Massachusetts Health Care Reform:
Chapter 58, the New Politics of Health Care, and Gravity Lessons

http://www.masscare.org/chapter-58/
Gov. Mitt Romney on Wednesday signed a law guaranteeing virtually all Massachusetts residents have health insurance, making this the only American state committed to comprehensive medical care, considered a right in most developed nations.

“This week, Massachusetts enacted legislation to provide health insurance for virtually every citizen within the next three years.”

“The bill does what health experts say no other state has been able to do: provide a mechanism for all of its citizens to obtain health insurance.”

“After so many years of false starts, our actions have finally matched our words, and we have lived up to our ideals.”

U.S. Senator Ted Kennedy

“We can all share the credit for this landmark legislation, but the biggest victory is for the people of Massachusetts, who will now have equal access to the most renowned healthcare in the world.”

Mass. Senate President Robert Travaglini

Commonwealth Care: Sliding subsidies for uninsured up to 300% of the federal poverty line.

Employer “Fair Share” Assessment: Small fee of $295 per year per worker for some businesses not covering their employees.

Individual Mandate: Requires that uninsured people above a certain income limit buy their own health care, or face severe financial penalties.

Medicaid expansions: children up to 300% of poverty, restored dental and eyeglass benefits.

Medicaid Rate Hikes: Significant increase in Medicaid payment rates to hospitals and physicians.
**Incremental State Reforms**

- Attempt to "plug the gaps" in health insurance coverage through new or expanded public programs.
- Programs are targeted and subject to appropriations.
- Programs are financed through new taxes and assessments, and through cost-containment measures.
- Massachusetts Reform Bill similar to many previous incremental reforms in scope and structure.
“Over the next five years, the Dirigo Health Program will provide coverage to the 180,000 Mainers who are currently without health insurance and, equally important, reduce health care costs for everyone. By utilizing an innovative blend of private and public resources, Maine has catapulted itself to the forefront of progressive health care reform.”

“Dirigo will fill the gaps in coverage starting next July, when the first 31,000 Mainers will be insured under the program. The remaining 130,000 uninsured Mainers will be covered by 2009.”

“Maine has just become the first state in the union to approve a plan to provide universal access to affordable health insurance.”

“More than 16 months after the Dirigo Health program was rolled out, fewer than 10,000 people are enrolled... It is now providing coverage to about 5,000 people who previously weren’t insured.”

“The imperfect beginnings of John Baldacci’s DirigoChoice health insurance and George Bush’s Medicare drug benefit - confusion, under-enrollment, cost questions and, naturally, lawsuits - provoke more or less the same response. These reforms will take time, but that’s only about a quarter of an answer. Why do they need time? To fail, of course.”

% of Uninsured in Maine 1987 - 2005
Minnesota has set a goal of achieving universal coverage by July 1, 1997. In 1992, the state passed legislation to subsidize premiums for the uninsured and let employers buy coverage from a state pool.

Minnesota is about to embark on a plan to solve the health-insurance crisis that could hold lessons for other states and the nation. It will begin to subsidize coverage for the uninsured. HealthRight will begin signing up families with children in the fall and will be fully open to Minnesota's estimated 370,000 eligible uninsured by 1994.


Minnesota 1992/1993

% of Uninsured in Minnesota 1987 - 2005

Oregon 1989 Headlines

- "A model for nation? Oregon's health care plan guarantees basic care for every resident"
- "Oregon's Health Law Cure for National Ailment"
- "A PIONEERING EFFORT--MEDICAL COVERAGE FOR ALL MAY BE COMING SOON IN OREGON"

Sources: Portland Oregonian 10/6/89; Tulsa World 10/10/89; Los Angeles Times 10/24/89.
"Tennessee Gov. Ned McWherter unveiled a plan April 8 for what he called 'the most radical health care plan in America' and claimed it would become the national model. The Tennessee plan would gather nearly 6 million current Medicaid patients with 500,000 uninsured Tennesseans into a single managed care program called TennCare."

"TennCare is a five-year demonstration project that will use managed care organizations to deliver care to a million Medicaid recipients. TennCare will cover an additional 300,000 currently uninsured in the first year. The number of uninsured enrolled in the program could reach 500,000 in the second year."

