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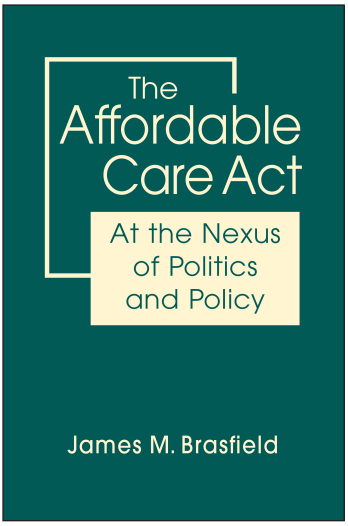
The Affordable Care Act: At the Nexus of Politics and Policy



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Contents

1

The Origins of the ACA: A Century of Debate

Past is prologue.

—William Shakespeare

They gathered around a table at the Truman Library in Independence, Missouri, on July 30, 1965. President Lyndon Johnson was joined by former president Harry Truman, who twenty years earlier had proposed a national health insurance program. Seventy-two pens were used in the Medicare bill-signing ceremony. One was distributed to Wilbur Cohen, an intellectual father of the Medicare idea. Various members of Congress and the administration who contributed to the bill's passage also received a keepsake. In his remarks, the president said, "No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime so that they might enjoy dignity in their later years."[1]

Many in the auditorium that afternoon were confident the new legislation was the first major step in the achievement of President Truman's goal of a universal public health insurance program as part of the Social Security System. Probably no one present could have imagined that the next signing ceremony for major legislation expanding health insurance coverage would take place forty-five years later, when President Barack Obama employed twenty-two pens to sign the Patient Protection and Affordable Care Act (ACA) on March 23, 2010. He commented before affixing his signature, "The bill I'm signing will set in motion reforms that generations of Americans have fought

for and marched for and hungered to see. . . .Today we are affirming that essential truth, a truth every generation is called to rediscover for itself, that we are not a nation that scales back its aspirations."[2]

The bill signed by President Obama did not follow Medicare as its organizing concept. The late 1960s expectation of an expanded social insurance approach to universal health coverage was not the nucleus of the new legislation. Rather, it built on Medicaid, barely noticed initially and a long-underestimated part of the 1965 law. The ACA expanded Medicaid and used premium subsidies to make private health insurance more affordable for those not part of the employment-based system.

Medicare and the ACA are the bookends of almost fifty years of national health policy debate. The 2010 social and political context was starkly different from that of 1964. The science of medicine had become more intricate, the aggregate health cost to society exponentially greater, and the medical system institutionally more complex. National and state politics have been transformed as the two parties sorted more consistently along geographic and ideological lines. Perhaps most significantly, citizen views of government as a provider of services have become much more negative. In 1964 three in four Americans trusted the government most of the time. Fifteen years later only a quarter of the population expressed the same trust. By 2010 only one in five reported trusting the government.[3]

The 1965 aspiration of Medicare as a first step toward a universal public health insurance program appeared unattainable by 2009. Neither public opinion nor elite support appeared sufficient in the first decade of the twenty-first century to expand Medicare to cover the entire population. It was Medicaid, the welfare-based afterthought, that became the most significant link between the Affordable Care Act and Medicare. The common thread across half a century was the idea that government ought to be responsible for arranging a system to assure financial access to health care.

By 2009 Medicare had evolved but remained largely the same program in scope and approach that it was in 1966. The primary beneficiaries were those over age sixty-five. The only additions were beneficiaries in the Social Security disability program and individuals suffering from end-stage renal disease. Medicare Part A covered hospitalization and was financed through the payroll tax paid by current workers. Part B covered physician costs and was paid for by a beneficiary premium set at 25 percent of program costs. The balance of Part B financing was from federal government general revenue. Most beneficiaries purchased private supplemental insurance to cover significant deductibles and copayments. A private insurance prescription drug program had been recently added, which combined a modest premium with significant general revenue financing. Medicare had also been modified to allow private insurance companies to offer plans in competition with tra-

ditional Medicare. This is Medicare Advantage, and it included about 20 percent of the Medicare population at the time of ACA enactment.[4]

Medicaid, on the other hand, had grown from a modest program providing medical vendor payments for some of the poor covered by the existing welfare system into a vast and complex funding system covering many of the poor and near poor. This was a federal-state program, with the federal government paying approximately 60 percent of the total cost and states covering the remainder, although the funding formula differed depending on the wealth of the state. Within federal guidelines, each state program could have different federal contribution limits, services covered, and eligible populations.[5]

In Chapter 2 we will explore in more depth the reasons why Medicaid, rather than Medicare, was chosen to be a major vehicle for the public expansion part of the ACA law. In the following pages of this chapter, we will summarize what President Obama called the struggle by generations in our examination of both the politics and the policy ideas associated with health reform beginning in the early twentieth century.

Dawn of the Twentieth Century

The story of the ACA is a quest tale that spans a century of American history. The Holy Grail pursued by various Galahads was universal financial health care coverage. As the nineteenth century turned into the twentieth, Europe and America experienced a series of transformative changes. The Industrial Revolution exploded in the United States in the decade after the Civil War. In his magisterial study of major changes in the American economy, Robert Gordon traces the development of unprecedented American economic growth from 1870 to 1970 and identifies revolutionary developments such as electricity, the telephone, refrigeration, and the internal combustion engine.[6] These were all in place before 1920. They were transformative changes, especially in urban America. Change came slower to the rural parts of the country. As the third decade of the twentieth century began, daily living would have been almost unrecognizable to a visitor from the Civil War era just fifty years earlier.

Life expectancy increased from forty to sixty-four years in the half century after 1890. Infant mortality and fatal childhood disease declined, and life expectancy after the age of twenty increased. Gordon and others have observed that enhanced medical treatment was not the only factor.[7] There was an exponential growth of clean water and sewer systems, and food became safer. A study by David Cutler and Grant Miller concluded that clean-water technologies, such as filtration and chlorination, caused a substantial reduction in urban mortality and accounted for most of the infant and child mortality reduction.[8]

The development of anesthetics, X-rays, and antiseptic surgery transformed the practice of medicine by the turn of the twentieth century. Louis Pasteur's germ theory of disease began to dominate medical science by then. Atkul Gawande, in tracing the history of surgery, observes that between the mid-1880s and the 1920s, surgical advances accounted for half of all *New England Journal of Medicine* articles. "Surgery became a dominant force in medical advancement," he concluded about the early twentieth century.[9] The Flexner Report was a comprehensive study of medical education, which in 1910 called for massive changes in the way doctors were trained, with greater emphasis on science education.[10]

In the nineteenth century the dominant mode of health care delivery was a doctor seeing patients in the office. Rosemary Stevens notes, "Between 1870 and 1917 the American hospital was transformed from an asylum for the indigent into a modern scientific institution."[11] As physicians practiced more scientific medicine, their authority and professional autonomy increased.[12] Physician specialization among surgeons grew as the types of surgery increased. By the end of World War I (1918), the hospital was already becoming an essential part of the delivery of medical services, with more than 1,500 hospitals across the country as early as 1904.[13]

The last decade of the nineteenth century and first two decades of the twentieth were the most transformative in American and world history. Critical technologies revolutionized daily living. Breakthroughs in medical technology made it possible to routinely open the chest and successfully perform surgery for a variety of medical problems. The hospital was becoming the major locus of medical treatment rather than a warehouse where the ill poor went to die.

When serious illness and early death were no longer seen as a routine part of life, the average American sought access to the latest medical treatment. However, the cost of care rose rapidly as hospitals could no longer afford to be purely charitable institutions. Several policy ideas and approaches began to be discussed. A progressive group, the American Association of Labor Legislation (AALL), proposed in 1915 a model state bill for working-class health insurance that included payments for physicians and hospitals as well as sick pay. Under the plan, workers, employers, and the state would participate in financing the benefits.

Despite initial physician support, the American Medical Association (AMA) ultimately joined labor unions and employers in opposing the AALL health insurance approach. At this point both Germany and Britain had, with national legislation, created early-sickness fund health insurance systems for workers, with payments by workers, employers, and the government. These models encouraged reformers to believe the same ideas could be brought to America. AALL plan advocates were hopeful that California would be the first state to enact a health insurance plan, but the voters rejected it in

November 1918. A similar proposal in New York passed in the state's Senate but was never brought to the floor of the House for a vote.

The plans for government-sponsored health insurance did not emerge, but individual industrial sickness funds sponsored by businesses or labor unions did grow significantly in the first decades of the twentieth century. The extent of their coverage of industrial workers is disputed, but John E. Murray claims the number might have been as high as 30 percent.[14]

These were not health insurance plans as we know them today. They provided payments in lieu of wages for employees who were too ill to work. The employer plans were financed by worker-paid premiums and shared payments by employers. The union plan funds were more often taken out of general union dues. In both instances premium payments would have needed to be much higher to also cover doctor and hospital costs. Typical plans did not cover medical costs. According to Murray, workers were unwilling to pay the additional premium for such benefits.[15]

Why would urban workers not want to have coverage for physician and hospital costs? A century ago office visits were usually in the neighborhood and probably relatively inexpensive. Surgery and extended hospital stays were still rare and likely not in the foreseeable future for a healthy worker. Public hospitals were also becoming more prevalent. In 1904, 15 percent of all hospitals were public hospitals, and 25 percent of all admissions were to public hospitals. Income from paying patients covered less than 10 percent of all costs.[16] The average urban worker might well have calculated that the local public hospital would be available in time of need for little or no cost and that the quality of care there was equivalent to that in a private facility.

