believe that the health care system is in crisis or has major problems, 83% rank the quality of their own health care as excellent or good and 67% rank their own health care coverage as excellent or good. Is there a coherent take-away message about what the electorate wants from this administration in the way of health care reform?

Certainly one interpretation is that whatever is done to reform health care, the majority of Americans are happy enough with the coverage they have but more than that, fear any change that might jeopardize or undermine their own personal coverage. This dichotomy may be even more compelling today because of the real fear of unemployment, the gateway for the majority of people under the age of 65 to health insurance. It may be that hard times, rather than increasing empathy for those without employment and therefore without health insurance, instead increases fear of the same for oneself and engenders protectionism for what one has however imperfect. In a culture that prizes individualism over community, that believes in equality of opportunity but clearly not in equality, those who do not or cannot take advantage of opportunity are considered redundant or superfluous and undeserving of support by the productive sector of society. It is only a belief in solidarity, i.e. that all members of society, regardless of their success or failure, deserve social aid to insure that their personal needs like health care are met. Social solidarity and human decency means that health care be available

187 Id. at 6-9.
189 In fact, because of unprecedented budget problems which forced the governor into a wholesale budget cut of ten percent, health care funding at the margins has gotten worse.
to those who most need it, not just those who can afford it.\textsuperscript{193} And those who most need it are always the sick and more often than not those who can least afford it.

Although single-payer universal health care is a political, economic, and cultural non-starter, apparently health reform in the new administration is not. While many remember the systematic dismantling of the Clinton Health Security Act by the various entrenched players in the health care arena, there seems to be general agreement that will not happen this time around. At the recent Wharton Entrepreneur Conference, there seemed to be general agreement among all the participants on the panel that health reform is nigh.\textsuperscript{194} As Len Nichols, a health economist and director of the Health Policy Program at the New American foundation, a non-profit public policy think tank, put it, “the currently economic slump has helped to make the case [that] we are indeed in one boat.”\textsuperscript{195} Perhaps something positive will emerge from this economic disaster of unprecedented proportions: the social solidarity necessary to make decent, affordable, health care available to all Americans. That would mitigate, to an extent, the pain we are all feeling not only for ourselves and our families but for all the strangers who make up this great nation.

\textsuperscript{193} Id.


\textsuperscript{195} Id.