Sources: Federal & State Insurance Week 4/12/93; and PR Newswire 11/19/93.


**TennCare Implementation**

- $2 in matching federal funds for every $1 spent in state funds (compared with $0.50 for every $1 spent in Massachusetts).
- TennCare has added an additional 400,000 enrollees to its 800,000 traditional Medicaid recipients.
- **1 out of every 4** Tennesse residents covered by TennCare by 2005: the most expansive and expensive health care program in the nation.
- After first year in 1994, TennCare caps enrollment at 1.2 million, and permanently closes enrollment for uninsured.

**TennCare Outcomes**

- Following enrollment year, percentage of uninsured plummeted from 14.7% to 11.2% of population. But it rises to 16.4% the very next year. In 2005, 16.3% of population was uninsured.
- Collapse of TennCare system is imminent. Under Democratic Governor, TennCare’s annual report for 2004-2005 states:

> “Despite the successes of extending health insurance to hundreds of thousands of non-Medicaid eligible Tennesseans through TennCare over the past 11 years, 2004 represented the year the state could no longer ignore the impending fiscal crisis that TennCare threatened if left unchecked.

> If left unchecked, TennCare would consume 91 percent of all new revenue growth by 2008, essentially eliminating the state’s ability to fund other state departments and priorities.”

**Other "Universal" Incremental Reforms**

- Hawaii Prepaid Health Care Act (1974)
- Washington Basic Health Plan (1987)
- Massachusetts Health Security Act (1988)
- California Affordable Basic Health Care Act (1992)
- Florida Health and Insurance Reform Act (1993)
- Washington Health Services Act (1993)
- Utah Primary Care Network (2002)
- Vermont Catamount Health Plan (2006)
Increase in Percentage of Uninsured 1987-2005
- United States: 3.5% increase (14.4% - 17.9%)
- Texas: 3.9% increase (23% - 26.9%)
- Florida: 3.9% increase (20.5% - 24.4%)
- Maine: 2.4% increase (9.9% - 12.3%)
- Minnesota: 2.4% increase (7.4% - 9.6%)
- Massachusetts: 4.1% increase (7% - 11.1%)
- Oregon: 1.1% increase (17.2% - 18.3%)
- Tennessee: 0.3% decrease (16.3% - 16.6%)

“History repeats itself, first as tragedy, second as farce.”

Why have incremental reforms proven so ineffective in practice?

1. Commercial health insurance markets prevent states from extending quality coverage to the uninsured.
2. Funding has been a major barrier: cost control strategies have had limited success, and few new sources of revenue have been sufficient.
3. Incremental reforms have not attempted to address the broader crisis of access and affordability, but have focused on the crisis of uninsurance.
The Role of Commercial Health Insurance

- Commercial Insurers cover workers with full-time, stable jobs and individuals with enough income to purchase individual insurance plans: those best able to pay.
- Public insurance plans cover the elderly, the young, the disabled, the sick, and those without income sufficient to purchase individual insurance: those with the highest costs.


Undermining The Principle of Insurance

• Purpose of insurance: to protect each other from the risk of health crises by sharing the costs of health care when we can pay.
• Commercial insurers have been given the market for those who are best able to pay, while public programs attempt to cover those least able to pay but with the highest health care costs.
• Richard Titmuss: “Programs for the poor are poor programs.” For two reasons:
  1. Fragmented risk pools – labor market separates those who can pay from those most in need.
  2. Public programs must be limited to preserve commercial health coverage.

Incremental Expansions and “Crowding-Out” the Commercially Insured

• States worry that public health coverage that is too accessible, affordable, or comprehensive will “crowd” insured people out of the private market.
• All incremental reforms intentionally limit access, impose cost barriers, and/or erode the quality of coverage to prevent crowding out.

Beyond the Rhetoric

Incremental reforms are not able to make health care a right, or to approach universal coverage, without causing the collapse of the private insurance sector.
Most Common Protections Against “Crowd-Out” in Incremental Reform Bills

- Exclusion of anyone who has been covered in past 6, 12, 18 months.
- Exclusion of the underinsured.
- Inclusion of only specific demographics (children, etc).
- Exclusion of anyone offered insurance by an employer, even if employer contribution is low or offered plan is poor.
- Exclusion of everyone above a certain income level.
- Charging premium payments depending on income.
- Imposing deductibles, co-payments, and co-insurance.
- Limiting service networks.
- Limiting benefits.

