

The U.S. Health Care System: Current Trends and Proposed Reforms

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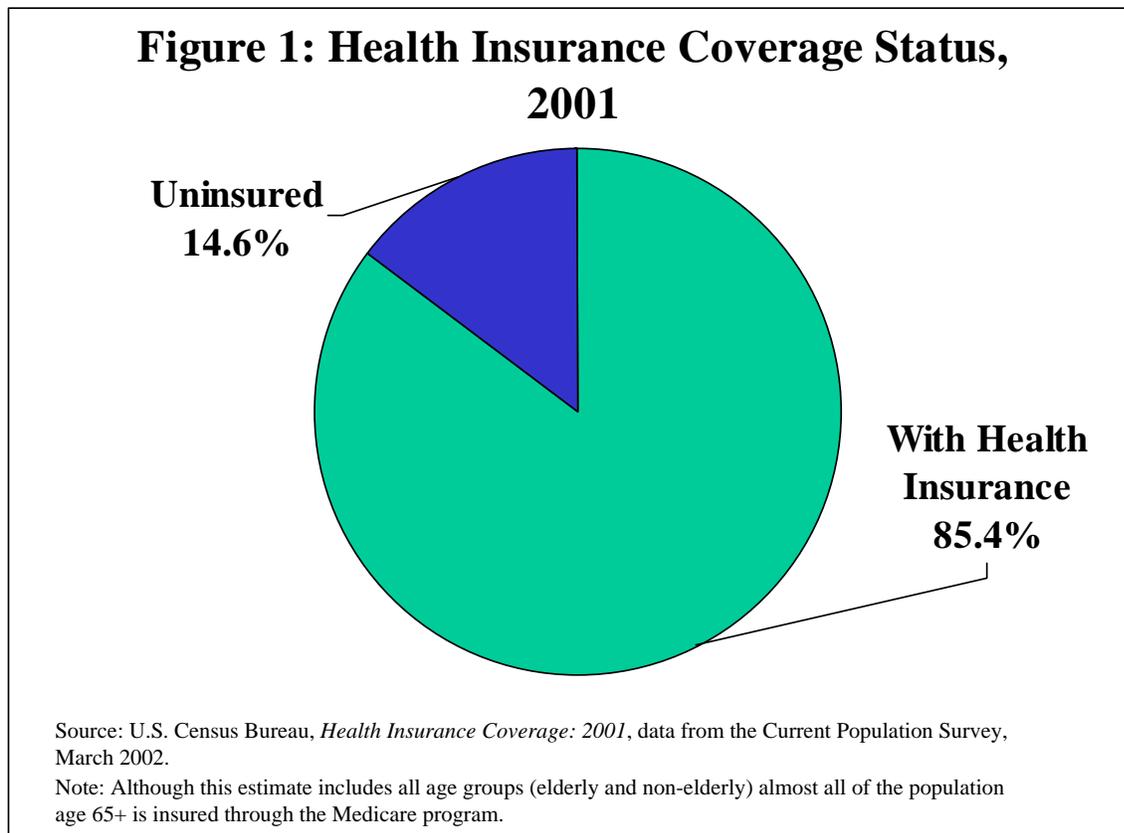
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U.S. Health Care System

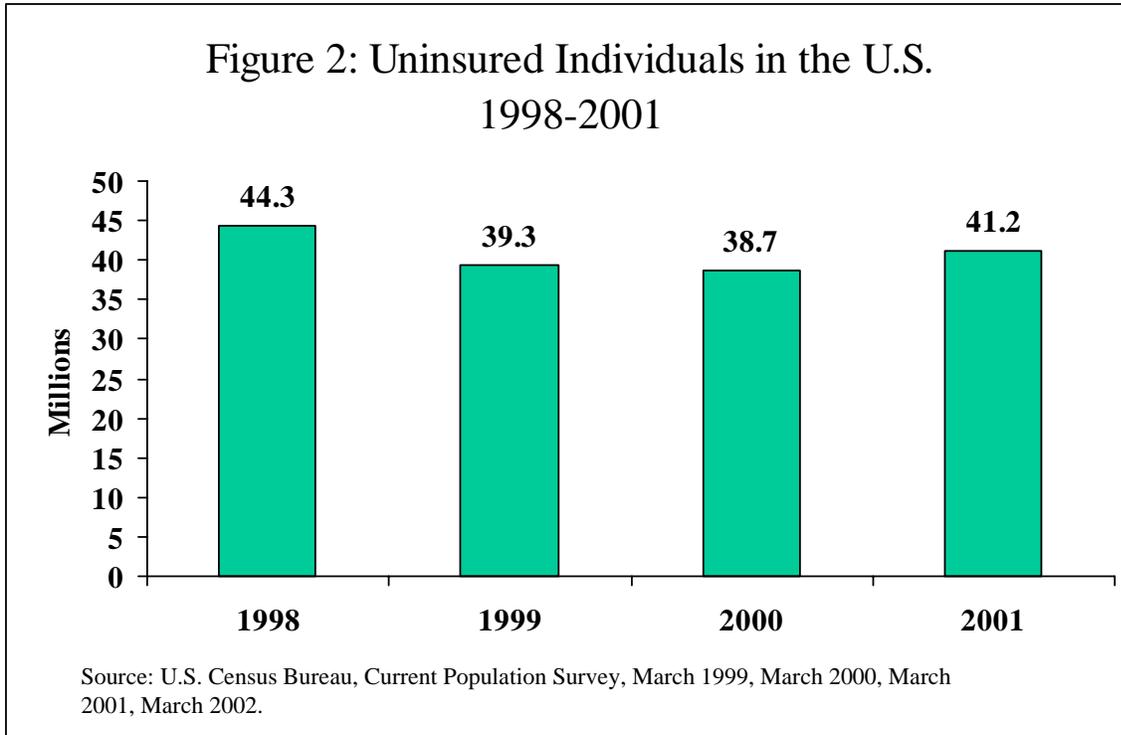
In contrast with most other industrialized nations, the health care system in the U.S. blends together public and private sponsorship of health insurance coverage, with the private sector playing the larger role with respect to workers and their families. This framework results in the introduction of competition, choice and other market forces to health care delivery, which fosters innovation and quality in the health care system. U.S. physicians and patients are highly supportive of the prompt introduction of new health care technologies, and the increased utilization of all forms of medical innovation – driven by major new advances in science – are a key factor behind a sharp rise in health care expenditures in the last several years.

