The Politics of Health Care Reform: How Political Interests and Preferences Shape Political Strategy

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“Having choices we don’t like is no choice at all,” Louise laments. “They choose,” Harry agreed. “We lose,” replied Louise.

—Ad sponsored by Health Insurance Association of America, July 1994

“Looks like we may finally get health care reform,” Harry says. “It’s about time,” Louise responds. “We need good coverage people can afford, coverage they can get. ..” Harry, finishing her sentence, says, “.. even if they have a pre-existing condition.”

—New ad sponsored by Pharmaceutical Research and Manufacturers of America (PhRMA) and Families USA, July 2009

The advent of a new, engaging president; a poor economy; and soaring health care costs made the time ripe for major health reform—both in 1993 and now in 2009. In 1994, Americans came to associate health care reform with a couple named Harry and Louise who, sitting at the kitchen table, fretted over the hopeless maze of bureaucratic procedures and seeming lack of choice in the Clinton health care plan. But as the current “Harry and Louise” television ads demonstrate, the environment has changed. From our vantage points as APSA Congressional Fellows—one working for an influential moderate Democratic senator on a key committee and one working for an influential moderate Democratic House member—we describe our view of the attempts to successfully pass health reform in the 111th Congress where similar attempts during the 103rd Congress failed.

Comparing the health reform process under President Clinton to what we have observed firsthand in 2009, we argue that the strategies and tactics used to achieve reform in 2009 are more likely to succeed, but are still subject to powerful pressure from outside interests and internal centrist members. By appealing to moderate Republicans, especially on the Senate Finance Committee, and by negotiating the support of interest groups who could derail reform entirely, pro-reform politicians are mounting a formidable campaign for a new health care system—yet this strategy may be insufficient to pass comprehensive reform. Learning from Earlier Mistakes

Much has been written analyzing the death of health care reform under President Clinton (Hacker 1997; Johnson and Broder 1996; Skocpol 1996). These studies demonstrate how the Clinton plan ultimately was sunk by a confluence of key actors in health reform, including the president, Congress, the parties, the interest groups, and the media. President Clinton himself has suggested that he “set the Congress up for failure” (Johnson and Broder 1996, 609). Having just come off a difficult campaign that achieved a plurality but not a majority of votes, the central theme of his campaign was the economy, not health care. However, in addition to addressing the widening budget deficit, he promised to—within 100 days—make significant progress toward completely revamping the nation’s health care system. Having no firsthand legislative experience, President Clinton treated health reform like another political campaign. The task force, led by first lady Hillary Clinton, swelled to more than 600 people in 34 working groups on a 100-day deadline. Internal bickering, exhaustion, and leaks resulted. At a critical point of momentum for health reform, the efforts went adrift into the issue of NAFTA (Skocpol 1996). Nine months after inauguration, the task force produced a fully specified proposal already written in legislative language and presented it to Congress.

The product of all this effort was not well received on Capitol Hill, where members generally prefer power over deference. The Democratic Party, having been in the majority for decades, was internally divided. While liberals in Congress favored a single-payer plan, moderate Democrats offered a “managed competition” plan that did not promise universal coverage. A left-leaning wing of Republican senators wanted to transform the health care system, yet conservative Republicans were completely opposed to reform.

Ultimately the proposal took an evolutionary path as a more expansive set of actors and interests got involved. During the presidential campaign, the proposal leaned conservatively toward “managed care”; then during the White House phase it moved left toward more generous benefits and tighter controls; and finally during the congressional phase it moved back toward less control and restricted benefits. The fissures between and within the parties made it easy for interest groups to defend the status quo and effectively attack the plan. The convergence of these factors led directly to failure of health reform: the bill failed to receive even a committee vote in the House and was not even introduced in the Senate.

In the absence of reform in the 1990s, the health care system has worsened. In 1993, health care consumed one out of every seven dollars while today it consumes one out of five. In 1993, there were 37 million uninsured Americans; today there are 46 million. The growing severity of these problems, especially the spiraling costs, has led stakeholders who previously did not support reform to a growing consensus that reform is necessary. Employers, beleaguered by health insurance premiums that increase 20% or more each year, come to Capitol Hill with a new perspective: we cannot afford these costs; we need government to help pay or to push costs down. In 1994, primary care doctors and specialists, drug and medical device mak-

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ers, hospitals and insurers, and employers 
opposed President Clinton’s Health Security 
Act; today health providers of all varieties tell 
members of Congress that they “want to be 
a part of health reform” (code for, “we will 
support it if we are taken care of”). Securing 
the endorsement, or at least the tacit sup-
port, of these interest groups is essential for 
the bill’s success.

