

HEALTH CARE REFORM—PAST AND FUTURE†

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In this article, Dr. Blumenthal explores the federal government's role in passing health care reform legislation. Dr. Blumenthal begins by postulating why health care reform legislation failed to pass Congress in 1994. Next, he reviews how Medicare legislation passed Congress in 1965. Dr. Blumenthal then compares the legislative successes of Medicare with the recent legislative failures of health care reform. Finally, using this comparison, Dr. Blumenthal predicts that federal health care reform will only materialize when there exists a combination of public support for and political skill in marshaling reform.

The demise of federal legislation to reform our health care system has frustrated the hopes (or quieted the fears) of millions of Americans. Nevertheless, the problems of our health care system persist, and efforts to reform it will proceed at several levels.¹ In the aftermath of the Republicans' resounding victory in the 1994 congressional elections, the private marketplace and, to a lesser extent, state governments seem likely to lead such efforts, but their ability to address problems of access to care—and its costs—is limited. The important role of the federal government in health care reform is therefore likely to emerge once again.

It is worthwhile for this reason to answer certain questions to help inform federal policy making when the shortcomings of private-

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1. Gregg Easterbrook, *Looking to 1995*, BOSTON GLOBE, Oct. 9, 1994, at 74.

sector and state-based health care reform become clear. Among these questions are the following: Why did federal health care reform legislation fail to pass in the U.S. Congress in 1994? What conditions or actions would be likely to lead to a different result in the future?

Given the many proposals that came to be called health care reform during the recent legislative debate, a definition is required at the outset. For this discussion, health care reform is taken to mean any federal legislative initiative that provides all Americans financial protection against the cost of illness and that also contains a coherent approach to reducing the rate of growth in health care expenditures.

I. Why Did Health Care Reform Fail?

The press, politicians, and health care experts have advanced several explanations for the failure of health care reform. They are by no means mutually exclusive, and can be summarized as follows.

First, it is argued that the Clinton administration failed to provide the necessary political leadership and managerial competence to take advantage of public support for health care reform.² This thesis is buttressed with a number of specific observations. The process of drafting the administration's bill, the Health Security Act, took much too long—nearly a year—with the result that it fell victim to time pressures at the end of the congressional session. The bill itself was technically sound but politically disastrous, since its length and complexity tended to support charges that it would create a bureaucratic nightmare. The managers of the health care reform process were academically talented but politically naive and inexperienced in the ways of Washington.

Second, special-interest groups manipulated Congress and important elements of the electorate, turning both against health care reform. This manipulation included the Health Insurance Association of America's successful "Harry and Louise" advertisements, in which a beguiling, articulate couple shared their fears that health care reform would insert government into their daily lives and deprive them of their right to choose their own physicians in the future. A number of news reports have also cited the large contributions to members of Congress by major interest groups that opposed meaningful health

2. Adam Clymer, *Hillary Clinton Says Administration Was Misunderstood*, N.Y. TIMES, Oct. 3, 1994, at A12.

care reform, including the National Federation of Independent Businesses and the Health Insurance Association of America.³

A third explanation for the failure of health care reform argues that our political leaders and institutions are corrupt, ineffective, and incapable of resolving vital, complex, and bitterly contested issues such as health care reform. The data to support this conclusion consist of the apparent success of special-interest groups in manipulating Congress, the inability of Congress even to bring the health care issue to a vote after four of its committees had reported out legislation, and the behavior of key congressional figures, such as Congressman Daniel Rostenkowski, chairman of the House Ways and Means Committee, and Senator Daniel Patrick Moynihan, chairman of the Senate Finance Committee. Just when his political skills were most needed, Rostenkowski, a proponent of health care reform, was indicted for corruption and forced to surrender his chairmanship. Moynihan displayed a combination of quirkiness and evasiveness on health care reform that communicated lack of interest, lack of commitment, lack of clout, or all three.

