Books & the Arts.

WHITE HOUSE/PETE SOUZA

President Obama making calls to members of Congress before a healthcare reform vote, March 19, 2010

A Spoonful of Sugar

by BERNARD AVISHAI

It is hard to read *Remedy and Reaction*, Paul Starr's remarkable chronicle of the hundred-year effort to legislate universal health insurance in the United States, without recalling Robert Gibbs's tortured quip that Democrats who've denounced the Obama White House for having knuckled under to Republican principles or intimidation "ought to be drug-tested." Nobody with a sense of history—that is, nobody who reads Starr's book—could doubt how sensible and brave was the president's effort to drive the Patient Protection and Affordable Care Act of 2010 through Congress. Nobody with a feel for the present moment should doubt how imminent is the threat to the act, how urgent it is for progressive Democrats to rally around Obama—and without all the condescending qualifications that "independents," who flock away from allegedly weak or incompetent leaders, interpret as contempt.

Starr, who teaches at Princeton and, with Robert Kuttner and Robert Reich, founded *The American Prospect*, has written 300-plus pages of tightly woven policy description, narrative and polemic; but one needn't be a wonk to benefit from the tutorial or detect an occasional sigh between the lines. Literary scholars speak of a pathetic fallacy, the idea that inanimate objects have intentions and feelings. Starr makes clear that various political commentators have been susceptible to a somewhat different fallacy, pathetic in its own way, that America's desires can be fathomed through polling and that the president must somehow be at fault if a desire is not fulfilled, as though flawed legislative institutions, entrenched political forces, conflicting popular incentives, regional rivalries and sheer corruption do not shape political outcomes.

Starr learned his lessons the hard way. He closely advised the Clintons on health strategy in the early 1990s (he still knows and has debriefed key Congressional staffers). The centerpiece of *Remedy and Reaction* is a long section, full of illuminating asides, on the frustration of the Clintons' plans. Starr shows that, even as Bill Clinton submitted his bill to Congress, some 70 percent of voters subscribed to the principles embodied in the legislation he proposed. Yet the bill didn't come close to being enacted. True, Clinton was losing altitude by then, but to suppose his failure was largely a matter of

Remedy and Reaction
The Peculiar American Struggle Over Health Care Reform.
By Paul Starr.
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leadership—you know, that he didn't use his bully pulpit forcefully enough, the sort of gripe heard relentlessly on MSNBC, the *Huffington Post* and *Daily Kos* about Obama and the "public option"—is to suppose that willows really weep.

Obama's actions were cannier than Clinton's, but they also amounted to a profile in courage. When Obama came into office, Starr explains, only 11 percent of Americans thought reform would have a "negative personal impact," but by August 2009 this segment of the population was trending to 31 percent. Both Rahm Emanuel and Joe Biden were urging retreat. Starr writes, "Obama not only resolved to go ahead; in September and again in the new year, the president took charge of the effort to steady the health-care initiative and prevent it from careening off the tracks." Nor was the final bill anything less than what might reasonably have been expected, filling as it did the negative space left by four generations of government programs and serial compromises. Starting with clean sheets of paper was never realistic when one-sixth of the economy was at stake.

Starr's great fear is repeal of the Affordable Care Act, which would not only deny healthcare to more than 30 million people but would cast doubt on whether "Americans will ever be able to hold their fears in check and summon the elementary decency toward the sick that characterizes other democracies." Obamacare, in short, was healthcare reform's best—and last—shot, and it would be unconscionable for liberals to remain cavalier about its defense, or Obama's, for that matter. It's past time to discard the misguided assumption that in a better economy, or with more of "a fighter" in the White House, something like a Canadian-style single-payer system might have been (or might sometime fairly soon be) enacted.

Don't be put off by the title of Starr's book, which sounds like a bland article in an academic journal. Starr presents the fate of very complex proposals with consistently graceful prose. Why have so many Americans wanted universal healthcare for so long and not achieved it? Why may opponents yet "react" against the "remedy"? The difficult truths are scattered over generations of political tussling.

