TESTIMONY BEFORE THE COMMITTEE ON THE BUDGET
UNITED STATES SENATE
11 SEPTEMBER 2007

by

Henry J. Aaron
Bruce and Virginia MacLaury Senior Fellow
The Brookings Institution[1]

America faces three equally important health care problems:

- needlessly high health care spending that is growing at unsustainably rapid rates;
- seriously sub-optimal quality of care; and
- large and growing numbers of people with inadequate insurance or none at all.

None of these problems is new. All have intensified in recent years.

Ideologically diverse proposals to deal with these problems have been on the table for years—in some cases for decades. These proposals fall broadly into three categories: conservative (mostly linked to tax incentives), liberal (mostly involving employer mandates or single-payer administration), and incremental (mostly involving extension of current programs and reinsurance).

- Each commands solid, but minority, support in Congress and among analysts. (Unfortunately, as Stuart Altman has remarked, the *status quo* seems to be everyone's second choice.)
- Each would boost *federal* spending in the short run. Some would do so in the long run as well, even if they lower *total* health care spending.
- Each holds the realistic promise over the long haul, *but only if implemented without slavish adherence to ideology*, to ameliorate all three problems—that is, to lower *total* (but probably not *federal*) health care spending, extend insurance coverage, and help boost quality of care.
- Achievement of significantly improved quality is possible under all three strategies for reforming health care payments. But extensive additional

---

[1] The views expressed here are my own and do not necessarily reflect those of the trustees, officers, or other staff of the Brookings Institution.

action by government, health care providers, and patients is necessary to realize the quality potential of modern health care.

- None of the three strategies for payment reform currently commands sufficient support in Congress to win approval both in the House of Representatives and the Senate, where overcoming a filibuster would probably be necessary. None is likely to achieve the requisite support in the foreseeable future.

Meanwhile, state governors and legislators have been proposing and, in many cases, implementing numerous and diverse proposals to deal with all three problems, especially insurance coverage. The willingness of states to move ahead creates an opportunity to break the decades-long deadlock on reform of health care financing. Massachusetts and several other states have already implemented such reforms. If other states—most notably, California—move ahead with such measures, the environment for national action will become far more favorable than it is today. Strong bi-partisan Congressional support now exists to encourage these state efforts. This support is contingent on assurances that various states will try ideologically diverse approaches to see which ones work best. I urge this Committee to support such state initiatives as the best opportunity for making progress in solving the three health care problems I just described.

I. THE THREE PROBLEMS

If you are a business executive, labor leader, or a budget analyst (including, I suspect, most members of this committee), the most pressing problem is the relentless increase the cost of financing health care.

- Business leaders bewail the large but unpredictable increase in the cost of a major element of labor compensation. They are persuaded that the increase in health care expenses hampers their ability to compete internationally.[2]

- Labor leaders find themselves embroiled in an endless rear-guard action to prevent erosion of one of organized labor's most prized achievements—collectively-bargained, comprehensive health insurance coverage.

---

[2] Economists almost unanimously disagree. They hold that the rising cost of health care for active workers comes at the expense of other elements of labor compensation and, so, has virtually no effect on product prices or competitiveness. So-called 'legacy' costs for unfunded health and pension benefits promised to retirees should be regarded as a charge against the balance sheet that reduces shareholder equity. Recent mandated changes in accounting rules embody this understanding. These legacy costs can, in extreme cases, affect companies' access to credit markets and may have some effect on competitiveness.

- And budget analysts increasingly recognize that rising health care spending is the sole source of projected federal budget deficits.[3]

The problem of rising costs is intensifying for a simple arithmetic reason. Real health care spending has been rising by about 2.7 percentage points a year more than income since about 1960. Because health care spending represents a progressively larger share of income, this excess growth takes an increasingly large bite out of income.

For many health policy analysts, the most pressing problem confronting the U.S. health care system is its failure routinely to deliver high-quality health care. An exhaustive study showed that half of all patients do not receive recommended care.[4] The Institute of Medicine finds that tens of thousands of people die annually because of needless medical error.[5] The United States lags embarrassingly and inexcusably in the adoption of electronic medical records that preserve patient confidentiality but are available to caregivers. The failure of U.S. physicians to recognize that provision of high-quality care has become a team sport, not a solo activity, exposes U.S. patients to needless risks and many to less-than-optimal care.[6] The failure to use efficiently the roughly $2.3 trillion that will be spent this year on health care is a massive lost opportunity for all Americans, including especially the insured 85 percent who think—perhaps erroneously—that they are getting the best care in the world.

