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## Our Troubled Health Care System: Why Is It So Hard to Fix?

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Our Troubled Health Care System:  
Why Is It So Hard to Fix?

*Judy Feder*

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This brief draws heavily on her 2004 article, “Crowd-Out and the Politics of Health Reform” *The Journal of Law, Medicine, and Ethics* 32(3): 461-464.

The Herbert Lourie Memorial Lecture on Health Policy, sponsored by the Maxwell School of Citizenship and Public Affairs of Syracuse University and the Central New York Community Foundation, Inc., honors the memory of Herbert Lourie, MD, a distinguished Syracuse neurosurgeon, professor, and community leader for nearly 30 years. Generous contributions from his family, friends, colleagues, and former patients have endowed this series.

The Policy Brief series is a collection of essays on current public policy issues in aging, health, income security, metropolitan studies, and related research done by or on behalf of the Center for Policy Research (CPR) at the Maxwell School of Syracuse University.

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## Policy Brief

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Our Troubled Health Care System:  
Why Is It So Hard to Fix?

*Judy Feder*



# **Our Troubled Health Care System: Why Is It So Hard to Fix?**

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## Introduction

It is such a privilege to be giving the Lourie Lecture. I did not know Dr. Lourie nor do I know the members of the family but he certainly sounds like an individual who would care very much about the issue that I'm going to speak about, which is the fundamental assurance that all of us have affordable health care when we're sick.

We know that affordable health care is now back on the political agenda, and it's about time! Because all of us—families, businesses, and governments—are struggling with the ever-increasing costs of care. Every year about a million people are added to the rolls of the uninsured. In 2006, it was many more, over 2 million (U.S. Census Bureau 2007a). The number of people without health insurance coverage has reached more than 47 million. People with insurance are seeing their benefits dwindle and their health care costs consume their wages (Kaiser Family Foundation 2007a, b). Even people with health insurance find themselves unable to pay their medical bills and going without needed care. The bottom line is that, increasingly, our health insurance system fails to protect us when we get sick.

I'd love to think that providing the evidence on the problems people are facing, along with the stories of their struggle, would be enough to get us the political action we need to get everybody coverage. But sad to say, we've been here before. Despite long recognition of the problems we face and spurts of activity, we have not acted to get us all coverage.

### *Lourie Memorial Lecture Policy Brief*

Why is it so hard for us to achieve a goal that for most of us seems so obvious? Since you know that I've been working on this issue for better than 30 years, I need to start by telling you that the failure is not because we're stupid. Rather, it is because we as a nation have become invested in a health care financing system in which 85% of us have health insurance and 15% of us do not. Although those of us who have health insurance could lose it at any time—by losing a job, getting a divorce, or even getting sick—at any point in time the minority 15% of people who are without health insurance are disproportionately low- or modest-income people in jobs that don't offer coverage. They aren't organized as a group. They are less likely to vote than those of us who have health insurance, and they definitely aren't making campaign contributions. The problem is that when we look at policies to get them covered, we can't get them coverage without in some way affecting everyone else's coverage as well.

It would be great if we could wave a magic wand, tap everybody who's uninsured on their heads, and bring them into the system. But it takes money from us to enable those with low and modest incomes to pay for health insurance. And any policy change that we are likely to make is unlikely to affect only the uninsured. Establishing a mechanism to get everybody covered is highly likely to affect those of us who already have coverage.

The political challenge, then, is to assure those of us who have coverage that we, along with the uninsured, will benefit, not lose, from political action.

### **Our Troubled Health Care System Is No Accident: How We Got Where We Are Today**

How did we get into a system that keeps leaving people out? When I use the term "system," I want to challenge many people who look at the fragmentation of different public and private plans, the fact that people can fall through cracks, and argue that we have no system. There certainly isn't a simple system, but if

*Judy Feder*

we argue there's no system it sounds as if we got here by accident. And that's not true.

