THE CLINTON HEALTH PLAN: WE DESERVED BETTER

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Today, nearly everyone agrees that America's health care delivery system is badly in need of reform. Its problems are manifold. First and foremost, it is too expensive. As a share of Gross Domestic Product (GDP) and on a per capita basis, America's health costs greatly exceed those of other nations.[1] Yet we, the American people, are not getting our money's worth; despite the expenditure of more than 14 percent of GDP,[2] our nation's public-health statistics compare unfavorably with nations that spend far less.[3]

Second, our health care delivery system does not cover all those who need care. Nearly thirty-nine million Americans have no health insurance,[4] and the rest of us risk losing coverage when we change or lose jobs. Coverage for catastrophic illness or long-term care is available only at great cost.

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1. *America's Picture of Health*, WASH. POST, Nov. 2, 1993, (Health), at 20 (noting that, in 1991, the United States spent more on health care per capita at $2,868 than Canada, Germany, Japan, or Great Britain yet had the lowest average life expectancy for men and the second-lowest average life expectancy for women); Dana Priest, *The Road to Health Care Reform*, WASH. POST, Jan. 26, 1993, (Health), at 12 ("While the United States spends more per capita on health care than any other country, its infant mortality rate is the highest among industrialized countries. . ."); Stephen Zuckerman & Jack Hadley, *Clinton's Cost Controls Can Work*, WASH. POST, Nov. 7, 1993, at C7 (observing that the United States spent 14.3 percent of GDP on health care in 1993, while no other industrialized nation spent more than 10 percent).

2. *See* 139 CONG. REC. H6897 (daily ed. Sept. 22, 1993) (quoting an address by the president of the United States concerning the Health Security Act, which would be introduced on October 27, 1993: "We are spending over 14 percent of our income on health care; Canada is at 10; nobody else is over 9."); *see also* Hubert B. Herring, *Business Diary: Health Bill Rising as Fast as Ever*, N.Y. TIMES, Jan. 2, 1994, § 3, at 2 (referring to a Commerce Department statement that the nation's health care spending would pass $1 trillion in 1994, rising 12.5 percent, and that health care spending was estimated at 15 percent of GDP for 1994).

3. *See infra* notes 44 and accompanying text.

4. Hubert B. Herring, *Business Diary: Going Without Health Insurance*, N.Y. TIMES, Dec. 19, 1993, § 3, at 2 ("In 1992 . . . the number of people without health insurance hit 38.9 million, up 2.3 million from 1991—a rise greater than in the two previous years combined.").

Third, our system creates enormous waste. Over 1,500 private health insurers[5] furnish a baffling array of plans that require physicians, hospitals, and other health care providers to waste precious time filling out multiple claim forms and verifying whether they will receive compensation for treatment. Health care providers create waste by ordering unnecessary procedures to protect themselves against malpractice suits.[6] Hospitals and other health care facilities create more waste by purchasing redundant high-tech equipment to attract patients.[7] Such excessive investment in technology may actually drive down quality and increase the cost of care.[8]

President Clinton's September 22, 1993 address to a joint session of Congress signaled the resumption of the debate on how best to reform America's health care system. This discussion, suspended during the long deliberations of the 500-member health care task force chaired by First Lady Hillary Rodham Clinton, became a major focus of national attention. The President framed the discussion around six basic principles: security, simplicity, savings, choice, quality, and responsibility.[9]

To address the security concern, the President proposed that all Americans should have non-cancelable health insurance via a national health security card. In the interest of simplicity, the President proposed a single, uniform claim form and would require only a few standardized packages of benefits. Since skyrocketing inflation in our nation's health costs was the catalyst for the now universal recognition that our system needs reform, saving money was the third cornerstone of the presidential plan. In addition, choice was crucial, since a majority of Americans treasure the right to select individual doctors, hospitals, and other providers. Finally, of course, quality health care is of vital importance to everyone.

Few will argue with any of the President's first five principles. They provide a basis for the rational, economical, and humane reform of our health care delivery system. The President's sixth principle, responsibility, however, is more problematic. Under the President's plan, everyone would be responsible for paying 20 percent of the cost of a presently undefined minimum package of benefits. The unemployed and others unable to pay

5. 139 CONG. REC., *supra* note 2, at H6897.

6. Paul Wallich & Marguerite Holloway, *Health Care Without Perverse Incentives*, SCI. AM., July 1993, at 109 ("[F]ear of malpractice litigation tends to encourage unnecessary tests and procedures."). *See* Lucian L. Leape, *Unnecessary Surgery*, 13 ANN. REV. OF PUB. HEALTH 363, 373-74 (1992) (stating that studies using explicit criteria concluded that at least 10 percent of surgical procedures are unnecessary).

7. DAVID U. HIMMELSTEIN & STEFFIE WOOLHANDLER, THE NATIONAL HEALTH PROGRAM BOOK 126 (1994) (arguing that hospitals often compete "not by improving quality or lowering prices but by engaging in a medical 'arms race,' " which results in wasteful duplication of equipment); *see also* Richard Koenig, *Lots of Hospitals Don't Add Up to Lower Prices*, WALL ST. J., Apr. 5, 1990, at B1 (reporting that hospitals in more competitive markets actually incurred substantially higher costs than hospitals facing less competition).

