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Long Time Coming: Why Health Reform Finally Passed

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ABSTRACT Health reformers have an established record of losing. Going into 2009, there were plenty of reasons to believe that they would fail again. A polarized political environment, soaring budget deficits, and myriad other obstacles stood in the way. Yet the Obama administration and congressional Democrats defied the odds. Democrats won the 2009–10 health reform battle by successfully applying lessons learned from past failures, including the importance of neutralizing interest-group opposition. The result is historic legislation that, given the constraints imposed by both the U.S. political and health systems, is probably as good as it gets.

The twentieth century was unkind to health reformers. National health insurance proved a maddeningly elusive goal, as a parade of presidents—Harry Truman, Richard Nixon, Jimmy Carter, and Bill Clinton—tried and failed to overhaul the nation's health system.¹ Every time reformers got their hopes up, their plans ran into an array of formidable obstacles, including fierce opposition from stakeholders such as the American Medical Association, business, and the insurance industry; fragmented political institutions that made passing health care legislation, even when a president's party controlled Congress, exceedingly difficult; and Americans' skepticism about government, which enabled opponents to scare the public with the specter of socialized medicine and tales of horrors in foreign health systems. Only Lyndon Johnson, with the 1965 enactment of Medicare and Medicaid, successfully traversed this gauntlet. But Johnson did so by dramatically narrowing the scope of reform.²

After 1969, debates over health care followed a predictable script. Costs rose, politicians rediscovered a health care crisis, and reformers argued that there were moral and economic imperatives to fix an unsustainable system.

Yet efforts at comprehensive reform failed, the supposedly unsustainable status quo persisted, and periods of inaction punctuated by incrementalism prevailed.³

The 2010 enactment of the Patient Protection and Affordable Care Act, however, marks a new chapter in American health politics. It is the most important health care legislation since the 1965 law that created Medicare and Medicaid. It breaks the cycle of incrementalism that has governed U.S. health policy for four decades. And it represents an extraordinary legislative accomplishment for President Barack Obama and the Democratic congressional leadership, including Speaker of the House Nancy Pelosi (D-CA) and Senate Majority Leader Harry Reid (D-NV). The question is this: After a century dominated by failure, why did health reformers win this time?

Obstacles To Reform

Barack Obama came into office with sizable Democratic majorities in Congress—59 Democrats in the Senate, 257 in the House of Representatives. But they were nothing like the huge partisan majorities that Franklin Roosevelt and Lyndon Johnson enjoyed when

Congress enacted Social Security and Medicare. Indeed, in its partisan composition, Obama's Congress closely resembled the one that Bill Clinton had in 1993–94. Barack Obama's greatest challenge was securing enactment of ambitious health care legislation similar in scope to Great Society and New Deal programs—without the benefit of the congressional majorities of those eras.

PARTISAN PRESSURES Even after the Pennsylvania Republican Sen. Arlen Specter switched parties in August 2009, giving Democrats the crucial supermajority of sixty necessary to overcome a Senate filibuster, the congressional environment remained challenging. In the Senate, absent any Republican support, Majority Leader Reid would have to hold onto all sixty members of the Democratic caucus—including independent Joe Lieberman (CT) and conservative Democrats such as Ben Nelson (NE). In the House, Speaker Pelosi would have to balance the competing demands of moderate Blue Dog and liberal Progressive Caucus members. In addition, she would have to find a way to win over anti-abortion Democrats who would not back legislation without restrictions on federal abortion funding abhorred by pro-choice House members.

DEFICITS AND DISTRUST In 2009, reformers also faced a soaring federal budget deficit, driven by the worst economic downturn since the Great Depression and subsequent financial bailout and economic stimulus legislation. Democrats would have to meet the Congressional Budget Office demands and generate enough “scorable” savings to pay for expanding coverage—with a \$1 trillion price tag—without worsening deficit projections. Outside of Congress, there was the prospect that broad support for change would dissipate as health industry stakeholders—whom the political scientist Lawrence Brown called “the coalition of the unwilling”—confronted the reality that reform meant reduced incomes and greater regulation.³ Then there was the perennial problem of building popular support for reform in a country where many citizens had little faith in government and where most insured Americans were satisfied with their own health care coverage.

Learning From Failure

How, then, did health reformers beat the odds? Why did Obama succeed where so many presidents have failed? At one level, the adoption of health reform is a story about contingency; after all, it could have failed, and it almost did. Who knows what would have happened if Arlen Specter had not switched parties?

