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Richard Kirsch
Roosevelt Institute

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THE POLITICS OF OBAMACARE: HEALTH CARE, MONEY, AND IDEOLOGY

*Richard Kirsch**

I. ONE HUNDRED YEARS OF POLITICAL CONTROVERSY

A recent article in *The New Yorker* on the origins of the campaign consulting business provided a fresh reminder—not that one was needed—of how the politics of health care and the politics of politics in the United States are intertwined.¹ *The Lie Factory* described how one of the earliest efforts, by the first two political campaign consultants, was to defeat a 1942 proposal by California Governor Earl Warren to establish a state-run program of health coverage for all of the state’s residents.²

For some one hundred years, there has been no more fertile political ground on which to play on people’s fear of change than health care. As I write in my book, *Fighting for Our Health: The Epic Battle To Make Health Care a Right in the United States*:

The reason that health care reform keeps rising to the top of the political agenda, no matter how often it goes down in flames, is that people deeply care about health care. When we meet an old friend, we often ask, “How have you been? How is your family?” If things are going badly, we may repeat the old adage, “At least I have my health.” We vow to stick with our betrothed “in sickness and in health.”³

So when we have to pay more to hang on to shrinking health coverage, when we can’t retire early or switch jobs or start a small business because we might lose our health insurance, when a serious illness threatens to drive us into bankruptcy, we demand that our political leaders do something! But when we care about something so deeply, change can also be terrifying. Specific solutions prompt people to ask, how will that change affect me? Will I be worse off than I am now? What will I lose?

The seeds of defeat of health reform in the past have been planted and cultivated in this fertile ground by opponents of reform motivated by money and ideology. They have understood, since the first debates around “compulsory health insurance” in the early 1900s, that they could defeat reform by frightening people about proposals for change. Fear could turn

* Senior Fellow, Roosevelt Institute.

1. Jill Lepore, *The Lie Factory*, NEW YORKER, Sept. 24, 2012, at 50.

2. *See id.* at 56–58.

3. RICHARD KIRSCH, *FIGHTING FOR OUR HEALTH: THE EPIC BATTLE TO MAKE HEALTH CARE A RIGHT IN THE UNITED STATES* 31–32 (2012).

consensus on the need to do something into paralysis. In short, as the title of that chapter in my book says, when it comes to getting comprehensive health care reform in the United States, “the solution is the problem.”⁴

A brief review of the history of reform illuminates the continuing struggle around the passage of the Patient Protection and Affordable Care Act (ACA) in March 2010,⁵ and how those history lessons were instrumental in the law’s historic passage. While the American Medical Association (AMA) supported “compulsory health insurance” when it first became a public issue in 1912,⁶ by 1920 pressure from their membership—many of whom feared that government mandated insurance would threaten their income—moved the AMA into opposition.⁷ A decade later, the AMA used ideology to combat President Franklin D. Roosevelt’s plans to include health care with retirement as part of what was to become Social Security.⁸ Just after FDR was elected in 1932, the *Journal of the American Medical Association* (JAMA), attacked compulsory insurance as socialism:

The alignment is clear—on the one side the forces representing the great foundations, public health officialdom, social theory—even socialism and communism—inciting to revolution; on the other side, the organized medical profession of this country urging an orderly evolution guided by controlled experimentation which will observe the principles that have been found through the centuries to be necessary to the sound practice of medicine.⁹

After Harry Truman was elected in 1948 on a pledge to push for “national, compulsory health insurance,” the AMA hired the California campaign consultants who had defeated the Warren plan to work their magic on Truman’s proposal.¹⁰ They launched the “National Education Campaign,” which included full-page ads, radio commercials warning of the dangers of socialized medicine, and won the endorsement of more than 1,800 private organizations for “voluntarism as the American way.”¹¹ Doctors became the leading organizers of the campaign, hanging 65,000 posters in their offices of a country doctor with the caption, “Keep Politics

4. *Id.* at 25.

5. Pub. L. No. 111-148, 124 Stat. 119 (2010), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (to be codified primarily in scattered sections of 42 U.S.C.).

