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The Prospects for Ending Obamacare: Learning from Health Policy History

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Abstract: *Based on Washington's record of health policymaking, ending or rolling back Obamacare is anything but implausible. Now that President Barack Obama has signed the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act, much of the focus of the nation's ongoing health care debate will center on the impact of Obamacare's provisions on businesses and employment-based health insurance, as well as the contribution of new taxation and regulation to the rising cost of health insurance premiums and the intrusive regulatory changes that will be imposed by the Secretary of Health and Human Services on state health insurance markets. One of the routinely stated objectives of the Obama health policy agenda was to get health care costs under control; it doesn't. Moreover, official Washington's obsession with controlling, defining, regulating, and restricting private-sector health insurance options overlooks the obvious: Real cost control begins with the nation's largest entitlements, Medicare and Medicaid, for which lawmakers have direct responsibility.*

President Barack Obama's signatures on the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act do not end the national debate on federal control of health care.[1] The debate merely enters a new and perhaps even more difficult and divisive phase. Based on current revelations and previous experience, this continuing debate gives Congress ample justification to repeal Obamacare. At the very least, Congress can dismantle or defund its damaging provisions.

Talking Points

- The repeal of Obamacare is necessary and plausible. The new law was enacted by a narrow partisan majority without majority support in public opinion surveys.
- Popular dissatisfaction with the Medicare Catastrophic Coverage Act of 1988, the Clinton plan of 1994, and now the Patient Protection and Affordable Care Act of 2010 has been driven by a growing realization that their true costs were much higher than politicians promised or health policy "experts" predicted.
- For a President, a legislative victory is not the same as a political victory or a win in the tough court of public opinion.
- Conservatives in Congress can reframe the debate and present an attractive alternative based on personal freedom and control of health care dollars; tax and insurance reform to expand portable coverage; robust free-market competition among private insurance plans; and state reform of insurance markets and provision of safety-net care.

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With 907 pages of statutory text, this federal overhaul of American health care—creating scores of new federal agencies, boards, and commissions—will undergo a long and contentious period of implementation, including the issuance of reams of complex and controversial regulations, stretching out over the next eight years.

Some changes, of course, are already underway, including initial Medicare payment changes, restrictions, and reductions. But major changes—most beginning in 2014—will intensify the continuing national debate: the imposition of the unprecedented and controversial individual and employer mandates and penalties; the requirement that states comply with a highly prescriptive congressional design for the establishment and management of the new health insurance exchanges; and new and increasingly substantial federal taxes, fees, and taxpayer subsidies.

The Administration has authorized the Department of Health and Human Services (HHS) and the Internal Revenue Service to mail out brochures touting the benefits of the new law to seniors and small businesses, two especially troubled constituencies. Liberal allies have launched the "Health Information Center" as part of an extraordinary five-year, $125 million public relations campaign to defend the new law.[2] Meanwhile, congressional leaders are feverishly engaged in "selling" the provisions (such as parental insurance coverage for adult children up to age 26) to a skeptical public, hoping that a focus on these particulars will somehow eclipse general dissatisfaction with the law.[3]

Historical Lessons

Based on Washington's record of health policy-making, ending or rolling back Obamacare is hardly implausible. The Medicare Catastrophic Coverage Act of 1988 (H.R. 2470) was enacted with huge bipartisan support in both the House and Senate and repealed one year later. The 1,342-page Clinton plan of 1994, its enactment initially considered inevitable, was brought to a grinding halt in the fall of 1994 and collapsed on the Senate floor. In both cases, despite positive support in early polling, a majority of Americans found the provisions of these proposals unacceptable.

Based on Washington's record of health policy-making, ending or rolling back Obamacare is hardly implausible.

In the case of Obamacare (enacted and modified as the Patient Protection and Affordable Care Act of 2010), its broad policy themes, such as protection of individuals from coverage exclusions because of pre-existing medical conditions, were also initially popular, but that popularity does not automatically translate into support for the law itself, which has been bedeviled by public scrutiny of its detailed provisions. Focus on troubling legislative details, combined with a spectacularly repulsive process of logrolling in the Senate, fueled a fearsome public backlash, and the massive national health legislation quickly lost popular support. Toward the close of the congressional debate and the bill's narrowly partisan enactment in March 2010, opposition solidified. Since that time, major surveys have registered continued dissatisfaction and strong support for repeal.[4]

In all three instances, the American public was on the receiving end of a series of unpleasant reve-

1. The Reconciliation bill modified the provisions of the Patient Protection and Affordable Care Act, the Senate bill, which is the basic legislative vehicle of the President's health policy agenda. For a description of the impact of that legislation, see Kathryn Nix and Robert E. Moffit, "What House Passage of the Senate Health Bill Means for America," Heritage Foundation *WebMemo* No. 2833, March 16, 2010, at *http://www.heritage.org/Research/Reports/2010/03/What-House-Passage-of-the-Senate-Health-Bill-Means-for-America*.
2. Mike Allen, " Health Reform," *Politico*, June 8, 2010, p. 3.
3. Sarah Kliff and Jennifer Haberkorn, "Health Law Packs Political Punch," *Politico*, May 18, 2010, p. 1.
4. For example, according to the May 31 *Rasmussen Reports*, 60 percent of American voters favor repeal of the new law. Earlier surveys, curiously enough, found less intense opposition. For example, the April 21 Zogby Interactive poll found 51 percent of voters opposed to the new law. Zogby noted that the strongest single objection is that it would give government too much control of health care decisions.

