



# Obama and the Transformation of U.S. Public Policy: The Struggle for Health Reform

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**OBAMA AND THE TRANSFORMATION OF U.S. PUBLIC POLICY**

**The Struggle for Health Reform**

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“The *New New Deal* – What Barack Obama can learn from F.D.R. – and what Democrats need to do” was the feature story in the November 24, 2008 issue *Time* magazine, which hit the newsstands not long after the historic 2008 elections. A striking mock picture appeared on the magazine cover -- showing Obama wearing a fedora and riding F.D.R.-style in an open convertible car, a cigarette in a silver holder dangling from his grinning lips. The cover story caught the mood of the moment, as many commentators suggested that the nation’s first African-American President might have the potential to redirect U.S. public policies in a way comparable to the shift in direction marked by the New Deal of the 1930s. Put another way, it seemed that the Obama administration and the Democratic Party might begin to use public programs and tax measures to mitigate and reverse trends toward greater inequality that have marked American society in recent decades. Obama’s presidency could be pivotal in the same way as F.D.R. and Ronald Reagan before him, shifting the role of government in U.S. life.

In this article, we first examine why the Obama presidency seemed poised to redirect U.S. domestic policy and probe the forces working for and against the accomplishment of major transformations. After delineating the overall context, we consider in detail the case of health reform where, in a White House ceremony on March 23, 2010, President Obama capped a year-long uphill battle by signing into law the Patient Protection and Affordable Care Act -- legislation characterized by *New York Times* columnist David Leonhardt as “the federal government’s biggest attack on economic inequality since inequality began rising more than three decades ago,” because it trims tax breaks and business subsidies and taxes the wealthy to

pay for benefits that “flow mostly to households making less than four times the poverty level -- \$88,200 for a family of four people.”<sup>1</sup> The case study of health care reform tells us quite a bit about what it takes to shift U.S. public policies in the direction of enhancing security for lower-income and lower-middle-income Americans. Furthermore, we will look forward, pinpointing the obstacles remaining to the full implementation of Obama’s health reforms in a U.S. polity racked with partisan polarization and public anxieties about a prolonged economic downturn. Again, the health reform scenario reveals the contending forces at work in U.S. domestic policy today.

### ***Why Did Another New Deal Seem Possible?***

Let’s remind ourselves of how the political terrain looked in late 2008 and early 2009. There were a number of reasons to believe that the November 2008 election had opened the door to more than incremental or routine shifts in U.S. public policy and politics.

First, the election outcomes themselves were remarkable. Most elections for years prior to 2008 had ended up in virtual stalemates, virtually tied between Democrats and Republicans. But Barack Obama won quite decisively, especially for a Democrat in recent memory. His margin over John McCain was 53% to 46% in the total popular vote, and 365 to 173 in the Electoral College. At the same time, Congressional Democrats strengthened their margins in both the House and the Senate — carrying forward a partisan shift that started in 2006. The Democratic margin kept growing in the Senate, and eventually, mid-way through 2009, when the protracted court battles in Minnesota were finally settled, the Democrats plus

two Independents ended up with what the media trumpeted as a “filibuster proof” super-majority in the Senate.

The U.S. elections of 2006 and 2008 were also marked by the mobilization of new blocs of voters into greater participation, as well as enhanced support for the Democratic Party. Younger voters raised their level of engagement; African Americans turned out in droves to vote for the first African American presidential candidate; and Latino voters increased their level of participation and shifted toward a greater margin of support for Democrats. After the November 2008 election, commentators especially noted the age-gradient of partisan divisions, and trumpeted the Democratic Party, preferred by under-45-year-olds, as the party of the future.

Obama also enjoyed an advantage that has been underlined in the research of political scientist Stephen Skowronek on the sequence of presidencies across U.S. history.<sup>2</sup> Obama arrived at the presidency at a juncture when most Americans of all political persuasions were disillusioned with his predecessor, George W. Bush, and soured on the economic and foreign policy directions the country had taken under the sway of the Republican Party (which controlled both Congress and the Presidency from 2000 through 2006). For a change-oriented President, this is the ideal situation: to come to office backed by his own party after the country has “repudiated” his predecessor.

In addition, some analysts would say that it is good for a President who wants to use federal power vigorously to come to office during a deep economic downturn, when businesses and people are more open to government help. During the original New Deal, certainly, President Franklin Roosevelt the Democratic Party were able to do a lot amidst the massive Great Depression; and Barack Obama took

office just as an epochal financial meltdown was plunging the country into the Great Recession, the deepest economic downturn since the 1930s. Certainly, the advent of this crisis helped Obama and the Democrats build their margins of electoral victory against McCain and the Republicans in the 2008 election.

Finally, Obama came to office after being unusually straightforward with the public that he would seek to change the direction of federal social and fiscal policies. During the general election and the interminable Democratic Party primaries, Obama had actually spoken about redistributive issues in a way highly unusual for any Democratic Presidential nominee in recent memory. He talked quite frankly about the need to do more to help average Americans, and he didn't even back off from the proposition that rich families, making more than \$250,000 a year, should pay higher taxes. No Democratic presidential candidate since the ill-fated Walter Mondale has been willing to talk about raising taxes on anyone.

### ***Caveats and Obstacles to Change***

Even at the height of the hoopla over a possible "New New Deal," many members of the political science profession, especially numbers-crunchers, sounded notes of caution. It is a well-known regularity that electoral outcomes tend to swing back and forth, especially in midterm Congressional elections held when one party has control of the presidency and both Houses of Congress. Older, richer, and whiter voters, moreover, are the ones most likely to appear at the polls in mid-term elections – and these were, all along, the demographics least enamored of Barack Obama. In addition, it has long been well documented in survey research that Americans are ideologically cautious about strong government or governmental

activism. From the very beginning of mass surveys, researchers have noted that if you ask Americans abstract questions such as “do you believe in government or the market?” they favor the free market. If you ask them specific questions, such as “do you support Social Security, do you favor education payments?” and so forth, they tend to support active government. Americans have long been philosophical conservatives and operational liberals.<sup>3</sup> This remains true and means that, even if the public may approve of many steps taken by President Obama and the Democrats, the reflexive anti-government worries of Americans can also be invoked by the political opponents of new measures.

