

## Presidents and the Health Care Promise

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*Many presidents have promised to fix the American health care system. Few have met with much success. This paper will examine the role of American presidents in health care reform. The next President of the United States will face a health care system with three overarching problems—access to medical care is restricted based on the availability of health insurance, the rising cost of medical care is becoming intolerable even for Americans with health insurance, and the quality of medical care has declined substantially in recent decades. In the first part of this paper, I will examine the problems in the American health care system presidents must address, the role of past presidents in the development of the present health care system, and the obstacles to reform presidents face in our political system. In the second part of this paper, I will evaluate the health care proposals of 2008 presidential primary candidates John Edwards, Barack Obama, and Hillary Clinton in terms of each plan’s practical and political feasibility.*

*“We have to stop using words like ‘access to health care’ when we know with certainty those words mean something less than universal care.....” –John Edwards, February 18, 2007*

*“It’s time to bring together businesses, the medical community, and members of both parties around a comprehensive solution to this crisis....” –Barack Obama, May 27, 2007*

*“And today...I believe everyone, every man, woman and child, should have quality, affordable health care in America.” –Hillary Clinton, September 17, 2007*

*“In a nation as rich as ours, it is a shocking fact that tens of millions lack adequate medical care. We...must have without further delay—a system of...medical insurance.” –Harry Truman, 1949*

### **Introduction: Presidential Promises and Health Care Reform**

Every president at least since Franklin Roosevelt has recognized the flaws in the American health care system. Yet each president since FDR has failed to achieve comprehensive health care reform. President Bill Clinton, in his 1994 State of the Union address, remarked, “[F]or 60 years this country has tried to reform health care. President Roosevelt tried. President Truman tried. President Nixon tried. President Carter tried. Every time the special interests were powerful enough to defeat them. But not this time.” (Clinton 1994) Shortly after, Clinton’s own plan would join the list of presidential failures in health care reform.

As the 2008 presidential elections draw nearer, comprehensive health care reform is once again an important issue in American politics. According to a poll by the Henry J. Kaiser Family Foundation, health care ranks, at 38%, as the second most important issue voters want presidential candidates to address—and it ranks first among domestic issues. (Kaiser Family Foundation 2007) Over the course of the 2008 presidential primary, several Democratic candidates produced health care plans calling for comprehensive reform. What chance did any of these candidates have to succeed, though, where so many others have failed?

Examining the prospects for any president to achieve comprehensive health care reform is the central goal of this paper. In the first part of this paper, I will describe the task presidents face in reforming health care—discussing the problems of access, cost, and quality that plague American health care; the role of past presidents in the development of our current health care system; and the obstacles to reform presidents face in our political system. In the second part of this paper, I will specifically examine the health care plans that have been offered by primary candidates John Edwards, Barack Obama, and Hillary Clinton. Each of these candidates promised comprehensive reform and universal, affordable, quality health care. Would these plans perform as promised, though, and what would their political chances of success be? To answer these questions, it is first necessary to study the problems of health care reform in the U.S.

### **Presidents and the American Health Care System**

The task of reforming health care is not simple. Presidents face a health care system which denies access to millions of Americans, fails to contain the rapidly rising costs of care, and shows declining standards of quality. Furthermore, the American health care system, with its mix of private and public insurance coverage, has developed in such a way as to make it resistant to change, and presidents face a number of political obstacles to health care reform. Past presidents have not failed to achieve comprehensive reform due to a lack of will, but because of the real and daunting challenges of such a complicated undertaking.

#### *Defining the Problem: Access, Cost, and Quality*

Understanding the scope of the problems inherent in the current health care system helps to put in perspective the failures of past presidents. The immense scale of each of the issues of access, cost, and quality—which any comprehensive plan must address—makes finding a lasting solution difficult.

*Access.* Alone among modern industrial nations, the United States fails to provide universal health care coverage. In 2006, the number of Americans without health insurance had risen to 46.5 million—including 9.4 million children. Most of the uninsured are low-income Americans. According to a report by the Kaiser Family Foundation, “Over a third of the poor and 30% of the near poor (100-199% of poverty) lack health coverage.” The same report noted that 82% of the uninsured are from families with at least one working adult. “Low-wage workers are at greater risk of being uninsured, as are those employed in small businesses, service

industries, and blue-collar jobs.” (Kaiser Family Foundation 2007) Lack of access to the American health care system is a growing problem which disproportionately affects those Americans who can least afford to pay for care.