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lations and regular reports of unforeseen or unintended consequences. In two out of three cases, liberal health care proposals failed. In the case of the Patient Protection and Affordable Care Act, despite its narrow legislative success, the powerful political dynamics that contributed to the Medicare Catastrophic Coverage Act debacle and the collapse of the Clinton health plan are very much in play.

Upwardly Mobile Cost Estimates. The Congressional Budget Office (CBO) seriously misjudged the costs of the Medicare Catastrophic Coverage Act's benefits; the projected cost of the Medicare drug benefit doubled within 12 months.[5] After President Clinton promised that his health plan was fully paid for, the CBO instead reported that the proposal would add tens of billions of dollars to the federal budget deficit.

President Obama promised that his plan would not add to the deficit, and the CBO projected a 10-year, $143 billion reduction in the deficit. This finding was based on a number of untenable assumptions.[6] Following enactment of the law, the CBO revised its official estimate upwards and added an additional $115 billion to the 10-year cost of the new law.[7] Most recently, noting the increasing pressure on the federal budget in the "next few decades and beyond," CBO Director Douglas Elmendorf declared that "in CBO's judgment, the health legislation enacted earlier this year does not substantially diminish that pressure."[8]

Disruption of Existing Coverage. Historically, Americans like and want to keep their existing health coverage. The Medicare Catastrophic Coverage Act of 1988 compelled senior citizens to pay for a drug benefit that many of them did not want through a special "supplemental premium" that was, in fact, a tax.[9] President Clinton proposed in 1993 that Americans, regardless of their wishes, would be required to get federally approved health insurance plans through congressionally created "regional alliances." In effect, the Clinton proposal would have herded millions of Americans into highly standardized managed care programs throughout the country.

At the inception of the national health care debate in 2009, President Obama insisted that if Americans liked their current health plan and wanted to keep it, nothing would change. But the incentives hardwired into the national health care law, especially the employer mandates, have made such an outcome fanciful.

The Office of the Actuary at the Centers for Medicare and Medicaid Services (CMS) estimates that 14 million Americans would lose or be transitioned out of their employment-based health insurance.[10] Former CBO Director Douglas Holtz-Eakin and

5. Robert E. Moffit, "The Last Time Congress Reformed Health Care: A Lawmaker's Guide to the Medicare Catastrophic Debacle," Heritage Foundation *Backgrounder* No. 996, August 4, 1994, at *http://www.heritage.org/Research/Reports/1994/08/bg996-The-Last-Time-Congress-Reformed-Health-Care*.
6. An example is the continuation of current law governing Medicare physician payment updates. The "doc fix" would add at least $250 billion to the 10-year cost. There is also the congressional creation of a new long-term care entitlement. It is financed by five years' worth of premiums before any benefit payouts, which makes the legislative product superficially attractive but fiscally unsustainable. Then there are 10 years' worth of Medicare payment cuts that are sometimes portrayed as enhancing Medicare solvency and at other times as financing the expansion of the new health care entitlements. Of course, both propositions cannot be true at the same time. For a more detailed discussion of these fiscal issues, see James C. Capretta, "Obamacare: Impact on Future Generations," Heritage Foundation *WebMemo* No. 2921, June 1, 2010, at *http://www.heritage.org/Research/Reports/2010/06/Obamacare-Impact-on-Future-Generations*.
7. Douglas W. Elmendorf, Director, Congressional Budget Office, letter to the Honorable Jerry Lewis, Ranking Member, Committee on Appropriations, U.S. House of Representatives, May 11, 2010, p. 2, at *http://www.cbo.gov/ftpdocs/114xx/doc11490/LewisLtr_HR3590.pdf* (June 8, 2010). The increased cost estimate was largely attributable to increased discretionary spending under the new law.
8. Douglas W. Elmendorf, Director, Congressional Budget Office, "Health Costs and the Federal Budget," Presentation to the Institute of Medicine, Washington, D.C., May 26, 2010, p. 2, at *http://www.cbo.gov/ftpdocs/115xx/doc11544/Presentation5-26-10.pdf* (June 8, 2010).
9. Moffit, "The Last Time Congress Reformed Health Care," p. 3.

Cameron Smith estimate that as many as 35 million Americans could be transitioned out of employer-based coverage as a result of the economic incentives driving employers to dump employees into heavily subsidized health plans in the congressionally designed state health insurance exchanges. Given the generosity of these subsidies, the real cost of the new law could skyrocket and increase the deficit by $554 billion in the first 10 years and $1.4 trillion over the succeeding 10 years.[11]

Metastasizing Bureaucracy. The Medicare Catastrophic Coverage Act of 1988 authorized HHS, including the then-Social Security Administration, to undertake a challenging set of complex administrative tasks. Reagan Administration officials warned Congress without success that these tasks were enormous.[12]

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The Clinton health plan of 1994 would have dwarfed the HHS bureaucracy envisioned under the 1988 Medicare Catastrophic Coverage Act. James Tozzi, formerly a civil servant at the Office of Management and Budget, identified 818 new mandates on federal and state agencies and the creation of 59 new agencies to administer the Clinton plan's new health insurance regime.[13] Laura Tyson, President Clinton's top economic adviser at the time, conceded that the state-based "regional alliances" alone

Virtually none of the President's high-profile promises concerning his health reform agenda are coming to fruition.

would require hiring for approximately 50,000 new positions.[14] Independent analysts offered higher staffing estimates. In a graphic display of the mind-numbing complexity of the Clinton plan, Senator Arlen Specter of Pennsylvania (then a Republican) unveiled a detailed chart of the federal agencies that would micromanage the American health care system. Specter's chart achieved iconic status.

