Prospects for Health Care Reform in 2009

Senator Tom Daschle*

INTRODUCTION

President Barack Obama has entered a White House burdened by myriad challenges. From the wars in Iraq and Afghanistan to global climate change, his administration faces a host of issues that will require strong bipartisan solutions in order to put our country back on track. Among the most daunting domestic policy crises is our crumbling health care system. Today, more than forty-five million people are uninsured in our country.¹ For those with insurance, the status quo is not much better; twenty-two million people incurred high costs relative to their income for medical expenses and coverage in 2007.² President Obama appreciates the unsustainable burden this places on everyday Americans and therefore has made reform of our health care system a top policy priority of his administration.

He will not be the first president who has taken on this challenge. For almost seventy years, political ideology and special interests have successfully ambushed efforts by policymakers to modernize our system. President Harry Truman was the first, presenting his plan to Congress in 1945, only to have it killed by doctors invoking the specter of “socialized medicine.” In 1972, President Nixon’s National Health Insurance Partnership Act failed to gain the nec-

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essary political traction because Democrats thought it was not good enough. Most recently, President Clinton proposed a comprehensive plan in 1993 to provide affordable health coverage to all Americans. Like so many other plans before it, however, President Clinton's suffered a partisan death in Congress with the help of special interests like insurers, who stood to lose under a revamped system. Reform of the American health care system, it seems, has become the Sisyphean challenge of American Presidents.

Under President Obama, however, the prospects for successful reform are higher than ever. The status quo is increasingly unacceptable for families, doctors, businesses, and governments. The interest in government action to fix our hybrid public-private health system is strong. And those who once thwarted previous attempts at health care reform, including partisan politicians and special interests, now recognize the need for such reform and even offer some shared principles for achieving it. To be sure, the road to reform will not be easy. But by capitalizing on areas of common ground between traditionally adverse parties, the new president and Congress have the best shot in years at providing Americans the health system they deserve.

I. The Status Quo Is Not an Option

The current health care system fails too many Americans and will continue to corrode unless our policymakers take action immediately. The system is broken; it costs too much, excludes too many, and delivers substandard care.

Cost is the primary problem. The United States spent about $2.1 trillion on health care in 2006, twice as much as in 1996 and half as much as forecasts predict for 2017. Our health care system is the most expensive in the world—more than twice as much per capita as the average among member nations of the Organisation for Economic Co-operation and Development (OECD). This great expense hurts our economy. As Federal Reserve Board Chairman Ben Bernanke notes, "[i]mproving the performance of our health-care system is without a doubt one of the most important challenges that our nation faces."
Businesses are feeling the crunch. Currently, American businesses directly finance about one-fourth of all health system spending. These climbing health care costs limit businesses' ability to invest, to improve workers' wages, and, increasingly, to offer coverage in the first place. The share of businesses offering health benefits to their employees decreased from sixty-nine percent in 2000 to only sixty percent in 2007. Businesses cited rising cost as the number one reason for the elimination of offered coverage.

Difficulties in finding affordable health coverage also affect families. The average cost of an employer-based family insurance policy in 2007 was $12,105—nearly twice the amount in 2000. On top of high premiums, people are paying higher deductibles and cost-sharing for services.

The economic crisis in health care has contributed to declining access to crucial medical services. Having insurance coverage is the most important determinant for accessing necessary treatment. Yet nearly one in six Americans, equivalent to the combined population of twenty-two states, lacks any such coverage. More than eight million children are uninsured, causing long-term detrimental health effects. Since the last attempt at health care reform in 1993, the overall number of uninsured citizens has increased by about ten million. Coverage among minorities is even more dismal. In 2005, nearly one in three non-elderly Hispanics and American Indians and one in five non-elderly African Americans lacked health insurance coverage.