COMMITMENT Reform certainly would not have passed without Obama's fateful decisions to pursue comprehensive action in 2009—and then to press on in 2010 when the outcome was in jeopardy. It would not have passed without Nancy Pelosi's unwavering determination to finish legislation, instead of retreating to incrementalism, when many Democrats temporarily lost their nerve following the special Senate election in Massachusetts. Reform also would not have passed without Harry Reid's underrated success in mobilizing all sixty members of the Democratic caucus in December 2009 to pass legislation on a party-line vote when conventional wisdom inside the Beltway held that only bipartisan legislation was possible.

LEARNING FROM HISTORY Yet this is also a story about political learning and broader changes in health care politics.⁴ The Obama administration's effort to pass reform in 2009–10 is best understood as a reaction to the Clinton administration's health care debacle during 1993–94. The Obama administration's strategy was evidently to do the opposite of what the Clinton administration tried; the Clinton plan became a blueprint for what not to do in health reform.⁵

Whereas Clinton moved slowly on health care, Obama tried to push legislation through Congress quickly. Whereas the Clinton administration developed a remarkably detailed health plan, once in office Obama did not release a fully elaborated plan, instead leaving it to Congress to flesh out the details.⁶ The Clinton health plan mandated that all employers pay for their workers' health insurance and changed how most Americans with employer-sponsored insurance would get coverage. The Obama administration sought to exempt small businesses from any mandate and reassure Americans happy with their insurance that they could keep their plans. And the Obama administration successfully pressed Senate leaders to put reconciliation instructions for health reform into the budget resolution—a filibuster shortcut that the Clinton administration had not obtained. Reconciliation gave Democrats the option of passing health care legislation in the Senate with a simple majority and without any Republican support—a key advantage, given the fragility of their filibuster-proof majority and the polarized partisan environment.

The Clinton administration had a grand theory of reform and a vision of transforming the delivery system through managed competition. It also ended up embracing—partly because of pressures from the Congressional Budget Office—strong, centralized, and systemwide cost controls, including premium caps and a national

health care budget. In contrast, the Obama administration touted incremental, friendly-sounding reforms such as electronic health records, prevention, and medical homes.

BUDGETS AND TAXES The Obama administration thus avoided proposals for budgeting or systemwide price controls, although it did fight to adopt the controversial “Cadillac tax” on high-cost health plans. Moreover, Congress and the Obama administration reversed course from 1993–94 by proposing tax increases on wealthier Americans to pay for expanding coverage. Although “New Democrat” Clinton had sought to avoid any new taxes, Democrats in 2010 embraced explicitly redistributive financing.

UNEXPECTED PROBLEMS Of course, not everything went according to plan. The late Sen. Edward Kennedy’s illness and the withdrawal of former Sen. Tom Daschle from consideration as the new secretary of health and human services (HHS) after a controversy over tax problems set reform efforts back. Notwithstanding the president’s considerable rhetorical skills, the Obama administration failed to maintain strong public support for health reform or to persuade many insured Americans—including Medicare beneficiaries—that reform would benefit them.

The administration also was seemingly unprepared for the intense opposition and fury that erupted during town-hall meetings in the summer of 2009. The Democrats’ focus group-tested mantra of “quality, affordable health care” was drowned out by Republicans’ false warnings of “death panels” and a “government takeover.” Meanwhile, Harry Reid held onto sixty Democratic votes to push reform through the Senate. But in doing so, he made deals that became enormous political liabilities—such as the so-called Cornhusker kickback that gave Nebraska additional federal Medicaid money in exchange for Senator Nelson’s support. Republicans consequently turned the health care debate into an argument about process.

Moreover, having identified time as an enemy of reform, the administration let the process in Congress—especially Sen. Max Baucus’s (D-MT) futile search for bipartisanship in Finance Committee deliberations—drag on too long, enabling opponents to mobilize. That delay nearly proved politically fatal when, in January 2010, Republican Scott Brown’s upset win in a special Senate election in Massachusetts to fill the seat left vacant by Senator Kennedy’s death nearly derailed reform.

