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Op-Ed

Wrong Turn: The Wayward Path of Health Care Reform

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Optimism is a justifiably rare commodity in health policy. After all, the history of health care reform in the United States has time and again vindicated the pessimists. Efforts to enact national health insurance have come and gone for almost a century, leaving each successive generation of reformers casting about for new solutions (or recasting old ones) to break the impasse [1]. It can hardly be reassuring to those willing to renew the fight that some of our most skilled presidents—Clinton, Nixon, Truman—have tried and failed at the task. And while the winning political formula has remained elusive, proposals for universal coverage have languished in obscurity for most of the past decade.

What is the current outlook for health care reform? Is there any reason for optimism amidst the rising tides of uninsured and health care spending? If by reform we mean either adoption of universal coverage or moving close to that, as well as serious action to control health care costs, then reformers can prepare for more disappointment. Indeed, I believe that if one cares about expanding insurance coverage and providing health security for all, contemporary American health policy is moving in the wrong direction, even as the existing patchwork health insurance system continues to fray.

The Politics of Reform

The political system, it would seem, is badly out of touch with the worsening realities of the health care system, judging by its lack of attention to the uninsured. Why the disjunction? Current political alignments in Washington, a burgeoning federal budget deficit, tax cuts that have drained potential revenues, and a continued focus on national security issues make comprehensive health reform a political nonstarter. Even if Washington were to belatedly turn its gaze to health care reform, success is hardly assured. Looming as large as ever is a gauntlet of perennial hurdles: fragmented political institutions that make enactment of any major legislation in Congress—let alone a policy as controversial as national health insurance—difficult; intense opposition from well-heeled and well-connected interest groups invested in the status quo that trumps the weak political pull of the medically disenfranchised; and a strain in American political culture and public opinion that is skeptical of centralized authority and federal government power in social policy [1].

Given these formidable obstacles and the current political environment, probably the most that can be hoped for in the short run is tax credits for private health insurance, a strategy likely neither to control costs nor to substantially improve coverage for the uninsured. Quite simply, the amount of tax credits generally discussed is insufficient to

enable much of the uninsured population (which is disproportionately low-income) to afford health insurance. There is also a chance of incrementally expanding existing public programs like the State Children's Health Insurance Program (SCHIP) or Medicaid (universal coverage for children would be 1 politically palatable version of this strategy), though for reasons discussed below this option confronts sobering fiscal barriers. More comprehensive reform proposals, such as single-payer or all-payer models similar to Germany's sickness fund system, that would impose cost controls and secure universal coverage, are presently marginalized, and there are few, if any, signs to indicate their political progress.

Eroding Coverage in Medicaid and Private Insurance

Health care reform, though—If reform means simply significant changes in health policy—is hardly dead, but, unfortunately, it's mostly going in the wrong direction. Indeed, if there is 1 trend emerging from the health care system in both public policy and the private sector, it is the movement toward eroding rather than expanding health insurance coverage.

In the public sector, Medicaid costs are rising faster than tax revenues at a time when states are still scrambling to put their budgetary houses in order following the economic downturn that began in 2001. The resulting strain on state finances—Medicaid now has surpassed education in many states as the most expensive budgetary commitment—is generating pressures across the country to cut Medicaid spending, and in some states that means dramatically curtailing enrollment. Tennessee's governor, Democrat Phil Bredesen, has proposed cutting 323 000 enrollees from the state's pioneering Tenncare program (that number may be reduced to a still sizable 226 000, depending on ongoing court proceedings) [3]. And in Missouri, legislators have enacted a bill that would end the existing Medicaid program altogether by 2008 while a state-appointed commission considers a new framework for the program; in the mean time, Republican Governor Matt Blunt has proposed dropping over 90 000 people from Missouri Medicaid [1]. Medicaid "reform" in these states, and in others that follow this path, will mean increasing the uninsured population among the most vulnerable groups in the health care system.

With recently enacted federal cutbacks in Medicaid spending, rising health care costs that make purchasing Medicaid services more expensive, pressures from growing numbers of the uninsured, and an aging population that will further strain the program's budget, Medicaid's financial future is shaky. This reality has been recognized by the National Governors Association, which is reportedly considering a proposal that would permit states to impose a greater cost-sharing burden on Medicaid recipients [5]. Yet such a move could endanger access for low-income patients who are sensitive to even modest copayments. And as Medicaid spending continues to rise, the appeal of systems with limited coverage like Utah's Primary Care Network (PCN) that redefine and contract the boundaries of Medicaid benefits will likely grow (see Judi Hilman's description of Utah's PCN in this month's policy forum) [6].

Meanwhile, in the private sector, workers and their families are losing health insurance at an alarming rate as premium costs increase and employers search for a "magic bullet" to stem the tide. The solution *du jour* (replacing managed care) is consumer-driven health care, especially in the form of Health Savings Accounts (HSAs) that are coupled with high-deductible catastrophic insurance. Advocates believe HSAs will control health care costs, but high deductibles are unlikely to prove successful in restraining spending over the long run [7] given: the concentration of medical care spending among a small percentage of patients; that HSAs don't address the diffusion of medical technology or the immense price-tag for administrative waste; and that providers and the supply-side of American medicine can be expected to respond aggressively to any slowdown in income. HSAs will, however, shift the costs of medical care directly onto sicker enrollees, who will have to pay out of pocket for their bills before they hit the catastrophic threshold (HSAs have even been proposed for Medicaid patients, a particularly ominous combination).

HSA's significance is as much philosophical as it is economic. At their core, HSAs represent a radically new vision of what health insurance should be and what type of coverage patients should have. That vision, boiled down, is of limited coverage and a shifting of the burden of rising medical care costs to patients under the rubric of "personal responsibility." In exchange for ownership over their medical care, the sick are, in financial terms, punished for being sick, an arrangement that is then justified under the theory that patients control and are thus responsible for their own health and health care. This theory can be expected to find little favor, with, say, a newly diagnosed breast cancer patient with overwhelming medical bills who has fate or genes rather than "bad behavior" to blame for her condition.

It is too early to know how far consumer-driven health care and HSAs will advance and, if they go far, they threaten to further undermine the pooling of risk in commercial health insurance [8]. But their rise may herald a shift in the terms of debate over health care reform that calls into question the meaning and purpose of health insurance itself.

Is there hope for the future?

If the thinning of health insurance coverage described above accelerates, it could paradoxically catalyze a new push for national health reform. The well-insured middle class is unlikely to take kindly to "consumer-driven" reform that cuts their health insurance coverage and increases their cost sharing, especially if economic uncertainty persists. The erosion of health insurance coverage could substantially increase the numbers and insecurity of underinsured Americans, thereby broadening the health reform coalition beyond the more politically expendable uninsured. In addition, a Medicaid financing crisis fueled by rising health costs could lead states to plead for federal action (calls that could be buoyed by businesses trying to get out from under soaring employee and retiree medical care bills) or initiate their own ambitious reforms (as Maine has done). In other words, as things get worse in the health care system, the political fortunes of health reform could actually improve.

Changing political tides from the 2006 and 2008 elections could also alter the balance of power and provide a more conducive environment for comprehensive reform. But the dire problems in the health care system will make the issue harder to ignore regardless of who is in power, especially if the "solutions" discussed above make things even worse. The stage seems set, then, for another round of the health reform debate.

Still, the United States has shown a prolonged ability to live with a health care system replete with profound inequities and staggering inefficiencies. These compelling realities have never been enough to force decisive political action. There is, as of yet, little to indicate that anything has changed.

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