Health Insurance Coverage

Over 240 million Americans had health insurance coverage in 2001, which is the most recent year national health data is available. This translates into 85.4 percent of the U.S. population with health insurance coverage and 14.6 percent that were uninsured for the year (see Figure 1).



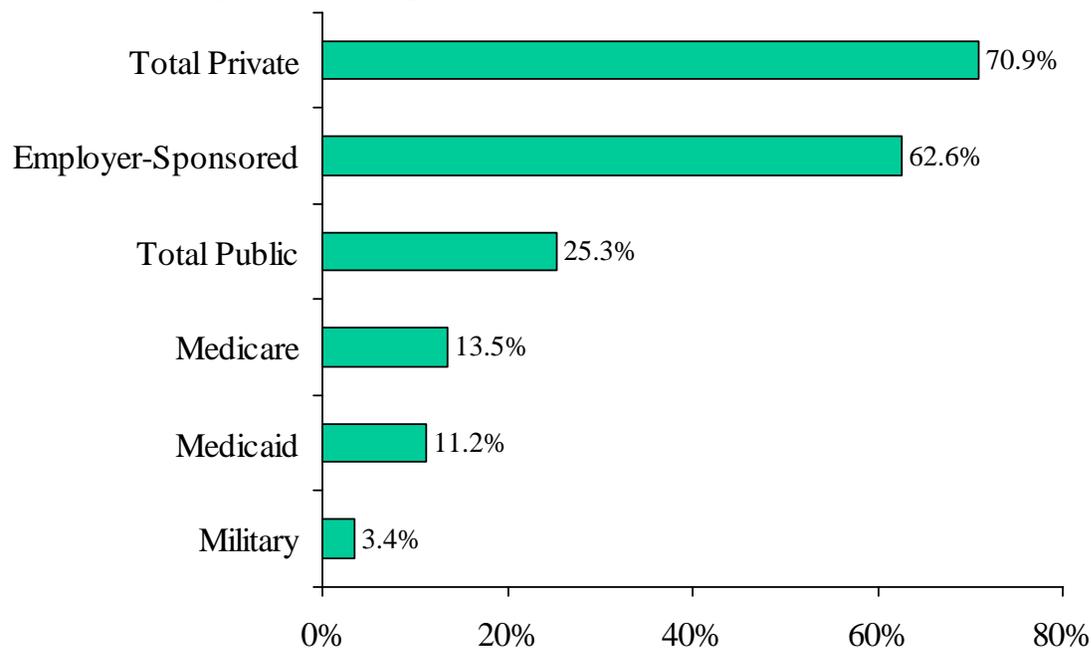
While the total number of Americans with health insurance increased to 240.9 million in 2001, the total number of Americans without health insurance also increased, up to 41.2 million. A substantial minority of individuals in the U.S. lack health insurance and the total number has fluctuated in recent years from 44.3 million in 1998, down to 38.7 million in 2000, and up to 41.2 million in 2001 (see Figure 2). The proportion of the population without health insurance has shifted from 16.3 percent in 1998, to 14.0 percent in 2000, to 14.6 percent in 2001.



Of Americans with health care coverage, most have private health insurance, 70.9 percent, compared with a minority that have public or government-sponsored health insurance, 25.3 percent (see Figure 3)¹. The most common type of private health insurance is employer-sponsored coverage, which provides health insurance to 62.6 percent of the population.

¹ Coverage categories are not mutually exclusive.

Figure 3: Type of Health Insurance, 2001



Note: Health insurance estimates include some individuals covered by more than one type of health insurance, so total private and total public coverage does not add to 100 percent.

Source: U.S. Census Bureau, Current Population Survey, March 2002.

