

Underrating Reform

Even with its compromises, health reform is the most ambitious effort in decades to reorganize a big part of life around principles of justice and efficiency.

BY PAUL STARR

If Congress can complete work on health-care legislation and send it to the president (as of mid-January, the final bill is still under negotiation), it will be a stunning historical achievement and the most important liberal reform since the 1960s. It may also be the most underappreciated social legislation in recent history. Never in my experience has such a big reform been treated as so small. Never have Democratic members of Congress who are putting their careers on the line for something they believe in been so vilified as sellouts by influential progressives. And never have those progressives been so grudging in their endorsement of landmark legislation or so willing to see it defeated.

How this happened is clear. Facing united Republican opposition, Democratic leaders made a series of concessions to win over centrists in their own caucus and to neutralize key interest groups. One point of contention—the public option—came to symbolize hopes on the left, and when that provision was unable to pass the 60-vote hurdle in the Senate, some progressives such as Howard Dean concluded that the entire bill had been gutted.

But that conclusion is wrong. The legislation would be a major advance in two important respects. After a long period of rising inequality, it would boost the living standards of low-wage workers and their families and improve economic security for the middle class as well. And it would be the most ambitious effort in recent history to reorganize a major institution on a basis that agrees more closely with principles of justice and efficiency.

In an ideal world the bill would be stronger, but we have to measure it against current reality and as a foundation for future progress. On those criteria it measures up well.

Here is our current reality: In most states, insurers can deny coverage to people they deem too great a risk, exclude pre-existing conditions for others, and charge however much they want based on health, age, or other characteristics. Routinely, subscribers whose health deteriorates have their coverage cancelled. Under existing law, insurers have an incentive to design every aspect of their business so as to avoid individuals with high health costs. People who obtain coverage individually or through small employers get an especially bad deal because they lack the purchasing leverage of large employee groups.

As a result of these and other problems, about 46 million Americans are uninsured at any one time, and millions more have

no coverage for pre-existing conditions or discover when they get sick that their policies have loopholes and limits that leave them bankrupt. Many people are locked into jobs for fear of losing insurance. Those without coverage are more likely to postpone treatment and to be denied care. Even before the recession, these problems were on the rise, and there is no prospect of their being solved privately; the share of employers providing health benefits dropped from 69 percent in 2000 to 60 percent in 2009.

And here is how the legislation would change that reality: It would expand coverage, first, by extending eligibility for Medicaid to people with incomes under or near the federal poverty line and, second, by subsidizing private insurance for people earning up to four times the poverty level. More than 30 million people would gain coverage as a result (the more generous the subsidies, the higher that number). The basic rules of the insurance market would change. Insurers could no longer exclude pre-existing conditions or charge according to an individual's health; they would be required to issue a policy and renew it for any legal applicant; and while they could vary premiums by age, they could do so only within limits, unlike current practice.

The law's central organizational innovation would be to create insurance exchanges offering multiple insurance plans, initially for those in the individual and small-group market, to give them the buying leverage and benefits of choice enjoyed by workers at larger firms. (An earlier name for the exchanges, "health insurance purchasing cooperatives," better conveys their function as a group purchaser.) The exchanges would play a critical role in restructuring and policing the market. To discourage insurers from cherry-picking the healthy, the law would require them to pay into a risk-adjustment fund if they enrolled a healthy, low-cost population; conversely, the fund would compensate insurers if they signed up a more costly group of subscribers.

Although these new rules would fundamentally alter how insurance works, critics on the left charge the legislation is a giveaway to health-care interests. They point not only to the defeat of the public option but also to deals with interest groups such as the pharmaceutical industry and hospitals.

If immaculate conception is a requirement for good public policy, few great legislative achievements will meet the test. The concessions on health-care reform are not nearly as egregious as the concessions made to pass Social Security in 1935, when Democratic leaders placated Southern lawmakers by excluding

agricultural workers and domestics, who happened to be heavily African American. To pass Medicare in 1965, Congress bought off the hospitals and doctors by agreeing to pay the former according to their costs and the latter according to their “customary” and “prevailing” rates. Those policies did long-term fiscal damage. By comparison, while making financial concessions to health-care interests, the current legislation claws back some of the revenue through taxes on those industries and ends excessive payments to private health insurers under Medicare.