During the first few months of the Obama presidency it appeared that the optimists, those who thought that this was a moment for major changes, were probably right. Obama started out with sky-high public approval ratings, and quickly persuaded Congress to pass the American Recovery and Reinvestment Act (the so-called “Stimulus”) that was not as large or as bold as progressives wanted to see, but nevertheless injected nearly a trillion dollars into the economy and included “down payments” on new policy initiatives in education, clean energy production, and health care. In health care, the fledgling Obama Administration also quickly signed into law expansions of health insurance for children that had been vetoed under President Bush. What is more, the first Obama budget was a bold and readable document, not the usual snoozy bureaucratic treatise. It outlined a very broad vision of how the new President planned to address major issues in education, health care, and energy and the environment. It called for regulatory shifts and new directions in taxing and spending -- away from providing subsidies to favored private industries and tax cuts for the very wealthy; and toward broadening access to higher education, stimulating K-12 school reform, paying for health insurance for all

Americans, and encouraging a new kind of environmental and energy policy.

But from the early weeks of the Obama presidency, there were also signs that changing directions in these ways would not be easy. With the national economy plunging into recession, the Republican Party nevertheless decided to go all-out in opposition to Obama's leadership. The White House devoted a major portion of the original Stimulus legislation to tax cuts for business, but in return got virtually no votes from Congressional Republicans, even as their home states clamored for fiscal relief. As the months went by, Republican opposition hardened – and grassroots populist movements arrayed under the banner of the Tea Party took to the streets to excoriate the President and federal initiatives being debated in Congress.

Though the press has emphasized Obama's "supermajority" in the Senate, the Democratic majority was remarkable only by quite recent standards. Throughout his presidential term, Jimmy Carter had a stronger Senate majority than Obama, and Clinton started his first term with 57 Democratic Senators. FDR and Lyndon Johnson had much larger majorities to work with when they pushed through far-reaching social programs – though back then, of course, many Democrats were southern conservatives. In any case, almost a year to the day after he was inaugurated, Obama watched his nominal supermajority disappear, as Tea Party darling Republican Scott Brown scored an upset victory to take the Senate seat formerly held by deceased liberal champion Ted Kennedy. This happened in the nation's most liberal and reliably Democratic state, and blue-collar workers disaffected by a sluggish economy and worried about health reform bills being debated in Washington DC gave more of their votes to Scott Brown than to the Democratic nominee. Apparently, the "New New Deal" that appeared possible in early 2009 was dead in its tracks by early 2010. And this included comprehensive



health reform, which had been debated in Congress for nine months and was on the verge of final enactment when Scott Brown won the Massachusetts Special Election and promised to go Washington and block final passage (as the 41st Republican vote needed to sustain a filibuster in the Senate).

### ***Comparing Two New Deal Periods***

Comparisons across time to that first New Deal can further deepen our sense of the obstacles Obama and the Democrats of 2009 and 2010 face. A crucial difference has to do with the timing of economic crisis relative to the arrival of a change-oriented Democratic president in the 1933 versus 2009. FDR took office several years into the Great Depression, when the U.S. economy was at a nadir, some 25% of Americans were unemployed, and the nation was begging for strong federal action. But Obama took office amidst a financial crisis and just as a massive recession was starting. Because FDR took charge at a moment of despair, Congressional Democrats and Republicans alike, southerners and northerners alike, voted for emergency bills he proposed before they even saw the written texts!<sup>4</sup> In contrast, Obama's steps to spur recovery met a nearly universal wall of Republicans in Congress determined to "just say no" to anything he favored.

This was a cold-blooded political bet by Republicans, made possible because the Great Recession was just starting, and came on the heels of Wall Street bailout undertaken by the outgoing Bush administration. The bailout was unpopular, and Congressional Republicans, who had largely supported it under Bush, nevertheless saw a chance to pin the bailout on Obama (indeed to try to convince the public that the bailout and the stimulus were one and the same). Republican strategists also

knew that unemployment was starting to skyrocket, and would remain high for a long time. If unemployment were to remain high all the way to November 2010, Republicans hoped to position themselves as the only alternative to Democrats. They did not want to be partners in early recovery steps. For Obama, it was as if he had to hold hands with Herbert Hoover, because of the timing of the economic downturn relative to his inauguration, and because his administration was of necessity involved in the early steps to stabilize Wall Street. Obama and the Democrats ended up facing the anxiety of Americans over a steep and stubborn Great Recession, without benefiting from the sort of boost in support for federal activism that FDR and his Congressional allies enjoyed at the depths of economic troubles in the 1930s. Obama also inherited a huge federal budget deficit from George W. Bush, who waged wars and expanded Medicare benefits at the same time that he pushed through a huge tax cut for the wealthy. Deficit worries have only grown under Obama, given the price tag of the economic recovery measures more or less forced upon him.

The partisan and media climates of the mid-1930s versus 2009-10 also differed in telling ways. Both FDR and Obama are presidents who tried to use the new technologies of their time to talk directly to the American people. Facing nearly unanimous opposition from the editorial boards of major newspapers, FDR used those “fireside chats” on the radio to get into the ears of ordinary Americans very regularly. President Obama has used YouTube presidential addresses that watched each week by millions of Americans at the click of a computer; and he has used television appearances or interviews to reach people and get around much of the reporter filter in other ways. But here the similarities end, because Obama faces a fragmented media environment that gives voice to extreme voices very easily. And

partisan polarization along divide between Republicans and Democrats as such is much more extreme now than it was in the 1930s. Back then, there were liberal Republicans and, of course, a large bloc of conservative Southern and Midwestern Democrats. Now conservatives and liberals are almost entirely sorted out along party lines. This does matter, because today's multiple media outlets look for extreme voices and controversy, and even mainstream outlets look for "balance" between the two parties. The end result is that Obama's White House faces a constant cacophony of highly publicized right-wing condemnations, above all on Fox News, combined with efforts by other outlets to balance every Democratic voice with a Republican voice. Democrats moreover, encompass a wide spectrum, from conservatives through centrists to liberals, while Republicans are overwhelmingly – and increasingly – militant right-wingers. From the very beginning, Obama faced opponents who had both the means and the will to disseminate colorful and vivid messages in opposition to him and to his party very quickly.

The biggest difference between the 1930s and now – and the one that matters most as we move toward analyzing the effort to do health care reform – has to do with the nature of preexisting domestic policies. Back in the 1930s, the New Dealers in Congress and in the FDR Administration were advocating new kinds of federal government interventions—financial regulations, social policies like minimum wage and maximum hour rules, benefits like Social Security, unemployment insurance, and welfare payments, and new rights for labor unions to organize. Previously, the U.S. federal government had become very active in economic and social affairs only temporarily during major wars, so the New Dealers, amidst a massive Great Depression, were advocating a series of innovative permanent peacetime interventions. They were selling new ideas in an emergency. But think about the

contrast for any fresh New Deal now. Obama and his Democratic majorities promised new frameworks for the U.S. economy and social programs – but not first-time interventions. They came to office following a half-century of previous accretions of pervasive regulatory and fiscal interventions into society and the economy.