The fragmented, unsatisfactory health financing system that we have come about as a result of political choices we made over the last half of the twentieth century (Starr 1982b; Fuchs 1993, Ch. 14). The failure of our political system to enact a national health insurance or health care system as was happening in other countries in the first half of the twentieth century meant that we only began to get coverage through the growth of private health insurance (Starr 1982a). Private insurance through our jobs began to take off in the 1940s. To circumvent wartime limits on wage increases, employers began offering broader fringe benefits (see Lawrence 1996, 5-6). There were favorable tax treatments of those benefits, and employer health insurance began to grow. As people who advocated public insurance observed these events and recalled the difficulty they had experienced in trying to get a public health insurance system adopted, they redirected their strategy toward building around the employer-based health insurance system.

And so it was in the 1960s that they began to advocate for health insurance for older people who, it could be argued, were not going to get coverage through the workplace. After a great political battle (Harris 1966; Marmor 1973), in 1965 we enacted Medicare for older people as well as Medicaid for some poor people who were also deemed unlikely to get coverage from the work-based system—largely children, pregnant women, and people with disabilities.

For a while those systems grew. Employer-sponsored health insurance kept on growing, Medicare expanded to people with disabilities, and Medicaid, with some serious ups and downs, has expanded substantially, particularly to cover children. But about the late 1970s and early 1980s the expansion of private health insurance through jobs began to slow, and it failed to keep up with the growth in population. That's when we began to see a system that had never covered everybody, even in times of

*Lourie Memorial Lecture Policy Brief*

prosperity, doing a worse and worse job over time. And public programs failed to fill the gap.

Who is left out of the employer-based health insurance system? I alluded to it earlier: low and modest wage workers in jobs that don't offer health insurance. They're the same people who are left out of our Medicaid system. Medicaid doesn't cover all poor people; it covers people whom we've labeled "the deserving poor." With the state children's health insurance program (SCHIP), which was recently extended until March 2009, Medicaid does pretty well by our kids, going up above the very poor to get into near-poor and modest income families who aren't getting coverage in other ways. But mothers are pretty much only covered when they're pregnant. In most states, parents are not eligible for Medicaid if they earn even the minimum wage. And adults who are not parents of dependent children are not eligible for Medicaid, no matter how poor they are, except in states that have special arrangements with the Medicaid program.

What that tells us is that the adults who don't get coverage through work don't get coverage through public programs. They are just plain left out. And they are not a very popular group to focus on when you're advocating for expanded coverage. The assumption seems to be by many in the political system and many in the public that these adults ought to just get jobs that provide them care—as if that were so easy to do.

So when we look at ways to expand coverage incrementally by picking one or another group that might be regarded as politically popular, now that we've taken care of, in some sense, older people, people with disabilities, and kids (although we're struggling here) what I believe is—all the good groups are taken.

### **Universal Coverage Is the Solution**

The only way to get everybody covered is to enact a policy of universal coverage. To get that action is going to require those of us who are committed to it, and those of us who are in political leadership, to persuade the 85% of us who have health insurance

*Judy Feder*

that we will be better off, not worse off, if we bring everybody else in.

*The 1993-94 Clinton Health Plan*

That was what we tried to do when I served in the Clinton administration, to get universal coverage. I don't want to dwell on that Clinton plan because I've got a lot of scars from that period, and I'm not sure it helps us a whole lot to dwell on the past. But let me just give you a little snapshot of what I think happened there.

The Clinton effort to get everybody health care coverage was focused like a laser on building confidence among people who had health insurance that we needed action to make our coverage secure, and that all of us needed to be in that health care system to make it efficient, fair, and effective. How did we design a policy to try to persuade everybody?

1. First, we tried not to mess with people who had health insurance. By requiring all employers to provide coverage we aimed to lock in the benefits that people who had coverage were afraid they were going to lose. And at the same time, we locked in the money that employers were paying for health care to keep the public cost of that initiative more affordable.
2. Second, we proposed to finance the subsidies that people inevitably need to make health insurance affordable not with new taxes but with the savings we were going to get by slowing the growth in health care costs.

