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Health care reform: Where do we go from here?

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Will universal health insurance ever become a reality? In the following article, based on his address in October as the 1994 Margaret Chase Smith Lecturer, former Massachusetts Governor Michael S. Dukakis suggests that efforts to establish universal coverage will continue. He argues, however, that the success of these efforts depends on the public adhering to the principle that all citizens will contribute to a system of universal coverage.

Michael S. Dukakis

For those of us who have been fighting the battle for universal health insurance over the past two decades, 1994 was a frustrating and difficult year.

A thoughtful, energetic and deeply committed young president had been elected in 1992. He had made health care reform a major issue in the campaign. He had begun work on it even before he took office in January of 1993. And he had asked his equally thoughtful, energetic and deeply committed wife to chair the task force that was asked to develop the details of the new program.

Some people thought that the role the President had asked Hillary Clinton to assume was unprecedented. But students of history know that Eleanor Roosevelt was deeply involved in a whole host of issues during the New Deal. Roslyn Carter made mental health her issue during the Carter presidency. And Barbara Bush had devoted hours and hours of her time to the cause of adult literacy while her husband was president.

Furthermore, many Republicans seemed to share the President's commitment to health insurance for all Americans, even though there was disagreement on some of the details. In fact, nearly two dozen Republicans, including Bob Dole, co-sponsored Senator John Chafee's bill that would have required all Americans to purchase health insurance for themselves and their families, coupled with a wide-ranging program of insurance and malpractice reform and subsidies for the working poor.

In short, the stage seemed to be set for what some were calling the most important piece of social legislation since Social Security. And the reasons for what seemed to be a broad bipartisan commitment to the principle of universal health coverage were not difficult to find. The U.S. was paying twice per capita what virtually every other advanced industrial nation in the world was spending on health care. These other countries provided insurance coverage for everybody while we were unable to do the same for forty million of our fellow citizens. A deep and prolonged recession had been a painful reminder to many Americans that to be laid off in the U.S. meant not only losing one's livelihood but one's health insurance as well. And the quality of the American health system, while admittedly the best in the world for people of wealth and those with comprehensive insurance, was anything but the best if one had the misfortune to work for an employer that did not provide health insurance for its employees.

Health costs had been growing for years at triple the rate of inflation. Small businesses in many cases found that it was impossible to insure their employees at a cost they could afford.

And God forbid you had been sick, were sick, or might be sick. You could not insure yourself at any price, nor could your employer.

What was even more troubling about the state of health care in America was that spending one trillion dollars per year and over fourteen percent of our gross domestic product on health care was not making us any healthier than our neighbors and friends in the other industrialized countries. In fact, our health outcomes were mediocre at best. The U.S. today ranks 17th in life expectancy. Cuba has a lower infant mortality rate than we do.

Furthermore, we had been debating the issue for years. In fact, the first president to seriously advocate universal health insurance for America was a progressive Republican named Teddy Roosevelt. Harry Truman first filed legislation in the Congress for universal coverage nearly fifty years ago. Congress passed Medicare and Medicaid nearly thirty years ago. Presidents Nixon and Ford both proposed universal employer-based plans not unlike the Clinton plan in the 1970s. In short, the issue had been discussed, debated and dissected for decades. 1993 finally seemed like the year when big things were about to happen.

So what went wrong?

Why, when all the stars seemed to have lined up in just the right way, did Congress fail to approve not only the president's plan but any one of a number of variations that would have given us universal, or near-universal, health security?

Let me begin by saying that I think the President and the First Lady deserve an enormous amount of credit for putting health care reform at the top of the national agenda. Without them we would not have had the year of debate and discussion we have had. Nor, in my judgment, without the threat of sweeping reform, would we have seen anything like the changes that are already taking place in the health care industry.

Furthermore, secrecy in developing the President's plan was not the problem. It is true that refusing to release the list of members of the President's task force was an avoidable mistake. I used to tell my staff members in the governor's office that if they put something in writing, they ought to expect that it would appear on the front page of the Boston Globe—and if they put "confidential" on it, guaranteed it would be a front page news story.

But the process itself was about as open as any we have ever had. Eighty or ninety members of the task force were top Congressional staff people. The First Lady met repeatedly with members of Congress. The administration attempted to involve virtually every constituency in the health care world—and there are hundreds of them. And once the plan had been developed, both the President and Mrs. Clinton did dozens and dozens of town meetings, sometimes separately and often together. Kitty and I were at one of them in Deerfield Beach, Florida, and it was the closest thing to real communication between average citizens and the First Family I had ever seen.

Nor should we be surprised that some of the issues involved in trying to make health insurance universal in this country were politically difficult. You cannot have universal coverage without a mandate — whether it is a tax mandate, an employer/employee mandate, an individual mandate, or a combination of all three. In fact, we have an employer mandate of sorts today that ought to have responsible members of the business community screaming for the kind of mandate the president proposed. Why? Because when seventy-five percent of the employers in this country do the right thing and insure their employees, they are forced to pay as part of their premium a hidden tax that represents the cost of free care to the employees of their competitors who don't insure. In some states, depending on the number of uninsured workers there are, that hidden tax can amount to twenty or twenty-five percent of the total premium.