Two Decades Between World Wars

No one reading this section will have a personal memory of the 1920s. Our collective sense of the decade is shaped by movies and popular culture. It was the era of flappers, Prohibition, speakeasies, and a booming stock market. Less well understood are the critical changes in the delivery and financing of health care that had been accumulating and became evident in the 1920s.

Cutler and Miller state, "Mortality rates in the US fell more rapidly during the late 19th and early 20th Centuries than any other period in American history."[17] They further argue that nearly all of the decline can be attributed to infectious disease decline due largely to the widespread introduction of clean water and sewer systems in urban areas.[18]

At the same time radical medical school reforms produced by the Flexner Report began to change the medical profession in several ways. New physicians were better educated and emerged from a revised system of supervised training that generated higher standards. Hospitals began to limit privileges, and surgery specialization quickly emerged. World War I

and the flu epidemic of 1918–1919 also contributed to the emerging central role of the hospital in the provision of medical services. Many doctors returning from field hospital experience during the war had gained a lifetime's worth of surgical experience in a year.

For the average middle-class person living in a city in the 1920s, routine surgeries were becoming more commonplace and expensive. Private hospitals had semiprivate rooms rather than wards, in addition to other amenities. But they also charged a daily room rate as well as fees for lab tests and other necessities. Physicians, especially surgeons, had incurred higher medical education costs, and with more regulated entry into the profession, they enjoyed more of a monopoly position. Market prices for medical services rose.

The creation of the Committee on the Cost of Medical Care (CCMC) was symbolic of the emerging concern with the impact of rising medical care costs for the average middle-class person. This group, organized by academic medicine leaders and funded by major foundations, instituted dozens of studies between 1927 and 1932, which constituted the first systematic review of medical costs. They identified hospital costs in 1929 as 13 percent of a family's total health costs—double the proportion of a decade earlier. They also identified a large variation among families reflecting extent of treatment with some spending much more because of serious illness.

The CCMC offered a series of recommendations that included delivery of services by organizations of physicians in group practice or community medical centers, rather than solo practitioners, and financing of medical costs on a group basis by insurance, taxation, or both. However, they did not endorse the idea of compulsory health insurance.[19]

During the Great Depression of the early 1930s, the work of the CCMC contributed to revamping the political and economic environment. Voluntary health insurance on a large scale appeared out of reach, and the possibility of a public compulsory insurance program again appeared to be politically feasible to Franklin Roosevelt's New Deal administration. By the mid-1930s the Roosevelt administration was planning a major social insurance program to include retirement benefits, unemployment compensation, old-age benefits, grants to the states for dependent children, and state grants for maternal and child welfare.[20] These policy ideas would ultimately become the Social Security Act of 1935.

The biggest controversy surrounding the development of the bill within the Roosevelt administration was whether or not to include health insurance as one of the elements of the program. The overall plan was developed by the administration's Committee on Economic Security. Was a health insurance component to be focused on income replacement for the sick, as with earlier proposals, or would this be an insurance plan to cover physician and

hospital costs? The final recommendation was the creation of state health insurance programs financed by a tax on employers for the middle class and general revenue for the poor.[21] The AMA opposed these ideas, and Roosevelt did not include them in the final legislative package sent to Congress, although the final law did include a provision for the new Social Security Board to study innovative ways to provide health insurance.[22]

This did not completely remove health insurance from the administration's long-range agenda. Roosevelt had essentially put off consideration of health insurance until after the 1936 election. In 1937 a technical committee was created that ultimately recommended a program that "included expansion of the maternal and child health program, federal grants for hospital construction, grants to the states to pay for medical care for the 'medically indigent' (those too poor to pay for medical bills), a voluntary program of grants to the states that wanted to set up statewide health insurance programs for the general public, and a disability program."[23]

Senator Robert Wagner introduced a bill with those provisions, but the absence of presidential backing and the outbreak of war in Europe, as well as AMA opposition, doomed the effort. Thus, the first attempt to create a publicly sponsored health insurance program failed to generate either broad public interest or political support. The basic policy idea was for the federal government to provide grants to states to organize health insurance programs and to pay for medical care for the medically indigent. From today's perspective this looks more like Medicaid than Medicare.

As the Roosevelt administration dipped its toe in the public health insurance water and found it too cold for a plunge, work-based private insurance was experiencing rapid growth. In the early twentieth century, a number of industries (railroads, coal, steel) organized hospital associations with prepaid care arrangements for company facilities. There were also industry and labor health insurance plans, which provided replacement income for sick or injured workers. The initiation of hospital insurance as we know it today began in Dallas in 1929. Local schoolteachers and the Baylor University Hospital entered into an arrangement in which a monthly fee entitled them to three weeks of hospital care. This quickly expanded to other hospitals in the area, and the concept spread to major cities across the country. These local arrangements were linked under a single insignia, a blue cross. The Blue Cross associations were closely aligned with the American Hospital Association.[24]

Commercial insurance companies were still reluctant to offer health insurance that covered hospitalization and physician services, and this left the market open for Blue Cross during most of the 1930s. The AMA had endorsed the idea of private health insurance as a better alternative to a public plan. State medical societies by the late 1930s had begun to form prepayment associations for physician payments that were eventually called

Blue Shield and marketed with Blue Cross, although they remained organizationally distinct.

By the end of the 1930s, 1.5 million individuals were covered by Blue Cross plans and 300,000 by commercial insurance companies that were beginning to find a market for this product.[25] Work-based private health insurance was expanding rapidly by 1940 and, perhaps as a consequence, moderating demand for a public program.

World War II and the Postwar Era

Little occurred during the 1940s that was not influenced by World War II. War production stimulated the economy and created a demand for factory labor. The wartime wage and price controls limited employers' ability to compete for workers by offering higher wages. However, offering health insurance benefits was not ruled to be in violation of wage controls. This incentive contributed to the rapid growth of work-based health insurance. By 1950, 140 million people were enrolled in private health plans, which was seven times more than in 1940.[26]

By the late 1940s labor unions had solidified their position as significant participants in most major manufacturing industries. In the postwar period, the unions sought expanded health insurance benefits as a key part of their contract negotiations. In the mid-1950s the Internal Revenue Service proposed to tax employer-sponsored health insurance as worker income, but congressional legislation upheld the tax-exempt status of the benefit.[27] In the decades ahead, the scope of work-based private health insurance benefits would expand, and by 1960 employment-based private health insurance with dependent coverage had become the norm for most American families.

Shortly before his death, President Roosevelt again initiated a discussion of public compulsory health insurance but did not advocate a plan. The Wagner-Murray-Dingell bill of 1943 shifted its approach from the earlier version, which proposed state insurance plans financed by employer taxes and federal grants. The advocates of public health insurance came to believe the states did not have the capacity to administer such programs. From this point forward, the series of proposals, including the one by President Truman in 1948, presumed a federal program financed by taxes, which would be placed in a trust fund. Opposition from Republicans and conservative Democrats in Congress, as well as from interest groups such as the AMA and the private insurance industry, rendered legislative passage impossible.[28]

Republican senator Robert Taft introduced alternative legislation that provided grants to the states to help the poor purchase insurance, and others advocated a similar private insurance approach rather than a public pro-

gram.[29] The outlines of the coming decades of struggle were clear in 1948. In May of that year, Helen Fuller wrote in the *New Republic*, "But clearly it will take more years and much more energy, on the part of the administration as well as of public minded lobbies, to force the passage of the Wagner-Murray-Dingell Bill, the first step in an adequate program of protection."[30] The advocates of compulsory public insurance had staked out the basic elements of their policy ideas. Opponents responded by arguing the emerging predominantly employment-based private health insurance system was a better approach. The basic philosophic debates would engage the opposing sides for decades to come.

In 1951 Oscar Ewing was a director of the Federal Security Administration, responsible for the administration of the Social Security program. He was one of the architects of the social insurance system created in 1935 and an advocate of universal health insurance. However, he and other colleagues were pessimistic that the legislation proposed by President Truman could pass Congress in the near future. Instead they suggested a narrower focus that concentrated on hospitalization insurance for the elderly. In the spring of 1952 House and Senate Democrats introduced the legislation that came to be called Medicare.[31]

During the eight years of the Dwight Eisenhower administration, liberal Democrats in Congress continued to advocate for the Medicare bill. By the late 1950s the Medicare bill sponsored by Representative Aime Forand was a top priority for many Democrats. Despite a Democratic congressional majority, a coalition of conservative Southern Democrats and Republicans managed to block consideration of Medicare. They were supported by interest groups, such as the AMA, which strongly resisted any public health insurance program. Since the elderly were largely excluded from the emerging system of work-based insurance, public support for a Medicare approach grew.

National Health Insurance for the Elderly: Medicare

Medicare advocacy was a major campaign issue during the 1960 presidential election. Representative Wilbur Mills and Senator Robert Kerr, both Conservative Democrats, pushed legislation through Congress in June 1960 that created an alternative approach to assist the elderly with medical bills. The Kerr-Mills bill provided matching grants to the states to assist low-income elderly with medical costs.