8. HIMMELSTEIN & WOOLHANDLER, *supra* note 7, at 86.

9. 139 CONG. REC., *supra* note 2, at H6895.

this premium would receive subsidies. Medicare, with its co-payments and deductibles, would continue as a separate program.[10]

This sixth presidential principle is opposed by the Gray Panthers,[11] who "have always believed health care is a right, not a privilege," and who "favor the same high-quality, truly comprehensive care for all Americans, regardless of income."[12] Everyone should have access to the care they need, not just the care they can afford or the care their insurance company will cover. No one should have to choose between addressing medical problems and putting food on the table. The best way to achieve the President's goals is to do what other nations do and eliminate *all* out-of-pocket expenses and pay for medical services through progressive taxation.[13]

Instead of tax-based financing, the Administration's plan was based on the payment of premiums,[14] with individuals sharing costs in a variety of ways. In addition to employees' partial premium payments,[15] the government-mandated package would preserve deductibles and co-payments. Many believe that this plan would reduce access to care for the poor, thereby compromising the President's goal of universal coverage.[16] President Clinton's cost-saving mechanisms were extremely controversial.[17] It

10. 139 CONG. REC., *supra* note 2, at 6896.

11. The Gray Panthers, founded in 1970, is a not-for-profit, intergenerational public advocacy group with forty chapters in the U.S. and others in Canada, United Kingdom, Germany, and Switzerland. In addition to its long support for national health insurance, it has advocated for such causes as peace and disarmament, anti-discrimination (with emphasis on ageism), low-income housing, and other social needs. It has consultative status with the Economic and Social Council of the United Nations and has membership in several of its non-governmental committees.

12. *Our Country Can Do Better*, NEWSLETTER (Gray Panthers of Bergen County, Leonia, N.J.), Oct. 7, 1993, at 1.

13. *See infra* note 76 and accompanying text.

14. *See* Howard Fineman, *Another Taxing Dilemma*, NEWSWEEK, Aug. 22, 1993, at 22, 23 ("[A] 'wage-based premium' . . . was rejected after the budget deal made the T word lethal. Instead, the administration will likely propose that employers and employees pay a flat amount, or 'contribution,' into the system.").

15. *See supra* note 10 and accompanying text.

16. *See* Robert Pear, *Health Plan Leans on the Employers*, N.Y. TIMES, Dec. 16, 1993, at A21 (referring to a statement by Diane Rowland, executive director of the Kaiser Commission on the Future of Medicaid, that the significant cost-sharing requirements that the Clinton plan would place on low-income Americans were "onerous financial obligations" that she doubted low-income Americans could meet. "The premium and cost-sharing levels in the [Clinton] plan may prove burdensome for low-income people and compromise access to care for those with health problems who use the most services." *Id.*); *see also A Weighty Health-Care Plan*, ST. LOUIS POST-DISPATCH, Oct. 29, 1993, at B6 (explaining that in percentage terms, wealthier families would pay far less than poorer families in health insurance premiums under the Clinton plan).

17. *See* Dan Goodgame, *Flies in the Ointment*, TIME, Oct. 4, 1993, at 31 (citing the doubt of Brookings Institution economist Henry Aaron that the savings called for by the Clinton plan could ever be achieved); *see also* Martin Feldstein, *The Health Plan's Financing Gap*, WALL ST. J., Sept. 29, 1993, at A18 ("Unless there is rationing and government controls on the use of medical care, the expanded health insurance benefits would cost much more than the plan projects."); Steven Greenhouse, *Many Experts Say Health Plan Would Fall Far Short on Savings*, N.Y. TIMES, Sept. 21, 1993, at A1 ("A wide range of [bipartisan]

remained unclear whether the proposed regional insurance purchasing cooperatives, or health alliances, could effectively restrain costs by stimulating competition between insurers,[18] since such managed competition had never been implemented on a meaningful scale.[19] The expenses of this new layer of bureaucracy could outweigh its savings.[20] Further, some argue that Health Maintenance Organizations (HMOs) are not cheaper at all.[21] In

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experts, including economists, consultants and members of Congress, say President Clinton's health care plan will not cut costs nearly as much as the Administration hopes."); Kevin Sack, *Study Says Clinton Plan To Burden Hospitals*, N.Y. TIMES, Jan. 12, 1994, at B4 ("While applauding the goals of President Clinton's health plan, a task force appointed by [New York] Gov. Mario M. Cuomo . . . expresses 'considerable skepticism' about [whether] health care costs can be controlled through a combination of government-imposed limits on insurance premiums and market competition among cooperatives of . . . health care providers.").

18. Robert Pear, *Warning on Clinton Health Proposal From Idea's Originator*, N.Y. TIMES, Jan. 13, 1994, at B8 (noting that Stanford University economist Alain C. Enthoven, who invented the concept of managed competition in health care, believes President Clinton's health plan should be completely rewritten because it "puts the federal budget at enormous risk and will result in huge tax increases."); *cf. Clinton Health Plan is Bad Medicine*, IN THESE TIMES, Oct. 18, 1993, at 2 ("If the administration proposal is adopted, five insurance company giants will own one-seventh of the American economy. And we can expect them to compete over prices in the same way the Big Three auto companies do—which is to say, not at all."); HIMMELSTEIN & WOOLHANDLER, *supra* note 7, at 231-32 ("J. K. Galbraith has noted that oligopolies don't compete. Three HMOs that dominate a region may tacitly collude to drive up prices, enlarging the pie of health care dollars rather than fighting for the biggest piece."); Melvin Konner, *If Insurers Win, We Lose*, N.Y. TIMES, Oct. 4, 1993, at A17 ("The Clintons are creating an insurance business oligopoly . . . in which a few powerful insurers would control the delivery of care from the top down.").