THE STRATEGY

In 2009, both the president and Congress 
knew that legislation should be a product of 
the legislative branch and not the White 
House. Importantly, this approach would 
give moderate Republicans and health 
care interests greater ability to influence 
the contents of the bill, and they therefore 
would be more likely to support it. Though 
the media refer to “Obama’s health care 
plan,” the president has not produced any 
legislative proposal. Rather, he has set 
out eight guiding principles of health care 
reform, held private meetings with mem-
ers, conducted public town halls, and del-
egated the details.

Obama’s approach is quite similar to the 
successful one used by President Johnson to 
pass Medicare. Johnson applied “relentless 
personal pressure to his staff and congressio-
nal leaders” while deflecting credit to 
Congress, and largely to Ways and Means chair-
man Wilbur Mills (Blumenthal and Morone 2009). Like Obama, Johnson acknowledged a 
short period of time—in his case 60 days—in 
which passing the bill was possible. As John-
son’s Social Security expert Wilbur Cohen 
recalled, Johnson told him: “... every day 
while I’m in office, I’m going to lose votes. 
I’m going to alienate somebody... We’ve got 
to get this legislation fast. You’ve got to get 
it during my honeymoon” (quoted in Blu-
menthal and Morone 2009, 2386).

Under President Obama, most pro-reform 
members of Congress agreed that the Senate 
Finance Committee (SFC) should be the first 
author, for several reasons. First, as the only 
committee in the Senate that pays for what 
the government wants to do, the SFC has 
greater jurisdiction than any other committee 
in Congress. Financing health care reform is 
no easy task as early estimates by the Con-
gressional Budget Office (CBO) scored the 
bill as high as $1 trillion.

Second, the SFC is known for its biparti-
sanship. A bipartisan bill would go far in get-
ing public “buy in” on legislation—without 
jeopardizing either party in the next election. 
Moreover, pivotal moderate-leaning Repub-
licans such as Senators Snowe and Grassley 
are on the SFC, and their votes are critical to 
“get to 60”—the new norm for passing bills 
in the Senate.1 Al Franken’s victory in July 
does not guarantee 60 votes, because Senators 
Byrd and Kennedy are away due to serious 
illness, and because party discipline in the 
Senate is far from absolute.

The other committee in the Senate with 
jurisdiction over health care is the Health, 
Education, Labor and Pensions (HELP) com-
mmittee. But HELP is missing its chairman, 
Ted Kennedy, who has made health care the 
hallmark of his career. His deputy and friend 
Chris Dodd, who already chairs the banking 
committee and is gearing up for reelection, 
was called to serve as surrogate chair with-
out the same long engagement on the issue. 
Moreover, Kennedy has a reputation for his 
cirumspect political and negotiating skills, 
and in his absence, Republicans on HELP 
were not deterred in voicing objections—
especially because they knew Republicans 
in the SFC would already be making com-
promises with Democrats. After 50 hours of 
marking up the bill, HELP voted out the bill 
without a single Republican vote.

Third, the House Democratic leadership 
faces the same problem in 2009 as it did in 
1994: internal division. Progressive House 
Democrats, who would prefer a European-
style single-payer system, want to “put a 
sta ke in the ground” and pass a bill before 
the Senate does in order to maximize the 
chances that the final bill contains a strong 
public option modeled on Medicare. Con-
servative Democratic Blue Dogs have raised 
concerns about high costs, increased taxa-
tion, and the potential burden on business. 
Meanwhile, the Speaker has coordinated and 
overseen the efforts of the chairmen of the 
“Tri-Committee”—the three committees of 
jurisdiction in the House consisting of Ways 
and Means, Education and Labor, and Ener-
gy and Commerce. House leadership even 
put together a one-page health fact sheet for 
each member showing how the bill would 
specifically benefit the representative’s dis-
trict. Although the institutional rules of the 
House grant leadership considerable power, 
especially relative to the Senate, to pass a 
bill the Speaker needs the support of at least 
some of the 51 Blue Dogs and 86 “Medicare 
for All” cosponsors.