Even if individuals do have health insurance, it does not guarantee sufficient coverage to protect them from financial hardship. As of 2007, twenty-five million adults in the United States were underinsured—meaning they have insurance but not enough to adequately cover high medical expenses—forcing them to increase personal expenditures for health care services. Consequently,

9. Id. at 35.
10. Id. at 18-21.
12. DeNavas-Walt et al., supra note 1, at 20.
13. Id. at 18-19.
15. Schoen et al., supra note 2, at w300.
twenty-nine million people, or roughly one of every six Americans under the age of sixty-five, have accrued debt from medical expenses.\footnote{Robert W. Seifert & Mark Rukavina, \textit{Bankruptcy Is the Tip of a Medical-Debt Iceberg}, 25 \textit{Health Aff.} W89, W90 (2006).}

Quality is another issue that must be addressed through health care reform. The current system in the United States can best be described as islands of excellence in a sea of mediocrity. For example, the Mayo Clinic in Minnesota and the Geisinger Health System in Pennsylvania provide world-class medical care, and their performance and health outcomes are remarkable.\footnote{See Denis Cortese & Robert Smoldt, \textit{Taking Steps Toward Integration}, 26 \textit{Health Aff.} W68 (2007); Ronald A. Paulus et al., \textit{Continuous Innovation in Health Care: Implications of the Geisinger Experience}, 27 \textit{Health Aff.} 1235 (2008).} Yet, not all Americans are fortunate to receive such outstanding treatment. In fact, the Institute of Medicine estimates that 98,000 Americans die from medical errors each year.\footnote{COMM. ON QUALITY OF HEALTH CARE IN AM., \textit{To Err Is Human: Building a Safer Health System} 26 (Linda T. Kohn et al. eds., 2000) [hereinafter \textit{To Err Is Human}].}

A comparison of health outcomes in other countries with U.S. data provides further evidence that quality remains a fundamental challenge to our system. For example, Americans have lower odds of surviving colorectal cancer and childhood leukemia than Canadians,\footnote{Peter S. Hussey et al., \textit{How Does the Quality of Care Compare in Five Countries?}, 23 \textit{Health Aff.} 89, 92 (2004).} and our survival rates are lower than Australians’ for cervical cancer and non-Hodgkin’s lymphoma.\footnote{\textit{Id.}} America scores even worse on basic indicators; we rank twenty-eighth out of thirty-seven in infant mortality\footnote{CTRS. FOR DISEASE CONTROL AND PREVENTION, \textit{Health, United States}, 2006, 189 tbl.25 (2007).} and thirty-first in life expectancy among 192 other countries.\footnote{WORLD HEALTH ORG., \textit{World Health Report} 2005, app. at tbl.1 (2005).} The Save the Children Foundation ranked the United States twenty-second in the world on women’s health, twenty-seventh on mothers’ health, and thirty-third on children’s health—behind Poland, Slovakia, and Latvia.\footnote{SAVE THE CHILDREN, \textit{State of the World’s Mothers 2008: Closing the Survival Gap for Children Under 5}, at 40 (2008).} Domestically, gaps in these basic welfare measures exist along socioeconomic fault lines, among different racial and ethnic groups, and across levels of educational attainment.\footnote{\textit{See, e.g., COMM. ON UNDERSTANDING AND ELIMINATING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE, Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care} 1 (Brian D. Smedley et al. eds., 2003).}
The issues of cost, coverage, and quality are not mutually exclusive; rather, all three are interdependent. The growing number of uninsured, for example, drives up overall health care costs, since the cost of uncompensated care results in higher premiums for the insured. Low-quality care, for its part, leads to misdiagnoses and mistakes that can exacerbate illnesses, causing increased waste and unnecessary costs. These problems have only grown over time and will continue to loom large unless we enact substantive and comprehensive reform within the system. The status quo is simply unsustainable.

II. The Shifting Landscape

By all accounts, the American people, businesses, special interests, medical specialists, and government have recognized the deficiencies in our health care system and have come to the table to discuss real reform. Consensus is growing among these parties regarding possible solutions. The wide range of stakeholders demanding reform has encouraged policymakers to find common ground and guiding principles on some important issues.

A. Growing Constituencies for Reform

The American people, as "consumers" of health services, are most cognizant of the system's deficiencies and, as such, loudly demand that reform become a national priority. These deficiencies, most notably lack of coverage and escalating costs, continue to rate very high among citizens' concerns. A survey conducted by the Commonwealth Fund in August 2008 found that eighty-one percent of insured Americans and eighty-nine percent of uninsured Americans agreed that the health care system needs either fundamental change or complete rebuilding. Twenty-five percent of Americans cite health care costs as a serious problem and want change according to a Kaiser Family Foundation poll conducted in June 2008. The same poll found that voters, regardless of party affiliation, wanted to hear presidential candidates discuss health reform; more than one in four Democrats and roughly one in six Republicans expressed such a preference.