6. See Kimberley Green Weathers, *Fitting an Elephant Through a Keyhole: America’s Struggle with National Health Insurance in the Twentieth Century* 26, 40–41 (May 2004) (unpublished Ph.D. dissertation, University of Houston) (on file with the Fordham Law Review).

7. See *id.* at 45–46.

8. KIRSCH, *supra* note 3, at 26.

9. See EMPLOYMENT AND HEALTH BENEFITS: A CONNECTION AT RISK 63 (Marilyn J. Field & Harold T. Shapiro eds., 1993) (quoting an editorial by Morris Fishbein, editor of JAMA).

10. See Dan Diamond, *How Political Consultants Defeated Health Reform, Again and Again*, FORBES (Oct. 15, 2012, 10:10 PM), <http://www.forbes.com/sites/dandiamond/2012/10/15/how-political-consultants-defeated-health-reform-again-and-again>.

11. Weathers, *supra* note 6, at 125.

Out of This Picture!”¹² The AMA’s women’s auxiliary and other groups of health providers, including dentists, pharmacists, and nurses, delivered some 55 million pamphlets that included a made-up quote that the consultants attributed to Lenin, “Socialized medicine is the keystone to the arch of the Socialist State.”¹³ That concocted quote made its way into newspaper editorials around the country and was repeated as recently as 2000 by the president of the conservative Association of American Physicians and Surgeons.¹⁴

The AMA failed to stop President Lyndon Johnson from establishing Medicare as a national health insurance program for seniors, but not for lack of trying. The AMA set up a front group called Operation Coffeecup and recruited actor Ronald Reagan to cut a record titled, *Ronald Reagan Speaks Out Against SOCIALIZED MEDICINE*, in which the future President says that Medicare would be the foot in the door for a totalitarian takeover.¹⁵ Almost half a century later, Sarah Palin quoted Reagan’s words during her speech accepting the Republican nomination for Vice-President.¹⁶

While the AMA was not able to stop the passage of Medicare, it did prevail on Congress to block the new law from setting the fees the government would charge for physician services, enshrining the fee-for-service payment system into the law, a major driver of higher health care spending to this day. By the time of Medicare’s passage in 1965, the modern health era of health care was in full bloom, as medical advances had made it possible to cure disease and lengthen life. As incomes rose, so did health care consumption. But during the first part of the twentieth century, other developed countries had instituted government-regulated systems, which provided access to affordable health care to all citizens. Health care in these nations was viewed as a public good, not a market commodity. The countries developed a variety of mechanisms to control the price and supply of health care, while assuring that all citizens had affordable coverage. As a result, health care spending rose with national incomes but without becoming a huge burden on citizens or business.¹⁷

By contrast, the United States continued its amalgamation of employer-provided health coverage and government provided health coverage through Medicare (for seniors and people with severe disabilities) and Medicaid (for

12. *Id.* at 126.

13. *See id.* at 125; Lepore, *supra* note 1, at 57.

14. *See* Lawrence R. Huntoon, *Universal Health Coverage—Call It Socialized Medicine*, 5 MED. SENTINEL 134, 136 (2000) (“Lenin once said that ‘medicine is the keystone in the arch of socialism,’ and I believe those who are promoting ‘universal coverage’ via government-run and government-controlled medicine know this.”), available at <http://www.haciendapub.com/medicalsentinel/universal-health-coverage-call-it-socialized-medicine>.

15. *See* Max J. Skidmore, *Ronald Regan and “Operation Coffeecup”: A Hidden Episode in American Political History*, 12 J. AM. CULTURE 89 (1989).

16. *See* WENDELL POTTER, DEADLY SPIN 81 (2010).

17. *See* OECD Health Data 2012: *How Does the United States Compare*, OECD (June 2012), <http://www.oecd.org/unitedstates/BriefingNoteUSA2012.pdf>.

the poor), which was also enacted in 1965. Without a national mechanism to control the increase in health care costs, over the next two decades health care came to claim a much greater share of the national economy, compared with other developed nations.¹⁸ Consumers and employers paid escalating health insurance premiums, and by the mid-1980s seniors were paying more out of pocket for health coverage than before Medicare's implementation. At the same time, the growth of the low-wage service sector, in which jobs often did not come with health coverage, combined with the loss of manufacturing jobs, began to erode employer-based coverage.