In order of magnitude, the level of bureaucracy embodied in the Patient Protection and Affordable Care Act is beyond anything previously attempted. There are scores of new federal agencies, boards, councils, commissions, panels, and programs. Depending on how they are identified and counted, the estimates vary. The most recent estimate is 160.[15] In any case, the regulatory reach is unprecedented. The new law will give birth to a regulatory regime, involving the rapid imposition of reams of red tape over the next few years, unlike anything Americans have ever experienced.

The Ongoing National Health Care Debate

Since the Patient Protection and Affordable Care Act is now the law of the land, its results are quickly becoming apparent. Virtually none of the President's high-profile promises concerning his health reform agenda—such as "bending the health cost curve" downward or insulating middle-class Americans from new taxation—are coming to fruition.

10. Richard S. Foster, Chief Actuary, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," April 22, 2010, p. 7.
11. Douglas Holtz-Eakin and Cameron Smith, "Labor Markets and Health Care Reform: New Results," American Action Forum, May 2010, p. 2, at *http://americanactionforum.org/files/LaborMktsHCRAAF5-27-10_0.pdf* (June 10, 2010).
12. Moffit, "The Last Time Congress Reformed Health Care," p. 5.
13. James Tozzi, *The Regulatory Requirements of the Health Security Act, Volume I, Methodology and Findings*, Executive Summary, Multinational Business Services Inc. Washington, D.C., March 1, 1994, pp. 1–2.
14. Robert E. Moffit, "A Guide to the Clinton Health Plan," Heritage Foundation *Backgrounder,* November 19, 1993, p. 13, at *http://www.heritage.org/Research/Reports/1993/11/A-Guide-to-the-Clinton-Health-Plan*.
15. Scott Gottlieb, M.D., "You're Losing Your Plan," *The New York Post*, June 14, 2010, at *http://ww.nypost.com/p/news/opinion/opedcolumnists/you_re_losing_your-plan_02H1EFmYIHSoQmqp48uDH1#ixzz0qql1N16m*.

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Moreover, the new law's glitches, mistakes, and unintended consequences continue to multiply. For example, perhaps because of sloppy drafting, Congress has even enacted its own exclusion from the Federal Employees Health Benefits Program (FEHBP) without an effective date.[16] Contrary to presidential and congressional assertions, corporations are signaling billions of dollars in increased health care costs.[17] Congressional leaders are belatedly acknowledging that fact even as more firms are reporting that the employer mandate provisions will discourage the hiring of low-income workers.[18]

Beyond the impact on employers and employees, the negative impact on taxpayers generally is becoming increasingly clear. The CBO reports that its estimates of the 10-year cost of the law were off by a stunning $115 billion[19] (mostly in additional discretionary spending), thus threatening the agency's earlier assessment of deficit reduction.

Congressional Oversight. Meanwhile, Congress must oversee the implementation of its own handiwork by various federal agencies and departments. The initial trickles of regulation will soon become a veritable flood of thousands and thousands of pages, engendering a sea of paperwork for state officials, doctors, hospitals, insurers, employers, and employees. The *Federal Register* will rapidly fatten as the Secretary of HHS takes on an unprecedented number of enforcement and regulatory responsibilities.

In addition, CMS officials will be tasked with developing highly prescriptive rules for notice and comment that touch on the smallest details of the law's implementation, such as setting guidelines for state officials and specifying how they are to format their Web sites. The Internal Revenue Service will be tasked with a new role of checking up on individuals to see whether they have or have not purchased the government-approved package of health benefits. The Office of Personnel Management (OPM) will be tasked with sponsoring two or more plans to compete against private insurance in the state health insurance exchanges in potentially every state of the union.[20]

With each passing day, the media report the emergence of current or future problems with the new law and its regulations:

- The limited scope and effectiveness of the small-business tax credits;[21]