The story begins with the Progressive Era, when proposals for government-sponsored healthcare were heavily influenced by, of all things, Otto von Bismarck's sly welfare legacy: the chancellor of Germany had introduced health insurance in 1883 as a way of co-opting proletarian leaders. Soon came the Coolidge-to-Hoover retrenchment. FDR's New Deal never seriously mooted universal healthcare—more on this presently—but the Truman administration did, proposing a single-payer scheme modeled after Social Security. This went down to defeat. The Eisenhower years focused on expanding employer-based insurance. The Kennedy and Johnson administrations finally delivered Medicare and Medicaid. Nixon attempted to advance "health maintenance organizations," and later, seeking to regain popularity during Watergate, he proposed an employer mandate and a "public program for those not otherwise insured," a formula many Democrats would now embrace but rejected then.

In retrospect, the saddest chapter was the ridiculously damaging Jimmy Carter–Ted Kennedy fight over universal coverage (Carter opposed it), which roiled Congress and paved the way for Reagan's reactionary "revolution," after which single-payer would never be seriously considered again. Then came the Clintons' letdown, though one triumph was the launch of the State Children's Health Insurance Program (or S-CHIP) in 1997, sponsored by Kennedy and Orrin Hatch. These advances were followed by the Bush years, in which S-CHIP expansion was twice vetoed but an (unfunded) prescription drug plan for seniors was unexpectedly passed. Finally, Starr tells us the story of the fight to pass Obamacare, which in context feels like a satisfying climax.

Each era had its champions, but Starr is particularly good at explaining the permanent counterforces that were salient on Washington's political landscape by the time Obama inherited it. First is the inherently conservative nature of Congress. From its inception, the Senate was designed to give disproportionate power to the more sparsely populated states. During the twentieth century, the arrangement favored Midwestern and Western rural states—bastions of Republican "self-reliance"—and the Democratic Jim Crow South. Universal healthcare, at least since the 1930s, meant creating a system of coverage for the working poor, a category that inescapably included urban laborers and Southern blacks. Getting legislators from the West and South to support this—or, if they did (as with the Robert Kerr–Wilbur Mills initiative for seniors in 1960), getting Southern and Western governors to opt in—was hopeless.

More recently, the extension of the filibuster gave a virtual veto to forty-one senators hypothetically representing less than a quarter of the population. We somehow manage to forget that Obama's supposedly impressive majority in the House in 2009 and 2010 was of no account—none—without a supermajority in the Senate, which Democratic leaders nominally enjoyed for only five months in 2010, and which even during that brief interlude relied on "moderates" whose views were indistinguishable from those of leading Nixon-era Republicans. (If they had enjoyed a Senate supermajority, the Obama administration would have gotten not just a "public option" but a second round of stimulus, a cap-and-trade energy bill, tighter bank regulations and immigration reform with the DREAM Act attached.) The House was hardly more responsive to Democratic presidents for much of the twentieth century. It was more reflective of the general will than the Senate, but its business was dominated by powerful committee chairs with seniority—again, for much of the story Starr tells, Southern Democrats. The fact that representatives face voters every two years makes them chronically susceptible to being lobbied (and threatened) by the healthcare industry triumvirate: the American Medical Association (AMA), the insurance industry and pharmaceutical corporations.

The second, and even more important, counterforce is accumulated material incentives. The tax reforms and IRS clarifications of the Eisenhower years—during which modern medicine and research hospitals rose in parallel with employment in large corporations—enabled businesses to deduct nearly all sums spent on employee group health insurance. Accordingly, businesses began to offer employees healthcare as a matter of routine in order to lure and retain talent in a hot employment market. Today, about 60 percent of Americans under 65 are covered through a private sector employer, while about 9 percent purchase health insurance directly, often through a trade association. (Plans negotiated by large unions in the 1960s and '70s were especially generous.) For this group, the goal of any reform was minimizing the risk of lapsed insurance if a job was lost and, upon being rehired, getting excluded from insurance pools for pre-existing conditions.