*Cost.* Compounding the issue of access is the problem that the cost of health care is growing uncontrollably. The Centers for Medicare and Medicaid Services (CMS) estimate that the cost of health care in 2007 will exceed \$2.26 trillion—or about 16.2% of the U.S. gross domestic product. By 2016, the CMS projects that health care spending will exceed \$4.13 trillion, or about 19.6% of GDP. (Centers for Medicare and Medicaid 2007) As is documented in a report by the Kaiser Family Foundation, this far exceeds health care spending in other industrialized nations. Among Organisation for Economic Co-operation and Development (OECD) countries, the United States is the leader in health care spending by a substantial margin. “U.S. health spending as a share of GDP in 2004 (15.2% in OECD accounting) was considerably higher than all other OECD countries, including Canada (9.2%), France (11.0%), Germany (10.6%), Japan (8.0%), and the United Kingdom (8.1%).” (Kaiser Family Foundation 2007) As the cost of health care has risen, it has become expensive beyond affordability for many Americans and American businesses.

*Quality.* Almost paradoxically, as the cost of health care in the U.S. has increased, the quality of care has declined. Even by basic measures of health, the U.S. ranks low. With an estimated life expectancy of 77.8 years in 2004, the U.S. ranked 24<sup>th</sup> among OECD nations. Japan ranked first with a life expectancy of 82.1 years. The U.S. ranked even lower in terms of infant mortality—27<sup>th</sup> with a rate of 6.8 deaths per 1,000 live births. Iceland ranked first with a rate of 2.3 deaths per 1,000 live births. Meanwhile, at 32.2%, the U.S. ranked first in obesity (the percentage of adults with a Body Mass Index over 30)—which is an indicator of future health problems. Japan had the lowest obesity rate, at 3.0%. The OECD average was 14.6%—less than half the U.S. percentage. (OECD Health at a Glance 2007: Health Indicators) Additionally, a report by the Institute of Medicine estimated in 1998 that the number of deaths caused by medical errors in the U.S. is between 44,000 and 98,000—which, if correct, would make such errors a leading cause of preventable deaths in the U.S. (Institute of Medicine 1998) The U.S. also spends an inordinate amount of money on preventable diseases. As Susan J. Blumenthal et al. note in a report for the Center for the Study of the Presidency, “Currently, more than 75% of health care dollars are spent on patients with chronic diseases, yet an estimated 80% of all chronic diseases are caused by preventable factors, such as smoking, obesity, and physical inactivity.” (Blumenthal et al. 2007) While the cost of health care in the U.S. steadily increases, measures of American health and the quality of health care continue to decline.

### *Creating a Broken System: The Development of American Health Care*

No one person intentionally designed the health care system we have today, with its glaring problems of access, cost, and quality. Rather, the development of our current patchwork system can be traced to a series of compromises and

incremental decisions which addressed some problems while creating others. The current health care system has a mix of private insurance for the employed and public insurance for the elderly, veterans, the poor, and lower income children. Presidents and their policy initiatives—from FDR and the New Deal through Lyndon Johnson and the Great Society and beyond—have played an important role in shaping the current system. Understanding this process of development will help show where it is possible for the U.S. to go from here.

The modern American health care system began to take shape with FDR's failure to include national health insurance in the New Deal. Rick Mayes, in *Universal Coverage: The Elusive Quest for National Health Insurance*, describes the circumstances surrounding this decision, and its consequences for the later development of the health care system. As Mayes documents, although the Great Depression presented a unique opportunity for the creation of bold new social welfare programs, FDR felt national health insurance—due to opposition in Congress and by the American Medical Association (AMA)—would jeopardize his Social Security legislation. “Intimidated by organized medicine in 1935, Roosevelt excluded health insurance coverage from the Social Security Act so that the program could pass in Congress.” (Mayes 2004, 2) FDR prioritized old age insurance over health insurance.

As FDR's successor, President Harry Truman, was to discover, national health insurance would not easily be incorporated into the New Deal social safety net afterwards. As Mayes notes, “The nation's most powerful political actor...had been missing from every effort for national health insurance prior to 1945. Harry Truman, however, made his support...clear from the beginning....” (Mayes 2004, 36) Despite presidential support, though, national health insurance could not overcome the opposition of the AMA and conservative Democrats and Republicans in Congress. Jonathan Oberlander, in *The Political Life of Medicare*, notes that in response to Truman's support of national health insurance, the AMA branded national health insurance as “socialized medicine” and “in 1949 launched the most expensive lobbying campaign in American history to raise public anxieties ...and, in conjunction with the insurance company Blue Cross, pushed the alternative of private (‘voluntary’) insurance as the ‘American way.’” (Oberlander 2003, 22) Again, facing stiff opposition, national health insurance went nowhere in Congress.