Rate of Growth of Health Expenditures

National health spending is expected to grow faster than GDP for the rest of the decade, with the health care share of GDP rising from 13.2 per cent – highest in the OECD – in 2000 to a projected 17.0 per cent in 2011. The aging of the U.S. population is one factor behind this projected increase. The large numbers of people born between 1946 and 1964 – the so-called “baby boom” generation – are reaching their peak medical consumption years and carry high expectations of access to advances in prescription drugs and other costly new technologies.

Hospital costs have been increasing significantly, due to the effects of a patient backlash against the harshest forms of managed care, consolidation in facilities that have increased hospitals’ bargaining power in obtaining payments from insurers, and a growing shortage of skilled labor. Pharmaceutical expenditures are also increasing, but here the factor is volume consumption rather than price increases.

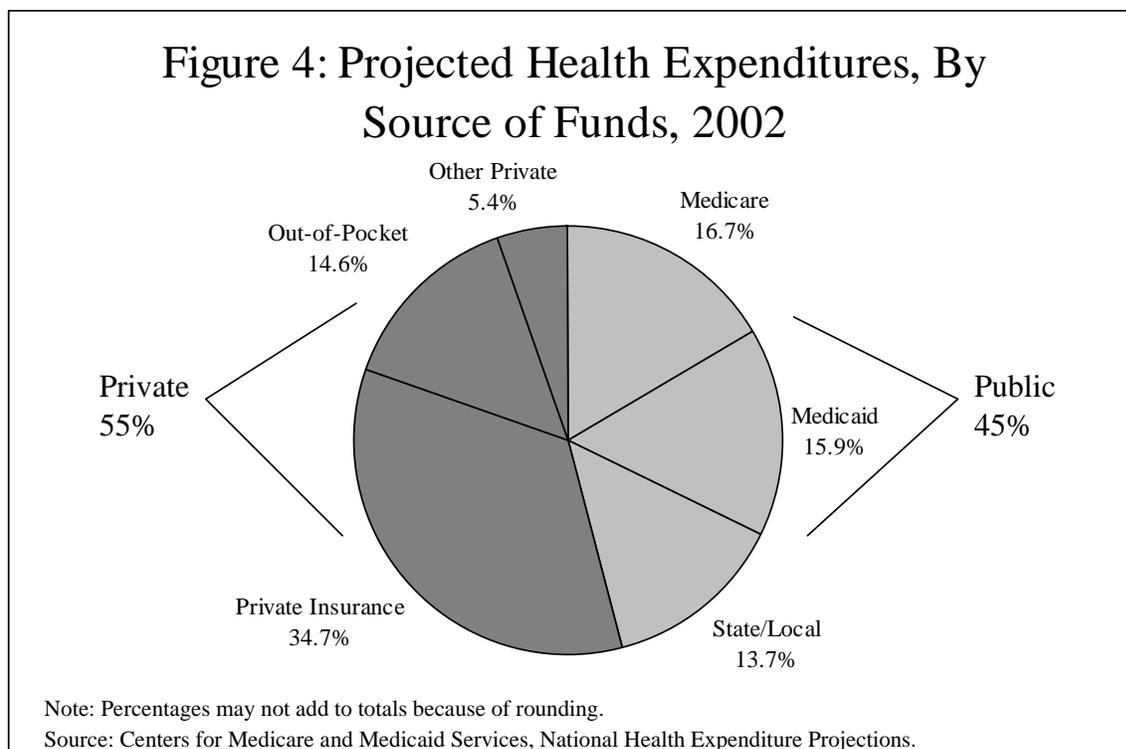
Although pressures from employers and government to contain these costs are rising, many Americans see health care costs as an investment and a valued social good. Increased spending on health is viewed as acceptable so long as wages and incomes keep growing and the economy does not sink into recession. Polls show that most Americans accept the fact that the U.S. spends more on health than any other nation – it is the price tag for preserving quality, access to the latest procedures,

and patient choice of providers. When voters are confronted with alternatives that appear to restrict these values in favor of lowering costs, they routinely reject them. This was evidenced in the decisive defeat of a universal health care plan proposal in Oregon on November 5.

Public vs. Private Spending

The majority of total health expenditures in the U.S. are financed through private health insurance, including out-of-pocket payments, at 55 percent of total expenditures, compared to all levels of government spending, at 45 percent of total expenditures (see Figure 4). The federal government accounts for approximately 32 percent of total U.S. health care expenditures in 2002.

The government share of total health spending in the U.S. is higher than often assumed by foreigners, and indicates that the level of government involvement in the financing and delivery of health care is substantial. It is in the nature of regulation and the diversity of stakeholders that makes the US market more supportive of competition and consumer choice. Many forecasts predict an increased level of government involvement in the years ahead, a trend that runs counter to the situation in other countries like Canada, where the private share of health spending is growing more prominent.