Since Medicare and Medicaid were passed in 1965, moreover, almost all seniors have grown attached to the status quo, as have their providers. Medicare has increased to become some 40 percent of total hospital revenue; 10 percent of patients incur about

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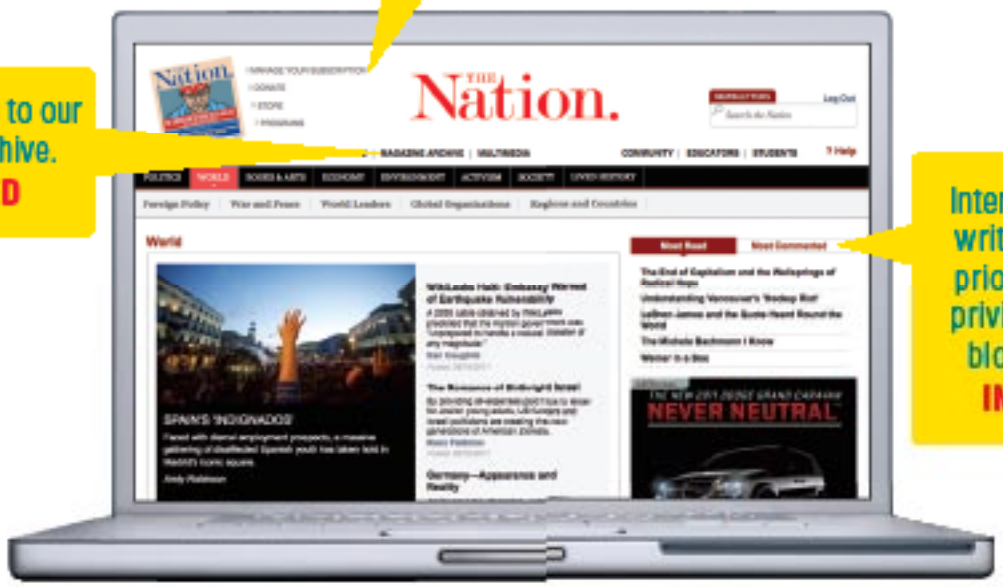

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70 percent of the costs. For a generation, seniors reasonably came to believe that unless the government ran out of money, their care would not be disrupted. By the time Obama came along, the vast majority of likely voters—the employed and seniors—saw health insurance less as a moral "right" to be extended than as an earned, established "benefit" to be reinforced.

The bottom line for voters, Starr explains, was that healthcare reform became practicable only as a guardian of, well, the bottom line. Premiums kept rising: overall expenditures jumped from about 9 percent of GDP in 1980 to about 14 percent in 1992 and 17 percent today. This frightening increase in the cost of care might seem to suggest an emerging conflict of interest between young and old (though the young worry about their parents, after all). What the increase really created, Starr shows, was a natural alliance in favor of "bending the cost curve" down while keeping the benefits up. Meanwhile, the expansion of "managed care" in Medicaid's network allowed most voters to feel, vaguely and incorrectly, that the indigent would not be abandoned.

A third counterforce is regional lobbying. Starr reminds us at the start of his book that "every dollar spent on health care is also a dollar that someone earns from health care." During the Clinton push, Florida legislators backed away from reform when the insurance industry mounted a TV campaign to convince seniors that Medicare benefits might be cut. And was there ever any point in trying to persuade Joe Lieberman, "the senator from Aetna," to allow people over 55 to buy into Medicare? Nancy Pelosi's staff told Starr that health industry lobbyists from states in which Medicare payment schedules were lowest are the ones who really killed the "public option," because the only conceivable plan of this kind would rely on Medicare to establish rates of compensation, and even Democratic representatives refused to appear to be forcing the short end of the stick on their state's providers. (Regional disparities, reflecting differing living standards, competencies of physicians and such, are pretty much inevitable and create permanent conflicts of interest impeding the creation of any uniform system of compensation. Canada's notionally single-payer system avoids the problem because it is actually a constellation of single-payer systems, with each province managing its own plan and negotiating rates independently with its providers.)

