

chase insurance, and it contains no politically controversial, centralized cost controls.

The lessons of 1993 and 1994 are also well understood in Congress. Two key Senators — Max Baucus (D-MT), chair of the Finance Committee, and Edward Kennedy (D-MA), chair of the Health, Education, Labor, and Pensions Committee — are developing legislation that largely tracks the Obama plan. Consequently, this time around, congressional Democrats may be more unified around a health care reform strategy. Baucus's support for reform is crucial, given the importance of financing issues, and Kennedy's staff has been holding meetings with stakeholders in an effort to build consensus. Both senators are determined to move quickly, fearing that delay could dissipate momentum, as it did in 1993.

Finally, in Barack Obama, health care reform has a president who could effectively use the bully pulpit to rally the public behind change. That effort could be aided by both the Obama campaign's grassroots network and organizations devoted to reform, whose resources can help mobilize public support.

Of course, these grounds for optimism hardly guarantee success. Financing health care reform in this fiscal climate will be an extraordinary political challenge, deep divisions persist in Congress, and many thorny problems are nowhere near resolution. Throughout the past century, reformers pursuing comprehensive change in the U.S. health care system have failed to overcome similar barriers. But the fact that reform has failed before does not mean it is fated to fail forever. As the elec-

tion of Barack Obama vividly reminds us, history is not always repeated. Sometimes it is made.

No potential conflict of interest relevant to this article was reported.

Dr. Oberlander is an associate professor of social medicine and of health policy and management at the University of North Carolina, Chapel Hill, and a visiting scholar at the Russell Sage Foundation, New York.

1. Pear R. Senator takes initiative on health care. *New York Times*. November 11, 2008.
2. Orszag PR, Kleinbard ED. Preliminary analysis of a proposal for comprehensive health insurance. Washington, DC: Congressional Budget Office, May 1, 2008.
3. Starr P. What happened to health care reform? *The American Prospect*. Vol. 6. No. 20. 1994:20-31.
4. Dorn S, Garrett B, Holahan J, Williams A. Medicaid, SCHIP and economic downturn: policy challenges and policy responses. Washington, DC: Kaiser Commission on Medicaid and the Uninsured, April 2008.
5. Oberlander J. Learning from failure in health care reform. *N Engl J Med* 2007;357:1677-9.

Copyright © 2009 Massachusetts Medical Society.

HEALTH CARE 2009

Medicaid and the U.S. Path to National Health Insurance

Michael Sparer, Ph.D., J.D.

The 2008 presidential election has rekindled long-simmering hopes for comprehensive health care reform. The policy debate includes references to new government programs (perhaps a federal program for the uninsured to buy into) and vague formulas for cost containment (usually involving overly optimistic assessments of savings to be generated by using health information technology). Ironically, however, the debate generally ignores what I see as the most plausible path toward universal coverage: first, expanding Medicaid to cover the largest portion of the uninsured, Americans with incomes below 350% of the federal poverty level (around \$62,000 for a family of three); and second, requiring everyone to carry health in-

urance and allowing people whose incomes are too high for automatic coverage to buy into Medicaid.

Previous efforts to enact universal coverage have failed in part because opposition from interest groups such as the business community and the insurance industry is far more influential than is organized support for uninsured low-wage workers. Reform opponents also take advantage of the anti-big-government ethos that pervades our political culture. Finally, our political institutions are designed to make it hard to enact comprehensive legislation, since our system of checks and balances provides opponents with numerous opportunities to block legislation.¹

Meanwhile, Medicaid, the federal-state program designed to

provide health insurance for the poor, has been quietly becoming the most successful program in U.S. history for aiding the uninsured. Since the Reagan administration, program enrollment has more than doubled (surpassing 59 million), softening the impact of the continuing decline in the number of Americans with employer-sponsored coverage.