The problem of sub-par quality is increasingly serious for a paradoxical reason—today's health care, at its best, can do far more than could yesterday's treatments. The staggering advances in bio-medical science mean that when providers fail now to deliver what health care has to offer, patients lose far more than they did in the past.

---

[3] Henry J. Aaron, "Budget Crisis, Entitlement Crisis, Health Care Financing Problem—Which is It?," *Health Affairs,* vol. 26, no. 6, November/December 2007, pp. 1-12; Peter Orszag, "Health Care and the Budget: Issues and Challenges for Reform," Testimony before the Committee on the Budget, U.S. Senate, June 21 , 2007.

[4] Elizabeth A. McGlynn et al., "The Quality of Health Care Delivered to Adults in the United States," *New England Journal of Medicine*, 348 (26), June 26, 2003, pp. 2635-45.

[5] Institute of Medicine, *To Err Is Human: Building a Safer Health System*, Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, eds. Washington, D.C., National Academy Press, 1999; *Crossing the Quality Chasm: A New Health System for the 21st Century*, Washington, D.C., National Academy Press, 2001.

[6] Thomas H. Lee and James J. Mongan, *Are Healthcare's Problems Incurable? One Integrated Delivery System's Program for Transforming Its Care,* The Brookings Institution, Health Policy Issues and Options, December 2006.

And if you are an American who takes pride in your nation's values, you should share the national shame that 47 million of your fellow citizens lack insurance coverage. To be sure, not all of the uninsured lack financial access to care—some can pay for the cost of treating most illnesses themselves. To be sure, some of the uninsured are eligible for coverage under Medicaid or other programs in which they neglect to enroll. To be sure, most of the uninsured will regain coverage before too very long. But, as well, far more than 47 million risk losing coverage if they become unemployed or change jobs or if some new federal regulation forces their state to curtail coverage of the poor.

We analysts can have a fine intellectual scrum over exactly what number best describes how many Americans face the risk of being financially unprotected when ill. Is it 47 million? More? Less? I do not denigrate the importance of that debate. But I defy anyone to try to explain to a Frenchman, a Canadian, a German, a Swede, or a Brit our failure to insure everyone without experiencing the "you Americans just don't get it" incredulity about how we can be so backward in this regard. Regardless of what others may think, we all fail our fellow Americans when we allow tens of millions—and more of them every year—to face the risk of illnesses they cannot afford to treat.

I do not think that this committee needs reminding of the importance of these three problems. You are all aware of them. But it is vital to keep in mind that they are linked, that it is impossible to solve one without solving the others.

II. THE THREE REFORM STRATEGIES[7]

Dozens of plans to reform the U.S. health care system have been put forward in recent decades. Though superficially dissimilar, all fall into one of three broad categories distinguished by the political ideology that they embody—conservative, incrementalist, and liberal. Like most people, I have my preference on what is the best strategy. So, I am confident, do you. But my purpose today is less to argue for or against any of them than it is to suggest that

- each holds out the promise of significant progress in dealing with some or all of the three problems I have described, *provided that it is implemented in a non-doctrinaire way*;

- each has the potential to aggravate these problems if implemented in an ideologically rigid manner; and

---

[7] This section of my testimony draws heavily from, but extends and modifies, Henry J. Aaron and Joseph P. Newhouse, "Meeting the Dilemma of Health Care Access; Extending Insurance Coverage while Controlling Costs," *Opportunity 08: Independent Ideas for America's Next President,* Michael O'Hanlon, editor, Brookings, *forthcoming in 2007.*

- none has a prayer of being enacted in the foreseeable future.

High-Deductible Insurance

President Bush has sought to establish high-deductible health insurance as the norm for health insurance. In so doing, he has been advancing an approach long espoused by political conservatives as the most promising way to extend coverage and to control spending.

