

10 Years Beyond the Health Security Act Failure

Subsequent Developments and Persistent Problems

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ON NOVEMBER 20, 1993, President Clinton sent Congress proposed legislation, “The Health Security Act of 1993” (HSA).¹ About 10 months later, the initiative was dead, having failed to pass either house of Congress. Comprising 1368 pages, the HSA would have established near-universal coverage, restructured the marketplace for health insurance, and also affected many other aspects of health services. The HSA’s framework is used herein to analyze the current health care situation in the United States because the HSA represents the last serious effort to craft a comprehensive approach to reforming our complex health care delivery system, and its content and its failure are still relevant.

Health reform for the 21st century did not occur during the 20th century,² and Congress has not since considered system-wide reforms. A decade of incremental change has left the United States with large numbers of uninsured, increasing costs, questions about quality, and dissatisfaction with managed care. Many have focused on purported reasons why the HSA failed, but that is not the purpose of this article. Rather, this analysis uses the framework of the HSA and subsequent developments in health services financing and delivery to seek insight into the persistent problems with the US system. It asks how health care

Ten years after the failure of President Clinton’s Health Security Act (HSA), the United States continues to face multiple stresses in health care, including large numbers of uninsured individuals, increasing costs, questions about quality, and dissatisfaction with managed care. Using the framework of the HSA—particularly universal coverage, spending and managed competition, insurance for low-income persons, and patients’ rights—the post-HSA evolution and current status of the US health care system is traced and lessons to guide future actions are outlined. Neither incremental legislation nor private sector changes in health care organization and financing during the past decade have ameliorated the problems addressed by the HSA, and new troubles have emerged. These problems affect every group in the country and continue to deteriorate health care, yet there has been no political support for large-scale reform. The core components of a vision for future action—universal coverage, quality improvement, cost containment, and subsidies for the economically vulnerable—are essential. There is a pressing need to construct a clear vision that would tie together incremental steps into a rational approach to comprehensive reform and to actually move toward the realization of that vision.

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issues were perceived a decade ago, outlines the HSA approach to addressing them, traces what happened during the intervening period, and draws implications to inform policy going forward.

The Uninsured

Problem in 1993 and HSA Approach. When the HSA was proposed in 1993, 39.7 million individuals were uninsured, a 28% increase of 8 million more uninsured than 6 years earlier.³ The HSA approach was unique: an individual mandate prescribed by federal law requiring everyone to buy a defined level of coverage and providing cross-subsidies from

employers and government to assist low-income individuals and low-wage workers or small-business employers. Near-universal coverage was anticipated by full implementation in 1998.⁴

The HSA reflected a view that large gaps in employment-related insur-

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See also pp 2007 and 2010.

ance dictated a largely workplace-related solution. Although the HSA established an individual, not an employer, mandate, employers faced numerous requirements. Large-business employers could self-insure through corporate alliances or could join regional health alliances. Other employers were required to make payments tied to local plan premiums plus cross-subsidies and special-purpose funds. Employers would help finance health care coverage, but workers would not depend on their own workplace for health insurance.

The legislation also set standards for health plans by requiring benefits at the level of “relatively generous employment-based policies.”⁴ Most individuals would have gained coverage of preventive, mental health, and substance abuse services and would have had reduced exposure to catastrophic health care expenses.⁴ Some would have faced higher drug and hospital cost-sharing⁵ because only one third of the privately insured population had a health plan below the actuarial value of the HSA.⁶ Certain plans could have provided more generous benefits than the standard HSA package.

What Has Happened in the Intervening Years? By 1998, when the number of uninsured would have declined precipitously under the HSA, the count had grown to 44.3 million. The number then fell briefly, dipping below 40 million in 2000, but soared by 5 million people in just 3 years to 45 million by 2003.³ Voluntary employer-subsidized health insurance remains the cornerstone of our system, but it is now eroding. In 1993, 60.4% of individuals younger than 65 years had employment-based insurance; that proportion increased throughout the 1990s, reaching 67.7% in 2000 but declined to 63.8% in 2003.⁷ In the short span from 2001-2004, the percentage of workers covered by their employer fell from 65% to 61%, and the percentage of employers offering coverage from 68% to 63%.⁸ More than 18% of workers, about 25.7 million employees—including nearly 15% of full-time, full-year workers—

are now uninsured.⁹ Workers account for about one half of the uninsured population,¹⁰ and with their families, they account for more than 80%.¹¹ Employees most likely to be uninsured are those in small firms, those working part-time jobs, those earning lower wages, or those who are self-employed.