This did not deter liberal Democrats from continuing to champion Medicare. Senator John F. Kennedy of Massachusetts became the party nominee and was elected president in November 1960. Medicare was at the top of his list of policy priorities. Despite controlling the White House, liberal Democrats still had to find a way to break the conservative coalition in

Congress. Over the next three years, the Kennedy administration worked to move the bill forward and gained important interest group support after a compromise with the American Hospital Association. Unlike a decade earlier with the Truman proposal, labor unions were key supporters of Medicare, but the AMA remained adamantly opposed.

After President Kennedy's assassination, President Johnson was unsuccessful in attempting to pass Medicare before the election.[32] His 1964 election campaign featured strong Medicare advocacy. The landslide victory over Barry Goldwater not only assured the Democrats of four more years in the White House but caused a seismic shift in their congressional majority. Liberal Democrats now had a working majority in the House and Senate. In January 1965 it was clear Medicare had the votes to pass in both the House and the Senate. President Johnson was a masterful legislative strategist who provided executive leadership in the building of a legislative majority coalition for Medicare. What followed in the next few months remains one of the most outstanding instances of legislative strategy and tactics in American history.

The King-Anderson bill, which became the vehicle for Medicare, proposed funding hospitalization insurance for the elderly through an expansion of the existing Social Security payroll tax and the creation of a separate Medicare Trust Fund. It was to be administered by the Social Security Administration. This was the policy idea Democrats had advocated for a decade. It was a scaled-down version of the Truman national health insurance proposal. Beneficiaries were limited to the elderly, and only hospitalization, not physician fees, was covered. The exclusion of physician fees was an attempt to mitigate some of the AMA opposition.[33]

The AMA had been the most vociferous opponent of any federal government role in the financing of health care. It had been joined by insurance companies, the US Chamber of Commerce, and other Republican-oriented interest groups. The labor unions were the strongest Medicare supporters.[34]

Congressional Republicans, sensing a political tide in support of King-Anderson, countered with a bill from Representative John Byrnes, which featured a voluntary insurance program covering both hospital and physician fees. It was to be financed by premiums and federal government general revenue. The AMA pushed Elder Care, which was a bill to expand Kerr-Mills as a state-federal grant program for the poor elderly. Both had broader benefits than King-Anderson. Separately, the Johnson administration was proposing the Child Health and Medical Assistance Act to expand Kerr-Mills medical benefits to include children on welfare.[35]

The House Ways and Means Committee became the key pivotal setting for moving Medicare through the legislative process. The support of Chairman Wilbur Mills was crucial. He had been an opponent but recognized that the November Democratic landslide had changed the majority

political coalition in the House and the committee. Two pro-Medicare Democrats had been added to the Ways and Means Committee. A new procedure for the powerful Rules Committee enabled the majority to force a bill from the committee after twenty-one days of inaction. These changes appeared to make House passage of Medicare inevitable with or without Mills's support. Recognizing this new reality, Mills moved from opponent to champion of Medicare.[36]

When Johnson administration officials appeared before the House Ways and Means Committee on March 2, 1965, to testify on the bill, Chairman Mills shocked them by not only supporting the bill but advocating a second element to cover physician payments based on the Byrne bill. In addition, he proposed the creation of a new matching grant program of medical vendor payments for those covered by the existing welfare system, which was a major expansion of the Kerr-Mills program.[37]

For decades it was assumed that President Johnson and those in his administration were taken completely by surprise by the Mills proposal.[38] We now know that for several months Johnson had been engaged in negotiation with Mills over a significant expansion of the Medicare bill to include physician fees and broadening of Kerr-Mills to include the poor of all ages covered under the existing welfare programs.[39] Before November, neither would have known the extent of the growth of the Democratic majority, especially in the House. The discussed expansion included "adding a Part B to Medicare based in part on a Republican proposal that would provide payments for physician fees expanding the Kerr-Mills program to include money for medical payments for the welfare poor."

Probably an important feature of the deal was Johnson's promise to let Mills take the credit for the idea. Mills had the ambition to be Speaker of the House. With the liberals now in a solid majority within the Democratic House caucus, his authorship of an expanded version of Medicare was perhaps a ticket to the speakership.[40]

Despite the size and scope of the new Medicare proposal, it moved quickly through the legislative process. After a March 29 Ways and Means Committee recommendation, it was taken up by the whole House of Representatives on April 8 and ultimately passed the House by a three-to-one margin, but a preliminary vote to recommit was much closer.[41] The Senate Finance Committee held hearings and deliberated until the end of June. The Senate version was more generous with benefits and also passed by a two-to-one margin. The Conference Committee quickly resolved a number of differences. Most of the issues in dispute reflected difference in the duration and type of benefit and were resolved by compromise. The most contentious question was whether hospital specialists, such as radiologists, would be paid under Part A or Part B. Mills successfully insisted on Part B payments.

On cost grounds the administration had not supported some Senate provisions, such as covering outpatient prescription drugs and catastrophic costs. David Blumenthal and James Morone note the Johnson administration was concerned about future costs but tended to downplay this element to help secure passage. If Congressional Budget Office economic analysis of proposals had existed in 1965, they speculate, Medicare may not have passed because of the projected costs.[42] By the end of July both Houses had passed the revised bill, and it was signed by President Johnson on July 30.[43]

While the hospitalization piece had been under discussion for a decade, the three-part version had only been part of the public discussion for four months when the bill was signed. What Mills called "the three-layer cake" consisted of the original Medicare hospitalization plan (Part A), the Republican version modified to focus on physician fees (Part B), and the expansion of the Kerr-Mills program to include the welfare poor (Medicaid). Despite the addition of significant new elements to the original Medicare policy idea, it was a quick legislative process, especially compared to the fifteen-month gestation of the Affordable Care Act.

The new Parts A and B were added as Title 18 of the original Social Security Act of 1935. Title 19 was the expansion of Kerr-Mills and labeled Grants to the States for Medical Assistance, not Medicaid, the name later applied. In the press coverage surrounding the passage, Medicare far exceeded the expansion of Kerr-Mills in number of mentions.[44]

The major participants recognized that Title 19 represented a major step forward in providing medical vendor payments on behalf of the welfare poor—namely, the poor who were beneficiaries of one of the federal-state welfare programs. The expanded Kerr-Mills program also created a new eligibility category, the medically indigent, composed of individuals who became poor as a result of high medical expenses.[45]

It seems unlikely that any of them realized how Medicaid's scope would expand in the decades to follow. Ultimately it became one of the centerpieces of the Affordable Care Act. In 1966 the Medicare supporters viewed it as the first step toward universal health insurance, and Medicaid was perceived as a temporary measure, until the goal of a single national program resembling Medicare could be enacted.[46]

At the bill signing, President Johnson turned to his aides and told them to make certain when the program went into effect eleven months later that any eligible person could walk into a hospital or doctor's office and be covered by Medicare. There were some rough edges in the early implementation of the program, but Johnson's demand was met.[47] On July 1, 1966, eligible beneficiaries across the country were effectively covered by Medicare.

The administration of Medicaid by the states developed much more haphazardly. The federal government had a cadre of capable and experienced administrators in the Social Security Administration. This was miss-

ing in most states, and it would be years before Medicaid had achieved an effective administrative apparatus.[48]

Universal Coverage on the Agenda

With the passage and quick implementation of Medicare in the mid-1960s, the basic structure of the current system of health financing was largely in place. A majority of working-age individuals and their families were covered by employment-based insurance, with the employer selecting a single insurance program for all employees. Over the decades the scope of coverage expanded, and greater cost sharing by employees has been the norm, but employers typically pay more than half the cost.

Those over sixty-five and retired are covered by Medicare, which is financed by a payroll tax, a premium, and general revenue. The introduction of private plans and a prescription drug program has modified Medicare but left the essential features in place. Medicaid covers the welfare poor with federal and state funding. Eligibility for Medicaid has broadened over the years, and states have frequently expanded coverage. Working-age families left out of the employer-based system were either uninsured or had to obtain coverage in the expensive individual market.

This description of coverage in 1970 continued to be fundamentally the same in 2009 when discussion of the Affordable Care Act began. However, between 1970 and 2009, there was an intermittent series of attempts to significantly change the system of financing health care. The leaders of the Medicare campaign always had universal social insurance as the ultimate goal. For them Medicare was an interim step in the journey toward universal coverage.

The first impediment toward quickly moving Medicare to universal coverage was the Vietnam War, which was rapidly draining resources that might have been used for additional social programs, such as expanded health care. Trust in government and confidence in the Johnson administration also declined as support for the war plummeted. A privately funded effort stimulated the next round of endeavors to achieve universal coverage.

Under the leadership of Walter Ruether of the United Auto Workers, the Committee of 100 was formed in 1969 to examine paths to universal coverage. It returned to an updated version of the Truman-era plan to achieve universal coverage with social insurance in a system resembling Social Security. Medicare, Medicaid, and work-based insurance would all be folded into a single federal government system that would provide coverage for all without copayments. The British system was a coverage model for this program without a move toward public ownership of facilities.

A key member of the committee was Senator Edward Kennedy of Massachusetts. Not only had Kennedy taken health care as a policy area of

special interest, but he was regarded at the time as the Democratic Party's most likely presidential nominee in 1972. His ability to generate media attention rivaled that of President Richard Nixon. Kennedy introduced legislation to achieve universal health coverage and launched a series of public hearings to highlight the problems with the current system, especially for those with serious illness and inadequate insurance.[49] This moved the issue to a high place on the congressional agenda.