The growing pressures on the health care system created the political conditions for President Bill Clinton to make health care a central promise of his 1992 election campaign and the centerpiece of his legislative agenda.¹⁹ It also convinced many industry players, including the AMA, the American Hospital Association, and the trade association representing large, nonprofit health insurance companies, to support some sort of comprehensive change, which they viewed as inevitable.²⁰

The twin scourges of money and ideology reemerged as the debate over the Clinton proposals took off. First Lady Hillary Clinton, charged by her husband to develop his health care plan, involved a host of industry players in her deliberations and tried to accommodate their needs. But the massive changes proposed in the Clinton plan still raised many concerns in the health industry, which they in turn raised with members of Congress. A breakaway group of smaller, for-profit health insurers under the banner of the Health Insurance Association of America had no reservations about taking their alarm at the Clinton plan to the public.²¹ Their famous Harry and Louise TV ads scared the public with an ideologically based message, attacking "mandatory government health alliances" and government bureaucrats.²²

Ideology took a highly partisan form in 1994, as Newt Gingrich lead the effort to defeat any health care legislation, correctly betting that the rejection would pave the way for the emerging new right of the Republican Party to take control of the House of Representatives.²³ While more moderate Republican senators like Rhode Island's John Chafee and Senate Minority Leader Bob Dole of Kansas were willing to entertain a compromise with Clinton on reform, Gingrich poisoned the well and was rewarded by becoming Speaker of the House in 1995.

Despite the political disaster of the Clinton health reform experience, by the mid-2000s, the rising cost pressures on consumers, business and government, and the growing number of uninsured Americans, began to bring comprehensive health reform back to the political agenda. One

18. *See id.*

19. KIRSCH, *supra* note 3, at 27.

20. *Id.* at 28.

21. *See id.*

22. *See id.*

23. *See id.* at 29–30.

reason that reformers finally prevailed in 2010 is that many of them, like myself, had lived through and learned the lessons of 1994. Advocates for reform outside of government, key members of Congress and their staffs, and advisors to the Obama Administration implemented a strategy that addressed the failures of the previous decade. In the following, I review the main components of that strategy.

II. STRATEGIC LESSONS FOR THE AFFORDABLE CARE ACT'S IMPLEMENTATION

Strategic Lesson One: An Acceptable Policy Approach. By 2008, reformers were committed to proposals designed to meet their central policy goals with minimal disruptions to the existing health care system. The objective was to appeal to two audiences. The first was the health care industry, aiming to win the support of major industry players and avoid the industry-financed opposition that killed the previous efforts. The second audience was the public, with reforms aimed at addressing people's biggest worries while avoiding changes to the financing arrangements that provided health coverage to 85 percent of the nation's residents.

The model for this approach to national reform was developed in Massachusetts, where it was enacted in 2006. The first decision that Massachusetts advocates—including health care consumers, labor unions, hospitals, and doctors—made was to focus on the goal of covering all of the state's residents, rather than controlling costs. Reformers intentionally borrowed from conservative and liberal ideas, coming up with an approach that would appeal to Republican Governor Mitt Romney and the large Democratic majority in the legislature.

The framework they developed, which became law, built on the four pillars of the current health care coverage system: employer provided coverage, Medicaid, Medicare, and individually purchased insurance. Massachusetts encouraged employers to continue to provide coverage by placing a small fine (too small to generate political opposition) on larger employers that did not provide coverage. It increased Medicaid eligibility (and the federal/state child health insurance program) to cover more adults and children above the poverty level. (It did not touch Medicare, a federal program.) These are all liberal ideas, which also gave more customers to health care providers and insurers without disrupting payment arrangements.

The important innovation—where conservative and liberal policies were blended—was in the individual market. Here an idea promoted by the conservative Heritage Foundation,²⁴ requiring individuals to purchase coverage and making coverage available from a health insurance marketplace, was made acceptable to liberals by providing income-based

24. See Avik Roy, *The Tortuous History of Conservatives and the Individual Mandate*, FORBES (Feb. 7, 2012 3:32 PM), <http://www.forbes.com/sites/aroy/2012/02/07/the-tortuous-conservative-history-of-the-individual-mandate/>.

subsidies to individuals to purchase coverage and regulating the new market. The regulations included establishing set benefit plans, limiting entry to plans that met quality and cost standards, and continuing insurance reforms that were already in place in Massachusetts, including bans on denying coverage due to a preexisting condition or charging people higher premiums because of their medical history.

