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Policy Brief

Universal Health Insurance Coverage: Progress & Issues

Jonathan Gruber

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Policy Brief

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Universal Health Insurance Coverage: Progress & Issues

Jonathan Gruber delivered this lecture on October 2, 2009, and his references are to Congressional bills that were under consideration on that date.

I'm going to lay out the universal coverage debate that's gone on for a long time in this country. Then I'll describe a new solution that we think we found for Massachusetts, describe how the Massachusetts reform works, and how it can be extended nationally. Finally I'll spend time on the key issues that Congress is facing right now trying to take this model to the national level.

Setting the Stage

There are really just three issues to consider if you want to get to universal health coverage.

1. Pooling

Insurers are like bookies. They don't want to pick a side; they just want to make their profit off the top. They want a nice even distribution of risks with a big risk pool; that's when insurance works best. When people wander off the street and say "Hey, I want insurance" insurers aren't happy, because they're not sure what they can predict about that person. Insurance only works well when there are large, well integrated pools of individuals who come together not on basis of health but the basis of something else, like where they work. The fundamental problem in the United

States is that the pooling mechanism doesn't work for individuals who can't get workplace insurance. About two-thirds of the uninsured don't get offered insurance at work, so they have to go to the non-group market, which is a harsh, unforgiving place to try to buy health insurance. Since it's not pooled, the prices can be high, variable, and most importantly, unpredictable. You can be fine buying non-group insurance for ten years; then one day you get cancer and the insurance carrier just yanks your non-group insurance away or raises your premiums through the roof.

2. Affordability

Health insurance is very expensive. The cost of a typical family health insurance plan ($12,680 in 2008, KFF 2009a) is about 50 percent of a four-person family's income at the poverty line in the US ($22,025 in 2008) and about 20 percent of the median income in the US ($50,303 in 2008). It's implausible to imagine we're going to insure all Americans without government financial assistance.

3. Mandates

You can't get to universal coverage in America, you simply can't, unless you mandate that <u>all</u> individuals have health insurance.

Where Were We Before Reform?

On the Left: Single Payer

Two or three years ago we were in a very polarized place. The political left said "The solution is to have a single payer. That solves all these problems. The pool, how can you get a bigger risk pool than the entire nation? Affordability? It's free! Free when you're born. And mandate, it's by default, everyone has health insurance." The only problem is it's politically infeasible, for several reasons.

One issue is concerns that with just one giant insurance pool there will be reduced innovation in the insurance sector. Insurers won't be able to accomplish some of the creative things they can do to try to control costs. Not, I think, as big an issue politically as some of the policy economists argue.

The second is that most people are pretty happy with the health coverage they already have. People who work for large firms may wish it were cheaper, but they value the number of choices and they are by and large satisfied. People are not going to be happy if you tell them "You have to give up what you like to go into some other plan."

Finally, the United States does not nationalize a $925 billion industry (Plunkett Research, Ltd. 2009), it just doesn't happen. The health insurance industry is not going away in this country, so quite frankly the single payer option is not worth discussing in the current political environment.

On the Right: Tax Credits

The political right said "The answer to solving the affordability problem is to give people tax credits to buy private health insurance." If the tax credits were large enough, this would help address the affordability problem, but half of the uninsured don't pay taxes. Furthermore, there's still no pooling mechanism. If I have a 15-year-old with cancer and I cannot get health insurance, it doesn't matter to me if there's a $2,000 tax credit. I still cannot get health insurance. Tax credits don't solve that problem, and by most estimates only cause modest increases in insurance affordability.

We were stuck between these two poles. The analogy I like to think of here is being in a sea of medical risk, with a very nice boat in it. That nice boat is called *more expensive insurance.* There are about 170 million people on that boat. And that boat is especially nice because those passengers buy their health insurance

with government tax subsidies. Then there are about 50 million people swimming in the water screaming for help; they're the uninsured. The people in the boat are waving to them, saying "Yes, it's a shame you're uninsured. And we'd like to help you." The solution for the left was "Let's march 170 million people off their nice boat into some new government boat that they've never seen before, and put the other 50 million people on that new boat as well." You can imagine that's not going to work very well, because the original 170 million people won't be so happy about it. The solution on the right was "Let's throw some hammers and nails to the people in the water and let them build their own boat." Which leads to the old story I like to tell of the health policy expert who dies and goes to heaven. When he gets to heaven St. Peter says "You're allowed to ask God one question." So the health policy expert asks God, "Will we ever have universal health insurance coverage in America?" And God answers, "Yes, but not in my lifetime."

