

PERSPECTIVE

Finally, Fixing Health Care: What's Different Now?

Six new developments in the health reform debate show that Americans are ready for change.

by Ron Wyden and Bob Bennett

ABSTRACT: Is now the time to fix the U.S. health care system? Those who remember the failed attempts of the past would say no. We see it differently. Our optimism is rooted in new developments that didn't exist the last time Congress addressed health care. These include bipartisan support for our Healthy Americans Act; an ideological truce over the role of government in health care; common ground between business and labor; the realization that states can't go it alone on health care; the plight of employers in a global marketplace; and the need for coverage that is affordable, accessible, and portable. [*Health Affairs* 27, no. 3 (2008): 689–692; 10.1377/hlthaff.27.3.689]

WITH HEALTH CARE all over the headlines on the presidential campaign trail, political observers are asking: “Can the president and Congress, in a political climate so divided, stop business as usual, come together, and fix health care?”

Many oddsmakers who remember the failed attempts of the past say that health care reform can't happen now. We disagree. The polls show that Americans are ready for change.¹ This is the perfect time to pass serious health care reform.

Reasons For Optimism

Our optimism is rooted in six new developments in the debate about health care reform—none of which existed during the Clinton reform discussions fifteen years ago.

■ **Bipartisanship.** For the first time in decades, a large group of influential Democratic and Republican senators have come together to support bipartisan, comprehensive health

reform legislation—the Healthy Americans Act (S 334). In the past twenty years, including the heated debate during the early 1990s, most comprehensive health reform legislation was introduced on strict party lines, with the one exception of legislation by the late Sen. John Chafee—the Health Equity and Access Reform Today Act of 1993 (S 1770). Our bipartisan group is working to build consensus and change the direction of the health care debate.

■ **An ideological truce.** After the demise of the Clinton plan in the early 1990s, both political parties spent years disagreeing on the issue of health care. Republicans said that Democrats wanted the government to take over health care, while Democrats accused Republicans of being influenced by health care lobbies. Charges and countercharges volleyed between the parties for more than a decade.

Today we believe that there are signs of an ideological truce: Democrats are correct in saying that universal coverage is necessary to

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fix health care. Republicans are correct in saying that market forces play an important role in health care by promoting competition and innovation. The Healthy Americans Act strikes a balance between these ideals.

■ **Common ground.** New alliances for health care reform are popping up everywhere, inside and outside of Washington, D.C. Groups that fought each other relentlessly over the Clinton plan—especially labor organizations and business groups—have spent more than a year huddled around conference tables discussing how to form common ground on health care. As an example of this, at the kickoff of the Healthy Americans Act, Steve Burd, chief executive officer of Safeway, and Andy Stern, president of the Service Employees International Union, stood side by side. Who would have imagined such an alliance fifteen years ago?

■ **States can't go it alone.** Following the enactment of health reform legislation in Massachusetts, scores of states and municipalities had high hopes of enacting legislation guaranteeing health coverage for all of their residents.² Governors in both parties have made herculean efforts; unfortunately, as recently seen in California, state and local government can't fix the health care system by themselves.³

The biggest hurdles to achieving major health reform were placed there by the federal government: the federal tax laws, the Employee Retirement Income Security Act (ERISA), and requirements under Medicaid and Medicare. The Healthy Americans Act addresses each of these issues and grants states a wide berth to innovate in health care and tailor reform to the unique needs of their residents.

■ **Modernizing employer-based health care.** Since 1993, the rising cost of health care has forced growing numbers of employers to stop providing health benefits for their employees.⁴ Employers that continue to offer coverage are increasingly disadvantaged relative to their global competitors.⁵ As a result, there is a new, bipartisan recognition in the U.S. Senate that our current employer-based system of private health coverage must be modernized to better meet the needs of both workers and em-

ployers.

Created in the 1940s, when wage and price controls led employers to offer workers health benefits instead of wages, the current employer-based system uses the federal tax code in a manner that subsidizes inefficiency and rewards the most affluent. Moreover, it props up a set of economic realities that are punitive for employers and workers alike.