Business and labor groups have played an instrumental role in garnering support for real health care reform. The coalition Divided We Fail (with members such as the American Association of Retired Persons (AARP), the Service Employees International Union (SEIU), the Business Roundtable, and the Na-
tional Federation of Independent Business) has engaged a host of not-for-profit organizations, elected officials, businesses, and individuals to find bipartisan solutions for ensuring affordable, high-quality health care for all Americans. Likewise, the coalition Better Health Care Together has inaugurated a similar effort, building bipartisan consensus with large corporations like AT&T and Wal-Mart, labor organizations such as SEIU, and public policy groups like the Center for American Progress and the Committee for Economic Development. The primary reform goal for both coalitions is ensuring that every American has high-quality, affordable health coverage.

The health insurance industry, health care providers, and some disease groups are also engaged in the search for solutions. America’s Health Insurance Plans (AHIP) has partnered with reform coalitions and advocated for bipartisan-supported legislation such as reauthorizing the State Children’s Health Insurance Program (SCHIP). Other groups such as the American Medical Association (AMA), the Blue Cross and Blue Shield Association, Pfizer, Johnson & Johnson, Kaiser Permanente, and AARP supported SCHIP renewal and called for new tax credits for individual and families struggling to afford health insurance. AHIP and other groups also have developed their own plans that would ensure every American has access to high-quality, affordable health care.

The AMA—once a stalwart opponent of health care reform, especially against President Truman’s and President Clinton’s efforts—has started its own public awareness campaign regarding the detrimental health effects caused by lack of insurance. And the American Cancer Society has followed a similar plan, dedicating $15 million to raising awareness of the growing number of un- and underinsured.

I am a member of the Board of Directors and Advisory Board for the Bipartisan Policy Center (BPC), an organization focused on locating and expanding common ground between political parties on issues of grave national importance, including health care and sustainable energy. Since 2008, I have joined with my BPC colleagues—former Senate Majority Leaders Howard Baker, Bob Dole, and George Mitchell—to find areas where Republicans and Democrats can work together specifically on health care reform.

B. Building Political Momentum

Many states and even some municipalities independently have sought bipartisan solutions to expand coverage and curb costs. In 2006, former Republican Governor Mitt Romney of Massachusetts worked with a Democratic legis-

lature to craft a plan so that roughly ninety-nine percent of the state’s residents would receive coverage. California’s Republican Governor Arnold Schwarzenegger also collaborated with a Democratic legislature and advocacy groups and nearly passed a law that would have covered all the state’s residents. Democratic Mayor Gavin Newsom of San Francisco also passed legislation—the first of its kind—that would provide universal coverage to the city’s residents. State legislatures are working to expand coverage through existing public programs. For example, many states have raised income limits for SCHIP eligibility, and others have increased coverage for young adults and cut the cost of health insurance for small businesses.

Federal policymakers have achieved similar success. In 2007, senators and representatives from both sides of the aisle worked diligently to reauthorize SCHIP, only to have their efforts thwarted by President George W. Bush’s veto. In the same year, Democratic Senator Ron Wyden and Republican Senator Bob Bennett, for instance, introduced a bill that would redesign tax breaks for health insurance, create new insurance rules, and guarantee health insurance to the entire citizenry. As a result of this activity, health care reform figured prominently in the 2008 presidential primaries and through the general election campaign. As early as March 2007, all Democratic presidential candidate hopefuls had unveiled health care plans, or, at the very least, assigned health care a prominent place in their respective platforms. As Senators Hilary Clinton and Barack Obama broke away from the pack during the Democratic primary, the debate over reforming our broken system became even more pronounced. Yet, the principle of ensuring affordable, high-quality insurance for all remained constant. Republican presidential candidates likewise began offering health care reform plans, but these proposals were not as prominent as among the Democratic contenders.