Employer Role

Employment-based health insurance is the most common source of health insurance in the U.S., covering approximately 160 million Americans under age 65 or about two-thirds of the population.² Employer-sponsored coverage is also the most prevalent type of supplemental health insurance for the post-65 population. A significant element of the health care system that encourages employer-sponsored health care is that employer payments for health care coverage are excluded from employees' income taxes. Employer coverage is also a means for employees to obtain discounted group rates in insurance.³

The vast majority of workers are offered health insurance by their employers, with the proportion of employers that provide health coverage varying by the size of the employer. For example, in 2002, 99 percent of large employers (with 200+ employees) offered health benefits to employees, but the offer rate dropped to 96 percent for employers with 50-199 employees, 88 percent for employers with 25-49 employees, 74 percent for employers with 10-24 employees, and 55 percent for employers with 3-9 employees.⁴ The level of employer-sponsored coverage has remained fairly constant in recent years.

“Safety Net” Coverage

Individuals lacking health insurance coverage are able to access health care services through public and private safety net programs. Low-income individuals can qualify for public health care programs such as Medicaid and state-operated pharmacy assistance programs if their income level meets eligibility criteria. Hospitals in poor urban or rural areas that treat disproportionate numbers of patients without insurance are compensated for the cost through a special federal program.

In fact, all uninsured individuals may also use health care services through hospital emergency rooms. Although uninsured individuals are not paying for these medical services, the costs of the services are paid indirectly through taxes and higher premiums for health care insurance. Estimates indicate that the government spends over \$1,000 on indigent health care for each uninsured individual in the U.S.⁵

Low-income individuals may also obtain prescription drugs for nominal or no cost through private patient assistance programs where pharmaceutical manufacturers provide medicines free of charge for patients who need treatment. In 2001, pharmacy assistance programs provided \$1.5 billion worth of prescription drugs to 3.5 million patients.⁶ Also, many pharmaceutical manufacturers have implemented prescription drug discount card programs in 2001 and 2002 under which the manufacturer provides its products to certain low-income, uninsured individuals at a discounted price or for a flat co-payment. Pfizer, for example, is offering its drugs to those patients who can meet specific income criteria, for a flat fee of \$15 per month. Last year alone, 1.4 million low-income patients received Pfizer medicines with a wholesale value of \$320 million.

² Employee Benefit Research Institute, *Employment-Based Health Benefits: Trends and Outlook*, May 2001.

³ Cutler, David, *Employee Costs and the Decline in Health Insurance Coverage*, prepared for the National Bureau of Economic Research conference on Frontiers in Health Policy Research, May 2002.

⁴ The Henry J. Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits*, 2002.

⁵ National Center for Policy Analysis, 2001.

⁶ Pharmaceutical Research and Manufacturers Association, *Pharmaceutical Industry Profile 2002*.

Current Issues and Trends

Rising health care costs, the pace of innovation in health care financing and delivery, and the significant number of uninsured Americans are leading to calls for health care reform at the federal and state levels. The U.S. health care market is a diverse and dynamic system that continually develops, as the following recent trends demonstrate.

Managed Care Evolution

Managed care refers to a variety of health care cost- and utilization-control techniques for influencing the behavior of patients and health care providers. Managed care organizations typically integrate the financing and delivery of health care services. Under health maintenance organization (HMO) plans, consumers obtain all health care services from the HMO or its affiliates, who receive a pre-paid amount for these services and manage patients' care, or pay added fees if care is provided elsewhere. Other managed care plans called preferred provider organizations (PPOs) establish networks that include a specified group of health care providers that accept discounted fees for certain services.

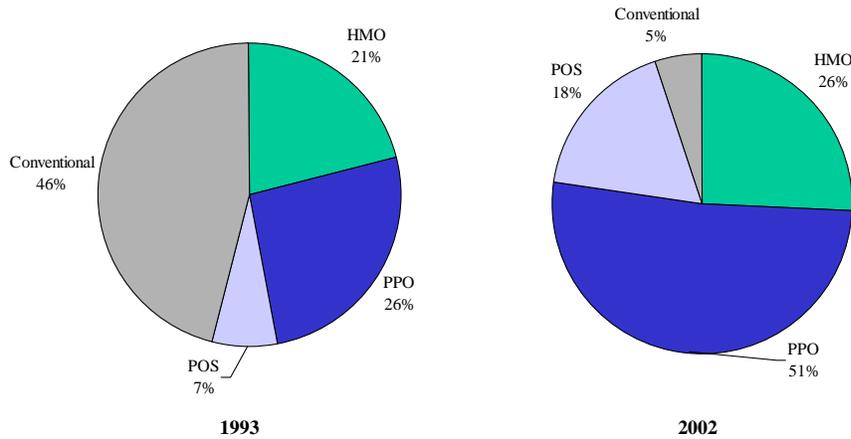
Double-digit health care cost increases in the late 1980s and early 1990s led health plan sponsors to shift enrollees into managed care plans as a way to control costs. Currently, 95 percent of Americans who receive health care coverage through employers are enrolled in some form of managed care and only 5 percent are in conventional indemnity plans.⁷ Conversely, in 1993, 46 percent of U.S. workers were enrolled in conventional indemnity plans and 54 percent were enrolled in managed care arrangements (see Figure 5).

