

Health Care: A Bolt of Civic Hope

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NAME a nettlesome social problem -- your favorite measure of cultural woe -- and chances are that today's record-long economic expansion has the statistics on it moving in the right direction. Violent crime, welfare rolls, child poverty, teen pregnancy, suicide, abortion, and divorce are all down. [Jobs](#), SAT scores, air quality, the Dow, charitable giving, and even wages for less-skilled workers are all up. The trend lines are almost uniformly encouraging -- all except one.

The number of Americans without health insurance has soared during the current boom, from 37 million in 1993 (when Bill Clinton said it was a national problem requiring immediate attention) to 44 million today. Why? In part because so many of the jobs being created are at the low end of the labor market, where employers can't afford to offer health benefits or, if they do, employees can't afford to pick up their share, and in part because health-care costs -- after a brief respite in the mid-1990s, thanks to managed care -- are on the rise again, leading smaller firms to drop coverage. Experts say that the number of uninsured people could soon rise to 50 million if times remain good, and to 60 million or more if the economy dips.

More than four in five uninsured Americans work year-round or live in families headed by someone who does. These waitresses, taxi drivers, and plumbers earn too much to be eligible for Medicaid but too little to buy coverage in the notoriously high-priced market for [individual policies](#). They contract preventable diseases and are avoidably hospitalized more often than the insured, and are vulnerable to devastating financial loss from illness in ways unthinkable in other advanced nations. To be sure, some folks go without insurance only briefly, and a few who can afford it go without by choice (mainly people in their twenties who feel certain they'll live forever). But "the hard fact is this: the percentage of the population going without insurance involuntarily is growing year after year, in good times and bad," as one politician wrote his colleagues last year. "This is clearly a structural problem we ignore at our peril." The writer? House Majority Leader [Richard Arney](#), of Texas.

Yet ignoring the problem of the uninsured is one of the few things that both Democrats and Republicans seem eager to do in the current presidential campaign. George W. Bush wants to offer tax subsidies of up to \$2,000 per family to buy private insurance. But decent family policies cost more than twice that amount. And the roughly \$10 billion a year Bush says he will devote to his plan means that his vaunted "compassion" will touch only a small fraction of the uninsured. This might not be surprising from a Republican candidate save for one striking fact: Bush's father in 1992 offered a version of the same plan that was considerably more generous -- \$5,100 per family, adjusted for inflation, at a cost of \$50 billion a year. And the father offered his generous plan when the federal budget deficit was nearly \$300 billion; the son puts forth his token gesture at a time of comparably outsized surpluses.

Curiously, this shrinking of ambition when federal resources are finally available on a scale equal to the problem also characterizes the Democrats. Vice President Al Gore is offering a patchwork of coverage extensions, mainly for children -- who, because they incur fewer costly illnesses than adults, are a bargain to insure. His plans are a pale shadow of what the Administration was aiming for back when the problem was smaller.

Why are our leaders content to let the problem worsen while our means for addressing it have grown? The unflattering answer is because doing so is both safe and cheap. Today's uninsured are low-income workers with little political voice; in the broad-based recession of the early 1990s it was middle-class anxieties that had politicians scurrying to respond. A policy of rationing [health coverage](#) by income also saves money. The uninsured do get care in emergency rooms, county hospitals, and other sites of last resort. But these citizens consume just two thirds as much in health resources as their insured neighbors, because they don't get preventive care, regular checkups, and other services most people take for granted. We can fix the problem of the uninsured only by spending more money on people with little political clout -- and, if necessary, by somehow disguising that this is what we're up to.

Any such attempt, of course, will take place in the shadow of the Clinton health fiasco of 1993-1994. The political lesson both parties drew when Hillary Clinton's bulky plan was attacked unfairly as "socialized medicine" but quite fairly as too complex was that efforts to expand coverage must be incremental. "Step by step" is the approved mantra.

