

Point/Counterpoint

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EXPANDING HEALTH CARE COVERAGE: NATIONAL VERSUS STATE LEADERSHIP

Richard P. Nathan

INTRODUCTION

This is the fifth feature in JPAM in the point/counterpoint mode. It is on health policy with two “inners and outers” in American government: Henry J. Aaron, Bruce and Virginia MacLaury Senior Fellow at the Brookings Institution and formerly U.S. Assistant Secretary for Planning and Evaluation, Department of Health, Education, and Welfare; and Paul H. O’Neill, a former U.S. budget official and Secretary of the Treasury, who has had major experience in corporate management. Both are people I know well and respect. This exchange focuses on federal versus state government leadership on health policy reform. Aaron’s position is to urge a federally funded program of state experimentation to expand health care coverage. O’Neill, who favors the same outcome, does not share Aaron’s view on state leadership. In fact, he is generally despairing of action to expand and reform health care coverage, although he strongly favors it.

THE WORST SYSTEM OF HEALTH CARE REFORM—EXCEPT FOR ALL THE OTHERS:
A FEDERALIST APPROACH TO HEALTH CARE REFORM

Henry J. Aaron

Health care is big and it is diverse.

- At \$2 trillion in 2005, total U.S. spending on health care exceeds the gross domestic product of Germany and nearly equals those of France and Spain combined.
- Spending varies enormously across the United States. Average per capita health care spending in 1998 ranged from \$2,731 in Utah to \$4,810 in Massachusetts. Average per capita public health care spending in 2003 ranged from \$59 in Iowa to \$499 in Hawaii.¹
- Rates of surgery and use of diagnostic procedures vary by ratios of 5 and 10 to 1 across U.S. counties, far more than any epidemiological differences can account for.
- Fewer than 1 in 10 residents of Hawaii and Minnesota, but more than a quarter of all Texans and more than 20 percent of New Mexicans, were uninsured on the average at any given point in time over a three-year period spanning 2002 to 2004.²
- Health maintenance organizations enroll at least 35 percent of the populations in California, Connecticut, and Massachusetts. Alaska has no health maintenance organizations operating within its borders. Three other states have only one.³
- Connecticut, Florida, and Maryland have 50 or more health care mandates covering such items as treatment for cleft palate, hair prostheses, in vitro fertilization, and morbid obesity treatment. These states forbear from mandating treatment for port wine stain elimination, but Minnesota and Washington do not. Idaho has the fewest mandates—13; Alabama is next, with 18.⁴

The historian Shelby Foote noted that before the Civil War people wrote: “The United States are . . .”; after the war, they wrote: “the United States is. . .” When it comes to health care, the United States *are* not one nation but 50—or 51, if one includes the District of Columbia.

Every prescription for reforming health care financing and provision should begin with the reality that the U.S. health “system” is not a system at all. Rather, it is a collection of many loosely linked, loose systems. Some legislation—notably Medicare—is putatively uniform across the nation. In fact, it isn’t. Medicare enrollees are nearly three times as likely to be hospitalized in Alabama as in Hawaii. They are four times

¹ Anne Martin et al., Health care spending during 1991–1998: A fifty-state review (2002). Health Affairs, 21(4), 112–126; United Health Foundation (2005) America’s health rankings, table 27, p. 100.

² Bureau of the Census, Health Insurance Coverage 2004, Table 11, Percentage of People Without Health Insurance Coverage by State Using 2- and 3-Year Averages: 2002 to 2004, <http://www.census.gov/hhes/www/hlthins/hlthin04/hi04t11.pdf>.

³ Kaiser Family Foundation, Managed care and health insurance, in 50 State Comparisons, www.state-healthfacts.org, accessed May 1, 2006.

⁴ Council for Affordable Health Insurance, Health insurance mandates in the states: 2005, January 2005.

DOI: 10.1002/pam.20233

as likely to be operated on for varicose veins in Maryland as in Alaska. They are twice as likely to die in hospitals in New Jersey and Mississippi as they are in Utah. In 2003 Medicare spent \$8,076 per person in New Jersey but only \$4,530 in Hawaii.⁵ Some national legislation—notably Medicaid—explicitly anticipates wide state-to-state variations. All in all, differences in medical practice and spending are as great among the 50 states as they are among the discrete national systems of the European Union.