16. Normally, such an undated provision would simply take effect on the date of enactment, but Administration lawyers have interpreted the provision to take effect in 2014, when the new health insurance exchanges in the states would be operational and thus able to accommodate the enrollment of Members of Congress and congressional staff with, apparently, some curious exceptions. For a more detailed discussion of this issue, see the memorandum to Representative Tom Price (R–GA) from Jennifer Staman, Edward Liu, Erika Lunder, and Kenneth Thomas, "Questions Regarding Employer Responsibility Requirements and Section 1312(d)(3)(D) of the Patient Protection and Affordable Care Act," Congressional Research Service, April 29, 2010, at *www.crs.gov* (May 22, 2010). Any congressional attempts to amend this provision or evade the transition into the federally mandated health insurance exchanges would doubtless arouse the intense interest of ordinary Americans.
17. Grace-Marie Turner, "Obamacare Means Millions Could Lose Coverage," *National Review Online*, May 10, 2010.
18. Under the new law, full-time employees must spend no more than 9.5 percent of their "household income" on health insurance coverage and can qualify for government assistance if they face higher costs. Most employers have no idea what their employees' "household income" is, but they will be required to find out, notwithstanding conventional privacy concerns. Starting in 2014, if a low-income employee gets government assistance to buy coverage in the new congressionally mandated health insurance exchanges, the employer can be fined $3,000 for that employee. This bizarre provision is likely to discourage millions of employers from hiring low-income persons in the first place. Executives for White Castle, the Ohio-based hamburger chain, have estimated that this provision alone could cut their income and future job expansion by 50 percent. See Representative John Boehner (R–OH), "Obamacare's War on White Castle Jobs," GOP Leader Blog, May 11, 2010, at *http://repeublicanleader.house.gov/blog?p=877* (May 22, 2010).
19. The most recent CBO estimates, as noted, would increase the total projected cost of the new law from $940 billion to over $1 trillion in the first 10 years. See Jennifer Haberkorn, "CBO Ups Health Care Cost Projections," *Politico*, May 11, 2010, at *http://www.politico.com/news/stories/0510/37081.html* (May 22, 2010).
20. Editorial, "Public Option Is Alive and Well, but Hidden," *Washington Examiner*, May 17, 2010.

- The burdensome paperwork of new IRS reporting rules for small businesses;[22]
- The impact of the new federal health insurance fees on business premiums;
- The powerful economic incentives for large companies to dump employees into the government-created health insurance exchanges;
- The impact of insurance rules on the ability of insurers to continue to participate in the markets and employees to keep their coverage.[23]

Not surprisingly, the Administration has already missed four statutory deadlines in the implementation of the law, including the official posting of HHS authorities.[24] Central planning is normally arduous; on this scale, it is truly Herculean.

Growing State Opposition. Under the Patient Protection and Affordable Care Act, by 2014, the federal government will commandeer the states as vehicles of federal health policy. States are required to establish at least one "American Health Benefits Exchange" for the purchase of federally approved health insurance and must make available a congressionally conceived nonprofit "co-op plan" along with one or more of the OPM-sponsored health plans to compete with private insurance.

States are also required to establish reinsurance programs for plans with high claims, with plan contribution levels to be determined by HHS. Additionally, and importantly, they are required to expand Medicaid eligibility for all persons under the age of 65 with incomes at or below 138 percent of the federal poverty level (FPL). The CMS Actuary estimates that slightly more than half of the estimated 34 million newly insured Americans under the law will be covered by Medicaid.[25]

While the new law provides for initial federal funding for Medicaid expansion, phasing it down over the years while increasing initial federal payments (based on the higher Medicare rates) for primary care physicians in treating Medicaid patients, the states will bear the additional administrative costs of the expansion, and the federal physician payment increases are funded only in 2013 and 2014. After that period, the Medicaid physician payments are to be picked up by the states and could amount to approximately $50 billion within 10 years.[26]

Stripped of their authority to regulate their own health insurance markets and facing a costly expansion of Medicaid, state officials have already become champions of popular opposition.

Stripped of their authority to regulate their own health insurance markets and facing a costly expansion of Medicaid—a poorly performing component of America's welfare state—state officials have already become champions of popular opposition. Thus far, 21 states have filed suit against the imposition of the individual mandate on constitutional

21. For example, the average payroll limit of $50,000 annually will exclude the eligibility of a large number of small firms, and the small business credits do not apply to the self-employed. The National Federation of Independent Business sees this approach as utterly ineffective. See National Federation of Independent Business Web site, at *http://www.nfib.com/hclawsuit*.
22. For example, the law imposes a requirement on small business to file a 1099 tax form for the purchase of any good or service from another business that annually exceeds $600. For small businesses, such IRS reporting, compliance, and paperwork requirements are far more burdensome than they are for large corporations. See *ibid.*
23. Beyond the independent economic projections based on the incentives embodied in the employer mandate, the business community is concerned about the impact of the Administration's regulations governing so-called grandfathered health insurance plans that employers and employers are supposed to be allowed to "keep" with the law's enactment. About half of all of these plans would be required to change by the end of 2013. See Robert Pear, "New Rules on Changes to Benefit," *The New York Times*, June 13, 2010, at *www.nytimes.com/2010/06/14/health/policy/14health.html*.
24. Jonathan Strong, "White House Misses Early Deadlines in Obamacare Implementation," *The Daily Caller*, June 2, 2010, at *http://dailycaller.com/2010/06/02/white-house-misses-early-deadlines-in-implementing-obamacare* (June 10, 2010).
25. Foster, "Estimated Financial Effects," p. 3.
26. United Health, "Coverage for Consumers, Savings for States: Options for Modernizing Medicaid," Summary of Key Findings, UHG *Working Paper* No. 3, April 2010.

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grounds. In direct support of these states, the National Federation of Independent Business, the largest association of American businesses, has also challenged the constitutionality of the law.