Yet incremental "achievements" since 1994 have been a bust. Senators [Ted Kennedy](#) and Nancy Kassebaum sponsored a bill passed in 1996 that was

hailed by both parties as a model for future health reform. The measure was supposed to guarantee continued access to [insurance](#) for those who changed or lost their jobs. But insurers were free to charge whatever they liked in these situations, and people quickly found that "access" meant very little when a policy might cost \$15,000 a year. Similarly, a plan costing \$5 billion a year for the nation's 10 million uninsured children passed with great fanfare in 1997; aid was targeted so narrowly and complexly, however, that only one in five children it was meant to reach have been signed up. Bolder proposals, meanwhile, have proved easy to shoot down as unaffordable. Just ask Bill Bradley.

Indeed, in a year when a Democrat won his party's presidential nomination by attacking another Democrat for trying to insure all Americans, it is tempting to declare universal coverage a lost cause -- tempting but wrong. As it turns out, circumstances have quietly evolved in recent years in ways that leave both parties ready to make an ambitious push, together, on health coverage. This has taken place in a way scarcely visible in the Capitol's day-to-day political jockeying, but the parties, as they align, are poised to produce a movement of surprising power. Republicans, reeling from the failed "revolution" of Newt Gingrich and their associated image as uncaring thugs, have looked for ways to address the frustrations wrought by managed care. Many believe that giving voters more power to choose their health coverage will derail heavy-handed Democratic efforts to regulate private health care. At the same time, many liberal Democrats have come to terms with the fact that power in Congress will be roughly balanced between the parties for the foreseeable future. They've therefore become open to ways of expanding coverage that were once ideologically out of bounds. It sounds perverse, but some optimists say we're just one good recession away from seeing the political energy unleashed to solve this problem.

Luckily, we don't need a recession, because there's a pragmatic solution at hand that can command bipartisan support: tax subsidies for people who need help to buy insurance from competing private health plans. This is basically the scheme that President Bush offered in 1992 and that his son -- in embarrassing (but expandable) miniature -- offers today. It is the same general [idea that Bill Bradley pushed](#) earlier this year, and that policy analysts from shops as diverse as the [Democratic Leadership Council](#) and the conservative [Heritage Foundation](#) have been refining for a decade. A few bipartisan groups of legislators have put forth tiny versions of such a plan, but the time will be ripe after next month's election for the real thing. And although tax subsidies are not perfect (experts say, for example, that the poorest Americans will still need

programs of direct aid and better-funded local clinics), and plenty of details remain to be thrashed out, this scheme offers the most realistic way of bringing the parties together to right an enduring wrong.

The story of the coming "grand bargain" on health care is one of Democrats accepting the existence of a private insurance industry and Republicans accepting the need to help make sure that everyone can buy a decent policy. It is a story of liberals agreeing that innovation shouldn't be regulated out of U.S. health care and conservatives agreeing that justice has to be regulated into it. It is a classic tale of mutual mistrust finally being trumped by mutual political advantage. I know this because after I had scoured Washington for months, talking with several dozen officials, health experts, and interest groups across the political spectrum in search of a workable way to get the parties together on this, an old-time single-payer liberal and a conservative Republican sat down with me and proved that the thing can be done.

The Politicians

THE moment [Jim McCrery](#) walked into [Jim McDermott](#)'s office, near the Capitol, I felt relief. At least the meeting was going to happen. For two weeks we had been planning this session, yet every day I'd half expected one or both of them to call the whole thing off as unnecessary and strange. Why, after all, would a Republican and a Democrat, both of whom serve on the health subcommittee of the powerful House Ways and Means Committee, want to sit down for a journalist in an election year for a session resembling a negotiation? Politicians don't generally volunteer for press encounters they can't control. And as I had learned while making the rounds of Washington's health-policy gurus, getting a liberal and a conservative to discuss a pragmatic way to work toward universal coverage can get complicated.

It was an easy decision to seek out a duo in the House rather than in the Senate, because "the people's chamber" is ground zero for the partisanship that any consensus would have to transcend. The first pairing I thought of was [Bill Thomas](#) and [Pete Stark](#) -- the chairman and the ranking member, respectively, of the Ways and Means health subcommittee. But Thomas sees Stark as a hopeless liberal relic, and Stark sees Thomas as a heartless market fundamentalist. Thomas made it clear that he would participate in such a discussion only if paired with a centrist Democrat, such as [Ben Cardin](#), of Maryland. But as I told Thomas, there was nothing interesting in the likelihood that he and a centrist Democrat could reach a deal. That happens every day. The question was whether a big-government liberal and a market-loving

conservative could get together. If they could, maybe there'd be a chance for progress.

