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ANALYSIS & COMMENTARY
Health Reform: Only A Cease-Fire
In A Political Hundred Years’ War

ABSTRACT Four dominant political forces drove the process and product of national health reform during the past two years: federal budget constraints; public concerns about the size and reach of the federal government; the time pressure of the congressional calendar; and the political parties’ high-stakes, all-or-nothing bets on what became President Barack Obama’s defining policy priority. Republican congressional leaders saw little advantage in offering more detailed alternatives. Congressional Democrats calculated that they had even more to lose politically by abandoning health reform legislation than by pushing it through Congress. This essay argues that passage of the legislation merely represents a cease-fire in a long-standing war and that more battles between forces for “implementation” and those for “repeal and replace” are to come.

The latest battle over various proposals for national health insurance began during the 2008 presidential election. I would argue that it was the latest phase of a Hundred Years’ War, which began when, as a third-party presidential candidate in 1912, Theodore Roosevelt issued the first call for a national health care plan. Despite enactment of health reform legislation in March 2010, it remains to be seen whether or not we have reached a hard-fought end to the struggle or merely a cease-fire.

The fundamental components of the Patient Protection and Affordable Care Act of 2010 largely reflect the 2008 campaign proposals of Barack Obama. They are employer play-or-pay mandates, insurance exchanges, a public insurance plan option, and the promise to achieve—eventually—universal health insurance while increasing federal taxes only on wealthy Americans and lowering the rate of growth in future health spending. Added to this list in the final law was an individual mandate. Although Obama did not endorse a full-fledged individual mandate during the campaign, he warmed to the idea shortly after the election.

Admittedly, these objectives included a number of initial limitations, exceptions, hedges, and political escape routes, such as affordability and firm-size exemptions from mandates, redefinition of “universal” coverage, and delegation to future administrative rule makers. But the larger Democratic majorities in Congress after the 2008 election had from the outset a firm understanding of the new president’s template for health reform. The year ahead appeared to offer yet another once-in-a-lifetime opportunity to enact comprehensive national health reform that greatly expanded insurance coverage.

Initial Political Game Plan For Democrats
LEARNING FROM THE CLINTON ATTEMPT The Obama White House overcompensated for the previous top-down strategy of the Clinton administration, which failed to get a health reform bill through Congress in 1994. The Obama administration decided to defer to congressional leaders on most of the actual legislative details needed to
flesh out president’s core proposals. This provided more congressional “buy-in” to the ongoing process, but it created later headaches. Initial bills were bloated, complex, extremely partisan, and hard to reconcile across various factions of the Democratic caucuses in each chamber, let alone between the House and the Senate.

**CO-OPTING INDUSTRY GROUPS** Another early strategy was to co-opt potentially hostile industry groups, by cutting deals that protected them against downside risks to their businesses in return for commitments of early support. Both the pharmaceutical and hospital sectors literally “gave at the office” in the first half of 2009, in return for negotiated limits on how much might otherwise be extracted from them. They were promised an expanded pool of millions of newly insured “paying” customers, so that they could make up their losses from lower-than-expected reimbursement levels and new taxes on their business operations.

Other groups were kept on a leash with few tangible benefits in return—for example, the American Medical Association, which appeared to care mainly about a looming cut in Medicare payments to physicians. America’s Health Insurance Plans (AHIP) went along out of a desire for expanded coverage, but was later used as a foil by the administration to embody the role of political villains primarily responsible for unaffordable or unavailable private insurance coverage, as well as a host of alleged sharp practices. The political downside for the White House from these “deals” was that some potential areas for additional cost containment were foreclosed. And the administration’s back-room arrangements with interest groups made it at least somewhat harder to sell health reform to the broader public.

**LACK OF PROGRESS IN CONGRESS** One key strategy failed: the plan to make quick, steady progress in moving bills through each chamber of Congress and maintaining an aura of inevitability. Like some species of shark, if the health reform package did not keep moving, it could sink and die. However, initial time lines for bringing a bill to the floor of both the House and the Senate by the end of July 2009 were extended. “Final” deadlines for approval of the overall legislation—initially by August 8, then later in the fall, and ultimately “before Christmas”—were missed repeatedly throughout 2009.

