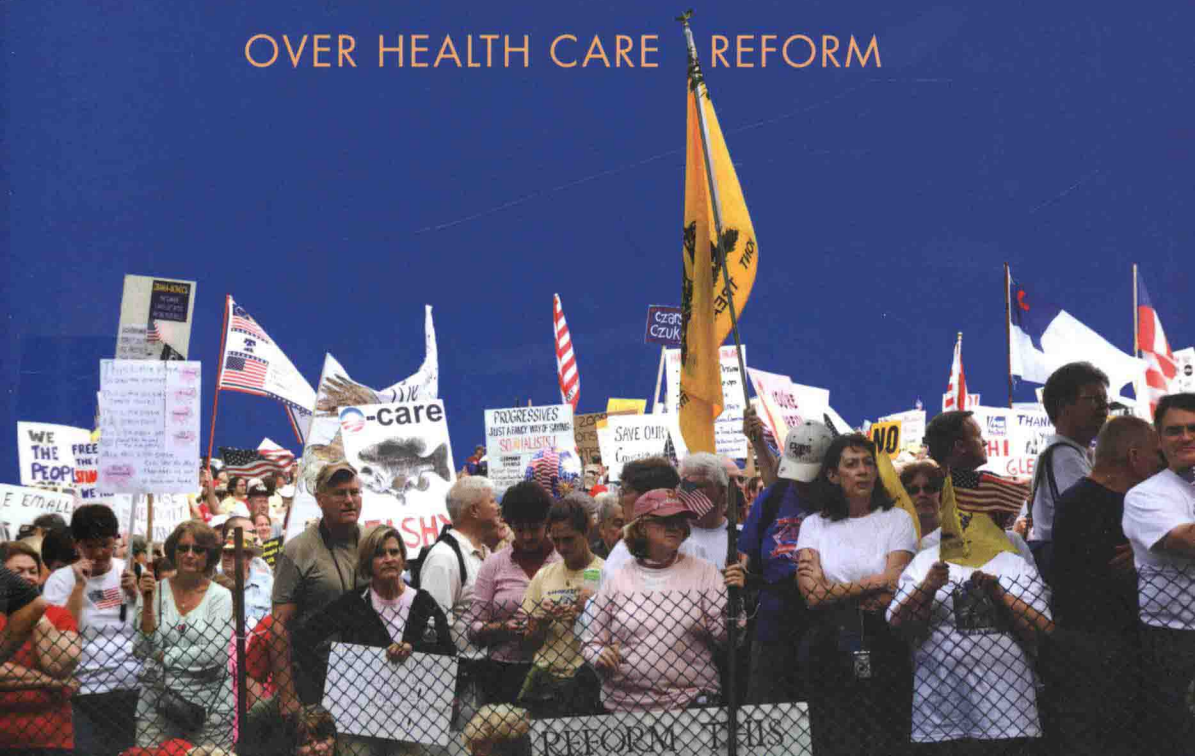
PAUL STARR

WINNER OF THE PULITZER PRIZE

REMEDY AND REACTION

THE PECULIAR AMERICAN STRUGGLE OVER HEALTH CARE REFORM



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Yale UNIVERSITY PRESS
NEW HAVEN & LONDON

Set in Scala type by Westchester Book Group.
Printed in the United States of America.

Library of Congress Cataloging-in-Publication Data

Starr, Paul, 1949–
Remedy and reaction : the peculiar American struggle over health care reform / Paul Starr.
p. ; cm.
Includes bibliographical references and index.
ISBN 978-0-300-17109-9 (cloth : alk. paper)
1. Health care reform—United States—History. 2. Medical policy—United States—History. I. Title.
[DNLM: 1. Health Care Reform—history—United States. 2. History, 20th Century—United States. 3. History, 21st Century—United States. 4. Insurance Coverage—history—United States. 5. Insurance, Health—history—United States. 6. Politics—United States. WA 11 AA1]
RA395.A3S768 2011
362.10973—dc23

2011019577

A catalogue record for this book is available from the British Library.

This paper meets the requirements of ANSI/NISO Z39.48-1992 (Permanence of Paper).

10 9 8 7 6 5 4 3 2 1

REMEDY AND REACTION

To Emanuel and Oren, Marghi, and the next generation

PREFACE AND ACKNOWLEDGMENTS

DURING THE PAST THREE DECADES, I've written about health care as a historian and sociologist and as an advocate for changes in national policy. In the 1990s that work led me to become involved in some of the events I would otherwise have studied at a distance, and it may raise a question in your mind as to what kind of a book this is.

