

# Health Reform and the Obama Administration: Reflections in Mid-2010

## La réforme de la santé et l'administration Obama : réflexions à la mi-2010



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### Abstract

The reforms that finally emerged from the Obama administration's initiative were the result of a year of nasty, demagogic and misleading claims in the US public forum, coupled with the complexities of crafting legislation that stood a chance of passing both the House of Representatives and the Senate. The resulting "hybrid" approach to healthcare reform produced a conservative strategy that ignores the experience of other wealthy democracies. More significantly, its long period of implementation, given a possible change of administration in 2012, increases uncertainty regarding whether and how reforms will be rolled out by 2014 and after.

### Résumé

Les réformes qui ont finalement émergé, suite aux initiatives de l'administration d'Obama, sont le fruit d'une année de revendications malsaines, démagogiques

et trompeuses dans les forums publics américains, auxquels s'ajoute la complexité d'élaborer une loi qui ait la chance d'être acceptée par la Chambre des représentants et par le Sénat. L'approche « hybride » visant la réforme de santé a donné lieu à une stratégie conservatrice, qui ne tient pas compte de l'expérience d'autres démocraties dans les pays riches. Plus encore, la longue période visée pour la réforme, avec la possibilité d'un changement d'administration en 2012, accroît l'incertitude quant à sa mise en œuvre d'ici 2014 et au-delà.

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“AMERICANS REMAIN DIVIDED ON HEALTH REFORM,” ACCORDING TO AN April 2010 news release of the Kaiser Family Foundation. In its first tracking poll since the passage of healthcare reform in March, the Foundation emphasized that a majority (55%) are “confused about the law and how and when it will affect them.” What else might anyone have expected after a year of nasty, demagogic and utterly misleading claims about healthcare reform, repeated endlessly in newspapers, magazines and television commentary? The premise of this commentary is that a lot remains to be understood about how and why the battle over healthcare reform was so confusing and why its result – the legislation signed in March – remains so elusive. For readers in Canada, the confusion is closer to bewilderment. So, we begin with the strategic premises of President Obama and his allies.

The gap between the problems of American medical care and the Democratic Party's healthcare reform proposals of 2009 was very large. Understanding why that was so requires familiarity with premises of the Obama reform team – both in the administration and in Congress. The most important assumption was that the Obama administration had to avoid the mistakes of the Clinton administration's disappointing reform experience in 1993/94. Indeed, it would not be too much to say that the reformers of 2009 assumed a good strategy was the *opposite* of the Clintons'. That meant, at the outset, leaving to Congress the bill-drafting process rather than sending up a 1,342-page bill, as the Clinton task forces had notoriously done. So it was that three committees of the House of Representatives were given the substantial task of coming up with a legislative proposal that could pass their institution and, prospectively, the Senate. It is easy in retrospect to pass over this unorthodox, multi-committee approach, but it represented an unprecedented aspiration of comity among staffs and congressional members who are more usually rivals in US healthcare policy making. The strategy called for separate action by the Senate, an institution nominally under the Democrats' control in 2009, but constrained by the filibuster practice that Republicans have increasingly favoured. In any case, turning to Congress for legislative formulation meant that for much of 2009, it was not the president who described Obamacare, but various congressional leaders. What Nancy Pelosi and

her Democratic House Committee chairs – Henry Waxman, George Miller (both of California) and Charles Rangel (New York) – proposed differed from what was acceptable to the leaders of the two Senate committees, Max Baucus (Montana) and Christopher Dodd (Connecticut).

This shift of emphasis to what Congress would be willing to pass was consequential for the policy proposals that emerged. The clearest guide to the Obama team's take on healthcare reform is former Senator Tom Daschle's book, *Critical*, published in summer 2008. Daschle, a friend and key health adviser to Obama during the presidential campaign, was preoccupied with avoiding the frustrating result of 1993/94, when "the great health-care debate ... expired with barely a whimper." From that perspective flowed the other key premises of the Obama reformers. First, they had to unite around a common and broadly acceptable message. That fact helps to account for the endless repetition by Democratic reformers of the goal of "affordable healthcare for all Americans," an aim that hardly anyone could, in principle, criticize. Second, reform proposals had also to avoid known controversial positions – most prominently, appeals to Canada's national health insurance experience in expanding medicare for all or, in some formulations, a "single-payer plan." Whatever the policy merits of such ideas, they appeared to threaten the goal of broad reform consensus and therefore were off the key reformers' agenda. From these presumptions followed a number of policy suggestions that showed up in most versions of what the congressional leaders proposed during 2009.