Given that "cost containment" became the game, and esoteric opinions about the numbers qualified one to play it, most voters were easily swayed by the claims and doubts of industry lobbyists presented as experts. Which is why it would have been irresponsible for Obama to try to pass reform without first lining up groups like the AMA, the drug companies and the hospital industry—all of which stood to gain new "customers" under the plan—in order to generate the kind of headlines that imply consensus.

Who killed the public option? Lobbyists from states with the lowest Medicare payments.

Fourth, and finally, are the politics of the not-quite-ideological sort: the egos of senators who expect to mark up bills (and slide in parochial advantages), Congresspeople who would not feel safe endorsing something that has not been demonstrated to work (which, for Obamacare, meant pointing to satisfaction rates in Massachusetts) and so forth. In this context, Starr emphasizes that Republicans under Obama became an all-but-monolithic party with a singular ambition: to regain the presidency. Starr implies, but does not say, that mainstream journalists have inadvertently colluded with Republicans by scoring politicians more on their electoral guile than on their public policies. Republicans have thus plausibly assumed that Obama would be blamed for any economic difficulties, even if they created or deliberately worsened them. Republicans were eager to subvert the administration's healthcare plan, never mind that Bob Dole (and, more recently, Mitt Romney) had pretty much designed it.

Obama found his work cut out for him in the spring of 2009. A year earlier he, Hillary Clinton and John Edwards had collectively stipulated the outlines of a future Democratic health bill during the primary campaign, incorporating private insurance companies into the delivery system ("If you like your health insurance, you can keep it") but prohibiting the denial of coverage to people with pre-existing conditions. All three agreed to look for ways to rein in Medicare costs by standardizing levels of, and procedures for, reimbursement. All agreed to reduce and eventually eliminate government subsidies (or overpayments) to Medicare Advantage programs, most of which flowed through to the profit margins of private insurance companies. All sought reductions in overall delivery costs through insurance "exchanges"—what President Clinton had called "alliances"—intensifying competition among insurers. These exchanges would become the means to make coverage more or less universal, providing subsidies for the uninsured while putting them into normal modes of preventive care—thus reducing dependence on emergency wards. All agreed to something like a "public option" on the exchange, and all assumed that costs for claims processing and administration would drop, owing to information technology and economies of scale. Subsidies for the uninsured would be paid for by eliminating Bush-era tax cuts for the wealthy.

Obama's only real point of disagreement with Hillary, which he eventually conceded, had been about mandating that all citizens—including healthy, employed young people who think they are immortal—buy insurance. Obama had first proposed a mandate only for parents to insure their children; by July 2008 he said simply, "I kind of think Hillary was right," and that was that. (The mandate, of course, was crucial to the act's balance sheet, though it launched the raft of lawsuits that the Supreme Court will begin hearing in March.) Given the history that Starr so lucidly recounts, it's clear that America's healthcare reform was bound to look, at best, more like Switzerland's mixed, complicated system, also based on private sector insurers, than like England's simple, unified one, in which doctors are essentially government employees. Nor, once Obama assumed office, was he going to make the mistake of excluding the heads of key Congressional committees from writing the legislation within the parameters described. If they wrote it, they'd own it. He also succeeded where Bill Clinton had failed, lining up the hospital and drug industries—too discreetly for some critics—in advance of the Congressional push.

