

Will it be Déjà vu All Over Again? Renewing the Fight for Health Care for All

Tales, Hopes and Fears of a Battle-Scarred Organizer

Richard Kirsch*

Authors Note: I intended to write this piece as a cautionary tale for both the new generation of organizers for universal health care and the veterans of the last fight. To my surprise, the writing led me to a fresh understanding of the paradox of achieving universal health care in the United States: the political debate about health care reform is turned upside down once the debate turns from the problem state to the solution stage. At that point, people become more scared about what they will lose from reform than what they will gain. This conclusion led me to reframe my view of how we go about organizing for universal health care, and – to my even bigger surprise – to outlining a new proposal for comprehensive reform.

Please share your reactions – the critical as well as the positive – by writing me at rkirsch@citizenactionny.org.

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Introduction

My standard speech during the last fight for health care for all, a decade ago, usually began with this story:

A wonderful senior citizen activist, and old friend, died recently. When she got to the Pearly Gates, St. Peter told her: “You’ve worked hard all your life to make health care affordable to everyone. For your all your good work you get to ask the Lord one question.” My friend stood up tall in front of the Lord and said, “I remember when FDR was about to propose national health care at the same time as Social Security, but the doctors were opposed and he was told that he might lose both if he pushed too hard, so he let it go. And I can still see Harry Truman, at the back of his train

on a whistle-stop, promising to fight for national health insurance and that was a big reason he surprised Mr. Dewey like he did. But the doctors had their way with him in Congress too. Even Mr. Nixon had a plan but it was different from Teddy Kennedy’s and never went anywhere. So my question is, will we ever see a time when the everyone in our great country has health care?” The Lord paused a moment, and said, “Yes my daughter, we will... but not in my life time.”

The story was a prelude to a speech about why the conditions were favorable to write a new history in the fight for universal health care, despite the formidable opposition facing us. As an organizer I believed we could do it and inspired others to engage in the struggle. As early as 1986, when we began to organize on health care, I was often asked when it would happen. I responded, “In 1994 or 1998, two years after the election of a Democratic President.” I was half right. Clinton made universal health care a major part of his 1992 campaign. The famous sign in the famous Clinton campaign war room read, “It’s the economy stupid, and don’t forget health care.” 1994 was the right year, with the wrong ending.

After 1994 I no longer began speeches with the story about my friend’s visit with the Almighty – it was too depressing – although I would tell the story when I got the inevitable question about the prospects for universal coverage in our nation. Of course I had to add one more sad chapter to my friend’s narrative – the collapse of the Clinton plan. The punch line had become a poignant epitaph.

Reading the current national press coverage about the health care system really is déjà vu all over again. The story is the same as it was in 1986 when the crisis in health care started to make headlines, but today the numbers are bigger and scarier. There are 43 million uninsured now, up from 35 million. We are spending 14% of our GNP on health care, up from 11%. Senior citizens struggle with the high cost of prescription drugs, a reminder that seniors spend more out-of-pocket for health care than they did before Medicare was established in 1965, a line they crossed in 1989. Once again health care inflation is outracing general inflation by three-fold, employers are shifting health costs to workers, health care costs are the biggest issue in union negotiations and the leading cause of strikes. Once

* Richard Kirsch is the Executive Director of Citizen Action of New York, a position he has held since 1987.

again the press is filled with stories about the growing crisis and Democratic presidential hopefuls are making health coverage a central plank of their campaigns.

The biggest difference between now and then is the defeat of the Clinton effort, which forcefully shapes the contours of today's health care politics. The ensuing decade also saw the rise and fall of managed care, a private attempt at fixing the system by moving medical decision-making from the doctor's office to the insurance company. It quickly became clear that managed care was really about managing *costs*. The public backlash against managed care precipitated a national wave of state consumer regulations and a consumer exodus from managed care's more stringent forms. American consumers got what the insurance industry's TV couple, Harry and Louise, promised in their ads targeting the Clinton plan: bureaucrats telling them what doctor they could see. The only difference was these bureaucrats worked for the insurance industry, not the government.

One of the other lines we often quoted in the early '90s was from Winston Churchill: "Americans can always be counted on to do the right thing... after they've tried everything else." Now that we've tried managed care and that hasn't worked, can we say we've tried everything else? Is this time really *the* time for universal health care? Is this "the perfect storm" as one hopeful commentator has written? Or will the political process invent other half-measures rather than provide a government guarantee of affordable, quality health care for all? It turns out that the booms and busts of the business cycle didn't end, as many wags predicted in the high-flying 1990's; do we have any hope of ending the cycle of struggle and failure for health care for all?

When I set out to write this piece, I wasn't at all sure where I'd end up. I knew that I wanted to share what happened to us ten years ago with those who are beating the drum again today. I wanted them to know that we thought we had a lot going for us, that we'd worked really hard and had good reason to be hopeful. I wanted them to think seriously about what happened and not rush to do the same things over again. Mostly I wanted to explore the reasons why I wasn't eagerly strapping on my armor and charging into battle.

But writing is a journey for the writer as much as for the reader and I found myself, after recounting the history below, with some firm ideas about what the past does say for the present and future. Even more to my surprise, I even woke up in the middle of the night a few weeks ago with an outline for a reform proposal in my head. So I'll share with you my thoughts on how we should organize towards health care for all in the coming years and, yes, what a reform proposal might look like. But first, I'll begin with a brief history of the campaign that interweaves organizing and politics, a history from an organizer's point of view.

History

In 1985 several national groups founded the short-lived National Health Care Campaign. These groups saw that the crisis in health care financing was creating the conditions for national organizing on health care: 1) the shift from a manufacturing to a service economy meant that private sector health coverage was shrinking for the first time since health coverage first became a major employee benefit after World War II; as a result a growing proportion of working people were now uninsured; 2) among the majority who still got health care on the job, the cost squeeze was forcing employers to raise out-of-pocket costs on workers and cut benefits; at unionized workplaces, health care became the number one issue at the bargaining table; 3) as advancements in medical care increased longevity (one observer remarked that for the first time in human history there was an entire generation, not just a few stragglers, over the age of 80), seniors and their families faced escalating costs that were not covered by Medicare, ranging from the unpaid share of doctor's visits, to prescription drugs, to long-term care.

