Promising prognosis: Close to a compromise on health-care reform

by Dennis P. McCann in the January 26, 2010 issue

If, at last, both houses of Congress unite to pass health-care reform legislation, the bill emerging from the conference committee will have to be the result of still further compromising. Though some Who've struggled long and hard for health-care reform—such as former Vermont governor Howard Dean—now seem ready to abandon the current effort because they feel betrayed by the compromises made so far, the way toward reform is not likely to be advanced by waiting for more favorable circumstances.

Were he still with us today, Reinhold Niebuhr—with his deep appreciation of "the nicely calculated less and more" of politics—would surely sympathize with Harry Reid and Nancy Pelosi and their efforts to make compromises designed to preserve, if not expand, the con gressional coalition for health-care reform. The more the debate has dragged on, the clearer it becomes that the goals of reform amount to a Rubik's Cube of conflicting exigencies. Back in June, President Obama asserted that "any health care reform must be built around fundamental reforms that lower costs, improve quality and coverage, and also protect consumer choice." He also emphasized that Congress must "develop a plan that doesn't add to our budget deficit."

When viewed against the challenges involved, the House and Senate bills exhibit contrasting strengths and weaknesses. The House bill is more generous in the benefits promised and more intent on coming as close as possible to providing Americans with universal access to health care. On the other hand, it costs significantly more than does the Senate proposal and is less rigorous about reducing costs.

To its credit, even in its final version the Senate bill incorporates virtually all of the strategies for gradually bending the cost curve on health care that were initially proposed by the Finance Committee. As is evident from Ronald Brownstein's

analysis prior to the final round of Senate negotiations, “A Milestone in the Health Care Journey” (*Atlantic Monthly* online edition, November 21, 2009), the Senate bill’s cost-containment strategies are likely to be more effective than anything short of a robust single-payer system.

Brownstein reported on the work of a group of economists led by Alan Garber of Stanford University who “identified four pillars of fiscally-responsible health care reform”: “They maintained that the bill needed to include a tax on high-end ‘Cadillac’ insurance plans; to pursue ‘aggressive’ tests of payment reforms that will ‘provide incentives for physicians and hospitals to focus on quality’ and provide ‘care that is better coordinated’; and to establish an independent Medicare commission that can continuously develop and implement ‘new efforts to improve quality and to contain costs.’” The fourth pillar is for the reform to be “at least deficit neutral over the 10-year budget window and deficit reducing thereafter.”

As both Brown stein and Garber later observed, what the Senate passed meets all four of these goals and thus “send[s] a signal that business as usual [in the medical system] is going to end.” Indeed, on December 21, Garber’s group of economists sent an open letter to Harry Reid praising the “manager’s amendment,” which contained the final round of compromises required to pass the bill. In their view, the amendment actually improves the cost-containment prospects for the legislation as a whole by strengthening the role of the proposed Medicare Advisory Board in managing a phased decline in the program’s costs, along with developing a set of innovative programs for changing the incentive structures for how health-care providers are paid for their services.

If the hopeful signs discerned by Brownstein and Garber are correct, then we need to think again about what can and cannot be compromised in the struggle for reform. Two major sticking points still seem capable of breaking up the coalition needed to get the legislation out of the conference committee. One is whether and how to include a “public option”—or government-administered public health insurance plan—in the exchanges that will be organized to move toward the goal of universal access. The other is whether the exchanges will allow federal funding of abortion, since those participating in the exchanges will be using government subsidies to pay for their insurance, either wholly or partially. Both points involve matters of moral and religious principle, and they are interrelated.

The public option—which survives in the House though not in the Senate bill—has provoked intransigence on both sides, with partisans threatening to filibuster the legislation or bolt from the coalition—some if a public option is included in the final bill, others if it is not. It must be remembered that for those who support it, the public option is already an attempt at compromise. Having met with the same kind of fierce resistance that a single-payer system might have provoked, the public option has been watered down to the point where its actual impact is either minimal or symbolic. It was, ironically enough, an attempt to find a market-friendly solution to the problem of cost containment by providing actual competition—that is, an alternative to private insurance policies—on the proposed exchanges. But why insist on the public option if there is a reasonable hope that cost containment can be achieved through a combination of other reforms?