Through the summer of 2009, Obama waited for Senator Max Baucus, chair of the Finance Committee—an ally of House Blue Dogs from the conservative state of Montana—to try to bring around Olympia Snowe, one of Maine's two moderate Republican senators. Baucus failed; there is no point rehearsing the sad story Starr tells. But did this mean Obama was deluded by his own rhetoric of bipartisanship and could have gotten a better deal had he been more combative? Not at all. Starr shows that Obama's real goal was "bipartisanship in one party," the not-monolithic Democratic

Party. He worked with Blue Dog sympathizers in the Senate like Baucus (and Kent Conrad of North Dakota, Ben Nelson of Nebraska, etc.) to woo Snowe and the few other Republican moderates, not because he expected to gain Republicans but because he feared losing Democrats. If the reputations of moderate senators did not become inextricably bound with the health reform effort, they'd be able to walk away and face no censure from their voters.

What emerges most vividly from reading Starr is how reckless it was for critics to charge Obama with not making his own views clear enough, or losing control of the narrative, because he resolved to leave to Congress—within an agreed timetable—the work of filling in the details. Yes, the schedule did slip a few months as Baucus worked his committee, but a few months in a century-long effort was a trivial delay. And it would have been widely recognized as such but for the righteous indignation Obama endured during his first spring in office, when anger over the bailouts was white-hot, and his administration's determination to regulate rather than nationalize the banks (remember Tim Geithner's "stress tests"?) gave critics, especially on the left, an opening to depict the president as a creature of Wall Street—catnip for the nascent Tea Party, as it turned out.

Starr shows that when the details of the health legislation finally came out, including proposals to stipulate new Medicare standards of care, talk of "death panels" inflamed latent anxieties about government interfering with personal choices. The left was also incensed by the deal the White House had cut with Big Pharma prohibiting, as part of the legislation, direct negotiations with Medicare over prescription drug prices and excluding medicines imported from Canada. (The industry group PhRMA agreed, in return, to find $80 billion in discounts to Medicare, and to pay for an ad campaign supporting the legislation.) Starr adds that, although this was not publicly known at the time, the health insurance industry wrote an $86.2 million check to the Chamber of Commerce to mount a campaign against the legislation. "If Obama and the Democrats had been in a stronger position politically," he writes, "they could have insisted on stronger cost containment and avoided making as large concessions to PhRMA and the hospitals as they did." But sixty Senate votes meant everything. "Reform needed interest group allies: there would be no way to pass it if the entire health-care industry went into all-out opposition."

Nevertheless, Obama pushed back hard. He called a press conference for July 22, laid out the elements of the plan as best he could and said of the insurers: "Right now, at the time when everybody's getting hammered, they're making record profits and premiums are going up." Starr—tactful to a fault this time—neglects to add that the real news made at the press conference was Obama's offhand remark that Cambridge police had acted "stupidly" in arresting Harvard professor Henry Louis Gates in his own home. The remark was true, but it put Obama on a kind of probation because it gestured toward the incipient gulf between the young, black, brainy president and lunch-pail whites like Sgt. James Crowley (the arresting officer), people who had first backed Hillary and then, like "Joe the Plumber," went in large numbers for John McCain.

Ironically, working-class voters stood to gain much more predictable medical coverage from healthcare reform, because pre-existing conditions and unemployment would no longer interrupt it. But the Gates incident reinforced how hard it would be for Obama to overcome latent suspicions that his healthcare plan was a new kind of affirmative action program or a new bailout for losers, foisted on ordinary people by a patronizing elite shuttling between Harvard Yard and Goldman Sachs. Obama finally stemmed the tide against the bill with a landmark speech to Congress in September, Starr recalls. But much damage had already been done. Months later, the Democratic nominee for Ted Kennedy's seat, Martha Coakley, campaigned ineptly, as if the healthcare proposal pending in the Senate, for which her vote would be crucial, did not exist. The loss of the Massachusetts Senate seat required Obama to hit the road and to embrace a tactical maneuver by which the House simply adopted the Senate bill.