**TACTICS TO LIMIT OPPOSITION AND REWARD SUPPORTERS**

As the Obama administration’s principles for health reform were converted into legislative language, the White House had to master a difficult political balancing act. This involved reassuring many Americans anxious about disruptions to their current health coverage and care arrangements or about mounting federal budget deficits, while offering more generously subsidized health benefits to lower-income constituents and more jobs to those who serve them.

The reassurance component necessitated reaching an initial truce with employer-sponsored insurance plans. Keeping employers’ “private” money on the table also helped limit the net budget cost of the first installment of insurance coverage growth. Insurance mandates for employers and individuals to pay for most new coverage with their own funds acted like a tax to help fund additional health spending that would not be counted in the federal budget. Relying on expanded Medicaid eligibility as a less expensive, “Hamburger Helper” equivalent to accomplish about half of the total targeted coverage expansion allowed federal dollars to be stretched further, given Medicaid’s very low reimbursement rates for providers.

**INCOME-RELATED SUBSIDIES** Meanwhile, legislating future income-related subsidies to individuals qualifying for coverage within insurance exchanges, along with insurance premium regulation that provided more cross-subsidies for older and sicker constituents, provided new tools for broader income redistribution—another Obama administration objective.

**FATE OF THE PUBLIC OPTION** The public-plan option, although very important to liberal activists, was always vulnerable to elimination as a sacrificial throwaway in the legislative endgame. The public plan was politically radioactive to highly energized grassroots opponents, who feared that the legislation would quickly lead to a single-payer system. It also made moderate Democratic members in Congress—especially those from swing districts—nervous about potential challengers in the November 2010 midterm election.

Moreover, the combination of vastly expanded “public plan” Medicaid coverage and much tighter political regulation of “private” insurers in subsidized health insurance exchanges accomplished most of the larger political objective of increasing dependency on politically brokered health care, with fewer of the flashing red lights signaling a more direct and expensive expansion of Medicare-like coverage to displace private insurance intermediaries.1

**DEFLECTING CHARGES OF HIGH SPENDING** To garner enough support to pass the legislation, its proponents needed to defuse charges that it would add to runaway federal spending and mounting federal debt in the midst of a sluggish economy. Some tax increases were repackaged as fees and excise taxes on parts of the health
industry, rather than being imposed directly on middle-class taxpayers. Reductions in future Medicare spending were primarily aimed at extra payments to private Medicare Advantage plans, which had been a long-standing sore point with many congressional Democrats.

**Republicans Counter: ‘Less Is More’**

Having lost seats in the 2008 election, congressional Republicans decided to play the best remaining cards they had. Although marginalized under the majority-friendly rules of the House, Republicans initially had some leverage by remaining unified in the Senate. However, a party switch by Sen. Arlen Specter of Pennsylvania and the final resolution of the contested Minnesota Senate race soon delivered enough votes to the Democratic majority to ensure cloture on a health reform bill—if the entire Democratic conference remained unified.

**FOCUS ON COST REDUCTION** As a result, the opportunities and incentives for comity and compromise in the Senate became even more limited than usual. In both chambers, Republicans had little opportunity to inject new elements into bills initially drafted by the majority. They focused more on the need for reducing health care costs before substantially expanding insurance coverage, limiting the complexity and pace of any health policy overhaul, and keeping further increases in the federal debt in check.

**RIDING A WAVE OF OPPOSITION** In the first half of 2009, most interest groups deployed their resources in attempts to optimize the terms, or limit the burdens, of forthcoming health reform legislation, which was generally seen as both likely and imminent. Republican members of Congress appeared to be surprised when early legislative proposals provoked a burst of public opposition that arose independently and outside of Washington, in congressional town-hall meetings and among newly organized “Tea Party” grassroots activists.

That initial uprising focused on fears about health care rationing and the expansion of the public plan option, but it later expanded into a broader base of opposition to the overall Obama health reform package. This emboldened Republicans in Congress to urge a “go slower” approach that might help them run out the clock on the majority’s original plan and see their political prospects improve over time. They found a reservoir of political support among elderly voters who feared destabilization of current Medicare arrangements and suspected that they would suffer from cuts in future Medicare spending growth.