The history of failed efforts to achieve uniform national health insurance spans seven decades. Chapter one in the chronicle of failures was written in President Franklin Roosevelt's first administration. He decided to not even try for national health insurance, despite the urging of many of his closest advisors. The reason? Including it in the Social Security Act of 1935 would have caused the American Medical Association and other vocal opponents of federal involvement to kill the entire bill.⁶ Chapter two was written when President Harry Truman failed even to get hearings in the House of Representatives for the Wagner-Murray-Dingell bill to provide national health coverage, although polls indicated that a large majority of the American people favored some form of national health insurance.⁷

Many were under the impression that the passage of Medicare was a way station to success. In 1965, after the Democratic party's landslide victory in 1964, Congress approved a national program of health care for the elderly. Even then, the bill was an amalgam of a national program and a federalist component, Medicaid, long preferred by the Republican minority that was lukewarm on universalist social insurance. That was pretty much the end of forward movement. With bipartisan impartiality, subsequent Congresses buried variously configured national health plans of Gerald Ford, Jimmy Carter, George H.W. Bush, and Bill Clinton.

Prospects for national action have, if anything, deteriorated since the last failure of health care reform in 1993. The current gusher of budgetary red ink threatens to become a torrent.⁸ Deficits matter for health care reform. Even if system reforms eventually slow the growth of spending, additional front-end spending is inescapable to cover the uninsured. Worse still, gerrymandering, engineered by incumbents to produce safe districts, has turned the political center into a wasteland. The near electoral dead-heat between the two major parties has produced political nastiness unprecedented in living memory. The disposition for political compromise necessary for

⁵ Dartmouth Medical Atlas, http://www.dartmouthatlas.org/data/download/2003_reimb_table_state.xls. Gaps in specific services were proportionately far larger. Per Medicare enrollee costs for extended hospital stays ranged from \$1,055 in Louisiana to just \$146 in Alaska.

⁶ Social Security, Chapter 2: The Second Round: 1927–1940, <http://www.ssa.gov/history/corningchap2.html>.

⁷ The polls were taken during World War II. "In addition, wartime public opinion polls had indicated broad public support for government health insurance. A 1942 poll by *Fortune* magazine had found no fewer than 74 percent of the respondents in favor, and in the following year a nationwide Gallup poll recorded 59 percent in favor." Social Security, Chapter 3; The Third Round 1943–1950, <http://www.ssa.gov/history/corningchap3.html>.

⁸ The projections of both the Office of Management and Budget and the Congressional Budget Office are made under assumptions acknowledged to be implausible. For example, each assumes the alternative minimum tax will not be changed and that the expiring tax cuts will not be renewed. For unblinkered projections, see Alan J. Auerbach et al., New estimates of the budget outlook: Plus ça change, plus c'est la même chose, Tax Notes, April 17, 2006, http://www.taxpolicycenter.org/UploadedPDF/1000873_Tax_Break_4-17-06.pdf; reprinted at Urban-Brookings Tax Policy Center, <http://www.taxpolicycenter.org/publications/template.cfm?PubID=9578>. The official CBO unified budget deficit for the period 2007–2016 is \$831 billion. After various adjustments to improve plausibility of assumptions and accounting concepts, Auerbach et al. report that the projected deficit over the same period is \$4.8 trillion (or \$7.8 trillion if one excludes temporary cash-flow surpluses in retirement programs that are underfunded in the long-term despite these short-term surpluses).

action on divisive issues when neither party holds a commanding majority is wholly absent. In a grotesque parody of Ronald Reagan's famous comment, Congress lacks both the will and the wallet to enact national health care reform. To be more precise, various minorities have the will, but, as Stuart Altman remarked, the status quo is everyone's second choice. And, so, nothing happens.