Under this approach, patients must pay directly for health care spending up to a dollar limit higher than most current insurance plans require. Beyond that limit, insurance would cover all or nearly all costs of care. Tax incentives would encourage most people to save in special health savings accounts (HSAs) to pay for most outlays below the deductible. The government would subsidize HSA deposits for low-income households. Unused balances would eventually be available for general consumption or for bequests.

Because savings would potentially be usable for purposes other than health care, advocates claim that account holders would have increased incentives to spend these dollars more carefully than they do when insurance lets them spend "other peoples' dollars." As a result, it is argued, growth of health care spending would slow. Health insurance would become more affordable than it now is. The trend toward narrowing of insurance coverage would be slowed or reversed.

The effect of such plans on spending is more complex than this simple argument suggests. Large deductibles do greatly reduce spending, compared to first-dollar coverage—perhaps by as much as 30 percent. But few people still have first-dollar coverage. So, potential savings from increased deductibles are much smaller than 30 percent. Furthermore, high-deductible insurance would raise spending by some people, notably those currently uninsured who would buy insurance because of tax incentives or reduced premiums for high-deductible insurance. The bottom line is that net savings are hard to gauge.

This approach has the potential to reduce the number of uninsured and help slow the growth of spending. Realizing that potential, however, depends on policies that comport uneasily with views commonly espoused by those who embrace market approaches to social policy. Sizeable subsidies for low-income households and aggressive regulation of insurance markets are both essential to ensure that reasonably priced plans are available to high-risk families and that low-income families can afford coverage.

Many conservatives regard aggressive regulation as antithetical to unfettered markets.[8] And they are surely right. But private insurance companies cannot be expected willingly to sell coverage for less than anticipated costs. Accordingly, regulation to assure the availability of affordable insurance is inescapable if the goal of ensuring fair access to insurance is to be realized.[9]

Furthermore, unless subsidies to low-income households shield them from nearly all out-of-pocket risk, many will not willingly buy insurance (if they must pay much of premium cost) or use ostensibly covered services (if they are exposed to significant deductibles). An individual mandate, as in Massachusetts, would be necessary to assure full coverage. But many conservatives deplore such an abridgement of individual choice.

Finally, recent research has shown that in some cases, the cost-minimizing strategy is to subsidize patients to follow recommended health care regimens, rather than to impose any cost sharing at all.[10] This finding refutes the idea that for all services, patients must have 'skin in the game' to minimize cost.

What this all means is that if the high-deductible/HSA approach to extending coverage and lowering costs is to work fairly and efficiently, it cannot be applied in a simple or ideologically pure way. Advocates must accept rather intrusive regulation and high subsidies for the sick and the poor. They must also recognize that the best way to minimize costs is not always to make patients pay something for the care they use.

---

[8] Not all conservatives take this position, however. See Stuart M. Butler, *Evolving Beyond Traditional Employer-Sponsored Health Insurance*, The Brookings Institution, The Hamilton Project, Discussion Paper 2007-06, May 2007.

[9] The point can be put simply: regulation is inconsistent with unfettered market competition; but unfettered market competition sometimes produces inefficient and unfair results.

[10] The cost-minimizing strategy for treating some diseases has been shown to involve subsidies to patients to take recommended drugs. This policy increases drug use and expense, but increased drug use reduces complications and associated outlays on physicians and for hospitalization by more than the added costs of drugs and subsidies. John T. Hsu, et al. (2006), "Unintended Consequences of Caps on Medicare Drug Benefits," *New England Journal of Medicine*, 354(22): 2349-2359. Stephen B. Soumerai, et al. (1994), "Effects of Limiting Medicaid Drug-Reimbursement Benefits on the Use of Psychotropic Agents and Acute Mental Health Services by Patients with Schizophrenia," *New England Journal of Medicine*, 331(10): 650-655. Stephen Soumerai, et al. (1991), "Effects of Medicaid Drug-Payment Limits on Admissions to Hospitals and Nursing Homes," *New England Journal of Medicine*, 325(15): 1072-1077.

Incremental Change

The second strategy seeks to strengthen and extend employment-based coverage, rather than replace it. One way would be for the federal government to provide reinsurance for all health spending above some threshold. The most immediate effect of such reinsurance would be to reduce insurance premiums. It would do so by paying through taxes costs that are now paid through premiums. By reducing premiums people face, this subsidy would increase demand for insurance. In particular, this approach would decrease the cost to insurers of covering people deemed to be bad risks. It would, thereby decrease the number of uninsured.