Remedy and Reaction is a history of the American struggle over health-care reform, which I hope people on all sides will find useful. The three parts of the book rest on somewhat different foundations: Part One on standard historical sources; Part Two on both public sources and my direct knowledge of events inside the Clinton White House; and Part Three on the methods of journalism and political analysis. Along the way, especially in Chapter 8 ("The Affordable Care Act as Public Philosophy"), I offer normative judgments of a kind that historians and social scientists usually refrain from making. Since I have been a participant as well as an observer in the recent phases of the national debate about health care, I will not test your patience by pretending to be neutral about it. Whether my involvement and viewpoint are an advantage or a liability in explaining historical developments, you will have to judge for yourself.

I want to thank my wife and family for their support during the work on this book in the past year. I am also grateful to the many people in Washington and elsewhere who shared their knowledge with me; to Princeton University and my colleagues at both the university and *The American*

Prospect; to Timothy Jost and Jon Kingsdale for corrections on some points of law and policy; to two Princeton students, Hope Glassberg and Trace Feng, who provided research assistance; and to my agent Scott Moyers and the people of Yale University Press who have helped bring this project to fruition.

Paul Starr
April 25, 2011

CONTENTS

Introduction

AN UNEASY VICTORY

AMONG THE RICH NATIONS OF THE WORLD, the United States stands out for the virulence of its political battles over health care. Unlike the other capitalist democracies, America has left a large population without insurance coverage—as of 2010, about 50 million people at any one time. The United States also spends far more on health care than other countries do—17.6 percent of its gross domestic product compared with an average of about 9 percent in the other economically advanced societies. For four decades, these differences have been growing. In 1970, when the uninsured were a considerably smaller fraction of the population, health-care costs in the United States were much closer to the levels in western Europe and Canada. Under President Richard Nixon, the United States also came close to enacting on a bipartisan basis a comprehensive health-insurance plan for its citizens. Since that time, however, the underlying problems of health coverage and costs have become more severe, and the attempts to remedy them have generated more rancorous partisan divisions. In no other advanced country does public responsibility for health costs provoke such deep and bitter conflict.

The ideological warfare over health care in American politics has its antecedents in the battles over health insurance in the first half of the twentieth century. It was in those years that the United States diverged from the more common path in western democracies, failing to establish a general system for financing health care. And when America finally

adopted critical tax and health-financing policies in the two decades after World War II, it ensnared itself in a *policy trap,* devising an increasingly costly and complicated system that has satisfied enough of the public and so enriched the health-care industry as to make change extraordinarily difficult.

Escaping from that policy trap has become a politically treacherous national imperative. Hoping to make it less treacherous—to attract support in the center and to avoid arousing the opposition of the protected public or the health-care industry—recent Democratic plans and legislation have called for the expansion of private insurance, once the core element of Republican proposals. The most ambitious of the Democratic efforts, the plan proposed by President Bill Clinton, came to grief in 1994 without the adoption of any legislation. But the supporters of health-care reform believed that they had finally reached their goals in March 2010, when Congress passed the Patient Protection and Affordable Care Act. Savoring the achievement, President Barack Obama and Democratic congressional leaders compared the law to such historic landmarks as Social Security, civil rights legislation, and Medicare.

It remains to be seen whether those comparisons will prove to be apt. Despite the exhilaration its supporters experienced in the moment, the passage of reform was an uneasy victory—uneasy because it was the victory of one party over a united opposition that threatened to repeal the legislation the first moment it had a chance; uneasy because many of those voting in favor had been obliged to accept compromises that they believed might jeopardize the program's success; uneasy because public opinion at the time was sharply divided; uneasy because Democrats had already suffered an unexpected reverse in an election in Massachusetts in January and were worried (for good reason) about more losses in the fall.

The law's passage was also an uneasy victory because its implementation was left in large measure to governors and state legislatures—some of whom fervently opposed the law and would challenge its constitutionality in court—and because no one could be certain the law would withstand all the attacks on it and lead to a stable and popular outcome. Even some of the strongest advocates of reform (and I am one of them) worried that the United States had become so entangled in the knot of problems it had

woven in health-care finance that any politically achievable response was bound to be imperfect and to be condemned for its limitations.