19. Carolyn M. Clancy, David U. Himmelstein & Steffie Woolhandler, *Questions and Answers about Managed Competition*, PHYSICIANS FOR A NATIONAL HEATH PROGRAM NEWSLETTER (Chicago, Ill.), Nov. 1992, at 3; SAM SMITH, SHADOWS OF HOPE 77 (1994) ("One of the most striking characteristics of the 'managed competition' idea in health care was that no one other than a small elite of academicians and corporate lobbyists had ever heard of it, let alone tried it out, before it became a major political issue. Clinton's health plan was a theory in search of proof, politics from the top down.") Although several regions, notably the states of California and Massachusetts, have had considerable experience with managed care networks, no region has implemented managed competition, under which many incentives combine to induce consumers to join such networks. At the time this analysis was prepared, managed competition legislation was enacted in the states of Washington and Minnesota, but had not yet gone into effect. MINN. STAT. ANN. § 62J.01 et. seq. (1994 Supp.); WASH. REV. CODE ANN. §§ 43.72.005 et. seq. (West 1994).

20. See *infra* note 59.

21. Many critics believe the costs of HMOs outweigh the savings they provide. *See* HIMMELSTEIN & WOOLHANDLER, *supra* note 7, at 215 ("HMO premiums have more than tripled since 1979. There is little evidence to support the contention that expanding HMOs, a central feature of Managed Competition, will contain costs."); *see also* Marcia Angell, *How Much Will Health Care Reform Cost?*, 328 NEW ENG. J. MED. 1778, 1779 (1993) ("What evidence we have, however, suggests that HMOs generally have lower premiums but have not been notably successful in slowing the rate of inflation."); Thomas Bodenheimer, *The Wrong Way to Solve the Health Care Crisis*, PHYSICIANS FOR A NATIONAL HEALTH PROGRAM NEWSLETTER (Chicago, Ill.), Nov. 1992, at 18 ("[T]here is no indication that the introduction of managed care during the 1980s had a measurable effect on the inflation of private insurance premiums. The current managed care mania on the part of health care pundits, cost controllers and the media has little justification."); William A. Glaser, *The Competition Vogue and Its Outcomes*, 341 THE LANCET (London) 805, 811

addition, although Clinton's proposal clearly contemplated that most people would be served by managed care plans such as HMOs and Preferred Provider Organizations (PPOs), these organizations allow insurers, rather than physicians, to make medical decisions and thus limit patients' choice of doctors.[22] Although President Clinton identified choice as crucial to health care reform,[23] the choice to which he referred was "among high quality *plans*,"[24] rather than among health care providers. This type of choice would reduce physicians' autonomy by presenting them with the "choice as to which plans they practice in."[25] Consumers' choice of their own health care providers, meanwhile, as well as their choice to seek needed care beyond the basic benefits determined by national and state health boards, would be limited by their ability to pay for the privilege.[26] If employers chose to provide better than basic coverage, the IRS would treat the difference in cost as taxable income to employees.[27] This push toward "managed care" could compromise health care quality as well as choice.[28]

(1993) ("[B]ecause 'managed care' has become so lax, it saves employers very little money. It has become a method of shifting costs to patients. American health care costs as a whole are not noticeably constrained."); Robert Pear, *Medicare to Stop Pushing Patients to Enter H.M.O.'s*, N.Y. TIMES, Dec. 27, 1993, at A1 (explaining that the Clinton Administration will no longer encourage Medicare patients to join health maintenance organizations, partly because the government loses money on people enrolled in HMOs, one study finding that Medicare patients in HMOs cost the government 5.7 percent more than regular Medicare patients).

22. *See* Goodgame, *supra* note 17, at 31 ("Most Americans with insurance currently receive treatment through a fee-for-service arrangement with a particular doctor, and they would have to pay more to keep that arrangement. The Clinton plan includes strong price incentives for patients to switch to more economical health maintenance organizations and preferred provider organizations, in which groups of doctors and hospitals provide care for a flat fee—and usually at a cost to the patient of longer waiting times and rationing of specialists' services."); *see also* HIMMELSTEIN & WOOLHANDLER, *supra* note 7, at 211 (arguing that Clinton's plan pushes most Americans into restrictive managed care plans that would limit patients' choice of doctors and hospitals and force doctors to become insurance company employees).

23. 139 CONG. REC., *supra* note 2, at H6898.

24. *Id.* at H6898 (emphasis added).

25. *Id.* Independent practitioners might not survive under the President's proposed plan. *See* HIMMELSTEIN & WOOLHANDLER, *supra* note 7, at 194 (arguing that if enough Americans enrolled in HMOs, non-HMO physicians, particularly specialists, would not have enough patients to maintain viable practices).

26. HIMMELSTEIN & WOOLHANDLER, *supra* note 7, at 195-96; *see also Health Care Relief for Consumers*, N.Y. TIMES, Sept. 20, 1993, at A18 ("[People] . . . could choose fee-for-service coverage, which provides a wide choice of doctors, but at considerably higher cost."). Some critics view the availability of fee-for-service health benefits as a flaw in the Clinton plan because it creates an inequitable, multi-tiered, "separate and unequal" system. *See* HIMMELSTEIN & WOOLHANDLER, *supra* note 7, at 211-12.