The Massachusetts Bill Imposes All Of These Limits On Enrollment!

Scylla: Barriers to Enrollment to Prevent “Crowding Out”

- Maine Dirigo: Expectation – 31,000 uninsured people enrolled in 1st year, remaining 130,000 by 2009. Reality – fewer than 10,000 enrolled by 4th year (2007), less than half of these were uninsured prior to enrolling.

Charybdis: Can’t Control Costs of Health Care or Afford to Cover Many New Individuals

- MinnesotaCare: Expectation – subsidized insurance up to 275% of poverty line: first 158,000 enrolled by 1997 at $252.3 million. Reality – 142,000 enrolled by 2005 and declining at $409 million.
Washington Basic Health Plan: **Expectation** – all residents below 200% of poverty for 1987 law, “universal” coverage from 1993 law. **Reality** – forced to cap enrollment at 125,000 in 2001, additional 400,000 residents eligible.

TennCare: **Expectation** – will cover all residents below 400% of poverty, 300,000 enrolled in the first year, 500,000 by second year (out of a total 700,000 uninsured).

Uninsurance and Underinsurance are Structural Features of Commercial Health Care

Uninsurance and Underinsurance Are Not A Math Problem

Reasons for Health Reform “Math Problems”

- Initial estimates of costs and revenues wildly unrealistic.
- Health care is a moving target – spiraling health care costs kick more off of private coverage and make public coverage more expensive every year.
- Cost control measures have had little success.
- Very limited new sources of revenue have been available beyond maintaining existing programs.

Little Savings from Cost Control, Limited Sources of New Revenue

- Managed Medicaid
- Lowered Capitation Rates
- Eroded Benefits
- Certificate of Need Statutes
- Managed Competition
- Tobacco Taxes
- Provider Taxes (on hospitals & physicians)
- Insurance Taxes
- Employer Fair Share Provisions
- Employer Free-Rider Surcharge
- Uncompensated Care Pool
- General Funds
- Uninsured People
Little Savings from Cost Control, Limited Sources of New Revenue

Cost Control
- Managed Medicaid
- Lowered Capitation Rates
- Eroded Benefits
- Certificate of Need Statutes
- Managed Competition
- Tobacco Taxes
- Provider Taxes (on hospitals & physicians)
- Insurance Taxes
- Employer Fair Share Provisions
- Employer Free-Rider Surcharges
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- General Funds
- Uninsured People

Chapter 58 Has No Cost Control & a Few Problematic Sources of Revenue

New Revenue

COST CONTROL

NEW REVENUE

Chpt. 58 Employer “Fair Share” Assessment

Expectation: Any employer not making “a fair and reasonable premium contribution” toward a group health plan will be fined $295 per employee, to help subsidize care for uninsured.

Reality: a “fair and reasonable” contribution was defined as any employer covering 25% of its employees, or offering to pay 33% of a health insurance plan. Few if any employers – even those with thousands of uninsured workers – will have to pay the assessment.

Sources: Chapter 58 of the Laws of 2006; and Massachusetts Division of Health Care Finance and Policy, Regulation 114.6 CMR 3.0.

A “Fair and Reasonable” Firm

- An average high deductible health plan comes with a $265 per month premium, and a $2,000 deductible for individuals. (Wal-Mart’s “Freedom Plan” for workers has an even lower premium and a $6,000 deductible.)
- An employer offering to pay $87 per month towards a crummy plan for its workers will be considered “fair and reasonable” – even if workers do not buy the plan – and will not have to pay the $295 fair share assessment.
- Few if any employers – even those with thousands of uninsured workers – will have to pay the assessment.

Sources: Kaiser Family Foundation, Employer Health Benefits 2006 Annual Survey.
Chpt. 58 Employer Free-Rider Surcharge

**Expectation:** Any employer who does not “offer to contribute toward, or arrange for the purchase of health insurance,” and whose workers use Medicaid or the Free Care Pool, will have to pay a portion of the costs of publicly supporting those workers.

