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Make No Big Plans:
The Democratic Party's Unity Platform for Healthcare

By Merrill Goozner

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Just a few months before the epoch-shifting 1932 election that put Franklin D. Roosevelt in the White House, the Democratic Party adopted a platform that called for a balanced budget and a 25% cut in federal spending. Once in office, FDR ignored that piece of paper. Combatting the Great Depression required new thinking and bolder measures.

That historical footnote came to mind as I read over the recommendations from the Democratic Party's Health Care Unity Task Force, appointed jointly by former Vice President Joe Biden, the presumptive nominee, and Sen. Bernie Sanders, his erstwhile challenger. Single-payer advocate Rep. Pramila Jayapal and former Surgeon General Dr. Vivek Murthy, who served under President Obama, chaired the task force.

The panel's six other members ranged from former CMS administrator Dr. Donald Berwick on the left to healthcare consultant Chris Jennings, whose central role in the Democratic Party reform efforts goes back to the "Clintoncare" fiasco of the mid-1990s. Given the breadth of representation on the task force, its recommendations will likely become the party's healthcare plank this August at the scaled-back Milwaukee convention.

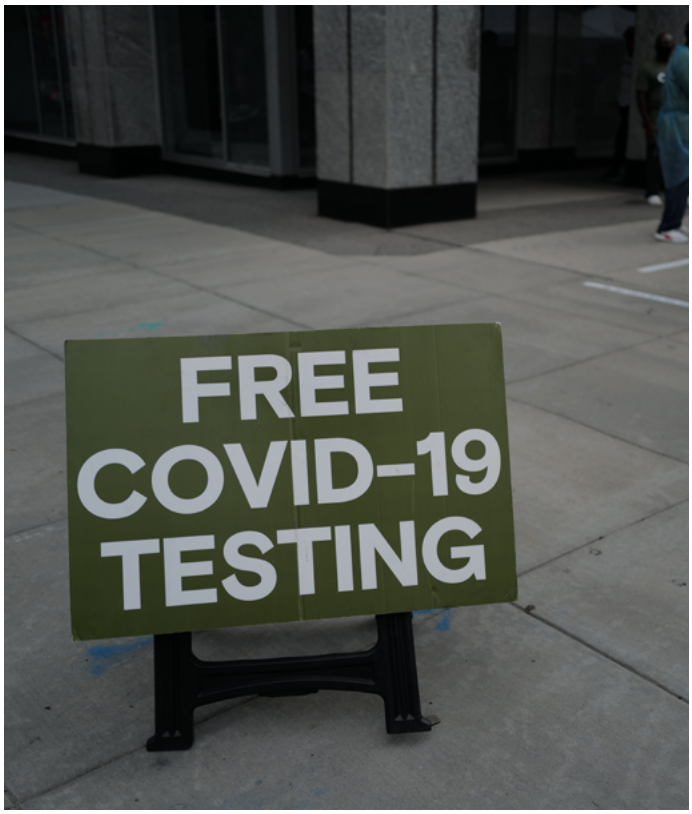
The task force's recommendation reflects the politics of the pre-pandemic era, in which Biden won by proposing modest insurance reforms and opposing Medicare for All. That modesty did not anticipate the rapid deterioration in health insurance coverage triggered by the coronavirus pandemic.

Key Takeaways

- The Democratic Party's emerging healthcare platform, crafted by a unity task force picked by former Vice President Joe Biden and Vermont Sen. Bernie Sanders, carefully avoids controversial issues.
- Its most significant new proposal is inclusion of a government-run public option to compete with private insurers on the Obamacare exchanges, which Biden backed in the debates.
- Its pandemic-relief measures would prevent widespread losses of health coverage by expanding and subsidizing existing programs like Medicaid and COBRA.
- Its post-pandemic approach to universal coverage relies on the continued expansion of Affordable Care Act coverage.
- The document gives short shrift to cost control, payment reform and delivery system reform.
- The surge in COVID-19 cases and the likelihood of renewed lockdowns this fall may force a new administration to adopt bolder measures.

Official government data on COVID-19's impact on the uninsured rate won't be available for another year. But it's clear millions of people are losing coverage just when they are being threatened by a potentially fatal disease.

The pandemic's economic fallout has disrupted employment in 20% of the households that depend on employer-based coverage, according to an early June Commonwealth Fund survey. About 20% of those households said they had lost their health insurance.



Further lockdowns will increase those numbers. The uninsured rate was already rising before the pandemic despite near full employment. It's certain to move well into double digits – something we haven't seen since the ACA's exchanges launched in 2013.

The vulnerabilities of the employer-based insurance system stand exposed. To counter this escalating disaster, the task force calls for special pandemic-related measures "until the economy has strengthened, and unemployment rates have fallen."