President Nixon responded with a plan of his own, which required employment-based insurance, retained Medicare, and expanded government-provided insurance for the poor and those not part of a work-based system. Thus, his plan preserved private insurance covered by employers for about half the population.[50] At this point work-based insurance had been in place on a large scale for three decades, and most American families were satisfied with their coverage.

In 1973 Kennedy joined with Representative Wilbur Mills in a compromise with an employer mandate and expanded Medicare with a public program for the rest of the population. Patient cost sharing was more extensive than under the earlier Kennedy bill, and employers/employees would pay a payroll tax.[51] This bridged some of the critical differences between the original Kennedy plan and the Nixon plan. It appeared to set the stage for a grand compromise leading to a national health insurance program, but the emerging Watergate scandal drove most policy issues off the legislative agenda.[52]

In August 1974 President Nixon resigned and was succeeded by Vice President Gerald Ford. By the end of the year Mills was involved in a personal scandal and was no longer the political deal maker he had been a decade earlier with Medicare. The Democrats won a substantial congressional victory in November 1974 and were confident of recapturing the White House in 1976. Kennedy and other leading Democrats returned to advocating for universal and comprehensive national health insurance legislation. They did not wish to compromise when total victory seemed to be at hand.

As anticipated, a Democrat, Jimmy Carter, was elected president in November 1976. During the campaign he had advocated for national health insurance. However, other issues had a higher place on the White House agenda during his first year in office. He faced problems of high inflation, a growing federal deficit, an oil crisis, and escalating health expenditures.

The Carter administration was reluctant to support the Kennedy-backed social insurance approach without first attacking health costs. After a systematic review of options over several months, the administration initially recommended a limited plan for a phased move toward universal coverage that first included all low-income children and catastrophic Medicare coverage. Only later would others be included without a phase-in timetable.[53]

This was not acceptable to Kennedy, and he countered with a plan to require all employers to provide insurance to full-time workers and depend-

ents, with premiums paid to a private insurance company, a health management organization (HMO), or a quasi-public corporation. In response Carter proposed requiring employers to pay for catastrophic coverage, expanded Medicaid for the low income, and provided a subsidy for small businesses to purchase insurance for employees.[54]

Despite a solid congressional majority, the Democrats were divided on the best approach to expanding health care coverage. Senator Kennedy challenged President Carter in the 1980 presidential primaries but failed to win the nomination. The Iran hostage crisis, not health insurance, dominated the 1980 election. In November, Governor Ronald Reagan defeated President Carter, and Republicans gained control of the Senate and picked up seats in the House. This effectively ended the decade-long effort by Democrats to enact a national health insurance program.[55]

This 1970s campaign for universal health coverage ended with the 1980 election. No one knows if a compromise along the lines of the Nixon or Carter plans would have succeeded. It is doubtful that the Kennedy national health insurance plan ever had a majority of votes in Congress. The debate did, however, manage to define two distinctive approaches to achieving a significant expansion of health insurance coverage.

The Kennedy/United Auto Workers plan embodied the social insurance ideal articulated by advisors forty years earlier in the Roosevelt administration and advocated by President Truman in his 1948 message to Congress. This strategy envisioned a universal public insurance program in which everyone participated on an equal basis with the same benefit structure. Unlike in the British system, the government would neither own hospitals nor employ physicians. Rather, it would be similar to the Medicare system, and the public entity would collect a payroll tax from current workers and also use general revenues to pay health care providers. The benefit structure would be comprehensive, with little cost sharing at the point of service. Medicare would be folded into the new plan, and benefits would be more comprehensive. The Medicare benefit structure resembled a standard 1964 Blue Cross plan. By the late 1970s, a typical employment-based insurance plan included a wider range of benefits and fewer limits on catastrophic illness coverage.

The strategy envisioned by the Nixon or Carter proposals retained the existing employer-based coverage, maintained a key role for private insurance companies, and replaced Medicaid with an expanded public program for the poor. Medicare would be retained, and thus the distinction between insurance for the aged and for the rest of the population would be maintained.

Many reformers today would be happy to have a version of the Nixon or Carter plans. Was this an example of a missed opportunity? President Carter's reelection defeat in 1980 ended the first major push for health finance reform legislation. The Carter administration never placed a top priority on health

reform. The Democratic congressional majority remained divided between those who sought a single universal plan and supporters of more modest change that retained work-based insurance at the center of the system. There was never a real legislative test of whether a universal coverage plan could pass the House and the Senate.

The Reagan Years: Health Reform in the Wilderness

The 1980 election of Ronald Reagan began a twelve-year hiatus in the long quest for universal coverage. Supporters understood that health reform legislation required presidential support, and that was not forthcoming under Republican presidents Ronald Reagan and George H. W. Bush. During the 1980s Democrats did succeed in expanding Medicaid coverage for children and pregnant women and passed a Medicare Catastrophic Coverage Act in 1988, only to see it repealed a year later.[56]

The most significant health reform development of the 1980s was the broad acceptance among reformers of new ideas about how to obtain the universal coverage goal. Kennedy's flirtation with a compromise approach and the retrospective assessment that expansion of Medicare to the entire population was going to be politically very difficult in a more conservative political environment caused reformers to explore alternative approaches.

Three related developments in the 1980s shaped the next round of health reform legislation in 1993 and 1994. During the Reagan and Bush administrations Medicare policy emphasis was on cost control, not expansion. Two significant Medicare reimbursement reforms were enacted into law. A shift to hospital prospective payments based on diagnosis-related groups contributed to a reduction in the rate of growth of Medicare hospital spending. This was followed by legislation that shifted the basis for physician payments to a fee schedule derived from a resource-based relative value scale. Together these and subsequent modifications allowed the federal government to temper the rate of growth of overall Medicare costs. Eventually many insurance companies began to use similar payment mechanisms but with generally higher rates of payment.

The single attempt to expand Medicare benefits during the Reagan administration was the Medicare Catastrophic Coverage Act of 1988. The administration proposed a Medicare catastrophic coverage limit on out-of-pocket costs to be paid for with an additional small premium. Democrats in Congress expanded the scope of the bill to also include prescription drugs and limited additional long-term-care benefits. The broadened bill was passed in June 1988. By summer 1989 strong opposition had developed because of the significant premium increases required. A movement to repeal most of the act succeeded with the repeal of most of the provisions in November 1989.[57]

As health care costs became a larger total share of gross domestic product in the 1980s, business leaders became alarmed by increasing health insurance premiums. Many companies instituted utilization review and other forms of managed care. Some saw HMOs and other types of limited networks as panaceas for escalating expenditures. The more aggressive stance of businesses toward employee health insurance costs led them to conclude that broader government intervention was unnecessary.[58]

In the world of health policy academics and think tanks, the view was emerging that neither government nor businesses were capable of controlling costs without significant structural change in the organizations delivering health care. The fascination with HMOs as a model for system change began in the 1970s and continued in the next decade, which featured a growth of HMOs seeking to both control costs and improve quality by creating an integrated delivery system with a fixed, prepaid yearly fee for providers.[59] In the dominant fee-for-service system, each provider action was billed. By the 1980s dissatisfaction grew with the fee-for-service payment model that dominated public and private payment systems and was seen as responsible for escalating costs. *Managed care* became an umbrella term for both traditional HMOs and the emerging practice of corporate health insurance plans to control cost growth by use of limited provider networks and prior approval for costly procedures. In the 1990s consumer dissatisfaction with some excessive managed-care practices led to modifications in but not elimination of the approach.[60]

Despite the inability of congressional Democrats to overcome the Reagan administration's opposition to expansion of health insurance using Medicare or other approaches to federal subsidy, the 1980s saw an incremental growth of Medicaid coverage, especially for women and children. Led by Representative Henry Waxman, chair of the House Health Subcommittee, Democrats used the annual reconciliation act to incrementally expand Medicaid availability for pregnant women and children in poor families. These so-called Waxman amendments separated Medicaid from the welfare system by first offering states options and later turning them into mandates.

Since they were part of the budget reconciliation, they were not subject to filibuster in the Senate, and many were not immediately effective, reducing the short-term budget impact. Several southern governors, led by Governor Richard Riley of South Carolina, advocated for these changes as part of their campaign to reduce infant mortality in their states. These changes were transformative for Medicaid enlargement to cover the poor, even those not eligible for existing welfare programs.[61]

The steady rise in premiums and out-of-pocket costs for the average American led, by the end of the 1980s, to putting health reform back on the policy agenda. In 1990 an underdog Democratic candidate for the Senate in

Pennsylvania won after he made health reform a major issue. As Democrats began the process of selecting their next presidential candidate, each of the contenders advocated health reform ideas and promised to make the issue a legislative priority. As the 1992 election approached, Democrats held a 12-vote advantage in the Senate and a 100-vote margin in the House. Health reform supporters believed that the election of a Democrat as president would make health reform a reality.

However, this was not the early 1970s, when most reformers agreed on a strategy built around a universal national health insurance proposal. Among policy analysts who favored health reform, there were clear divisions of opinion on how to best achieve the common goal. This was also true within the solid Democratic majority in Congress.

Some continued to support a universal national health insurance program similar to what Senator Kennedy had proposed in the early 1970s. Others sought to build on the entrenched employment-based system by mandating that all employers provide health insurance and expanding public programs to cover others. This resembled what President Nixon had proposed.