Managed care has also become more prevalent in public health insurance programs such as Medicare and Medicaid. Currently, 13 percent of Medicare beneficiaries are enrolled in managed care plans, which are called Medicare+Choice organizations under Medicare. For Medicaid, in 2001, over half of the 44 million Medicaid beneficiaries received health services through managed care arrangements.⁸

⁷ The Henry J. Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits*, 2002.

⁸ Kaiser Commission on Medicaid and the Uninsured, *Medicaid and Managed Care*, December 2001.

Figure 5: Enrollment by Plan Type, 1993 and 2002



Source: The Henry J. Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits*, 2002.

Managed Care Backlash

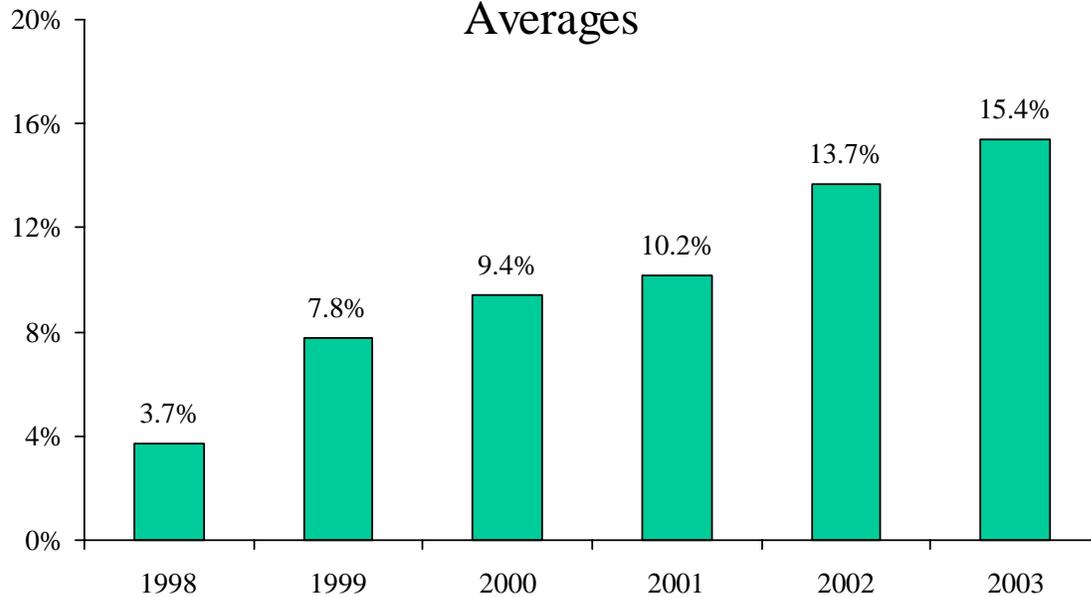
As managed care grew in prevalence, some of the cost- and utilization-management techniques used by health plans created a backlash against managed care by patients, providers, and the general public. For example, denials for non-covered services, imposition of referrals to see specialists, limited access to network providers, and reduced hospital stays sometimes resulted from managed care arrangements and have led to growing resentment. Public opinion of managed care further eroded as premiums and out-of-pocket costs increased. Generally, patients' disdain the administrative complexities and insensitivity to personal complaints and reduced choice under managed care. Providers dislike the cuts in payments imposed by managed care plans and some coverage decisions made by health plans for provider services.

The widespread criticism of managed care, especially in the news media, an increasing number of lawsuits and the threat of possible mandates under new federal and state laws forced health plans to loosen managed care restrictions and improve flexibility in response to consumer demands. For example, health plans shifted away from the HMO model and increasingly offer PPO plans, where enrollees have increased choice in selecting doctors and hospitals. Also, managed care plans are relaxing restrictions that require a referral for enrollees to see specialists and now more plans allow enrollees to see specialists without prior approval. But as the managed care industry relaxed its controls, health costs resumed their upward trajectory.

Rising Health Care Costs

Since 1998, health care costs have been growing at rapidly increasing annual rates (see Figure 6).

Figure 6: Large U.S. Employer Annual Health Care Cost Increases, National Averages



Source: Hewitt Associates, Hewitt Health Value Initiative, October 14, 2002.

In 2003, health care costs are projected to rise by 15.4 percent, which is the fifth consecutive year of high growth in health expenditures. The average large employer health plan is projected to cost \$6,295 per employee in 2003, compared with \$5,456 in 2002. For employers, the average health care cost per employee varies by type of plan and has increased from 2002 to 2003, as follows⁹:

	HMO	PPO	POS	Indemnity	Average
2002	\$5,157	\$5,545	\$5,639	\$6,304	\$5,456
2003	\$5,982	\$6,367	\$6,485	\$7,249	\$6,295

Impact of Aging

The elderly constitute a substantial and growing portion of the population in the U.S., which has implications for the health care system because they have higher utilization and expenditures for health care services compared with other age groups. In 2000, there were almost 35 million elderly

⁹ Hewitt Associates, *Health Care Cost Increases Expected to Continue Double-Digit Pace in 2003*, October 14, 2002.