But ideology often triumphs over reason, even when the corporate bottom line is directly involved. It was perfectly predictable that an employer mandate would face opposition from the National Federation of Independent Business, the principal small business lobby in Washington. What was not so obvious was that the United States Chamber of Commerce would first endorse an employer mandate for all the right reasons and then do a 180 degree turnabout within a matter of months.

Moreover, any effort to get the rate of increase in health care costs down to something close to the general rate of inflation, either through the creation of health alliances or the imposition of some kind of premium cap, was bound to generate opposition from health care providers, insurers and others in the health care industry who, not surprisingly, prefer no limits on what they can charge or earn.

Three things, however, clearly did great damage to the President's effort.

First, the fact that the president's budget and economic program were not finally approved until early August meant that he could not bring health care reform to the Congress until September rather than May, as he had originally planned. Under the circumstances, serious debate on health reform could not begin until well into an election year, and the closer we got to the Congressional elections, the more difficult it was to get the kind of bipartisan consensus that everybody said they wanted. Bob Dole is a case in point. Early in the deliberations Senator Dole said that universal coverage was a must, and the only question was how to get it. As if to underscore that point, he was one of the most prominent co-sponsors of the Chafee bill. But the closer the debate got to the Congressional elections, the weaker the Senator's commitment seemed to be to anything worth passing. And as the public relations assault continued to mount on the President's plan, Senator Dole finally abandoned all pretense of support for a meaningful plan and even refused to participate in the work of the so-called "mainstream" group that included Republican Senators like Chafee, Danforth and Durenberger.

Secondly, the president's plan and both the House and Senate bills that followed it were hit with an opposition campaign that Newsweek magazine estimates cost some \$300 million, \$100 million of which was spent on paid television advertising alone. We have seen multi-million dollar television campaigns in political races; we have never seen anything quite like what happened this past year in which opponents of the president's plan outspent proponents on television by something like six to one.

Finally, the president's plan — and the House and Senate Democratic versions — were done in by their complexity. Keeping it simple is always the best policy. Proposing a version of the health alliances first advocated by Alan Enthoven and the so-called Jackson Hole group would have introduced a new institutional layer of bureaucracy into what is already one of the most complicated and bureaucratic health care systems ever devised. Furthermore, suggesting that these alliances be given monopolistic purchasing power within their designated regions not only conjured up visions of a network of all-powerful entities accountable to no one but also dramatically changed the relationship between employers and their employees on health care issues, one of the strengths of an employer-based system.

Now, in fairness to the President, he made it clear in his September 22 address to the Congress that his one bottom line was universal coverage and that he welcomed any and all suggestions, amendments and modifications that would improve his bill. But opponents seized on every paragraph and every comma of the plan to accuse the President of wanting a "government-run" health care system. Ironically, in recommending an employer-based system with non-profit purchasing alliances, the President bent over backwards to try to keep the government out of it. Furthermore, government already pays for over forty percent of the nation's health care, which makes suggestions that we keep the government "out of it" ludicrous on their face.

In short, it was a difficult, frustrating and ultimately disappointing year for so many Americans who believe in the importance of universal coverage and felt that we would finally reach that goal.

Is reform dead?

So, where do we go from here? Is health care reform dead or can we learn from the lessons of the past year and begin to make some progress toward the ultimate goal of basic health security for all Americans?

For one thing, public opinion has not changed all that much. \$100 million in TV spots certainly created doubts about the President's plan in the minds of many of Americans. But the most recent national polls tell us that Americans have not backed away from the same basic concerns that made this one of the nation's most important domestic issues during the 1992 campaign.

Seventy-two percent of us favor universal coverage. Seventy-three percent of the American people think we need meaningful cost control — and that the federal government is the only institution that can make it happen. Approximately the same percentage believe that employers should contribute to their employees' health insurance. And seventy-eight percent favor an increase in the cigarette tax to help pay for it.

We have certainly learned several lessons in the past twelve months. And one of the things we might do in looking at 1995 is to pay more attention to what the states of this country have been doing over the past fifteen or twenty years. Because if we do, we might avoid some of the stumbles as well as the missed opportunities of 1994.

And the state in which to begin is unquestionably Hawaii, which, alone among the fifty states, has been able to provide its people with virtually universal health insurance since 1974. Hawaii's system is simple, nonbureaucratic and very effective. All employers and employees must contribute to the cost of every employee's health insurance. There is a legislatively mandated core benefit package that must be provided by every insurer and health maintenance organization doing business in Hawaii. Coverage cannot be denied because of a preexisting condition. There is a single average rate for all businesses with under a hundred employees. The state buys coverage through the private market for the temporarily uninsured and those on Medicaid. There is a business hardship fund for all employers whose health insurance costs exceed five percent of their gross revenue.