The Massachusetts framework appealed to all of the major constituencies. Consumer groups saw that individuals would have access to affordable coverage. Health insurers got new customers, and hospitals would get more patients and fewer uninsured for whom to care. From the public's point of view, the only change would be positive: affordable coverage if you did not get health insurance at work.

The one constituency that was not happy with the Massachusetts policy were the champions of public health insurance, known as "single-payer," because, under this approach, everyone is insured by one government-run insurance plan. Proponents of single-payer often framed it as extending Medicare for all, which would have been the most obvious way to implement it at the national level and was touted as a message that built on Medicare's popularity.

Single-payer advocates made up a significant force in the health reform movement, whose support would be crucial to winning comprehensive reforms nationally. In fact, the health reform movement had been divided for decades about how much to insist on reforms based on national health insurance and how much to work within the current, multipayer U.S. health care system. Those divides made it very difficult to build a unified campaign that would organize support for reform and fight the strenuous opposition to actual legislation.

But single-payer policy suffered from a deep political flaw; it violated the "change as little as possible" rule, because the 150 million people with employer-based coverage would have to give that up for government insurance. It would provide a great target for opponents who wanted to scare people about change.

The solution to bridging the gap among health reform advocates while appealing to the public was another policy innovation, which came to be known as the "public option" during the legislative campaign to pass legislation in 2009. I came up with the idea for the public option in 2003, when in writing a history of the Clinton effort, I realized that providing a choice between the two competing reform visions (the other being working within the multipayer system) could provide a bridge.²⁵ Independently,

25. See RICHARD KIRSCH, WILL IT BE DÉJÀ VU ALL OVER AGAIN? RENEWING THE FIGHT FOR HEALTH CARE FOR ALL (Mar. 2003), available at http://www.fightingforourhealth.com/chapter/1-3/documents/2-Deja_Vu_Final.pdf.

Yale professor Jacob Hacker came up with almost the same concept in 2001.²⁶

The ideal behind the public option was to offer a choice of a national health insurance plans to compete with regulated private insurance. The proposal appealed to most of the progressive health reform movement, although not all. It proved to have great appeal to many single-payer activists, who participated fully in rallies and events to support health reform legislation in 2009 and 2010. In fact, it became the cause célèbre that kept progressive activists behind health care reform through most of the legislative campaign. And despite continual attacks against the public option from conservatives and the health insurance industry, it maintained its popularity with the public, which liked being able to choose between regulated private insurance or a public plan.

Strategic Lesson Two: Win or Neutralize Industry Opposition. While the public option was not favored by mainstream health care providers (doctors, hospitals, drug companies) and was abhorred by health insurers, the bulk of the proposal framework agreed to by Democrats in Congress and the Obama Administration—the Massachusetts approach—was acceptable. The approach offered new customers under existing financing mechanisms. Insurance companies were willing to offer insurance to people with preexisting conditions as long as the requirement to purchase coverage prevented the problem of people remaining uninsured until they needed medical care.

A good deal of work went into encouraging the health industry to support reform, including a set of conversations before Obama's election and a multistakeholder process run by Senator Ted Kennedy's Senate Health, Education, Labor, and Pensions Committee.

The White House and Senate Finance Committee Chairman Max Baucus worked to formally line up support from key industry players, by negotiating industry specific trade-offs, under which an industry would agree to some changes in payments in return for two things: the anticipated new customers as tens of millions more people became insured and no other reductions in revenues.

The most important of these deals was with the prescription drug lobbying group, PhRMA. Democrats agreed not to press for negotiating drug prices in Medicare and to oppose allowing importation of drugs from Canada, reversing two long-held positions. In return, PhRMA agreed to reduce the prices it charged for drugs to seniors in the Medicare Part D prescription plan and to finance advertisements in support of the health care legislation.²⁷ If no deal had been reached, PhRMA would have spent its \$100 million on ads opposing the proposed law.