But, critics ask, isn't the entire program a gift to the insurance industry because of the mandate—the requirement that individuals purchase coverage? The mandate or its equivalent would be necessary in a reformed system regardless of whether health insurance were public or private. If there were no mandate, but people could, whenever they wanted, get coverage with no pre-existing-condition exclusions, the rational choice for the healthy would be not to buy insurance until they got sick. But because insurance works only if the healthy as well as the sick pay for it, the system would break down. It would be like saying people needed to pay for the protection of the local fire department or for fire insurance only when a fire broke out in their home. As a practical matter, without a mandate, health-insurance premiums would have to be significantly higher—and government subsidies would rise along with them, making the program more costly.

The insurers, I am confident, would be happy to keep the present system, which has been highly profitable for them. From their standpoint, reform presents both economic and political risks. Although the mandate would bring them new customers, many of those customers are people whom no insurer has been willing to cover in the past because of their poor health. Moreover, if the federal government is on the hook for subsidies for private insurance, it will develop a direct interest in keeping down insurance rates. Under the reform plan proposed by Bill Clinton in 1993, the government would have imposed a cap on increases in the average premium in the insurance exchanges. The current legislation does not include such a budget cap, but the insurers must be concerned that it could be enacted after the exchanges are established.

As the debate began in 2009, the public option took the place of the budget cap as a way to limit the industry's control over premiums. In its original “robust” form, the public option would have paid doctors and hospitals at Medicare rates, which are now 20 percent to 30 percent below what private insurers pay. If such a plan had been offered to everyone below age 65, it would have had a significant price advantage over private insurers, who predictably opposed it for fear of being driven out of business. But a Medicare-like plan would have also reduced the revenue of hospitals and other providers so sharply as to plunge them into a crisis, so they opposed it too. There was never any chance that Congress would approve that version of the public option, even within the exchanges. After all, the proposal threat-

ened to reduce providers' revenues below their existing levels, which not even the Clinton plan's budget cap would have done.

By the time the public option died, however, the version under discussion was no longer much of a threat to insurers or providers, who would have been paid negotiated rates, just as they are under private plans. And because the public plan would likely have attracted more of the chronically ill (and the risk-adjustment system would not have corrected 100 percent for their costs), the Congressional Budget Office estimated that the public option would have had higher premiums than those of private insurers and would have enrolled only about 2 percent of the population.

Still, the public option might have provided some protection against exorbitant premiums in states where there is little competition among insurers. And it polled well in public-opinion surveys, though if things had worked out as the CBO projected, the public option would have been a big letdown—and a conservative talking point against future government action.

Last year I suggested that the public option would likely serve as a sacrificial lamb in the effort to pass a bill, and that is what happened. Democrats sacrificed it to propitiate the lords of the Senate—Ben Nelson and Joe Lieberman. But that may not be the end of the story. If costs prove to be higher than projected, the public option will have been spared any of the responsibility and may, like the budget cap, yet have its day. The current legislation includes a variety of provisions to control costs, but it has no hammer to ensure that they are controlled, and we may ultimately need one.

If the legislation passes, it will be three to four years before it is fully carried out, which is plenty of time for it to be improved—or torpedoed. This past year, Republicans savaged the entire idea, while Democrats bickered over the specifics, and public support for reform predictably fell. So much attention was devoted to the public option that when it collapsed many people were confused as to what was in the bill. Even worse, much of the criticism on the left about special interests dominating Congress validated the objections on the right and fed a general suspicion that insidious forces were at work. If progressives keep it up, they can ensure we never get anywhere on health-care reform.

What an effective politics requires is not a reckless insistence on unachievable purity but the kind of judgment—and courage—that Harry Reid and others in Congress showed in working out deals that preserved the core objectives of reform, even though they knew that compromise would expose them to a storm of abuse from both the left and right. The history of health-care reform has enough defeats, and nothing good has come of them. If this latest effort overcomes all the obstacles in its path, it will be a moment to savor—before reformers get to work trying to ensure that the legislation is carried out and strengthened rather than undone. **TAP**

If immaculate conception is a requirement for good public policy, few great legislative achievements will meet the test.