These measures include:

- Free testing and vaccines
- Direct support to states to maintain and expand Medicaid enrollment
- 100% COBRA coverage
- Expanded eligibility for subsidies for exchange enrollment beyond the 2020 ACA limit, so people making more than 400% of poverty level are eligible.
- Cap premiums at 8.5% of income, for everyone.

Looking beyond the pandemic, the task force doubles down on the ACA approach. They call for states to complete the Medicaid expansion, and offer new subsidies for people who lose employer-based coverage. The task force also made two major additions, drawn from Biden's proposals during the debates: the addition of government-run public insurance option; and allowing Medicare enrollment at age 60.

The document includes a repeal of the firewall that blocks people with skimpy employer plans from buying something better on the exchanges. If implemented, many low- and moderate-income families would get better coverage through exchange plans, coverage that would cost less because of the availability of government subsidies.

NO VISION, MORE COMPLEXITY

The first thing that jumps out from this laundry list of new proposals is how they would only add to the complexity of a system already overburdened by administrative waste.

The plan is not single payer.

It's not universal coverage.

It contains no overarching vision for reforming the health insurance marketplace.

The proposal fails to discuss the ill-effects of insurance fragmentation as it offers automatic enrollment in the public option for people losing coverage during the pandemic and those receiving food or public assistance. That ignores the discontinuity in care caused by people moving between private and public plans, or those switching between private plans as they change employers. The plan doesn't offer a vision for insurance portability or any way to prevent people from ever falling through the cracks.

The document also doesn't mention Medicare Advantage, the fast-growing private insurance option that now covers about a third of senior beneficiaries. MA plans offer a potential model for order, consistency and seamlessness to the private insurance marketplace.

To use the task force's own words, it is, at best, a recognition:

"that there is more to do to secure health care at last as a human right for all Americans."

OBAMACARE AMNESIA

The document barely touches on cost control, payment reform and delivery system reform. When it does mention those issues, its recommendations are even less inspiring than its insurance proposals. The ACA devoted almost half of its 900 pages to those issues.

The task force's lead strategy for controlling costs is just a pledge to pursue aggressive enforcement of antitrust laws to prevent "costly consolidation and price increases." The platform also calls for a transparent database that lists the prices paid for individual services by different payers.

The assumption is that increased competition among providers, brought about by preventing consolidation and encouraging new entrants into the market, will bring down prices.

It's interesting to note this echoes the views of current CMS administrator Seema Verma, who, in a blog post last year, wrote the following:

> ***"The role of government policies should be to facilitate a competitive healthcare market where consumers have options, and providers must prove their value and compete on the basis of cost, quality, and innovation to attract business."***

It's an enticing vision that appeals to Americans' free-market sensibilities, but where has it worked? No country on earth relies on competition to hold healthcare prices in check. Most have some form of price and use controls and use government regulation to prevent overcapacity.

Moreover, consumer choice is meaningless for the majority of healthcare services. Who, in the middle of a heart attack, is in a position to question the choices made in the ER based on the cost or quality of that particular facility?

In areas where U.S. consumers have been given more choice in how to spend their healthcare dollars, primarily through high-deductible health plans, studies have repeatedly shown that they are just as likely to forego necessary services as unnecessary services.

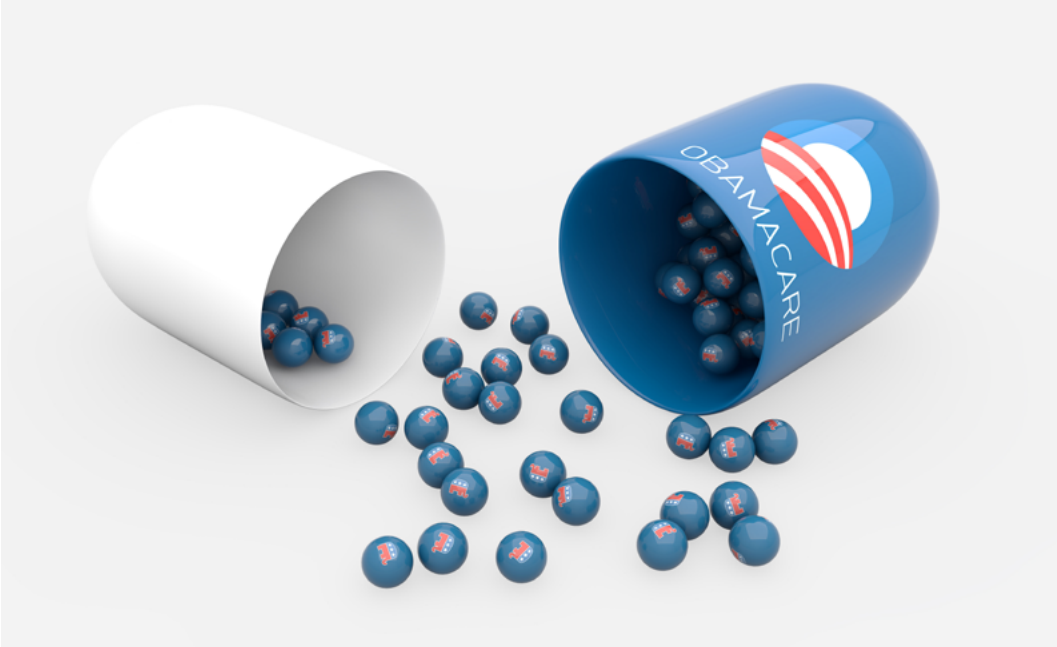
Alternative visions for controlling costs go unmentioned in the document. Care delivery strategies like care coordination and team-based care have demonstrated their effectiveness in lowering costs for heavy users of medical care. They are nowhere to be found.

