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On the Issues

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The Making of the Next President's Health Plan: Will It Be Déjà Vu of 1992?

By Thomas P. Miller

Parallels between U.S. health-care politics in 1992—the last time health issues played a highly significant role for presidential contenders—and today's early campaigns have been overstated. Both periods share broad-based electoral frustration with the health-care system, but convergence on substantive solutions remains elusive. Leading Democratic presidential candidates have been more vocal thus far than leading Republicans. Serious consideration of more modest policy approaches will not move forward before mid- to late 2009.

Today's political conventional wisdom assumes that proposals to address the chronic problems of U.S. health care will regain the domestic policy spotlight in the 2008 presidential campaign. Steadily rising costs of health-care services, growing gaps in access to care, and mounting strains on the predominantly employer-based system of private insurance coverage are not necessarily new problems. They appear, however, to have stimulated a new round of more intensive political responses.

Several dozen states are experimenting with various stages of health reform plans. Multi-interest coalitions of business, labor, and advocacy groups are probing and repositioning to gain the high ground in the developing health-care debate. Accordingly, a number of the leading presidential candidates are staking out their policy priorities and perspectives, if not concrete solutions.

1992 and 2007: A Connection?

Are we in the early stages of a replay of 1992, the last presidential campaign to set the stage for a comprehensive health reform debate? Not exactly.

In any case, will it be followed by another whimper (like the unraveling of Clinton Care in 1994) or a big bang that transforms U.S. health care? Neither one is likely, but expect some grudgingly modest progress—eventually.

Current similarities to the dynamics of the campaign trail fifteen years ago are limited. This time, a war in the Gulf has not gone as well. Unlike its predecessor, this war continues to dominate the overall political landscape. The economy is somewhat healthier, though not a political plus. Another incumbent named Bush has a low job approval rating, but he cannot seek reelection this time. Control of Congress switched to the opposition party last fall.

The common element that 1992 and 2007 share is the electorate's unease, if not discontent, with the workings of the existing health-care system. In each case, the increasingly less affordable cost of insurance coverage raised anxieties about its current stability and future availability. No single triggering political event like the 1991 Pennsylvania Senate race (when Harris Wofford upset Dick Thornburgh, relying on a health reform platform) stands out today that would make nervous incumbents scramble to address perceptions of a swiftly changing landscape.

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However, the cumulative effects of a widening gap in recent years between the price of health coverage and what many Americans are willing or able to pay for it, either individually or collectively, once again have reinvigorated political impulses to do something. As always, deeper disagreements over the degree of change needed and the problematic details of implementation remain. But some of the early parameters of today's "soft consensus" for health policy reform seem more clearly defined than the fuzzier concept of "managed competition" tentatively voiced by the 1992 Clinton campaign.

The 2008 Presidential Election

In one form or another, most of the leading 2008 Democratic presidential aspirants favor moving more aggressively toward universal coverage within the context of a mixed public/private system. John Edwards would do so most comprehensively, by conspicuously endorsing higher taxes and imposing more binding pay-or-play coverage mandates on employers. Barack Obama pledges to achieve universal coverage within four years, but allows for the need to help make health care and health insurance more affordable first. Hillary Clinton, reflecting the hard-earned lessons of overreaching hubris in her first White House tour, suggests now that it might take her a "second" term as president to finish the job with a step-by-step strategy. She has begun by talking about how to contain rising costs before raising new revenue for universal coverage, but that is just a warm-up act for her more detailed volumes of directives not much further down the road.

The Democratic frontrunners also support the creation of large public/private pooling mechanisms to supplement, if not fully replace, employer-group coverage, along with expansion of more traditional public insurance coverage through Medicaid and the State Children's Health Insurance Program (SCHIP). Those "pools" tend to provide holding tanks for much tighter restrictions and mandates on quasi-private insurance coverage, and they confuse redistributing and redirecting the high costs of care toward newer and healthier conscripts with actually providing better incentives for more individuals to choose higher-value but less comprehensive versions of care and insurance. Similar to their Republican competitors, they would also place faith in the as of yet unproven virtues of information technology and electronic medical records (without necessarily paying for what apparently "pays for itself"). And just about everyone has joined the parade behind more preventive care and better care coordination to lower costs and improve quality.

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At this stage of the presidential campaign, health-care issues have figured much more prominently in Democratic candidates' appeals to potential primary voters. Republican presidential frontrunners Rudy Giuliani and John McCain have been less vocal, let alone detailed, thus far in addressing health-care reform (compared to national security issues such as terrorism). Nevertheless, one might predict their preferences: favoring tax-based subsidies more than increased public spending to expand access to insurance, bolstering private forms of insurance coverage, and limiting the expansion of publicly administered health programs. They would not make universal coverage, per se, their foremost health policy goal. Giuliani has expressed interest in expanding coverage options through the individual insurance market and relying on the latter to increasingly replace the employer-sponsored version of private health insurance. Although Mitt Romney may share the private market emphasis of his Republican rivals, the former governor is more heavily invested in the future success of his Massachusetts model, which combines an individual mandate, income-based subsidies, and a "connector" insurance-purchasing mechanism to aim for near-universal insurance coverage. He has pulled back, however, from touting it as a single model for national health-care reform.

The traditional cut and thrust of presidential politics suggest that less is often more on the campaign trail. One should not expect more detailed blueprints of a health system overhaul, as opposed to poll-tested aspirations, until the winner answers the question, "What do we do next?" in mid- to late 2009. Substantial evidence of a successfully implemented state-level health reform would make a difference, but do not hold your breath waiting for it. The recurring cycles of our health reform debates usually peak with broad agreement on what we do not like, or wish could be different, but break down over what settling for second-best compromises might entail.

A Healthier Way Forward

The gravitational pull of universal coverage nostrums and stylized bipolar disputes between national health insurance and free market medicine tends to distract our national political debate from confronting more serious matters that need greater attention. The unfunded future liabilities of both Medicare and Medicaid pose more pressing fiscal threats to the national economy's balance sheet today than they did in 1992. Although Republican candidates can point to some promising inroads in delivering new drug benefits to seniors through private plan choices, neither party's standard bearers are likely to highlight the need for significant belt-tightening or restructuring of health-care entitlement programs before the inevitable becomes inescapable. Whereas more observers have questioned the proposition that U.S. health care is the best in the world, the bedrock belief of middle-class voters that they should continue to have their own opportunity to consume American-style health care à la carte, as long as they do not see the full price tag directly, helped sink an earlier Clinton plan for universal coverage and health security, and it remains quite resilient today.

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Hence, the unexploited opportunity thus far to transform the national health-care debate involves offering voters new mechanisms to gain access to higher-value care and to improve their overall health. It does not mean promising the illusion of as much as you want, whenever you want it, from whomever you choose to provide it, at less cost, based on magical assumptions. It would start with leveling a bit more with voters that we will need to develop and disseminate better (though far from perfect) measures of the comparative effectiveness and efficiency of more accountable health-care providers, provide stronger incentives and tools for consumers to make smarter choices, promote healthier behavior well before one enters the doctor's office (and between visits, too), target public subsidies more narrowly on the basis of income and health status—regardless of age—and acknowledge that it is time to reconcile better the limits of public resources with needs, not wants.

Defining better choices in the gray zone between "you get what you pay for" and "you will get what we decide to pay for" might not fit within a sixty second campaign spot or the paragraph of a stump speech, but it could begin to move us past the dead end of 1992 and beyond the initial teases of 2008.