**LEGISLATIVE PROCEDURE** Given the procedural rules in the Senate that make it easy to delay legislation or even prevent its consideration on the floor, and the opportunity to simply ride on the back of growing public concerns about the probable legislation, Republican congressional leaders saw little advantage in offering more detailed alternatives. A bipartisan “Gang of Six” effort among Senate Finance Committee members to develop a compromise bill broke down by early September. A later decision by Majority Leader Harry Reid (D-NV) to revive the public option in his November 2009 revamping of the committee’s bill lost the support of Olympia Snowe (R-ME), the last remaining moderate Senate Republican still in play.

House Republicans lacked the procedural opportunities of their Senate colleagues to delay legislation. They simply offered a limited alternative proposal in late October, as an amendment that they proposed to substitute for the main bill advanced by the House Democrats, the Affordable Health Care for America Act. The Republican amendment focused on reducing the cost of health care and included only modest increases in insurance coverage.

**Democrats Regroup**

As most opinion surveys indicated sinking support for the proposed legislation in the fall of 2009, congressional Republicans began to anticipate substantial electoral gains in the November 2010 midterm election. They felt that time was on their side. Congressional Democrats scrambled to get their plans into law while still holding substantial majorities in both chambers.

**FROM HEALTH CARE REFORM TO HEALTH INSURANCE REFORM** Facing a different political landscape, President Obama adjusted his health reform strategy. The administration began referring to the legislation as “health insurance reform.” Private insurers increasingly were targeted in the political cross-hairs. Universal coverage was redefined as insurance for almost everyone, except for more than ten million noncitizens, those who could not afford to buy even subsidized coverage, and those who would rather risk paying a penalty than purchase more costly mandated insurance.

**WEAKENED INDIVIDUAL MANDATE** Meanwhile, that mandate was weakened in reaction to political concerns about whether it was fair and represented an undue burden on some Americans. This in turn led several private insurers to back away from their previous soft support for the Senate version of reform legislation and to begin funding efforts to change, if not oppose, the evolving bills.

**HOUSE AND SENATE ACTION** Despite a late flare-up of the always controversial issue of insurance
coverage for abortion, House Speaker Nancy Pelosi (D-CA) managed to adjust and deliver to the floor a final House bill in late October. She cut an uncomfortable but necessary deal with right-to-life Democratic members. The House Republican substitute was defeated, and the final House bill passed on 7 November, although by a margin much narrower than expected.

The Senate version of health reform legislation traveled a slower route in November and December. Still, following a series of behind-the-scenes deals with wavering Democratic moderates, Majority Leader Reid pulled together his sixty-vote partisan supermajority and gained final Senate passage on Christmas Eve.

The Senate bill was designed to do whatever it took to clear procedural hurdles and provide a necessary placeholder for a House-Senate conference committee in early 2010. That next stage was supposed to iron out remaining differences between the two bills and correct various drafting errors, oversights, and omissions.

Then came a political bolt from the blue: Scott Brown’s surprise win in the 19 January Massachusetts race to fill the seat of the late Sen. Edward M. Kennedy upset all previous calculations. Brown represented the forty-first Republican vote against cloture for Senate approval of a final conference report. It appeared to most instant pundits that national health reform was dead for the rest of 2010. But they were wrong again.

**The Endgame**

These pundits’ error was in forecasting that neither of two scenarios was possible. They doubted that House Democrats could trust their Senate colleagues enough to pass the “old” Senate bill intact and then count on both chambers’ revising it shortly thereafter. Nor did they expect that the one-party majorities could be reassembled to write a new bill—amid more public opposition than support for either the older House or Senate bills. However, for President Obama, failure was not an option. Congressional Democrats also calculated that they had even more to lose politically by abandoning health reform legislation than by pushing it through Congress by whatever means were necessary.

House Democrats agreed to approve the older Senate legislation verbatim, with a separate package of limited changes enacted through budget reconciliation, which would require only a majority vote (fifty-one votes) to pass the Senate, and bypass the need for achieving another sixty-vote approval of cloture.

**Political Realities** The final legislation reflected the political limits of the ongoing debate and the need to delay and temper the impact of discomfiting change. The difficulty of navigating through congressional rules for budget reconciliation “fixes” also meant that both House and Senate Democrats were largely stuck with the December 2009 Senate bill framework that neither group had expected to be the final product. Its health insurance exchanges would be state-run, rather than national. The public option could not be revived, although heavy doses of insurance regulation and expansion of Medicaid coverage achieved some of that option’s original objectives.