Meanwhile, legislators in 37 states have introduced or enacted resolutions to advance "health care freedom" legislation, enabling persons to pay directly for medical services and prohibiting the imposition of penalties on individuals for declining to participate in a particular plan.[27]

The Fate of the Medicare Catastrophic Coverage Act of 1988

Over the past three decades, the political battles over the substance of health care policy have been fought over specific issues, but always against the broader backdrop of the proper role of government. While Americans of all political persuasions have embraced the central ideas behind health reform—controlling costs, expanding access to coverage, and improving the quality of care—it does not follow that they embrace specific policy prescriptions, particularly when the trade-offs of those prescriptions are made clear. In health care policy, "details kill," as former Senator Tom Daschle once famously remarked.[28]

There is another factor that has remained constant in Washington's great health care debates: distrust of government control. Recent survey data indicate that most Americans oppose the expansion of the government's role in health care and believe this expansion will cost too much. According to the prestigious Gallup organization, popular support for the proposition that it is the government's responsibility to make sure that all Americans have health coverage has fallen sharply in recent years from a high of 69 percent to 47 percent.[29] Americans do not support health legislation that will impose higher costs or higher premiums or threaten the coverage they like or the quality of their health care. For all of the real problems that beset their health care, ordinary Americans do not support legislation that will make matters worse.

The Unlikely Debacle. In 1986, the Reagan Administration announced its support for the addition of a catastrophic benefit to the Medicare program. President Ronald Reagan and his team at HHS argued that this could be accomplished at a modest cost—the monthly cost of a carton of cigarettes—and would secure "peace of mind" for the nation's senior citizens. To this day, traditional Medicare does not provide catastrophic coverage, which, curiously enough, is the rationale for health insurance in the first place.

Shortly after President Reagan announced his proposal, Democratic leaders on the House Energy and Commerce Committee and the House Ways and Means Committee set out to recraft it. They embarked on an aggressive effort to expand Medicare by adding new benefits and provisions, including a prescription drug benefit. Medicaid was also expanded. This pattern was repeated in the Senate.

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In sharp contrast to the later Medicare Modernization Act of 2003, backed by the second Bush Administration, the congressional Democratic leaders determined that they were not going to shift the costs of the drug entitlement expansion to working families and confined its financing to Medicare beneficiaries themselves in the form of an income-related surtax.[30] In the process, they beat off a vigorous floor challenge from Representative Claude Pepper (D–FL), a popular House liberal, who

27. See American Legislative Exchange Council, "ALEC's Freedom of Choice in Health Care Act," at *http://www.alec.org/AM/Template.cfm?Section=ALEC_s_Freedom_of_Choice_in_Health_Care_Act*.

28. "Details kill. If we get too far into the weeds, if we produce a 1500 or 1600 page bill, we're going to get hung up on all the details and we're never going to get to the principles." Former Senator Tom Daschle, remarks delivered to the Colorado Health Care Summit, Denver, Colorado, December 5, 2008.

29. For the Gallup health care findings, see *http://www.gallup.com/poll/4708/healthcare-system.aspx*.

wanted to go further and add a hugely expensive long-term care benefit to Medicare.

For almost two years, including regional public hearings sponsored by the Reagan Administration, there was a high-profile debate and discussion in the House and Senate. With fairly careful deliberation, Congress hammered out the landmark health care legislation. It was the largest expansion of Medicare since the program's creation in 1965. With enormous popular support in the polls and huge bipartisan majorities in the House and Senate, the Medicare Catastrophic Coverage Act of 1988 became law. One year later, it was repealed.[31]

Details killed the Medicare Catastrophic Coverage Act. Americans realized that they were being compelled to pay for benefits that they did not want. Once senior citizens, the new law's alleged beneficiaries, became aware of the costs to themselves and the impact on their existing benefits, a shocked and bewildered Congress found itself on the receiving end of a particularly bitter backlash marked by angry public protests. The high-profile endorsements of large, well-financed special-interest groups like the American Association of Retired Persons (AARP) only sharpened the embarrassing and politically disastrous gap between professional lobbyists and the millions of Americans whom they claimed, erroneously, to represent. Meanwhile, HHS was undertaking a comprehensive public information program to explain the benefits of the new law, preparing a revised *Medicare Handbook* to mail to the 32 million Americans who were enrolled in the program.

Problems began to surface immediately. First, the administration and implementation of the complex new law required the close cooperation and coordination of a variety of federal agencies, including HHS, the Social Security Administration, the Department of the Treasury, the Internal Revenue Service, and OPM. This was proving to be difficult.

Second, in a monument to central planning, Congress tasked HHS with administering the new prescription drug benefit, establishing the regulatory framework for processing an estimated 300 million claims per year, adopting new information systems to do the job, and monitoring 67,000 pharmacies. HHS was tasked with getting the new system up and running by 1991 and was exploring the employment of private contractors who would set up the claims processing system.

The statutory language required the creation and operation of an electronic "point of sale" system for processing these claims, meaning that computer terminals would have to be set up in every participating pharmacy in the United States. The contractors, to be assigned on a regional basis, would also have had to devise a system to process the paper claims for the drug benefit for beneficiaries who patronized non-participating pharmacies. For anxious HHS officials, success would depend on the willingness of tens of thousands of pharmacists to participate in this new program, the reliability of the new computer systems, and the ability to keep the administrative costs of the claims processing for drugs at an acceptable level.

At the time, it did not seem likely that the administrative costs for administration of the new Medicare catastrophic drug program would be nearly as low as the administrative costs of administering the Medicare Part A and Part B benefits, which were officially scored at 2 percent annually. During the legislative debate, Reagan Administration officials warned Congress that the administrative tasks imposed on HHS were daunting, but Congress dismissed the warnings.