And so I turned to the Democrat Jim McDermott, of Seattle, and the Republican Jim McCrery, of Shreveport, Louisiana. McDermott, age sixty-three, went to Congress in 1988 after sixteen years in the state legislature. A psychiatrist by training, he is the longtime leader of the single-payer advocates in Congress, who wish to adopt a Canadian-style approach, under which the government doles out cash to regional health authorities that cover everyone and private insurance essentially doesn't exist. Since the Republican sweep of 1994, however, McDermott has stopped pushing this system. He even co-sponsored a Republican bill backing modest health tax credits in 1997.

McCrery, age fifty-one, is the Republican to watch on health care, according to several prominent Republican policy analysts. Also a member of Congress since 1988, he has studied the issue intensively in recent years, and argues that smart politics and sound policy require Republicans to shed their traditional view that health is not "their" issue. McCrery is among those being named as possible successors to Bill Archer, the retiring chairman of Ways and Means, in the scramble expected if the Republicans hold the House this fall.

McDermott scores 85 percent "liberal," McCrery 83 percent "conservative," on rankings compiled by *National Journal*, a Washington-based politics and policy magazine. They voted opposite ways on ten of twelve important votes tracked by that magazine in the past Congress. Personally, too, as I couldn't help noticing while they kibbitzed in McDermott's office, they're a study in contrasts. McDermott is a big man with a hearty laugh, whose boisterous energy seems better suited to the stump than to the Freudian couch. McCrery is slender and soft-spoken. He had to be asked to speak up for my tape recorder.

Staffers for both men had been pressing me for days for a write-up of the plan I had said I would offer as a point of departure for our talk. In the end, however, I decided that putting anything in writing was too risky -- it would be combed by staff members for unacceptable terms and could easily become a pretext for cancellation. Now, while a photographer posed McDermott and McCrery in unnaturally close positions, the two men, who plainly like each other, cracked uneasy jokes about what they had gotten themselves into. Finally they sat down -- McDermott on my left, of course, and McCrery on my right -- on a standard-issue government couch, beneath a wall of photos that included Mahatma Gandhi and a younger, dark-haired McDermott with Ted Kennedy. McDermott, smiling, said he appreciated the gesture his colleague had made by agreeing to

meet in the office of the minority party. The tension soon eased, and they took off their jackets; in the event, they put off meetings and skipped a vote to extend an hour of planned conversation to nearly two.

"What We're Gonna Give Everybody"

WE began. I sketched out an approach that my interviews with them, with their House and Senate colleagues, and with assorted analysts and interest groups had suggested could gather broad support. The basic idea would be to offer people a tax credit usable for the purchase of a health-insurance policy (and to pay the

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TRANSCRIPT

[A Conversation With Jim McDermott and Jim McCrery](#)

The full transcript of Matthew Miller's conversation with the two congressmen.

amount of the credit directly to those too poor to owe income taxes). It would be generous enough to buy a decent "Chevrolet" from among competing private health plans. Individuals would have access to some form of insurance pool to ensure affordable group rates. It might be phased in to establish a system parallel to today's employer-based coverage -- offered first, perhaps, to those not covered by either a government plan (such as Medicaid) or a company. The idea would be to avoid giving employers an incentive to drop existing coverage in the near future. Over time, however, it could move the nation away from a system centered on coverage offered by employers to one in which individuals received subsidies and were responsible for -- and perhaps mandated to buy -- their own coverage in the private market.

Obviously, a hundred difficult details are glossed over in this sketch, I said, but something similar was outlined repeatedly by the diverse group I consulted. Could something like this be the beginning of a deal? What follows is a compressed account of the conversation.

McDermott spoke first. "In order to get us off dead center," he said, "we've got to try something in the middle here and see if it'll work. I'm so frustrated by having spent thirty years watching it get worse that I'm willing to try practically anything to get us moving."

