



ELECTION 2008

Presidential Politics and the Resurgence of Health Care Reform

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Comprehensive health care reform disappeared from the national agenda after the Clinton administration failed to enact universal coverage in 1993 and 1994. Instead, Congress adopted incremental

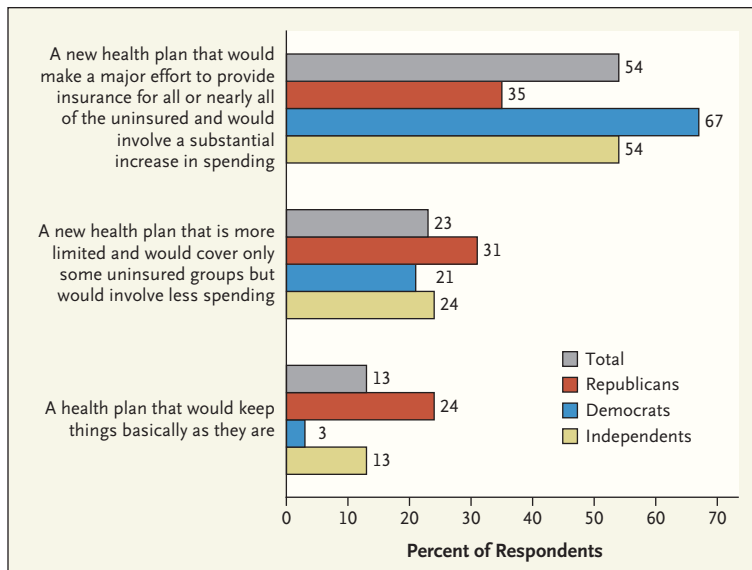
measures that enjoyed bipartisan support, including the State Children's Health Insurance Program (SCHIP) and the Health Insurance Portability and Accountability Act (HIPAA). The retreat from comprehensive reform reflected, in part, the calculus that ambitious plans were too controversial and too hazardous to their sponsors' political health to attempt. But that political calculus is changing. Health care ranks as the top domestic issue in opinion polls, and talk of major reform is back in vogue as the 2008 election approaches.

Democratic and Republican voters have contrasting views on health care reform (see graph), so

not surprisingly, the issue is playing out very differently in the parties' presidential primaries. The leading Democratic candidates have all released comprehensive, detailed plans. Former Senator John Edwards (NC) was first out of the gate with a plan, and Senators Barack Obama (IL) and Hillary Clinton (NY) subsequently unveiled their own proposals. The plans are remarkably similar. All three aim to cover all or nearly all uninsured Americans, to build on the current mixed system of private and public insurance, and to avoid making any changes that would unsettle people who are currently insured.

The Democratic plans (see box)

all rely on a "play-or-pay" employer mandate to move toward universal coverage, requiring businesses to either offer workers insurance or pay a tax. Play or pay was the reform plan of choice for many Democrats in the early 1990s, before President Bill Clinton switched gears to pursue the more ambitious model of managed competition within a budget (which sought to promote competition among private insurance plans while also establishing government-determined limits on national health spending). The reemergence of play or pay is a testament to the enduring political appeal of building on the status quo: employer-sponsored insurance has been a cornerstone of the U.S. health care system since the 1940s and now covers about 160 million nonelderly Americans. Play-or-pay models enable reformers to finance universal coverage mainly



What the U.S. Public Wants to See in a Health Care Reform Proposal, According to Political Party.

Data are from the Kaiser Family Foundation, August 2007.

through employer payments rather than creating a publicly funded system that would require new broad-based taxes. However, any employer mandate is likely to ignite substantial controversy over expanding governmental authority and opposition from businesses that don't currently insure their workers. The current Clinton and Obama plans seek to temper that opposition by exempting small businesses from the mandate; the Clinton plan also grants a tax credit to small businesses that choose to offer insurance.

Although the Democratic plans would retain private insurance, insurers would be tightly regulated to ensure that all Americans have access to coverage, regardless of their health status. New purchasing pools would be established through which businesses and individuals could buy insurance from any of a number of private plans, with individuals receiving government subsidies that varied according to income. Medi-

care would be retained, and Medicaid and SCHIP would be expanded to cover more low-income Americans. In addition, the Clinton, Edwards, and Obama plans all create a new public insurance plan that would be available alongside private options. It is hard to anticipate what enrollment in such a program would be, but if, over time, more businesses opted to pay the tax rather than offer insurance, and if more individuals chose public over private coverage, the number of Americans with government insurance would increase.