Although prospects for action have deteriorated, the need for legislation has increased. The number of uninsured has risen—from 27 million in 1977 to 47 million in 2005—and promises to keep on rising.⁹ A falling proportion of employers are offering coverage—down from 69 percent in 2000 to 60 percent in 2005—and fewer employees are accepting insurance when it is offered—down from 85.5 percent in 1996 to 80.3 percent in 2003.¹⁰ Part of the reason for both trends is the continuing increase in health care spending, which for decades has outpaced income growth by an average 2.5 percentage points a year. If that gap persists, health care, which in 2004 accounted for 16 percent of gross domestic product, will absorb 30 percent by 2032. If current trends continue, *growth* of health care spending will absorb half of the growth in GDP by 2022 and all of it by 2051.¹¹

Even if every dollar spent on health care yielded benefits greater than cost, the growth of spending would create difficulties. Much health care spending is—and soon most will be—funded through the public sector. The tax increases necessary to pay for currently promised Medicare, Medicaid, Tri-care, and veterans health benefits would create severe political strains. But, of course, much of health care spending—as much as 30 percent, according to some estimates—buys care that is not worth what it costs. Many analysts and health practitioners alike believe that the cost of producing even demonstrably beneficial services could be sharply reduced.

Thus, three facts confront would-be health care reformers: 1) Insurance coverage is narrowing; 2) expenditure growth is problematic; 3) successful national action to deal with problems 1) and 2), however urgent, is improbable.

Against this depressing background, it would be desirable, I believe, to encourage the various states, individually or in groups, to try alternate approaches to health care reform. The federal government should offer each state or group of states limited financial incentives to extend health insurance coverage. States should be free to use any of a wide range of approaches, spanning the policy spectrum from right to left. Tax incentives, association health plans, individual mandates, employer mandates, single-payer (Medicare for all) plans all would be acceptable. So would other policy approaches approved by a bi-partisan panel, subject only to disapproval by Congress within a fixed period. Initial funding would be limited so that only a few states could be approved.

This approach is “pay-for-performance” in the purest sense. States would get money (aside from small planning grants) only when and as the numbers of uninsured are reduced. Federal subsidies would cover only part of the incremental cost of covering the

⁹ The 1977 figure is based on Mark L. Berk and Alan C. Monheit, *The concentration of health expenditures: An update*, *Health Affairs*, Winter 1992, p. 147. They report that 12.3 percent of the population was uninsured in that year. Applied to the 1977 population, 12.3 percent corresponds to 27 million people. The later number is from U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2005*, U.S.G.P.O., Washington, D.C. 2006, table 1, p. 6, accessed on 12 October 2006 at <http://www.census.gov/prod/2006pubs/p60-231.pdf>.

¹⁰ Kaiser Family Foundation, Exhibit 2.1: Percentage of firms offering health benefits, 1996–2005, *Employer Health Benefits 2005 Annual Survey*, accessed May 1, 2006, at <http://www.kff.org/insurance/7315/index.cfm>; Center for Financing, Access, and Cost Trends, Agency for Healthcare Research and Quality, *Health insurance component analytical tool (MEPSnet/IC)*, accessed May 1, 2006, at www.meps.ahrq.gov/mepsnet/IC/MEPSnetIC.asp.

¹¹ Aaron, H. J., & Meyer, J. (2005). *Health*, in A. M. Rivlin & I. Sawhill (Eds.), *Restoring fiscal sanity 2005: Meeting the long-run challenge* (pp. 73–97). Washington, DC: Brookings Institution.

uninsured, creating incentives for states to control costs. The funding would also be conditioned on adherence to strict evaluation protocols to maximize the likelihood that these pilot programs generate information to guide other states or the federal government.

A host of major analytical and political problems would have to be surmounted to make this approach work. Enlarged and accelerated surveys would be necessary to collect information on the number and distribution of the uninsured. As states are starting from widely varying initial positions, formulas would have to be designed that reward them fairly and in a politically acceptable manner. Federal preemption of state regulation of self-insured plans would have to be managed. Legislation would have to protect those now served by Medicaid. A fuller exposition of how this approach could work and the problems that would have to be overcome can be found in “How Federalism Could Spur Bipartisan Action on the Uninsured” by me and Stuart Butler in *Health Affairs Web Exclusive*, March 31, 2004 (<http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w4.168>). This general approach is embodied in draft federal legislation with bi-partisan sponsorship (Senators Jeff Bingaman, D-NM and George Voinovich, R-OH) has been introduced in the Senate. A bi-partisan team has introduced similar legislation in the House.¹² Recent state political activity indicates that governors and legislators across the nation are anxious to tackle this problem. Federal backing would reinforce this interest.