These initial failures to install national health insurance in the U.S. are important in a study of our current health care system in two respects. First, private insurance companies grew to fill the gap created by the absence of a public health insurance system. Second, in light of the substantial obstacles to comprehensive reform, subsequent health care reformers adopted an incremental approach to expanding public health insurance. Mayes documents the incredible growth in private health insurance in the post-war years. “[I]n 1948 only 8 percent of all Americans had comprehensive private health insurance....By 1957 the proportion had tripled to 24 percent, with 60 percent...in possession of at least hospital insurance.” (Mayes 2004, 45) This rapid growth was precipitated by Truman's failure to institute national health insurance, when labor unions began pushing for

private health insurance through employers. As Mayes notes, “In 1948, only 2.7 million workers had private health insurance negotiated by their unions.... By 1954, 12 million workers—together with their 17 million dependents—had health insurance as a result of unions’ bargaining with employers.” (Mayes 2004, 48) In the absence of national health insurance, private insurance flourished.

As opposition to national health insurance remained implacable following the 1940s and private insurance began to fill the health insurance void, health care reformers adopted an incremental approach to expanding coverage. In particular, Medicare and Medicaid were created in the 1960s to provide health insurance for the elderly and the poor. As Oberlander describes, “[T]he narrowing of the Truman national health insurance proposal into Medicare reflected an incrementalist strategy of ‘consensus-mongering.’ The aim was to identify less controversial problems and more politically feasible solutions....” (Oberlander 2003, 25) With his landslide victory in 1964 (and a shift in the ideological balance in Congress), LBJ had just enough political capital to make Medicare law and provide universal coverage for the elderly. (Medicaid, federal assistance for state health insurance programs for the poor, was also included in the final bill.) This incremental approach has been adopted by later reformers—leading to, for example, the State Children’s Health Insurance Program (SCHIP), which provides federal assistance for state health insurance programs for poor children. The result has been the hodgepodge system we have today—with health insurance provided to most of the employed, the elderly, the poor, and some children, but not to 47 million Americans. Clearly, there are still holes in our patchwork health care system.

#### *Surveying the Field: Obstacles to Presidential Reform*

The next President of the United States will pursue health care reform in a more complex political environment than was experienced by FDR, or even LBJ. This is because the actions of past presidents continue to have implications today. As Mayes explains, decisions made at “critical junctures” in policymaking tend to have “increasing returns” which foster what he calls “path dependency.” In other words, key decisions tend to have “self-reinforcing effects” which make drastic policy changes increasingly difficult. (Mayes 2004, 5-7) In the case of health care, FDR’s omission of national health insurance led to the development of a system with a mix of private and public health insurance. Due to the complexity of the established system, instituting an entirely new national health insurance system now would be nearly impossible. Despite their significant political resources, presidents are still single actors in a complex political environment, and must work within our current health care system in the process of reform. To achieve meaningful health care reform, the next president will need to accommodate a number of disparate ideas, interests, and institutions involved in the politics of health care.

*Ideas.* The ideology which FDR’s opponents used to dissuade him from creating a system of national health insurance is still pervasive today. In particular, wariness about government bureaucracy and the desire for choice in health insurance and doctors remain. As Theda Skocpol documents in *Boomerang*:

*Clinton's Health Security Effort and the Turn Against Government in U.S. Politics*, such ideas were effective in defeating Bill Clinton's plan for comprehensive reform in the 1990s. Epitomizing the successful use of these ideas were the "Harry and Louise" ads, paid for by the Health Insurance Association of America. As Skocpol describes, "Harry and Louise were an obviously well-off, forty-something middle-class white couple....What Harry and Louise found in the Clinton plan worried them....they discovered the horrible possibilities of bureaucrats choosing their health plan..." (Skocpol 1996, 137-138) The Harry and Louise ads played on the fears of insured Americans that national health insurance would remove freedom of choice from health care and result in lower-quality care. A letter in the *Wall Street Journal* by Representative Dick Armev struck similar chords. As Skocpol notes, "According to Representative Armev... 'the Clinton health plan would create 59 new federal programs or bureaucracies....[and] will ultimately result in higher taxes, reduced efficiency, restricted choice, longer lines, and a much, much bigger federal government.'" (Skocpol 1996, 143-144) Invariably, the same fears of government bureaucracy and a lack of choice recur in debates over reform.