The projected costs of the new law soon exploded. Congress had statutorily prescribed the premium rates for the drug benefit, but it also prescribed maximum increases. Looking over the data in 1989, the Medicare Actuary projected that by

30. The Medicare catastrophic benefit expansions were to be financed by increases in Medicare Part B premiums. This was supplemented by an additional financing mechanism for the catastrophic and drug benefits: a new income tax–related supplemental premium to be effective in 1989 for all taxpaying Medicare beneficiaries. The premium rate for the first year was limited to a maximum of $800 per individual and $1,600 per married couple.

31. For an account of the enactment and repeal of the Medicare Catastrophic Act, see Moffit, "The Last Time Congress Reformed Health Care."

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1992, the Medicare drug trust fund would face a $1.7 billion shortfall and the deficit in the trust fund would continue to increase. The Secretary of HHS was constrained by the statutory language in taking any remedial administrative action until 1993, so the financial condition of the drug program was projected to worsen progressively.

Though the Obama plan was a legislative success and the Clinton plan was a legislative failure, both health plans lost in the court of public opinion.

The CBO had initially taken a more sanguine view of the drug benefit's financing, assuming that the statutorily authorized financing would be sufficient to meet what CBO also assumed: a comparatively slower demand for drugs among the senior population. The Medicare Actuary assumed a more robust demand.

But the CBO soon revised its own assessment and reported that it had seriously underestimated the price tag of various provisions of the bill, including hospitalization and skilled nursing costs and, most important, the costs of the new Medicare prescription drug benefit. In 1988, at the time of the Medicare law's enactment, CBO projected that the five-year cost of the drug benefit would be $5.7 billion; one year later, it estimated the five-year cost at $11.8 billion.[32]

In June 1989, matters came to a head. Chairman Lloyd Bentsen (D–TX) of the Senate Finance Committee called CBO to testify on its latest findings. That was the beginning of the end of the once popular, though poorly understood, health care law.

The Medicare Catastrophic Coverage Act of 1988 was designed as traditional social insurance: The beneficiaries were going to be the ones who paid for the benefits, particularly the drug benefit. Low-income seniors already had drug coverage through Medicaid, but millions of middle- and upper-income seniors already had drug benefits through other sources, including supplemental coverage or other lower-cost options. As a result, many middle- and upper-income seniors saw themselves as victims of this congressional surtax scheme and did not like being forced to pay for benefits that they did not want or need and that were more expensive than the benefits that they already had.

In 1989, an increasing number of Members of Congress were introducing bills to repeal or change the law. On the Medicare drug benefit issue, in particular, there seemed to be few viable options. They could perhaps increase the Medicare payroll tax, hardly a politically attractive idea, or just create another pipeline to the federal Treasury to funnel back general revenues to cover the drug benefit shortfalls. That, however, would have been a confession of political failure in their attempt to create a fiscally responsible drug benefit that did not involve yet another income transfer from working families.

During 1989, the congressional leadership and the newly installed Bush Administration officials largely doubled down in defense of the law, but they found themselves on the losing side of the growing national debate.

The Clinton and Obama Health Plans

Key elements of liberal health policy proposals of the early 1990s and of the Obama agenda of 2009–2010 are strikingly similar in substance, though their presentation and legislative development were very different. Though the Obama Administration's relentless work on behalf of the President's health care agenda culminated in legislative success and the Clinton plan was a legislative failure, both health plans lost in the court of public opinion at the climax of congressional deliberations. They shared certain common problems.

Unappealing Centralized Control. Both the Clinton plan and Obamacare sought to concentrate decision-making on health care financing and delivery in Washington. Both included a highly prescriptive federal definition and control of the content of "acceptable" health insurance benefit packages; individual and employer mandates to purchase federally approved health insurance plans; multi-year Medicare cuts to finance the expansion of health

32. *Ibid.*

care coverage; centralization of federal control of health insurance markets, manifest in federally designed health insurance exchanges in the Obama version and geographically based "regional alliances" in the Clinton version; and federal control of health care financing, characterized by taxpayer subsidies and premium rate regulation in the Obama version and "premium caps" and a "global budget" governing all health care spending in the Clinton version.

Recurrent Rhetorical Gaps. Both Clinton and Obama were undermined by yawning gaps between their rhetoric and reality. In his stirring September 1993 speech to a joint session of Congress, President Clinton emphasized the need to curtail the role of bureaucracy and rely on the free-market forces of choice and competition. But when Clinton unveiled his giant Health Security Act one month later, the reality was a massive, mind-numbing bureaucratic system of federal command and control of virtually every aspect of the health care system.[33]

President Obama, in his September 2009 speech before a joint session of Congress and in other forums, likewise promised that Americans who were satisfied with their health plans would be able to keep them, that the health care cost curve would bend downward, that proposed Medicare cuts would not affect benefits, that there would be no middle-class tax increases, that families would see an annual reduction in their health care costs, and that taxpayers would not be forced to fund abortions. Moreover, even as the President proposed federal control of both health benefits and health financing, he denied that his proposals amounted to a federal "takeover" of Americans' health care.

On all of these topics, the President's repeated assertions were thoroughly refuted by both official and independent analyses of the legislative language.[34]

Recurrent Financial Gaps. In 1993, President Clinton insisted that his massive health plan would not add to the federal deficit, but would instead "pay for itself." In February 1994, the CBO reported that the Clinton plan would in fact add tens of billions of dollars to the deficit.