As a result, all but a tiny fraction of Hawaiians have health insurance. The Hawaiian health care system is very competitive. Health costs are equal to Canada's and some thirty percent below those on the mainland. This is even more remarkable in a state where the cost of living is thirty-five to forty percent higher than it is in mainland states. And Hawaii's health outcomes are the best in the nation: the highest life expectancy and one of the lowest infant mortality rates in America.

Don't let anyone tell you that this is because Hawaiians are all out surfing at three in the afternoon and sipping Mai Tais while looking at those magnificent sunsets. What makes the difference in Hawaii is that just about everybody has health insurance and goes to the doctor when they first get sick. As a result, Hawaiians spend about forty percent less time in the hospital than we do — and that saves a lot of money.

Other states can teach us some things, too. The 1988 Massachusetts universal health law has not yet been fully implemented. But a modest surcharge on unemployment taxes of \$16.80 per year per employee now provides sufficient funds so that all employees who have been laid off and their families can get health insurance while they are on unemployment compensation. California, Massachusetts, and a handful of other states have reformed their malpractice laws. Today in Massachusetts doctors are paying malpractice insurance premiums that are substantially lower than they are in comparable states.

Failures at the state level can also teach us something. We made a serious mistake in Massachusetts in 1988 by not insisting on community rating for small businesses at the time we passed our employer mandate. States like Minnesota, which are trying to provide subsidies for uninsured workers without an employer mandate, have been forced to confront the obvious consequences of such a policy: subsidies without an employer mandate are an open invitation to employers to disinsure and are a guaranteed budget buster.

Moreover, a complex system of subsidies based on income requires another massive bureaucracy — something its largely conservative supporters say they abhor. Efforts at the state level to create pooling arrangements that make it possible for small businesses to voluntarily insure their employees have not been very successful. And unless there is meaningful health cost control — right now health costs are still rising at double the rate of inflation — more and more employers will either drop coverage for their employees or continue to cut back on their contribution and the benefits they offer. In fact, the census bureau informed us last week that a million more

Americans lost their insurance in the past year. There are now forty million of us without health insurance and two thirds of these forty-million are members of working families.

One final and all-important lesson emerges from our experience at the state level. Despite strenuous reform efforts in many states and the success of the Hawaiian system, it is inconceivable that the states by themselves can do the job. The reason for this should be obvious. If one state decides to impose a requirement on its employers and their employees to insure and its neighbors do not, it will inevitably be hit with the charge that it is forcing employers out of the state. In fact, Hawaii is the only state that has reached the goal of universal coverage in part because it is a little difficult to move. No other state can claim that distinction.

That does not mean that states should not continue to try. But it is highly unlikely that state efforts alone will move us rapidly toward the goal of basic health security for all Americans. Washington once again will be the battleground. And I would like to venture a few predictions as to what is likely to happen.

First, the President will not give up the fight, although I suspect he will go back to Congress with a set of basic principles and then work with them to craft the best possible bill. But a lengthy and detailed bill like the one he sent Congress in September of 1993 is simply not in the cards.

Secondly, a more conservative Congress is even less likely than the current one to give us legislation that will insure everyone in America. That means, I suspect, that it will be the so-called mainstream proposal that will serve as the basis for a compromise plan. That bill was the product of a lot of work by a bipartisan group of Senators. It includes needed insurance reform. It might help to cut down on unnecessary forms and paperwork. Its proposed subsidies for the working poor will help somewhat.

But even if the plan that the mainstream group produced is enacted into law, some twenty million Americans will still be required to plead for care in the emergency rooms of hospitals because they do not have health insurance. And subsidies without a mandate, as we have seen from our experience at the state level, virtually invite employers to drop health coverage for their employees and look instead to the government for subsidies.

Finally, our continued failure to require everybody in this country to contribute to the cost of health insurance will continue to impose a hidden tax in the billions of dollars on those employers and employees who do the right and responsible thing. That is not only poor health policy; it is grossly unfair. At a time when the real income of most Americans continues to decline and the gap between rich and poor is greater than in any other industrialized nation in the world, it raises serious questions about what both liberals and conservatives like to call an "opportunity society."

There is, of course, one alternative that responds to the concerns of the overwhelming majority of Americans and does so without the complexity and bureaucracy that plagued the Clinton bill and some of its successors; that is a national version of the Hawaiian system. It is certainly simple. It has been tried and tested. It has produced remarkable results. And it takes advantage of

the strengths of the private market while emphasizing that we will no longer permit the practices that have denied millions of Americans the health coverage that so many of us enjoy.

This alternative does depend, however, on the basic principle that unless we all contribute to the system, it will be virtually impossible to provide health insurance for all. That was a major sticking point in the 1994 debate. It will continue to be so in 1995 and beyond.

Michael S. Dukakis was the Democratic candidate for President in 1988. He declined to run for reelection as governor of Massachusetts in 1990. He currently is a visiting professor at Northeastern University's political science department.

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