Those who believed the existing work-based system had significant defects advocated individual choice of insurance companies for families, with premiums subsidized by employers and tax credits for insurance purchase for those not part of the existing system.

Each of these sets of policy ideas had a common goal, which was universal or near-universal coverage with affordable payments by consumers. For reform to succeed in the early 1990s, a legislative majority would need to coalesce around a single policy idea.

Democrats Regain the White House: The Clinton Years

Conservative Republicans had occupied the White House for twelve years when Bill Clinton was elected president in 1992. For much of the time Democrats had controlled Congress, but health reform seemed out of reach without presidential support. During the campaign Clinton advocated a managed-care approach but did not provide detail about his plan. Soon after the election, he appointed a task force headed by Hillary Clinton to develop a plan.

The evolution of the policy ideas that ultimately became the Clinton health plan began in the late 1970s and were debated and refined during the health reform legislation hiatus of the Reagan years. During the debate of the 1970s, the central issue was whether or not to move toward a social insurance system with the government in the central role. The alternative was seen as a retention and expansion of the existing employment-based system, with the government responsible for those not covered by their employer.[62] The preferred policy for many reformers was universal social insurance.

As the 1992 presidential contest began, several other ideas were receiving attention in the health policy community. The Heritage Foundation, a conservative think tank, proposed a consumer-choice plan that would replace the tax exclusion for employer-sponsored insurance with a universal tax credit to be used to purchase insurance in the marketplace, regardless of work status. Everyone would be mandated to have at least catastrophic coverage, with a right to renew at a reasonable premium irrespective of health status.[63]

Alain Enthoven, a Stanford business professor, articulated what he called a "managed-competition" approach. Employers would be required to offer employees a choice among several health insurance plans and pay a fixed part of the cost. Competition among health plans, including HMOs, would restrain costs. In each state a public sponsor would offer a choice of insurance plans for those outside work-based insurance systems.[64] A group of insurance executives, Republican members of Congress, and academics with a similar perspective met in Jackson Hole, Wyoming, and fashioned a proposal based on Enthoven's managed-competition ideas.

Conservative Democrats, led by Representative Jim Cooper of Tennessee, proposed a variation of Enthoven's managed-competition idea. Their proposal left employers the option of providing health insurance and thus did not envision universal coverage.[65]

On the liberal side, two sets of policy ideas were gaining support among health policy experts and political leaders. Some still supported the universal social insurance approach advocated by Kennedy and organized labor in the 1970s.[66] A subset of this group pointed to the more decentralized example of universal coverage that had developed in Canada, with each province assuming responsibility and the national government setting general rules and paying a share of the costs.[67]

Some Democrats had concluded that moving away from the employment-based system was politically unwise because of the large tax increase it would require and the general satisfaction people had with their own health insurance coverage. They supported a "play-or-pay" approach. This combined an employer mandate with a public program financed by taxes and premiums for those outside the work-based system. Employers could "play" (provide insurance) or "pay" taxes to support their employees in the public program.[68]

During the campaign Clinton vacillated between the advice of two sets of health policy experts. At first, he seemed to endorse the "play-or-pay" approach but then began to move in the direction of a liberal version of the "managed-competition" approach. The plan developed by California insurance commissioner John Garamendi seemed to combine elements of managed competition with a social insurance approach seeking universal coverage and regulation of participating private insurance plans.[69] Clinton campaign advisors, such as Paul Starr and Ira Magaziner, convinced the

candidate to support managed competition rather than play-or-pay as his basic health policy position.

Early in the first year of the Clinton presidency, a task force was formed to develop a health reform plan. It was chaired by Hillary Clinton, with Ira Magaziner as the key staff person. The Garamendi plan was modified. A detailed proposal and accompanying bill were sent to Congress in September 1993 after a national address by the president.

Key elements of the bill were as follows:[70]

- All residents would be covered with a standard benefit package.
- States would create regional health alliances (health purchasing cooperatives) to collect premiums and arrange insurance plans to sponsor coverage. Alliances could be nonprofits or state agencies.
- Large employers (over 5,000 employees) could be their own alliance.
- Health plans might be fee-for-service, preferred provider, or health management organizations and would be paid by alliances on a risk-adjusted basis; health plans would set their prices and offer different levels of cost sharing.
- Premiums would be based on community rating, with employers paying 80 percent of the average premium.
- Low-income individuals would receive assistance with premiums and cost sharing.
- Medicaid recipients' premiums would be paid by federal and state governments.
- Medicare would remain the same, except for the addition of a prescription drug program.
- A home-based long-term-care program would be added for the disabled.

The Clinton plan was comprehensive in its approach to universal coverage. It retained a role for insurance companies, although they would exist in a more tightly regulated environment. Like the original managed-competition idea developed by Alain Enthoven, it envisioned an expanding role for closed-panel HMOs. Enthoven, a Stanford professor, was familiar with the Kaiser-Permanente system and believed this type of structure was the best way to achieve quality care at a reasonable price.[71] The plan retained a major role for large corporations but limited their ability to trim expenses by increasing worker cost sharing. Private insurance plans continued to have a part in the system, but it limited their ability to sweeten their risk pools by not accepting poor risks. Overall, the Clinton plan represented a major shift in the financing of health care, but it was not as radical in its strategy as the social insurance approach.

When Congress received the Clinton plan in the fall of 1993, there were serious roadblocks to building a supporting majority coalition. The Demo-

crats enjoyed a fifty-seven to forty-three majority in the Senate but lacked the sixty votes to break a filibuster. In the House there were eighty-two more Democrats than Republicans, which meant they could lose support from thirty-eight of their members and still have a majority for passage.

However, legislation must come to the floor from a committee. There were multiple committees of jurisdiction and sharp divisions of opinion within the Democratic majority. Committee work did not begin until March 1994. The House Energy and Commerce Committee could not produce a bill, despite the presence of Representatives John Dingell and Henry Waxman, who were health policy leaders in the chamber. The committee members best represented a cross-section of Democrats in the House.

In 1994 the Education and Labor Committee reported both a benefit-expanded version of the Clinton plan and a universal social insurance bill in June. This reflected the liberal orientation of the committee, but its bills clearly did not have the support of a majority of House Democrats.

A subcommittee of the Ways and Means Committee reported a bill in March with the key element being an expansion of Medicare for those not covered by work-based insurance. It also dropped several key elements of the Clinton plan, such as the alliances. Full committee chairman Sam Gibbons reworked the bill to respond to some business concerns and provide a larger role for private insurance. It was reported out in late June.

On the Senate side, the Education and Labor Committee was led by Senator Kennedy, who attempted to gather Republican support by weakening some key features of the Clinton plan, such as making the alliances voluntary. The effort to build bipartisan support was unsuccessful as only one Republican voted for the bill in committee.

Senate Finance Committee chairman Patrick Moynihan was not committed to health reform. At the last minute the committee reported a bill that did not have an employer mandate or a goal of universal coverage.[72]

As the congressional committees were struggling to find a health reform approach acceptable to a legislative majority coalition, interest groups were vocally supporting or opposing the Clinton health reform effort. Initially, it appeared as if a wide spectrum of groups were supportive. AARP, organized labor, the AMA, and the Chamber of Commerce expressed support for reforming health insurance coverage. From the beginning opponents included the National Federation of Independent Business, the insurance industry, and the Christian Coalition. Additionally, congressional Republican leaders were determined to oppose the effort with no willingness to compromise in the legislative process, and conservative groups followed this approach in their denunciation of the reform plan with very strident language.

By the summer of 1994 some of the key groups began to peel away or became less than fully supportive of the Clinton plan with organizational

resources. Labor was fighting the North American Free Trade Agreement, and AARP was cautious, recalling that it had been burned by support for the Medicare catastrophic bill four years earlier. Both AMA and Chamber of Commerce national leaders were challenged by local branches because of their support. As Congress struggled to find a majority for health reform, the enthusiasm of key groups withered.[73]

The House leadership selected the Ways and Means Committee's Medicare-oriented bill to bring to the floor, even though it appeared to lack majority support. In the Senate, the Finance Committee bill was the leadership vehicle, although it did not appear to have enough votes to overcome a filibuster threat. By September 1994, one year after the dramatic presidential speech announcing a health reform plan, the White House and congressional leaders recognized Congress was near adjournment prior to that year's midterm elections, and in neither the House nor the Senate did any of the committee-recommended bills appear to have the support of a majority coalition. They announced the end of the effort to secure passage of a bill in that legislative session.[74]

Two months later Republicans would sweep to a stunning congressional victory that ousted the Democratic majorities in both the House and the Senate. Democrats would not regain majority status in Congress for another twelve years.

Much has been written about why the Clinton effort was unsuccessful.[75] Was it just a partisan political defeat of a sound plan? Or did the central policy idea itself not resonate with key legislators in both parties? There is a variety of opinion among those who have studied in detail the 1993–1994 saga of the Clinton health plan.