In 2009, President Obama promised that his proposal for $900 billion in additional spending would neither add to the deficit nor bend the "cost curve" upward. In fact, the new health care law meets "deficit neutrality" targets only by taking liberties with common sense.

For example, as noted, the CBO modeled the Senate version of the Obama-backed legislation on the sponsors' unrealistic assumption that the Medicare physician payment rules would remain unchanged, thus effecting an initial 21 percent reduction in physician payments. Sponsors also assumed that Congress would follow through with hundreds of billions of dollars in other Medicare payment cuts, and they carefully crafted the 10-year financing to make sure that the revenues would commence immediately and benefit payouts would commence later.

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During debate on the Senate floor, Senator Max Baucus (D–MT) conceded that the real 10-year cost of the Senate health bill—depending on when and how one calculates the combined revenues and payouts—could be $2.5 trillion. Meanwhile, The Heritage Foundation's Center for Data Analysis estimates that under the Senate bill, America's publicly held debt would be $755 billion higher by 2020.[35]

33. For an analysis of the Clinton health plan, see Moffit, "A Guide to the Clinton Health Plan."

34. For an analysis of the original Obama proposal, see Robert E. Moffit and Nina Owcharenko, "The Obama Health Care Plan: More Power to Washington," Heritage Foundation *Backgrounder* No. 2197, October 15, 2008, at *http://www.heritage.org/Research/Reports/2008/10/The-Obama-Health-Care-Plan-More-Power-to-Washington*. For the various House and Senate iterations of the Obama health care agenda, see "Fix Health Care Policy," The Heritage Foundation, at *http://www.fixhealthcarepolicy.com*.

Recurrent Popular Opposition. In 1993 and 1994, initial polling showed strong popular support for comprehensive health care reform, and the Clinton Administration rode that initial wave of popularity. But with closer public scrutiny of the provisions of the Health Security Act, popular support plummeted. In the spring of 1994, congressional town halls were a public relations disaster for the Clinton health plan, just as the August 2009 congressional town halls proved disastrous for the Obama Administration. Since enactment of the Patient Protection and Affordable Care Act, as noted, polling indicates continued and deepening majority opposition. [36]

In both cases, increasingly sophisticated information technology guaranteed rapid transmission of legislative details. And in both cases, opponents successfully framed the terms and decisively won the health care debate in the high court of public opinion.

Political Defeat and Policy Victory

Legislative victories and policy victories are not identical. A President's legislative victory can easily translate into a political defeat, both at the polls and in the court of public opinion, and a President's legislative defeat does not necessarily mean loss of control over the terms of the policy debate.

In June 1988, Congress enacted the Medicare Catastrophic Coverage Act by huge bipartisan majorities[37] with the full support of Washington's political class and powerful lobbying forces in the health industry and interest groups like the AARP. Though there was internal dissent within the Reagan Administration over the final bill's broad reach, additional drug benefit, and cost, President Ronald Reagan, who wanted to provide a catastrophic benefit in Medicare, nonetheless signed the bill into law.

Even as the rebellion among senior citizens spread across the country and repeal measures were being introduced in Congress, by the spring of 1989, senior officials in the succeeding Bush Administration and especially at HHS were convinced that the law would survive and were stubbornly committed to making it work. In the face of growing congressional and popular opposition, they were pondering temporary "fixes" to the financing of the drug benefit, such as increasing their borrowing authority or scaling it back or altering it.

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But they had misjudged the depth of popular opposition. The Medicare law's repeal in October 1989 was a stunning blow to Washington's political establishment.[38] It was both a political and a policy defeat.

In September 1993, after a particularly effective televised speech to Congress and the nation on his health care reform proposal, President Clinton defined the terms of the forthcoming debate and enjoyed momentum going into the legislative consideration of his plan. With the unveiling of his giant proposal in legislative form in October 1993, revealing the nitty-gritty details of his agenda, Clinton's prospects for legislative success steadily declined.

In the fall of 1994, as noted, the Clinton health agenda died on the Senate floor without a vote. The intense public hostility to the Clinton health plan itself—*not* Congress's decision to defy public opinion and enact it anyway—contributed directly to

35. Karen Campbell, Guinevere Nell, and Paul L. Winfree, "Mandates and Taxes Re-Burden Health Insurance Markets," Heritage Foundation *WebMemo* No. 2834, March 16, 2010, at *http://www.heritage.org/Research/Reports/2010/03/Mandates-and-Taxes-Reburden-Health-Insurance-Markets*.
36. For a summary of the polling data on the new health care law, go to *fixhealthcarepolicy.com.*
37. On June 8, 1988, the conference report on the Medicare Catastrophic legislation (H.R. 2470) cleared the Senate by a vote of 86 to 11; the Stark–Gradison bill, the House version, had previously passed the House of Representatives by a lopsided vote of 302 to 127.
38. On October 6, 1989, the Senate passed S. 1726, the bill to repeal the Medicare Catastrophic Coverage Act, by a vote of 99 to 0, with one abstention. One minute later, the House concurred.

the 1994 Republican takeover of the House of Representatives.