From the start of the general election campaign, health care reform became a defining policy difference between Senator Obama and Republican Senator John McCain. Although both candidates’ plans reflected fundamental differences in policy and perspective, each was significant and comprehensive in scope, not trivial or piecemeal. This development likely reflected the American people’s demand that the next administration address the health care affordability crisis.

III. Finding Common Ground

The fruit of these organizational coalitions and policy debates has been recognition that special interests, experts, and politicians are beginning to agree on key principles and policies that will help reform and improve our health care system. In this Part, I list ideas that could and should be part of the solution.

A. Emphasizing Prevention

Leaders from both political parties agree that we must change our system from one focused on sickness to one promoting wellness. In the summer of 2008, I had the pleasure of speaking with former Secretary of Health and Human Services Tommy Thompson at the National Constitution Center’s John M. Templeton, Jr. Lecture on Economic Liberties and the Constitution in Philadelphia. Although I was asked to provide a counterpoint to Secretary Thompson’s address, we both found ourselves in agreement on the issue of wellness and prevention.\(^{32}\) Investments in prevention and health promotion are simply commonsense means of reducing costs while keeping people healthy. The statistics are especially telling: The United States spends more on health care than any other country in the world, nearly fifty percent more per capita than the next highest spending country.\(^{33}\) Yet, we are far from the healthiest nation in the world. We have an obesity rate—thirty-four percent of adults—that is far beyond that of other countries.\(^{34}\) Our diabetes-related death rate, furthermore, is one of the highest among industrialized countries.\(^{35}\) For the most part, these are preventable conditions.

The structure of our health care system is partly to blame. It focuses on treating diseases after they occur rather than promoting good health at an earlier stage. This practice has a devastating impact on individual health and quality of life, causing many to live, perhaps unnecessarily, with chronic conditions. For example, our growing obesity rate contributes to increasing rates of chronic conditions ranging from diabetes to stroke to cancer. What is so harrowing about the obesity epidemic is that, if trends continue, our grandchildren’s expected life spans may be shorter than our own. This trend clearly is a step in the wrong direction and one that has not occurred in about a century.\(^{36}\)

Our declining health and lack of preventive medicine also have contributed to the nation’s soaring health care costs. One study found that virtually all of the spending growth in Medicare over the past fifteen years resulted from in-


\(^{33}\) See supra note 5 and accompanying text.


\(^{35}\) OECD Health Data 2008—Frequently Requested Data, http://www.oecd.org/document/16/0,3343,en_2649_34631_2085200_1_1_1_1,00.html (last visited Sept. 30, 2008).

creased spending on people with multiple chronic conditions. Another found that Medicare could save an estimated $890 billion from effective control of hypertension and $1 trillion from reducing obesity rates to their 1980s level over the next twenty-five years.

Despite these facts, proven preventive services remain largely unused, and healthy communities and lifestyles remain undervalued. For instance, medical technology advances have dramatically improved the survival rates of babies with low birth-weights over the last several decades but at a cost of over $100,000. The same result could be achieved by giving pregnant smokers advice on how to quit, paying for cessation aids, and following up with them regularly. These measures would cost just $50 per woman. The Partnership for Prevention, a non-partisan organization that advocates for prevention measures, estimates that if physicians advised all adults with a high risk for heart disease to consider taking aspirin, it would save 80,000 lives annually and result in a net medical cost savings of $70 per person advised.

Fortunately, there is mounting consensus that prevention and wellness should be the cornerstones of a reformed system. This consensus means that the medical community needs to invest in developing a prevention-oriented workforce and training them to deliver counseling on behavior changes and to improve compliance with prescribed medications that prevent death and disease. As Secretary Thompson has noted, prevention and health promotion are “low-hanging fruit” in the health reform debate. We can all reach and partake of them.

B. Increasing Value

The value of the health care coverage that some of us receive needs to increase by raising quality and lowering costs. Two bipartisan solutions to achieve a value-enhancing system are investments in health information technology and comparative effectiveness research.