Under today's status quo, the day an American business opens its doors, it is faced with the undesirable dilemma of whether or not to offer coverage to its employees. If it offers coverage, it faces the high costs at the same time as it is faced with other start-up costs. If it does not offer coverage, it risks not being able to attract the talent it wants and needs for short- and long-term success. In addition, the high costs of health care coverage in the United States put U.S. employers at a disadvantage in the global marketplace. While U.S. employers' costs for health care often go up more than 10 percent annually, much of their foreign competition does not bear anywhere close to the same level of health care-related costs as U.S. employers bear.⁶

In addition, U.S. employees who are lucky enough to have coverage usually have no bargaining power to get the best deal on health care and generally have access to a single plan offered by their employer.⁷ Worse, when employees want to change jobs, their health coverage isn't portable. Workers who may have advancement opportunities elsewhere often stay put out of fear that their family might not get coverage if they change employers.⁸

By reducing the burden on employers and increasing the clout and portability of workers in the health care marketplace, the Healthy Americans Act starts to modernize our employer-based system.

■ **Accessibility.** In 1993, Congress was asked to pass a 1,364-page health care bill, whose very complexity and length made it vulnerable to opponents' attacks. Many said that it was drafted in secret and filled with incomprehensible bureaucracy. No one believes that comprehensive health reform legislation can be written as a billboard, but the sponsors

of the Healthy Americans Act have learned a key lesson from 1993: make it simple. The act is 166 pages long and is available on the Web for public comment.⁹ We are committed to providing convenient opportunities for Americans to meaningfully participate in the debate about how to fix health care in this country.

These six major differences from past failed health reform efforts—particularly 1993—create a window for the president and Congress to break sixty years of gridlock.

The Healthy Americans Act

■ **Guarantees and requirements.** The Healthy Americans Act guarantees every American—other than those already covered by Medicare or the military—market-driven health care choices like those that members of Congress have today. Under the act, millions of Americans would receive incentives (pay increases and subsidies for the low income) to buy a basic private insurance policy. Costs would be restrained by enrolling everyone through a single state or regional entity. Also, every person would be required to buy health coverage, and there would be funds available to subsidize insurance purchases for those up to 400 percent of the federal poverty level (the poverty level is \$21,200 for a family of four in 2008).

■ **Conditions for a dynamic insurance market.** Private insurance companies would compete for subscribers on the basis of price, benefits, and quality rather than on their ability to selectively enroll healthier members and refuse to cover others. An even playing field where all insurers must play by the same rules would go a long way toward creating a more dynamic insurance market.

■ **Incentives for prevention.** Our bill also includes major incentives to promote personal wellness and preventive medicine. These include reducing family premiums for parents who enroll their children in preventive health programs as well as lowering Medicare Part B premiums for seniors who reduce their blood pressure or cholesterol or who stop smoking.

■ **Easy access to health care information.** The legislation would establish a new

system to provide easy access to information about available health care—for both specific services and health plans. It would create new options for compassionate, high-quality end-of-life care. It would also offer incentives for states to enact responsible legal reforms that would reduce the practice of defensive medicine and frivolous legislation.

■ **Transition period.** Under the legislation, employers now offering coverage would convert what they currently spend on their workers' health care into additional salary for their employees during a two-year transition period. The tax code would be adjusted so that employees would not pay extra taxes on their compensation, an amount they would then use to purchase coverage. Knowing that if they find a better deal they will retain the savings, employees would have the option of continuing with the plan offered by their employer or signing up for one of several state-certified plans. Employers that are not offering coverage to their workers would be required to pay an assessment, depending on their size and per employee revenue, with these funds used to help subsidize coverage for those with modest incomes. At the kickoff of the Healthy Americans Act, employers of all sizes—from more than 100,000 employees to just eight—said that this financing system would work for them.

■ **Estimated costs and health spending.** Analysts from the nonpartisan, independent Lewin Group found the Healthy Americans Act to be revenue-neutral for the government at the outset even while expanding coverage to all Americans.¹⁰ They found that it would lower the rate of growth in health care and reduce overall national health spending by almost \$1.5 trillion over the next ten years.

By modernizing the employer-employee relationship on health care, the Lewin Group found, the act would contain costs as consumers use health care more efficiently. Redirecting federal tax expenditures on health by both employers and employees would create more funds to subsidize those who have difficulty affording basic coverage.

Several aspects of the Healthy Americans Act would provide for additional cost containment, according to Lewin's analysis. These include significant administrative savings (a one-stop sign-up process and premiums withheld from paychecks); insurers' competing for business; spending less on hospital acute services; providing private outpatient health care; and revamping Medicaid.