Criticism of the Obama administration gained momentum through 2009, and even became strangely vogue among economists and columnists who were widely thought to be on the president's side. It was in this context that voices who had lionized Obama—from seasoned pragmatists like Robert Reich (who blurbs Starr's book) to MoveOn.org—spoke of the "public option" as the holy grail, and of Obama as its perfidious guardian. Perhaps it was the magical word "public," or the vague sense that Obama, having worked to salvage banks and restructure the car companies, was now protecting the profits of insurance companies. Perhaps it was the way this insinuation was magnified by the charge that the members of Obama's economic team were mostly disciples of Robert Rubin, thus to blame for deregulating investment banking and causing the financial crisis in the first place. Perhaps it was the way Obama's half-heartedness about a public plan, which he knew the Senate would never give him, suggested timidity. In any case, Obama's left critics now lambasted him. Former DNC chair Howard Dean declared in November 2009 that without the public option "this bill is worthless and should be defeated"—not grounds for drug testing, perhaps, but possibly for prescribing some Xanax.

The schedule did slip, but a few months in a century-long effort is a trivial delay.

The bill eventually passed, but it had become advantageous on the right, and fashionable on the left, to hold Obama responsible for failing to bring unemployment down to pre-recession levels in just twelve months. The most photogenic attack—already ubiquitous in Republican ads—came in the fall of 2010 when Velma Hart ingenuously upbraided Obama in a nationally televised town-hall meeting, complaining that she was "exhausted" from defending his administration. ("I've been told that I voted for a man who said he was going to change things in a meaningful way for the middle class," she said; "I'm one of those people.… I'm waiting, sir. I don't feel it yet.") There followed a spasm of second-guessing: the pleasure principle unbothered by the reality principle. Obama should have put "jobs" first: that is, the stimulus should have been larger, as if the stimulus had not come before healthcare and been considerably larger than Congress had first been inclined to pass; as if Obama had not made healthcare the centerpiece of his campaign and had not gone back for a second stimulus, which the Senate killed; as if "jobless recoveries," which reflect tectonic shifts in the technologies of production, are not structural innovations Keynes may not have thought of in an age of telegraph, shortwave and surface mail; as if Fox News does not give a whole new meaning to the phrase "bully pulpit." The Affordable Care Act, Starr shows, even gave relief to badly

strapped state budgets by assigning 100 percent of the responsibility for Medicaid to the federal government for the first three years; traditionally red states, "with historically low Medicaid eligibility and large uninsured populations"—along with the highest rates of unemployment—stood to gain the most. "If ideology did not trump self-interest," Starr laments, "these states would be the Affordable Care Act's biggest fans."

For the first African-American president, surely the cruelest charge from the left was that in pursuing healthcare the way he did, he had wasted an "FDR moment." Unlike Obama, presumably, Roosevelt had summoned the courage to take a radical case to the people against Congressional resistance—to be transformational, not merely transactional. Starr's review of the New Deal refutes that myth, reminding us that Roosevelt avoided a healthcare fight almost from the start, not only because he didn't want to take on the doctors but also because he didn't want to ruffle the feathers of Southern Democrats. Indeed, FDR's entire reform strategy depended on holding together a coalition that required him to ignore, if not pander to, the grotesque racism of the South. He got Social Security (and other bills) passed by appealing to immediate and universal pocketbook interests, and with a larger Senate majority, which reserved the filibuster mainly for civil rights; to appease Southern Democrats, he agreed to exclude domestic servants and farm laborers (e.g., sharecroppers) from the initial Social Security program.

Were Dean and the others right? Was the public option really the signal way to extend care and reduce costs? Starr shows that the issue is much more complicated today than it might have been, say, when Medicare was launched and economies of scale were the only way to reduce transaction costs—when, that is, only the government had the money to buy the IBM counter-sorters. Obama had not just seen the writing on the wall in Congress before his left accusers; he seemed to have grasped the problem of costs more deeply. This is why he hinted early on that he might favor Senator Conrad's idea of promoting health cooperatives as an alternative to a Medicare-like plan. (In Conrad's North Dakota, "agricultural and other co-ops have historically played an important role.")