*Interests.* No interest groups actively oppose helping the sick. Many interests, however, stand to lose from changes in the current system. The AMA has been a powerful interest opposed to national health insurance and related reforms from the beginning. With the growth of private insurance since the 1940s, this industry too has emerged as a strong force against expanding public health insurance. Other health industries, such as hospitals and pharmaceuticals, could also be hurt by changes in the status quo.

Since the rise of Medicare, the AARP has also emerged as a powerful interest in health care politics. The AARP is not against national health insurance, but it opposes reforms which threaten to curtail benefits to the elderly. Oberlander notes that, thanks to its large membership (around 28 million in the 1980s), substantial budget, and vast organizational resources, "By 1990 the AARP had arguably replaced the AMA as the most prominent interest group engaged in Medicare politics." (Oberlander 2003, 45) As will be discussed below, however, medical care for the elderly is expensive—so maintaining and expanding Medicare makes it more difficult to propose spending increases for other groups.

To give some idea of the influence of these interests in American government, it is helpful to examine some spending figures assembled by the Center for Responsive Politics. According to the Center, the AMA spent the second most on lobbying of all spenders for the period from 1998-2007, with a total of \$157,247,500. The American Hospital Association was fourth, spending \$138,084,144. The Pharmaceutical Researchers and Manufacturers of America were fifth, spending \$115,008,600. The AARP was sixth, spending \$112,732,064. Blue Cross/Blue Shield was 11<sup>th</sup>, spending \$90,163,317. (Center for Responsive Politics 2007) Clearly, these are interests whose voices are heard.

*Institutions.* Just as the health care interest group environment has grown more complex since the 1940s, so too has the institutional structure in which health care reform takes place. One institution all presidents must deal with is Congress—

where the partisan balance and committee structures can determine the success or failure of health care proposals, and where there are many points at which a bill can be stalled. LBJ was only able to pass Medicare after securing wide Democratic margins in the House (295-140) and Senate (68-32) in the 1964 elections. Even then, it was only with the timely reversal of Ways and Means chair Wilbur Mills that Medicare and Medicaid became law. (Oberlander 2003, 29-30)

Several health care institutions have developed since the 1940s. In particular, the presence of a vast private health insurance system has lessened the urgency of creating a comprehensive public system. Medicare itself, despite expanding public insurance coverage, has become an obstacle to national health insurance. In part this is because Medicare and Medicaid have expanded coverage enough so as to make comprehensive coverage less urgent. Additionally, though, the rising cost of maintaining Medicare serves to hamper further expansion of health coverage. Oberlander notes that “by the middle of the 1990s there remained only one significant bastion of ‘unmanaged’ care in the United States: Medicare.” (Oberlander 2003, 169) The high costs of providing public health insurance for the elderly has made it difficult to expand health coverage to other groups.

As well, Medicaid has been stretched since its inception to cover different aspects of health care, which has increased the costs of maintaining the program. Mayes documents that Medicaid “according to 2002 data, has surpassed Medicare in numbers of beneficiaries (51 million to Medicare’s 41 million) while almost equaling it in terms of total spending (roughly \$250 billion).” This is in part because Medicaid now provides for services it was not originally designed to cover. As Mayes notes, “As the nation’s largest health insurance program, Medicaid insures 20 percent of the nation’s children...provides for the care that two-thirds of the nation’s nursing home residents receive...finances the bulk of the care provided to AIDS patients, half of all states’ mental health services, and one-sixth of the nation’s pharmaceutical drug expenses,” among other things. (Mayes 2004, 155)

The bottom line is that the institutional environment for the politics of health care in the U.S. is highly complex; presidents cannot simply turn back the clock and create a simple, universal health care system. Instead, they must propose plans that somehow work within the health care system we have today.

### **Proposed Solutions and Prospects for Success**

Having outlined the task presidents face in comprehensive health care reform, I will now turn to an analysis of the health care plans offered by 2008 Democratic presidential primary candidates John Edwards, Barack Obama, and Hillary Clinton. They offered detailed plans that would purportedly provide universal access to care, contain costs, and increase the quality of care. My intention is not to promote one plan over another, but to analyze the strengths and weaknesses of these three plans in order to study what the features of a viable health care plan might be.