The Internet plays an increasingly significant role in our daily lives. Yet, at times, it seems as if our health care system is stuck in the informational “dark ages.” Only a small fraction of the billions of medical transactions that take place each year in the United States are conducted electronically, preventing


39. Daschle, supra note 3, at 150.

40. Id.

many doctors from consulting a patient’s privacy-protected, full medical record and delivering the most appropriate care.

Modernizing our system through advanced health information technology (HIT) would ensure that patients not only receive the most appropriate but also higher quality care. The Institute of Medicine has suggested that up to 98,000 people die annually from medical errors such as poor physician handwriting, incomplete charts, and other “low-tech” problems. To contextualize this figure differently, imagine if one 747 commercial airplane carrying 400 passengers crashed. A tragic event of that magnitude would appear on the front page of every newspaper in America. Yet rarely do deaths attributable to medical mistakes make the news, even though 98,000 annual deaths roughly equals four 747s crashing each week for an entire year.

Medical errors can be reduced by ensuring that the most accurate information on treatments and patients are at our physicians’ and nurses’ fingertips. As with preventive medicine, bipartisan consensus on the benefits of HIT has already developed. Last fall, I met with former Republican Speaker of the House Newt Gingrich to discuss how we might advance this goal. We concluded that the nation must invest in HIT to the same extent that we did in our interstate highway system over fifty years ago. In the halls of Congress and among think tanks, there are proposals to use HIT not only to improve the quality of care delivered but also to lower health care costs in the long run. These are commonsense solutions behind which policymakers, regardless of party affiliation, can stand.

Another priority for improving the value of care we receive is developing better information about what constitutes high-quality, high-value care. Currently, most medical research focuses on whether a particular medicine or treatment is safe and effective. However, we also need data on the comparative clinical- and cost-effectiveness of available treatment options. This information would enable patients, providers, and payers to make rational and sensible health care choices. Bipartisan legislation has been introduced to create a trust fund that would invest in such information. The Congressional Budget Office has estimated a similar bill would save public and private purchasers $6 billion over ten years.

Information is only valuable when used. Support for aligning payment systems with our health care values and priorities has grown. Currently, our incentives are inverted. We pay little for a diabetic’s podiatrist visit but dearly for the amputation that may result without preventive care. We pay more for new, fashionable drugs when older, equally reliable ones are more effective or less expensive. A hospital that makes a mistake—operating on the wrong leg or

42. To Err Is Human, supra note 18, at 26, 29.
leaving an instrument in a patient's wound—receives payment for the original and the corrective surgery, twice as much as a hospital where doctors were more careful and attentive. We must invest our money in procedures and programs that work, with Medicare leading the way. We should focus its reimbursement policies on preventive and primary care and make critical investments in developing and deploying best practices through information technology and reimbursement policy.

High-value health care and best practices should not be determined by Congress or any other politicians. Instead, I propose the creation of a Federal Health Board (the Board). Modeled on the Federal Reserve Board, it would remove technical, difficult, and important decisions on health system design from the political arena. It would be comprised of health experts appointed by the President and confirmed by the Senate, with long terms to protect their independence. The Board would provide the national blueprint for our public-private health system. It would make tough coverage decisions, collect evidence, and identify weaknesses. The Board also would set standards of care and coverage to be followed by Medicare, Medicaid, SCHIP, the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service, all through which nearly a third of the country is served. The federal program would, in turn, become a model for every other stakeholder in the health care system.

IV. Affordable Health Insurance Options

In any reformed health care system, everyone must have access to the system through adequate financial coverage. Not only do we have a moral obligation to pursue this policy but also it will reduce system-wide and individual costs. Studies have shown that the uninsured forego needed medical care, often avoiding care until a health issue has escalated in both severity and treatment cost.45 Furthermore, an insured family pays on average an extra $922 per year in health care premiums to cover the cost of care for the uninsured.46 We simply cannot prevent illness and manage chronic disease if one in three Americans cycles in and out of coverage for at least one month over the course of two years.47

A variety of ways to insure all Americans exists. Ideas span the spectrum from creating a single-payer system, to one that is purely market-driven, to one that would depend solely on employer responsibility. In my view, we should

46. Families USA, Paying a Premium: The Increased Cost of Care for the Uninsured (2005), available at http://www.familiesusa.org/assets/pdfs/Paying_a_Premium_rev_July_13731e.pdf.
forego a "pure" system, i.e., one that incorporates features of only one model, and build upon our current scheme by retaining the options of employer coverage and private plans as well as strengthening proven public programs such as SCHIP, Medicaid, and Medicare.