Think, for example, about the bill for a knee replacement under Medicare. (I have; my wife just received one.) There is the cost of the surgeon, the anesthesiologist, the surgical support staff, the hospital room, the nurses, the prescribed hospital procedures, the drugs, the physical therapy and claims processing. Virtually every one of these costs is driven by different considerations, some susceptible to being lowered by government action, some not, and some more likely to be lowered by private sector competition. True, if all surgeries of this kind were estimated with doctors and hospitals in advance, and paid according to a fixed budget—the way home repairs might be negotiated with a contractor, or Ontario negotiates with its providers—then all-in costs would be contained. Powerful customers—in my wife's case, Medicare—could use their market power to bargain down at least the part of the bill related to professional services, doctors and nurses, and hospital beds (though, again, payments vary in different states, and Medicare patients would not want the best surgeons, such as those at Massachusetts General, where my wife's surgery was performed, to refuse them). On the whole, moreover, there might be other advantages to fixed budgeting. Hospitals would be induced to focus on measuring financial outlays against the quality of outcomes. Physicians would have incentives, as at Mass General, to communicate about patient care more as a team, or to institute the kind of cost-reducing quality procedures you find in airplane maintenance or computer chip fabrication. Starr recalls Atul Gawande's famous *New Yorker* article, which Obama circulated among his staff, showcasing the Mayo Clinic, a facility that has emphasized just such teamwork since its inception, and has been among the highest-quality and most cost-effective in the nation. (Cost control through fixed budgeting was the logic behind the rise of HMOs in the 1980s until, Starr explains, patients began to realize that unregulated HMOs controlled costs by denying needed care.)

Anyway, to have imagined the wholesale reinvention of the American healthcare system as a big network of Mayo Clinics, however tantalizing, would have been fanciful. Yes, over time the proliferation of best practices, especially those established by Medicare's professional oversight boards and hospice counselors (it was in this context that the "death panel" charge exploded on the scene), would systematically bring costs down. But Starr shows that in Teddy Roosevelt's day, the AMA—fearing, precisely, that the Mayo model would restrict doctors' compensation—had turned against health insurance altogether. From that time on, fee-for-service medicine became the norm: providers charge, patients have no notion and insurance pays. Even Medicare, for all its scale, could restrain costs only around the edges; this is why healthcare in America eats up almost double what it does in other Western democracies.

Dean supposed that the proposed public option would compete with private insurers on the exchanges and cause the costs of premiums to fall. But would they have? Dean was right that a public option keyed to Medicare rates would have saved the government considerable money—$110 billion over ten years, according to the Congressional Budget Office (CBO). But, again, states where Medicare payments were low killed the idea. Pelosi was stymied. Without Medicare as the basis, any imaginable public plan would not have been cheaper than private plans. A public one would have been more expensive, because it would have drawn from a higher-risk pool of people who for whatever reason had been uninsured. The CBO reckoned that only about 2 percent of people seeking insurance would opt for it. Ironically, Starr says, the left was backing "the high-cost option as an example for the conservative case that the government is incompetent." True, one could hope that if a public plan started up, and if it launched with compromise rates between Medicare and private plans, and if panels could be established to bend reimbursements down later on, then such a plan could both grow and reduce costs. Then again, what politician from a disadvantaged state was prepared to embrace a question loaded with three ifs?

But wait. Wouldn't a public plan enjoy critical savings in claims-processing and administration, especially if it didn't have to pay dividends to shareholders or engage in marketing? This, Starr shows, is also an illusion. According to former White House adviser Ezekiel Emanuel, administration does account for "roughly 14 percent of what the United States spends on health care, or about $360 billion per year," about half of which is borne by Medicare, Medicaid and insurance companies, the other half by doctors and hospitals. But the most important issue in claims processing, Starr argues, is a "unified or standardized" system. He doesn't pursue the point in his book; but as his Princeton colleague Uwe Reinhardt has stressed, savings could be realized only through a common taxonomy for diseases and procedures and standard reporting methods for billing from hospitals and medical offices. Emanuel elucidated the six steps necessary to standardize the billing

process in a recent article in the *New York Times*: "determining a patient's eligibility for services; obtaining prior authorization for specialist visits, tests and treatments; submitting claims by doctors and hospitals to insurers; verifying whether a claim was received and where in the process it is; adjudicating denials of claims; and receiving payment."