"Jim's not going to get what he wants [that is, a single-payer system] anytime soon," McCrery said. "I or some right-wing person is not going to get an unfettered market, which is the individuals fending for themselves. So if we want to solve the problem, we've got to come up with something that's kind of a combination. I think that's possible along the tax-subsidy lines. If we don't do anything, if we just keep going like we're going, eventually I think we'll end up with single-payer. We'll end up with the government controlling just about everything in health care."

This was an argument that McCrery had made to me earlier: that the tendency today to put a patch here and a quick fix there, typified by the push for an HMO patients' "bill of rights," leads inexorably toward heavy-handed federal solutions. "That might take forty years or fifty years," he continued, "but we're going that way now. So I'm willing to accept a lot more government intervention in the market than I normally would to create a system that will have some vestige of the market left in it."

We turned to the key components of a potential health deal, starting with benefits. If a tax subsidy were used, "there would be the element of different levels of health care for different people," McCrery said. "Somebody who is wealthier is probably going to buy a policy that would be richer in benefits than the basic benefit package that I would pay one hundred percent for from the government. That would enable the market to continue to be more innovative than under a single-payer system."

It's the classic conservative argument: beneficial innovations always begin as luxuries for the wealthy. Think of automobiles, telephones, airplanes: first came the breakthroughs funded by the rich and benefiting the rich, and later came dissemination to the masses. This pattern of capitalism, as Milton Friedman argues, has produced higher living standards for more people than any rival form of social organization.

McDermott seemed unconvinced. "But if you and I both need to have doctor visits and all this stuff, right up to the level of a bone-marrow transplant at a hundred and twenty thousand dollars a crack," he asked, "why wouldn't you guarantee that to everybody in the United States? What would you leave above the line that you would say that people who are wealthier can get for themselves?"

"The catastrophic examples are not the kinds of things I'm talking about," McCrery replied. "I'm talking about variances in bells and whistles in insurance policies -- if you want a private room, if you want extra [nursing] help in the

room, all those things that people could purchase if they wanted to. The basic plan that would be provided by the government to low-income folks would not have all those."

McDermott wasn't satisfied. "One of the big difficulties will be us agreeing on a basic package."

"But having said that," McCrery added, "I don't think it's impossible."

"No, it's not impossible," McDermott agreed.

McCrery, like Bill Bradley earlier this year, suggested the [federal-employee health plan](#) as a model. It doesn't define benefits down to every test and procedure, but it assures general areas of coverage, such as major medical expenses and surgical fees. This way there's no stifling of the extraordinary innovation that is now sweeping health-care delivery, whose future shape can't be foreseen. Go too far in defining things rigidly, the Republicans argue, and you end up with inanities like Medicare, which unaccountably still fails to cover prescription drugs, thirty-five years after the program's inception.

"Ultimately," McDermott said, "there has to be a come-to-Jesus meeting someplace where that package is defined: This is health insurance for the country. This is what we're gonna give everybody."

I asked McDermott why defining a detailed benefit package is crucial to liberals when there's no government-defined package in the employer-based system under which most Americans now get their coverage. What's more, as Bill Thomas argues, any honest observer has to concede that a move to what Democrats deride as "two-tier" care would be a vast improvement over the five- or six-tier care we have today, which runs from princely to truly pauperish. And as Richard Armev told me, there are precedents for leaving the actual benefit undefined: with food stamps, Uncle Sam provides the wherewithal but doesn't tell poor folks what to eat; the mortgage-interest deduction helps millions without any need for the government to tell people what kind of house to buy. Why not simply make the health subsidy generous enough and let people pick among competing offerings?

McDermott responded that it's hardly an advertisement for the system of different employers' plans we have today, under which one person may be covered for, say, certain cancer treatments, while another cancer patient is exposed to financial ruin. In any major reform such inconsistencies should be rationalized in favor of some common notion of what every citizen ought to

have. It will also be a fight, McDermott believes, to make any tax subsidy substantial enough to buy a decent package, because many Republicans essentially want a cheap tax-style voucher that they can ratchet down over time to limit costs.

Yet both men think that differences here can be bridged. The occupant of the Oval Office, McCrery said impishly, needs to "lock us in a room with his people and say, 'Okay, let's come up with a [benefit] plan that Jim McDermott, Jim McCrery, and President Bush can support.'" McDermott moaned at the very thought. But later he agreed. "If you locked the door and said we don't get any lunch until we come up with a benefit package," he said, "we would have one and be out of here."