I think as analysts we did a great job in designing that plan. It worked fabulously—on paper. But the politics were, in a word, a disaster. We made what we thought were going to be well-received new rules for insurance companies, so that everybody could get insurance without being discriminated against based on their health status, and would also save money. But rather than

### *Lourie Memorial Lecture Policy Brief*

welcoming that as a simpler, fairer system, opponents challenged it as big government messing with people's insurance plans.

On cost containment, where we aimed to slow the ever-increasing growth in health care costs and get better value for the dollar, instead of appreciating that, we were challenged as rationing health care.

These charges of big government and rationing scared the voters, who came to believe that they would be worse off, not better off, if the Clinton health reforms were enacted. Were they right? I don't think so, but the charges worked. So the question for us today is whether charges—like calling an expansion of state children's health insurance programs "socialized medicine"—still work to scare us away from the reform we need.

### **Campaign 2008: Candidates' Proposals for Universal Coverage**

There are several proposals for universal coverage coming out of the presidential debates ([health08.org](http://health08.org)). We know from experience it is really hard for people to follow these proposals, much less to judge whether any of them are really good. There are many ways to get to universal coverage, but not just any way will get us there.

#### *The Three A's: Adequacy, Affordability, Availability*

How can we distinguish a good proposal from a bad one? There are three critical elements that will help us know when we have a plan for good, meaningful health care coverage and when we have a fake. These three elements can be thought of as the three As: if you satisfy them all, your plan gets a AAA rating.

The three A's are:

1. Adequacy
2. Affordability
3. Availability, without regard to health status.

*Judy Feder*

Let me go through them, one by one, telling you what to watch for and what to watch out for.

#### Adequacy of coverage

This means a set of insurance benefits that actually protects people when they're sick. It has to cover the full range of medical services that medical practitioners are likely to prescribe. It's all right for us to pay something, but cost sharing has to be limited to levels where what we pay is reasonable in relation to our income; and there has to be some cap on out-of-pocket spending that people can realistically afford, so that those of us who have health insurance don't go broke when we get sick. An adequate benefit can't be a doughnut, with a hole in the middle, like we see in the Medicare part D drug benefit, and it can't be Swiss cheese, with all kinds of holes and limits that are only in the fine print of our health insurance policy, our contract, and that we never become aware of until we need care.

When we look for adequacy of coverage, we have to be aware of at least two other types of proposals, those that don't specify benefits but leave it to insurers to define what's covered, and those that require deductibles so high they impede access to care, for example, as in health savings accounts.

In short, a proposal with adequate benefits differs from proposals that are based on the premise that any insurance, being better than none, is good enough. That is simply not true if the goal is to assure meaningful access to care when we're sick.

#### Affordability of coverage

We have abundant evidence that without subsidies, low- and modest-income people will not buy insurance voluntarily. And that's reasonable, that makes sense. Two-thirds of the people without insurance have family incomes that are below twice the federal poverty level, or about \$40,000 for a family of four (U.S. Census Bureau 2007a). Do we really think it's reasonable for families with incomes of this level to spend on average \$12,000—the cost of a comprehensive family insurance policy—

*Lourie Memorial Lecture Policy Brief*

from their own pockets? (Kaiser Family Foundation 2007b) That is more than families can afford. And those are just the premiums, it doesn't even count payments for cost sharing or services not covered by insurance.

What about mandates?

We hear a lot about mandates, about requiring individuals to have coverage. Personal responsibility is a fine thing, and I believe that everybody should pay a fair share, taking their income into account. But rather than being a policy in and of itself, a proposal for a mandate is often a smokescreen for inadequate coverage. A mandate without a subsidy is either punitive or pretend. It either shouldn't happen or it won't happen, because you can't get blood from stones.