Unless the subsidy were large, however—that is, unless the reinsurance threshold were low—the reduction in the number of uninsured would likely be modest. Approximately half of large and medium-sized establishments self-insure or buy reinsurance now. In the individual and small group markets reinsurance would reduce, but not eliminate, insurers' incentives to select against bad risks who, even with reinsurance, would remain unprofitable.

A second incremental strategy would be to authorize currently ineligible individuals, employers, or other groups to "buy in" to Medicare or to the Federal Employees Health Benefits Program (FEHBP). Premiums could be actuarially fair or subsidized. A third strategy would be to expand Medicaid eligibility—for example, to parents of currently eligible children.

The major advantage of the incremental strategy is also its principal weakness. It disrupts current arrangements least. It requires few large shifts in financing that might necessitate large tax increases, generate windfall reductions in costs for businesses, or impose large payments on individuals. For the same reasons it would do little or nothing to simplify the current crazy-quilt of financing arrangements. In addition, it would weaken the already tenuous incentives of employers to act as cost-control agents on behalf of their employees. Finally, broadening employment-based coverage by itself would do nothing to deal with the unfortunate consequence of employment-based health insurance that forces workers to change health insurance whenever they change jobs and that confronts many two-earner families with needless and complex decisions about which spouse's plan to use when both are eligible. The latter problems could be solved if federal or state governments created something akin to the 'insurance connector' which is part of the recently implemented Massachusetts plan.

Medicare-for-All

A sizable minority of Americans has long embraced the principle that a single, nationally-uniform insurance plan should cover all Americans. One current embodiment of that strategy would enroll everyone in Medicare. Each would have a single menu of benefits financed jointly by earmarked taxes and premiums. As now, Medicaid could cover

some or all premiums, cost sharing, and additional charges for low-income enrollees. Medicare beneficiaries would continue to be able to join health maintenance organizations, where available, and Medicare would pay their premiums in place of covering standard benefits.

No advocate of Medicare-for-all has fully explained how it would work. Would employers be required to pay taxes equal to some or all of what they now spend on health insurance for employees? If so, how would the taxes be designed? What charges, if any, would be imposed on employers who currently do not offer health insurance benefits? In general, how would revenues be raised to cover insurance costs? What premiums and cost sharing would people face? What relief from those charges would low-income households receive? Would supplemental insurance, which most Medicare beneficiaries now have, be folded in? Would people now eligible for Medicaid shift to Medicare?

Other variations on the 'single-national plan' approach exist and some have addressed the financing issues in some detail. All suffer from a politically challenging feature. They would shift a large part of currently privately financed costs of health care to public budgets. The apparent hesitancy about expanding the size of the federal government budget by the amounts implied in these plans will remain a formidable obstacle to their serious consideration.

Single-payer approaches that run through direct government payment for services would encounter many of the same problems that have troubled Medicare. These problems include a cumbersome system of administered prices, a lack of choice regarding benefits within the traditional program, controversy over which new services to cover, when, and at what price, and the political impossibility (at least so far) of excluding inferior providers from the program. The problem of a lack of choice can be solved if the government offers a modest number of alternative plans. The other problems might be solvable if the government was able to contract with one or more private plans that would compete to win the service contract or to attract patients. But this feature would be at odds with the single-payer approach, as critics of the Medicare prescription drug program emphasize.

III. QUALITY

No payment reform will suffice to close the gap between the quality of care that the U.S. system currently provides and what it is capable of providing. To achieve that goal, two additional steps are necessary:[11]

[11] Whether they will prove *sufficient* will depend on the will of patients and of private and public payers to use evidence and change practice to cut spending—that is, to ration care.

- create an organization, backed with ample funding and independence from political influence, to evaluate currently-used and newly-developed medical procedures, drugs, and devices;

- supply assistance, through funding and regulation, to help private hospitals, physicians, and other health care providers adapt modern information technology to the delivery of health care.