The Democratic health plans share three other key features. First, they avoid any explicit budgeting of health care spending or centralized cost controls — provisions that the health care industry would fiercely resist. Instead, they offer a politically friendlier assortment of cost-saving measures, including electronic medical records and a focus on prevention and disease manage-

ment. These measures may be good health policy, but their capacity to generate large savings is uncertain, and they are unlikely to restrain health care spending for long.

Second, the Democratic plans are financed largely by rolling back tax cuts adopted by the Bush administration for families making more than \$200,000 (Edwards) or \$250,000 (Clinton and Obama) annually. That makes health care reform explicitly redistributive and turns the election into a referendum on tax policy. Democratic presidential candidates are, in essence, betting that the public would rather spend federal money on covering the uninsured (and making coverage for the already-insured more secure and affordable) than on extending tax cuts for the wealthy. The Democratic plans thus depend crucially on the politics of tax reform.

Third, these plans apply a lesson learned from the Clinton administration's misadventure with health care reform. All of them contain provisions designed to reassure insured Americans that they can keep their current coverage if they want to and that health care reform means more, not less, choice and better quality of care. Nowhere is this lesson more visible than in Hillary Clinton's American Health Choices Plan, which contains a simple chart illustrating how Americans would obtain insurance in a reformed system — a striking contrast to the infamously labyrinthine diagram that then-Senate minority leader Bob Dole (R-KS) used in 1994 to lampoon Bill Clinton's proposed health care plan.

In addition, the Clinton and Edwards plans include an individual mandate requiring all Amer-

| Key Elements of Democratic Plans. | Key Elements of Republican Plans. |
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| <p>Employer mandate requiring businesses to either offer workers insurance or pay a tax (some plans exempt small businesses)</p> <p>Regulation of private insurance companies to ensure universal access to coverage</p> <p>Establishment of new insurance purchasing pools for businesses and individuals</p> <p>Government subsidies for individuals to purchase insurance, varied according to income</p> <p>Expansion of Medicaid and SCHIP to cover more low-income Americans</p> <p>Creation of a new public insurance plan as an additional option</p> <p>Various cost-saving measures, including electronic medical records and a focus on prevention and disease management</p> <p>Financing largely from rollback of tax cuts for high-income families</p> <p>Provisions designed to reassure insured Americans that they can keep their current coverage and have more choices</p> <p>In some plans: an individual mandate requiring all Americans to have insurance</p> | <p>Changes in tax policy (new income tax exclusions or credits) to improve access, control costs, and provide incentives for purchasing insurance outside the workplace</p> <p>Deregulation of insurance markets</p> <p>Increased investments in health information technology</p> <p>Reform of the medical malpractice system</p> <p>Expansion of health savings accounts</p> <p>In some plans:</p> <ul style="list-style-type: none"> Promotion of the development of generic drugs Reform of provider reimbursement to encourage care coordination Creation of federal–state partnerships to develop state-specific solutions Redirection of existing public subsidies to help low-income Americans buy private insurance. |

icans to have insurance; the Obama plan mandates coverage only for children but does not rule out a broader individual mandate in the future. The Clinton and Edwards proposals follow the precedent of Massachusetts, where under a new law, residents deemed able to afford insurance must purchase coverage or pay a penalty. There is both a substantive and a political rationale for individual mandates. They allow reformers to talk about health care as a responsibility and not simply as a right — a rhetoric with bipartisan appeal — and they ensure that healthy persons join insurance pools, thereby helping to spread risk and ensure universal coverage. However, individual mandates are vulnerable to charges of unfairness, since health insurance remains unaffordable for many Americans; the political risk is that health care reform could appear punitive. The impact of an individual mandate ultimately depends on enforcement mechanisms, the price of insurance, and the generosity of available subsi-

dies — how such a mandate would work in practice in the Democratic plans remains unclear.