Surprisingly, the very factors that defeated President Bill Clinton's proposal for universal coverage have actually encouraged expansions of Medicaid. Business leaders support Medicaid expansions because they relieve the pressure on employers to cover low-wage employees. Private insurers support such initiatives because they leave intact the core of the

current system and because many states use commercial health plans to serve Medicaid beneficiaries. Institutional providers (hospitals and nursing homes) are supportive, since they rely on Medicaid dollars. Medicaid is also administered in very different ways by different states, which minimizes complaints about a monolithic national program. Perhaps most important, Medicaid's intergovernmental structure encourages expansion: since the program is financed primarily with federal dollars, states can increase coverage while shifting much of the cost to the federal treasury.²

The 2007 battle over Medicaid's sister program, the State Children's Health Insurance Program (SCHIP), illustrates this broad acceptability. The congressional proposal to increase SCHIP funding emerged from a bipartisan process and was supported by both Senator Edward Kennedy (D-MA) and Senator Orrin Hatch (R-UT). Even President George W. Bush hoped to increase funding, though by less than Congress had proposed. The bone of contention was the income ceiling for eligibility. New Jersey, at the high end, covers children from families with incomes up to 350% of the federal poverty level. That's about as high as moderate Republicans (and the business community) might plausibly be willing to go.

This history points us to an obvious path toward national health insurance: combine a Medicaid expansion and buy-in with an individual mandate. Most Americans would find it fair to require those who can afford insurance to buy it, especially when they can pay into an affordable public insurance plan rather than being forced to buy private policies.

I believe that this is the only universal coverage plan with a de-

cent chance of succeeding politically. Employer mandates face treacherous politics: big business doesn't want government telling it what sort of coverage to provide, and small business argues persuasively that many "mom and pop" shops simply cannot afford the bill. Even less likely to fly are Medicare-expansion proposals, given both the cultural opposition to anything that could be labeled a single-payer program and the fierce opposition of the private insurance industry. But the same interest groups that would oppose these alternatives would probably support the Medicaid strategy.

Relying on Medicaid is also good policy. Medicaid provides decent health insurance to more than 59 million Americans (including more than 25% of U.S. children).³ Some people complain about interstate variation in eligibility, benefits, and reimbursement, but if eligibility were standardized and minimum benefits defined, variation in other areas could result in learning and innovation. Medicaid encourages state-based experimentation in responding to local health care needs. For example, most states deliver benefits through managed care, but some rely on commercial insurers and some on nonprofit health plans, whereas others act as the plan themselves. And Medicaid offers such flexibility within an overarching federal structure. Similarly, interstate diversity in cost-containment strategies, programs for the chronically ill, and outreach and education is a good thing. Moreover, states are already experimenting with Medicaid buy-in programs, and one state (New Jersey) has even enacted an initiative combining a Medicaid buy-in with an individual mandate for parents to cover children.⁴ Letting the laboratory of federalism work

is a better idea than using Medicare or the congressional health plan as the basis for a reformed system — and a much better idea than creating a brand-new administrative infrastructure.

However, the road to any type of national health insurance is littered with obstacles, and the "Medicaid for More" model certainly faces barriers. First is the stigma attached to the name. Many middle-class workers would be reluctant to buy into a "welfare medicine" program. One solution is to give the program a new name and thus a new identity as a middle-class entitlement. States tried this strategy with some success when implementing SCHIP (hence the "Dr. Dynasaur" program in Vermont).

More difficult would be convincing physicians to support a Medicaid expansion and participate in the program. Although Medicaid participation is high in some states, it is more typical for office-based physicians to refuse to treat Medicaid patients, citing low reimbursement rates and long administrative delays.⁵ Medicaid agencies (or the managed-care plans they rely on) will need to pay higher rates, though increases that are substantial enough to attract physician participation would undermine cost-containment efforts. Medicaid agencies could also rely more heavily on nurse practitioners and physician assistants, but any effort to simply bypass the physician community will fail. Here again, however, the laboratory of federalism could help, since there are states that effectively partner with office-based physicians and have lessons to share.