A fourth thesis suggests that federal health care reform failed to pass in Congress because in the end the American people did not support it. Opponents have argued a version of this position, contending that the American people looked at the various proposals and walked away.⁴ Some supporters have bitterly concluded that many Americans came to view the universal-access provisions of health care reform as benefiting only a small underclass, and selfishly rejected sacrifices needed to help this less fortunate minority.⁵

II. The Perspective of History

To assess the validity and importance of these various explanations for the failure of health care reform in 1994, it is useful to examine the contrasting example of the most successful effort in history to revamp the American health care system—the passage of Medicare legislation in 1965. Although much has changed since the 1960s, and

3. CITIZEN ACTION, UNHEALTHY MONEY XII: THE SPECIAL INTERESTS KILL HEALTH CARE REFORM (1994).

4. Robert J. Dole, *Who Killed Health Care Reform*, BOSTON GLOBE, Oct. 2, 1994, at 74.

5. Uwe E. Reinhardt, *The Health System as a Mosaic of Cost Centers*, Address to the Montgomery Dorsey Symposium (July 14-16, 1994).

lessons must be drawn cautiously, there are interesting parallels between the Medicare case and our recent experience.

Certain factors now cited to explain the failure of health care reform legislation in 1994 were clearly present during the debate over Medicare as well. One is the existence of powerful special-interest groups opposing the new health care program under consideration. The dominant interest group in health care policy during the 1950s and 1960s was the American Medical Association (AMA). Before the Medicare debate, the AMA had acquired an aura of invincibility as a result of its successful effort to kill national health insurance legislation during the late 1940s and early 1950s and its subsequent success in defeating Medicare legislation repeatedly during the 1950s.⁶ The AMA hired public-relations firms for lobbying efforts that at the time were unprecedented in scope and expense. During the 1960, 1962, and 1964 congressional elections, it made opposition to Medicare a key condition of financial support for candidates.⁷ As a lobbying group, the AMA of the 1960s would seem every bit the equal of the Health Insurance Association of America in 1994.

Second, American politicians and political institutions were not qualitatively different in 1994 from what they were in 1965. "Gridlock," questionable ethics, and eccentricity were at least as typical of our national legislature and legislators in the 1960s as they are today. In what seems a preview of recent events, the Medicare legislation passed in the Senate in 1964, then failed to pass in the House of Representatives and died in a deadlocked conference committee when Congress adjourned so that its members could return to their districts to campaign for the 1964 congressional elections. It has been argued that the repeated use of the filibuster to frustrate the passage of health care reform and other initiatives during the last Congress constituted a qualitative departure from previous congressional practice and elevated gridlock to a new level. However, the filibuster has been used repeatedly to block controversial legislation in the past, including civil-rights legislation throughout much of the 1950s. Furthermore, the record of the last Congress clearly illustrates that our national legislature remains capable of decisive action when the political consensus supports it. Congress did, after all, enact major new measures in the

6. RICHARD O. HARRIS, *A SACRED TRUST* (1969).

7. Robert G. Pear, *The Way It Used to Be*, N.Y. TIMES, Oct. 9, 1994, at 4.

areas of crime and foreign trade (the North American Free Trade Agreement and the General Agreement on Tariffs and Trade).

Though Chairman Rostenkowski may have been unavailable at a critical time during the recent health care debate, at least both he and his replacement as chairman of the House Ways and Means Committee, Congressman Sam Gibbons, were firm supporters of health care reform. In contrast, Wilbur Mills, chairman of Ways and Means during the critical years of the Medicare debate, was either opposed to or ambivalent about Medicare and blocked it repeatedly up until its final passage in 1965. His political career ended ignominiously in 1972 when he took a drunken midnight swim with a belly dancer in the reflecting pool of the Washington Monument. Russell Long, chairman of the Senate Finance Committee and heir to a Louisiana political dynasty with a shady past,⁸ was a firm opponent of Medicare and tried to prevent its passage at every turn.⁹