Breaking the Logjam: Massachusetts Health Reform

Onto this stage came what I think is a really phenomenal success model in Massachusetts (for a detailed description see McDonough et al. 2006). The key insight to what we did in Massachusetts was *we married the notion of incremental with the notion of universal.* For instance, incremental—they've been expanding Medicaid from 100 percent to 110 percent of the poverty line, a little change. But incremental by definition means building on what we have already. There's no way you can't get to universal coverage by building on what already works. And that is basically the Massachusetts approach.

Key Features of the Massachusetts Plan

Chapter 58 of the Acts of 2006 established a system to require individuals to obtain health insurance. The key provisions of the law are:

1. It provides heavy subsidies for those with family income up to 300 percent of the poverty line, about $60,000, to buy health insurance.

2. It merges the non-group market, which was not functioning, with the small-group market, which was functioning pretty well, into a newly formed health insurance marketplace that allows individuals to get health insurance at lower group rates. This market does not discriminate against people based on their health status. Insurers can charge older enrollees more than younger enrollees, but they cannot discriminate based on health. There is one large pool where sick and healthy alike pay the same price.

3. It establishes an individual mandate. Everyone in the state of Massachusetts, with some exceptions I'll come to, is required to buy health insurance or pay about $1,000 tax penalty.

4. It establishes a modest employer obligation. There isn't very much of a role for employers in this system beyond what already exists, which is important for the current debate. Employers who do not offer health insurance have to pay $300 a year, or 15 cents an hour, per worker, to the state, basically nothing.

5. The legislation is deliberately vague, with key decisions made by the Health Connector Board of ten experts, of which I'm one, which implements the program. This increases flexibility and takes many of the politically difficult decisions out of the political arena.

Current Status of the Reform

Where are we now in Massachusetts? First, we newly insured about 450,000 people. Our uninsurance rate is 2.7 percent in 2009, by far the lowest in the nation (Long and Phadera 2009). It's about one-third of where it was before we started this grand experiment.

Second, employee response to insurance has actually gone up. If you ask many economists or policy experts what their fear is with

big government intervention in insurance markets, they respond, "Workers will leave their employer insurance and go to the new government insurance, the so-called *crowding out* phenomenon." Instead, in Massachusetts workers are crowding in. So not only did insurance coverage increase, it happened in a way that supplements the private sector rather than displacing it.

Third, the individual mandate, a radically new invention in government, turned out to be incredibly administrable. Everyone got a new form in the mail, called a 1099HC, which lists the policies available for their health insurance. They either fax back their tax form or fill out an exception form explaining why they weren't. Ninety-eight percent of taxpayers got that right the very first year!

The Massachusetts reform is quite popular. Initially we had about 75 percent public approval, although that's down in the most recent polls to about 60 percent, as people aren't happy in the recession. But that is still 2-to-1 approval over disapproval of this program in the state.

Finally, the Health Connector Board, the expert board making all these decisions, did so with virtual consensus, which I think is helpful in the political system. So—based on all these factors, I think the reform has worked very well.

Taking this to the National Level: The Big Picture

Cost: A Big Number or a Little One?

There's no reason this can't work nationally, except that, of course, it's very expensive. The cost is about $800 million, the federal match is about half. Is that a big number or a little number? I can't tell you that. You have to look inside your soul and decide if that's a big number or a little number. What I can tell you is that, relative

to what the government currently spends on health insurance, it's a little number.

Think of it this way. Massachusetts covers about 450,000 people for about $800 million, which is about $2,000 a person. Let's compare that to the last major government intervention in health insurance, the Medicare part D program, a program that provides prescription drugs for the elderly. Medicare Part D costs the federal government about $40 billion a year to improve benefits for about 10 million elders (Engelhardt and Gruber 2009). That's $4,000 per elder just for their drugs, while Massachusetts is covering everybody's health insurance for $2,000 per person. That's a pretty good outcome. By my estimate it will require about $1.2 trillion over ten years to take the Massachusetts approach and extend it nationally.