"It Would Fundamentally Alter the Insurance Business"

I ASKED the congressmen to turn to another central issue: if individuals are subsidized to buy coverage from private plans, how do we protect people who have predictably high medical costs from sky-high insurance premiums that leave them shouldering the full burden of their own care? Everyone agrees that access to reasonably priced insurance for these unlucky souls should be a priority. How to go about achieving it is another matter. [Chip Kahn](#), the head of the powerful [Health Insurance Association of America](#), the industry's lobbying group, told me that insurers want a separate "high-risk" insurance pool, funded by broad-based taxation, to handle these people (as happens now in some states). Liberals say that such funds invariably mean lousy care, and prove that greedy insurers want only healthy customers who don't actually need insurance. Pete Stark is sharp in his response. "Let's cut the crap," a longtime aide told me he has said, and just redline. "You tell me, Chip Kahn, which healthy folks you want to make money off of, and which sick folks you want the government to take, and we'll cut out all the make-believe."

McDermott was warming to a similar rant when McCrery interrupted him. "I wouldn't have a high-risk pool," he said. "I'd just do community rating."

"Community rating" means that everyone pays the same premium, regardless of age, sex, or medical history. This is, of course, the liberal dream. Rates for decent policies in the individual market can easily top \$10,000 a year for people with a history of health problems. Community rating, though controversial in theory, is actually widespread today. Employees of large companies enjoy it on a de facto basis, as health risks are spread among

thousands of workers. It is the chief virtue of today's otherwise anomalous employer-based system, in which the United States, alone among advanced nations, looks to employers to manage most health coverage.

Our employer-based system was a federally engineered accident. Wage freezes during World War II left fringe benefits as the chief means by which big firms were able to compete for employees. Health care as a job-related perk became common. The government then established a large tax subsidy to ratify this arrangement. Every big company is essentially a socialized health republic, in which the young subsidize the old, and the healthy subsidize the sick -- all of whom pay the same premiums for the same plans.

Reorganizing the individual insurance market to make such pooling work would be more complicated. If insurers were forced to offer the same rate to all comers, young workers would pay far more than they would under policies that recognized their relatively low actual health costs. In large companies young workers opt into such a system because their bosses pick up most of the tab. For this to work in an individual market, the incentive must somehow be replicated -- or else coercion must be involved.

What cannot be done is to let young, healthy workers opt out, or the insurance pool will face a classic actuarial disaster. It's not physics: if younger workers decline coverage, the average health costs of those remaining in the pool will be higher, and premiums will rise. But higher premiums will prompt more young, healthy workers to drop coverage. The vicious circle will continue until premiums are sky-high and only the sickest are insured, at exorbitant rates.

This is essentially what happened in New York in 1993, when the state forced insurers to apply community rating to their individual policies. Well-meaning officials hoped to extend affordable coverage to everyone; instead they got a new glut of uninsured. The lessons of Insurance 101 are clear: community rating in an individual insurance market requires either a mandate that everyone buy insurance or a subsidy generous enough to keep younger and healthier people in the pool.

McCrery said he was for both the mandate and the generous subsidy -- at least for people of lower income. That a conservative on the health subcommittee of Ways and Means backs these ideas is stunning. McCrery is one of few in his party at present who take this view. He is also one of few Republicans who have studied the issue so closely.

McDermott was amazed. "Did you know that?" I asked him.

"No, I didn't know that."

I asked McCrery, "What brought you to community rating?"

"I looked at it nine ways to Sunday," he explained, "and I don't think there's any other way to do it. I mean, that's not true, there is another way to do it, but I think the simplest way to do it is just to have community rating. Yes, you can have a high-risk pool, with people moving from under the red line to above the red line, but why fool with all that? It's complicated, it's troublesome, it distorts the market. Why not just have community rating and then let insurance companies compete on the basis of value?"

"Covering everybody," McDermott said.