As the uninsured population has grown, covered benefits for insured individuals have changed with increased and new cost-sharing requirements.¹² Not long after the HSA failed, about 9% of insured working-age families spent more than 5% of their incomes on out-of-pocket expenses for health care services and 3% spent more than 10%, not counting the employee share of premiums.¹³ The employee share of premiums stabilized in recent years, but premiums grew by 59% between 2000-2004 compared with 12.3% growth in workers' earnings.⁸ Thus, as wages decreased as a proportion of total compensation,¹⁴ premiums now consume more of the worker's total income.

Health Expenditures and Health Plan Competition

Problem in 1993 and HSA Approach. The HSA emerged in an era of rapid growth in health care spending. National health expenditures had increased at average annual rates approaching 12% from 1960 through 1990, vastly outpacing expansion in the population or the gross domestic product (GDP).¹⁵ Between 1980 and 1993, per capita health care expenditures had trebled, and the health share of the GDP went up by more than 50%, from 8.8% to 13.4%. President Clinton's preamble to the HSA predicted that without intervention, health care expenditures would surpass 20% of the GDP by 2000.

The HSA combined market and regulatory approaches to cost containment. The core concept was that health plan competition would rationalize and, thereby, constrain expenditures. But the bill also reflected skepticism that such competition would develop on its own and incorporated 2 broad regulatory measures, one to manage and, thereby, maximize competition and the other to

cap health plan premiums if market forces proved inadequate.

A market defect that managed competition tried to address was that employees could only choose among plans offered through their employers. The HSA proposed moving the locus of choice from employers to consumers and the marketing of plans from employers to the alliances. Eligible persons could join any health plan in their community, using standardized information on comparable plans to make more informed decisions. Portability of plans within an alliance area would have allowed continuity of physician care. Individuals were expected to become price-conscious consumers because of mandatory premium and other out-of-pocket cost-sharing requirements, together with clear plan pricing. The HSA also proposed incentives for plans to have exclusive provider networks, particularly of specialists, with gate-keeping by primary care clinicians.

If competition had failed to constrain premiums within statutory limits, a state-specific global budget cap to reduce future premium growth would have been triggered and enforced through plan and provider payment reductions. After premium increases of 12% in 1988, 18% in 1989, and 14% in 1990,¹⁶ those regulatory provisions portended sharp limits on premium growth, as low as 2.0% to 4.5% between 1996 and 2000.¹ Such low caps were largely a fail-safe measure to spur legislative action, with little expectation that they would have been imposed automatically without public debate.

What Has Happened in the Intervening Years? Following introduction of the HSA, the growth rate of national health care expenditures slowed remarkably. Rather than reaching 20% as predicted, the health share of GDP remained between 13.1% and 13.4% for the rest of the 1990s, even falling below growth in the GDP for several years. Premium increases were even below targets in the HSA, with rates as low as 0.8% in 1996.¹⁶ Premium increases then rebounded, returning to double-digit rates since 2001, and total spending skyrocketed.

eted, climbing to 14.9% of GDP in 2002 and expected to reach 18.4% by 2013.¹⁷

Health plan competition developed but not as envisioned in the HSA. Workers offered coverage generally have more plan choices now—between 1988 and 1998, offerings with more than 1 plan increased from 53% to 66%, most with 3 or more options.¹⁸ But a critical difference is that employee choices are often options from the same carrier, not from competing insurance companies. Some large employee groups, such as government workers in the California or federal systems, can choose among numerous highly competitive plans, but the one-employer, one-insurer approach and various self-insurance arrangements still dominate.

Instead of competing directly for consumers, managed care plans competed vigorously for market share through employers after failure of the HSA. Plan options changed to those providing leverage in containing costs—only about 14% of workers are now given the choice of open-ended conventional indemnity plans compared with 90% in 1988 and 52% in 1998.¹⁹ Plans limited expenditures through tight controls on the use of specialty services and hospitalization and by shifting financial risk to providers through capitation payment arrangements.