From an organizer's perspective this was a potent mix: unions, seniors and low-and-moderate income families bound by the same interests. The National Health Care Campaign itself didn't last long, as the founding groups quickly discovered they didn't have a shared policy agenda, but around the country state health care campaigns began to form, focusing on expanding coverage to the uninsured and opposing overcharges by physicians under Medicare. Most of the energy for these efforts came from state-based citizen action groups (both those that were part of national Citizen Action and others),

unions, senior citizen groups, groups representing the disabled and sick, nurses organizations and faith-based groups.

The first notable success came in 1988 when the State of Massachusetts enacted a law that would require – but not immediately – every employer to provide health coverage for its workers or pay into a state pool that would provide that coverage. This approach, known as “pay or play”, was designed to circumvent the federal ERISA law that forbade states from requiring employers to provide coverage.

But it was another reform proposal that galvanized organizing efforts around the nation and demonstrated the power of a big idea. Two Harvard physician/professors, David Himmelstein and Stephanie Woolhandler, published an article in the *New England Journal of Medicine* in 1986 that compared the administrative cost of the Canadian health care system with that of the United States. Himmelstein and Woolhandler pointed out that while both countries have private systems of delivering medical care – doctors in private practice and hospitals as private entities – Canadian provinces act as a “single-payer” for the services of these health providers. The single-payer system, the Harvard team found, dramatically reduced the administrative cost of multiple insurance companies, each with multiple insurance plans, paying tens of thousands of health care providers. In later articles, the authors calculated that the administrative cost savings were sufficient to pay for universal coverage in the United States, if our nation were to adopt the single-payer approach.

The seductiveness of the Canadian system can hardly be overstated. This was not socialized medicine and it didn’t require higher spending. It made enormous common sense to practical Americans looking for a solution that would cover everyone, while letting people keep their doctor and not requiring cuts in health services. The big loser would be the insurance companies, an industry that was fast losing popularity as it raised premiums, cut benefits and rejected claims, a widespread practice even before managed care.

A single-payer proposal has advantages in addition to the lower cost of administration and the elimination of insurance hassles. It is a national health insurance system that covers everyone, regardless of

his or her work status or income. It provides comprehensive benefits, saving money by slashing administrative costs rather than rationing care. And it provides a way to control costs throughout the system, since it controls payments for virtually all health services. As such, it is a comprehensive and equitable solution to the most vexing problems of the American health insurance system: covering everyone and controlling costs.

Amongst advocates and organizers for reform, the debate between pay or play and single-payer continued until the Clinton plan took center stage. Pay or play advocates pointed out that their proposal built on the current, employer-based system and that it didn’t create nearly as many adversaries as single-payer. Since pay or play retained employer based coverage, and the role of private insurers, it would not threaten the existence of the health insurance industry. Many employers and many unions were invested in their established role of providing and choosing health benefits; pay or play would let them continue to provide coverage. And while doctors and hospitals were not enamored of insurance companies before the days of managed care, they were not yet constantly at war with the insurance industry as they would be in a few years. Pay or play did not present the specter raised by single-payer: a government system that would limit their revenues.

But those of us on the single-payer side saw no reason to back a compromise system which would: continue several, inequitable tiers of coverage; force the government to pay for the poor, working poor, elderly and disabled while the insurance industry profited from insuring better-paid workers; do nothing to eliminate insurance company hassles; and fail to control costs in the system overall. On a gut level, pay or play wasn’t really a change; single-payer was, it appeared to be both visionary *and* practical.

One thing single-payer supporters didn’t do a very good job of was pointing out that we already had a single-payer system in the US for seniors and the disabled: Medicare. About the only time that we made the Medicare analogy was in calculating the administrative savings of single-payer, in which we compared the administrative cost of Medicare (around two percent of revenues) with that of private insurance (from ten percent of revenues for non-profit insurers to 33% for commercial insurers).

In the post-mortems after 1994, our failure to talk about Medicare for All, instead of single-payer, was the most-widely shared self-criticism voiced by the single-payer movement. Single-payer is a wonky term that was never accessible to a broad public (which is why we never used it in our public organizing in New York). The Medicare program was (and is) very popular and it would have been an American model that people could understand. Single-payer was a foreign import. But I also think that the attraction of single-payer to many of its most ardent supporters was that it was foreign and new. In a “the grass is always greener” way, Medicare’s problems – high out-of-pocket costs, gaps in coverage for drugs and long-term care, fights with providers about payments – were too close to home to make it exciting reform. To acknowledge that Medicare was America’s single-payer system for seniors and the disabled would have saddled the single-payer vision with too big a dose of reality.

The Himmelstein and Woolhandler articles helped focus the organizing efforts in states around the country. The emerging state health care campaigns soon began working on single-payer proposals in their states while nationally we began to look for single-payer champions in Congress. The Ohio coalition drafted a single-payer bill that became the model for many state efforts. Several state legislatures enacted bills that were designed to explore establishing state single-payer systems. In New York, in 1992, the New York State Assembly passed a complete, single-payer bill that included full financing of the program. In 1991 the Illinois coalition convinced Rep. Marty Russo (D-Chicago) to introduce a full single-payer proposal for the nation into Congress. We recruited 72 Congressional sponsors for the Russo bill and in 1992 many of us worked to inject the bill into the Congressional elections. Paul Wellstone introduced the bill in the Senate.

Throughout this period the organizing accelerated as groups: built grassroots campaigns on issues like Medicare costs and Medicaid coverage; highlighted the growing number and predicament of working uninsured; and supported unions who struck because of health benefits.

In the fall of 1991 we took an idea that had been pioneered in New York to the national level. In 1989, Citizen Action of New

York rented an old ambulance and drove it on a twelve-city tour across the State, collecting stories from people without health coverage. We delivered the stories on an oversized stretcher to the State Capitol in Albany. In September of 1991, five caravans of ambulances left cities on the West Coast, and Minnesota and headed by separate routes, stopping in dozens of cities, collecting postcards, holding rallies and highlighting health care horror stories, before convening at Lafayette Park across from the White House.

It was a special election for US Senate in 1991 that catapulted the issue to center stage politically, triggered by the death of Pennsylvania Senator John Heinz in a plane crash. The Democratic candidate, a long shot named Harris Wofford, made universal health care the major issue of his campaign, which was run by two up and coming campaign consultants, James Carville and Paul Begala. Wofford’s ads asked, if everyone was entitled to lawyer, why wasn’t everyone entitled to a doctor? After Wofford’s upset victory the health care issue could no longer be ignored. And Carville and Begala were hired by Arkansas Governor Bill Clinton to run his Presidential campaign.