27. Steven Pearlstein & Dana Priest, *Some Spoonfuls of Sugar Help the Medicine Go Down with Special Interests*, WASH. POST NAT'L WEEKLY ED., Sept. 27-Oct. 3, 1993, at 7. However, pre-existing benefit packages with better than basic coverage would not be treated as taxable income. *Id.*

28. *See* HIMMELSTEIN & WOOLHANDLER, *supra* note 7, at 227-28 (discussing the Rand Health Insurance Experiment, conducted in the 1970s, the only randomized trial of HMOs versus fee-for-service care, which found that HMO patients suffered more serious symptoms

Upon its introduction, critics characterized the Clinton plan as an unnecessarily complex creation.[29] Many simpler, more cost-effective models have functioned efficiently for years in other industrialized nations, including Australia, Belgium, Canada, France, Germany, Great Britain, and Italy.[30] Why, then, did our newly-elected President propose such a cumbersome, problematic plan? Some believe it was the result of the influence of special interests on our political processes.[31]

A disproportionate number of representatives of the health care industry shaped the new health proposal, each of whom had a stake in preserving its economic position.[32] Health professionals were underrepresented, as were consumers.[33] Organized labor, formerly an effective advocate for workers and their families, failed to adopt a clear position. Constituent union leaders were reluctant to give up the potential for well-paying jobs as administrators of labor-management health plans[34] in favor of a more efficient, unified system.

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and spent more days in bed than comparable patients randomized to fee-for-service care without co-payments).

29. Stuart M. Butler, *Rube Goldberg, Call Your Office*, N.Y. TIMES, Sept. 28, 1993, at A25 (contending that the Federal government tends to make simple tasks complex).

30. *See* Hilary Stout, *A Radical Cure: Bill Clinton's Proposal to Revamp the Health Care System is Both Extreme—and Untried*, WALL ST. J., Jan. 20, 1993, at R12 (explaining that most countries finance universal health care through taxes on individuals and businesses). Of the industrialized nations, only the United States and South Africa lack a national health system that ensures basic health care to all citizens. George D. Lundberg, *National Health Care Reform: An Aura of Inevitability is Upon Us*, 265 JAMA 2566 (1991); Alice A. Martin, *Health Care is Everyone's Problem*, N.Y. TIMES, Apr. 15, 1990, § 12 (Long Island), at 14.

31. Pearlstein & Priest, *supra* note 27, at 7 (describing Clinton's health reform plan as "a painstakingly constructed political document designed to ensure a solid base of support from the nation's governors and some of the nation's most powerful lobbies: senior citizens, big business, organized labor and veterans"); *U.S. Health Reforms: Clichés, Cost, and Mrs. C.*, 341 THE LANCET (London) 792 (1993) (suggesting that the Clintons are soft on the insurance industry because that industry spends so much money buying political influence).

32. *See* MELVIN KONNOR, DEAR AMERICA, A CONCERNED DOCTOR WANTS YOU TO KNOW THE TRUTH ABOUT HEALTH REFORM 81 (1993) (arguing that the dominant advisors in the health reform task force were insurance company and corporate executives); *see also* Robert Pear, *Justice Dept. Defends Setup of Care Panel*, N.Y. TIMES, July 26, 1994, at A16 (as the basis for their contention that the health reform task force illegally excluded the public from its meetings, plaintiffs have argued that "many [health reform task force] staff members came from businesses in the health care industry that stood to profit from the President's plan. . . .").

33. *See* Steffie Woolhandler & David U. Himmelstein, *Giant H.M.O. 'A' or Giant H.M.O. 'B'?*, THE NATION, Sept. 19, 1994, at 226 ("Hillary Rodham Clinton's Task Force of 500 included only a handful of people who had ever been to a hospital ward outside of visiting hours; most were too young and healthy ever to have served as patients.").

34. *See* Pearlstein & Priest, *supra* note 27, at 7 (noting that under the Clinton plan the Postal Service unions would be allowed to stay in the "lucrative business" of administering their own health plans); *see also* Steven Pearlstein & Dana Priest, *Ensuring a Healthy Chance; Reform Plan Tailored to Attract Base of Allies*, WASH. POST, Sept. 22, 1993, at A1.

In sum, the task force was more concerned with brokering the differences among competing special interests than fashioning a coherent, comprehensive plan. The same is true of most of the other health reform bills that were introduced in the 103d Congress. Perhaps this result was inevitable, since our elected representatives have benefitted from hefty campaign contributions by industry associations and their members.[35]

Our country deserves better. It demands a single-payer plan, with the government as the only health insurer. The Gray Panthers suggest that this system would "be simple and cost-efficient, eliminating insurance company waste and complexity; provide equal access to everyone; be financed by progressive taxes; provide full freedom of choice of providers; [and] emphasize health promotion."[36]

Unlike the President's approach, the single-payer approach is not based on untried theories but on proven models, one of which has been successfully implemented in Canada.[37] Further, a single-payer plan can realize the President's goals more effectively. Although political demagogues deride government health insurance plans as "socialized medicine,"[38] these plans are more accurately termed "social insurance." They would provide all Americans with health security because everyone would have equal access to care. Replacing the myriad public and private insurance plans with a unitary system would greatly simplify the system.