The so-called Cadillac tax on high-cost insurance plans was first inserted into the Senate bill in the fall of 2009 as both an attempt to put a lid on tax-favored health care coverage and a revenue raiser. But it was resisted fiercely by organized labor groups and many House Democrats, and it was eventually delayed until at least 2018 and diluted to a substantial degree. Increased Medicare payroll taxes on higher-income individuals and families were substituted for the loss of the projected Cadillac-tax revenue.

**Fixes to Medicare** Wary senior voters were promised an early injection of taxpayer funds to help fill most, if not all, of the so-called doughnut hole, or coverage gap, for prescription drug expenses at a certain level. Medicare Advantage plan payments were cut a bit more, to help offset somewhat more generous subsidies in the health insurance exchanges. Insurance coverage mandates remained relatively weak, with exemptions for smaller businesses and individuals whose out-of-pocket insurance costs exceeded various income-related ceilings.

**New Entitlements and Soaring Debt** The seemingly counterintuitive adoption of a new entitlement program amid already soaring levels of national debt magnified the political need to assure voters that health reform would be “paid for” without increasing long-term deficits. Hence, many health spending obligations, such as...
as subsidized insurance coverage in the new state-based exchanges, were delayed in the final law (in this case, until 2014).

Offsetting revenues, such as fees on providers in the pharmaceutical, insurance, and medical device sectors, as well as other Medicare program “savings,” were to begin in the early years of implementation. But the related deferral of promised benefits left the final law more vulnerable to second-stage political opposition by voters disappointed by its initial effects.

**Protracted Implementation** The final law relied on ambiguity, deferred decision making, and administrative complexity to dampen political concerns about a federal “takeover” of traditionally private spheres of health care decision making. Even after delivering almost 3,000 pages of legislative text for the president’s signature, Congress delegated a vast amount of multiyear implementation and interpretation work to various executive-branch agencies and newer advisory bodies.

However, gaining permanent regulatory authority over a vast expanse of health care operations and decisions—regardless of how many blanks needed to be filled in later—fulfilled a crucial political imperative for Democratic Party leaders. It also facilitated the continued, less-threatening appearance of private operation of most current health care arrangements, albeit under tighter—and potentially expanding—political management.

**Conclusion**

The surrounding political terrain grew less favorable over the first fifteen months in office for the initially large congressional majorities that favored the president’s version of national health reform. Each delay in meeting optimistic deadlines encouraged opponents, magnified divisions within the majority party’s ranks, and threatened to bump up against preparations for the November 2010 election season.

As any remaining expectations, or illusions, of bipartisan compromise eroded by the end of 2009, each party hunkered down for an all-or-nothing vote on whatever the Obama White House and its congressional allies felt it had to achieve to claim victory. Winning ugly looked much better at closing time than the danger of implicit “regime change” in the near future.

When President Obama signed the second and final piece of his health reform proposal into law, the equivalent of the first Hundred Years’ War of national health reform was over. I would argue that the second one—between those who support implementation and those who favor “repeal and replace”—has just begun.

**Note**


**About the Author: Thomas P. Miller**

Thomas P. Miller is a health policy expert and resident fellow at the American Enterprise Institute, in Washington, D.C. He served as senior health economist for the Senate’s Joint Economic Committee from 2003 to 2006. In that position, he focused on such topics as reforms in private health insurance and Social Security. Miller also served as a member of the National Advisory Council for the Agency for Healthcare Research and Quality, at the U.S. Department of Health and Human Services, from 2007 to 2009.

Miller has testified before Congress on issues including the uninsured, Medicare prescription drug benefits, and health insurance tax credits. He also was a health policy adviser for the presidential campaign of Arizona Republican Sen. John McCain. A former trial attorney, journalist, and sports broadcaster, Miller holds a J.D. from Duke University Law School. Miller says he was skeptical that health reform would be enacted “due to long-standing political and historical forces,” he says. Now, he sees challenges ahead. These include “making something work that was poorly designed, left many implementation steps to be determined later, and will grow increasingly unaffordable and unpopular,” he predicts.