While Clinton embraced health care for all in his campaign, he said little about the policy he would propose. But when he did address a specific solution, he endorsed “managed competition.” For Clinton, a “new Democrat” who was running as a candidate with business support, who would promote innovative ways to promote social equity, managed competition seemed made to order.

Managed competition, first proposed by Alain Enthoven in 1978 in an article in the *New England Journal of Medicine*, was revived by Enthoven and a group of business leaders known as the Jackson Hole Group (named for the Wyoming resort at which they met) and by the California Insurance Commissioner, John Garamendi. California was the home to Kaiser Permanente, the nation’s biggest HMO. The idea behind HMOs is that by coordinating a patient’s care in one system, the most appropriate care can be provided, controlling costs and improving quality.

By the early ‘90’s, businesses and insurers were looking more closely at the HMO model as a potential new way to control costs. Fee-for-service medicine – in which patients choose to go to any doctor any time, and the insurance company’s only role is to verify

that the service is a covered benefit and pay its share of the bill – has three major problems: 1) there is no coordination of a patient’s care; 2) doctors have a financial incentive to provide more services, whether needed or not, and; 3) neither the insurance company nor doctor have incentives to provide preventive care¹. The idea behind HMOs – and managed care more broadly – is that by providing a fixed payment to a health system to care for a patient, the system has a built-in incentive to prevent illness and to provide appropriate, coordinated care.

Managed *competition* proposed to put everyone in regional managed care systems. Several managed care systems in each region would compete on the basis of cost and quality. Businesses and individuals could compare quality, cost and benefits and choose the best health care system for their medical needs.

As with single-payer, managed competition was a powerful idea: it would maintain private insurance and use competition – an American ideal – to improve quality and control costs; the resulting savings could be used to expand coverage. Its biggest appeal was to those like the Clintons who wanted a “new” solution that wouldn’t antagonize business. Boy were they wrong.

After Clinton’s election he took the audacious – and politically inept – step of appointing his wife to come up with his health care proposal. The political error was that it made the success or failure of the proposal that much more personal to the President’s opponents and also to the average American. This was not just a matter of challenging gender roles or the role of First Lady; it meant that the President could not in any way divorce himself from whatever Hillary came up with.

Hillary Clinton and Ira Magaziner – a Rhodes Scholar Friend of Bill’s– spent a year devising their managed competition proposal, employing a large task force and getting input from every side of the reform debate (including national Citizen Action and

¹ It might seem that an insurance company would want to keep a patient healthy but that assumes the patient will be with the insurer for a long time. In a system like ours, in which companies switch insurers and employees switch jobs, preventive care doesn’t provide any reliable savings to the insurer.

Himmelstein/Woolhandler). They clearly understood the problem and came up with a massive proposal that truly was comprehensive, dealing substantively with an array of trenchant health care problems, from things that were essential to managed competition, to the Indian Health System. They also aimed to please everyone who might oppose the system, putting in measures aimed at alleviating concerns from provider groups, insurers and consumers (yes, we got some of our concerns met too, including the option for states to implement a single-payer plan instead of managed competition).

While the Clinton plan was being put together a coalition of groups including Citizen Action, Families USA, Jobs with Justice, the National Council of Senior Citizens, AFSCME, CWA, SEIU, the Teamsters and others – began a massive national effort to collect postcards calling on the President to propose reforms based on a number of principles. The postcards – one million of them – were delivered to the White House in early 1993 by a delegation led by Rep. Marty Russo.

The President announced his proposals for reform in a national address delivered in the early fall of 1993. The White House launched – from the Democratic Party – the Health Security Campaign – to promote their proposal. Polls showed that, after the address, many Americans thought that his proposals were now the law of the land! But it was clear immediately that the President’s proposal was in serious trouble.

There have been books written on what went wrong. Some of those focus on the brouhaha around Hillary’s secret task force or the Whitewater distraction that kept the President on the defensive throughout much of 1993 and 1994. Others emphasize the failure of the administration to involve their Democratic allies in Congress in designing the program, ignoring both their views and political judgments. But in my view, two issues that are fundamental to the dynamics of health care politics sank the plan, issues that will apply to the next struggle as well. The first is the organized opposition to change. The second is that once the debate moves from the problem stage to debating a solution, the political terrain is turned upside down.

The Opposition: First, let's take a look at the organized opposition, which came from three fronts: the business community, the insurance industry and the Republican Party.

Business: Under the Clinton plan, all employers would have been required to contribute to their employee's health coverage, a provision known as an "employee mandate." The Clinton administration had hoped that businesses – particularly larger businesses with high health care costs – would support its program because it would have lowered the cost of coverage for employers who provided good health benefits. A handful did lend lukewarm support, particularly the auto industry and American Airlines. But the Business Roundtable, the big-business lobby came out against the plan, for three reasons:

- 1) Business groups like the Business Roundtable include major health care industry groups – the insurance industry, drug companies, medical device manufacturers – whose vociferous opposition won the day over the tepid support of other members.
- 2) Pepsico is a good example of why even larger businesses that might stand to gain, opposed the plan. The traditional core of its business, beverage bottling, would have seen lower employee health costs but the fast-food part of the business – KFC and Taco Bell – would have experienced higher costs because fast food chains don't provide health benefits to most of their employees. On balance, Pepsico didn't want to be forced to pay for health coverage for all of its employees.
- 3) Ideology matters. On principle, most businesses don't like government regulation and they don't want to see an expanded role for government in the economy. So CEOs simply didn't trust changes that would have: required them to provide coverage; mandated benefit; and set up a substantial government role in regulating employee health coverage and the health care

system. As the *Wall Street Journal* reported at the time, "but above all, it boils down to a visceral feeling among executives that, despite the Clinton's claims to the contrary, the administration is proposing a big-government solution to a problem better left to the market."

In the end, the interest that put the nail in the Clinton plan's coffin was small business. The fatal blow was delivered in the House Commerce Committee, in March 1994. The angry, well-organized opposition from the National Federation of Independent Businesses (NFIB) was lethal. Why did they hate the plan so? At first blush the reason is straightforward: NFIB's rallying cry was opposition to the mandate that small employers pay for health coverage. But Commerce Committee Chairman John Dingell – who had been working for national health care for four decades – tried to quell small business opposition by reducing the tax for small businesses to as little as 1% of payroll. Not only is this a very affordable cost, it actually would have saved money for the many small business owners who pay for expensive coverage for themselves. But NFIB leadership ignored reason and held to its strident ideological opposition to any employer mandate or government regulation of the health care system.