You can turn on the television almost any day and hear pundits declare that we in the early twenty-first century are fighting about “government” versus “the market.” But this is nonsense. Over the past six decades, Democrats and Republicans alike in Washington D.C. have sponsored and presided over more or less steady increases in taxes and tax subsidies, regulatory interventions, social spending, and the like. Both parties have participated in the building up of a massive, ramified, expensive, and pervasive subsidy and regulatory state.<sup>5</sup> It is true that Democrats on the margin tilt the tax advantages and the subsidies to the working and middle class, and it is certainly true that Republicans since 1980 have mainly tilted those subsidies and advantages toward favored industries and very wealthy taxpayers. But neither party has really cut back. Every region of the United States, and every industry and social stratum, has a stake in some aspect of existing federal interventions into the economy and the society.

So when a change-oriented president like Obama arrives in Washington aiming to transform, in some big way, the scale and redistributive impact and the import of federal government interventions, he is not starting from scratch like FDR and the New Dealers did. He is redirecting resources, asking some people who are already the beneficiaries of regulatory advantages, governmental subsidies or benefits, or tax breaks to accept less. Those asked to give up something will be quite alert to their potential disadvantage, and quick to mobilize against change -- while

people who might benefit from rearrangements in some hypothetical future are likely to be skeptical, and certainly not yet concretely accustomed to the new advantages they could enjoy. The disparity of mobilization only becomes worse when the previously advantaged are wealthier and/or better organized, while the potential beneficiaries are lower or lower-middle income Americans who may not even vote regularly.

This dilemma has bedeviled the Obama project from the very beginning, although there are some policy realms where change has been a bit easier than in others. Obama's promise to end the Bush Jr. tax breaks for the very wealthy did have a certain advantage – to carry it out, all that was required was for Congress to take no action, because a number of the original Bush tax-cut provisions were set to expire automatically. Even so, it is hard for Obama to keep even Democrats in Congress from voting to extend tax breaks to wealthy supporters. Yet he must do so if he is to have any resources to shift toward tax cuts or benefits for the majority of Americans. By contrast, in most of the policy areas where Obama aims to move federal policies in new directions, he cannot not just use “expiration dates” to get things done. Especially if he wants to control costs, he necessarily must propose higher taxes on the privileged or cut backs in subsidies or benefits to entrenched interests, in order to free up resources for new social measures.

Take higher education loans, for example.<sup>6</sup> The United States has fallen to tenth or eleventh place in the proportion of our youthful population who earn college degrees, and in large part this is because the cost of college is too high, or too unpredictable, for lower-income and lower-middle-income families. Over recent decades, moreover, federal higher education subsidies, and state subsidies too, have been diverted toward middle class families and away from grants to lower-income

students. Federal monies have also been used to subsidize guaranteed profits to middleman banks who lend to students. If students, after college, fail to repay their loans, the federal government picks up the cost. So banks enjoy guaranteed profits. A key Obama administration proposal was to get rid of these guaranteed profits to private bankers, and have the government deliver loans directly to students through the colleges. This would save tens of billions of dollars a year – and Obama proposed to use the savings to make Pell Grants and lower-cost loans more available to less privileged Americans, and to subsidize community colleges. In a way, this was a simple idea, almost a no-brainer. Save money wasted on banks that provide very little public benefit, and redirect the resources toward expanded social opportunity. But, of course, banks and their supporters in Congress were strongly opposed to giving up subsidized profits! For many months, this Obama administration proposal was stalled in Congress -- unable to overcome a Senate filibuster, because conservative Democrats like Senator Ben Nelson of Nebraska were determined to join Republicans in opposition, in order to defend the established subsidies enjoyed by private lenders prominent in their states. (In the end, a version of student loan reform passed only because, as we describe below, it was bundled with the final steps in health reform in a bill that could pass the Senate as well as the House by simple majority.)

The instance of higher education funding makes it easy to understand how difficult it is to legislate even a modest redirection of existing federal expenditures, away from subsidizing privilege and toward expanding opportunity. It does not matter how “logical” such a shift seems; it is much harder than creating a new federal program in the first place. At this point in U.S. history, any fresh New Deal involving redirection of federal interventions in an equality-enhancing direction is a

much more fraught undertaking than an original New Deal. Many additional examples of such dilemmas appeared in the 2009-10 struggle for comprehensive health care reform, to which we now turn.<sup>7</sup>

### ***Enacting Comprehensive Health Reform in an Entrenched System***

Before 2010, powerful entrenched interests had defeated health care reform in America for almost one hundred years. The first attempt at broad health insurance was in the 1910s, scotched by the insurance companies and the American Medical Association (AMA). The second opportunity came in the 1930s, when Roosevelt considered including health insurance in the Social Security legislation. It was left out because the AMA again mobilized against it. Harry Truman's effort to pass "compulsory health insurance" – probably not the best label – was derided as socialism. The next effort was in the 1960s, when reformers decided to start on universal insurance by providing coverage for the elderly. This bill faced less opposition because the insurance companies didn't really want to cover expensive, older, sick people – but Medicare did not lead to insurance for everyone. In fact, it pulled a major voting bloc, seniors, out of the fight for reform and gave conservatives a new scare tactic, convincing the elderly that Medicare might be cut back to pay for other people. In the 1970s, under Nixon and Carter, Democrats refused to accept a better deal than they would get now. And then there was the spectacular failure in 1993-94 under Hilary and Bill Clinton, which led to a Republican takeover of the Congress.

Thanks to this century of failed reform, the United States has been left with a system that is very unusual by international standards. Between the late 1800s

and the end of World War II, most other advanced-industrial nations created systems of universal health insurance coverage. In America, a patchwork of policies leaves more than 46 million Americans uninsured. Most working-age people get their health insurance through their employers, while federal programs provide coverage for the elderly, the poor and near-poor, and for military veterans. And we pay an enormous premium for this inefficient, piecemeal system. The United States spends about twice as much per person as other industrial countries do on average, and more than fifty percent more than the next-biggest spender, Switzerland.

The complex system also disguises high risks. For doctors, getting paid requires filling out thousands of forms, without the certainty that an insurer will agree to pay. Hospitals have to cope with an unpredictable influx of uninsured people who appear in their emergency rooms. And many Americans, even those who are insured, face the risk that an illness can wipe out the family savings. In fact, catastrophic health care costs are the leading cause of bankruptcy in America.