Currently, 160 million Americans receive employer-based insurance. Individuals who want to retain this coverage, and employers who want to continue to offer it, should be able to do so. To reach the less fortunate, we should expand upon the Federal Employee Health Benefits Program (FEHBP)—the coverage that members of Congress and every federal employee enjoys—or create a group purchasing pool resembling it. FEHBP covers more than eight million workers and their dependents through a menu of private health plans, and I know from personal experience that the system is exceptional. The crucial point of an FEHBP-type system is that such plans guarantee access to decent benefits without exclusions, denials, or discrimination against the infirm. Nevertheless, a variant of FEHBP may not be the right choice for everyone. As such, I also support allowing a public plan option like Medicare to compete in a pool of private insurers. We should let Americans, not politicians, decide whether they want private or public insurance coverage.

We must also ensure that health coverage becomes and remains affordable. Although this principle is one with which both parties can agree, differences remain among policymakers about the preferred methods for reducing costs. Some advocate strongly for the expansion of tax credits and health savings accounts (HSA). These policies tend to provide more to higher-income taxpayers than Americans struggling to pay for health coverage and care. Indeed, last year, the Government Accountability Office reported that tax filers with HSA activity in 2005 had an average adjusted gross income of about $139,000, compared with about $57,000 for other filers.48 Flat tax credits do not account for individual circumstances, as they force lower-income taxpayers to contribute a larger share of their income to cover medical costs. The same inequity occurs between the young and healthy and the old and sick, especially those with chronic illnesses. While such policies likely will remain part of our health care system, I believe that we must also provide financial help on a sliding scale to those in need. We could potentially guarantee that nobody pays more than a certain percentage of her income for health insurance through refundable tax credits. These tax credits would apply to employer-based health insurance as well as insurance obtained through the pool.

I also would expand and strengthen our Medicaid and SCHIP programs. They now serve about fifty million of the nation's most vulnerable children, low-income parents, people with disabilities, and seniors. Yet eligibility varies from state to state, and major gaps still exist in the program. For example, childless adults are not eligible for Medicaid coverage. I would eliminate population-specific or categorical eligibility, i.e., coverage only for low-income chil-

dren or parents, and extend Medicaid benefits to anyone under a defined income level, possibly with a higher limit for children.

I strongly believe that every player in the health care system should help support a rational, sustainable system. The government, employers, providers, insurers, and patients have a shared responsibility to promote reform, with the government leading the way. Conservatives may agree with the ideology of shared responsibility, but they emphasize individual responsibility for shoulder ing the cost and navigating the system. Hospitals and providers, for instance, should have to harmonize care more effectively across practices and facilities. They should deliver care that is scientifically-based and provides patients with the highest quality care for each dollar spent. In return, they would enjoy the benefits of a coordinated and seamless system. Moreover, insurers who participate in an FEHBP-like pool would have to follow federal rules on coverage and cost.

Finally, employers would have to continue covering workers or helping fi nance the pool’s resources. This coverage would ensure that employers fulfill their responsibilities, yet guarantee that it is shared more equitably across the economy. Individual patients would have their own responsibilities as well. They not only would be responsible for obtaining some form of coverage, but, as a result, they also would be more proactive in their choices about health and health care. It is up to each one of us to take ownership over our health and well-being.

Conclusion

Reform of America’s health care system is finally within reach. Sadly, we have been driven to this point by a crisis so severe that simply maintaining the status quo is no longer an option. Stakeholders from all sides of this debate now recognize that they must come to the table together in order to achieve a universal solution to this critical challenge. Moving forward, we should consider failed efforts at reform in the past and avoid the partisan and special interest pitfalls that snared previous attempts. The most important element to successful health care reform, however, will be presidential leadership. In choosing Barack Obama, the American people selected a candidate who not only shares their priorities for health care reform, but who also has the ability to build consensus among policymakers that could finally produce effective reform of our health care system.