McCrery nodded. "They'd have to take all comers, but they would compete on the basis of service, economies of scale, efficiencies that they could muster to provide better prices, all those kinds of things. They could still be in the business; they'd just have to compete on those bases and not on getting lucky [that is, picking healthier people to insure]."

I turned to McDermott. "You like that?" I asked. His eyes opened wide.

"Yeah," he said. "I don't want to say anything to mess it up." Both men laughed.

The top insurance lobbyist insists that community rating is a nonstarter, I pointed out. Is there anything legitimate in his opposition?

"Depends on what you mean by legitimate," McCrery said. "To them, it's legitimate. Because, I mean, much of their business now ..."

"They don't have the problems that Jim and I face, which include equity in the society," McDermott injected. "They have a different mandate. I mean, corporations take in as much money as they can, pay as little out so that they have it to give to their stockholders. It's not good or bad, it's just what they are." He looked at his colleague. "That's not what Jim and I are. He represents all 600,000 in his district, and I represent all 600,000 in my district. I can't say, well, I represent 440,000 and the other 160,000 are not my concern. I don't have that option."

"It would fundamentally alter the insurance business," McCrery said.

It would -- by bringing the business back to the way it was, in a sense. Community rating was the way health insurance worked, even in the individual market, until the 1960s. Before then insurers didn't have the data to segment people in sophisticated ways according to health risks. Furthermore, health costs were a fraction of what they are today, meaning that people didn't have much to gain by shopping for cheaper plans, and unlucky insurers burnt by a few high-cost illnesses weren't left reeling. But costs and premiums have soared famously for decades now. The data and the technology needed to identify and price policies for lower-risk customers became available. It didn't take long for entrepreneurs to realize that they could target younger, healthier people with lower rates, sweep up a ton of customers, and make a bundle. The fragmentation of the insurance market -- with its emphasis on "cherry picking" the best risks -- began in earnest.

"The [Human Genome Project](#) is going to have an impact on this whole process unlike anything we can really imagine at this point," McDermott said. "Because if I'm an insurance company and I get a drop of your blood and I can do your genetics and I find you have these and these and these proclivities, I'll insure you for everything but those. What is insurance at that point?"

"The game is over at that point," McCrery agreed.

I told them I had asked Chip Kahn, of the insurance association, about this, and he had assured me that insurers would never use genetic information that way. The two legislators exploded in thigh-slapping laughter.

"No comment," McDermott finally managed to say.

Is it reasonable to think that community rating could succeed politically? I asked McCrery. Sure, he said -- group insurers essentially already operate under such a system in big companies. I said, But what about the individual marketplace?

"Well, I may have to settle for less [than its purest form]," McCrery said. "I've talked with insurance companies about this. They tell me that as long as they can underwrite based on age and gender [but not health status], they have no problem, they can make it work."

Cecil Bykerk, an executive vice-president and the chief actuary of Mutual of Omaha, one of the largest insurers in the individual marketplace, later told me the same thing. Mutual looks at people's health status only when they sign up, he explained; once they are in the pool, it doesn't go back and adjust their rates for subsequent health developments (as auto insurers do after accidents). As it turns out, prudent pricing can be based largely on age and sex. (This is true, of course, as long as everyone buys insurance as insurance, and doesn't buy in only when he or she becomes sick; as the famous example has it, buying insurance only when the house is on fire defeats the risk-pooling concept altogether.)

At a minimum, then, McCrery's approach would remove any detailed assessment of health risk from the underwriting process, making it impossible to demand unaffordable premiums from sick Americans or to leave them uninsured. McCrery added that if insurers could go this far, they could go all the way and offer the same rates to everyone, period. He would use a reinsurance fund to compensate unlucky insurers that ended up with an undue share of high-cost cases. McCrery conceded that his scheme would make health insurance look more like a regulated utility, and would put today's entrepreneurial cherry pickers out of business. But better that government guarantee access to insurance at equitable prices, he reasons, than that government involve itself directly in the delivery of health care, or in drug prices, doctors' fees, and more -- as it is sure to do, he thinks, if the present system continues to erode until voters ask liberals to fix things their way.

"If we want to save the private health-care system," McCrery told me in a separate conversation, "Republicans are going to have to accept some things that normally would be contrary to our basic philosophy."

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