As for financial savings, the federal government's General Accounting Office estimated in 1991 that a single-payer system would have saved up to

35. *See* Neil A. Lewis, *Medical Industry Showers Congress with Lobby Money*, N.Y. TIMES, Dec. 13, 1993, at A1 (noting that members of Congress received unprecedented contributions from the medical industry just when they prepared to debate changes to our health care system); *see also* Jennifer A. Baratz, *In Whose Interest?*, NAT'L VOTER (League of Women Voters, Washington, D.C.), Dec./Jan. 1994, at 5 ("With health care reform looming on the horizon during the 1991-92 election cycle, health care political action committees (PACs) increased their giving to federal candidates by 36 percent, and insurance PACs upped their ante by 6 percent. That's in addition to the more than $4 million in 'soft money' contributions from the health sector to the political parties . . . ."); Joan Claybrook, *The Road to Health Reform is Paved with Bad Intentions*, PUB. CITIZEN, Sept./Oct. 1993, at 2 ("The 15 largest health industry PACs donated more than $9 million to candidates in the 1992 election."); Vicki Kemper & Viveca Novak, *What's Blocking Health Care Reform?*, COMMON CAUSE MAG., Jan./Feb./Mar. 1992, at 9 (noting that between 1980 and the first half of 1991, more than 200 medical, pharmaceutical, and insurance industry PACs contributed over $60 million to congressional candidates, more than $18 million of which went to members of the four congressional committees handling health related legislation).

36. NEWSLETTER, *supra* note 12, at 1.

37. HIMMELSTEIN & WOOLHANDLER, *supra* note 7, at 228.

38. *See* Michael Wines, *At Capitol, Selling Health Proposals as Cure-Alls*, N.Y. TIMES, Oct. 28, 1993, at A24 ("A principal Republican barker, Senator Phil Gramm of Texas, said in his finely honed country-boy drawl: 'The President is a good salesman. The First Lady is a good salesman. But the bottom line is, they're trying to sell you socialized medicine, and that is a bad product.' "); *see also* Robert Pear, *10 Doctors' Groups Endorse Clinton's Health Plan*, N.Y. TIMES, Dec. 17, 1993, at A26 ("Representative Newt Gingrich of Georgia, the House Republican whip, said the Clinton proposal would lead to too much central planning and could bring 'socialism' in the health care system.").

$67 billion of America's total 1989 health expenditures.[39] A 1993 study by the Congressional Budget Office projected savings of $150 billion in the year 2000.[40] Furthermore, administration of the Canadian single-payer system absorbed only 11 percent of that country's total expenditures in 1987, compared with 23.9 percent in the United States.[41] Clearly, these savings show that the single-payer approach to health care reform deserves serious consideration.[42]

In Canada's system, consumers pay nothing out-of-pocket for covered services and enjoy full freedom of choice of their own doctors, hospitals, and other providers. Doctors and hospitals practice independently, ordering procedures according to medical need, without bureaucratic interference from insurance company pencil-pushers. Since consumers cannot purchase covered services outside the system, providers cannot charge whatever the market will bear. Instead, they are subject to policies, prices, and priorities that are openly and publicly decided.[43]

A single-payer system can also furnish high quality care. Public health statistics indicate a slightly higher life expectancy rate for Canadians than

39. U.S. GENERAL ACCOUNTING OFFICE, CANADIAN HEALTH INSURANCE: LESSONS FOR THE UNITED STATES, REPORT TO THE CHAIR OF THE COMMITTEE ON GOVERNMENT OPERATIONS 6-7 (1991).

40. CONGRESSIONAL BUDGET OFFICE, ESTIMATES OF HEALTH CARE PROPOSALS FROM THE 102D CONGRESS 18 (1993); *see also* Pear, *supra* note 38 (explaining that the Congressional Budget Office predicted savings between the years 1997 and 2003 as low as $70 billion or as high as $292 billion, depending on the national limit set on health spending).

41. Steffie Woolhandler & David U. Himmelstein, *The Deteriorating Administrative Efficiency of the U.S. Health Care System*, 324 NEW ENG. J. MED. 1253, 1256 (1991); *see also* W. Evan Golder, *These Are the 37 Million Without Health Insurance*, PLAIN DEALER (Cleveland, OH), June 9, 1993, at 5B ("If we really want to reduce waste and cut costs, let's go after the 1,500 health insurance companies that sponge up billions of dollars each year for burdensome paperwork to verify coverage."); HIMMELSTEIN & WOOLHANDLER, *supra* note 7, at 124 (explaining that on average U.S. private insurers keep 14 percent of total premium dollars for overhead and profits, while Canada's provincial health insurance plans run at less than 1 percent overhead).

42. *See* HIMMELSTEIN & WOOLHANDLER, *supra* note 7, at 118-19 (arguing in favor of the cost-containing characteristics of a single-payer system, including administrative savings, setting and enforcing overall budgetary limits, and health care planning to eliminate duplication of facilities and technology); *see also id.* at 135 (applying the results of a 1991 U.S. General Accounting Office study and calculating that "reducing administrative costs to the Canadian level would have saved $641 per capita in 1993. . . . [I]mplementing a Canadian-style system in the U.S. would save about 10% of total health spending (more than $90 billion in 1993) by eliminating much of the paperwork and administration of the U.S. system. . . .").

43. CANADIAN EMBASSY, HEALTH CARE IN CANADA 3 (1993) (explaining that in Canada, hospitals must negotiate their budgets with the provincial ministry of health; community and provincial authorities must approve expansion of programs; providers openly negotiate compensation for physician and nurses services; and public, voluntary, and private sectors jointly fund capital expenditures); *see also* HIMMELSTEIN & WOOLHANDLER, *supra* note 7, at 131 ("Overall, the U.S. could save about $50 billion each year on hospital billing by adopting the Canadian global budget-type system.").