The NFIB led a winning battle in the Commerce Committee, obtaining the votes of two Democratic Congressman who hoped to win higher office in 1994, Jim Cooper, who wanted to be the US Senator from Tennessee and James Slattery, who hoped to become Governor of Kansas. When the powerful committee chair couldn't get the Democratic votes to pass a bill out of his committee, further House action was blocked. (It is small comfort that both Cooper and Slattery lost in the Democratic debacle of the 1994 elections, a debacle brought on in part by their votes).

The Insurance Industry: The insurance industry's central contribution to the defeat of the Clinton plan was Harry and Louise. The industry put that upscale, suburban couple on TV in late 1993 in a series of ads that defined the Clinton plan for many Americans. The ads made two points: first that government bureaucrats would tell people what doctor to see and what medical care they could get. The second was that the plan was long and complicated, 1342 pages

filled with hidden provisions. In each ad, Harry and Louise agreed that action was needed but concluded by saying “Government run health care. There’s got to be a better way.”

There are several notable things about the ads:

- They didn’t argue that there wasn’t a problem or that reform wasn’t needed. The ads staunchly criticized the Clinton solution, while agreeing that something must be done.
- The focus of the attack was that under the Clinton plan, government threatened the quality of health care. Americans who had health coverage were convinced by the ads that they would lose what they valued highly, i.e. their doctor, and would see health care rationed, by the government.
- The government couldn’t be trusted to get it right, emphasizing the public’s fear of change and the unknown.

The Republican Party: Newt Gingrich decided in 1993 that if he blocked *any* Congressional action on health care, he could win control of the House. He understood that denying Clinton any credit for the reform on which he had staked the first two year’s of his presidency, under his wife’s direction, would discredit the President’s domestic agenda. And so he both actively coordinated opposition to the Clinton plan and blocked any attempts at legislative compromise that might have resulted in even modest reforms.

On the Senate side, Bob Dole, who was planning to run for President in 1996, took a different tack. He effectively lampooned the complicated nature of the Clinton plan, highlighting a comically complex flow-chart that portrayed the managed competition proposal. Meanwhile, he introduced an alternative proposal that took some steps towards making it easier for individuals to purchase coverage. Dole’s proposal would have had little impact on anything, coverage or cost (it too ran to more than 600 pages!), but it allowed him to say that he too was concerned about the problem and had a better solution.

It’s the Solution that’s the Problem: To understand how debates about health care reform are turned on their head when they move from “problem” to “solution”, let me start with an example from New York. We began organizing to expand coverage in 1986, holding regular press events and public activities, but the first time we ever got any negative press is when we held a big lobby day for New York Health, our single-payer bill, in 1992. A surprisingly enterprising television reporter interviewed a local plumbing company and found that the New York Health legislation would increase the cost of coverage for that small business.²

What is fundamentally true about our nation’s health care system is that it works for most people, most of the time. Five out of six people under the age of 65 – and virtually all seniors - have health coverage. Most people believe they get good care from their doctor. Almost everyone knows a family member or close friend whose life has been saved by treatments delivered in a hospital or by other medical miracles. Even people who aren’t insured usually get some care.

The reason the Clinton message mavens called their plan the Health Security Act is that people were most scared of *losing* coverage, which means people place a high value on what they *have*. Yes it costs too much, but people pay these costs because they place a high value on access to health care.

So on the most fundamental level – before you get to the narrow self-interest of the insurance companies or health care providers or employers – change is potentially much more threatening than the status quo.

The Harry and Louise ads directly exploited the fear of change, of losing what people have. If the ads had challenged the premise that there was a health crisis, they would have been ineffective. Instead, the ads agreed that there was a problem while criticizing the

² We had anticipated the importance of this issue. The New York Health bill set the employer payroll contribution for New York Health at a rate well lower than the average business paid for coverage. Our campaign circulated forms that allowed businesses and local governments to calculate their payroll savings. But it still didn’t take much for the reporter to find a company that would see some increase in costs.

proposal – it would take away the choice of doctor and ration care, and God knows what else. There *must* be a better way.

The Clinton proposal exacerbated this problem by proposing a system that was deliberately unfamiliar. With their desire to be new Democrats with a new idea – managed competition – the Clintons rejected the two competing familiar ideas: pay or play and Medicare for all. While either one would have had its own set of significant problems, the virtue of either one would have been familiarity to both the public and health care industry. Pay or play could have been portrayed as building on the employer-based system that worked for most employed Americans. Medicare for all could have been sold as expanding the system that was already popular with tens of millions of seniors by offering it to their families. Either proposal would have been reform that was familiar, which is incredibly important once the focus switches from what’s wrong to what may be lost in trying to fix what’s wrong. Faced with the actuality of reform – not just the vision – the exotic quickly becomes suspect.

Layered on top of this bedrock problem is the fact that reforming an extraordinarily complex system really does mean a lot of change, a lot of uncertainty and a lot of winners and losers. Hillary Clinton and Magaziner went to enormous and understandable lengths to design a solution that met the objections of just about every organized interest in health care. Their plan had features aimed at reassuring organized consumer groups, doctors, nurses, other health professions, hospitals, clinics medical equipment providers, union health and welfare funds, businesses large and small, and even insurers. John Dingell, after listening to the complaints of many of these interests – not just small business – came up with a host of clever solutions that met many of their stated objections.

What did this buy? Not only wasn’t it enough to placate the insurance industry or business community, it also it didn’t buy *aggressive, organized support from the many other interests*. Consider the medical profession. The AMA killed national health care under Roosevelt and Truman and almost stopped Medicare. The AMA did not ardently oppose the Clinton plan and some medical specialty groups actually supported it. But the AMA didn’t put its considerable grassroots clout behind the plan either. Neither did hospitals, which can be incredibly effective lobbyists. And very few

labor unions mobilized for the plan. For these groups, concerns about how the details would affect their self-interest outweighed support for universal coverage. Most groups that represent health care providers offered general support for the proposal but pressed some specific objections on details key to their interest. They nit-picked. What most members of Congress heard from these groups was a drone of mind-numbing, technical nit-picks.