The nation's large integrated delivery networks (think Geisinger, Intermountain and Kaiser Permanente), say their integrated provider organizations, when coupled with an insurance arm, hold out the greatest promise for holding down costs. The plan doesn't mention this vision as an alternative policy approach. Indeed, a vigorous antitrust policy would move the country in the opposite direction.

Even on the limited notion of payment reform, the document merely "encourages" the expansion of alternative payment models in Medicare, Accountable Care Organizations and the proposed public option plan. It has nothing to say about providers assuming downside risk or working under capitated contracts. Nor does it encourage states to explore alternative reimbursement schemes like all-payer pricing or global budgets.

The bottom line is that the "unity" task force carefully avoided offending all significant healthcare constituencies. Its writers clearly wanted to avoid alienating potential political allies in the healthcare industry.

Whether that will be an effective strategy for getting elected remains to be seen. It surely is not a roadmap for bringing the U.S. significantly closer to having a healthcare system that is "affordable, accessible, and equitable," the goals outlined in the very first paragraph of this milquetoast document.



SAILING BLIND INTO THE HEADWINDS

The pandemic shows no signs of abating. Unless something changes in the next few weeks, the rising number of cases and deaths, the jammed hospitals and the palpable fear that grips most citizens will still be with us on election day.

So far, the Democratic Party has not provided voters hungry for change with a clear direction of where they intend to take our dysfunctional healthcare system. Its proposed reforms are largely expansions or restitutions of existing approaches, which the pandemic-induced economic downturn has exposed as totally inadequate for maintaining continuity of coverage and care.

Should he win the election, and should Democrats gain control of the Senate, Joe Biden and his brain trust may find his party's healthcare platform about as useful as FDR found the party's 1932 economic platform. Between now and next January, his healthcare advisors have a lot of work to do if they plan to hit the ground running.

As a first step, they should outline a set of core principles they intend to pursue. Subsequent policy proposals can then be evaluated in that light.

Here's my recommendations for what those core principles should be:

1. **Coverage must be universal and cover all essential services;**
2. **Moving between plans must be seamless with all records instantaneously portable;**
3. **No one should ever pay more than 7% of income for out-of-pocket expenses; and**
4. **Per capita costs must never be allowed to grow faster than the rest of the economy.**

Affordable. Accessible. Equitable. And without the presumption, trumpeted on both the left and right, that there's only one way to get there.

AUTHOR

Since retiring from day-to-day management at Modern Healthcare in May 2017, ***Merrill Goozner*** has continued to write the weekly opinion column for that leading healthcare trade journal. He also speaks and serves as moderator for panel discussions at numerous industry and Modern Healthcare events.

From 2012 to 2017, Goozner led the editorial direction and content for Modern Healthcare's magazine, e-newsletters and website. Prior to joining Modern Healthcare, his journalism career spanned nearly 40 years as an editor, writer and journalism educator. In 2004, he authored ***The $800 Million Pill: The Truth Behind the Cost of New Drugs*** (University of California Press). He previously served as a foreign, national and chief economics correspondent for the *Chicago Tribune* and a professor of journalism at New York University. He has contributed to numerous news outlets, opinion journals and scientific publications over the course of his career including the *New York Times, Democracy: A Journal of Ideas, JAMA Internal Medicine, PLOS Medicine*, and the *Journal of the National Cancer Institute*.

He earned his master's degree in journalism from Columbia University in 1982; and his Bachelor of Arts degree in history from the University of Cincinnati in 1975. The U. of C. named him a Distinguished Alumni in 2008 and inducted him into its Journalism Hall of Fame in 2016.

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