Americans.[44] In 1992, a study by an American medical publication found that over 90 percent of Canadian consumers and 84 percent of Canadian doctors rated the quality of care provided by their system as good to excellent.[45] In contrast, "[o]pinion polls indicate that 90 percent of Americans believe the nation's health care system needs 'fundamental change' or a 'complete rebuilding.' "[46] Eighty-five percent of Americans want a plan that serves all people, regardless of age, income, health status, or employment.[47] In addition, "[m]ore than 60 percent of the public tell pollsters they want a Canadian-style system of national health insurance . . . ."[48] In well-financed public relations efforts to maintain their profits,[49] major American health industry interests raise the specter of health care rationing. They exaggerate the extent to which Canadians must sometimes wait for non-emergency procedures[50] and emphasize that a few Canadians have crossed the American border in pursuit of faster service. In fact, many

44. In 1986, Canadians' life expectancy at birth was 76.5 years, compared to 75 years in the United States. Centers for Disease Control, U.S. Dept. of Health & Human Services, *Mortality in Developed Countries*, 39 MORBIDITY AND MORTALITY WEEKLY REPORT 205, 206 (1990); *see also* ORGANIZATION FOR ECONOMIC COOPERATION AND DEVELOPMENT: DATA FILE 189-90 (Paris) (1989).

45. CANADIAN EMBASSY, *supra* note 43, at 3 (citing Robert H. Overmyer, *What Canadians and Their Physicians Like and Dislike Abut Their Health Care System*, PHYSICIAN'S MANAGEMENT, Aug. 1992, at 55).

46. Kemper & Novak, *supra* note 35, at 8.

47. According to a Consumers Union/ Gallup survey, 55.1 percent agree completely and 30.1 percent mostly agree with the proposition that everyone should have access to the same type of health insurance coverage. CONSUMERS UNION/GALLUP, SURVEY ON HEALTH CARE 12 (1993).

48. Barbara Ehrenreich, *A Cure for the Wrong Disease*, TIME, Mar. 29, 1993, at 70; *see also* HIMMELSTEIN & WOOLHANDLER, *supra* note 7, at 16 ("Nearly 75 percent of Americans want a national health insurance system. In a democracy, this should be the number one contender of all health care proposals.").

49. Baratz, *supra* note 35, at 5; *see also* Adam Clymer, *Hillary Clinton Accuses Insurers Of Lying About Health Proposal*, N.Y. TIMES, Nov. 2, 1993, at A1 (reporting on Hillary Rodham Clinton accusing the health insurance industry of lying to the public in order to protect its profits and denouncing television advertisements run by the Health Insurance Association of America); Bernard L. Remakus, *On Propacanada*, 8 INT'L MED. WORLD REP. 6 ("Propacanada is the term I use to describe the purposeful and systematic dissemination of misinformation about the Canadian health-care system by individuals and groups whose special interests would be threatened by the institution of a Canadian-style health care system in the United States. From the recent glut of negative publicity that the Canadian health-care system has received in many of our leading newspapers and medical journals, it would appear that Propacanada is on a roll."); Patrick Woodall, *Beware of 'Astro Turf' Grassroots Lobbying!*, ACTION FOR UNIVERSAL HEALTH CARE, Aug.-Sept. 1993, at 8 (citing efforts by the medical and insurance industries to influence and derail debate on health care reform).

50. *See* CANADIAN EMBASSY, *supra* note 43, at 4 ("While waiting periods do at times exist in some regions for certain diagnostic and elective surgical procedures, those who are in need of emergency treatment receive it without delay."); *see also* HIMMELSTEIN & WOOLHANDLER, *supra* note 7, at 100 (citing a study comparing breast cancer treatment in the province of British Columbia and the state of Washington that found that Canadians receive more timely breast cancer treatment than Americans; Canadian women are less likely to suffer delays between diagnosis and surgery and few wait more than three months for the pronouncement of a diagnosis).

Americans cross the Canadian border to use the Canadian system.[51] Moreover, we already suffer from waiting lines in this country. Patients in rural areas travel hundreds of miles for treatment that is not available locally,[52] and uninsured inner-city residents sit for hours in overburdened hospital emergency facilities.[53] The United States rations care[54] according to patients' ability to pay, their employment status, and their past and present health status. The well-off get red carpet treatment, while insurance companies manage care for the less fortunate by denying claims or by altogether avoiding poor-risk insurees in the first place.[55] Some have called our system immoral.[56] Barbaric might be a better term.

The President's plan, like most of the competing bills introduced in the 103d Congress, relied on the myth of a free market for health services. In large measure the burgeoning costs of our present system are fueled by the inability of even the most informed consumers to shop around for affordable care.[57] Who, after all, can bargain with a surgeon on the eve of an operation or negotiate the price of a prescribed medication? Most people will beg, borrow, or steal to meet the costs of care, especially in life-threatening situations.

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51. Clyde H. Farnsworth, *Americans Filching Free Health Care in Canada*, N.Y. TIMES, Dec. 20, 1993, at A1 ("A report prepared for Ontario's Health Minister indicated that from August 1992 to February 1993, 60,000 medical claims had been made on behalf of patients who held American drivers' licenses.").