The solution stage of the debate split our side too, creating bitter divisions between hard-core single-payer advocates and Citizen Action and the handful of other groups and unions that aggressively fought for reform. Single-payer advocates around the nation felt betrayed by Citizen Action, accusing us of supporting the Clinton plan. Actually, Citizen Action never endorsed the Clinton plan, choosing instead to do our own version of nit-picking, pointing out changes that would bring the plan closer to our goals. But what the single-payer die-hards had right is that Citizen Action and its allies made the strategic decision to focus on attacking those who were trying to kill reform. What did distinguish us from the rest of the nit-pickers is that we didn’t just nit-pick. We put everything we could into going after those in Congress who were siding with Harry and Louise.

I am as passionate about this as those who attacked us. I remember talking, in 1991, with a top aide to Governor Cuomo who had been very active in the previous national health care debate, the Nixon-Kennedy stand off. He regretted his insistence at the time on the Kennedy proposal and the failure of both sides to find a compromise. He shared with me his belief that the new effort would be dashed on the same rocky shore.

I vowed to myself that I wasn’t going to be complicit in that and I wasn’t alone. What I remain very proud of is that we at Citizen Action, and those who joined us, understood that the enemy wasn’t a Clinton administration that was struggling – that had staked its political success on – finding a solution to one of the most intractable problems in our nation’s social structure. In his 1994 State of the Union speech, the President said he would veto any plan that didn’t cover every American. The enemy was, in this legislative battle, those members of Congress of both parties that were trying to deny

the President the opportunity to sign a health care bill that met his broad test.

Where the Clinton administration did err was in its failure to aggressively attack its enemies and rally the public to its cause. Hillary Clinton tried, once. She gave a speech to a diverse group of health care providers early in 1994 in which she went after the insurance industry, in what should have been the first step in an assault on industry opponents by the White House. But instead, it was Hillary Clinton who was fought by the White House. The First Lady's speech prompted harsh criticism from business "allies" and corporate Democrats and she was forced to beat a fast retreat.

Unfortunately, the White House never mounted a counter-attack on Harry and Louise. The President should have used his fund-raising prowess to have the Democratic Party run hard-hitting campaign-style ads to put the insurance industry on the defensive for putting profits ahead of health care and denying health security to American families. The White House instead chose to employ a field strategy, working with allies to build grassroots, coalition-based support for the President's plan. But in a battle of this dimension the field could have succeeded only if the White House had engaged its biggest weapons – the President and First Lady – supported by spending tens of millions of dollars on paid media to define the debate on its terms. Doing so would have forced President Clinton to lead an anti-corporate, populist charge anathema to his DLC identity and campaign contributors. As Hillary found out, that was not acceptable politics for her husband's administration.

Of course, these aggressive politics were possible for us in Citizen Action, and the coalition allies who remained with us in the fight. And fight we did, although the divide within our ranks and the growing disaster in Congress made it a difficult struggle. Our campaign included a message and tactics aimed squarely at Congressional opponents.

The message we came up with was, as the poster still hanging on my office wall today reads, "Health care coverage as good as Congress has. Nothing less!" This was both a principled test, since every member of Congress has a full package of health benefits, and a focus on whether Congress would deliver. But it proved to be too populist a message for members of Congress to use... until they got

desperate at the end. In the closing weeks of the Congressional debate that message is what the Congressional supporters of the Clinton plan were saying, over and over again. It was the only thing they found that had any resonance with the public, but it was too late.

Our actions were aimed at the Democrats in the House and Senate who were preventing the Party from moving forward with their President's program and at leading Republican opponents. We ran hard-hitting radio ads aimed at moderate Republicans who were sticking with Gingrich in opposing reform. We released reports tying campaign contributions from the health care industry to the policy positions held by members of Congress on reform. We collected more postcards, this time aimed at opponents of reform.

We targeted campaigns at leaders of the opposition, including Democrats in this Democratic controlled Congress. We met with Rep. Jim Cooper, the Democratic champion of the insurance industry plan (and the leading Democratic collector of insurance industry campaign cash) in his Capitol Hill office, and invited CNN and the Wall Street Journal. (Cooper told us that the problem was that consumers used too much health care, at which point the Director of New Jersey Citizen Action, a cancer survivor, took off her wig).

In New York we took aim at Senator Daniel Patrick Moynihan, who chaired the key Senate Finance Committee. Early on, Moynihan had famously stated that there was no health care crisis; he was widely expected to propose a solution in his committee that started far short of universal coverage. We initiated a series of escalating actions that culminated in a large, all-day rally in the Senator's small, Catskill Mountain hometown. After the rally the Senator agreed to meet with us, venting his anger, but then surprised Washington insiders by presenting his committee with a bill that largely met our core demands, only to quickly abandon them.

By June of 1994 it was pretty clear that we had lost but we decided not to go down without a fight. We planned a series of raucous Capital rallies and civil disobedience. We marched through the Hart Senate Office building, chanting and handing out "Dole Dollars," dollar bills with the names and faces of senators of both parties who opposed reforms and the list of their health industry campaign contributions on the back. We stormed into their offices, leaving only when the Capitol police insisted. And then we didn't

leave, with more than a hundred people being arrested first in Bob Dole's Capitol office and then in Jim Cooper's House office and Connecticut Senator Joseph Lieberman's senate office.

But there weren't nearly enough of us to transform the debate; we were a sliver of the movement that was needed. The final demonstration of how weak we had become was an ill-fated national bus ride of un-and-underinsured Americans, organized by Families USA and the Democrat's grassroots operation, during which the right-wing organized hecklers were more visible than the riders and their supporters.

And in November, Gingrich was proven correct, as Republicans picked up 52 seats in the House and won control of that body, and both houses of Congress, for the first time in 50 years.

Hopes and Fears

Until recently, the conventional wisdom in Washington was that the only possible reforms, post-Clinton, are incremental. The Clinton administration did succeed in enacting the State Child Health Insurance Program, which provides substantial federal funding for states that agree to spend some of their own money covering children. Every state in the country enacted SCHIP and 4.3 million kids had coverage by 2002. Another step was taken in the welfare reform law of 1996, which included a provision that provides federal matching funds under Medicaid for states to cover adults whose incomes are above the poverty level. Several states have utilized this option, although many of these expansions are becoming some of the first casualties of the current state fiscal crises.