A substantial consumer, employer, and clinician backlash developed, fueled by restrictions on access and by the costs²⁰ and burdens on clinicians and beneficiaries of determining an individual patient's allowable coverage. One result is that health maintenance organizations (HMOs), with the most potent mechanisms for controlling hospitalization and referrals, are still often offered to employees, but HMO enrollment declined after a brief increase from 16% in 1988 to 31% in 1996 and to 24% in 2003. The respective proportions of medical groups, hospitals, and covered lives under capitation have been declining.²¹ At the same time, plans allowing self-referral to specialists and paying fee-for-service (ie, preferred provider organizations and point-of-

service plans) now have 71% of the market, despite their higher cost compared with HMOs. Those plans are now increasing the number of physicians or hospitals in their networks,²² thereby lessening their financial leverage. People have been “voting with their feet” for less restrictive plans,²³ even when they had to share the higher price.

Most recently, consumer choice has taken on a new meaning.²⁴ Consumer-driven plans now engage consumers actively in deciding whether to spend money on health care by increasing their out-of-pocket payments. Such plans may have high deductibles joined with medical savings accounts or more varied options with respect to network arrangements and co-payments.^{25,26}

Coverage for Low-Income Persons

Problem in 1993 and HSA Approach. By 1993, Medicaid served many low-income individuals without employment-related insurance, but, for all its strengths, the program had serious limitations from the perspectives of its stakeholders—the federal government, states, beneficiaries, physicians, and hospitals. State Medicaid plans covered close to 32 million people, yet many low-income individuals were still uninsured.³ Medicaid spending had grown nearly 22% per year between 1988 and 1992, with total spending going from \$51.3 billion to \$112.9 billion. Increases in 1990-1992 of nearly 28% per year in total Medicaid expenditures and in disproportionate-share hospital payments from \$1.3 billion to \$17.7 billion²⁷ created a sense of crisis. Yet, low payments to physicians and hospitals and state limitations on the scope and duration of benefits created barriers to access for beneficiaries and difficult financial consequences for clinicians serving Medicaid patients. States and federal government pursued strategies to control spending, emphasizing waivers to require enrollees to join Medicaid managed care organizations.

The HSA proposed a historic change that was little recognized as such at the time: It proposed privatizing Medic-

aid medical coverage by incorporating nonelderly beneficiaries into alliance plans with everyone else. Plans and clinicians would have received information on an individual's income to adjust his or her cost sharing, but clinicians would have been paid the same for treating patients receiving Medicaid benefits as they would have for anyone else. Thus the stigma from Medicaid's association with low payments would have been largely eliminated at the point of service. For the core HSA benefits, states would have paid into the regional funds. States also would have faced requirements for financial maintenance-of-effort and cost-sharing reductions and responsibility for supplemental Medicaid services beyond the HSA benefit package.

What Has Happened in the Intervening Years? Medicaid has undergone many significant changes. The traditional relationship between cash benefits and Medicaid was severed by welfare reform in 1996.²⁸ Spending growth slowed dramatically, as overall inflation fell with a strong economy; enrollment growth slowed or reversed following welfare reform; Medicaid managed care expanded through state waivers; and Congress limited disproportionate-share hospital payments.²⁹ All children living in poverty gained eligibility for Medicaid, and the State Children's Health Insurance Program (SCHIP)³⁰ extended coverage to somewhat higher income levels. The Balanced Budget Act of 1997 removed restrictions on Medicaid-only plans and allowed states to require beneficiaries to join managed care plans.³¹

In other aspects, not much has changed for Medicaid. States continue to serve as insurers in fee-for-service arrangements responsible for enrollment, direct payment, and oversight and as purchasers who must negotiate contracts and oversee Medicaid-specific managed care organizations, many of whom have dropped their Medicaid contracts. In both cases, states must ensure provision of federally mandated benefits, frequently involving wrap-around services. Delinking wel-

fare and Medicaid succeeded in formally eliminating the basis for the “welfare stigma” often associated with receiving Medicaid benefits but created new complexities by separating application and eligibility determination processes for cash from those for medical assistance. Persistently low provider payments have sustained access barriers for many beneficiaries. Nevertheless, Medicaid buffered the declines in employment-related coverage during the past decade, notably for children. Medicaid enrollments fell somewhat in the late 1990s but have climbed ever since. Average monthly enrollments in the program now approach 40 million, and Medicaid provides services to more than 50 million individuals annually.³²

Spending continues to increase, with total Medicaid expenditures in 2002 exceeding \$250 billion and growth exceeding 25% between 2000 and 2002. These increases were the result of many factors, including losses of employment-related health insurance, increased drug prices, and continued expansion of acute care spending for all enrollment groups.³² Medicaid, the second-largest item in most state budgets, accounts for about 21% of total state spending and 16% of state general revenue expenditures and is a component of fiscal difficulties in most states.³³