In order to be successful, a health care plan must strike a delicate balance between what is practically feasible (solutions that will actually work in reality) and

what is politically feasible (proposals that can actually become law). Oberlander, in the article “The Politics of Health Reform: Why Do Bad Things Happen to Good Plans?” discusses this balance in finding policy that is both technically sound and politically viable. As he puts it, “The search for a technical solution to what is fundamentally a political problem is not likely to succeed.” There are ways to address the problems of access, cost, and quality—but practical feasibility must sometimes be sacrificed for political feasibility. The problem with incremental or compromise reforms is that they are often not sustainable or absolute. As Oberlander says, “Their acceptance of the status quo guarantees that they will fail to control costs or assure universal coverage.” (Oberlander 2003) Edwards, Obama, and Clinton have all attempted to strike upon politically feasible yet technically comprehensive solutions by working within our current health care structure, but will their plans perform as promised? The plans that follow are presented in chronological order according to the date they were released to the public.

*John Edwards: “Universal Health Care through Shared Responsibility”*

John Edwards released the details of his health care plan on February 18, 2007. The Edwards plan has four basic parts aimed to provide universal coverage and contain costs. The first part, “Business Responsibility,” states, “[Businesses] will be required to either provide a comprehensive health plan to their employees or to contribute the cost of covering them through Health Care Markets.” Businesses would either have to cover their employees directly or pay into government programs so that their employees have some form of coverage. The second part of the Edwards plan, “Government Responsibility,” would expand the government’s role in health care. “Edwards will create a new tax credit to subsidize insurance.... expand Medicaid and SCHIP....require insurers to keep plans open to everyone and charge fair premiums, regardless of preexisting conditions, medical history, age, job, and other characteristics....” A combination of tax incentives, Medicaid and SCHIP expansions, and regulations for private insurance providers would aim to expand both private and public insurance. The third part of the Edwards plan, “New Health Care Markets,” is the centerpiece of Edwards’ guarantee of universal coverage. Edwards would create “regional...non-profit purchasing pools that offer a choice of competing insurance plans,” with at least one “public program based upon Medicare” in order to expand coverage, provide choice in plans, and contain costs. “Health Care Markets will give participants a choice among affordable, quality plans...a choice between private insurers and a public insurance plan...negotiate low premiums through their economies of scale...minimize administrative burdens for participating businesses and other employers.” Health Care Markets would use purchasing pools to reduce costs, and would contain public insurance similar to Medicare (but open to all Americans) and offer a choice of private plans. The fourth part of Edwards’ plan, “Individual Responsibility,” requires that “Once insurance is affordable, everyone will be expected to...[obtain] health coverage.” In other words, all individuals would be required to have some kind of health insurance, whether public or private.

The Edwards plan contains six features to improve quality. The first part, “Help Doctors Deliver the Best Care,” contains such measures as “disseminat[ing] information on medical advances,” (which includes the establishment of a non-profit research organization), “help doctors implement new advances,” “improve the health care delivery system,” and “prevent medical errors.” The second part, “Invest in Preventative Care and Health,” aims to promote preventative care—which lowers costs and improves health by avoiding future illnesses. The third part, “Empower Patients through Transparency,” aims to provide more information to patients about their options. The fourth part, “Reduce Health Disparities,” calls for the reduction in the discrepancies in the quality of care for “people of color.” The fifth part, “Improve Productivity with Information Technology,” calls for an improvement in efficiency through the use of the newest technology. The sixth part, “Protect Patients against Dangerous Medicines,” calls for greater stringency in the approval of new prescription drugs and medical technology. (Edwards 2007)

*Barack Obama: “Plan for a Healthy America”*

Barack Obama publicized the details of his health care plan on May 29, 2007. There are six key features of his plan to provide universal coverage while containing costs. First, his plan would “establish a new public insurance program, available to Americans who neither qualify for Medicaid or SCHIP nor have access...through their employers....” This would be an attempt to fill the gap between current public insurance available to the poor and private health insurance. Second, Obama would “create a National Health Insurance Exchange to help Americans and businesses that want to purchase private health insurance directly.” This Exchange would facilitate the acquisition of private insurance by using purchasing pools—and would also make sure private plans matched the standards of the new public insurance plan. Third, Obama’s plan would “require all employers to contribute towards health coverage for their employees or towards the cost of the public plan.” As in the Edwards plan, employers would share some of the burden in expanding health coverage. Fourth, Obama would “mandate all children have health care coverage” though he would not mandate coverage for all Americans. Fifth, Obama would “expand eligibility for the Medicaid and SCHIP programs.” Existing public insurance programs would be expanded to cover more of the uninsured poor or near poor. Sixth, Obama would “allow flexibility for state health reform plans.” Recognizing that some states have already initiated their own plans for universal coverage, Obama would allow states to continue these efforts as long as the state plans meet a national standard.