However, I would argue this is not money down the drain. It is consistent with both our short- and long-term economic goals. That is, even if you don't care about the uninsured, even if you don't think it's a moral issue that we cover the uninsured, economically this is well spent money in the short term. This is stimulus money that can go through states, and in the medium term this is money that should create quality jobs. Let's face it, jobs in the future in the United States will be in the service sector, and the health sector can be a great source of quality jobs, particularly as we move primary care away from people with eight years of medical training and let people take blood pressure after just one year of medical training. We can actually make jobs for people that don't have enormous barriers to qualify for them, to help with primary care. And in the long term this sets the stage for the real battle, which is controlling health care costs.

Incremental Universalism: The Policy Decisions

If you're going to take the Massachusetts reform national, as we're currently debating doing, there are decisions you have to make.

We currently have six proposals: three bills in the House that are basically the same, two in the Senate that are quite different, and President Obama's recent speech to a joint session of Congress, in which he laid out certain goals to achieve. Let's look at where there is agreement among all these sets of actors and where the disagreements arise.

1. Individual Mandate

You cannot get to universal coverage without an individual mandate. It's simply impossible. I know that because today one-third to one-half of the uninsured are already offered free or heavily subsidized insurance but don't take it. Four-fifths of uninsured kids right now could walk into a Medicaid office and get free public health insurance but don't do it. One-third of the uninsured are offered heavily subsidized health insurance by their employer, but they don't take it because they think they're invincible and they don't need it. So there's no way to get to universal coverage unless you have a mandate.

Moreover, remember when I talked about the three things you need to do—the first one was to enforce pooling. If you want to have the health insurance market work, you have to pool the healthy and sick. You can't have just a pool of the sick or it won't work. The problem is you can't do that without a mandate. Six states have tried, including both New York and Massachusetts. Six states have passed laws that said, "In the non-group market you can't charge the sick more than the healthy." So what has happened? Those six states are now six of the eight most expensive states in the country in which to buy non-group insurance because insurers say, "If we can't tell who's sick and who's healthy and charge them differently, we're just going to charge everyone a fortune to make sure we don't lose our shirt on the sick people." In Massachusetts, before we passed our law, a typical individual at age 40 who wanted to buy non-group health insurance would pay $8,000 for the first year, because insurers had to cover their bases to make

sure they were charging enough to cover the inevitably sick people who were signing up (America's Health Insurance Plans 2007). Without a mandate that forces the healthy people to come in and buy, you can't get that pooling that's so important, and, as I said, that worked in Massachusetts.

There's general agreement on this first issue. President Obama, after opposing it—to my chagrin—in the primaries and the general election, has embraced the individual mandate. There's a lot of differences on the details, but the general principle is supported by all six players at this point. That's a major accomplishment.

2. Employer Responsibility

Here's where some of the differences lie. What should the role of employers be? One view, which is sort of a center-right view, is "Employers already help provide health insurance. They're doing their job. Let's leave them out of this." The political left counters, "But many employers aren't doing their jobs. They're not providing health insurance. We need to force them into the system, make them players in the system." The extreme version of this is the House bills, which I will call the 8 percent pay-or-play tax, in which employers above a certain size who do not offer health insurance have to pay 8 percent of their payroll in a fee to the government.

The key point supporters like to raise is that this is "shared responsibility." You have to have employers share responsibility. But here's also where economists call the bluff of the policy makers, which is that any charge on an employer is just passed on to the workers in the form of lower wages. All you're really doing with employer responsibility is taxing low-wage workers who aren't offered health insurance. It's not clear why that is something you want to do in the next health care reform.

Moreover, many people say if we don't have a pay-or-play system for employers then employer-sponsored insurance will go away. Once again, we've seen in Massachusetts that's not the case. We don't have a pay-or-play and employer insurance has not gone away. But employer responsibility is going to be one of the two or three major dividing issues as we attempt to merge the bills in the Senate, as we go ultimately to conference.

3. Affordability

The number one issue before Congress is that you can't mandate that people buy health insurance if it costs 40 percent of their income. That's just mean, and it doesn't work. So what can you make work? We could make it free for everybody, as it is in Canada; that's pretty moral and that's affordable. But it's a budget buster for our government. We need to think about affordability as a tradeoff between affordability to people and affordability to the government, which is a very hard tradeoff.