Patients' Rights

Problem in 1993 and HSA Approach. When the HSA was being considered in 1993-1994, certain consequences for states involving the Employee Retirement Income Security Act of 1974 (ERISA)³⁴ were becoming evident. States, not the federal government, have traditionally regulated insurance. But ERISA precludes states from requiring employers to offer health benefits and also preempts long-standing state laws authorizing steep damages for serious abuses by insurers, such as wrongful denials of health benefits, when coverage is employment-related. ERISA limits damages to the value of the benefit that should have been paid by an employment-based plan, no matter how seri-

ous the resulting harm³⁵ while state remedies survive for policies purchased outside of employment. By the early 1990s, some egregious denials of benefits were reported and enrollees in employment-based plans had little recourse to correct, be compensated for, or punish such abuses.

The HSA proposed striking a new balance between state and federal regulatory power. Health plans were to establish procedures for timely decisions on benefits and to submit appeals of denials to external review. Unreasonable delays or denials would not have been subject to unlimited damages but could have triggered substantial civil monetary penalties.

What Has Happened in the Intervening Years? The increase of managed care plans severely restricting access and utilization had political consequences as members of Congress briefly pursued anti-managed care provisions, enacting federal maternity length of stay and mental health parity provisions.³⁶ The Balanced Budget Act established federal controls on Medicare and Medicaid managed care organizations, and a presidential commission released its Consumer Bill of Rights and Responsibilities report in 1997.³⁷ Legislation mandated that managed care organizations and other health insurers cover mastectomies, lumpectomies, and related services.³⁸

More than 170 patients' rights and managed care reform proposals were introduced in Congress during 1997-1998, most requiring both internal and external appeals processes. Some reinstated state authority over lawsuits and damages³⁹ while others expanded damages available in federal court. Ultimately, the issues of damages and benefit-determination procedures helped stalemate consideration of a Patient's Bill of Rights. Some plans have since expedited appeals and loosened restrictions on care to reduce pressure for legislation and to respond to market forces. But subscribers in employment-related plans are largely in the same position as they were 10 years ago when wrongful denials cause harm, despite

legal challenges and state efforts to expand health plan responsibility for wrongful benefit denials.⁴⁰⁻⁴³

Additional HSA Provisions. Several HSA provisions are not analyzed in depth herein because of space constraints. In particular, Medicare, which presents some of the most pressing issues today and for the years to come, is not discussed because the HSA left the program intact while offering states an alliance option, substantially cutting Medicare funding and proposing a prescription drug benefit. Three HSA provisions merit brief comment because they addressed important health care concepts and one led to subsequent legislation.

Health Insurance Portability and Accountability Act. The HSA sections dealing with information systems, privacy, and administrative simplification formed the core of corresponding provisions enacted in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).² Early attention focused on highly promoted health insurance reforms in HIPAA that have had negligible effect⁴⁴ while the privacy and information systems sections have required extensive measures to comply with requirements for standardization, privacy, and security of health data.⁴⁵

Tort Reform. The HSA proposed to lead the federal government squarely into medical malpractice liability reform but did not stimulate subsequent federal legislation. The HSA required use of alternative dispute resolution prior to filing a lawsuit, imposed other procedural requirements, capped attorney fees, and reduced awards by payments from other sources. An early centerpiece of HSA malpractice reforms to shift liability from physicians to health plans and other enterprises became a demonstration project in the final bill and has not been resurrected.

Quality Management. The HSA proposed a national quality management program involving both research and application to clinical practice. The program would have established national measures of quality performance, ultimately leading to performance goals.

Box. Past, Present, and Future of Health Care Coverage and Delivery**Uninsured Crisis**

Ten years ago: 39.7 Million uninsured, a 28% increase from 6 years earlier, viewed as a serious societal problem; Employer-sponsored insurance coverage declined; Public programs expanding but unable to fill the growing gaps; The Health Security Act (HSA) proposed near-universal coverage by mandating individuals to buy insurance with help from employer payments and government subsidies

In the intervening 10 years: Employer-sponsored insurance coverage increased in the 1990s with the strong economy; Since 2000, nearly 4 million lost employer-sponsored insurance; From 2000-2003 the uninsured increased by 5 million to 45 million; Employee share of costs increased faster than income; small businesses increasingly unable to provide coverage

Future implications: While coverage deteriorates, the diversity of public and private coverage arrangements inhibits comprehensive solutions that could solve systemic problems and fosters only uncoordinated incremental measures reflecting disparate interests