26. See JACOB S. HACKER, ECON. AND SOC. RESEARCH INST., *MEDICARE PLUS: INCREASING HEALTH COVERAGE BY EXPANDING MEDICARE* (2001), available at <http://www.esresearch.org/RWJ11PDF/hacker.pdf>.

27. See KIRSCH, *supra* note 3, at 135.

Negotiations with the AMA and the American Hospital Association also secured their support for the legislation. The health insurance industry withheld opposition until the early fall, when the Senate reduced the penalties for individuals who did not get insurance, over the insurance industry's opposition. The industry then secretly funneled \$86 million to oppose the law through the U.S. Chamber of Commerce; it was too unpopular a messenger to oppose the legislation itself.²⁸ But too much momentum had been built up by that time for the opposition campaign to work.

Strategic Lesson Three: Let Congress Lead with Legislative Deals. While the Clinton Administration had spent nine months developing its own bill, the Obama Administration deferred to the considerable expertise among Democrats in Congress, as well as to their institutional pride. By deferring to the congressional leadership, the White House avoided fanning intramural fights that would have delayed the legislation and offended many members of Congress. And as Democrats had all agreed on the overall approach, both Houses wrote bills that were readily reconcilable.

Strategic Lesson Four: A Well-Organized and Funded Grassroots Campaign. In the past efforts, supporters of reform did not field a well-organized, national campaign to demonstrate grassroots support for reform to members of Congress. Starting in 2007, a coalition of many of the largest progressive organizations in the country—including unions, community organizing networks, netroots, think tanks, and constituency groups—began to prepare for passage of health reform, contingent on a Democrat winning the presidency in 2008. Launched in July 2008, with simultaneous press conferences in fifty-three cities in thirty-eight states, Health Care for America Now (HCAN) ran grassroots field campaigns in some forty states.²⁹ The effort bolstered Democratic champions in Congress and prevailed on a critical mass of conservative Democrats to support the legislation. The strategy fully proved its worth when, in response to the right-wing grassroots attack on reform by tea party activists in August of 2009, HCAN and other allied efforts rallied support for Democratic legislators who were being attacked.³⁰

HCAN also ran national TV ads that responded to the anti-government rhetoric of conservative opponents with a message, “If the insurance companies win, you lose.”³¹ In addition to HCAN's \$50 million, other major groups such as AARP and labor unions spent large sums on grassroots and netroots support. It was the first time that health reform proponents were able to withstand the opposition campaign.

28. See Drew Armstrong, *Insurers Gave U.S. Chamber \$86 Million Used To Oppose Obama's Health Care*, BLOOMBERG (Nov. 17, 2010 4:32 PM), <http://www.bloomberg.com/news/2010-11-17/insurers-gave-u-s-chamber-86-million-used-to-oppose-obama-s-health-law.html>.

29. See KIRSCH, *supra* note 3, at 65–71.

30. *Id.* at 189–212.

31. *Id.* at 225.

Strategic Lesson Five: The President Needs To Move Fast and Keep Pushing. President Obama took a key lesson from Lyndon Johnson, who pushed hard for Medicare and Medicaid early in 1965, after his landslide victory the previous November. President Obama held a health care summit with congressional leaders and major stakeholders in March of 2009, and by June, legislation started to move. Most importantly, at three times between February 2009 and February 2010, when many of the top White House staff argued against pushing for comprehensive reform, President Obama insisted on going ahead. He was assisted by brilliant legislative maneuvering by both House Speaker Nancy Pelosi and Senate Majority Leader Harry Reid.

III. THE NEW POLITICAL CONTEXT FOR HEALTH REFORM

The reelection of President Obama ushers in a new era of health care in the United States, an era in which the question is not whether there should be a government guarantee of access to affordable health coverage, but how that guarantee is implemented. By all rights, the signing of the Patient Protection and Affordable Care Act on March 23, 2010, should have marked the beginning of that new era. But the political fight continued for another twenty months, first through a politically charged legal challenge, which the Supreme Court settled in June of 2012,³² and then through the presidential election in November.