Those who believe that the only true reforms are ones that mobilize market forces should have enough confidence to test their beliefs. So should those who think that only a national system such as Canada’s would work. They should also recall that our northern neighbor, in fact, has a provincial system, under national legislation. It may well be that a nation as diverse in every dimension as the United States should embrace a measure of differentiation in its health care system. But whether one is a passionate free-market advocate or a devoted single-payer advocate, isn’t it a bit arrogant to require that tens of millions of Americans remain uninsured until one side or the other persuades the rest of our fellow citizens that our particular vision is the only way to go?

THE RIGHT TO MEDICAL CARE IS NATIONAL

Paul H. O’Neill

The discussion of “46 million Americans without health insurance” is really a false front for an agenda. Implicit in the observation is the argument that not having health insurance is undesirable and something ought to be done about it. But lack of insurance is not the real issue. This is an indirect way of saying many Americans do not have access to medical care and something should be done about it.

Lamenting the size of the population without health insurance is a dressed-up, politically correct way to argue that Americans should have universal access to medical care.

¹² Representatives Tammy Baldwin (D-WI), Tom Price (R-GA), John Tierney (D-MA), and Bob Beauprez (R-CO) comprise the group.

Put squarely, here is the question: Should American citizenship bring with it the right to have access to medical care? If the answer is no, then there is no need for concerted action by the society at the national level.

If the answer is yes, then leaving the subject to be addressed by our political subdivisions will not produce an American right of citizenship and we must, therefore, act at the national level.

Over time, we have evolved an answer that is some yes and some no. At the most observable level, we don't let people die on the steps of our hospitals because they lack the ability to pay for needed care.

We provide access for the poorest citizens through a mixed federal/state program (Medicaid), and then there is charity care at the local level. During the Second World War, we induced employers to provide health benefits to employees by exempting such compensation from wage and price controls, thus creating a common practice; and then, to incent employees to accept compensation in this form, we make it free of taxation.

The older population and the disabled are provided some access to medical care through Medicare, which is financed through a combination of mandated payroll taxes and some coinsurance and deductibles. Members of the military services and some veterans get medical care through those affiliations. Individuals can finance medical care needs from savings or current income, or if they want to "pre-fund" the potential cost, they can buy individual medical insurance policies.

In all, we have a patchwork that results in vastly different levels of financial access to medical care for our citizens. What to do about this condition is not an answer we can get from a fact base. It requires a value judgment from the society.

My judgment is that we are sufficiently wealthy and advanced as a society that we should declare that Americans will have financial access to needed medical care as a birthright. I use "right" here in a context that couples "rights" and "responsibilities" to separate what I intend from the popular notion of "entitlement," which often means a clear benefit with a vague or unknowing or unsuspecting benefactor.

What comes to mind is the scene of President George W. Bush seated at the document-signing table in the Rose Garden at the White House; behind him a group of grinning legislators on the occasion of making Medicare Part D part of the law of the land.

At that event, much was made of the great boon this law would be for our older citizens: helping to pay for needed drugs. One might have gathered from this celebration that the generosity of spirit of the president and the legislators had been combined to personally pay for this gift. They were delighted to claim credit for this new entitlement but no one said a word to the tax-paying citizens who, at this same bill signing, were being given the responsibility to pay the cost of this "gift" from the president and the Congress.

I choose to make so much of this example because it has become the general case—a bipartisan, tacit agreement to obscure rather than illuminate, to appeal to blocks of voters rather than to educate on the conjoined issues of rights and responsibilities. In effect, we now have government as an institution apart from the people: of itself, by itself, for itself.

So as not to be guilty of this same one-dimensional advocacy, I want to be clear. If we're going to have a new American birthright, there will be new American responsibilities.