52. *See* Teri Randall, *Rural Health Care Faces Reform Too; Providers Sow Seeds for Better Future*, JAMA, July 28, 1993, at 420 ("The federal Office of Rural Health Policy estimates that more than 1400 rural communities in virtually every state in the nation suffer critical shortages of health care providers. During the 1980s, more than 230 hospitals closed, most of them rural facilities with less than 100 beds. Since 1990, 35 more have closed. Emergency medical services are also threadbare or absent in many areas.").

53. *See* HIMMELSTEIN & WOOLHANDLER, *supra* note 7, at 87 (stating that, in the United States, patients commonly wait many hours for admission in the emergency rooms of public and private hospitals. For example, "[i]n New York City, the average hospital's ER was overcrowded on 95% of all days. The wait for an ICU bed was 8 hours, with some hospitals having average waits of 48 hours per bed.").

54. David Van Biema, *Out in the Cold?*, TIME, Oct. 4, 1993, at 35 (quoting President Clinton, who stated: "Every system has some rationing. The system we're in now severely rations care in all kinds of ways.").

55. KONNOR, *supra* note 32, at 16. The Administration's proposal will effectively reward these policies with "an insurance company preservation plan." Russell Baker, *Now Perhaps To Begin*, N.Y. TIMES, Oct. 30, 1993, at 21. Some have criticized the administration's de facto support of such practices. *Id. See also* Ehrenreich, *supra* note 48, at 70 (criticizing the willingness of the insurance industry to put its own needs before those of the public).

56. *See* HIMMELSTEIN & WOOLHANDLER, *supra* note 7, at 88 (arguing that the practice of rationing despite America's over-supply of resources is morally repugnant).

57. David E. Rosenbaum, *Economic Outlaw: American Health Care*, N.Y. TIMES, Oct. 26, 1993, at A1 (arguing that normal free market mechanisms do not operate effectively in the health care industry); *see also* Angell, *supra* note 21, at 1778; Wallich & Holloway, *supra* note 6, at 109 ("Many economists . . . argue that the task force is ignoring fundamental economic principles, which put efficient, competitive health care markets in the same class as powdered unicorn horn.").

The President's proposed caps on premium rates[58] may or may not be able to restrain health costs.[59] If these caps can restrain costs, savings are more likely to come from limiting care.[60] On the other hand, a single-payer structure can effectively control costs without degrading care because the affluent can not bid up prices by purchasing covered services outside of the system.

A single-payer health care reform proposal, entitled the *American Health Security Act of 1993*, was introduced in Congress on March 3, 1993 by Senator Paul Wellstone (D-MN) and Representatives Jim McDermott (D-WA) and John Conyers (D-MI). Designated as S. 491 and H.R. 1200, the bill was co-sponsored by 98 more Representatives and Senators.[61] It sought to establish an insurance program administered by the federal and state governments and would have provided the following:

- Universal access to health care for all Americans, regardless of employment status, income, age, or medical condition, through a single program[62] federally funded and administered by the states.[63]
- Consumer freedom to choose doctors, hospitals, and other health care providers, including the choice of managed care plans within the parameters offered by the States.[64]

58. *See* 139 CONG. REC., *supra* note 2, at H6895-98.

59. *See* Robert Pear, *Premium Limits In Health Plan Draw Criticism*, N.Y. TIMES, Sept. 18, 1993, at A1 ("In its report [to House Ways and Means Subcommittee on Health Chairman Fortney H. (Pete) Stark], the Congressional Budget Office said federal regulation of insurance premiums 'could be difficult to design and costly to put in place.' ").

60. *See supra* note 28 and accompanying text.

61. S. 491, 103d Cong., 1st Sess. (1993); H.R. 1200, 103d Cong., 1st Sess. (1993); *see also The Most Sincere Form of Flattery*, CONGRESSMAN JIM MCDERMOTT'S AMERICAN HEALTH SECURITY NEWS, (Office of Congressman Jim McDermott, Washington, D.C.) Sept. 15, 1993 at 2 (explaining the controversy over the titles of Clinton's and McDermott's health care proposals).

62. S. 491, *supra* note 61, §§ 101(a), 102(a), 106; H.R. 1200, *supra* note 61, §§ 101(a), 102(a), 106 (incorporating all current programs, including Medicare and Medicaid, except the Veterans Administration health program and the Indian Health Service, both of which would still be provided for under current laws).

63. S. 491, *supra* note 61, § 604; H.R. 1200 *supra* note 61, § 604 (providing for the federal government to fund a percentage of the states' health care costs).

64. Sen. Paul D. Wellstone & Ellen R. Shaffer, *The American Health Security Act*, NEW ENG. J. MED., May 20, 1993, at 1489; Rhoda H. Karpatkin, *Single-Payer Plan Provides Best Health Choice*, N.Y. TIMES, Nov. 16, 1993, at A26. The parameters for acceptable managed care plans are found at S. 491, *supra* note 61, §§ 301-303; H.R. 1200, *supra* note 61, §§ 301-303.

- Comprehensive benefits, including primary and preventive care,[65] hospital and practitioner care,[66] treatment for mental health and substance abuse,[67] long-term care,[68] and outpatient prescription drugs.[69]
- Emphasis on primary and preventive care[70] and expansion of services to underserved rural and inner-city communities and special populations.[71]
- Effective cost control through annual budgets,[72] national fee schedules,[73] control over fraud and abuse,[74] and streamlined administration.[75]

65. S. 491, *supra* note 61, §§ 201(a), 202(b)(2); H.R. 1200, *supra* note 61, §§ 201(a), 202(b)(2) (including coverage of developmental screening and examinations, basic immunizations, prenatal, and well-baby care, but excluding over-the-counter drugs, cosmetic surgery, and physical examinations for the purposes of litigation or obtaining life insurance).