Theda Skocpol argues that among Democrats there was never a majority coalition prepared to support the central idea of the Clinton plan: managed competition with a budget. She contends that no other set of policy ideas could have garnered a majority either. While some Republicans initially expressed support for the concept of reform, there was an explicit effort by their leadership to present a solid front of opposition. As public support declined, the opposition solidified.[76]

Polls taken between the fall 1993 rollout of the plan and the following spring confirm a significant drop in public support. This reflected both greater awareness of some plan details and the partisan critique that accelerated in the spring.[77] Lawrence Jacobs argues that negative polls were perhaps the result, not the cause, of shifts in position among policymakers, who arrived at negative views based on their ideology and policy preferences, then used the polls as an excuse.[78] Their opposition caused further decline in the polls. The average citizen, who supported the concept of health reform in the abstract, became less sympathetic if reform threatened their existing health service arrangements or resulted in higher taxes.

Generic poll questions found support for reform centered on coverage for everyone and moderated costs increases.

Sven Steinmo and Jon Watts contended that the fundamental problem with health reform in the early 1990s, and previously, was the structural nature of the American government. The decentralized power structure in Congress allowed for interest group pressures to maintain the status quo over any proposed changes.[79]

Jacob Hacker critiqued the Clinton team for a policy development strategy utilizing a policy analysis approach to finding common ground rather than more traditional political compromise. This led them to see the managed-competition idea as a middle ground, when in fact scores of members of Congress perceived it as a radical reform. In retrospect he also did not see any of the other major alternatives as having sufficient congressional support to pass in 1994.[80]

James Morone asserted that the central policy idea, managed competition with a budget, represented a significant new strategy with little initial public understanding of its implications. He contrasts this with the Medicare concept adopted thirty years earlier, which had been the subject of debate for several years before enactment. He concluded that a "Medicare for All" approach would have been more understandable to the public.[81]

Allen Schick criticized the Democratic congressional leadership for failing to better manage the legislative process. He lamented the lack of a bipartisan approach but did recognize that the Republicans in Congress sought greater unity with outright opposition, not compromise.[82]

In the end, the Clinton plan never had enough votes in either the House or the Senate. For a decade Democrats had been divided over the best approach to health reform. When health reform was not on the agenda, the differences were debating points that did not matter. The Clinton administration attempted to use a new policy idea that it perceived as a compromise among the various positions but was never able to convince congressional Democrats to rally around a single plan. Republicans concluded that opposing all reform, rather than seeking common ground, was the better political position for them. It does not appear that a different policy idea or better leadership would have ever produced the three or four Republican votes in the Senate necessary to overcome a filibuster.

The 1994 congressional elections ended any attempt at comprehensive health reform for the rest of the Clinton presidency. Subsequent Republican congressional attempts failed to shift Medicare to a voucher system or transform Medicaid into a block grant.

A significant incremental reform, the State Children's Health Insurance Program (SCHIP), was adopted in 1997 as a result of bipartisan compromise between Senators Ted Kennedy and Orrin Hatch. This effectively expanded coverage for children of the working poor through either state

expansion of Medicaid or a separate state insurance program. It was still a federal-state program, but the federal share was larger than under traditional Medicaid.[83] The SCHIP program was part of the Balanced Budget Act of 1997. This was not a new idea.[84] For more than a decade, advocates for children had argued for coverage expansion for uninsured kids. At the heart of their argument were two main points: the cost of health coverage for children is cheap relative to that for adults, and finding and treating problems early can lead to a healthier life for decades.

Several key policy issues separated the bipartisan supporters of better coverage for children, especially for working-poor families. Should this be an expansion of Medicaid eligibility or a subsidy for private health insurance? How broad should the scope of benefits be? How should the costs be apportioned between the state and federal governments? Should coverage funding be structured as an entitlement or a block grant?[85]

The SCHIP legislation reflected a series of bipartisan compromises on these issues. It was a block grant approach in which the federal government paid a higher share than the existing Medicaid formula. States could choose to fold the new program into Medicaid, create a separate program, or devise a hybrid. It was authorized for only ten years, not an open-ended entitlement like Medicare and Medicaid. States had to at least provide benefits comparable to Medicaid. The beneficiaries would be children in working-poor families—namely, those with incomes a little above the Medicaid cut off.[86]

As the decade ended and the process for selection of a new president began, both Democrats and Republicans advocated ideas for expanding Medicare to cover what was found to be a major coverage gap: prescription drugs. The idea of expanding Medicare to include prescription drugs first appeared in a report to the president in 1967, one year after the start of the program. This was also part of the Clinton health plan. President Clinton had proposed expanding Medicare to include a voluntary prescription drug benefit plan in his final year in office. In the 2000 election campaign, both Governor George W. Bush and Vice President Al Gore offered different Medicare prescription drug plans.[87]

In 2003 Congress passed a Medicare Prescription Drug Plan (Part D), which provided significant subsidies for Medicare beneficiaries to purchase a private plan that covered most, but not all, of the costs for consumers. One of the major issues of contention was the original Bush administration proposal that conditioned prescription drug eligibility on beneficiaries selecting a Medicare-subsidized private plan rather than traditional Medicare. This was rejected by Congress. Part D employed competitive insurance plans offering drug-only insurance, which was heavily subsidized by public funds in addition to a modest premium for beneficiaries.[88]

An enduring controversial provision of the Part D legislation was the "doughnut hole." In order to both meet a low administration budget con-

straint and avoid a high deductible for all participants, the bill provided for a deductible for individuals after a certain level of spending, which continued until a higher plateau was reached. At that point most of the cost was again covered. Thus, the term *doughnut hole* referred to a spending level in the middle, which was the responsibility of the beneficiary.[89] This was a political construct, not a logical approach to insurance. The ACA incrementally eliminated the doughnut hole.

For the first six years of the new decade, Republicans held both the White House and slim congressional majorities. But reformers continued to discuss ways of expanding affordable health insurance coverage. This included both the liberal and conservative perspectives. In 2001 the Economic and Social Research Institute published the first of a three-volume document titled *Covering America: Real Remedies for the Uninsured*.[90] In the series academic policy experts offered plans for health reform from a wide variety of intellectual perspectives. There was anticipation that the next round of reform would be on the political agenda before the end of the decade.

Conclusion

After the 2006 midterm election, the Democrats gained control of both the House and the Senate for the first time in more than a decade. President George W. Bush was leaving office in two years and had a low approval rating. Thus, Democrats were very optimistic about achieving the political trifecta of control of Congress and the White House in 2009. There was optimism within the health policy community that the century-long quest for universal health insurance was at hand.

We will take up the quest story again in Chapter 2 with an in-depth look at the politics and policy issues involved in the creation of the Affordable Care Act in 2009 and 2010, the first two years of the Obama presidency.

John Kingdon's policy-streams conceptual framework provides an approach to understanding the complex policymaking process. He suggests *issues* appear high on the legislative agenda when situations are perceived as problems, especially when the president signals a high priority. Over time *policy ideas* are discussed and refined by experts in academia, think tanks, and interest groups, which constitute *advocacy coalitions*, whose members share a similar intellectual perspective on problems and solutions.

In the *political arena*, building majority legislative coalitions is the key endeavor. Elections, interest groups, and public perceptions shape and reshape possible coalitions. A window of legislative opportunity is created when issues are high on the agenda, a set of policy ideas appears to be a viable solution to the problem at hand, and there exists the possibility of a majority coalition in the legislature to support the proposed idea.

Windows of opportunity usually only remain open for a brief period. If action is not taken, the window closes, and another might not open for years or decades. Throughout the rest of the book, this conceptual framework will help organize the explanation of what happened with the Affordable Care Act and why events unfolded as they did.[91]

In our brief jaunt through a century-long quest for health financing reform, Kingdon's framework enables us to understand and explain what happened. Several times health reform achieved a place on the agenda because the conditions related to health care were perceived as problems to be addressed. Under the presidencies of Truman, Kennedy/Johnson, Nixon, Carter, and Clinton, health reform had an elevated place on the agenda. In each instance the placement of health reform on the presidential agenda was the consequence of unique circumstances. Truman, shortly after ascending to the presidency, proposed universal health care as an expansion of Roosevelt's New Deal. Kennedy and Johnson pursued health insurance for the elderly after the idea had been advocated by liberal Democrats for several years.

Presidents Nixon and Carter appeared more reactive than committed to reform. Nixon's health reform proposal was a response to a push for universal coverage by congressional Democrats, and thus the issue was really placed on the agenda by Congress, with the president responding with a plan of his own. During the primary season, Carter responded to pressure from liberal Democrats for health reform by making it a central part of his campaign rhetoric, but once he was in office it seemed to be a low priority.

It was congressional Democrats with a proposal of their own who pushed Carter to advocate a plan, but divisions within the party prevented passage of a bill. In the lead-up to the 1992 nomination, Clinton and all of the other Democratic candidates promised to push for health reform, and he did make this one of his major priorities in his first year in office.

The issue was off the agenda in the 1980s not because the problem had essentially changed but because it was not a priority for Presidents Ronald Reagan and George H. W. Bush. After two years President Clinton faced Republican majorities in Congress and removed health reform from his priorities. In 2000 President George W. Bush did not place a high priority on health reform despite early Republican congressional majorities, but he did push for Medicare drug coverage.

Beginning in the early 1970s there was continuing and active discussion of health reform policy ideas. As time progressed a multitude of diverse policy ideas floated around within diverse advocacy coalitions. Debates among individuals in the broad health policy community continued year after year irrespective of how high the issue might be on the agenda. The analysis of a wide range of ideas contributed to a set of distinctive policy options during the policy windows that occurred in 1978 and 1992.