Despite the complexities and costs of the existing private and public patchwork that makes up the nation's health care system, Democrats were committed to modifying the system rather than replacing it root and branch. Many supporters of health reform would prefer a "single payer" system like Canada's, where the government handles all payments for health services delivered by private doctors and hospitals. Democratic Presidents and elected officials may agree that such a system would be more efficient and less costly in principle, but in practice they are not prepared to disrupt existing arrangements between employers and private insurance companies (which are major employers in their own right). So Democrats since the 1970s have advocated reforms in existing arrangements. But preserving the employer core of the system also means taking a very mature system



and simultaneously trying to improve its efficiency while expanding its reach. It means trying to squeeze out the resources to cover the uninsured, while readjusting existing institutions to operate more effectively and at lower cost.

This is a heavy lift politically. Most Americans do not believe that you can pay for forty-six million more people and save money at the same time. No health economists will convince them otherwise. Even more telling, many powerful groups and economic interests have a stake in the current broken system – where one person’s waste is another’s cherished benefit or corporate profit. Insurance companies, pharmaceutical manufacturers, and hospital systems all find aspects of the current health system very profitable, indeed. Unions, too, have a strong incentive to protect the very expensive health plans that generations of workers had fought for. During the health reform battles of 2009 and early 2010, each of these powerful lobbies could stand in the way of critical legislative provisions. And each interest found it easy to run advertisements preying on public skepticism and aiming to convince people that reform would negatively affect their own health care.

The challenges of a health care fight were certainly clear in the minds of the Democrats in Congress and in the White House, especially those who had lived through the failed reform of the Clinton years.<sup>8</sup> One could easily imagine, particularly given the deepening economic crisis, that health care would get pushed from the top of the agenda. And yet Obama declared during the campaign and early in his presidency that he would make health care reform a priority in his first term. This was a long-standing Democratic Party priority, and the competition with Hillary Rodham Clinton in the Democratic primaries had cemented this issue as something that Obama had to act on in year one. Within the White House, moreover, fixing health care was perceived as a necessary component of a larger plan to put the

federal budget in order. So in the early weeks of President Obama's administration, the decision was made to move forward with comprehensive health care reform – tackling expanded access and cost controls at the same time.

The Obama Administration approached health care reform with a three-part strategy. First, the White House outlined only general, popular principles to define what health care reform would look like, and left the details to Congress. Second, the Administration tried to sideline the likely opponents of new health care legislation by protecting or replacing some of the profits threatened by reform. Finally, the Administration focused on the financial aspects of health care reform, promoting far more specific proposals about how to *pay for* health care reform than how to *implement* it. Each of these strategies was designed to promote comprehensive reform in an environment of entrenched opposition.

Featuring broad principles was an attempt to avoid “fighting the last war.” When President Clinton had sought health care reform, the Administration had assembled a 500-person presidential commission headed by Hilary Rodham Clinton, and presented a 1,342-page document to the Congress in the fall of his first year in the presidency. The plan was so complex that nobody could understand it – except the people who were going lose out under the new system, and they mobilized very effectively against it. Not only did the entire reform get nixed – legislation did not make it out of a single committee – but the debacle helped sweep the Republicans into Congress in the fall of 1994. Determined not to repeat that mistake this time, Obama decided instead to give speeches outlining broad, popular principles—health care for more people, insurance that is more reliable, cost containment for business and lower prices for families, and better benefits for the uninsured and the elderly. When it came to specific provisions – such as an individual mandate requiring

everyone to purchase insurance; expansions of Medicare; or the so-called “public option” to set up competition between public and private insurance plans for working-aged Americans – the Administration left the fight to Congressional Democrats. The aim was to let Congressional committees work out compromises that could actually pass the House and the Senate.

The Obama Administration did intervene, however, to try to manage and defuse longstanding interests opposed to health care reform. On March 5, 2009, the White House held a forum on health care reform that included representatives from insurance companies, doctors and hospital groups, and the pharmaceutical industry. In their talks with health sector representatives, the White House had some leverage. Health care reform held risks for industry groups, particularly to the extent that it held down medical spending – but it also held new opportunities for profits. To the extent that reform insured more Americans, it also opened up a new customer base. So the Obama Administration worked with the health care sector to get them on board with reform; and the strategy worked to a considerable degree. By May 2009, six major advocates in the health care industry signed onto a letter nominally supporting reform of health care and offering some voluntary cost-cutting measures.<sup>9</sup> Though they continued to lobby actively to increase their profits under the new reform, these interests did largely avoid the kind of public opposition that derailed the Clinton health care reform.

The Obama Administration also had some success getting concessions from popularly based interest groups. The Obama Administration worked with AARP to ensure seniors saw benefits from health care reform, including the closure of the gap in Medicare prescription drug coverage known as the “donut hole.” After a great deal of effort, the Administration also convinced the unions to accept some very

limited taxes on the most expensive health care plans – a policy Obama himself had opposed during the campaign. The White House insistence on including some kind of “Cadillac tax,” as this measure was called, was partly about raising revenue to finance reform, and even more about creating credible cost controls for the future.

When it came to asking for other kinds of financial concessions to help cover the cost of extending insurance, the Obama Administration had failures as well as successes. For instance, early in 2009, Obama proposed to equalize the charitable tax deduction for wealthy people and less wealthy people; this would reduce Treasury losses currently incurred when the wealthy are giving more generous deductions for their charitable giving. Again, as with higher education reform, this might seem a logical step to take to squeeze out more resources to help provide health insurance for all Americans. But even though the research shows that most wealthy people would give almost as much to charities with or without a special deduction, that didn’t matter.<sup>10</sup> Democratic constituencies in the nonprofit community nixed that policy right from the get-go. This was a clear-cut instance of supposedly “liberal” groups fighting to retain privileges, even if that meant less money to help lower and middle-income Americans. The dilemma of reforming an already established system does not just pit liberals against conservatives, or against business, but liberals against liberals – as demonstrated by both the fight with the unions over the Cadillac tax, and the fight with nonprofits over upper-income charitable deductions.

So far, we’ve seen two strategies from the Obama Administration that served to appease entrenched opponents of health care reform: compromise with major opponents and flexibility on the structure of reform. Overall, however, the Obama administration intervened more specifically and more often when it came to paying

for reform, and adding up the costs and revenues. The White House had to make adjustments repeatedly, but they paid continuing attention to the total price tag and the sources of savings or revenues to pay the costs of reform.