Political leadership requires different sorts of courage. Sometimes it is the physical courage to face down a hostile mob—and Democratic members of the House of Representatives had to show that fortitude as they walked to the decisive vote on March 21 through right-wing protesters who spat on them. Sometimes it is the courage to put a political career at risk for the sake of deeply held principles; many legislators had to do that as well. And sometimes it is the courage to make a decision when the choices are less than ideal and the prospects for success are uncertain. All those who voted for reform had to make that leap too.

This book is about why health care in the United States became so vexed a problem. My aim is to provide an analytical account of the struggle over reform, attentive to both stubborn social realities and the critical choices that political leaders and other individuals have made. Institutional and political constraints are not imaginary, but political leadership often involves testing how strong those chains are—sometimes breaking them, and sometimes falling short.

The Making of a National Impasse

Large-scale innovation in national policy has never been easy in the United States, nor was it intended to be. In a parliamentary democracy, a party that wins a legislative majority thereby controls the executive and usually can carry out its program by a vote of the lower house. But America's constitutional system sets up a series of impediments even for a winning party: the division of Congress into two co-equal houses; the short, two-year intervals between congressional elections; the separation of the executive from the legislature; a Supreme Court with lifetime tenure. Additional institutional obstacles have grown up in the form of powerful congressional committees controlled by senior lawmakers and procedural rules in the Senate that enable a minority of 40 members to prevent legislation from coming to a vote. With so many veto points along the journey to law, supporters of major reforms usually cannot put them into effect by winning only one election.

After gaining power, they often need to retain it through several elections in order to control every point where their program may be blocked.

The American political system does offer ways of working around its impediments. The most important of these is the ability of the states to serve as "laboratories of democracy" for policies blocked at the national level. States also face constraints: federal law often limits their authority, and they cannot let their taxes and regulations get too far out of line with those of other states, lest businesses and jobs go elsewhere. Nonetheless, national reforms have often begun with state programs, and the federal system enables Congress to build in flexibility for states so that they may, for example, set eligibility and benefits for a program above a national minimum, obtain waivers of particular requirements, or opt out of some programs entirely.

In nearly a century of struggle—from 1915 until 2010—the advocates of a public program to provide all Americans access to health care and shield them from the costs of illness tried virtually every course possible in a federal system. At first they sought to pass laws in the states. Later they offered proposals for a federal program that would have been carried out through the states and allowed them to opt out. Still later, they tried purely federal measures. Then while some reformers advocated a federal program, others went back to pushing for action in states where they had the best chance of success. But they were unable to pass and carry out a universal program at either the federal or the state level, at least until they succeeded in Massachusetts in 2006.

The failure of the more ambitious proposals led to the adoption of a series of compromises benefiting particular groups to varying extent. As they had from early in American history, some states and local governments provided support for hospitals and clinics for the poor. Beginning after World War I, Congress established a separate hospital and medical system for veterans. In the 1940s and '50s, the federal government began providing a tax subsidy for those with employer-provided private health insurance. In 1965 Congress enacted a purely federal program for the elderly (Medicare) and a mixed, federal-state program (Medicaid) for specific categories of poor people. Some federal and state programs targeted funds to support treatment for particular types of disease. Nonetheless, many

Americans remained without access to care or financial protection when illness struck.

By the second half of the twentieth century, the United States was the only major advanced society without a system for providing health care for all its citizens. After the enactment of Medicare and Medicaid, roughly 10 to 12 percent of people remained without coverage in the early 1970s. Then, in line with other measures of growing economic inequality and insecurity, the uninsured population began to increase, rising to 16.7 percent of Americans, or 50.7 million people, in 2009.[1] These Census Bureau figures are estimates of the numbers of uninsured at a given time. The number who lose insurance for some period during a year is about 50 percent higher, and according to a Treasury Department study, almost half of the non-elderly population, 48 percent, were uninsured for some time over the decade from 1997 to 2006.[2] Many with insurance also had coverage that proved inadequate in serious illness, particularly if they had a pre-existing condition or their policy had other exclusions. As a result of the various limitations of the insurance system, Americans experienced forms of economic insecurity virtually unknown in the other advanced countries: "medical uninsurability," "medical bankruptcy," and "job lock" (inability to start a business or change jobs for fear of losing health benefits).