Obama also offers several measures aimed to improve quality and reduce costs. First, Obama would “[offer] federal reinsurance to employers to help ensure that unexpected or catastrophic illnesses do not make health insurance unaffordable....” As catastrophic illnesses place a huge financial burden even on people with health insurance, this would reduce the overall cost of insurance. Second, Obama would “[ensure] that patients receive and providers deliver the best possible care” through the exchange and dissemination of information, “incentives

for excellence,” and addressing disparities in the health system. Third, Obama would “[lower] costs through investment in electronic health information systems.” Fourth, Obama would “[lower] costs by increasing competition in the insurance and drug markets.” Obama hopes to increase market competition to force private insurance companies to reduce their premiums. Finally, Obama advocates preventative care as an important component of improving the quality of health in the U.S., as well as reduce the costs imposed on the health care system by diseases with preventable causes. (Obama 2007)

*Hillary Clinton: “American Health Choices Plan”*

Hillary Clinton is in the unique position as a presidential candidate of having, as First Lady, spearheaded her husband’s failed attempt at comprehensive health care reform in the 1990s. As such, her plan stresses choice in health insurance coverage, and reassures the reader that, if you are “happy with your current health care coverage,” you will be able to keep your current insurance plan. She released the details of her plan on September 17, 2007.

Part one of her plan, “Offer New Coverage Choices for the Insured and Uninsured,” emphasizes choice—without new bureaucracy. “Americans can keep their existing coverage or access...a new Health Choices Menu, established without any new bureaucracy as part of the Federal Employee Health Benefit Program (FEHBP). In addition to the broad array of private options...they will be offered the choice of a public plan option similar to Medicare.” Private plans in this purchasing pool would be required to meet the same standards as the new public plan. Part two of Clinton’s plan, “Eliminate Insurance Discrimination, Improve Quality, and Rein-in Costs,” would lower costs by emphasizing preventative care, improving health information technology, and ending “health insurance discrimination” by requiring insurers not to deny coverage to anyone. Clinton’s plan would also create a “Best Practices Institute” to fund and disseminate new medical research. Part three of Clinton’s plan, “Promoting Shared Responsibility,” would spread the responsibility for expanding coverage and reducing costs to insurance companies, drug companies, individuals, employers, and the government. All individuals would be required to have health insurance under the Clinton plan.

Part four of Clinton’s plan, “Ensuring Affordable Health Coverage for All,” would keep the cost of health insurance down while expanding coverage by providing “refundable, income-related tax credits” to working families, “limiting premium payments to a percentage of income,” requiring “large employers...to provide health insurance...or make some contribution to the cost of coverage,” “creating a small business tax credit” to alleviate costs, extending Medicaid and SCHIP to “serve all low-income individuals,” and “[providing] a tax credit...to offset...catastrophic expenditures...” Part five of Clinton’s plan, “Fiscal Responsibility that Honors our Priorities,” would contain costs by reducing “excess expenditures” through modernization and removing “overpayments” for insurance, medical care, and prescription drugs. Clinton would also “[redirect] tax breaks” for wealthy Americans. (Clinton 2007)

### *Plans Compared: Separating Rhetoric from Specifics*

The three plans summarized above are all crafted to sound appealing, and all promise universal, affordable, quality health care. How, though, do the plans of Edwards, Obama, and Clinton compare? A recent study conducted for the Center for the Study of the Presidency by Susan J. Blumenthal, M.D., et al., as well as a similar report by the Kaiser Family Foundation and Health Policy Alternatives, Inc., offer side-by-side comparisons of the three Democratic health care plans.

The main difference among the three plans is the manner in which each candidate proposes to expand health insurance coverage through a combination of public and private insurance. Edwards uses Health Care Markets, regional “nonprofit purchasing pools offering competing public and private health plans,” and a new public health insurance program to expand coverage. Obama also creates a new public plan, but would use a “National Health Insurance Exchange through which small businesses and individuals...could enroll in the new public plan or approved private plans.” Clinton would make “Private and public plan options...available to individuals through a new Health Choices Menu operated through the Federal Employee Health Benefits Program (FEHBP).” Each of these three slightly different methods would serve as “insurance pooling mechanisms” to expand coverage and reduce the cost of insurance through economies of scale. (Kaiser Family Foundation 2007, Blumenthal et al. 2007)

All three candidates propose expansions of Medicaid and SCHIP and would compel private insurers to expand coverage. They all utilize what has been called a “pay or play” system, in which employers must either provide insurance to their employees or help subsidize their coverage. However, only Edwards and Clinton would require all individuals to have health insurance of some kind. Obama seeks only to make health insurance available to all individuals. The three candidates’ other proposals to contain costs and improve quality are sufficiently similar (and lacking in implementation details) that I will not repeat the summaries above.