On the Republican side, no top-tier candidate has released a health plan as detailed or comprehensive as the Democratic proposals — a gap that underscores the difference between the constituencies that each party appeals to in its presidential primaries. Former Massachusetts Governor Mitt Romney, former New York City Mayor Rudy Giuliani, and Arizona Senator John McCain generally favor incremental expansions of insurance coverage and changes in tax policy to improve access and control costs (see box). Former Tennessee Senator Fred Thompson has not yet announced a plan for health care reform.

Giuliani proposes a new income tax exclusion that would give Americans incentives to purchase their own health insurance outside the workplace (echoing a plan introduced by President Bush in January 2007), with additional tax credits to help low-income

persons afford coverage. The aim is to shift enrollment away from employer-sponsored insurance and into the individual market. McCain similarly would create a tax credit for Americans purchasing health insurance, regardless of whether they obtain it through an employer (current rules favor employer-sponsored insurance, since employers' premium contributions are tax exempt). He would also promote the development of generic drugs and, in an effort to encourage coordinated care, reform the way health care providers are paid.

Romney's plan, by contrast, emphasizes a federalist approach, whereby the federal government would partner with states to craft solutions that fit their particular circumstances and redirect existing public subsidies to help low-income Americans buy private insurance. Romney would also change tax rules to allow more people to purchase private insurance on a pretax basis. All the Republican plans call for dereg-

ulation of insurance markets, investments in health information technology, medical malpractice reform, and expansion of health savings accounts (tax-preferred accounts that can be used to pay for medical expenses in conjunction with high-deductible health insurance).

These Republican plans are also noteworthy for what they do not do: propose the establishment of any major new federal insurance programs or the adoption of any new employer or individual mandates. The focus is on decentralized, market-oriented reforms rather than on achieving

universal coverage. Without more details, it is difficult to assess the plans' potential impact, but their incremental measures are unlikely to substantially increase health insurance coverage or effectively control costs.

The 2008 presidential election will not resolve the debate over health care reform, but the results will go a long way toward determining the future of U.S. health policy. It would be a mistake, however, to read the candidates' plans too literally. A plan offered during the primaries usually looks different in key respects from the plan that a newly elect-

ed president takes to Congress, to say nothing of any legislation that Congress actually passes. Still, it is clear that there is a wide partisan gap on health care reform that reflects ideological divisions over the roles that government and market forces should play in the health care system. And the further U.S. health policy moves from incrementalism, the more that partisan divide is likely to be exposed.

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The Fate of SCHIP — Surrogate Marker for Health Care Ideology?

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To appreciate the power of the U.S. presidency — even when its current occupant's approval rating is only 31% — one need look no further than the political brawl over the State Children's Health Insurance Program (SCHIP). On October 3, 2007, President George W. Bush vetoed legislation that would have reauthorized SCHIP for 5 years, asserting that it was too expensive and would lead down a path to socialized medicine. On October 18, despite pleas by Democrats and some senior Republican legislators, the House failed to garner the necessary two-thirds vote to override Bush's veto; the vote count was 273 to 156. In addition to many legislators, a large majority of the public, major private stakeholders, and 43 governors strongly support ex-

pansion of the program. By contrast, in an effort to appeal to the conservative base of their party, the leading Republican presidential candidates agreed with Bush's veto — despite the fact that the program, though signed into law by a Democratic president, originated in a bipartisan compromise and was enacted by a Republican-controlled Congress.

A few months ago, reauthorization of SCHIP seemed like a routine matter. Then Bush decided to single it out as a target of the administration's newfound fiscal discipline. The program was created in 1997 to provide coverage to "targeted low-income children" who are uninsured and not eligible for Medicaid — typically, families with incomes up to 200% of the federal pov-

erty level, or about \$41,300 for a family of four in 2007. As the cost of private insurance has increased and the number of employers offering it has decreased, the ranks of the uninsured have grown — by 2.2 million in 2006, including 710,000 children, half of them with a family income between 200 and 399% of the poverty level (see bar graph)¹ — and government has tried to fill the gap. While 24 states still use SCHIP to cover children with family incomes up to 200% of the poverty level and 8 states set their income thresholds below 200%, the other 18 states have extended their thresholds above 200% — 16 of them to 250% or above. Through waivers approved by the Bush administration, 5 states cover pregnant women under SCHIP, 11 cover