But even with these programs, the number of uninsured rose through most of the 1990s, despite the longest period of sustained economic expansion in our nation's history. By 2001, health care inflation was once again rampant, as the dampening impact of managed care had been exhausted.

The resurgence of health care inflation and the prospect of a growing number of uninsured during a recession, led one observer to write, in 2001, that a 'perfect storm' was happening in health care and that the prospects for reform were once again bright. This

metaphor made the rounds among pundits and players, many of whom joined together in The Robert Wood Johnson Foundation's project to bring together "strange bed-fellows" to support the idea of covering the uninsured. But the circumstances cited by the originator of the perfect storm metaphor – rising costs and uninsured – are no different from those of 1990 and don't, by themselves, portend a better outcome.

I would have expected supporters of the perfect storm analogy to point to some positive changes in the political economy of health care since 1994 as reason to think that change was possible. In my view, there are two such developments, both deriving from the experiment with managed care. First, managed care has shown employers the enormous difficulty of trying to impose rationality on the health care system. Large employers imagined that by becoming more informed purchasers, with sophisticated quality measurements, they could bring a great deal more value to their health care purchases. They also thought that by charging employees more for health plans with more freedom to choose doctors, they would control costs. But these employers found that measuring health quality, and applying it to purchasing, is very difficult. They also found that employees get angry when they lose their choice of physician or face restrictions on access to care imposed by insurance company bureaucrats. As a result, large employers seem less enthusiastic about retaining their role as health benefit managers than they did a decade ago, and are now more open to giving employees a fixed amount of money with which to purchase health coverage, rather than serving as the purchaser themselves. Unions too are starting to view their health funds more as a burden than a benefit. This means that two groups that wanted to preserve the employer system in 1994 are less inclined to do now.

The other positive political impact on the prospects for reform that has resulted of managed care is the growing alienation of the provider community and, in particular, many physicians. Doctors who had worried about government bureaucrats second-guessing their medical decisions and limiting their income found themselves living that reality under a myriad of private health plans. Physicians now have to face the difficult decision of which plans to join, what discounts to accept and even – with capitation and other payment schemes – how to ration health care to increase their incomes. After

living with the reality of managed care, a government option doesn't look as bad. This increased provider support for a national health insurance system was demonstrated just this winter when Rep. John Conyers of Michigan introduced a "Medicare for All" bill with the endorsement of several prominent physicians.

Before we get carried away with these hopeful signs, however, let's read the AMA President's view of the health care crisis. In his version of the perfect storm metaphor, delivered in a speech in of March 2002, Dr. Richard Corlin reminded us what's at stake: "But as we address this issue [covering the uninsured] we need to remember that much of our health care delivery system functions pretty well – and that we shouldn't throw the baby out with the bath water in seeking solutions. Most attempts to get coverage to those without have failed because they try to replace everything – everything – in our system with experiments and theories. And of course this discourages the support of the majority for whom the system does work."

Dr. Corlin then goes on to describe the AMA's preferred remedy that "depends on the private sector to do its part." Unfortunately his solutions – defined contribution accounts, tax credits and medical savings accounts – would do little to solve either of the problems he identifies, coverage and cost.

The hard truth is, there aren't any piecemeal solutions that would really solve the big problems with health care coverage and cost. The best analogy for health care is not a perfect storm but a bursting balloon. Push in one spot on the balloon and out it will pop in another place. Absent a way to control the system, health care costs will always shift someplace else. Costs can't be controlled in one sector without controlling other sectors. One can't provide incentives for coverage without requiring coverage because adverse selection – the sickest people will be the ones most likely to purchase coverage – will undermine the financial foundation of the expansion.

The flip side of this truism is that since incremental reforms ultimately can't solve the underlying problems, they can temporarily turn down the heat but they can't douse the fire. Of course, some incremental changes are much bigger than others are. There is an enormous difference between the establishment of Medicare – an increment that is a major building block for a comprehensive health

care system – and medical savings accounts, a proposal that lowers the cost of coverage for a handful of wealthy and/or temporarily healthy individuals, while shifting costs to others.

The Solution Remains the Problem

In his State of the Union speech this past January, President Bush embraced our goal using the exact words we have repeated over and over again, (in italics): "Our second goal is *high quality, affordable health care for all* Americans. The American system of medicine is a model of skill and innovation, with a pace of discovery that is adding good years to our lives. Yet for many people, medical care costs too much – and many have no coverage at all."

In his next sentence, the President then laid down the gauntlet: "These problems will not be solved with a nationalized health care system that dictates coverage and rations care."

The prominent progressive Democratic pollster, Celinda Lake, observed recently that Republicans have learned to stop debating the ends, preferring to fight about the means. It used to be that Republicans were opposed to social programs, against public education and health care. But, under Bush, they are no longer conceding that turf to the Democrats.

During the last two elections, Democratic Congressional candidates started with a big advantage amongst the electorate on the issue of Medicare prescription drugs. But Republicans were savvy; they too campaigned as supporters of Medicare drug coverage. The Republican candidates' heavy campaign spending touting their prescription drug proposals were bolstered by tens of millions of dollars of advertising paid for by the drug industry using senior citizen front groups. By Election Day, in both 2000 and 2002, most of the Democratic advantage had been swept away.

The political consensus on the goal of providing a drug benefit as part of Medicare has not made it any easier to come up with a means that both parties agree on in Congress. Republicans want to provide coverage through private insurance companies while most Democrats want to run the program through Medicare directly. But since even most Democrats won't propose meaningful price controls, that party is divided between those who are willing to spend a lot to

provide an attractive benefit and those who are more worried about too much government spending.

Even Republicans are having trouble agreeing on a solution. Both Speaker of the House Hastert and Senate Finance Committee Chair Grassley have told the Bush administration that a proposal to force seniors into insurance company plans to get prescription drug coverage is a non-starter.

Ideology Matters. If the battle is to be fought over means rather than ends, about which proposals to enact rather than about whether reform is needed, then both the right and left start with advantages. For the left, our advantage is that our proposals are actually better for most people: benefits are more comprehensive; out-of-pocket costs are lower; there are fewer restrictions on access. But convincing people of these advantages is not easy; it's hard enough for organizers, let alone the average citizen, to follow the distinctions between out-of-pocket costs in one plan or another, or to grasp the relationship between a the size of a tax credit – which sure sounds good – and the cost of an insurance policy. Given the amount of attention that people – and more specifically voters – are able to pay to these differences, we can not expect that individual self-interest will be clear.