For a number of reasons, the “number crunchers” played a prominent role in guiding Obama Administration strategy during the battle for health care reform. The memory of the Clinton reform effort led White House strategists to emphasize the importance of the Congressional Budget Office (CBO), the nonpartisan federal agency tasked with calculating the budget impact of legislative proposals. A bad (that is to say, high-cost) CBO “score” can be a death knell for bills in Congress. Moreover, a key player in the Obama cabinet was Peter Orszag, the former CBO director who now runs the White House’s Office of Management and Budget (OMB). Orszag’s significance in the health care debate was only increased by his relatively rapid Senate confirmation at the start of the Obama Administration, as Obama’s first nomination for Director of Health and Human Services, Tom Daschle, foundered.

When it came to financing health care reform, Obama was quite specific in his recommendations. The first Obama budget, released at the end of February 2009, included more than \$600 million in new taxes and cost-cutting measures, intended as a “down payment” on health care reform. In June, Obama sent a letter to Senate committee chairmen Max Baucus and Edward Kennedy, in which he spoke in the broadest terms about what benefits should be included in health care reform, but explicitly outlining the budget cuts and tax increases he would recommend to pay for the bill. For instance, when it came to whether to include an individual mandate requiring people to have health insurance, Obama told the Senators he was “open” to their ideas. But regarding cuts to Medicare spending, Obama specifically

reiterated his budget recommendations, and called for “another \$200 to \$300 billion” in cuts on top of his earlier recommendations.

Focusing on the financing side of health care reform had important strategic consequences. First of all, the cost-cutting provisions helped identify up front which entrenched interests were going to lose out in order to make health care reform affordable. Obama’s advocacy on the funding sources also provided Democrats in Congress with support in the face of heavy industry lobbying, and cleared the way for negotiations. Perhaps more important, setting a benchmark in terms of savings also created the room for some significant expenditures, and therefore expanded the scope of possible reform.

[Figures 1 and 2 about here]

Though progress was painfully slow, the Obama strategy – setting out principles, providing a lot of behind-the-scenes budget advice, and letting Congressional committees do their work – seemed to be proving its worth by late 2009. Relatively similar bills were passed in November by the House, and then, finally, just before Christmas, by the Senate. As Figures 1 and 2 spell out, although there were differences between the two houses and between their bills and what the White House originally outlines, the final House and Senate bills met most of the principles the President laid out at the start of the battle for health care reform – increased affordable coverage, support for small businesses, an end to insurers’ most abusive practices, and a national exchange to encourage insurer competition. The House bill was generally considered more liberal – it included a public option, more generous benefits, and higher taxes on the privileged. But both bills fell relatively

close to the promises Obama had made during the campaign. As of the end of 2009, it looked as if comprehensive health reform would soon appear on the President's desk to be signed into law, after a few compromises were worked out between the House and the Senate early in 2010.

### ***How Scott Brown Threatened – and Then Strengthened – Health Reform***

Yet even this close to success, reform very nearly did not happen. In mid-January 2010, a special election was held to fill the Senate seat held for decades by a liberal champion of comprehensive health reform, Ted Kennedy of Massachusetts, who died in the late summer of 2009. The election occurred just after unseemly deals were struck to get sixty votes to break a filibuster in the Senate, and at a time when Americans were increasingly angry about the deep economic downturn. Facing an inept Democratic opponent, Scott Brown promised to oppose costly deals in Washington DC and offered to protect Massachusetts, which already has universal health insurance coverage, from having to pay for benefits for people in other states. Brown won amidst low Democratic turnout, and with considerable support from blue collar workers – whose union leaders had spent the previous month complaining about health reform provisions that might reduce insurance benefits for unionized workers. The union leaders persuaded the White House to scrap most of these provisions, but the word did not get around before the Massachusetts election.

After the surprise election of Scott Brown in Massachusetts, it looked very possible that, once again, as repeatedly over the past century, health reform would fail. Because of the threat of the filibuster, an evolution of Senate procedure beyond the original Constitutional scheme, major legislation required a 60-vote

supermajority to move forward.<sup>11</sup> Brown's election made him the 41st Republican, which all in his party pledged to vote against reform.

For a time, the Democrats seemed paralyzed, despite their still sizable majorities in the House and the Senate. In due course, however, the Brown victory in Massachusetts spurred Democrats to cooperate to finish a bolder and more comprehensive health reform. Provoked in part by the announcement of huge insurance rate hikes – which reminded the public of the need for some new legislation to rein in insurance companies -- the President took the lead at a public health care summit convened in late February 2010. For the first time, President Obama advocated a fully fleshed out legislative approach – not coincidentally, including the very provisions that the House and Senate bills already agreed upon. In taking responsibility for finishing health care reform, Obama gave the Democrats in Congress the cover they needed to put together a negotiated agreement between the House and Senate Democrats.

Under the agreement they reached, the House would vote for the Senate's version of the bill, and then pass a second "sidecar" bill that included a list of agreed-upon fixes and improvements. The House Democrats received a public promise from more than 50 Senate Democrats to support the sidecar bill, which they could pass with less than 60 votes by a process known as "reconciliation." An established procedure by which fiscal bills can avoid filibusters, reconciliation has been used repeatedly by Republicans to pass tax cuts and other policy priorities.

Ironically, the election of Scott Brown gave Congressional Democrats the leeway to use reconciliation -- and this meant that a more progressive reform could be enacted by majority, not supermajority, votes. Though the reconciliation procedure did not allow changes in administrative or regulatory aspects of the



health reform bill passed by the Senate in late 2009, it did enable adjustments in fiscal matters. In addition to removing a number of special deals – such as the Cornhusker Kickback that the Senate had used to get Ben Nelson’s vote in December 2009 -- the sidecar bill reduced and delayed the “Cadillac tax” on generous employee health plans, increased taxes on health care industries, and imposed higher taxes on the wealthiest Medicare beneficiaries. The final bill also folded in the student loan reforms that had previously be stalled by the Senate filibuster. This had the effect of moving federal dollars from the pockets of bankers to the students they were intended to help in the first place – and it also allowed some of the savings from reduced bank subsidies to be used to cover health reform costs and reduce the long-term federal budget deficit. Thanks in part to this progressive measure, the Congressional Budget Office projected that health care reform would actually cut the federal deficit. The final health reform bills passed in late March 2010 had a much stronger redistributive component than the Senate legislation passed in 2009. Scott Brown’s election therefore backfired on the political intentions of his promoters, because it not only failed to prevent the enactment of health reform, it made it more generous toward average Americans, and shifted costs toward the wealthy.

