

HEALTH REFORM IN NORTH CAROLINA

Health Reform. Or Not?

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Since I have been eligible to vote, one-third of the presidential elections have ended with a young, energetic, Democratic president promising to tackle health care reform once and for all. It appears likely that 100% of these efforts will end in dismal failure, both for these presidents and their political party. And for the country.

As I write this on February 15, 2010, it seems as though the best chance for health reform is for the House to pass the bill that passed the Senate on Christmas Eve, with or without a reconciliation clean-up bill. I have been telling myself there is a 5% chance of this taking place. The President has invited Republican and Democratic members of Congress to engage in a televised discussion of health reform ideas on February 25, 2010. Perhaps something will come from this effort, but there seems to be little incentive for Republicans to help provide anything that appears to be a victory. We will see, but I still think the most likely outcome of the health reform debate of 2009 is no legislation. But, I hope I am wrong.

Why has the United States had so many failed attempts during the past two centuries at adopting a comprehensive health care reform that provides insurance coverage to (almost) all Americans? There are idiosyncratic reasons for why the varied efforts of Franklin Roosevelt, Harry Truman, Richard Nixon, and Bill Clinton have failed. However, there is one consistent theme to these failures. The proponents and advocates of the reforms failed to convince average middle class persons that their efforts would help them. In addition, organized medicine has consistently opposed reform efforts.

There is one notable change in the latest reform effort: this time organized medicine in the form of the American Medical Association (AMA) has consistently supported efforts at comprehensive reform. Even after the Medicare physician payment update did get enacted in the fall of 2009, the AMA continued to urge passage of a comprehensive bill without insisting on many specific conditions or programs.

In the end, the primary reason reform has likely failed again is that advocates were unable to convince the average middle class person that reform would benefit them. The hurdle to do so was undoubtedly made very high by the willingness of opponents of reform to say just about anything in opposition. A plan that is essentially the Republican alternative to the Clinton Plan (Chafee Plan, 1994) with an individual mandate, a Medicaid expansion, and the development of a private insurance market with an income-based subsidy that would more than double the number of Americans that actually shopped for and purchased their own insurance, became a socialist-statist-government takeover of the health care system.

Senator Tom Coburn (R-OK) said on Meet the Press in August, 2009, that cost-effectiveness research in the Democratic bills will kill people. If you are ever bored, you should read title VIII of the Patients' Choice Act (PCA) of which he is a co-sponsor (pages 206-215 to be exact) and see that he proposed fairly widespread use of cost-effectiveness research supported by an advisory commission. So, a month before the first Democratic bill was reported in the House (PCA was introduced on May 20, 2009), he and Senator Richard Burr (R-NC) had proposed a fairly comprehensive bill with a model for the Independent Medicare Advisory Commission that would be included in the Senate bill that passed Christmas Eve. It is quite a reasonable policy to take a look at what Medicare covers, and when and how it is financed. A Commission allows this to be done in a manner that gets Congress out of the details of Medicare policy, which is a good thing. However, by August, cost-effectiveness research in Democratic bills killed people according to Senator Coburn. This is just an example of the willingness of reform opponents to say anything.

Then approximately six weeks were spent refuting non-existent death panels, a phrase that has now entered the cultural lexicon.

By January, 2010, the primary narrative of health reform was special deals: Nebraska and Louisiana Medicaid provisions and the delay in the imposition of the tax on high cost health insurance for labor

union insurance plans. Or abortion. Somehow, the abortion provisions in the House or Senate bills both rolled back a woman's right to choose and would lead to an explosion of abortions—all at the same time!

The last time reform failed I was in graduate school, the most dangerous of graduate students—one who had finished comprehensive exams and had yet to complete a dissertation. But boy was I smart. And so proud of myself for thinking the Clinton Plan was a sell-out. You see, "single payer" was my preferred alternative, and we would inevitably have one soon. Just you wait. God forgive me, I didn't know what I was saying or thinking. I am just glad we didn't have blogs then so there is no record of my smugness.

My good friend (and dissertation advisor, the person who first got me interested in health policy as an undergrad at UNC Chapel Hill) Tom Ricketts asked me to write this piece and in doing so to reflect on reform, but also my transformation in how I viewed things. I think he meant how did a "single payer guy" become someone who talked so much about costs and the need to slow cost inflation? Of course, one of the primary arguments for single payer is that it would likely be cheaper than what we have now. But, then what wouldn't be? I would be fine with Medicare for everyone. I keep thinking either it's pretty good or my grandmother should be liberated from it.

This time I was happy to not start at single payer, just because I thought it a waste of time politically. A single payer system is not going to happen so why even pretend. My preferred solution now if I were the King would be to provide universal catastrophic coverage via the Medicare program, with people able to purchase private coverage in the gap using after tax dollars. Altering the tax exclusion is key. Over the last few years I have come to believe that not only is the tax exclusion of employer paid insurance distortionary, but that talking about this exclusion and altering or ending it could help ignite a cultural conversation about health care, costs, and the existence of limits.

I became totally convinced of the need to end the exclusion when talking with people where I work (Sanford School of Public Policy) who were griping that Duke's insurance had gone up so much and now cost over \$350 per month for family coverage. I explained that was the employee portion and that Duke was paying over \$600 per month on top of what we pay. Blank stares and disbelief. It can't be good for people to have no idea how much their health insurance costs.

In the end what changed the way I looked at things was having kids and thinking about their future. Kids have this sort of effect on many of us. As I view the baby boomers moving into Medicare I affirm our responsibility to care for them. It is simply one of the most practical ways in which we live out the adage 'Honor thy father and mother' (and grandmother and grandfather, etc.). We must continue doing this; we just don't have to be insane in the manner in which we do it. We don't need apocalyptic statements about the baby boomer generation and what paying for them to age through Social Security and Medicare will do to the nation. We simply need some practical solutions to slow the rate of health care inflation, while covering all persons. In the end, you will never have any hope of getting control of cost inflation without covering all persons with at least a basic level of coverage, because otherwise the costs of the uninsured will be unpredictably spread throughout the system.

The biggest problem with passing no bill is that it is hard to imagine how our country will take on these issues later if the status quo reigns. Will Democrats risk more political failure in the future? They will not likely have as many seats in Congress as they have now any time soon. And Republicans are good on defense with health care, where strident ideological talking points help undermine any proposal. But they have shown no inclination to take on reform proactively when they have been in power. And ideology doesn't easily translate into actual policy in the health care arena.

I have written that the House should pass the Senate bill, because it is a good step ahead. And just as importantly, it would ensure that health policy and health reform will be addressed again in the next few Congresses as inevitable problems emerge, and tweaks are developed. If we turn away with nothing this time, it is hard to imagine how we come back.

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