In contrast to such misguided mandates, proposals that provide significant subsidies, that assure coverage at no cost for people with very low incomes and then have a sliding scale—which is exactly what SCHIP is doing, although SCHIP does not have a mandate—that is a reasonable basis for requiring people to pay, because it requires something that people can afford.

Availability of coverage

By this I mean assurance of a place to buy insurance, somewhere that makes adequate, affordable health insurance available to everybody without regard to their health status or their age. That place can offer a choice of health plans, like members of Congress get, or it could look like Medicare. Or, if we change the rules for private insurance so that they can't discriminate or charge higher prices because we're older or sicker, it could even be existing private insurance plans. When we look at a proposal and try to assess availability, we have got to beware of proposals that simply send people shopping for insurance in a market where insurers deny coverage to people when they need care, like the current non-group health insurance market, or charge more because you're older or have had an illness or are cherry-picking us when we're healthy and avoiding us when we're sick. Any

*Judy Feder*

proposal worthy of the name insurance has got to work for us when we're sick.

In addition to getting a AAA rating, an effective health reform proposal has to have enough financing behind it, whether from individuals, employers, or tax payers, or some combination most likely of all three. And it can only sustain that protection over time if it includes a way to slow health care cost growth, not only for people who are now uninsured, but for everybody, including those of us who depend upon Medicare and Medicaid. We can all be better off, and more willing to commit to universal coverage, if we invest in research that determines for us which medical services work and which do not, and an information and payment system that helps providers deliver the former and avoid the latter.

A recent RAND study tells us that we are only likely to get the right treatment about half the time (McGlynn et al. 2006). This is widely regarded as providing very strong evidence that our likelihood of getting appropriate care is no better than a coin toss. We need to invest in the mechanisms that will help our providers do better.

When we look at the proposals that are on the presidential candidates' websites, we find that the Democratic candidates' proposals do pretty well by these AAA criteria, whereas the Republican proposals do not. I will admit that I am a Democrat, but I want to assure you, this is not a partisan conclusion (see <http://health08.org> for a current side-by-side comparison of the candidates' proposals). Because when we look at what's happening in the states, whether it's with former governor Romney in Massachusetts (Boston Globe 2006) or Governor Schwarzenegger in California (O'Malley 2007), those Republican governors were building proposals that are on their way to satisfying the AAA criteria. What works here is not partisan, it's what evidence tells us makes sense.

To have those proposals on the table is a wonderful thing. It gives us hope that after the next presidential election we will move

*Lourie Memorial Lecture Policy Brief*

forward with the universal coverage legislation that we need. But our history is filled with debates on coverage policies that generate far more heat than light. For decades, instilling fear among those of us who have health insurance, even if it costs too much or covers too little, that political action is going to put us in a worse position, not a better one, has taken health reform off the political agenda. Most recently we can see those efforts in SCHIP, calling the expansion “socialized medicine.” I wish we were winning that debate, but as we have seen in the past couple months, the President and a minority in the Congress are still able to carry the day and leave our children at risk (Iglehart 2007). But the majority in the Congress, and I believe the majority in the public, can see through the smokescreen that’s being put up to prevent access. I believe that we are exposing the rhetoric opposing SCHIP for what it is—empty, ideological, and mean spirited.

I’m hopeful that the worse cost and coverage gets, the harder it is going to be to scare us away. Whether that’s true will depend in the next couple of years on whether we can trump fear with confidence that we can do better—because we can. In the Clinton reform days, I know many of you will remember Harry and Louise, fictional characters in the health insurance industry’s ad campaign who misleadingly, but effectively and relentlessly, picked apart the Clinton health reform proposal by asserting over and over again, “There’s got to be a better way.”

We don’t need fictional characters today to tell us our system is broken. Our moms and dads, our brothers and sisters, and our friends and co-workers fill that role every single day. The time for debate and discussion was more than a decade ago. Please join me in making the time for action now.

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*Judy Feder*

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