With the political path clear, the federal and state governments are turning to the task of implementing the two central provisions aimed at making health coverage affordable. The first is the establishment of the health care marketplaces, called “exchanges.” States will decide whether to set up an exchange on their own, in partnership with the federal government, or cede responsibility to the Feds. Whichever level of government is in charge will need to make a host of decisions on the exact level of benefits and the extent of regulation of insurance companies in the exchange. Some will opt to allow any qualified insurer to offer its products. Others will limit the exchanges to insurers that meet quality standards at a reasonable price. None of these decisions will be static; they will become the substance of political debate every year.

The second major coverage expansion will be through the ACA’s raising the income eligibility for Medicaid to 133 percent of the Federal Poverty Level (FPL). The Supreme Court gave states the ability to opt-out of that provision. Most states are expected to comply, as the federal government will pay 100 percent of the cost initially, tapering down to 90 percent over ten years. We can expect to see political debate over this provision in a handful of states for a number of years, although over time, all are likely to implement the expansion.

The public will become more heavily engaged in debates about the levels of subsidies for purchasing coverage. While the subsidies are large enough

32. *See Nat’l Fed’n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (2012).

to make health insurance affordable for many low and middle income people, premiums will be a financial strain for some, particularly those with more income (subsidies are available up to 400 percent of the FPL), who will still be required to pay a substantial amount for coverage. The debate on Congress will be whether or not to increase subsidies, while conservatives will push for reducing them to save the government money. There will be other major debates over a host of issues, including the responsibilities of employers to provide coverage, further regulation of insurance companies, and most centrally, how to control health care costs.

The new political context will also focus public debate on systemic cost controls. We can see the future by looking at what has happened in Massachusetts since their law was enacted. While ObamaCare remains politically contentious, RomneyCare is very popular, a settled part of the political landscape. It is working well: Romney even bragged that 98 percent of Massachusetts residents were covered in the second presidential debate.³³

But because the state is now responsible for more of the cost of health coverage, the Massachusetts legislature, with the encouragement of Governor Deval Patrick, has engaged in vigorous annual debates on how to better rein in the growth of health spending. In 2012, the legislature passed a law intended to set limits on the rise in health spending. Under pressure from the new law, health insurance companies and hospital systems are agreeing to new cost control measures. At the same time, the people who run the Massachusetts Exchange have used their market clout to get insurers to improve quality while controlling costs. And in liberal Massachusetts—I won't predict this for Congress—there has been no serious consideration of cutting benefits or subsidies to people.

We are certain to see the same accelerated debate on cost controls at the federal level. The ACA establishes Accountable Care Organizations (ACOs) in Medicare, networks of hospitals, and doctors who integrate delivery with the goal of providing higher quality care at lower cost. The ACOs are modeled after organizations like the Mayo Clinic and Cleveland Clinic, which have a track record of achieving these goals. We can expect those ACOs with the best track record to become models for Medicare and private insurers over the next few years. The public health insurance option, designed to be a competitor with private insurance to put downward pressure on costs, may reemerge at the state or federal level. There will be renewed pressure for Medicare to negotiate prescription drug prices. Vermont has voted to implement a single-payer system in 2017, when the ACA allows states to innovate as long as they achieve the same coverage

33. See *Transcript and Audio: Second Presidential Debate*, NPR (Oct. 16, 2012 11:01 PM), <http://www.npr.org/2012/10/16/163050988/transcript-obama-romney-2nd-presidential-debate>.

goals without increasing spending.³⁴ And through all this, conservatives will continue to push for more market solutions, as the health care system becomes an annual part of government policy and political debate nationally.

With President Obama's reelection and the Democratic majority under Harry Reid in the Senate, there is no doubt that the Affordable Care Act will be fully implemented in 2014. And a new era in health care, an era in which the right to health care is a public matter, a matter of regular, government policy, will finally have begun in the United States.

34. See Zaid Jilani, *The Vermont Senate Passes Bill Establishing a Single Payer Health Care System in the Senate*, THINKPROGRESS (Apr. 26, 2011 5:59 PM), <http://thinkprogress.org/politics/2011/04/26/161413/vermont-senate-single-payer/?mobile=nc>.