After some intricate maneuvering by Senate Majority Leader Harry Reid and House Speaker Nancy Pelosi, the House and Senate Democrats finally had the votes to pass health care reform – without the support of a single Republican. The House passed the Senate’s health care reform by a vote of 219-212, and the sidecar bill by a vote of 220-211. The Senate, after a week of wrangling and delays, passed the reconciliation bill by a vote of 56-43. On Tuesday, March 23, 2010, several hundred people crowded into the East Room of the White House to watch President Barack

Obama sign into law the Patient Protection and Affordable Health Care Act. One week later, he signed the sidocar bill, and comprehensive health care reform was finally complete. It was a major victory for Obama, who had declared at the very start of his campaign for the presidency, “I will judge my first term as president based on the fact on whether we have delivered the kind of health care that every American deserves.”<sup>12</sup> The enactment of comprehensive health reform was also extraordinary against the backdrop of the previous century of failed efforts to accomplish similar changes in U.S. health care.

### ***The Next Fights Over Reform Implementation***

In many ways, of course, the enactment of the new laws in March 2010 marked a beginning, not an end, a promise of accomplishment, not a fait accompli. Like Social Security and Medicare, Affordable Care is likely to face obstacles and redirections long after passage of the legislation itself. Looking at the response so far to the passage of health care reform, we can discern the likely outlines of the upcoming battles over implementation.<sup>13</sup>

After a year of confusing and ugly legislative wrangling, the public’s support for the new legislation is lukewarm, while on the far right, there is significant motivation to repeal the legislation entirely. Analyst Nate Silver looked at multiple national polls conducted after the passage of health care reform and concluded that the bill itself had received a small bump in support, and that Democrats were doing “marginally better,” at least in comparison to their terrible approval rates as health care appeared to stall out.<sup>14</sup> There was no overwhelming shift in support towards

the new health care law, nor towards its proponents. Among the conservative base, however, the repeal of health care reform quickly became a rallying cry.

Within hours of the passage of health care reform, more than a dozen conservative state officials, most of them candidates for office in fall 2010, rushed to court to argue that the new laws are unconstitutional. Republicans in Congress promised their supporters a complete repeal of the new legislation. For the midterm election, when turnout is heavily dependent on the party faithful, this could be an effective strategy. In any case, the history of incumbent losses in midterms suggests that the Democrats are almost guaranteed to lose seats in 2010, particularly in light of the struggling economy. A motivated Republican base could hand a major loss to Congressional Democrats, perhaps large enough to cede control of the House or the Senate to the Republicans, or at least spook conservative Democrats into derailing health care implementation.

By the summer of 2010, cautious majorities of the American public seem more amenable to “wait and see” than total repeal – and many concrete steps have already been taken to implement Affordable Care through negotiations between the Obama administration and health insurance companies. Even if Republicans win resoundingly in the fall 2010 Congressional elections, President Obama would veto any outright repeal legislation. Presumably, Republicans can elect a President in 2012 and then try to repeal Affordable Care. But by then, many Americans will be used to new insurance regulations that protect patients; young Americans will enjoy staying on parental health plans until age 26; older Americans will enjoy enhanced prescription drug coverage under Medicare; and millions of lower and lower-middle income Americans will have health coverage through Medicaid or by purchasing plans on the new health insurance exchanges. Some Republican strategists have

worried publicly that pushing a repeal might alienate more moderate voters, especially after the quick implementation of more visible and popular provisions.<sup>15</sup>

Instead of repeal, gradual chipping away at tax and regulatory and benefit provisions is more likely. Many of the most redistributive policies in the health care reform package do not come into effect until 2014. It is not impossible that the tax increases on the wealthy and the subsidies for lower-income Americans could shrink before they are ever delivered, if Congresses dominated by Republicans, or by Republicans and conservative Democrats, take a series of quiet actions to modify the reform framework enacted in 2010.

In the end, much of the fight over implementation is likely to happen in a less-visible arena: the states. Affordable Care, in its final version, called for state-level health insurance marketplaces, rather than creating a national exchange. In states dominated by conservatives, and where administrative capacity is weak, it will be relatively easy for lobbyists to undercut Affordable Care's new consumer protections. On the other hand, in states with strong progressive majorities, it may be possible to create highly effective health insurance exchanges that can serve as models to other states. The effectiveness of the health insurance exchange provision, therefore, is likely to vary across state lines – and it may be many years before we know whether particular state solutions to widespread problems of access and cost can serve as a model for additional states or the nation as a whole.

### ***Conclusion***

How ever the future implementation struggles play out, the passage of Affordable Care in 2010 is a remarkable achievement – enough to make a least a

partial case that Barack Obama and the Democrats in Congress during 2009 and 2010 *have* fashioned parts of another New Deal. In a highly partisan atmosphere, in the midst of a burgeoning economic crisis, and with comparatively small majority compared to other Democratic presidents who have pushed through major social reforms, Obama sailed through a sea of entrenched interests and secured a wide-ranging and remarkably progressive health care bill, a bill that draws resources from the privileged to spread access to affordable health insurance to most of the U.S. citizenry. But Affordable Care is a blueprint far from fully implemented, and the bitter politics of comprehensive health reform continues. In the coming months and years, we will see to what extent the promise of Affordable Care can be made a reality.

## END NOTES

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- <sup>1</sup> David Leonhardt, “In Health Bill, Obama Attacks Wealth Inequality,” *New York Times*, March 23, 2010.
- <sup>2</sup> Stephen Skowronek, *The Politics Presidents Make: Leadership from John Adams to Bill Clinton*, Cambridge, Mass.: Belknap Press, 1993.
- <sup>3</sup> Lloyd Free and Hadley Cantril, *The Political Beliefs of Americans* (New Brunswick, NJ: Rutgers University Press, 1967).
- <sup>4</sup> James T. Patterson, *Congressional Conservatism and the New Deal* (Lexington: University of Kentucky Press, 1967), chapter 1.
- <sup>5</sup> See Paul Pierson and Theda Skocpol, editors, *The Transformation of American Politics: Activist Government and the Rise of Conservatism* (Princeton, NJ: Princeton University Press, 2007).
- <sup>6</sup> Shailagh Murray, “Proposals Would Transform College Aid,” *Washington Post*, May 4, 2009; and David M. Herszenhorn, “Obama’s Student Loan Overhaul Endangered,” *New York Times*, March 11, 2010.
- <sup>7</sup> The following account is further elaborated and documented in Lawrence R. Jacobs and Theda Skocpol, *Health Reform and American Politics: What Everyone Needs to Know* (New York: Oxford University Press, 2010).
- <sup>8</sup> Theda Skocpol, *Boomerang: Health Reform and the Turn Against Government* (New York: Norton, 1996).
- <sup>9</sup> Karen Tumulty, “Health Care: The Industry Steps Up. Maybe.” *TIME*, May 11, 2009.
- <sup>10</sup> Paul N. Van de Water, “Proposal to Cap Deductions for High-Income Households Would Reduce Charitable Contributions by Only 1.9 Percent,” Center on Budget and Policy Priorities, March 31, 2009.
- <sup>11</sup> Binder, Sarah A. and Steven S. Smith. *Politics or Principle? Filibustering in the United States Senate*. Washington, DC: Brookings Institution, 1997. p. 33.
- <sup>12</sup> Transcript of “New Leadership on Health Care: A Presidential Forum,” Cox Pavilion, Las Vegas, Nevada. Saturday, March 24, 2007, 9:15 a.m.