The most obvious consequence of this strategy was the truncated range of proposals that would supposedly bring "affordable healthcare to all Americans." Although private health insurance left 50 million Americans without coverage and all Democratic proposals criticized the exclusions, restrictions and other miseries associated with commercial health insurance, the 2009 reform agenda required relying on that very same industry. The Obama administration and its congressional allies essentially proposed a patchwork of adjustments to an existing patchwork system of financing American medicine. Though broad in describing the problems of American medical care, the reformers of 2009/10 were clearly narrow in their remedies.

Among the more prominent components, the most obvious was to expand insurance coverage using the Massachusetts reform of 2006 as the basic model. The idea was to combine an individual mandate to buy insurance with subsidies to make such purchases more affordable. But in practice that meant insurance expansion short of universal coverage. The Massachusetts model required most of the uninsured to buy coverage and provided subsidies to those with lower incomes. But in the end, the target in 2009/10 was to insure about 30 million of the 50 million uninsured. To complement expanded coverage through individual mandates, other substantial measures were proposed. The most important was to expand Medicaid – America's Poor Law program administered by the 50 states. The proposal to increase eligibility for this means-tested program came with promises of increased federal funding (at least in the

short-run). These elements were what Senator Daschle imagined as part of a politically acceptable “hybrid” reform, one that builds upon both public and private health insurance programs already in place. The Obama administration’s road to universal health insurance, then, was to be paved with the existing Medicare program, Medicaid expansion, the Veterans Association program, bolstering employment-related health insurance and, finally, insurance exchanges where those without insurance could get coverage at rates below the prevailing market rate. Most noteworthy, in the context of expanding health insurance coverage, was the modest attention to the problem of underinsurance. Insurance law reform would help; mandates would help, yet no simple national catastrophic limit was part of the original strategic design.

Nor was cost control addressed in any form that would be recognized by the rest of the industrial democracies. Cost control fell from favour for the very same reasons that led to a patchwork rather than a more radical reform of how Americans pay for medical care. The strategic aim was reform over time. The operational premise was to get Americans covered via the least ideologically sensitive means, and then other improvements would follow. Clichés such as “a step in the right direction” spring to mind, but this conservative strategy was born of bitter experience, not merely hackneyed language. For cost control, however, there was not so much a search for small but serious steps as an embrace of wishful thinking.

In practice, that meant proposing approaches that have broad popular appeal – e.g., promoting prevention, encouraging healthier lifestyles, expanding electronic medical records, researching medical effectiveness and experimenting with paying doctors and hospitals by different methods, including more “bundling” of activities and more use of per capita, rather than per service, payments. Without elaborating, it is safe to say that none of these policies, however much they might improve care, would be effective anti-inflationary measures in US medicine.<sup>1</sup> Over the course of 2009, this cautious strategy took precedence, with one exception. The reformers, when forced to explain how subsidies would be financed, came to rely on reductions in Medicare reimbursements as an answer. And that, in turn, prompted endless disputes about whether access to Medicare was being sacrificed to health insurance expansion.

A final illustration of the power of the reformers’ assumptive world was the use of historical parallels in the case made for what I have labelled Obama’s reform. There were, as suggested, innumerable reflections on the alleged mistakes of the Clinton reform strategy. There were as well frequent invocations of the way in which the struggle over Medicare in the 1960s justified the hybrid approach, and its accompanying hope of getting enough bipartisan support to make the bill’s passage through the Senate filibuster-proof. The claim was that the political history of US Medicare’s enactment illustrated both bipartisan support and the long-term impact of that support on the program’s stability over decades. The analogy was wrong factually, and the implications were misleading. Medicare was bitterly fought over from the time it was

introduced in the 1950s until 1965, when the Democratic electoral landslide of the previous November ensured passage. The alignment then was not simply Democratic versus Republican views of government health insurance, but rather a deeply divisive liberal–conservative battle. The conservative coalition of the early 1960s – with senior Southern Democrats in charge, for instance, of the congressional finance and rules committees – meant that Democratic majorities did not guarantee policy victories for the Kennedy administration.<sup>2</sup>

The implications of this difference were not appreciated in either the assumptions of the 2009/10 reformers or in the justifications offered for the reform strategy. Instead, the effort to get Republican support for the hybrid strategy continued for most of 2009, with protracted soliciting of Republican moderates such as Senators Snowe and Collins of Maine and endless indulgence of the Senate Finance Committee negotiations among what came to be considered the “gang of six.” In the early 1960s, no such efforts were made to adjust the reform proposal – 60 days of public hospital insurance for all retirees under Social Security. Rather, the effort was to elect a Congress that would support this social insurance approach. Each year, the conservative coalition blocked enactment with one or another move, pitting conservative Democrats and orthodox anti–social insurance Republicans against liberal Democrats and some moderate Republicans. The strategy of building up a liberal majority worked, though only after Kennedy’s death and the 1964 electoral landslide. But the point is simply that the Obama reformers never took into account the Medicare strategy as a real alternative.