Policy entrepreneurs are individuals who seek to build a majority coalition by combining ideas into a package that can gain broad support. Big policy ideas have multiple components. Entrepreneurs will attempt to build a plan to solve a problem by combining pieces from different ideas. In both 1978–1979 and 1992–1993, entrepreneurs were unable to fashion a package of ideas capable of drawing the support of a majority coalition.

Table 1.1 illustrates a series of health reform open windows and whether a policy was enacted.

As we reflect on this century of effort, several policy ideas have been central to the debate over health reform. The most persistent concept has been universal public insurance. Under this idea all citizens or residents would be eligible for the same set of health benefits, with taxation the major method of financing.

Table 1.1 Health Policy Windows of Opportunity

Time/ Window	President	Central Policy Idea	Competing Idea	Outcome
1935	F. D. Roosevelt	Health insurance as part of Social Security		Never proposed by administration
1948	H. Truman	Comprehensive national health insurance program	Expansion of private work-based insurance	President proposed; Congress never acted
1961–1965	J. Kennedy and L. Johnson	National health insurance for the elderly	Private insurance	Medicare/Medicaid enacted
1971–1975	R. Nixon and G. Ford	Universal national health insurance	Work-based insurance and public program for others	Democrats waited for 1976 elections
1978–1980	J. Carter	Employer mandate for catastrophic coverage; subsidized premiums for small business, and public program for unemployed	Universal national health insurance	Democrats were divided and did not act
1993–1994	B. Clinton	Managed-competition plan with budget	Universal national health insurance Pay-or-play employer mandate	No majority for single idea by Democrats; no floor vote
1997	B. Clinton	Block grant to states for children's coverage for working poor		Bipartisan support; legislation passed
2003	G. W. Bush	Medicare prescription drug coverage using private plans	Prescription drug coverage as part of basic Medicare	Enacted with close vote

The second idea is provision of private health insurance by employers. For decades nearly two of three nonelderly have received their health coverage in this fashion. Since the enactment of Medicare/Medicaid, the employment-based system has existed beside public programs to cover the elderly and many, but not all, of the poor. In recent decades a related idea is to require that all employers provide coverage and at the same time to expand public programs to cover those not employed.

A third idea that has gained credence among conservative policy analysts is to replace employment-based insurance with a tax credit that can be used to subsidize premiums. They have also proposed a voucher system to replace Medicare and Medicaid. Eligible individuals would receive a voucher to cover most, but not all, of the cost of a private insurance policy as a substitute for a public financed plan.

In the policy stream, variations of these three basic policy ideas have been proposed, analyzed, and modified since the late 1970s. In our examination of the Affordable Care Act, we will see that it is a product of combining parts of each of these broad ideas to create a plan capable of sustaining majority coalition support in the legislative arena.

Notes

1. John D. Morris, "President Signs Medicare Bill; Praises Truman," *New York Times*, July 31, 1965, 1.

2. Sheryl Gay Stolberg and Robert Pear, "Obama Signs Health Care Overhaul Bill, with a Flourish," *New York Times*, March 23, 2010, A19.

3. Pew Research Center, "Public Trust in Government: 1958–2014," Pew Research Center, November 13, 2014, www.people-press.org/2014/11/13/public-trust-in-government.

4. For an excellent history of Medicare's first four decades, see Jonathan Oberlander, *The Political Life of Medicare* (Chicago: University of Chicago Press, 2003).

5. To further explore the history of Medicaid, see David G. Smith and Judith D. Moore, *Medicaid Politics and Policy*, 2nd ed. (New York: Routledge, 2017); Laura Karz Olson, *The Politics of Medicaid* (New York: Columbia University Press, 2010). A recent assessment of both is Alan B. Cohen et al., eds., *Medicare and Medicaid at 50: America's Entitlement Programs in the Age of Affordable Care* (New York: Oxford University Press, 2015).

6. Robert J. Gordon, *The Rise and Fall of American Growth: The U.S. Standard of Living Since the Civil War* (Princeton, NJ: Princeton University Press, 2016).

7. Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (New York: Basic Books, 1982).

8. David Cutler and Grant Miller, "The Role of Public Health Improvements in Health Advances: The 20th Century United States," NBER Working Paper No. 10511, National Bureau of Economic Research, February 2004, www.nber.org/papers/w10511.

9. Atkul Gawande, "Two Hundred Years of Surgery," *New England Journal of Medicine* 366, no. 18 (May 3, 2012): 1716–1723.

10. Thomas P. Duffy, "The Flexner Report—100 Years Later," *Yale Journal of Biological Medicine* 84, no. 3 (September 2011): 269–276.

11. Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (New York: Basic Books, 1989), 17.

12. Starr, *The Social Transformation of American Medicine*, 144.

13. Rosemary Stevens, *American Medicine and the Public Interest* (New York: Yale University Press, 1971).

14. John E. Murray, *Origins of American Health Insurance: A History of Industrial Sickness Funds* (New Haven, CT: Yale University Press, 2007), 91.

15. Ibid., 92.

16. Stevens, *In Sickness and in Wealth*, 24.

17. Cutler and Miller, "The Role of Public Health Improvements in Health Advances," 3–4.

18. Ibid.

19. Joseph S. Ross, "The Committee on the Costs of Medical Care and the History of Health Insurance in the United States," *Einstein Quarterly Journal of Biological Medicine* 19 (2002): 129–134, www.einstein.yu.edu/uploadedFiles/EJBM/19Ross129.pdf.

20. "Legislative History: Social Security Act of 1935," Social Security Administration, www.ssa.gov/history/35act.html.

21. David Blumenthal and James A. Morone, *The Heart of Power: Health and Politics in the Oval Office* (Berkeley: University of California Press, 2009), 37.

22. Ibid., 38.

23. Ibid., 44.

24. Louis Reed, "Private Health Insurance in the United States: An Overview," *Social Security Bulletin* (December 1965): 4–5, www.ssa.gov/policy/docs/ssb/v28n12/v28n12p3.pdf.

25. Ibid.; Sylvia A. Law, *Blue Cross: What Went Wrong?*, 2nd ed. (New Haven, CT: Yale University Press, 1976), 11.

26. David Blumenthal, "Employer-Sponsored Health Insurance in the United States—Origins and Implications," *New England Journal of Medicine* 355 (July 6, 2006): 83.

27. Thomas C. Buchmueller and Alan C. Monheit, "Employer-Sponsored Health Insurance and the Promise of Health Insurance Reform," *Inquiry* 46 (summer 2009): 188.

28. Jill Quadagno, *One Nation Uninsured: Why the U.S. Has No National Health Insurance* (New York: Oxford University Press, 2005), 34–43.

29. Blumenthal and Morone, *The Heart of Power*, chap. 2; Rick Mayes, *Universal Coverage: The Elusive Quest for National Health Insurance* (Ann Arbor: University of Michigan Press, 2004), 36–39.

30. Helen Fuller, "Playing Politics with the Health Issue," *New Republic*, May 3, 1948, https://newrepublic.com/article/122399/playing-politics-health-issue.

31. Blumenthal and Morone, *The Heart of Power*, 94–95.

32. Julian E. Zelizer, "How Medicare Was Made," *New Yorker*, February 15, 2018, www.newyorker.com/news/news-desk/medicare-made.

33. Theodore R. Marmor, *The Politics of Medicare*, 2nd ed. (New York: Aldine De Gruyter Publishing, 2000), 17–21.

34. Ibid.

35. Edward Berkowitz, "Medicare and Medicaid: The Past as Prologue," *Health Care Financing Review* 27, no. 2 (winter 2005–2006): 18.

36. Zelizer, "How Medicare Was Made."

37. Wilbur Cohen, "Reflections on the Enactment of Medicare and Medicaid," *Health Care Financing Review* (Suppl.) (1985): 6–7.

38. Marmor, *The Politics of Medicare*, 62–70; Mayes, *Universal Coverage*, 68–69; Oberlander, *The Political Life of Medicare*, 30–31.

39. Blumenthal and Morone, *The Heart of Power*, 178–180; Shanna Rose, *Financing Medicaid: Federalism and the Growth of America's Health Care Safety Net* (Ann Arbor: University of Michigan Press, 2013), chap. 1.

40. Ibid., 178–181.

41. Ibid., 192.

42. Ibid.

43. Marmor, *The Politics of Medicare*, 47–58; Cohen, "Reflections on the Enactment of Medicare and Medicaid," 7.

44. Olson, *The Politics of Medicaid*, 25–26.

45. Aid to the Blind, Aid to the Permanently and Totally Disabled, Aid to Families with Dependent Children; for a detailed discussion of the provisions, see Smith and Moore, *Medicaid Politics and Policy,* chap. 2.

46. Jonathan Oberlander and Theodore R. Marmor, "The Road Not Taken: What Happened to Medicare for All," in *Medicare and Medicaid at 50: America's Entitlement Programs in the Age of Affordable Care*, ed. Alan B. Cohen et al. (New York: Oxford University Press, 2015), 55–74.

47. Judith Feder, "Medicare Implementation and the Policy Process," *Journal of Health Politics, Policy and Law* 2, no. 2 (summer 1977): 173–189.

48. For an early history of Medicaid problems, see Robert Stevens and Rosemary Stevens, *Welfare Medicine in America* (New Brunswick, NJ: Transaction Publishers, 2003); Frank Thompson, *Health Policy and the Bureaucracy: Politics and Implementation* (Cambridge, MA: MIT Press, 1983), chap. 4.