In a mutually beneficial society, individuals and families need to provide for all of their own needs and then join together to provide for shared needs. For example, national defense, schools for their children, roads, and the other needs that are diffi-

cult or impossible to provide for individually. So, as a first principle, individuals should provide for their own medical care needs so they do not, intentionally or unintentionally, impose their requirements on other members of the society. To bring this mandate into effect, we will need a law requiring Americans to pre-fund medical care needs that would otherwise cause them to shift their responsibilities to other citizens.

In other words, every American would be required to pre-fund medical expenses that for them would produce an inability to pay—a mandated system of catastrophic health insurance. In practical terms this would require first dollar coverage for those with no income or wealth accumulation and, obviously, those in society with more financial means would be required to share this burden in addition to financing their own mandate. There are complex problems in deciding at what income level lower-income people should be required to shoulder some and then all of their own medical care insurance needs.

From an individual perspective, medical care needs are far less predictable than other needs. These natural circumstances create the need for a mechanism to spread the risk of a medical event that could create an individual financial catastrophe, and this is the role of health insurance. Health insurance does not reduce the societal cost of medical care; it simply spreads it out among participants in the insured pool.

If these principles are agreed upon, there are many other complex issues that must be decided. For example, should there be one insurance pool for the entire population or should there be sub-national pools? Should individuals or families be assessed extra premiums related to age or chronic conditions or abusive behavior such as drug or alcohol addiction?

In a system such as this, most individuals would have a significant personal cost until the catastrophic coverage took over, in effect a large “deductible” that, at least in theory, would cause consumers to shop for the best product (lowest cost, best quality).

In this crossover from financing access to consuming medical care services there is even greater complexity. First, in our current system of care there is virtually no cost/quality transparency. Charges that appear on bills are almost never paid in full except for those unfortunate citizens who have no financial intermediary. To make the point clear; in 2004, in Pennsylvania (a typical state), the actual reimbursement to medical service providers was 28% of the amounts they billed. How is a consumer supposed to make sense out of that? This problem requires a national rethinking to create a system that providers and consumers can understand. This does not mean we should federalize the system. It does mean we should have a system that is rational, beginning with Medicare, which has fostered the cynical system we now have. This problem cannot be fixed at a sub-national level because Medicare sets the framework for everyone else.

There is a second serious complexity on the medical services side of the equation. Namely, there is a wide variation in the competence and quality of care provided to people with the same medical need, and the availability of care is not distributed uniformly across the nation. These differences will not disappear but, connecting back to the payment side, we should look at the question as to whether we financially reward or penalize the good and the bad.

Finally, there is a national need to create a framework for continuous learning in the practice of medical care. No other sector of our society does such a bad job of learning from things gone wrong.

A major part of the reason for this failure to learn from an open sharing of incidents is the fear of legal action on the part of those injured.

While I believe the fear is greater than the reality, the fear provides a convenient excuse not to share much of anything gone wrong. We should take away the excuse. The way to do it is to abandon the conventional medical malpractice system. In its place we should implement a system that is consistent with the facts. There are two important observable facts. First, there are virtually no medical care providers who set out to injure patients. Second, patients are injured in the administration of medical care.

In our current system we square these facts by turning over practitioners and patients to the legal process to adjudicate claims of malpractice.

If in the alternative we required medical care providers to report every injury within 24 hours of its occurrence, we would have an opportunity to learn from everything gone wrong and then have an independent body determine the economic damage to the injured party and pay it from the general revenues of the U.S. Treasury.

In parallel with this change, we need the medical societies to step up to their responsibility to weed out providers who do not consistently exhibit high quality skills in their licensed work.

An illustration of the kinds of things that need to be done at the national level is underway, with the effort to create a common standard for individual medical records. From both the patient and provider point of view, the most valuable medical record will be one that begins to collect data even before birth and then systematically records all patient data from every encounter with medical care providers. Such a cyberspace-based record will assure providers that all patient relevant information is available at every new encounter with the medical care system. Leaving framework issues of this kind to the vagaries of action by 50 state legislatures is to perpetuate chaos and serious underperformance in this vital part of our individual and national life. We can do much better and we should start now.

RESPONSE

Henry J. Aaron

That financing and organization of health care in the United States is flawed and should be changed is something on which Paul O'Neill and I both agree. The United States spends vastly more on health care than do other developed nations. We achieve inferior health outcomes. Our delivery system is rife with error—omission of needed care and provision of unneeded care. The malpractice system is a mess. And 47 million people are uninsured. Told that such a system needs change, the only sensible reaction seems to be that of bored teenagers, “Well, duh!”