Once a strategy was established, the year unfolded with an extraordinary mix of earnest cooperation among House Democratic leaders and dismaying differences within the Senate. Moreover, the public debate was a shambles, with false charges of “death panels,” illusory claims about what “government medicine” would bring, and downright lying left and right. Equally obvious were the complete failure of the bipartisan strategy and the misreading of the history of social insurance reform. Government health insurance reform, whether indirect or direct, is a source of fundamental cleavage in American politics. And American politics is sufficiently fragmented, and power so dispersed, that there are ample opportunities both to sustain ideological charges endlessly and to delay legislation even when one party “controls” both houses of Congress. So, what transpired in 2009 was an ideological battle that would hardly have been different had President Obama proposed a “Medicare for all” plan financed by social insurance taxes and a bank tax. And yet, what finally emerged was a breathless victory that took every skill House leader Pelosi and Senate leader Reid could muster.

Most of the legislative uncertainty of 2009 arose from the simple fact that the support of 60 senators was needed to avoid a filibuster. That, in turn, required support from all the Democrats, including as many as 10 or more who would not easily support any healthcare reform the more liberal House bill would produce. There were

other sources of uncertainty, of course. Government institutions disperse power, but they also de-link the fate of individual politicians from whatever a president may propose. Local considerations bear on Congress crucially, yet much more media attention was given to the health industry groups that were obviously enticed to go along with the cautious reforms of 2009, especially given Congress' reluctance to take on boldly the cost of drugs, devices, hospitals and doctors. And yet in the end, the calculations of individual congressional positions turned out to be key. The anti-abortion group in the House of Representatives would play a vital last-minute role. So too would the voters of Massachusetts, whose election of Senator Brown in December 2009 shocked the chattering classes and, in an ironic twist, nearly stopped the reform cold. Where else, one might ask, could a change from a 60% legislative party majority to a 59% majority throw into question the fate of a major-party reform proposal? The answer is nowhere among the United States' trading partners, but it took place in the wake of the Massachusetts special election of 2009. Institutions mattered in the fate of reform in 2009/10. So did ideological convictions and interest-group influence.

What, in conclusion, is worthy of emphasis for an audience outside the United States? Three come to mind as possible aids to understanding this major episode in American politics.

The character of American institutions explains much of the peculiar features of this complex reform legislation. To avoid a filibuster and to hold together a coalition of Democrats with divergent views and constituencies, the reformers of 2009/10 believed a conservative strategy was required. Their strategy may well have been overly cautious. It is certainly the case that they ignored the example of how Medicare came to pass in 1965 by a process of increasing support for a controversial program. But a gap between the rhetoric of America's healthcare problems and the remedies that the Obama administration and its allies accepted was not the product of ignorance or foolishness. It reflected political judgment, which in turn had much to do with the influence of holdovers from the Clinton presidency, both in the Congress and in the executive.

That institutional influence shaped all features of the reform that emerged legislatively. The absence of serious cost control, the failure to ensure universal insurance coverage, the reliance on the private health insurance industry and subsidies, the expansion of federal regulatory authority in health insurance, the barrage of experimental programs – all followed from the exclusion of more straightforward reforms. What also followed was almost a complete ignoring of the experience of other rich democracies with healthcare reform. This was especially striking in connection to Canada, the United States' closest neighbour in both geography and medical care arrangements. From 1992 to 1994, Canada's experience with its own medicare was prominent in the debates over the Clinton plan, as were discussions of the German social insurance experience. Nothing like that took place in 2009/10, with the exception of some right-wing groups in the United States repeating false horror stories

about Canadians fleeing south for life-saving treatment. The provincialism of the discussion meant that there was precious little clarification of what different conceptions of public policy were at work in the world of modern medical care financing, delivery and regulation.

Finally, the striking feature of this reform episode is how much of its impact will be decided in implementation over a very long time period. The expansion of insurance coverage will not take place on any large scale until 2014. Between now and then, two congressional elections and a presidential race will occur. That means the reform disputes of 2009/10 will continue, with less settled by the dramatic actions of the Democratic Congress of 2010 than anyone might have imagined at the outset of the Obama administration. That, in turn, means that any understanding of what reform actually will produce is subject to enormous uncertainty. Stay tuned.

#### NOTES

<sup>1</sup> For a fuller discussion of the limited cost control potential of prevention, electronic medical records and other delivery system reforms, see Marmor et al. 2009.

<sup>2</sup> That history is presented in detail by my book *The Politics of Medicare* (2000).

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