Effectiveness Research

The first step is to increase the body of knowledge about which medical procedures work best and are cost effective. On several occasions in recent history, Congress has established or empowered agencies to evaluate medical technology. Unfortunately, Congress then made two key errors. First, the resources provided such agencies were never adequate to do the job well. The size of the task is enormous. Most of what physicians now do has never been adequately evaluated. Second, when these agencies tried to do their jobs and found some procedure or device dear to providers or investors ineffective or not worth the cost, those who were adversely affected quickly attacked the findings. Congress, alas, did not defend the agencies for doing the jobs they were charged to do, but instead gelded or killed them.

The stakes in money wasted on low- or no-benefit care and lives blighted by inferior care are too great for this dereliction of responsibility to continue. I urge Congress to create an agency with two key attributes.

- It should be funded adequately from sources independent of annual appropriations.

- It should be managed under rules that protect the organization from short-term political interference.

The legislative mandate should be to evaluate both currently-used and newly developed medical procedures and devices not only against placebos, but also against other available treatments, for effectiveness and cost-effectiveness. Various funding methods would suffice—a small set-aside on each dollar spent through Medicare or charges on private providers or insurers, for example. Independence of political influence would be adequate if the agency was managed under rules similar to those under which the Board of Governors of the Federal Reserve are appointed.

Rather than traveling this route, however, it appears that Congress may be repeating past errors. The House of Representatives included a provision in the recently passed SCHIP reauthorization bill to increase effectiveness research. This provision reflects admirable intentions but is, in my view, inadequate. The sum envisaged to support this activity, approximately $3 billion over ten years, according to the Congressional Budget

Office, comes to about one one-hundredth of one percent of health care spending projected over this period.[12] An initial commitment ten times as large would not suffice for this huge challenge. Furthermore, the responsibility for spending this paltry sum would rest with the Agency for Health Research and Quality, an admirable organization, but one that is politically vulnerable, as documented by its experience with previous efforts to carry out effectiveness research.

The development of a body of knowledge will not instantly transform the delivery of medical care, a point strongly emphasized by the Congressional Budget Office. But without such information, there is no way that an insurer or a government agency or business can long withstand the demands by patients and providers to cover procedures, drugs, and devices that are alleged to deliver some benefit. With such information, there is some chance.

Information Technology

The application of information technology to the delivery of health care is a means not an end. The end is replacement of the traditional view of physicians as solo, all-knowing managers of each patient's care with a new model of health care as a team activity involving many specialist providers who work together.[13] This new model is essential for high-quality care. The body of medical knowledge has become too large for any one person to master, and new information is becoming available too fast for any one person to absorb it all. Information technology is the instrument that makes such collaboration possible by making all facts and research relevant to a patient's care instantly available to all care-givers, avoiding pointless, duplicative, and lost tests, and minimizing the risk of adverse drug interactions.

The transformation of the medical culture from physician-as-all-wise-captain to physician-as-member-of-a-team is something that the medical profession itself will have to manage. But federal support of information technology, a critical input to this transformation, is important and has so far been lacking. The law creating the federal office charged with promoting information technology, headed for some time by the very capable David Brailer, explicitly stated that no new funds should be appropriated to aid its work.

IV. COVERAGE

With metronomic regularity, the United States has undergone spasms of generalized angst about the plight of the uninsured. These spasms have occurred at intervals of ten to

---

[12] Peter B. Orszag, "Letter to the Honorable Pete Stark," September 5, 2007.

[13] Thomas H. Lee and James J. Mongan, *Are Healthcare's Problems Incurable? One Integrated Delivery System's Program for Transforming Its Care,* The Brookings Institution, Health Policy Issues and Options, December 2006.

fifteen years. Public opinion polls indicate general support for such reform. Presidents put forward detailed plans. Confronted with a specific plan, the U.S. political system rejects is. Why? What is going on?

Part of the reason is ideological disagreement. These disagreements remain as strong today as they were when President Franklin Roosevelt withdrew universal health insurance coverage from the Social Security Act because he feared that its inclusion would cause the whole bill to be defeated, or when President Harry S Truman could not persuade Congress even to hold hearings on his proposal for health insurance coverage. The fate of President Bill Clinton's health reform plans simply continued an old and established political tradition.