people (age 65+) in the U.S., which comprises 12.4 percent of the total U.S. population in 2000.¹⁰ The elderly are projected to increase as a proportion of the U.S. population from 8.2 percent in 1950, to 12.4 percent in 2000, to 20.3 percent in 2050. A global comparison of nations demonstrates that the elderly population in the U.S. is expected to grow almost 80 percent between 2000 and 2025, while the elderly in other more developed countries as a group are expected to increase 46 percent from 2000 to 2025.¹¹

The growth of the elderly population in the U.S. impacts the health care system because the use of health care services increases as the age of a patient increases. For example, the elderly had approximately four times as many days of hospitalization (1.6 days) as the under age 65 population (0.4 days) in 1999. The elderly spent, on average, \$3,019 in out-of-pocket health care costs, while the total population averaged \$1,959 in out-of-pocket costs in 1999.¹² Elderly individuals experience higher rates of disability and chronic conditions than non-elderly individuals too. Prescription drug utilization rises with age, as individuals ages 18-34 fill, on average, 3 prescriptions annually, compared with 6 for individuals ages 35-49, 13 for individuals ages 50-64, 20 for individuals ages 65-79, and 22 for those ages 80 and over.¹³ A related increase is observed in average annual prescription drug expenditures by age group, from \$124 for individuals ages 18-34 to \$811 for those ages 65-79.

Elderly people in the U.S. are a political force because they constitute a significant portion of the population and a higher percentage of the elderly vote compared with other age groups. In the 2000 U.S. elections, the age group with the highest voting rate was 65 to 74 year old individuals (72 percent), while 18 to 24 year olds had the lowest voting rate (36 percent). One of the largest associations in the U.S. is AARP (formerly called the American Association for Retired Persons), with over 35 million members. AARP promotes the interests of individuals ages 50 and older at the state and federal level through its offices in all 50 states and in Washington, D.C.

Medicare

While Medicare remains a very popular program with retirees, there has been a public outcry by beneficiaries in recent years to add prescription drug coverage, which is currently not included as a Medicare benefit. Approximately 27 percent of Medicare beneficiaries do not have drug coverage and other beneficiaries may have inadequate coverage. The elderly use prescription drugs more than the rest of the population and drug costs have become a growing financial burden to many seniors. In response to this coverage gap, U.S. pharmaceutical manufacturers have expanded access to their products by means of prescription drug card programs, with very low copayments or discounted drug prices.

Medicaid

The Medicaid program provides health care benefits to targeted low-income populations and covers more individuals than Medicare. For two consecutive years, Medicaid spending increased over 10

¹⁰ National Center for Health Statistics, Centers for Disease Control, *Health, United States, 2002*.

¹¹ U.S. Census Bureau, *The U.S. in International Context: 2000*, February 2002.

¹² U.S. Department of Health and Human Services, Administration on Aging, *A Profile of Older Americans, 2001*,

¹³ Center on an Aging Society, *Prescription Drugs*, Georgetown University, September 2002.

percent, with states reporting that Medicaid spending grew 13 percent in 2002.¹⁴ Most states indicate that Medicaid is the fastest growing component of the state budget and constitutes over 20 percent of the budget. States have reported that collectively their budgets faced a deficit of over \$40 billion in 2002. Therefore, states are looking for ways to control costs, especially in the Medicaid program, with the goal of balancing their budgets.

¹⁴ Smith, Vernon, *Medicaid Spending Growth: Results from a 2002 Survey*, Kaiser Commission on Medicaid and the Uninsured, September 2002.

Health Reform Proposals

Collectively, rising health care expenditures, the backlash against managed care, and consumer demand for information and choice act as catalysts spurring reforms to the U.S. health care system. As these factors continually shape the health care marketplace, legislation has been proposed at the federal and state level to modify the rules governing the health care sector. Also, many policymakers embrace health care reform because it is a populist political issue that appeals to a large share of voters. The primary health care reform proposals under consideration at the federal and state levels are described below.

Federal Health Reform Issues

Patients' Bill of Rights

The House and Senate each passed different versions of patients' bill of rights legislation that would mandate new protections for patients. The proposals are similar in that they each require direct access to specialists and pediatricians without a referral, mandate coverage for emergency services, and elimination of gag rules and financial incentives that restrict dialogue between patients and providers. However, the bills have significant differences concerning external review of coverage denials and liability provisions that would allow individuals to sue health plans and employers for decisions involving medical care that resulted in harm to the individual.

For the patients' bill of rights to become law, a compromise version of the legislation has to be agreed to by both the House and Senate and then signed into law by President Bush. In 2002, informal negotiations were unsuccessful in reaching an agreement on an alternative proposal that would blend elements of the House- and Senate-passed legislation. Action before Congress adjourns in October 2002 is unlikely. If a compromise version is not enacted into law this year, the next Congress that begins in 2003 will most likely continue the debate and introduce new patients' bill of rights proposals. However, because the proposed patients' rights legislation would add to already escalating health costs, it faces an uphill battle.