In the House bill insurance will be free until about 150 percent of the poverty line, about $30,000 for a family of four. From that point, people will start to pay on a rising basis until they get to 400 percent of the poverty line, or about $80,000 for a family of four, about 12.5 percent of their income. So people go from paying nothing at about $30,000 to about 12.5 percent of income at $80,000 on a rising basis. That is the House's view of affordable.

The Senate's view is that people pay 3 percent of their income right at the poverty line, right at $10,000, and the premium rises to 13 percent of their income at $60,000. The Senate views affordability as people paying much more than the House does. There's a real debate about what is affordable, and there's no right answer here.

The problem is it starts to go hand in hand with the mandate; you can't mandate insurance that's not affordable. This is going to

be a major issue. Right now there's a Senate Finance Committee bill that costs about $750 billion over ten years and a House of Representatives bill that costs about $1.2 trillion over ten years. The big difference is: how much are poor people going to pay under the mandate?

That's the single biggest difference, the only substantive fight. If some wonderfully generous donor came forward tomorrow to the government and said "Here's a trillion dollars to pay for health insurance," this thing would be over in two weeks. It's the money, it's basically raising the money, and how much you want to spend on this versus other domestic priorities.

4. Minimum Benefits

You also can't have a mandate without defining the minimum benefit. If you just say there's a mandate to have health insurance, then anyone can start a health insurance company that sells a health insurance policy for $1 so people can meet the mandate.

This gets tough because people all have different views about what should be in a health insurance plan. The more richly you define the minimum package, (a) the more it costs people, so you're mandating they buy some expensive benefits, and (b) the more you're telling people who already have insurance they have to buy up. Remember, the goal of this reform is to leave those people who are happy alone. For instance, during the presidential campaign Hillary Clinton initially said everyone should have health insurance that's as good as members of Congress. But members of Congress have health insurance that's more generous than that of 90 million Americans, so if you did that you'd be telling 90 million Americans "Now you have to buy more expensive insurance than you used to buy." That's like pulling them right off that boat, that's not going to work. The problem with minimum standards is our general liberal instincts to want to cover everything run into the

fact that you can't have an even standard that goes too far above what people have today or they'll revolt.

Isn't This Rationing?

What I've been talking about—paying doctors less and defining what's in the benefit package—is not rationing. What we're talking about is the government establishing the minimum level of benefits that we subsidize, after which people can buy as many additional benefits as they want. I think that's very important to keep in mind in this debate.

5. Tax Exclusion of Employer-Sponsored Insurance (ESI) Benefits

Remember I mentioned the people who are fortunate to buy insurance on that nice boat? Here's why they're on this nice boat—because they're not taxed on the health insurance they get from their employers. We have to pay for health reform, and there's a natural way to pay for it—tax their ESI benefits.

Think of it this way. Let's say my employer comes to me and says, "We want to give you an orthodontia benefit to cover your children's braces. That orthodontia benefit will cost us $1,000. But we're going to offer you a choice. We can give you the orthodontia benefit and not give you a raise or we can raise your salary by $1,000. Think about it." Well, the way that I should think about it is, is the orthodontia benefit worth $1,000 to me? But that's not the way I think about it.

Instead, I think: if I get that $1,000 in wages I'm going to be taxed on that as income. At my tax rate I'll only take home $600 from the $1,000 in wages. So it's really $1,000 of orthodontia versus $600 in wages. If I take that $1,000 in wages I'm only going to keep $600 of it. If I get the $1,000 of orthodontia I keep the whole $1,000. So I'll take the orthodontia benefit.

Now I'm overinsured, because the government has bribed me to be overinsured. By not taxing the health benefit and taxing my wages, they have bribed me to overinsure. This tax bribe cost the federal government $250 billion this year in lost tax revenues, an enormous amount of money.

Moreover, it's what we call regressive, that is, the higher wages you earn the bigger tax break you get. If my employer pays my secretary wages of $1,000 a week, she takes home more like $700 or $750 dollars compared to my take-home of $600. So it's a bigger tax break for me to get that health insurance instead of the wages.

Eliminating this tax exclusion is a natural source of financing health care reform except, of course, for the politics. It's pretty hard to defend to constituents, because it feels like a tax increase. If the government now taxes some of your health insurance, that feels like a tax increase. And that's not going to fly with the American public.