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<sup>13</sup> This brief discussion draws on an article by Theda Skocpol about the politics of health reform implementation in press for the July 2010 issue of *Health Affairs*.

<sup>14</sup> Nate Silver, “Are Democrats Better Off for Having Passed Health Care? Yes – and No.” Fivethirtyeight.com, March 25, 2010.

<sup>15</sup> Christina Bellatoni, “Republicans Back Off Health Care Repeal Pledges,” TPMDC, April 1, 2010

## The Trajectory of Health Care Reform: Major Benefits

|   | <b>OBAMA PLAN</b>   | <b>HOUSE BILL</b>  | <b>SENATE BILL</b>  | <b>FINAL LAW</b>  |
|---|---|--|---|---|
|   | Drawn from Obama's platform as a presidential candidate <sup>i</sup> and his proposals during his first six months as president.  | HR 3962: Affordable Health Care for America Act<br>Passed: 11/7/09   | HR 3590: Patient Protection and Affordable Care Act<br>Passed: 12/24/09   | PL 111-148: Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act                          |
| <b>Universal Coverage</b><br><i>Overall increase in coverage from the current rate (83% of legal U.S. residents under 65).<sup>ii</sup></i> | In his campaign, Obama called for a mandate that all children have health care coverage. His FY2010 budget proposal suggested that health care reform should "aim for universality." <sup>iii</sup> | 96% covered.   | 94% covered.  | 95% covered.  |
| <b>Competition to Make Care More Affordable</b>   | Obama supported the creation of a National Health Insurance Exchange, and the establishment of a public insurance program. <sup>iv</sup>  | Sets up a national insurance exchange marketplace.<br><br>Includes a public option to compete with private health insurance plans.<br><br>Would remove the health industry exemption from antitrust legislation. | Sets up state-based insurance exchange marketplaces.<br><br>Does not include a public option or remove the health industry antitrust exemption. | Sets up state-based insurance exchange marketplaces.<br><br>Does not include a public option or remove the health industry antitrust exemption. |

Strongest Provision    Weakest Provision



|  | <b>OBAMA PLAN</b>  | <b>HOUSE BILL</b>   | <b>SENATE BILL</b>   | <b>FINAL LAW</b>  |
|--|--|---|--|---|
| <p><b>Support for Low-to-Middle Income Americans</b><br/> <i>The federal poverty line (FPL) was set in 2009 at \$10,830 for a single person and \$22,050 for a family of four.</i></p> | <p>As a candidate, Obama called for the expansion of Medicaid and SCHIP programs. In addition, under his plan, "individuals and families who do not qualify for Medicaid or SCHIP but still need assistance will receive income-related federal subsidies to keep health insurance premiums affordable."<sup>v</sup></p> | <p>Expand Medicaid to all under 65 with incomes up to 150% of the FPL.</p> <p>To families with incomes between 133 and 400% of the FPL, provide tiered premium credits so families contribute between 3 and 12% of income to paying for insurance, and subsidies to cover up to 97% of medical costs.</p> | <p>Expand Medicaid to all under 65 with incomes up to 133% of the FPL.</p> <p>To families between 133 and 400% of the FPL, provide tiered premium credits so families contribute between 2 and 12% of income to paying for insurance. To families between 100 and 200% of the FPL, provide a sliding scale of credits to cover up to 90% of medical costs.</p> | <p>Expand Medicaid to all under 65 with incomes up to 133% of the FPL.</p> <p>To families between 133 and 400% of the FPL, provide tiered premium credits so families contribute between 2 and 9.5% of income to paying for insurance, and subsidies to cover up to 94% of medical costs.</p> |

Strongest Provision  Weakest Provision

|   | <b>OBAMA PLAN</b>   | <b>HOUSE BILL</b>   | <b>SENATE BILL</b>  | <b>FINAL LAW</b>   |
|---|---|---|---|--|
| <b>Support for Young Adults and the Elderly</b> | As a candidate, Obama supported closing the donut hole gap in Medicare prescription drug benefits, <sup>vi</sup> and recommended allowing those up to age 25 to stay on their parents' health insurance plans. <sup>vii</sup> | Over a ten year period, closes the "donut hole."<br><br>Children can stay on their parents' plans until age 27.<br><br>Insurance companies cannot charge more than twice as much for older people's premiums compared to those they offer younger people. | Reduces but does not close the "donut hole." <sup>viii</sup><br><br>Children can stay on their parents' plans until age 26.<br><br>Insurance companies cannot charge more than three times as much for older people's premiums compared to those they offer younger people. | Closes the "donut hole" gap in Medicare prescription drug benefits by 2020. <sup>ix</sup><br><br>Children can stay on their parents' plans until age 26.<br><br>Insurance companies cannot charge more than three times as much for older people's premiums compared to those they offer younger people. |
| <b>Effective Regulation</b>                     | "No American will be turned away from any insurance plan because of illness or pre-existing conditions."  | Effective in 2010, prevents insurance companies from charging women higher premiums than men, excluding customers because of a "pre-existing condition," rescinding a policy when a person becomes sick.  | Prevents insurance companies from charging women higher premiums than men, excluding customers because of a "pre-existing condition," rescinding a policy when a person becomes sick. Effective in 2010 for children, 2014 for adults.                                      | Prevents insurance companies from charging women higher premiums than men, excluding customers because of a "pre-existing condition," rescinding a policy when a person becomes sick. Effective in 2010 for children, 2014 for adults.   |

## Endnotes

Unless otherwise noted, summary of provisions drawn from the Kaiser Family Foundation's Side-by-Side Comparison of Major Health Care Reform Proposals, available at the Kaiser Family Foundation website, [www.kff.org](http://www.kff.org).