Even if these ideological divisions had narrowed—for which there is little current indication—health care reformers would still have to confront another equally formidable obstacle: arithmetic. For starters, health care reform is big. The U.S. health care system annually spends a sum equal to the combined gross domestic products of France and Spain.[14] That means that the financial and political interests in the *status quo* are vast—as vast as the entire economies of France and Spain. Second, unless health care reform greatly boosts spending—something that virtually no one considers necessary or desirable—it is zero-sum politics. That is, *health care reform is first and foremost redistribution*—redistribution from those who now receive services to those who don't; redistribution of income from providers for whose services demand will fall to those for whose services demand will increase; and redistribution of financial responsibility among individual consumers, businesses, and government (that is, taxpayers).

This latter point is particularly tricky and poorly understood. Those who write checks to pay for health care include individuals, businesses, state and local governments, and the federal government. Reform will redistribute who writes checks to pay for health care. That means that if total health care spending is unchanged—and even if it is reduced—some groups will end up paying more. In particular, a larger share of the total cost of care under most options is likely to flow through the federal government, which means taxes will probably have to go up, even if total spending goes down.

The key point is that changing financing arrangements means that some of those who provide health care will gain and a roughly equal number will lose. And while advocates of reform may claim that their really terrific plans will so greatly boost efficiency that nearly everyone will eventually gain, those efficiencies will take years to realize. Meanwhile, vast economic and political interests will lose. The identity of the losers is never apparent as long as one is debating broad principles. That is what various labor-

---

[14] In 1993, my colleague, Charles Schultze, noted that the Clinton health plan would reorganize, with one bill, activities as large as the gross domestic product (GDP) of France. Since then, U.S. health care spending has outpaced French GDP.

business groups and policy elites are doing just now. And it is a major reason why a gauzy health-care-reform-is-possible-at-last euphoria seems now to be enveloping many political leaders and analysts. But the identity of losers or possible losers will snap into focus as soon as one specific proposal becomes the subject of serious debate. At that point, those who think or fear they will be losers will mobilize, along with those who disagree ideologically with the particular approach embodied in the plan. The political result, though not perhaps written in the stars, has been depressingly consistent for a very long time.

IV. THE WORST ROAD TO REFORM—EXCEPT FOR ALL THE OTHERS

Although the likelihood of national health care reform of any stripe remains poor, prospects for making progress in extending health insurance coverage and reining in the growth of spending are better than they have been in decades. (And, as noted in the preceding section of this testimony, the federal government can do much to support the medical profession in improving the quality of health care services.) The reason is that state governors and legislators are responding to the widespread concern about a lack of coverage for many and rising costs for all.

- The Massachusetts plan is the most widely known. It mandates that every individual have insurance or pay a tax penalty, provides subsidies to members of low- and moderate-income families to help them buy it, and creates a state-run agency that enables individuals and employees of small businesses to buy insurance through a large pool at community-wide rates.

No other state has implemented so sweeping a plan, but some have them on the drawing boards, and many are moving aggressively to extend coverage.

- Maine's governor has proposed to implement an individual mandate, as in Massachusetts.

- Illinois has implemented a program to offer insurance to all children under Medicaid or SCHIP with a sliding premium scale. The governor has also proposed to make insurance available to all residents and free of charge to low-income residents.

- Pennsylvania has instituted a Cover All Kids program that provides insurance at no cost to children in families with incomes below 200 percent of poverty, at a sliding-scale premium to those from families with incomes below 300 percent of poverty, and at pooled cost to all other children.

- Tennessee has converted SCHIP into a CoverKids program that is available to all children from families with incomes below 250 percent of poverty, a CoverTN program to offer portable and affordable insurance to small business and

their employees, and a high-risk pool for people who have been turned down by insurance companies.

- Arizona's governor Napolitano proposed to extend SCHIP to children from families with incomes below 300 percent of official poverty thresholds.

- California's governor Schwarzenegger has proposed a plan to provide universal coverage free to low-income adults and children financed by a combination of payroll taxes and surcharges levied on physicians and hospitals. Like Massachusetts, the California plan would establish an agency to create a pool for individuals and small businesses.

- Connecticut's governor has proposed a plan that would make health insurance available free of charge to low-income residents and at a premium of no more than $250 per month per person to all residents.

- New York's governor has proposed to extend free or subsidized health coverage to all children from families with incomes below four times official poverty thresholds.