My friend Senator John Kerry actually came up with a clever solution, which was debated seriously within the Senate Finance Committee. Originally the debate was about capping the taxes. If your health insurance is more than a certain level, you get taxed on the excess. So if your health insurance costs more than $10,000 you get taxed on the extra. But that's the wrong road to follow. Kerry suggested, "Let's tax the insurance companies for selling high cost policies." And that is actually in the Senate Finance Committee proposal.

That provides about $250 billion raised over ten years by taxing the insurance plans that cost more than $8,000 for an individual and $21,000 for a family. Just to get a sense of proportion, that's about the richest 10 percent of health insurance plans, plans with the 10 percent most generous benefits.

6. Specificity/Governance

How specific should this legislation be? In Massachusetts our legislation was deliberately quite vague. It said things like, "We should have a mandate if it's *affordable* but we're not going to define affordable. We're going to have subsidies but we're not going to specify what they are. There should be a minimum benefit package but we're not going to tell you what it is." And then the Health Connector Board had to make all these decisions. I think we made them pretty well, and we certainly made them with great consensus and in a politically successful way. In some sense the Congressional legislation is getting hung up right now on details like these, which I would suggest should be left to a process down the road, where more expert people can deal with them.

Cost Control

This is an important issue to understand and put in the context of the current debate. There are basically two types of cost control.

What I call win-win cost control sounds good and does good. But it doesn't save any money.

- Invest in *information technology,* electronic medical records. Great idea; it won't save any money, but it will improve the quality of our health care.

- *Preventive care;* great idea, it will improve our health, but there's no evidence it will actually save us any money.

- *Comparative effectiveness research and guidelines,* study what works and what doesn't. How can you be against studying what works? But it doesn't matter just to study it. Unless you tell doctors they can't do it, it's not going to save any money to just know it doesn't work. We know lots of things don't work that people still get.

The real substance of cost control is all about a single thing: *telling patients they can't have something they want.*

- It's about telling patients, "That surgery doesn't do any good, so if you want it you have to pay the full cost." It's basically about saying that we as a society are going to have a minimal insurance package that reimburses effective treatments but that makes people pay on their own for ineffective treatments.

- It doesn't deny treatment. For instance, in England you *can't* get an organ transplant if you are over a certain age. That may be good policy or not, but it will never happen in this country, not in our lifetime.

There's no reason the American health care system can't be, "You can have whatever you want, you just have to pay for it." That's what we do in other walks of life. We don't say everyone has to have a large screen TV. If you want a large screen TV, you have to pay for it. Basically the notion would be to move to a level where everyone has a solid basic insurance level of coverage. Above that people pay on their own, without tax-subsidized dollars, to buy a higher level of coverage.

The Public Option

The closest we have come to that in the debate is the so-called public option. The public option was a brilliant idea of Jacob Hacker, a political scientist at Yale. The left wants single payer and the right wants no government involvement in health care. What if we say we're going to have an option for people to buy government insurance? The left says aha! the government's going to take over. The right is thinking to themselves, aha! the government as an insurance provider will be run out of business. But both sides have to put their money where their mouth is. If they really believe what they believe, how could they be against this? If the left really believes it's better to have the government

run insurance, how can they be against having them compete with private insurance? If the right really believes the government's a terrible provider of insurance, how can they be against putting it to the market test? Very clever idea. But basically what happened was that the left realized the public option wasn't as good as a single payer and the right realized that the government might actually succeed. So at the end it's become very unpopular.

Two Elements of the Public Option

There are two elements to the public option, one meaningful, the other meaningless.

- The public option provides a mechanism for the government to *regulate provider rates*.

This is important. There's a fundamental problem with the market negotiation between insurers and providers. In the 1970s health care providers charged whatever they wanted insurers to pay them. Then, starting to ease into the mid-90s, insurers began saying to the hospitals, "We're not going to send you patients unless you give us a discount." To which the hospitals responded, "Oh, OK! Here's a big discount!" and health care costs actually grew less than inflation from 1995 through 1997. Then in the late 1990s the providers woke up: "Nobody's going to buy insurance if it doesn't include us in the network. We can charge whatever we want!" Providers realized they had what is called in economics *monopsony power* (in a market dominated by a single buyer, the market power to set the price of whatever it is buying). They had the power that comes from their strong reputations. As a result, it is very hard to allow competition to actually get that market to work. You need regulation.