Finally, there is the question of paying the bill, especially in the midst of an economic crisis. Here, too, there are no easy solutions, especially for a society disinclined

to limit the diffusion of new health care technology or to regulate the prices and salaries paid by the private health care sector. One lesson of the recent Medicaid expansions, however, is that intergovernmental financing programs are the most plausible fiscal route to health insurance expansions. States will complain about having to pay their share, though Congress could tie increased federal funding to innovative case management for chronic diseases (or other performance measures). Federal budget officials will also be skeptical, but any national health insurance system is going to cost money, and at least in this scenario the cost would be divided among the federal treasury, the

states, and the businesses or individual consumers who buy in.

Proposals for national health insurance have a long history of failure in this country. But expanding Medicaid in combination with an individual mandate offers a good policy solution that might have enough political appeal to succeed. And if the recession and other priorities discourage President Obama from seeking universal coverage in one fell swoop, the model could be phased in, starting with a more modest Medicaid expansion, a buy-in program, and an individual mandate covering only children. Ultimately, I see the Medicaid model as providing the most likely path to solving the crisis of the uninsured.

No potential conflict of interest relevant to this article was reported.

Dr. Sparer is a professor of health policy at the Mailman School of Public Health, Columbia University, New York, and the editor of the *Journal of Health Politics, Policy and Law*.

1. Oberlander J. The politics of health reform: why do bad things happen to good plans. *Health Aff (Millwood)* 2003;Suppl Web Exclusives:W3-391-W3-404.
2. Sparer MS. Leading the health policy orchestra: the need for an inter-governmental partnership. *J Health Politics Policy Law* 2003;28:245-70.
3. Kaiser Commission on Medicaid and the Uninsured. The Medicaid program at a glance. Washington, DC: Henry J. Kaiser Family Foundation, November 2008.
4. Kenney G, Blumberg L, Pelletier J. State buy-in programs: prospects and challenges. Washington, DC: Urban Institute Health Policy Center, November 2008.
5. Cunningham PJ, O'Malley AS. Do reimbursement delays discourage Medicaid participation by physicians? *Health Aff (Millwood)* 2009;28:w17-w28.

Copyright © 2009 Massachusetts Medical Society.

Online Disclosure of Physician–Industry Relationships

Robert Steinbrook, M.D.

The Cleveland Clinic and some of its leading physicians have been criticized for their financial associations with industry and the limited disclosure of these relationships to patients and the public. In response, the medical center has strengthened its policies and oversight with regard to conflicts of interest and required that all industry relationships be submitted for approval. Since December 2008, it has also disclosed on its Web site (www.clevelandclinic.org) some of the industry ties of its 2000 physicians and researchers and their immediate families.¹

The posting of physicians' financial information by a leading academic medical center, along with continuing revelations about prominent doctors and their apparent failures to accurately report or disclose their links to industry, has intensified interest in the on-

line disclosure of these relationships.² Concerns about privacy notwithstanding, accurate, interpretable, and timely online disclosures can provide immediate access to potentially relevant information and demonstrate that relationships are not being hidden. Other similar efforts include the voluntary posting by some faculty members at the Duke Clinical Research Institute of their conflict-of-interest statements (www.dcri.org/research/coi.jsp; see box for the categories of commercial relationships tracked by the institute) and the provision of financial disclosure statements for the members of the editorial board of *Psychiatric Times* (www.psychiatrictimes.com/editorial-board) and the trustees of the North American Menopause Society (www.menopause.org/aboutnams/trustees.aspx).

More online disclosures are

forthcoming. For example, Eli Lilly and Merck have said that they will soon begin disclosing on their Web sites some payments to physicians, and the University of Pennsylvania School of Medicine and its health system have made a similar promise. Massachusetts is in the process of requiring the reporting and subsequent online disclosure of fees, payments, or subsidies "with a value of at least \$50" as part of new regulations on the conduct of pharmaceutical and medical-device manufacturers³; it is uncertain whether the requirements will be limited to payments for sales and marketing activities or include consulting fees and research grants as well. Six other states and the District of Columbia have laws or regulations with regard to the conduct of pharmaceutical or medical-device manufacturers, but only in Minnesota are