The right's advantage is on ideology; their solutions are driven by the dominant view of how wealth is created in our society and framed with a story that people readily grasp. No matter what the question – and for that matter the subject – the right has the same solution: private markets. For education it's vouchers, for Social Security it's private accounts, for the environment, it's trading in pollution "rights." For health care, it's organizing the system through private insurance plans, giving people a choice among plans (as opposed to a choice of health providers) and relying on the market to control prices.

I call this market theology because it is based on the belief that the market is always good. In fact, the corporate right has even seen to it that the religious right preaches that God has ordained market solutions, while government programs are evil; charity given by individuals and the church is good but support given by the community through government violates God's wishes.

Market theology is the closest thing we have to a state established religion in the United States, rooted in the history and myths of our economic and territorial expansion. And in the past 30 years – in response to Goldwater's defeat, the Great Society and the counter-culture revolution of the 1960's – the right organized to reaffirm the preeminence of smaller government and private solutions to public problems. While just about everyone in this country can tell the right's story about how wealth is created and the role of government, the left's story is hazy, confused and out of focus.

The left has not had organizers, think-tanks or political leaders telling a clear, consistent story of our view about how to organize the political economy. We've relied on a litany of programs that benefit people – notably Social Security and Medicare – but people don't understand how those programs reflect our values or understanding of what makes a successful society. When the right embraces our values – health care for all, retirement security – they are able to base their solutions on a more powerful story about how to achieve those ends.

On the other hand, many people haven't got a clue to the basics of our story. No American captured this better than the senior citizen from Louisiana who told US Senator John Breaux, during the Clinton push for national health care, "Whatever you do, keep the government out of my Medicare."

Let's turn back to President Bush's State of the Union address. Two sentences after the President trashes "nationalized health care" he says: "Health care reform must begin with Medicare; Medicare is the binding commitment of a caring society." But of course Medicare *is* our nationalized health care system for seniors and people with disabilities. But do we on the left ever say that? Imagine how different the American view of national health care might be if every time we organized around Medicare, and every time that Democratic political leaders spoke about Medicare, we called it our national health care program for seniors.

To take another example, government price controls (a solution used by the Nixon administration!) are now considered off of the political agenda; price controls are a solution that doesn't fit into today's dominant, market-defined story. Not only do Republicans

rail against them, Democrats are afraid to talk about them. What are price controls? Simply the use of government power to lower prices. Who gets the lowest drug prices in America? The Veterans Administration, which uses its vast purchasing power to force drug companies to sell drugs at a lower price. So is the VA un-American?

Last year the President of the Pharmaceutical Research and Manufacturers of America (PhRMA) told his own members, as reported in the *New York Times*, that the public supports price controls for prescription drugs. Democratic pollsters told Congressional Democrats the same thing. And a member of Congress from Chicago won the Democratic primary for Governor of Illinois (and the election) by attacking insurance company “price gouging.” Americans are outraged when they learn that American drug companies sell drugs made in this country at half the price in Canada. Still Democrats in Congress are too scared to propose Medicare price controls on prescription drugs. Ideology matters.

We cannot win our version of health care reform in a political culture in which people cannot envision how government can make their lives better. We can’t win if the right is successful in destroying the tax base and shrinking government to so small a size that it can be drowned in a bathtub, in Grover Norquist’s infamous phrase. Which means we can only win if we do two things: extend the struggle beyond the fight for health care to other key issues and link the various issue campaigns to a common story about what makes society work for American families.

In practical terms that means that those of us who are driven by the inequities of our current health system, and entranced by a vision of health care justice, must also become engaged in the struggle for a fair tax system, the battle against privatizing social security, the fight for public education. I’m not saying to put aside work on health care to organize solely on those other issues. I am saying we need to link health care to those other issues, articulating common themes and goals and helping people understand a common view of the world. And yes, pitch in on other issues when opportunities arise.

It also means that in our health care organizing we must deliberately make the connections between the immediate issues at hand and our story about the kind of reforms that really work for

American families. Remember, if we are no longer arguing about ends we have got to start arguing effectively about means.

These next two years will see a major Congressional struggle about how to “strengthen and improve” – in the words of one Bush administration official – Medicare. Let’s start reminding people that Medicare is our national health care system for seniors and people with disabilities. We must explain that Medicare works because the government makes sure that everyone is in it, that everyone gets the same benefits and the government holds down costs. When we remind people of the failures of Medicare HMOs, we have to go beyond pointing out that hundreds of thousands of seniors have been dropped by those plans. We need to explain that, “the reason that hundreds of thousands of seniors have been dropped by HMOs is because private insurance companies will always put profit before people’s health, unlike Medicare, our national health care program for seniors.”

Or let’s take another example. The Bush administration will push tax credits as its way of expanding coverage to the uninsured. Until now, our main public argument has been that the tax credits aren’t big enough to purchase a policy. But that traditional, consumer self-interest argument doesn’t wash with most people. After all, it’s still a tax credit and it’s got to help *some*. Instead, we need to argue that you can’t trust a for-profit insurance company because if you get sick, they’ll just jack up the premiums or drop you to protect their profits. Wouldn’t it be better to have Medicare, a national insurance system in which the government guarantees coverage, at an affordable price, no matter how sick you are?

One way people sort out arguments about what someone stands for, i.e. about ideology, is by understanding whose side that person is on. We clarify what we stand for by making it clear who’s not on our side. People like their doctor but hate insurance companies; we need to make it clear – as in the examples above – that insurance companies are on the other side. People have mixed feelings about drug companies, but they understand about drug company price gouging. We can discredit proposals based on privatization by linking those proposals to their industry proponents.

We also need to understand people’s ambivalence about government. We can’t rehabilitate the role of government if we don’t

make it clear that we want a government that is accountable to us and not insurance companies and drug companies. It also helps for us to remind people of the role of campaign contributions in the health care – and other debates – and to support public financing of campaigns.

And we need to stick with our message. A great deal of what the Bush administration is pushing now was far to the right of the accepted political debate 20 years ago. If we are driven by what message polls best now, and by current political wisdom, we will both continue to be on the defensive and never put ourselves in a position to be on the offensive, to set the terms of debate. (This doesn't mean that we have to take unpopular positions; it does mean we have to frame our positions in terms of our larger story).