**Reality:** Any employer setting up a cafeteria plan for its workers – even if they contribute nothing towards it – will not have to pay the surcharge, even if all their workers rely on public assistance.

Source: Kaiser Family Foundation, Employer Health Benefits 2006 Annual Survey.

The Uncompensated Care Pool (UCP)

**Expectation:** “Subsidies for low-income residents would total about $720 million a year, figures Massachusetts Secretary of Health Tim Murphy, but the law would tap into the large pot of dough his state has set aside to pay for the costs hospitals and other providers bear when the uninsured get free care at emergency rooms and elsewhere. Most other states don’t have such available funds.”

**Reality:** The UCP has run out of money for 7 of the last 10 years; the UCP spends *much* less per person than it would cost to insure them; most of the funds raised for the UCP cannot be reused for subsidizing the uninsured.


If 1/4th of UCP users were fully insured for 2004, the state would be able to fully reimburse hospitals – with no surplus.

Source: Division of Health Care Finance & Policy, Uncompensated Care Pool FY 2005 Annual Report.
Regressive Financing – The Uninsured

- **Expectation**: Subsidies for the uninsured below 300% of poverty will charge affordable premium rates. An individual mandate will require all uninsured people to purchase private health insurance, only if they can afford to do so.
- **Reality**: The State’s definitions of “affordable” are unrealistic for many people. Individual premium payments are the most regressive and wasteful way of financing health care expansions. Individual mandates address no cause of the health care crisis and involve punitive enforcement mechanisms that effectively criminalize the uninsured.

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**Are The Subsidized Premiums Affordable?**

- The Greater Boston Interfaith Organization (GBIO) surveyed 350 members of affiliated congregations.
- Fully 59 percent of those lacking insurance, with incomes between 100% and 300% of poverty, reported they would not have the discretionary income to afford the established premiums, and could not buy into the subsidized plans.
- GBIO concluded that: “The premium schedule developed by the Commonwealth Connector does not reflect the real-life expenses of Massachusetts residents.”

Source: Greater Boston Interfaith Organization, “What Is Truly Affordable For Massachusetts?”
Three Ways To Extend Health Care Coverage

- Rights Based: Access is an entitlement, funded through socialized taxation. The only proven means of achieving universal coverage.
- Incentive Based: Access is purchased and voluntary, but subsidies are offered as an incentive.
- Criminalization: Purchasing access is required by law, failure to purchase access is penalized.

The Individual Mandate

- Governor Mitt Romney: “40% of the uninsured were earning enough to buy insurance but had chosen not to do so. Why? Because it is expensive, and because they know that if they become seriously ill, they will get free or subsidized treatment at the hospital. Why pay for something you can get free? Of course, while it may be free for them, everyone else ends up paying the bill, either in higher insurance premiums or taxes.”
- Chapter 58: Individuals who can “afford” to must buy health insurance on the private market, or lose their personal tax exemption and be fined half the cost of the cheapest insurance plan available.

Background of “Personal Responsibility” Movement

- Rooted in attack on welfare receipts: “Personal Responsibility Act” was 3rd plank of Newt Gingrich’s “Contract With America” following 1994 Republican sweep of Congress.
- Attempts to prevent “free riding” by public program recipients, shifts financial burdens onto disadvantaged communities, often relies on punitive enforcement mechanisms.
- Revived in 21st century to reform health care, offered as major alternative to incremental expansions as solution to health care crisis.
Personal Responsibility Reforms
The Third Foot Falls

- **Private Insurance**: Health Savings Accounts (HSAs) and High Deductible Health Plans attempt to hold individuals responsible for their use of health care system by shifting from insured to out of pocket costs.
- **Public Insurance**: Medicaid reforms in West Virginia, Florida, and South Carolina deny enrollees benefits if they do not conform to healthy lifestyle and standards for "responsible behavior."
- **The Uninsured**: Individual mandate laws require the uninsured to purchase their own insurance or pay for costs out of pocket if they are deemed able to.

Is The Uncompensated Care Pool “Freedom to Mooch”? 