HOLDING DEMOCRATS TOGETHER Still, the Obama administration’s strategy of doing the opposite from the Clinton administration largely worked. Congressional Democrats applied sim-

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ilar lessons. In 2009 the House Democratic leadership introduced a “Tri-Committee bill”—a single health reform bill jointly sponsored by Charles Rangel, Henry Waxman, and George Miller, the respective chairs of the House Ways and Means, Energy and Commerce, and Education and Labor Committees. That coordinated approach contrasted with divisions that helped doom reform during 1993–94, when congressional Democrats pursued different reform strategies.

The Tri-Committee bill also reflected much greater agreement among Democrats about the shape of reform than during the Clinton years. If the Clinton plan left a blueprint for how not to enact health reform, Massachusetts—with its combination of subsidized coverage, individual mandates, expanded Medicaid, and a health insurance Connector—provided a working model that Democrats scaled up into national legislation.

Nowhere was the legacy of the Clinton experience more evident than during the closing days of the health reform battle, as Speaker Pelosi pressed wavering Democrats to support the final legislation. She had a trump card: Democrats had already seen what happens when health reform fails. Their losses in the 1994 congressional elections after the Clinton plan’s demise helped ensure a different outcome in 2010, as Democrats decided to push ahead with comprehensive reform despite the political risks. The risks of not enacting reform, shown in 1994, seemed even greater.

If You Can’t Beat Interest Groups, Co-Opt Them

Arguably the most consequential decision that reformers made in 2009 was to work with, rather than against, health system stakeholders. The Clinton administration fought an unsuccessful

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two-front war against the insurance industry and the small-business lobby. This time around, the Obama administration and congressional Democrats sought to neutralize any stakeholder opposition. The administration negotiated deals with health industry groups to support reform in exchange for the promise of having millions of newly insured patients to treat. These deals included pledges from Pharmaceutical Research and Manufacturers of America (PhRMA) and the American Hospital Association to contribute to health reform financing through reduced Medicare and Medicaid payments.

ACCEPTANCE BY INDUSTRY Other stakeholder groups, including the insurance industry, were also more willing to accept health reform in 2010 than during the 1990s. Their stance probably reflected a combination of financial motives, including the lure of expanded markets from covering the uninsured; political calculations such as expectations that reform was likely to pass, so they had better influence it from within; and fear of an uncertain future in which the accelerating erosion of employer-sponsored insurance threatened their bottom lines. Stakeholders may also have feared that if reform was not adopted, in coming years the health care industry could face more scrutiny, tougher regulation, and less favorable legislation.

Moreover, pro-health reform organizations—such as the newly formed Health Care for America Now, allied with organized labor—spent considerable resources campaigning for comprehensive legislation. Consequently, the traditional imbalance in health politics—with opponents badly out-maneuvering, out-lobbying, and out-spending reformers—did not materialize during 2009–10. To be sure, the Chamber of Commerce emerged as a vocal opponent, and the insurance industry’s support for reform faded over time. Ironically, though, reports of Anthem’s huge premium increases in California provided a late assist to Democrats by allowing them to cast insurers as the villain

in the health reform narrative just as the debate entered its final weeks. Additionally, many stakeholder groups fought against specific features of reform, especially the public option.

POLITICAL COSTS The Democrats’ accommodation of stakeholder groups was crucial to their legislative success, but this strategy also was costly. It limited the amount of savings that reformers could obtain from the health care industry, sparing the pharmaceutical industry the prospect of drug reimportation or negotiated prices from Medicare. The Democrats’ strategy also played into the Republicans’ argument that the closed-door health reform process embodied, as Sen. John McCain (R-AZ) put it, “unsavory deal-making.”

Still, this was a health reform fight unlike almost any other in American history, characterized by relatively weak interest-group opposition—a shift epitomized by PhRMA’s running advertisements on behalf of reform and the American Medical Association’s endorsing the Democrats’ legislation. The realignment in health politics culminated a decade-long effort by reformers, from Families USA’s “strange bedfellows” coalition with the insurance industry to the Children’s Health Insurance Program reauthorization campaign and Senator Kennedy’s convening meetings of stakeholders to build consensus in advance of the 2009 debate.

Political Pragmatism

The willingness to make deals with health-industry groups underscored another key reason why reform passed in 2010: commitment to compromise and pragmatism. Since the 1940s, many Democrats have dreamed of enacting national health insurance, a government-sponsored insurance program for the whole country. Even Medicare, the archetype of demographic incrementalism, was envisioned by its creators as a step toward that goal, and subsequent generations of liberal reformers invoked Canada’s single-payer system or “Medicare for all” as a rallying cry.