Thus the strategy became clear: let the 
moderate Senate Finance Committee go first, 
granting influence to key moderate Repub-
licans. House leadership would work toward 
passing a Democratic bill that might include 
a public option, ensuring Blue Dogs that the 
legislation would become more conservative 
in conference compromises with the Senate. 
SFC chairman Max Baucus’s guiding prin-
ciples were three: put all options on the table, 
involve everyone so as to minimize push back 
from stakeholders, and compromise with 
Republicans to reach a bipartisan consensus. 
The resulting bill would need to be merged 
with the HELP bill before being passed on 
the Senate floor, while the House leadership 
made compromises with the Blue Dogs neces-
sary to pass the bill in that chamber, and all 
this would have to be done before the August 
recess to meet Obama’s deadline.

THE PROCESS

Chairman Baucus’s actions matched his 
principles. Shortly after the presidential 
election Baucus released an SFC white 
paper proposal outlining his ideas for 
reform. The SFC grouped reform ideas 
into three buckets, or areas, starting with 
the easiest elements and ending with the 
most difficult. On each topic the committee 
held a novel open roundtable hearing with 
invited experts followed by a closed-door 
walkthrough for members and staff, and 
presented publicly available options books 
that ruled no proposals out or in.

In the first area, delivery system reform, 
there was consensus across party lines that 
health care payments should shift from fee 
for service, which creates an incentive for 
unnecessary procedures, drugs, and treat-
ment, toward pay for performance, which
rewards providers for better health outcomes for their patients, such as avoiding hospital readmissions. As individual categories of Medicare providers were threatened with cuts, the delivery system reform negotiations grew tenuous. Groups made the case for why their services should not be cut, often framing their requests as wanting a seat at the table. Skittish Republicans touted employer wellness programs and eliminating fraud and abuse as the best ways to cut costs.

The third area of reform, financing, would go beyond controlling costs. The economists consulted by the SFC focused on limiting the tax-free status of employees' health benefits, which would also bend the cost curve by disincentivizing overspending on health care. CBO found that a high cap on tax-excluded benefits would produce hundreds of billions of revenue dollars, and the SFC proposal rested on capping the exclusion as the largest "pay for" in health reform. However, President Obama had used Senator McCain's proposal to limit the tax exclusion against him in the presidential race, and the proposal was challenged by labor unions that had negotiated for benefits enhancements and Senators in high-cost states who would be disproportionately affected. Around the time when the original SFC markup had been slated to occur, the number-one source of revenue to pay for health reform was off the table.

This bump in the road for Senate Finance allowed both HELP and the House to go first. Feeling pressure from the White House, the Senate majority leader, and Senators on both sides of the aisle, Baucus created a small bipartisan group of Senators Bau- cusc, Bingaman, Conrad, Enzi, Grassley, and Snowe nicknamed the "coalition of the willing" (or COW, as a skeptical staffer joked). This group spent hours each day hammering out compromises over controversial provisions. Reporters camped out waiting for these meetings to end so they could get an update, but Baucus and the other willing members would say only that progress was being made. Many members—even those on the Finance Committee—complained that they did not know what was going on behind closed doors. This secretive activity reminded some in the press of earlier battles, such as immigration reform in 2007, in which back-room deals caused resentment and eventually resulted in no bill. Still, COW's small size and its inclusion of pivotal moderate Republicans Grassley and Snowe made negotiating easier, and the group became the Senate's best hope for passing a bill.

THE DEALS
In 1993–94, interest groups tended to lobby for or against the entire health bill. In 2009, groups focused on individual pieces of the package. When the House bill was introduced, a new phase of lobbying began, as groups zeroed in on how the bill would affect them. Radiologists complained about changes in the assumed utilization rate of imaging equipment; nurse-midwives wanted to be reimbursed at the same rate as other obstetrics providers; pharmacists asked for compensation for time they spent managing patients' medication usage; podiatrists and optometrists wished to be included in the definition of "physicians." Even in the Finance Committee, which does not require legislative language prior to mark-up, members and staff were lobbied on every aspect of health reform. These staff examined costs, consulted experts, assessed the politics, and made decisions subject to the members' approval. Their choices were ultimately aimed at obtaining the support of the moderate Senate Republicans.