But what change? And how do we get it? The first step is to understand that many so-called solutions will not get at the three major flaws in our current health care arrangements—lack of access to care by the uninsured and under-insured, expenditure growth that promises to ravage public and private budgets, and excessive medical error that is costly and lethal.

DOI: 10.1002/pam.20235

The currently fashionable faux solution is consumer-directed health care—a prettified public relations euphemism for high-deductible insurance. The problem to which this solution is aimed is that few health care consumers know how much their care costs. How can sick people buy “smart” or buy “cheap,” the argument goes, if they don’t know what their health care costs? Paul O’Neill echos this criticism.

The simple fact is that no other developed nation, most of which have better health outcomes and spend much less than we do, relies on consumer cost awareness to control health care spending. No developed nation is prepared to expose seriously ill patients to the cold wind of market pressure at time of illness. Instead, they have universal insurance coverage and limit spending through various forms of government regulation. The whole point of insurance is to shield people from cost when they are sick. Negligible exposure to cost means negligible cost awareness (well, duh!).

Raising deductibles will have some impact on demand for care, to be sure. But switching to high-deductible insurance today would save much less than suggested by simple reference to savings observed in the RAND health insurance experiment of a couple of decades ago. That experiment excluded the elderly and disabled. Per capita health care spending is higher among these groups than among the young. The elderly and disabled have a much higher incidence of chronic illness. They are more likely than are the non-disabled young to be Medicaid eligible and, hence, insulated from cost sharing. These facts mean that the impact of increased deductibles for the general population would be smaller than it was under the RAND experiment. Furthermore, prevailing cost sharing is much higher than it was in the RAND experiment. So the impact of shifting to high-deductible insurance would be correspondingly smaller.

Capping awards for non-economic losses from medical malpractice is another chic but misconceived solution to excessive increases in health care spending. There are two problems with this “solution” to rapidly rising medical costs. First, malpractice premiums have actually fallen since 2000, the very period during which growth of health care spending has accelerated. Second, evidence that fear of malpractice much increases total medical spending is hard to find and then only in a few medical specialties. These findings should not shield the malpractice system from scorn. It fails miserably to compensate victims of medical malpractice. Barely half of every malpractice premium dollar goes to victims. Fewer than 10 percent of actual victims of medical negligence receive any compensation. And the current system does little to cause negligent practitioners to clean up their acts or find alternative employment. So, by all means, let’s reform the malpractice system. But let’s do it in a way that gets at the real problems, not an imaginary one. Senators Hillary Rodham Clinton and Barack Obama have advanced a constructive proposal to do just that.¹³ It could do much to improve the quality of care. In fact, it would implement part of Paul O’Neill’s agenda to promote health care quality. It might help victims of medical negligence. But slow perceptibly the growth of health care spending or extend insurance coverage? Fuhgeddaboutit.

Well, how about computerization? Electronic medical records, some claim, will lower costs and improve quality. Alas, another RAND study has deflated at least the first of these hopes. Computerization will take up-front investments. Eventually, after 10 or 15 years, RAND estimates that health care spending might be \$81 bil-

¹³ Clinton, H. R., & Obama, B. (2006). Making patient safety the centerpiece of medical liability reform. *The New England Journal of Medicine*, 354(21), 2205–2208, <http://content.nejm.org/cgi/content/full/354/21/2205>.

lion less than it otherwise would have been.¹⁴ That's a lot of money, isn't it? Well, yes. But keep in mind that annual health care spending, now \$2 trillion, will grow to roughly \$4 trillion in 15 years if the flow of new technology continues and people keep getting older. So, if the \$81 billion in savings are actually realized—and that is far from certain—health care spending would be only 96 percent, instead of 100 percent, higher than it is today.

On the quality front, computerization is indeed promising. It could support fundamental reorganization of health care delivery, allowing unprecedented linkage of primary care, specialty care, and hospital care. It also can be used to minimize errors and to generate data inexpensively to evaluate the efficacy of various interventions. That information could change medical practice. But computerization is not likely to have a first-order impact on spending or on health insurance coverage.