49. Richard Lyons, "National Health Insurance Proposed by 15 Senators," *New York Times*, August 28, 1970, 1; Quadagno, *One Nation Uninsured*, 113. The full transcripts of the 1971 hearing scan be found at "1971 Public Hearings on the Health Care Crisis in America," Healthcare-NOW, www.healthcare-now.org/legislation/1971-public-hearings-on-the-health-care-crisis-in-america. That same year both the Senate Finance Committee and the House Ways and Means Committee held extensive hearings on national health insurance.

50. Karen Davis, *National Health Insurance: Benefits, Costs, and Consequences* (Washington, DC: Brookings Institution, 1975), 89–97.

51. Ibid., 105–109.

52. "Health Insurance: No Action in 1974," *CQ Almanac*, 1974, https://library.cqpress.com/cqalmanac/document.php?id=cqal74-1225149; Blumenthal and Morone, *The Heart of Power*, 242–282.

53. Quadagno, *One Nation Uninsured*, 129–132.

54. Ibid.; Blumenthal and Morone, *The Heart of Power*, 271–278.

55. A comprehensive analysis of the failure of the Carter proposal can be found in Robert Finbow, "Presidential Leadership or Structural Constraints? The Failure of President Carter's Health Insurance Proposals," *Presidential Studies Quarterly* 28, no. 1 (winter 1998): 169–189.

56. Rose, *Financing Medicaid*, 110–118; Frank J. Thompson, "Medicaid Rising: The Perils and Potential of Federalism," in *Medicare and Medicaid at 50: America's Entitlement Programs in the Age of Affordable Care*, ed. Alan B. Cohen et al. (New York: Oxford University Press, 2015), 194–196; Colleen Grogan and Eric Patashnik, "Between Welfare Medicine and Mainstream Entitlement: Medicaid at the Political Crossroads," *Journal of Health Politics, Policy and Law* 28, no. 5 (October

2003): 829–836; Marilyn Moon, *Medicare Now and in the Future*, 2nd ed. (Washington, DC: Urban Institute Press, 1995), chap. 5.

57. Ibid.; Mark A. Peterson, "Reversing Course on Obamacare: Why Not Another Medicare Catastrophic?" *Journal of Health Politics, Policy and Law* 43, no. 4 (August 2008): 605–650.

58. Cathie Jo Martin, "Together Again: Business, Government, and the Quest for Cost Control," *Journal of Health Politics, Policy and Law* 18, no. 2 (summer 1993): 359–393.

59. Lynn R. Gruber, Maureen Shadle, and Cynthia L. Polich, "From Movement to Industry: The Growth of HMOs," *Health Affairs* 7, no. 3 (summer 1988): 197–208.

60. Jonathan P. Weiner and Gregory de Lissovoy, "Razing a Tower of Babel: A Taxonomy for Managed Care and Health Insurance Plans," *Journal of Health Politics, Policy and Law* 18, no. 1 (spring 1993): 75–103; Jacob Hacker and Theodore R. Marmor, "The Misleading Language of Managed Care," *Journal of Health Politics, Policy and Law* 24, no. 5 (October 1999): 1033–1043. The latter article is part of an excellent special issue on managed care.

61. Grogan and Patashnik, "Between Welfare Medicine and Mainstream Entitlement," esp. 832–833, for an excellent summary of the reconciliation measures; Smith and Moore, *Medicaid Politics and Policy*, 169–183, for detailed discussion of the amendments; Rose, *Financing Medicaid*, chap. 4; Michael S. Sparer, "Medicaid at 50: Remarkable Growth Fueled by Unexpected Politics," *Health Affairs* 34, no. 7 (July 2015): 1084–1091.

62. For a contemporary assessment of the various perspectives, see Davis, *National Health Insurance*.

63. Stuart Butler, "Assuring Affordable Health Care for All Americans," Heritage Lectures 218, October 2, 1989, http://thf_media.s3.amazonaws.com/1989/pdf/hl218.pdf; Robert Moffit, "Consumer Choice in Health: Learning from the Federal Employee Health Benefits Program," Heritage Foundation, February 6, 1992, https://www.heritage.org/social-security/report/consumer-choice-health-learning-the-federal-employeehealth-benefits-program.

64. Alain Enthoven and Richard Kronick, "A Consumer Choice Health Plan for the 1990s," parts I and II, *New England Journal of Medicine* 320, no. 5 and 320, no. 12 (January 1989): 29–37 and 94–101; Alain Enthoven, "The History and Principles of Managed Competition," *Health Affairs* 12 (Suppl. 1) (1993): 24–48.

65. Jacob Hacker, *The Road to Nowhere: The Genesis of President Clinton's Plan for Health Security* (Princeton, NJ: Princeton University Press, 1997), 131–132.

66. David Himmelstein and Steffie Woolhandler, "A National Health Program for the United States: A Physicians' Proposal," *New England Journal of Medicine* 320 (1989): 102–108.

67. Theodore Marmor, "Canada's Health Insurance and Ours: The Real Lessons, the Big Choices," *American Prospect*, December 5, 2000, http://prospect.org/article/canadas-health-insurance-and-ours-real-lessons-big-choices.

68. Sheila R. Zedlewski, Gregory P. Acs, and Colin W. Winterbottom, "Play-or-Pay Employer Mandates: Potential Effects," *Health Affairs* 11, no. 1 (spring 1992): 60–83.

69. Thomas R. Oliver and Emery B. Dowell, "Interest Groups and Health Reform: Lessons from California," *Health Affairs* 13, no. 2 (spring II 1994): 123–141; Walter Zelman, "The Rationale Behind the Clinton Health Reform Plan," *Health Affairs* 13, no. 1 (spring I 1994); Susan Moffat, "Insurance Chief Offers Universal Health Care Plan," *Los Angeles Times*, February 13, 1992, http://articles.latimes.com/1992-02-13/business/fi-3139_1_universal-health-care.

70. Zelman, "The Rationale Behind the Clinton Health Reform Plan"; Paul Starr and Walter Zelman, "Bridge to Compromise: Competition Under a Budget," *Health Affairs* 12 (Suppl.) (1993): 7–23.

71. Enthoven, "The History and Principles of Managed Competition," 25–48.

72. Excellent sources for the legislative process are Julie Rovner, "Congress and Health Reform," in *Intensive Care: How Congress Shapes Health Policy*, ed. Thomas Mann and Norman J. Ornstein (Washington, DC: American Enterprise Institute and Brookings Institution, 1995), 179–225; Allen Schick, "How a Bill Did Not Become a Law," in Mann and Ornstein, *Intensive Care*, 227–272.

73. Theda Skocpol, *Boomerang: Health Care Reform and the Turn Against Government* (New York: W. W. Norton, 1996), chap. 5.

74. Rovner, "Congress and Health Reform"; Schick, "How a Bill Did Not Become a Law."

75. Hacker, *The Road to Nowhere*; Skocpol, *Boomerang*.

76. Skocpol, *Boomerang*, chap. 5.

77. Ibid.

78. Lawrence R. Jacobs and Robert Y. Shapiro, "Don't Blame the Public for Failed Health Care Reform," *Journal of Health Politics, Policy and Law* 20, no. 2 (summer 1995): 411–424.

79. Sven Steinmo and Jon Watts, "It's the Institutions, Stupid! Why Comprehensive National Health Insurance Always Fails in America," *Journal of Health Politics, Policy and Law* 20, no. 2 (summer 1995): 329–372.

80. Hacker, *The Road to Nowhere*, 179.

81. James A. Morone, "Nativism, Hollow Corporations, and Managed Competition: Why the Clinton Health Care Reform Failed," *Journal of Health Politics, Policy and Law* 20, no. 2 (summer 1995): 391–398.

82. Schick, "How a Bill Did Not Become a Law," 265–272.

83. Alice Sardell, *Insuring Children's Health: Contentious Politics and Public Policy* (Boulder, CO: Lynne Rienner Publishers, 2014).

84. Alice Sardell and Kay Johnson, "The Politics of EPSTD in the 1990s: Policy Entrepreneurs, Political Streams, and Children's Health Benefits," *Milbank Quarterly* 76, no. 2 (1998): 175–205.

85. Kenneth E. Thorpe, "Incremental Approaches to Covering Uninsured Children: Design and Policy Issues," *Health Affairs* 16, no. 4 (July/August 1997): 64–78.

86. Sara Rosenbaum et al., "The Children's Hour: The State Children's Health Insurance Program," *Health Affairs* 17, no. 1 (January/February 1998): 75–89; Frank J. Thompson, *Medicaid Politics: Federalism, Policy Durability, and Health Reform* (Washington, DC: Georgetown University Press, 2012), chap. 3.

87. Thomas R. Oliver, Philip R. Lee, and Helene L. Lipton, "A Political History of Medicare and Prescription Drug Coverage," *Milbank Quarterly* 82, no. 2 (2004): 283–354.

88. Ibid.

89. Ibid.

90. This three-volume work is no longer readily available online but may be accessed through Google Books or in selective libraries. Jack A. Meyer and Elliot Wicks, eds., *Covering America: Real Remedies for the Uninsured* (Reston, VA: Economic and Social Research Institute, 2001), www.google.com/books/edition/_/WDv7QgAACAAJ.

91. John Kingdon, *Agendas, Alternatives, and Public Policies*, 2nd ed. (New York: Harper Collins, 1995).