Politicians knew that if groups got something they wanted, they would be more willing to accept something they didn't want. Members and staff in both chambers talked of getting the endorsement or the sign off of the AHA, PhRMA, and the AMA. The support of these hospital, pharmaceutical, and doctor groups (respectively) was so great that the White House and congressional staff made deals with each group. The American Hospital Association agreed to Medicare and Medicaid cuts of $150 billion but raised concerns about creating an independent commission to set Medicare rates that would make it harder for the industry to lobby against payment reductions. The drug manufacturers offered to discount Medicare drugs by $80 billion and to invest another $80 billion in the Medicare drug rebate program—but these discounts would apply only to brand-name drugs, which would actually cost patients and the government more. Physicians, who stand to benefit from universal coverage, object to basing a public option on historically low Medicare rates; they also want medical malpractice tort reform and a repair of the sustainable growth rate (SGR) of Medicare reimbursements. Each year the AMA lobbied successfully for Congress not to implement the growing cuts that the SGR would mandate. While no tort reform is currently included, the "doc fix" is in the House bill.

In many cases the interests were not present on the Hill as lobbyists but were in the members' minds as they considered how health reform would affect their districts and states. Senators from rural areas such as North Dakota, Montana, New Mexico, Wyoming, Iowa, and Maine—the states represented in the coalition of the willing, and prominent Blue Dogs from rural districts including Representatives Ross, Hill, and Shuler—were sensitive to the low reimbursement rates those states' Medicare providers received. Likewise, members in poorer areas with hospitals that provide a large amount
of uncompensated care (the so-called disproportionate share hospitals or DSHs) were concerned about cuts to Medicaid despite the promise of universal health insurance. Further, some members are guided by ideological beliefs with which they assume their constituents generally agree. House Blue Dogs feared the bill would not sufficiently “bend the cost curve” and would put jobs in jeopardy with a pay-or-play policy for employers. Many Republicans were resistant to government involvement in health care, calling it “socialized medicine” and warning the public about “rationing.” Democratic freshmen, having faced a tough vote on the climate change bill, were concerned about the electoral consequences of supporting health reform legislation, which polls were showing did not have widespread support. In some instances these differing convictions can be reconciled, as proposals are altered or eliminated. In other instances, appeasing one side means risking losing the support of others. Energy and Commerce chairman Waxman’s compromise with the Blue Dogs, for example, caused progressives to worry that they would not support the bill if it were watered down to get the Blue Dogs’ support.

As of this writing, the outcome of health care reform is still unclear. Our experience in the front row persuades us that the efforts to secure the support of important interest groups and moderate Republicans are the best chance reformers have of passing comprehensive health reform. President Obama, the five committee chairs, and Democratic leadership have made a concerted effort to avoid the mistakes made in 1993–94. With the stakes so high, the president and congressional leadership have carefully navigated the stakeholders’ and members’ interests to minimize strong, organized opposition to the bill. However, the fate of health care reform will ultimately rest on the preferences of members of Congress, especially the three Republican “COW” senators, and the organized—and unorganized—interests they serve.

NOTES

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1. It is also possible to pass health reform through the budget reconciliation process in the Senate, which would require only a majority. However, reconciliation requires the legislation to be deficit-neutral over a five-year window rather than the CBO window of 10 years. Since health reform would require substantial initial outlays, it would be much more difficult to raise the revenue necessary to balance these expenditures within five years. In addition, the Byrd rule of reconciliation makes any provision not directly related to balancing the budget out of order, which confounds attempts to include substantive legislation.

REFERENCES


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In an effort to increase graduate student participation at the annual meeting, the association awarded Advanced Graduate Student Travel Grants for the 2009 meeting in Toronto. Recognizing challenging economic times across academia, Cambridge University Press offered $7,500 to supplement the APSA travel grant program and support U.S. graduate students taking part in the annual meeting. The names and institutional affiliations of the awardees follow.

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