- **Governor Mitt Romney**: “No more ‘free riding,’ if you will, where an individual says: ‘I’m not going to pay, even though I can afford it, I’m not going to get insurance, even though I can afford it. I’m instead going to just show up and make the taxpayers pay for me.’”
- **Robert Moffitt (Heritage Foundation)**: “Governor Romney sought a way to prevent the free-rider problem: those who take advantage of emergency services skip out on the charges, leaving taxpayers to cover the bill. Romney proposed that state residents either purchase health insurance or, if they chose not to do so, ‘self insure’ by posting a $10,000 bond that could be put towards the cost of any hospital care they might use but be unable to afford.”
- **Uwe E. Reinhardt (Professor of Economics at Princeton University)** said that he has long believed that the American system of allowing uninsured patients to receive care at the government’s expense was nothing more than “freedom to mooch.”

Source: Scott Greenberger, Boston Globe, 6/22/05; David Fahrenthold, Washington Post, 4/5/06; Robert Moffitt and Nina Owcharenko, WebMemo #1045, 4/20/06.

Less than 5% of uncompensated care costs are from patients at 300% of poverty and up — those targeted as “free-riders” by individual mandates.

Source: Division of Health Care Finance & Policy, Uncompensated Care Pool FY05 Annual Report.
**First, Do No Harm?**

A Massachusetts Punitive Index

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<tr>
<th>#</th>
<th>The Crime</th>
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<tr>
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<td>2</td>
<td>Employers Failing to Partially Subsidize a Poor Health Plan for Workers</td>
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<td>Illegal Sale of Firearms, First Offense</td>
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<td>Driving Under the Influence, First Offense</td>
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<td>Domestic Assault</td>
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<td>6</td>
<td>Cruelty to or Malicious Killing of Animals</td>
<td>$1000 max.</td>
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<td>7</td>
<td>Communication of a Terrorist Threat</td>
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<td>8</td>
<td>Being Uninsured In Massachusetts*</td>
<td>$1500 min.</td>
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*Note: Original version of House Bill would have suspended individuals’ driving licenses for uninsurance as well.*

**Democratic Support for Individual Mandates as Progressive Taxation**

Question: To achieve universal health coverage, one proposal would require that everyone have health insurance, the way all drivers are required to have automobile insurance. People with higher incomes who do not have coverage would be required to buy insurance, and the government would help pay for insurance for those who can’t afford it. Would you favor or oppose such a plan?

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<td>25%</td>
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<td>37%</td>
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<td>22%</td>
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**Progressive, Flat, and Regressive Taxes**

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19
Can Middle-Class Families Afford to Self-Insure?

<table>
<thead>
<tr>
<th>Have three months of income worth in financial wealth</th>
<th>Can cover unemployment spell</th>
<th>Can cover medical emergency</th>
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<tr>
<td>2001 28.8%</td>
<td>39.2%</td>
<td>34.8%</td>
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<tr>
<td>2004 18.3%</td>
<td>28.8%</td>
<td>22.3%*</td>
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</tbody>
</table>

**Medical Emergency** is defined as the median cost of one emergency room visit and one hospital visit in a year, $3,313 dollars for 2004.

Source: Calculations from Christian Woller and Eli staub, "Middle Class in Turmoil," Center For American Progress and SEIU.

The Industry Coalition Behind Mandates

- **Insurance Companies** stand to gain a vast individual market of people forced to buy private plans from individual mandates.
- **Employer Associations** support as an alternative to employer mandates that shifts burden of responsibility onto individual workers.
- **Hospital Associations** hope mandates will reduce "bad debt" (non-payment) cases, for which they often take losses.

Health Care Reforms Are Complex
Evaluating Health Reforms Is Simple

- **Does the Reform Control Costs?** Without cost control, the private insurance sector will continue to erode, increasing burdens on workers and businesses; even maintaining public insurance programs will strain state and local budgets, expanding them becomes difficult.

- **Does the Reform Raise New Revenues, and Who Pays?** Without cost controls, we can only expand access by spending more. But regressive financing will not be sustainable, and could create personal crises.

- **Does the Reform Reduce Inequalities In Access and Financing?** Although equitable distribution of a crisis is not the peak of humanitarian action, the United States has one of the most discriminatory health systems in the developed world – in terms of financing, in terms of access to care, and in terms of outcomes.