A final difference among the three plans is the issue of how each candidate would finance his or her plan. Edwards estimates the cost of his plan to be between \$90 and \$120 billion per year, financed by “rolling back tax cuts for those earning more than \$200,000 a year.” He expects his plan to save between \$100 and \$150 billion per year. Obama projects the cost of his plan to be between \$50 and \$65 billion per year, to be paid for by “discontinuing tax cuts for those with incomes over \$250,000.” He expects his plan to save as much as \$200 billion per year. Clinton expects her plan to cost about \$110 billion per year, to be covered through the savings generated from her plan as well as rolling back tax cuts for Americans earning more than \$250,000 per year. She expects savings from her plan to total around \$120 billion per year. (Kaiser Family Foundation 2007)

### *Delivering on Promises: Practical Feasibility*

Would the plans of Edwards, Obama, and Clinton truly provide universal, affordable, quality health care? One *USA Today* editorial accused all three candidates of having “extensive health care plans that are heavy on dessert and light

on spinach.” (*USA Today* 2007) In each of the areas of access, cost, and quality, it is unclear whether any of the Democratic plans would deliver as promised.

*Access.* As Edwards, Obama, and Clinton vied for their party’s nomination, much of the harshest criticism for their plans came from each other. Clinton charged that, because Obama does not require all individuals to purchase health insurance, he would leave 15 million uninsured. As an article in the *Wall Street Journal* documents, “If people aren’t required by law to buy insurance, many won’t. There are millions of children, for instance, who remain uninsured, even though they qualify for free or subsidized government programs.” (Meckler 2007) The mandates for health insurance contained in Clinton and Edward’s respective plans, however, do not guarantee universal coverage either. An article in the *New York Times* notes, “Mandates have not worked with auto insurance. While all drivers are required to have it, 15 percent of the nation’s drivers have none...” (Seelye 2007) None of the three leading Democrats’ plans—though each would expand coverage—can truly guarantee universal coverage.

*Cost.* All three candidates have made bold predictions about how much money each of their health care plans would save. The specific details of their cost containment plans, however, are somewhat soft—they emphasize cutting costs through improving efficiency and preventative medicine, but offer few implementation details. All three candidates would offer tax credits to make health care more affordable, but outside of insurance pooling, none of them offer hard proposals to stem the rising cost of care. Oberlander, in a *New England Journal of Medicine* article, notes that more rigorous cost-control measures would encounter resistance. “[Edwards, Obama, and Clinton] avoid any explicit budgeting of health care spending or centralized cost controls—provisions that the health care industry would fiercely resist.” The three candidates’ cost control measures may be more politically feasible than more stringent measures. As Oberlander puts it, “[T]hey offer a politically friendlier assortment of cost-saving measures, including electronic medical records and a focus on prevention and disease management.” He goes on to say, though, “These may be good health policy, but their capacity to generate large savings is uncertain, and they are unlikely to restrain health care spending for long.” (Oberlander 2007) The rosy savings projections of each candidate aside, it is unlikely that any of the three plans contains a permanent solution to the rising cost of health care.

*Quality.* Each candidate’s plan to improve health care quality is likewise vague. In part this is because the issue of health care quality is particularly complex—with multiple factors contributing to a lower standard of care—and will require sustained efforts over the long term to be successfully addressed. Without more details, especially as regards implementation, though, it is impossible to know how well any of the three plans would address quality. It is one thing to call for more preventative medicine and promote the use of “best practices,” for instance—it is quite another entirely to make the systemic changes necessary to do so. Other than the creation of an independent research organization to promote best practices

(a component of all three plans), none of the leading Democratic candidates have made many concrete proposals to improve the quality of health care in the U.S.

*Delivering on Promises: Political Feasibility*

Realistically, due to the magnitude of the issues involved, no health care plan could completely address the problems of access, quality, and cost. The health care plans of Edwards, Obama, and Clinton all seem likely to improve the American health care system overall. Are any of these plans politically feasible, though; could they succeed where so many other comprehensive plans have failed?