Medicare Drug Coverage

Another key health reform issue is to establish a prescription drug benefit in the Medicare program. In 2002, the House passed legislation (H.R. 4954) largely along party lines that would provide drug coverage to Medicare beneficiaries through competing prescription drug-only health insurers. The Senate considered several different proposals but was unable to generate enough support to pass any legislation.

Generally, Republicans and Democrats disagree over the scope and administration of the proposed prescription drug benefits. The House-passed bill and other Republican proposals in the Senate would offer a standard benefit to all Medicare beneficiaries but drug plans could provide alternate

coverage that is actuarially equivalent to the standard benefit. The standard benefit would contain an annual deductible, cost-sharing up to a specified threshold, and stop-loss coverage. Beneficiaries would be responsible for the full cost of drugs in the gap between the threshold and the stop-loss benefit. Private entities that accept financial risk would provide the drug benefit and be eligible for reinsurance payments from Medicare.

Democrats favor proposals that provide more generous drug coverage to beneficiaries but at a higher total cost to Medicare. For example, Democrats' proposals generally do not have a deductible and include cost-sharing for drugs up to the stop-loss benefit, with no gap in the coverage. Private entities would administer the drug benefit but Medicare would maintain financial risk for drug coverage. The entities would have to place a portion of their administrative fees at risk.

It seems unlikely that a Medicare drug benefit will be enacted into law in 2002 because the Senate has not passed such a proposal and differences would have to be worked out between the House and Senate legislation. These tasks are a lot to accomplish in the little time remaining in this congressional session. However, the public, especially the elderly, strongly supports enactment of a Medicare drug benefit and this issue will be prominent in the next Congress in 2003.

Pharmaceutical Patent Reform

The Senate passed legislation (S. 812) in July 2002 that would modify the existing drug patent law to facilitate the Food and Drug Administration (FDA) approval process for generic drugs. Rising health care costs have led state governments and some large employers to lobby for expanded availability of generic drugs by limiting the ability of pharmaceutical manufacturers to extend pharmaceutical patent protections. These efforts would shift the delicate balance of current drug patent laws to a more restrictive environment for pharmaceutical manufacturers that could stifle drug development and innovation.

The Senate bill would narrow the ability of pharmaceutical manufacturers to contest the application of generic drugs. For example, the proposal would limit the current 30-month stay of approval for a generic drug when a brand drug manufacturer sues for patent infringement to only one 30-month stay per generic application. Additionally, an amendment was added to the bill that would allow pharmacists and wholesalers to import prescription drugs from Canada into the U.S.

The House has not passed similar legislation to modify the drug patent law but House Democrats are trying to act on such a proposal. Although it is unlikely the House will pass a drug patent reform bill in 2002, issues involving prescription drug costs are popular in Congress and with the public and will likely resurface again in 2003.

Mental Health Parity

The Senate passed legislation in 2001 to expand the current mental health parity act to require full parity in the coverage of mental health and other medical services. The current law does not achieve full parity because although it requires parity in annual and lifetime dollar limits, health plans may implement other design features to restrict coverage for mental health services, such as higher cost-sharing or limits on the number of covered visits or days of hospital stay. The Senate bill would prohibit plans from implementing treatment conditions and financial requirements for mental health benefits that are stricter than for other health benefits.

The House has not passed expanded mental health parity legislation and has blocked efforts to enact such a law in recent years. However, the current mental health parity law expires at the end of 2002 and Congress will most likely enact legislation to continue and expand the mental health parity law prior to its expiration. Mental health parity generally has bipartisan backing and President Bush has expressed support for the concept of expanded mental health parity, but not specifically for the Senate bill.

Health Insurance Coverage

A variety of incremental proposals have been introduced with the goal of reducing the number of uninsured individuals. A provision in a trade bill that was enacted into law in August 2002 provides tax credits for health insurance expenses to a limited number of individuals. Under the new law, workers that lose their jobs because of international trade may receive a refundable tax credit equal to 65 percent of the cost of purchasing health insurance coverage. The tax credit may be used with continuation of employer coverage (so-called COBRA coverage), state-based health insurance pools, and individual insurance under certain conditions.

Other proposals were considered that would provide tax incentives for the purchase of health care coverage. These plans range from refundable tax credits that could be used by a broader group of individuals (not just trade-displaced workers) for the purchase of health insurance to refundable tax credits that would only be applied to COBRA coverage. Expanding health care coverage to the uninsured is likely to be a significant policy issue again in 2003.

Defined Contribution Health Accounts

The Internal Revenue Service and the Treasury Department issued guidance in June 2002 that provides favorable tax treatment to the coverage and benefits of defined contribution health care accounts. The new accounts, called health reimbursement arrangements (HRAs), allow employers to fund the account for the reimbursement of employee medical expenses. The new accounts are expected to foster the development of consumer-driven health care benefits by providing consumers with increased choice and control over their health care benefits.

Under this consumer-driven model, HRA accounts would be combined with a high-deductible health benefits plan. The rules for HRAs allow unused funds to be rolled-over to the next calendar year, which provides consumers flexibility and encourages cost-effective decision-making.