66. S. 491, *supra* note 61, § 201; H.R. 1200, *supra* note 61, § 201(a) (including inpatient and outpatient hospital care, diagnostic tests, and services of health care professionals authorized to provide covered services under state laws).

67. S. 491, *supra* note 61, §§ 201(a), 204(b); H.R. 1200, *supra* note 61, §§ 201(a), 204(b) (subjecting providers to regulated utilization review after 15 days of inpatient care and 20 outpatient visits per year).

68. S. 491, *supra* note 61, § 201; H.R. 1200, *supra* note 61, § 201 (providing nursing facility services, hospice care, home care, and community-based services for individuals unable to independently perform at least two activities of daily living, including "bathing, eating, dressing, toileting, and transferring in and out of a bed or in and out of a chair").

69. S. 491, *supra* note 61, § 201(a)(6); H.R. 1200, *supra* note 61, § 201(a)(6).

70. S. 491, *supra* note 61, § 701; H.R. 1200, *supra* note 61, § 701 (ensuring that fifty percent of medical residents are in primary care programs within five years, and training more mid-level practitioners such as nurses, midwives, physician's assistants, and community health outreach workers by the year 2000).

71. S. 491, *supra* note 61, §§ 703, 711, 713; H.R. 1200, *supra* note 61, §§ 703, 711, 713 (doubling funding for community-based primary care services and public health block grants, greatly increasing funding through such grants for services, including maternal and child health care and care for people with AIDS, and expanding funding for the National Health Service Corps, which sends doctors and mid-level practitioners into underserved areas in exchange for help with educational expenses).

72. S. 491, *supra* note 61, § 603; H.R. 1200, *supra* note 61, § 603. The American Health Security Standards Board would implement guidelines and would require detailed state budgets. Advisory boards representing both consumers and health care providers would advise the implementation of the program at local, state, and federal levels. *Id.*

73. S. 491, *supra* note 61, §§ 613, 616, 617; H.R. 1200, *supra* note 61, §§ 612, 615, 616 (requiring states' health security programs to establish prospective fee schedules for provider services and a professional board to determine maximum product prices for drugs and other medical devices and equipment).

74. S. 491, *supra* note 61, §§ 412-413; H.R. 1200, *supra* note 61, §§ 412-413 (establishing a national fraud and abuse data base and state fraud and abuse control units, which review complaints of abuse and neglect and prosecute criminal violations of the law).

75. Title IV of S. 491 and H.R. 1200 lays out a new administrative structure of American health care, which would include standardized reporting as well as centralized oversight. S. 491, *supra* note 61, § 401 et. seq.; H.R. 1200, *supra* note 61, § 401 et. seq. *C.f. supra* notes 39-42 and accompanying text.

• Progressive financing[76] so health care is affordable to all without out-of-pocket expenses[77] for patients, such as co-payments, deductibles, and "balance billing," which prevent low-income consumers from obtaining care. Most businesses and individuals would spend less on health care under the bill's provisions than they do at present.[78]

Despite the American people's long-standing support of this simple, efficient, and egalitarian model for health-care delivery, prospects for rational health reform legislation in the 103d Congress were killed by an "unholy mix of money, power, and politics."[79] A significant local initiative, a single-payer state health insurance plan known as Proposition 186 was placed on California's November 8, 1994 election ballot.

Although Proposition 186 was defeated by a substantial margin, its proponents plan to reintroduce the initiative in the 1996 elections. It is our hope that not only California voters, but also the Clinton administration and the 104th Congress will realize that the single-payer model provides the best blueprint for national health reform. And if political feasibility (read special-interest payoffs) again supersedes such enlightenment, we hope that the electorate will begin to understand how their interests are being sabotaged by big-money interests, and will take steps to change this in future elections.

76. The legislation called for increasing the Medicare payroll tax on employers, increasing the corporate tax for businesses with more than $75,000 in profits, increasing the personal income tax rates from 15 percent-28 percent-31 percent to 15 percent-30 percent-34 percent with a top rate of 38 percent for some individuals, adding premiums for health and long-term care, and increasing the amount of Social Security benefits included as taxable income. S. 491, *supra* note 61, §§ 811, 813, 821, 836, 837; H.R. 1200, *supra* note 61, §§ 811, 813, 821, 836, 837.

77. S. 491, *supra* note 61, § 201; H.R. 1200, *supra* note 61, § 201.

78. Adam Clymer, *House Bill Asks 8.4% Payroll Tax For Canadian-Style Health Plan*, N.Y. TIMES, Jan. 28, 1994, at A19 (Representative Jim McDermott stating that "under the taxes proposed today, 75 percent of all Americans would pay 'substantially less' for health insurance than they do today" and Senator Paul Wellstone arguing that "the 8.4 percent payroll tax was 'well below the 12 percent of payroll most employers pay now for health insurance.' "); HIMMELSTEIN & WOOLHANDLER, *supra* note 7, at 147 (explaining that a Canadian-style system could save billions by eliminating bureaucratic waste and incentives for unnecessary procedures. New taxes would replace insurance premiums and out-of-pocket expenses. Thus, costs to the average taxpayer would be equal to or lower than under our current system.).

79. *Why Health Care Fizzled: Too Little Time and Too Much Politics*, N.Y. TIMES, Sept. 27, 1994, at B11 (statement by Sen. Paul Wellstone).