Nevertheless, despite the apparent similarities, there were also two important differences between the conditions prevailing during the Medicare debate of the 1960s and those of the health care reform debate of the mid-1990s. The first had to do with the talent and experience of the political team that championed the Medicare program. President Lyndon Johnson, a former Senate majority leader and legendary congressional tactician, has had few peers before or since as a master of the congressional process. Wilbur Cohen, assistant secretary for legislation in what was then the Department of Health, Education, and Welfare (now the Department of Health and Human Services), was responsible for drafting the Medicare legislation. He had worked for decades in the Social Security Administration, had drafted a number of national health insurance proposals and many other pieces of health care legislation, and was known and trusted by both Democrats and Republicans in the U.S. Congress. In other words, the effort to enact Medicare was led by a team of gifted professionals who knew from personal experience both the politics and the substance of the issues they were dealing with.

A second and even more important difference between the struggles to enact Medicare in 1965 and health care reform in 1994 concerns the strength and commitment of the political constituencies

8. See generally Curtis Wilkie, *Huey Long's Legend Lives on in Exhibit*, BOSTON GLOBE, Oct. 3, 1994, at 3.

9. David Blumenthal, *Medicare: The Beginnings*, in RENEWING THE PROMISE: MEDICARE AND ITS REFORM, 3, 19 (David Blumenthal et al. eds., 1988).

supporting the two initiatives. Medicare was supported, of course, by elderly Americans, who constituted then, as they do now, a very powerful voting bloc. Comprising members of every racial, ethnic, and socioeconomic class, the elderly were a group with whom many non-elderly people could identify. Many Americans had aging parents, and most expected to be old someday themselves. Elderly people's need for assistance was also clear and incontrovertible. In 1962, 50 percent of Americans over the age of 65 were completely uninsured against the cost of illness, and only half of those with health insurance had good coverage for hospitalization expenses.¹⁰ Furthermore, the potential strength of elderly voters had been fully mobilized by 1965. Elderly groups, Democrats, and organized labor had spent at least five years generating grass-roots support for the Medicare legislation.¹¹

The strong political support for Medicare was brought home to elected officials through data much more convincing than opinion polls. In the congressional elections of both 1962 and 1964, the American people ignored the AMA's opposition and elected majorities that favored the passage of Medicare legislation.

The political fundamentals of the Medicare situation contrast markedly with those of health care reform in 1994. The uninsured of 1994 constituted a much less cohesive and powerful potential voting bloc than did the elderly in 1965. Furthermore, today's insured Americans seem to have much more trouble identifying with the needs of the uninsured than did younger Americans with the needs of the elderly 30 years ago. Though advocates of health care reform correctly argue that any American could become uninsured, that risk seems much more hypothetical today than the prospect 30 years ago that parents would become ill or that young voters would be old someday themselves.

Most important, the apparent sacrifice required of insured Americans in 1994 on behalf of the uninsured was substantially greater than that demanded of the non-elderly on behalf of the aged in 1965. The enactment of Medicare required an increase in Social Security taxes. Meaningful health care reform today requires not only higher taxes but also changes in the organization and financing of health care that potentially affect the personal health care arrange-

10. PETER A. CORNING, U.S. DEP'T OF HEALTH, EDUC., AND WELFARE, *THE EVOLUTION OF MEDICARE . . . FROM IDEA TO LAW* (1969).

11. SHERI I. DAVID, *WITH DIGNITY: THE SEARCH FOR MEDICARE AND MEDICAID* (1985).

ments of all Americans. Since the great majority of Americans are currently insured and satisfied with their health care, this prospect is worrisome even for those who might otherwise support health care reform. The resulting anxiety provides an opening for special interests and political opponents of health care reform to create suspicion and uncertainty in the electorate.

In fact, the apparent success of interest groups in blocking health care reform during 1994 says more about the weakness of the political support for reform legislation than about the strength of the opposing groups. Complex social legislation such as Medicare or health care reform will always meet strong opposition from interest groups, who will work hard to sow seeds of doubt among the electorate at large. The critical question is whether those seeds fall on fertile ground. In 1965 the strong political support for Medicare rendered that soil hard and unreceptive. In 1994, however, the ground was soft and ready.