The key issue here, and one not to be underestimated going forward, is the integrative power of information technology. Once, nothing less than a single bureaucracy, exploiting centralized information databases, was required to execute claims-processing transactions efficiently. No more. So long as standards are adhered to—which the Affordable Care Act mandates—nodes in distributed networks (doctors' offices, hospitals, pharmacies) are perfectly capable of supplying or aggregating data from federated sources without transaction costs that are appreciably higher than what was once available only from a mainframe. Physicians wouldn't need a single-payer system to gain efficiencies and curtail administrative costs any more than they would need, say, all patients who pay with a credit card to be customers of a single bank. Streamlined electronic billing and credentialing could save $32 billion a year. Incidentally, co-ops and nonprofits—other kinds of public options—would benefit the same way private insurers would.

But much more important to costs than claims processing is the nature of the risk pool. Obamacare—in denying private plans the right to sign up only the young and healthy—promised to move all plans closer to an average pool: to use the business school lingo, it promised to obviate "cherry-picking" and yet "commoditize" procedures. Assuming the promise is realized, moreover, all plans will have incentives to reduce costs by accepting industry-standard taxonomies and reporting forms. Private insurance companies will have an even greater incentive than nonprofits to do so first, because innovations in claims processing, streamlining and specializing in the delivery of procedures and so forth will be the only way for them to gain the profit margins they need to satisfy share-holders if they can't take it from the care of patients. (Think of how Southwest Airlines, the most consistently profitable airline in the industry's history, moved to simplify its logistics and standardize maintenance.) All plans, correspondingly, will have a common incentive to use peer-to-peer networks to create buying alliances and bid down the cost of drugs.

Arnold Relman, former editor of *The New England Journal of Medicine*, has been hammering away at these points for many years. Quantum savings in healthcare delivery will be impossible to realize until fee-for-service is gradually curtailed. The public option could not curtail it. In the meantime, and as the act warrants, Medicare can only empower expert panels to determine best practices and mandate how these will be proliferated. And the only way for society as a whole to cover the excess cost of the uninsured is to collect more revenue from the wealthy.

This last point, of course, is the timely one. Starr is priming us for the 2012 election, the run-up to which will pose a fundamental choice. All the costs of the act, including leaving Medicare's cost-curve unbent, could be covered more or less by letting the Bush-era tax cuts on people earning more than $250,000 a year expire, which would yield more than $900 billion. Americans will soon decide whether or not to leave in place a president who, among other things, will leave the act alone. It would be a shame, Starr warns, if the president who husbanded this once-in-a-lifetime legislation to victory is beaten by a Republican claiming the need for "leadership" in the White House—a double shame if misinformed Democrats, nursing their "disappointment," continue to help make that need seem plausible. ■

Complaint

Walk out the front door, the dog tugs
Boyishly at the leash.
I sit at my desk. A breeze
Floats up from Oakdale on the hottest day of the year.
This is the climate of reason.

But in the climate of no reason
I look out the window at midnight.
My mother appears in a red coat, raking the leaves.

Always she wore that coat in autumn,
The tattered wool, the large
Black buttons,
But only to rake leaves.

Why my house was built on the dividing line
I cannot say. Walk out the front door,
Somebody dies.
Walk out the back,
The rabbit jumps out of his hole.

Bedroom in one world, kitchen in another—
You could say it's always
September here,
Every day the first day of school.

The bus is waiting.
I've got books, my lunch,
My gym clothes in a plastic bag.

JAMES LONGENBACH