*Ideas.* Despite the efforts of each candidate to distance his or her plan from the failed comprehensive efforts of the past, critics have employed many familiar themes against each plan. These themes are encapsulated in comments made by Republican presidential primary candidate Rudy Giuliani in July. Of health care reform, Giuliani said, “America’s health care system is being dragged down by decades of...wasteful, unaccountable bureaucracy. To reform, we must empower all Americans by increasing health care choices and affordability, while bringing accountability to the system.” Implicit in this statement is criticism of the Democrats’ plans, which seek government-driven reform. Giuliani went on to say of the leading Democrats’ health care plans, “[French President Nicholas] Sarkozy is...headed to the United States, and Hillary and Barack and John Edwards are...headed to France...They are looking for the socialist solution they have in Europe, and Sarkozy is looking for the free-market private solutions that work so well in the United States.” (Steinhauser 2007) The rhetoric of choice, bureaucracy, and socialized medicine is clear. Each of the three plans discussed above would face sharpened criticism from Republicans and others if introduced to Congress.

*Interests.* Some of the interests that blocked comprehensive reform in the past have already mobilized. In August, the AMA launched a public relations campaign called “Voice for the Uninsured,” to promote the expansion of health insurance through market-driven reform. According to the *Los Angeles Times*, the AMA will “direct \$5 million this year to advertising in Iowa, New Hampshire and South Carolina....” Later, the AMA “will take the advertising campaign to the rest of the country...in advance of the presidential election.” After the election, the AMA “will lobby Congress and push for legislation to offer a solid plan by the end of 2009.” (Lauer 2007) The AMA will employ substantial resources against any significant moves towards national health insurance. Other interests can be expected to oppose facets of the three Democratic plans. Insurance companies will likely oppose requirements to keep premiums low and to extend private coverage to costlier high-risk patients. Pharmaceutical companies will probably oppose regulations allowing for generic and inexpensive prescription drugs. Businesses and employers, who would be required to contribute more for health insurance, will likely oppose the pay or play aspects of the Democratic plans. To give some idea of the influence of the business lobby in American politics, the U.S. Chamber of Commerce alone spent more on lobbying than the AMA in the period from 1998 to 2007, for a total of \$338,324,680. (Center for Responsive Politics 2007)

There are some indications, however, that health care interests will also try to work with the Democratic candidates. According to an October article in the *New York Times*, Democratic presidential candidates have raised more money from “Hospitals, drug makers, doctors and insurers” than the Republicans—\$6.5 million to \$4.8 million. With \$2.7 million raised, the candidate favored most by the health industry was Hillary Clinton. Obama came in a close second with \$2.2 million. (Hernandez and Pear 2007) In 2009, health care interests may negotiate, rather than obstruct the process of comprehensive health care reform.

*Institutions.* Although all three Democratic plans would almost surely face substantial institutional and logistical obstacles during their implementation—whether in the creation of insurance pooling mechanisms, in the expansion of Medicaid and SCHIP, in the modifications to Medicare, in the regulation of the private insurance and prescription drug industries, or in the creation of new public insurance programs—each plan’s implementation details are sufficiently vague that it is difficult to say exactly where problems would arise. As all three Democrats chose to approach reform within the current health care system, though, they would all undoubtedly face substantial obstacles in implementation.

To even reach the stage of implementation, however, a plan must first pass through the institution of Congress. Although the Democrats took control of both houses of Congress in the 2006 midterm elections, in 2009 (barring the type of landslide election LBJ enjoyed in 1964), the next president will be forced to pass health care reform legislation through an evenly divided Congress. If the Democrats maintain control of Congress, a Democratic president will at least be able to rely on friendly committee chairs, rather than obstructionist chairs that could bottle up reform legislation indefinitely. As debates in 2007 on SCHIP reauthorization showed, it is possible to pass health care legislation—but neither will it be an easy prospect. Additionally, one should bear in mind that President Clinton enjoyed Democratic control of both the House and Senate in 1993, but his health care plan was politically defunct before it even reached Congress.

### **Conclusion: A Mended System or Broken Promise in 2009?**

Any health care plan proposed at this point will undoubtedly undergo multiple changes in the coming months before it is even introduced to Congress. Judging from the three comprehensive plans analyzed here, though, it is unlikely that the problems of access, cost, and quality will be solved in any lasting way by the next President of the United States. The patchwork system of private and public insurance that has developed since FDR dropped national health insurance from Social Security forces would-be reformers to act within a complex ideational, interest group, and institutional environment that is resistant to change. As such, politically feasible solutions must often sacrifice technical soundness. If Edwards, Obama, or Clinton was elected, it is unlikely that any of them would be able to implement their plans to meet the expectations they have promised. Though they may make positive improvements to our health care system, it is unlikely that any of them would be able to fulfill their promises of universal, affordable, quality care.

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