During the past 40 years, America also became an outlier in health-care costs. In 1970 the United States spent 7 percent of GDP on health care, the same proportion as Canada, about the same as Sweden (6.8 percent) and Denmark (7.9 percent), more than France (5.3 percent), and considerably more than Britain (4.5 percent). By 2007, in dollar terms, the United States spent two and a half times per capita as much as the average of other rich countries—and more than 50 percent more than the next highest spenders (Norway and Switzerland).[3] Since health expenditures vary directly with national income, the United States would be expected to spend more on health care than other countries did. But by the early 2000s, health spending was 42 percent greater in the United States than its income would predict.[4] Variations in disease rates also do not explain these differences in spending, nor do Americans visit the doctor more often or spend more time in hospitals. The main difference is not volume but price—Americans pay more for drugs, medical equipment, hospital care, and doctors' visits.[5]

High costs and spotty insurance inevitably lead to less access to care: in a 2008 study, 52 percent of Americans with incomes below the median reported that they went without medical treatment or a prescription because of cost, compared with 24 percent of the comparable group in Germany, 18 percent in Canada, and 9 percent in Britain.[6] And despite the excellence of American medicine at its best, the U.S. system did not show up particularly well in international comparisons. A rating of the overall performance of health-care systems by the World Health Organization in 2000 ranked America's thirty-seventh.[7]

With all the many problems of America's health-care system, why has it been so hard to change? Three familiar lines of explanation focus on special interests, national values, and the daunting complexity of the problems of health care and health policy.

The "special interests" that many people have in mind as obstacles to change are the insurance and pharmaceutical companies, hospitals, physicians, and others who make money from health care. The basic equation of health economics remains: health-care costs equal health-care incomes. Since every dollar spent on health care is also a dollar that someone earns from health care, interest groups predictably resist government policies that limit spending. Most businesses do not want regulation by the government or competition from it, and Americans who earn their living from health care are no exception. Physicians, in particular, have historically opposed any intrusion by the state into their professional terrain that would limit their income or autonomy, and during the past century, particularly from 1935 to 1965, "organized medicine" fought repeatedly against a public program for health insurance. As the health-care industry has mushroomed, groups with a stake in the system have also proliferated. When the major European countries created their national insurance systems between the 1880s and early 1900s, health care was a small portion of their economies, probably no more than 3 percent of GDP. In the United States, reforms affect a much larger industry, now more than 17 percent of the economy, and they may threaten more substantial (and more heavily commercialized) interests.

The opposition of physicians and insurers in the first half of the twentieth century was unquestionably a factor in blocking adoption of early

proposals for government health insurance programs. But special-interest influence is not as good an explanation as it may initially seem for the persistence of the status quo. In recent decades, the major health-care interest groups have not been uniformly opposed to large-scale reforms, including measures that would cover the uninsured. Faced with political leaders and movements advocating expanded coverage, health-care industry stakeholders have sometimes thrown their support to policies they see as beneficial or at least as less distasteful than other likely alternatives. Economic interests are often hard to calculate. Groups continually face difficult choices about whether to pursue their interests by trying to shape the content of reforms or by blocking them altogether, and even those with shared interests may disagree about what to do because of conflicting political judgments (for example, about the form that legislation is likely to take when it finally emerges from the "sausage-making" in Congress).

The special-interest explanation for the status quo also has another serious deficiency: it seems to imply that if not for special interests, the public would overwhelmingly welcome reform. But one of the legacies of American health policy is that it has split the interests of the public. The government has given generous tax benefits for private health insurance to unionized workers and other employees of businesses that offer health benefits. Veterans have their medical system, the elderly and the disabled have Medicare, and some of the poor qualify for Medicaid. These members of the protected public may still be vulnerable to problems in paying for health care if their status changes, as when insured workers lose their jobs. But they may worry less about those possibilities than about the unknown risks of reforms that could upset arrangements that satisfy them reasonably well. The persistently uninsured are a mostly low-income population with no coherence, organization, or political power, even though the numbers uninsured at any one time have grown to about 50 million. In contrast, the protected public is not only larger but also consists of highly organized and vocal groups.

Moreover, many of those who are reasonably well protected—veterans, the elderly, the families of employees with good benefits—believe that they have earned their coverage, whereas others have not. These moral perceptions contribute to the intense, often vituperative tenor of public debates