Understanding our long-term goals and values can also help us determine what we work on now. The most immediate battle is protecting Medicare from being privatized. As part of this struggle we must aggressively oppose a Medicare prescription drug benefit that is provided by private insurance companies. We must also vigorously take on the Bush administration's plans to rid the federal government of much of the obligation for Medicaid. Under current law, the federal government shares the burden of paying for the health care needs of poor families, including the long-term care costs of low-income seniors and people with disabilities, with state governments. The Bush administration proposes to limit federal cost-sharing, leaving it to state governments to ration care among the poor.

Understanding that the battle is over how to reform the system, and not whether, also points out the limitation of organizing strategies that focus on the problem. The most notable is the multi-year effort sponsored by The Robert Wood Johnson Foundation which brings together groups whose solutions run the entire gamut, from the Health Insurance Association of America to the single-payer supporting American Nurses Association. I liked seeing their *New York Times* ads reminding us that there are uninsured people and activities like covering the uninsured week do generate a burst of such publicity. But when the rules of engagement are that solutions can't even be discussed, the result is an effort in self-congratulations.

There's no harm in reminding people there's a problem, but we shouldn't pretend that such activity moves us any closer to reform.

A Solution to the Problem?

The paradox of reform, I have argued here, is that no matter how much demand there is for change, it is impossible to find a consensus on how to implement all but very incremental reforms. Major reforms gore the ox of too many institutional interests in the health care industry, run up against strong ideological currents in American society, ultimately scaring people more about what they might lose than what they might gain.

If we are to find an answer to this riddle, it must be based on the familiar, on reforms that respect as much of the status quo as possible, while achieving some basic goals. For me, the basic goals are to: first, to provide coverage for everyone, both because that is just and because it is the foundation for controlling costs throughout the system; and two, to achieve universal coverage in such a way that allows the system to continue to evolve towards greater equity and more effective cost controls.

So here's my proposal, in a nutshell: provide everyone in the country with the option, and the means of paying for, coverage through Medicare or through private insurance. Such a proposal: achieves the two core goals outlined above; is built on two familiar systems; allows institutional forces to protect, and even expand, what they have now; and provides room for both sides of the ideological divide. Here's how such a proposal might be implemented:

- ◆ Require all employers to either purchase a private insurance policy for their employees or pay into the Medicare system, which would be expanded to include people of all ages. Mandate a basic benefit package for both the private and public system, which is equivalent to a good private insurance plan now (medical; hospital; mental health; prescription drugs; preventive services; limits on out-of-pocket costs). The cost to employees, regardless of which system their employer

chooses, would be set as a percentage of pay. Employers who chose the private system would pay the difference between the private insurance premium and their employees' payments. Employers who chose Medicare would pay a percentage of payroll. (The proposal would also include basic insurance regulation: patients' bill of rights and protections against discriminating against the sick).

- ◆ The unemployed and self-employed would pay a percentage of their income for the same package of health benefits as provided in the employer-based system, and would also choose either to receive coverage through Medicare or through a private insurance plan purchased by the federal government. The poor would not have to pay any portion of the premium. This would include families that now receive coverage through Medicaid or SCHIP.
- ◆ With the unemployed and self-employed in the federal system, states would save a lot of money on Medicaid. However, states would be responsible for paying out-of-pocket costs for low-income people and for extra benefits, such as dental and special needs for people with disabilities, specified by the federal government.³
- ◆ Make the Medicare benefit for current beneficiaries the same as that offered to employees. Allow seniors and the disabled the choice of Medicare or a private plan.

Such a system would provide all Americans with comprehensive coverage based on the ability to pay, and would establish a national health insurance for Americans of all ages and incomes, while providing financing for private insurance plans to compete with the national health insurance program. It would be sold as providing all

³ I'm punting on the question of whether the states should continue to pay a portion of long-term care costs, which would be made easier after the federal government picks up much of the cost of acute care, or whether this too should become a federal responsibility.

Americans a choice of two approaches that works now, assuring that all Americans have affordable access to the best of the American health care system.

Of course, this also may be too much change for the system. The biggest obstacle to passage of such a proposal is the requirement that all employers pay into the system, which will be vigorously opposed by the small business lobby and by significant sectors of big business. There's no way around this, short of a dramatic restructuring of the tax system that would require a much higher income tax or a some other new tax source to pay for health care. As a policy matter that would be fine, but it is too much change at once for our political system and would hopelessly complicate the struggle. On the other-hand, by limiting employers' obligations to a proportion of payroll, the cost of health coverage to employers— and in particular to small, low-wage employers – would be much less under the proposal above than that is available now from private insurance. Ultimately, this would be a political test of whether the leadership is able to organize enough political support for the program, including the support of enough small business people who would stand to gain significant savings under such a program.

Perhaps the proposal I've made doesn't have the allure of a grand new idea, but that's in fact the point. It's designed to be familiar, not threatening, a compromise which allows all the current players to keep playing. Because it is familiar, it could be easily explained to the public: every American will be able to choose affordable health coverage from a private insurance plan or from Medicare.

Some readers may be surprised and disappointed that I have not proposed we fight for Medicare for All, that is, a dressed up single-payer plan. Why would I argue – I imagine them saying – so strenuously for the importance of defending Medicare and of reframing the ideological debate in terms of progressive values, only to abandon the single-payer ideal? Don't I understand that private insurance will always look for an advantage, will cherry-pick the wealthy and healthy, will force the Medicare system into a kind of lemon-socialism?

The reason I argue for bolstering Medicare, and resurrecting the positive role of government in achieving social goals, is that I don't

think we can even win the expanded role that I propose for Medicare without reframing the debate about health care and the role of government. What may seem like a half-solution to some seems like a long reach to me now. As to the second point, that private insurance will always have an unfair advantage, I have faith in the ability of a national health insurance system, that covers a significant portion of the population of all ages – with its administrative savings and market clout – to compete quite well against for-profit insurers that will always squeeze care and abandon people to make a buck.

I'm not wedded to this proposal. I'll take any proposal that can achieve the core goals I outlined above and become the law of the land. From my reading of history, that's a pretty tall order.

The heart of the matter is that I want to believe that we can write a different ending to my old friend's story, that we will see national health care in our lifetime. My favorite quote as an organizer is from Antonio Gramsci: "Pessimism of the mind, optimism of the will." The foundation for my optimism must be rooted not in wishful thinking about what kind of country and political tradition I wish we had. My hope springs instead from the belief that if we build out of the best of our national history we can write a new, brighter chapter.