Retaking the Offensive. In spite of this legislative and political setback, neither President Clinton nor his liberal congressional allies lost control of the national health policy agenda. Throughout the 1990s, they framed and advanced the ongoing health care debate on their terms. Their allies in the states, including Kentucky, Minnesota, and Washington State, pressed ahead to enact mini-versions of the Clinton health plan.

At the federal level, Congress enacted the Health Insurance Portability and Accountability Act of 1996. It included large chunks of the text of the Clinton Health Security Act, notably the complex "administrative simplification" provisions that were anything but simplifications. In 1997, Congress also enacted the State Children's Health Insurance Act (known as SCHIP), which has since blossomed into the equivalent of a new and costly entitlement for middle-class families. Likewise, the Balanced Budget Act of 1997 included an unprecedented statutory restriction on private contracting in the Medicare program and a historic government intrusion into the traditional doctor–patient relationship.[39]

Neither Republican domination of Congress in the late 1990s nor control of the White House in 2001 significantly altered the general trajectory of federal health policy, including the creation of a universal Medicare drug entitlement (long a liberal policy goal) as part of the Medicare Modernization Act of 2003. As John R. Graham, Director of Health Policy Studies at the Pacific Research Institute, has noted, during the period 1998–1999 through 2008–2009, federal health care regulation, as measured by the sheer number of pages in the *Federal Register*, increased a hefty 56 percent.[40]

In the case of the Obama health policy agenda, the legislative situation turned out to be very different. In contrast to President Clinton, President Obama won a major policy victory through the enactment of the Patient Protection and Affordable Care Act by a narrow partisan majority. And even then, the razor-thin legislative victory was possible only because of a last-minute decision by Representative Bart Stupak (D–MI) and a few like-minded Democratic colleagues, who agreed to a bargain with the Administration (including the promised issuance of an executive order) on federal abortion funding.

In 2010, President Obama and the congressional leadership secured a major health policy victory while enduring a damaging public relations defeat, losing the hearts and minds of the public. Both the President and his congressional allies lost public trust on the health policy agenda by insisting on transparently untrue promises concerning what the law would deliver, on a variety of topics ranging from future cost control to middle-class taxation, that were directly at odds with independent analyses of the provisions of the law or even official assessments by the CMS Office of the Actuary.

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The President's narrow legislative victory, in other words, came at the expense of forgoing popular support for his signature legislative accomplishment in the court of public opinion. This gives conservatives in Congress a tremendous opportunity to reshape the health policy debate.

The Next Battle

In Washington's policy battles, the players are either on offense or defense. Those who frame the terms of the debate are on offense and, by outlining a compelling program for change, can win.

39. On the Medicare contracting issue, see Robert E. Moffit, "Congress Should End the Confusion over Medicare Private Contracting," Heritage Foundation *Backgrounder* No. 1347, February 18, 2000, at *http://www.heritage.org/Research/Reports/2000/02/End-the-Confusion-Over-Medicare-Private-Contracting*.

40. John R. Graham, "Repealing Obamacare," *The Washington Times*, May 17, 2010.

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For the first year of his Administration, President Barack Obama pursued an aggressive and ambitious offensive strategy, winning lightning legislative victories in the House and Senate. Even before enactment of the Patient Protection and Affordable Care Act, President Obama had already surpassed President Clinton's measured, incremental success in expanding the federal government's role in Americans' health care.

For example, in 2009, Congress enacted a major SCHIP expansion. Shortly thereafter, with enactment of the giant stimulus bill, the President secured a major Medicaid expansion, an unprecedented role for the federal government in the regulation of health information technology, and the creation of a government council to research "comparative effectiveness" of medical treatments and procedures. By every measure, the President's performance in advancing his policy agenda was impressive even as his popular job approval steadily declined.

The experience of the Medicare Catastrophic Coverage Act of 1988 demonstrates that full-scale repeal is not politically unrealistic. Indeed, for conservatives in Congress, repeal is a priority, and it is clearly what the majority of their fellow citizens want them to do.

Meanwhile, it is not sufficient for conservatives in Congress to play defense on the emerging regulatory regime. They should also advance a consequential health care agenda that would positively affect the lives of millions of Americans. This can be done by:

- **Fixing** the glaring inequities of the federal tax treatment of health insurance, giving millions of Americans individual tax relief and thus new opportunities to secure affordable, portable private health insurance;
- **Promoting** interstate competition among insurance plans, encouraging them to compete directly for consumer dollars and deliver value for those dollars; and
- **Pursuing** aggressive state-based health policy experimentation with grants and waivers, which would unleash robust competition in health insurance markets while guaranteeing affordable, high-quality care for the poorest and sickest citizens who depend on the social safety net.

Much of the focus of the health care debate will center on the impact of the Patient Protection and Affordable Care Act's provisions on businesses and employment-based health insurance, as well as the contribution of new taxation and regulation to the rising cost of health insurance premiums and the intrusive regulatory changes that will be imposed by the Secretary of HHS on state health insurance markets.

One of the routinely stated objectives of the Obama health policy agenda was to get health care costs under control, but official Washington's obsession with controlling, defining, regulating, and restricting private-sector health insurance options overlooks the obvious. Congress must recognize that real cost control begins with the nation's largest entitlements: Medicare and Medicaid, two programs for which lawmakers have direct responsibility.

The health care debate is not over. For millions of Americans living today, it will never be over. It has only begun.

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