This listing, although extensive and impressive, is only a partial enumeration of state initiatives to extend coverage, improve quality, and hold down spending. It excludes several states seeking to cover additional children through the SCHIP program by raising income eligibility thresholds.

Federal legislation could encourage these efforts. Three bills, all with bi-partisan sponsorship and co-sponsorship, have been introduced to provide such encouragement—two bills in the Senate (cosponsored by by Senators Jeff Bingaman [Democrat of New Mexico] and George Voinovich [Republican of Ohio] and by Senator Russ Feingold [Democrat of Wisconsin] and Sen. Lindsey Graham [Republican of South Carolina]. The House bill (cosponsored by Representatives Tammy Baldwin [Democrat of Wisconsin] and Tom Price [Republican of Georgia], has seventy co-sponsors, thirty-nine Democrats and thirty-one Republicans. This is the kind of bi-partisan support that is vital to the success of health care legislation.

Although the bills differ in important respects, all would establish, under federal sponsorship, a bi-partisan commission to vet and recommend to Congress state plans to reduce the proportion of state residents who are uninsured. States would have to set specific targets and their performance would be evaluated on whether they met those targets. States would be encouraged to use any of a wide range of instruments to extend coverage. These instruments would include ones commonly espoused by both conservatives and liberals—such as health savings accounts, SCHIP expansions, enrollment in the Federal Employees Benefit Plan, and single-payer reforms. Commission rules would be structured so that an ideologically diverse menu of plans would be approved. These plans

could include waivers of some current regulations to permit funds to be combined in imaginative ways.

The bills differ in whether additional funding would explicitly be provided to the states whose plans were approved. I believe that additional funding, as called for in the Feingold-Graham bill, will be necessary for two reasons.

- Any reform that extends insurance coverage will at first boost total health care spending. The currently uninsured on the average consume less care than do the insured. States should assuredly shoulder part of this added cost. But, for obvious reasons, some federal support for the added costs of coverage will encourage states to move on what is a national as well as a state goal.

- The greatest risk to ***sustained*** state support for extended health insurance coverage is the business cycle. During recessions, states must cut back spending. Recession would likely force states to renege on commitments to support insurance coverage. For that reason, some form of counter-cyclical back-up for state plans is essential if the commitments to expand insurance coverage are to be sustained.

Thus, a sort of syllogism argues that the most promising avenue for extending health insurance coverage, limiting growth of spending, and improving the quality of care lies in action by the states, abetted by federal legislation and regulation that will encourage this state action.

The premises of the syllogism are straightforward:

1. Effective actions to extend (universalize?) health insurance coverage, control growth of health care spending, and improve health care quality are critically important.

2. Federal legislation to achieve these goals is highly improbable in the foreseeable future because of political gridlock.

3. This gridlock arises not only from ideological disagreement, but also from large differences in objective conditions across the United States that no federal legislation can quickly override.

4. Many states are willing to undertake actions to achieve, in varying degrees, the three goals listed above.

The conclusion follows directly: Members of Congress can do more to reform the U.S. health care system by encouraging the states to carry through with plans they are clearly anxious to implement than in any other way.

Some analysts believe that action by the states would make eventual national action more difficult even than it already is by creating diverse entrenched interests in the various states. I believe that this view is profoundly mistaken for two reasons.

The first is that we have much to learn about how to make universal coverage work. This is the most important single lesson resulting from the efforts now underway in Massachusetts to implement its universal coverage plan. They are encountering problems no one foresaw. So far, at least, members of both parties and diverse interests are working together to solve them. If they, and other states, succeed, they will teach the nation invaluable substantive and political lessons necessary for eventual nationwide action.

The second reason is that success in a number of states in extending coverage in practical and affordable ways will transform the political dynamic throughout the rest of the United States. How different the debate in Washington would be today if the Massachusetts plan were fully operational, if it were joined by a version of what Governor Schwarzenegger has proposed in California, if all children were covered under a sliding fee scale as Governor Blagojevich has proposed in Illinois, and if Governor Baldacci had successfully modified Maine's Dirigo to implement an individual mandate. We would be focusing on the fact that extending coverage is feasible, not bewailing that narrowing coverage seems the nation's fate. So, I encourage members of Congress to get the process started in the only way that is currently feasible—by encouraging the states in their obvious desire to move ahead.