Health Expenditures and Health Plan Competition

Ten years ago: Experts predicted national health expenditures (NHEs) costs would reach 20% of the gross domestic product (GDP) and needed restraint; Competition barriers included limited consumer choice of health plans and insurance models that supported unfettered choice of physicians; The HSA proposed limiting expenditures through managed health plan competition, with cost controls when targets exceeded

In the intervening 10 years: The rate of cost increases slowed and then increased precipitously; NHEs neared 15% of the GDP; Employers eschewed purchasing alliances with HSA-type managed competition; Health plans initially reduced costs through strict use and payment controls; A subscriber and physician backlash to managed care led to health plan models with reduced financial leverage and easier access to specialty care

Future Implications: Current movement to increase consumer price sensitivity runs counter to the strong consumer preference for broad insurance coverage, particularly with wide choice of providers

Coverage for Low-Income Individuals

Ten years ago: Governmental costs for low-income individuals seemed in crisis with a Medicaid growth rate of 28% each year from 1990-1992 and 22% annual increases from 1988-1992; Yet, access

was limited because of low reimbursement to physicians and hospitals; The relationship between the federal and state governments viewed as excessively complex and restrictive; The HSA proposed privatizing care by including nonelderly in the alliance plans through state, federal, and private subsidies

In the intervening 10 years: Medicaid managed care became the principal state strategy to control spending; States pursued numerous federal waivers to expand coverage and constrain spending; All children under the federal poverty level eligible for Medicaid coverage; The State Children's Health Insurance Program enacted; Medicaid was severed from welfare; Growth of Medicaid enrollments helped offset decreases in private coverage

Future implication: Medicaid's importance may increase as employer-sponsored coverage declines

Patient's Rights

Ten years ago: Evident that some employment-based health plans inappropriately deny benefits with little punishment under the Employee Retirement Income Security Act of 1974; The HSA proposed statutory procedures for benefit determinations, an appeals process, and proposed civil monetary penalties for wrongful behavior

In the intervening 10 years: Employment-related insurance providers remain insulated from damages for wrongful benefit denials; The Patient's Bill of Rights initiative rose and fell in the Congress; States maintained health care quality control responsibility without remedies for abuses in employment-based plans; The Balanced Budget Act included some protection for Medicare and Medicaid beneficiaries; Some managed care plans had voluntary constraints for egregious benefit denials

Future implication: Not hopeful for patient's rights legislation without broad health care reform

Solution

Comprehensive systemic reform that incorporates universal coverage, cost containment, quality improvement, and subsidies for economically vulnerable individuals is needed; Reform most likely cannot pass in a single HSA-like bill but may be achieved incrementally by integration into an overall vision; Presidential and congressional leadership and action required for federal or state administration; Private, public, and mixed approaches can achieve this goal

Despite growing concerns about quality^{46,47} and the developing movement toward evidence-based medical management,⁴⁸ no such program has come into existence.

Comment

Developments over the past decade lead to a number of observations that can inform policy going forward. (BOX) One that stands out is the effect of dispersion of US health care coverage arrangements among employment-based and public programs. The fragmentation of risk pools and funding arrangements

means that individuals focus on their own health coverage rather than the national situation. No large constituency sees immediate benefit from universal coverage even though employers, workers, early retirees, persons 65 years and older, and low-income families all identify serious problems with health insurance. Each group, including physicians and other clinicians, views the situation from their own perspectives, but the issues affecting them are intimately intertwined. This fragmentation allows narrowly focused and influential interests to dominate health

care policy a small slice at a time thereby sustaining the systemic problems and inhibiting development of comprehensive solutions that could resolve the problems. As a result, wide-ranging reform measures have not gained political viability and only an uncoordinated series of incremental initiatives have been undertaken.

The direction of health care coverage runs counter to the manifest preferences of the US population for increased choice covered by insurance. Managed care enrollees deeply resented strict controls on their access to

advanced medical care and moved into plans offering fewer controls with consequent increased spending. Now, however, these consumer preferences are precisely why employers are moving in the opposite direction, increasing choice but reducing coverage through far higher cost-sharing. The implication for future policy is that consumer preferences should caution us that the drive to constrain expenditures by increasing out-of-pocket expenses among insured individuals will be tolerated only up to a breaking point. Moreover, that approach has no likelihood of successfully addressing the larger issues of coverage and quality.