AMERICA CURRENTLY spends enough on health care to pay for health coverage for all Americans. For the amount we spend collectively today, we could hire a physician for every seven families in America.¹¹ We certainly have the talent and wherewithal to fix health care. Thousands of dedicated health care providers are ready for reform that works. With commonsense provisions and principles that span the political divide, we believe that the Healthy Americans Act can be the catalyst to finally end the nation's paralysis on health reform.

NOTES

1. A survey by *Consumer Reports* found that 82 percent of Americans support reforms that would ensure that all uninsured Americans have access to high-quality, affordable health care. See *Consumer Reports* National Research Center, "Six Prescriptions for Change," March 2008, <http://www.consumerreports.org/cro/health-fitness/health-care/insurance/health-care-security-3-08/overview/health-care-security-ov.htm> (accessed 14 February 2008).
2. See National Conference of State Legislatures, "2007 Comprehensive Health Care Reforms: Side-by-Side Comparisons," <http://www.ncsl.org/programs/health/2007Comprehensive1.htm> (accessed 14 February 2008); Stateline.org, "2007 'State of the State' Addresses: Health Care Looms Large," 8 January 2007, <http://www.allhealth.org/briefingmaterials/StateoftheStateAddresses-HealthCareLoomsLarge-726.pdf> (accessed 14 February 2008); and Kaiser Commission on Medicaid and the Uninsured, "States Moving toward Comprehensive Health Care Reform," 7 February 2008, http://www.kff.org/uninsured/kcmu_statehealthreform.cfm (accessed 19 February 2008).
3. Following the failure of the California health reform, experts concluded that states are handicapped in implementing health reform because of fiscal limitations. See C. Lee, "Health-Care Reform to Shift Focus," *Washington Post*, 31 January 2008. In addition, states' efforts are limited by ERISA and the tax code. See National Academy for State Health Policy and AcademyHealth, *ERISA Implications for State Health Care Access Initiatives: Impact of the Maryland "Fair Share Act" Court Decision* (Portland, Maine, and Washington: NASHP and AcademyHealth, November 2006).
4. See R. Kuttner, "The American Health Care System: Employer-Sponsored Health Coverage," *New England Journal of Medicine* 340, no. 3 (1999): 248-252; and Henry J. Kaiser Family Foundation/Health Research and Educational Trust, "Employer Health Benefits: 2007, Summary of Findings," Exhibit D, p. 3, September 2007, <http://www.kff.org/insurance/7672/upload/Summary-of-Findings-EHBS-2007.pdf> (accessed 19 February 2008).
5. L.H. Teslik, "Healthcare Costs and U.S. Competitiveness," <http://www.cfr.org/publication/13325> (accessed 14 February 2008).
6. L.M. Nichols and S. Axeen, *Employer Health Costs in a Global Economy: A Competitive Disadvantage for U.S. Firms* (Washington: New America Foundation, forthcoming).
7. A retrospective study of the National Employer Health Insurance Survey (NEHIS) found that 57 percent of U.S. workers who were eligible for employer coverage were offered just one plan. C.H. Park and R. McDevitt, "National and State Variation in the Choice of Health Plans Offered to Employees," in *Abstract Book Health Services Research: Implications for Policy Delivery and Practice*, p. 288, <http://gateway.nlm.nih.gov/MeetingAbstracts/102234562.html> (accessed 4 March 2008).
8. V. Colliver, "Stuck on the Job: Fear of Losing Insurance Keeps Workers from Moving On," *San Francisco Chronicle*, 12 June 2003.
9. See Sen. Ron Wyden, "The Healthy Americans Act," http://wyden.senate.gov/issues/Legislation/Healthy_Americans_Act.cfm; and Sen. Bob Bennett, "The Healthy Americans Act," <http://bennett.senate.gov/healthyamericans/index.cfm> (both accessed 19 February 2008).
10. J. Sheils, R. Haught, and E. Murphy, "Cost and Coverage Estimates for the 'Healthy Americans Act,'" 12 December 2006, http://wyden.senate.gov/issues/Healthy%20Americans%20Act/HAA_Cost_Coverage_Report.pdf (accessed 14 February 2008).
11. Based on authors' calculations assuming \$2.2 trillion in health care spending and family size of four.