The fight over the public option has been complicated still further by the abortion question. If ever there were a silver bullet designed to fragment the coalition for health-care reform, the Stupak-Pitts Amendment attached to the House legislation is it. To understand why, one must recall the current status quo in which the Hyde Amendment and its successors have prohibited direct federal funding of abortion. The exchanges and the public option disturb that status quo by offering a policy that, unlike the current Medicaid program, inevitably draws on both private and public funds to pay for health insurance. Those who opposed the Stupak-Pitts Amendment did so because they felt that the original House bill already was in line with the status quo by prohibiting direct federal funding while indicating that abortion services could be funded by the portion of the insurance premiums paid from private funds.

The supporters of Stupak-Pitts dismissed this proposal as a sham, a mere accounting trick. In their view, the status quo could be defended only by extending the prohibition to all policies offered on the exchanges and within the public option. In order to keep the funds strictly separate, they proposed that women could privately purchase an abortion “rider” for their own policies, a proposal widely criticized as demeaning to women and completely out of touch with the problems that women face with unwanted pregnancies.

The Senate bill tried to maintain the status quo by stipulating new procedures to prevent the mingling of private and public funds used to pay for health insurance policies providing coverage of abortion services. While some—notably, the United States Conference of Catholic Bishops—rejected the new attempt at compromise as

“morally unacceptable,” the Catholic Health Association, representing hundreds of Catholic hospitals, as well as the Leadership Conference of Women Religious, came out in support of it, expressing their confidence that the Senate bill’s provisions were sufficient to maintain the status quo. As reported in the *New York Times* on December 26th, the willingness of these Catholic groups to accept the Senate bill’s stipulations may be crucial in persuading Catholic members of Congress to support a final compromise without the divisive Stupak-Pitts Amendment.

Given the lingering controversies over the public option and federal funding for abortions, is there a way forward for reform? I think there is. One has to remember that the public option is merely a means to an end. It was proposed as way of making progress on both universal access and cost containment. But what if both these goals can be met just as well or better with other provisions? If the “four pillars” identified by Garber and other economists are a credible means for fulfilling the cost-containment goals, why not trade the public option for other ways that will expand coverage, while preserving the status quo on federal funding of abortions?

A compromise between the House and Senate bills should seek to honor the House’s commitment to expanded access to health care while finding the means to fulfill it in the specifics of the Senate’s bill. If the public option must be withdrawn, those who support it should get something substantial in return, pushing still further along the lines of the improvements incorporated into the final version of the Senate bill. They might negotiate for the earliest possible implementation of those reforms that will enable people currently lacking health insurance to be covered and for more robust regulation of the health insurance industry, including higher fees and penalties on any attempt to evade their social responsibilities and a windfall profits tax to be triggered whenever their activities demonstrate a lack of commitment to health-care reform. Dean was on the right track when he suggested that, in the absence of a public option, the insurance companies ought to be heavily regulated like public utilities—only he seems not to realize just how close to that strategy the Senate bill already is.

Christian realists will realize that creating and implementing policies that guarantee everyone’s basic moral right to health care will involve an ongoing struggle that is not likely to be completed in a single piece of legislation, no matter how historically significant. What lies ahead is a process rightly characterized by Nie buhr as “piecemeal” reformism. If Atul Gawande’s reading of the lessons to be drawn from the history of the government attempts to reform American agriculture (*New Yorker*

on line edition, “Testing, Testing,” December 9, 2009) offers any reliable roadmap, a piecemeal approach may actually be preferable because the health-care system is so convoluted that its reform inevitably will have unforeseen and unforeseeable consequences that require continual re thinking and readjustment.

All the more reason to get on with it now by accepting the compromises that will at least ensure expanded health insurance coverage while respecting the status quo on abortion and making substantial progress in cost containment. This may sound like asking Congress to solve the Rubik’s Cube, but all of us have watched some friend or acquaintance do just that. Those who succeeded did so through sheer persistence—continually learning from the ways they’d almost got it right the last time. Persistence like that will surely pay off, if only Congress can find the wisdom and the courage needed to make the right kind of compromises on the way toward genuine health-care reform.