Costs to employers and individuals have risen not only because insured individuals demanded freer access to specialty care and its associated costly technology but also in part because of the internal cross-subsidies needed to pay for uncompensated care and to cover shortfalls in payment levels from public programs. Major corporations that would be relieved of those costs and the price of subsidizing working spouses have not been outspoken in favor of a national plan. Small businesses and those with many low-wage employees—often cited as the core of the uninsurance problem—have not expanded coverage under state initiatives.⁴⁹ Employers have taken so little initiative that a modest proposal to offer unsubsidized group insurance to part-time and other ineligible workers attracted national attention.⁵⁰ Now, there is even growing skepticism among employers⁸ and other private sector health care leaders that market forces or employer actions will resolve problems with the current system, leading to an emerging willingness to consider other initiatives, even those managed by the government.²³ The clear lesson is that voluntary employment-based health coverage is declining and shows no signs of being the solution to widespread uninsurance, let alone to the other problems facing our health system.

As employment-related coverage contracts with economic shifts and as more people leave the workforce and

retire, public financing of health care expands to buffer the impacts. Health coverage for children would be at catastrophically low levels without Medicaid, and the growing population of low-income elderly and disabled relies on Medicaid to fill gaps in Medicare. The principal strategy to reduce spending in Medicaid has been to divert acute care coverage for children and their parents into Medicaid managed care organizations. That has not solved the growth in expenditures and cannot be expected to because the bulk of Medicaid spending is for long-term care payments and acute care for low-income older individuals and disabled beneficiaries. Without comprehensive system reform, larger public insurance programs are an increasingly essential, albeit imperfect, component of coverage in the United States.

Finally, it appears that absent wide-ranging reforms, patients' rights will not be addressed legislatively. ERISA leaves states with authority over the quality of health care, yet the direct consequences for quality of administrative decisions denying medically necessary care in employment-based plans are beyond state authority to redress. Federal legislation is needed to limit plan abuses but has no prospects for enactment on its own as an incremental reform.

So what can be done? The HSA, proposed a specific vision of how to increase both efficiency and equity through universal entitlement to coverage combined with health plan competition, global budgets, subsidies, and evidence-based medicine. Congress rejected the HSA's complicated scheme for carrying out that vision in one far-ranging piece of legislation. In the absence of a single comprehensive approach, numerous public and private incremental measures have been crafted. Piecemeal legislative tinkering^{30,51,52} over the past decade has not resolved many serious problems with our health care system but has proceeded because it does not require public support for all-inclusive reforms. Rather, it mobilizes the self-interest of specific groups to produce targeted changes, such as the pharmaceu-

tical industry in shaping the Medicare Prescription Drug program or the insurance industry in limiting the reforms in HIPAA. Such enactments may not even resolve the isolated problems they purport to address and certainly do not lead to systemic reform.

The crucial element missing from this pragmatic approach is an overall vision. Comprehensive reform is needed but cannot be accomplished through incremental measures without a vision that weaves the individual parts into a functional system.⁵³ Only the president and Congress can execute a comprehensive plan to integrate the multitude of market-based, governmental, employment-related, societal, and individual responsibility forces that form our complex and deeply stressed health care delivery system. Presidential leadership and congressional action is also necessary to provide funding flexibility and amend ERISA if comprehensive reform were to come successfully from state initiatives, such as the one in California.⁵⁴

Developments over the past decade make it clear that we are not heading in a positive direction. Without a game plan, we will fulfill Yogi Berra's observation that "if you don't know where you are going, you will wind up somewhere else." In the case of health care, we are continuing to stumble toward somewhere else, and it is probably not a place we should want to go.

The HSA has come and gone, but the problems of uninsurance, uncompensated care, high cost, poor quality, and limited access that present day-to-day crises for individuals and health care providers in communities across the 50 states remain. Given the many and growing problems, there is a pressing need to craft an integrative vision and to pursue the incremental components that it requires. An HSA-like bill that does everything at once would probably not survive our legislative processes, but comprehensive reform implemented through coordinated incremental steps leading to a well-defined, integrated system might find broad political support because it would reduce the perceived risk to the in-

sured public while moving in a positive direction. The core components of a vision for future action are universal coverage, quality improvement, cost containment, and subsidies for the economically vulnerable. These core elements can be accomplished through a variety of public, private, and mixed approaches. There is an urgent need for our national leadership—the president and Congress—to articulate the vision, develop a plan, and implement the steps necessary to accomplish the goal.

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