Unless the flow of new technology slows, which is improbable (and would be most unfortunate), or the baby boomers stop getting older, which is impossible (and would be even more unfortunate), health care spending will tend to keep on going up. That in turn means that employers will grow increasingly reticent to sponsor health insurance for their employees. And employees, offered increasingly costly coverage, will be increasingly likely to decline it.

Against that background, the deadlock in Washington persists. Fortunately, the interest of state officials in trying to break it is increasing. California flirted with requiring employers to offer insurance coverage. Maine enacted a technically flawed plan to extend coverage to the uninsured. Illinois is reviewing a series of prototype plans with an eye to implementing one of them by mid-2007. Massachusetts has enacted an individual mandate backed up by state subsidies for low earners. Vermont has enacted a plan under which everyone with incomes under 300 percent of the poverty threshold will be eligible for premium subsidies. None of these plans is perfect. And most of these states are spared the difficult coverage problems found elsewhere. All states have to worry a lot about taking on obligations that will prove ruinous when their economies sag.

But this is where the federal government comes in. By providing some financial support to states that successfully extend health insurance coverage, the federal government can make it easier for states to try out different approaches to extending coverage. If they do, we just might learn something. That might lead to concerted national action. True, it might not. But suppose all that happens is that maybe 10 or 20 million of the currently uninsured gain financial access to care from which a lack of insurance now excludes them. Would that be so awful?

No, state initiatives would not transform the health care delivery system. They would not instantly create a delivery system that produced health care as efficiently as Paul O'Neill's Alcoa produced aluminum. That job would remain to be done. And it is a vitally important job because the current system provides the wrong care or fails to deliver needed care far too often. Paul O'Neill has been a relentless and visionary crusader for such reforms. But there is more than one important job to do. So, Paul, keep up your good work. But while you are at it, let's see if we can break the national legislative log jam that now allows 45 million people to go without health insurance by helping state leaders who find that situation unacceptable to move ahead.

¹⁴ Hillestad, R., et al., (September 14, 2005). Rand study says computerizing medical records could save \$81 billion annually and improve the quality of medical care, <http://www.rand.org/news/press.05/09.14.html>.

RESPONSE

Paul H. O'Neill

It is probably only a romantic illusion, but I remember working in Washington (from 1961–1977) when those of us interested in advancing the condition and prospects of our society were alive with new ideas and committed to proceeding through the gathering of facts and rational thought. We were undeterred by today's "political correctness" and, while there were some ideological lunatics on both ends of the political spectrum, they could be safely ignored for what they were. It was a time before today's endless, sickening "sound bites" that reduce even the most important human issues to a level that infers that the attention span of the average American is 30 seconds and the capacity for coping with complex problems is that of a four-year-old—"Wanted Dead or Alive" or "Cut and Run" come to mind as examples. The effect of the current condition of the environment for public policy dialogue is reflected in Henry Aaron's paper on health care reform. His assessment is that society cannot work on this problem at the national level now, so let's create a set of federal grants and contracts for states. We have come to an unfortunate state of domestic public affairs when we accept the idea that society as a whole is incapable of acting in the broad interest of all people.

I have my own prescription for those who are interested in a major improvement in the value equation for the American health care system—go and sit in a hospital ward for a month. Observe what goes on. Sit and observe the admissions process. Sit and observe the activity in the pharmacy. Follow the medical records process. In a word, become knowledgeable about the current condition on the ground. What you will see is the opportunity, on a national basis, to markedly improve outcomes from encounters with the medical care delivery system— while reducing the cost by 50%. Think of it. *Reducing* the cost of American medical care by \$1 trillion per year with better outcomes. That is a worthy public policy goal. In recent testimony to the Senate Finance Committee, I urged them not to schedule people to testify before the committee unless they had "on the ground" knowledge and something to say about how to speed up the adoption of practices that have been demonstrated to work. This is how we can create the potential for giving life to the idea that all Americans should have access to needed medical care. If we accept, as inevitable and unfixable, the current pitiful non-value performance of the medical care delivery system, there is no hope.