State Reform Issues

Medicaid

Most state activity on health policy issues in 2002 is focused on containing costs under Medicaid, which is the fastest growing element of state budgets. As the majority of states contend with budget deficits in 2002, they are considering proposals to modify their Medicaid programs to control the growth rate of health expenditures. Many state efforts address pharmacy benefits under Medicaid because drug costs are the most rapidly increasing annual expenditures.

Reports indicate that the majority of states took action in 2002 to reduce their Medicaid program expenditures. For example, 45 states implemented measures to reduce Medicaid spending in 2002

and 41 states have plans underway to reduce Medicaid spending in 2003.¹⁵ Of these states, 32 started new prescription drug cost controls in 2002 and 40 states are planning more measures for 2003.¹⁶ The tools states are using to control drug costs include implementation of preferred drug lists, prior authorization for certain drugs, supplemental drug rebates, required generic substitution, quantity limits, and increased copayments.¹⁷ Also, substantial numbers of states limited Medicaid expenditures this year through reduced provider payments decreased program eligibility, and reduced dental and home health benefits.¹⁸

States are also considering applying for waivers from the federal government to provide health insurance to uninsured state residents. For example, states may seek waivers under the Health Insurance Flexibility and Accountability initiative and the Pharmacy Plus program where the state extends health insurance and prescription drug coverage to residents while using existing federal contributions in a budget neutral manner.

Budget/Revenue

In addition to enacting changes to Medicaid, states addressed their 2002 budget shortfalls by using extra state funds, called “rainy day funds”, for Medicaid costs and by increasing state cigarette taxes to generate revenue. Some states have excess financial reserves in rainy day accounts that accumulate during economic booms and periods of financial growth. States reportedly used some of these funds this year to pay for costs that exceed funds available from the annual budget. In 2002, at least 33 states considered increasing the state tax on cigarettes and 16 states actually increased the tax.¹⁹ This is a significant change considering that a maximum of 4 states in any given year in the recent past had increased cigarette taxes.²⁰

Other Issues

As noted above, the foremost policy issues considered by states in 2002, which are likely to continue in 2003, are balancing state budgets and controlling Medicaid expenditures. However, states also directed some attention to medical malpractice, health care coverage, and long-term care issues. Premiums for medical providers’ medical malpractice insurance have experienced tremendous growth in rates and liability reform has become the leading state legislative issue for providers. In 2002, 12 states enacted laws ranging from studying malpractice reform options, to limiting attorney’s fees and awards, to establishing state insurance programs.²¹ Also, nine states enacted provisions to extend health care coverage to the uninsured through reforms such as state pooling arrangements and modifications to existing laws for small group and individual markets.²² On the issue of long-term care, several states established planning commissions to identify barriers to providing community-

¹⁵ Smith, Vernon, *Medicaid Spending Growth: Results from a 2002 Survey*, Kaiser Commission on Medicaid and the Uninsured, September 2002.

¹⁶ Ibid.

¹⁷ National Conference of State Legislatures, Health Policy Tracking Service, *July Mid-Year Review*, State Health Policy Brief, July 11, 2002.

¹⁸ Smith, Vernon, *Medicaid Spending Growth: Results from a 2002 Survey*, Kaiser Commission on Medicaid and the Uninsured, September 2002.

¹⁹ National Conference of State Legislatures, Health Policy Tracking Service, *July Mid-Year Review*, State Health Policy Brief, July 11, 2002.

²⁰ Ibid.

²¹ Ibid.

²² BlueCross and Blue Shield Association, *State of the States: Mid-2002 Update*, July 2002.

based health care and a few other states enacted laws to add some home and community-based services for individuals in need of long-term care.²³

Conclusion

As the U.S. health care system continues to evolve, trends in the delivery of health care services through managed care arrangements and cost pressures serve as a catalyst for efforts to reform the federal and state health care laws. Although some changes were enacted in 2002 at the federal level, such as the regulation allowing favorable tax treatment of defined contribution health accounts, and at the state level, such as changes to state Medicaid programs, many key health policy issues were left unresolved and are likely to resurface again in 2003.

For example, Congress will most likely continue to consider proposals at the federal level to establish a Medicare prescription drug benefit, establish a patients' rights bill, reform drug patent law, and extend health coverage to the uninsured. In particular, the Republican majority in the Senate as well as the House of Representatives is likely to lead to increase prospects for passage of the House Republican approach to a Medicare benefit, which focuses on giving incentives for private insurers to provide the benefit with government oversight guarantees. Some influential Democrats – like Louisiana Senator John Breaux – are reviving ideas rejected in the 1990s, like requiring mandatory insurance coverage for all Americans.

Because any federal reform plan will require some Democratic Party support, and must also meet the test of complying with the need to control growth in the federal government deficit, stalemate over the details of reform is still the most likely scenario, with employers increasingly driving decisions on a “muddle through” basis. Meanwhile, the 50 states are expected to continue working to contain their budgets and limit health care cost increases under Medicaid.

²³ National Conference of State Legislatures, Health Policy Tracking Service, *July Mid-Year Review*, State Health Policy Brief, July 11, 2002.