Part of the public option that would have worked well would have been to actually regulate rates. The public option would have paid Medicare rates. Now, one might argue the Medicare rate is too

low. Should the rate be Medicare plus 5 percent, or Medicare plus 10 percent? I can't tell you. The key point is, if we're going to get health care costs under control we're going to have to include some rate regulation by the government as part of that ultimate package.

That part is dead in the water. First, doctors don't like it. Second, the insurance companies don't like it because they know if there's a public option available at lower rates then the public option will wipe them out. The doctors and the insurers formed a pact opposing this bill. So while lower rates, that part of the public option, is in the House bill it's not going to happen.

- The public option provides competition to keep private insurers honest.

Unfortunately, this is what the debate has actually focused on. When you hear about the public option it's not about the rates, it's about how we need a government run insurance plan to keep the private insurers honest. But this is just not a big deal. Yes, insurance markets aren't that competitive. But if you have an insurance market and add one more insurer, even the federal government, it's not going to make it that much more competitive. If the public option pays the same rates as the private sector it just isn't that big a deal.

That's why I predict the final bill will have no public option, or if it does it will have some incredibly toothless version triggered in the year 2073. This debate has gotten far more attention than it deserves.

Moving Forward Incrementally

The public is not yet ready to perceive the need for health care reform as a crisis. The analogy is something like the different responses to global warming and chlorofluorocarbons (CFCs).

For about 20 years, up until the 1970s, we used aerosols with CFCs (non-reactive, non-flammable, and non-toxic propellants) in them. But evidence started to accumulate that CFCs might destroy the ozone layer, which protects human and animal life by absorbing ultraviolet rays from the sun. So the United States banned the production of CFCs in 1977. Then, in 1985, an article documenting an overlooked hole in the ozone over Antarctica appeared, and all of a sudden people went "There's a hole in the ozone layer! We have to do something about it!" Several countries got together, banned chlorofluorocarbons, and the chlorofluorocarbon market today is 3 percent of what it used to be. It worked!

By comparison, global warming is a much weightier issue. Skin cancer is bad but drowning is worse. But there's no hole in the ozone layer, there's no parallel shocking revelation, and that's why we aren't moving forward on global warming.

Health care reform is similar. We all know it's a problem. We all know that the US is being bankrupted by rapidly rising health care costs. Just to finance the Medicare program, to put it on a solid footing for the foreseeable future, would require imposing a 15 percent payroll tax. Every person in America would have to pay 15 percent of their wages to the government, basically doubling the tax burden of most American families. This is a huge long-run problem.

But it's not a short-run problem. Sure, we would like health care to be a little cheaper, or the cost to rise more slowly, but Americans aren't ready to deal with the hard measures we'd have to take to get health care costs under control. That's why I've been arguing strenuously that even though the bills that will come out of this process in the end won't do a whole lot about cost control, they're still a critical first step. Because, to wax political economy here for a second, what's the history of health care reform in the US? We have tried on average every 17.9 years for the last 50 years to have

a major health reform, and every time it's been killed because the people who would get hurt by cost controls have opposed it.

Divide and Conquer: First Universal Coverage, Then Cost Control

So what's different this time? Why are we closer than we've ever been before? Because there are no cost controls in these proposals. Because this bill's about coverage. Which is good! Why should we hold 48 million uninsured people hostage to the fact that we don't yet know how to control costs in a politically acceptable way? Let's get the people covered and then let's do cost control.

Now you might say "That's a leap of faith—just getting people covered makes the costs go up." But look at what happened in Massachusetts. They pushed through a universal coverage bill. About six months later they realized, "Whoa, wait a second! We'd better get health care costs under control or we're not going to be able to afford this program." So they lobbied and the Massachusetts legislature passed one of the most important health care cost control pieces of legislation in the country, which set up a commission that recommended—we're working on the legislation now—to move to a new physician reimbursement system to try to deal with some of the excesses that these powerful hospitals are charging for care. That happened because first we got to universal coverage. Now everyone is pulling in the same direction.

It's the same in the US. We need to get the coverage question out of the way, get everyone pulling in the same direction, and then we'll get to cost control. But if people hold out for a bill that controls health care costs we won't have a bill. And then 48 million people, 50 million a year later, and so on, will still be uninsured. That really is a moral failure.

That's why I say, let's not let the perfect be the enemy of the good. Let's get the bill done now that covers people for health insurance,

and then let's move forward to cost control as we can do it, as we go along.

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