III. Lessons for Health Care Reform

The contrasting experiences of Medicare in the 1960s and health care reform in the 1990s suggest a number of lessons concerning the necessary conditions for health care reform and the strategies likely to create those conditions in the future.

The most important condition necessary for the enactment of federal health care reform legislation is the existence of a political constituency so strong and committed that neither special interests nor the inevitable bumps and detours of the congressional process will be able to block reform legislation. The generation of this constituency will require that middle-class Americans in large numbers become firmly convinced that health care reform, with all its attendant risks and uncertainties, is preferable to maintaining the status quo.

What will cause middle-class Americans to reach this conclusion? One requirement seems to be that the problems of our health care system will have to affect the personal lives of many voters who have not yet been touched by its deterioration. Millions of additional Americans will have to lose their health insurance, believe strongly that such loss is possible at any time, experience major erosion of their existing insurance benefits, or become dissatisfied with the health care they are receiving. Even if the spread of managed-care organizations in many markets were to accelerate this result, it would not occur overnight. It seems unlikely that the constituency needed for health

care reform will materialize for at least the next three to five years. When it does, Congress may not recognize its presence until health care has been a central issue in a congressional election and the public has elected majorities in the Senate and House that are committed unequivocally to health care reform. Given the results of recent congressional elections, the earliest this seems remotely possible is the election of 1998, but 2000 or 2002 seems more likely.

Though changes in the underlying realities of our health care system will be decisive in creating a constituency for health care reform, political leaders can affect the process in several ways. One way is by keeping the issue of health care reform before the public. Continued public debate will have the effect of familiarizing the electorate with the issue and, perhaps, reducing the public's fears of the changes health care reform entails. Medicare legislation had been the subject of electoral debate during three elections before it passed. In retrospect, it seems unrealistic to have expected the American people to embrace health care reform during the first congressional session that treated the issue seriously.

Public leaders should also stay alert to opportunities to build novel alliances in support of health care reform. The current market-driven upheaval in the health care system seems likely to create growing discontent among physicians; many already find the changes in private markets increasingly distressing. Such changes seem likely not only to reduce their incomes (notably for specialists) but also to require that physicians affiliate with large managed-care organizations in order to preserve access to patients. If physicians perceive such organizations to be limiting their clinical autonomy, they may turn to the public sector to provide protection against the real or imagined predations of these managed-care organizations, and federal health care reform may come to seem relatively more appealing. A decision by physicians' organizations, and especially the AMA, to support meaningful health care reform (as I defined it earlier) would go a long way toward defusing the public's concern that change will jeopardize access to and quality of care. The AMA's flirtation with so-called any-willing-provider legislation may represent the first of many attempts by physicians over the next decade to enlist the help of government in protecting themselves from hostile changes in the private health care system.

Finally, the president—whoever he or she may be at the time—must assemble the best possible team of health policy experts and

political tacticians to manage the process of enacting health care reform. This team should include people who have direct personal experience with every aspect of the policy process in health care: the politics of the issue, its interest groups, the drafting of health care reform legislation, the shepherding of it through Congress, and its implementation once enacted. Ideally, the team should include members of both parties or at least policy makers known and respected by congressional leaders of both parties.

There is an unfortunate tendency among some new presidential administrations to assume that all the work done before they arrive in Washington is flawed or inferior and that the people involved in that work have little to contribute to whatever new era seems to be dawning. The business of passing health care reform is too difficult, complicated, and precarious to permit indulgence in such a simplistic and naive approach to policy development and management.

Health care reform is not for the faint-hearted. The 1994 congressional session made that clear. An examination of the Medicare experience also suggests, however, that the American people will accept major changes in their health care system when the conditions are right. To achieve those conditions in the modern era, advocates will have to persist in educating the public about options for reform while waiting for Americans to conclude from personal experience that health care reform is worth its undeniable risks.