The elected leadership of the Democratic party has long since moved away from the single-payer concept. But liberal Democrats started this debate with, in their view, a compelling alternative: the creation of a new, Medicare-like government insurance program that would compete with private insurers and thereby hold down health spending while offering a safe haven for Americans seeking shelter from the for-profit insurance industry. For many Democrats, the public option became the centerpiece of reform. Howard Dean, a former governor of Vermont and the chair of the Democratic National

Committee from 2005 to 2009, argued that health care legislation did not constitute “real” reform if it simply added tens of millions of new customers to private insurers’ rolls.

As the debate moved through Congress in 2009, though, it became apparent that although the public option had majority support in the House—albeit only with serious limitations on both its size and cost-containment powers—it could not pass in the Senate. It also quickly became apparent that the Obama administration was quite willing to discard the public option during negotiations if that was what it took to pass reform. A series of alternatives—creating a “trigger” mechanism that would bring a public option online only if certain goals, such as expanding coverage, were not met; allowing states to opt in or out of a national public plan; expanding Medicare so that Americans age fifty-five and older could buy into the program; establishing a national insurance exchange—all failed to clear the Senate during 2009–10. Instead, liberals were left with the nebulous prospect of creating a new network of not-for-profit health care co-operatives, and multistate nonprofit plans contracted by the federal Office of Personnel Management and offered through state exchanges.

Still, absent the public option, liberal Democrats ended up supporting the legislation, even though health reform in 2010 arguably had less in common with traditional Medicare than with Medicare Part D—sponsored by the Bush administration—through which beneficiaries receive federal subsidies to choose from competing private insurance plans. The final plan also bore similarities to Republican reform plans from yesteryear, such as the 1993 proposal of the late Sen. John Chafee (R-RI) for reform built on an individual mandate.

Political pragmatism carried the day as reformers made compromises on a range of additional issues—abortion, cost control, the scope of benefits, the narrowing of universal into “near” universal coverage—in order to pass legislation.

The all-or-nothing mind-set that more than once has sunk health care reform was history.

Conclusion

The Patient Protection and Affordable Care Act of 2010 reflects these compromises and political strategies. The legislation greatly expands access to health insurance, but it will still leave an estimated twenty-three million Americans without coverage. It takes major steps toward slowing down the rate of growth in Medicare spending and promotes experiments in payment and delivery system reform, but it lacks reliable, systemwide cost control. It leaves employer-sponsored insurance in place, but it does not permit most insured Americans to join the new insurance exchanges. And its major coverage provisions—the expansion of Medicaid, establishment of state insurance exchanges, and the introduction of federal subsidies to purchase private insurance—do not begin until 2014, a delay that allowed Democrats to fit the bill under a trillion-dollar price tag.

Reformers often talked of crafting a “uniquely American solution,” and the new law is certainly that. It is a patchwork, reforming our complex, incoherent insurance nonsystem with a complex, somewhat coherent mix of subsidies, regulations, mandates, and public and private insurance expansions. The legislation does not so much create a new health system as fill in gaps in the existing system, since the first principle of feasible reform was to build on current arrangements. It is a product of our fragmented political institutions, which compel compromise, and our fragmented health care system, which limits reformers’ options to move away from the status quo.

For health reform in the United States, this is, given those powerful constraints, probably as good as it gets. Even with all of its shortcomings, the Patient Protection and Affordable Care Act is a great leap forward for the American health care system. ■

NOTES

- 1 Blumenthal D, Morone JA. *The heart of power: health and politics in the Oval Office*. Berkeley (CA): University of California Press; 2009.
- 2 Marmor TR. *The politics of Medicare*. Chicago (IL): Aldine; 1973.
- 3 Brown LD. The amazing noncol-

lapsing U.S. health system—is reform finally at hand? *N Engl J Med*. 2008;358(4):325–7.

- 4 Jennings C. Proving the skeptics wrong: why major health reform can happen despite the odds. *J Law Med Ethics*. 2008;36(4):728–30.
- 5 Oberlander J. Great expectations:

the Obama administration and health reform. *N Engl J Med*. 2009;360(4):321–3.

- 6 Daschle T, Lambrew JM, Greenberger SS. *Critical: what we can do about the health care crisis*. New York (NY): St. Martin’s; 2008.