Evaluating Chapter 58

- **Does the Reform Control Costs?** No. Creates a Health Care Quality and Cost Council with no powers.

- **Does the Reform Raise New Revenues, and Who Pays?** Attempts to raise new revenues from employers not insuring their workers were weak to begin with, and have been completely undermined. The Uncompensated Care Pool can offer very small resources if significant reductions in Pool users are realized. Subsidies for the uninsured must come from the General Funds, and thus compete with other social programs (mostly other health programs). Charging uninsured people themselves with their own insurance costs is regressive financing and potentially a danger for middle-class household budgets.

- **Does the Reform Reduce Inequalities In Access and Financing?** No. Creates a Health Disparities Council with no powers.

What Can We Expect From Chpt. 58?

(If Mass. Bill plays out like similar reforms)

- Tens of thousands of uninsured will receive subsidized coverage.

- Numbers of enrollees will either fall short of projections (due to premium costs) or will run up against budget constraints and have to be capped.

- Funding will have to come predominantly from the General Fund, and the political will to continue high-level spending at the expense of other social programs will diminish over time.

- If health care costs continue to rise, the percentage of uninsured residents will return to levels prior to reform within 1-4 years.

- The individual mandate is an untested policy tool. It will probably be difficult if impossible to implement: expect delays, lifting of income levels at which households must pay, or repeal.
Crisis of Access & Affordability Larger Than Crisis of the Uninsured

Source: Graph by PNHP, R.J. Blendon et al., JAMA 1994, 271:198.

Insured Populations Face Crisis of Cost-Sharing and Risk-Sharing


New Phenomenon for Labor Movement—Era of Health Care Concession Bargaining

Reforms Addressing Only the Uninsured Are Limited & Can't Work Alone

- Not because they do not attempt to do all things for all people at once.
- But because the presence of a crumbling private market limits the capacity of public programs to provide a safety net for the uninsured.
- Because access and affordability can be just as far out of reach for the insured, obfuscating the real issue in policy debates.
- Because a crumbling private market creates a growing burden for public support programs, while at the same time capturing the resources of the healthiest segments of the community.
- Because the cause of the health care crisis for the well insured, the underinsured, and the uninsured is the same: health care costs.

High Health Care Costs Due To Our Insurance System

Source: Alan Sager and Deborah Socolar, "MASSACHUSETTS HEALTH SPENDING SOARS TO $62.1 BILLION IN 2006," 6/28/06

Difference in Health Spending Per Capita U.S. vs Canada, 2005

Sources: Woolhandler, Himmelstein, Campbell, NEJM 2003; 349:788 (updated); NCHS & CIHI.
Health Costs As % Of GDP: U.S. and Canada, 1960-2010

Incremental Reform in Massachusetts

“You Can’t Cross a Chasm in Small Steps”
- David Lloyd George
"Gravity Lessons" From State Reforms

- Incremental expansions do not actually take steps towards universal coverage: they are extremely important damage control efforts for the uninsured.
- The task of damage control will get more, not less difficult with rising costs.
- Personal responsibility advocates have taken a more realistic approach to cost control than incrementalists: the movement for "personal responsibility" would limit costs by shifting expenses onto patients at the point of access, reducing illegitimate and legitimate use of care.
- Champions of universal, comprehensive access need a sweeping, proven strategy for cost control to represent a viable option for states, municipalities, employers, and residents.

A Pragmatic Approach

idealism - 2. The practice of idealizing or tendency to idealize; the habit of representing things in an ideal form, or as they might be; opp. to realism. Also, aspiration after or pursuit of an ideal.

pragmatism - 3. A method of treating history in which the phenomena are considered with special reference to their causes, antecedent conditions, and results, and to their practical lessons. Obs.

- Actively support damage control measures, because the "damaged" are our brothers, sisters, grandmothers, children, loved ones, and ourselves at some point in our lives.
- Strive to speak above the din of well-intentioned journalists, legislators, and activists who would call incrementalist measures steps towards universal coverage; or who would further victimize marginalized communities by shifting the growing health care burden onto individuals.
- Remain pragmatic in supporting the movement for single-payer health care.