Strongest Provision  Weakest Provision

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- <sup>i</sup> Candidate Obama's full health care plan was outlined in a document called "Barack Obama's Plan for a Healthy America," available online at <http://www.barackobama.com/pdf/HealthPlanFull.pdf>.
- <sup>ii</sup> All data on coverage rates comes from Lea Winerman, "Compare the House, Senate and Reconciliation Bills," *PBS News Hour*, March 19, 2010.
- <sup>iii</sup> FY2010 budget proposal, "A New Era of Responsibility," p. 27.
- <sup>iv</sup> See the plan released by the Obama 2008 campaign, "Barack Obama's Plan for a Health America," p. 4.
- <sup>v</sup> See the plan released by the Obama 2008 campaign, "Barack Obama's Plan for a Health America," p. 4.
- <sup>vi</sup> See "The Obama-Biden Plan" at [change.gov](http://change.gov), the website for President-Elect Barack Obama.
- <sup>vii</sup> See the plan released by the Obama 2008 campaign, "Barack Obama's Plan for a Health America," p. 5.
- <sup>viii</sup> Kathleen Masterson and Mary Agnes Carey, "Charting the Future of the Health Overhaul Bill," *NPR*, December 24, 2009.
- <sup>ix</sup> Lea Winerman, "Compare the House, Senate and Reconciliation Bills," *PBS News Hour*, March 19, 2010.

## The Trajectory of Health Care Reform: Major Financing Provisions

|   | OBAMA<br>PROPOSAL   | HOUSE BILL  | SENATE<br>FINANCE   | SENATE BILL  | FINAL LAW   |
|---|---|---|---|--|---|
|   | Drawn from Obama's platform as a presidential candidate <sup>i</sup> and his proposals during his first six months as president.  | HR 3962: Affordable Health Care for America Act<br>Passed: 11/7/09  | America's Healthy Future Act (as amended in Senate Finance Committee)<br>Announced: 9/17/09 | HR 3590: Patient Protection and Affordable Care Act<br>Passed: 12/24/09  | PL 111-148: Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act  |
| <b>High-Earner Tax:</b><br><i>Tax increases for the wealthiest Americans.</i> | Proposes tax increases (including a reduction in the mortgage interest and charitable deductions) for those making over \$250,000. Estimated ten-year revenue: \$318 billion. <sup>ii</sup> | Institute a 5.4% increase the income tax on individuals earning more than \$500,000 or families earning over \$1 million. Estimated ten-year revenue: \$460 billion. <sup>iii</sup> | None.   | Increase Medicare tax rate from 1.45 to 2.35% for individuals earning over \$200,000 and couples earning over \$250,000. Estimated ten-year revenue: \$87 billion. <sup>iv</sup> | For individuals earning over \$200,000 and couples earning over \$250,000, increase Medicare tax rate from 1.45 to 2.35% and institute a 3.8% tax on unearned income. Estimated ten-year revenue: \$210 billion. <sup>v</sup> |

Strongest Provision  Weakest Provision

|   | <b>OBAMA PROPOSAL</b>  | <b>HOUSE BILL</b>   | <b>SENATE FINANCE</b>   | <b>SENATE BILL</b>   | <b>FINAL LAW</b>  |
|---|--|---|---|--|---|
| <b>Cuts to Government-Guaranteed Corporate Profits</b><br><i>Reductions in overpayments to insurance companies, health care providers, drug companies,<sup>vi</sup> and student loan bankers.</i> | FY2010 budget proposes health care savings totaling \$316 billion, including \$177 billion in savings from Medicare Advantage overpayments. <sup>vii</sup> In June 2009, Obama calls for an additional \$309 billion in savings from Medicare and Medicaid. <sup>viii</sup>                | Reduce Medicare overspending by \$440 billion over 10 years, including \$170 billion in Medicare Advantage savings. <sup>ix</sup> | Reduce Medicare overspending by \$404 billion over ten years, including \$117 billion from Medicare Advantage. <sup>x</sup> | Reduce Medicare overspending by \$395-\$400 billion over 10 years, including \$118 billion in savings from Medicare Advantage. <sup>xi</sup> | Reduce Medicare overspending by \$390 billion over 10 years, including \$136 billion in savings from Medicare Advantage. <sup>xii</sup>                               |
|   | <i>Note: Originally a separate piece of legislation, student loan reform was highlighted by the President in his first State of the Union and passed by the House in September 2009, but stalled in the Senate until a version was included with the final vote on health care reform.</i> |   |   |  | Restructure student loan process, cutting middlemen bankers (who profit from government-guaranteed student loans), saving \$61 billion over 10 years. <sup>xiii</sup> |

Strongest Provision  Weakest Provision

|  | <b>OBAMA PROPOSAL</b>  | <b>HOUSE BILL</b>            | <b>SENATE FINANCE</b>   | <b>SENATE BILL</b>   | <b>FINAL LAW</b>  |
|--|--|------------------------------|---|--|---|
| <b>Industry Fees:</b><br><i>Annual fees and taxes affecting health sector companies.</i> | In May 2009, President Obama meets with health sector companies, and claims to have secured voluntary pledges from the industry to cut national health-care spending by 1.5 percentage points each year, but the plan lacks detail. <sup>xiv</sup> | 2.5% tax on medical devices. | Fees include an annual fee of \$2.3 billion for drug companies, \$4 billion for medical device companies, and \$6.7 billion for insurance companies. Estimated ten-year revenue: \$88-93 billion. <sup>xv</sup> | Fees include an annual fee of \$2.3 billion for drug companies, \$2 billion for medical device companies (rising to \$3 billion after 2017), and a tiered fee system for insurance companies: \$2B in 2011, \$4B in 2012, \$7B in 2013, \$9B in 2014-2016, and \$10B thereafter.<br><br>10% tax on tanning salons. | Fees include a 2.3% tax on medical devices, and a tiered fee system for drug and insurance companies. Insurance industry payments are delayed until 2014, but are linked to premium growth. These changes are expected to raise about \$6B more than the Senate bill over 10 years, and more thereafter. <sup>xvi</sup><br><br>10% tax on tanning salons. |

Strongest Provision  Weakest Provision

|  | <b>OBAMA PROPOSAL</b>   | <b>HOUSE BILL</b> | <b>SENATE FINANCE</b>  | <b>SENATE BILL</b>  | <b>FINAL LAW</b>   |
|--|---|-------------------|--|---|--|
| <b>Cadillac Tax:</b><br><i>Tax on the most expensive health plans.</i> | None. Obama strongly opposed a tax on health care plans during his campaign, attacking Senator McCain for his support of such a proposal. | None.             | On most health plans valued at over \$8,000 for an individual or \$21,000 for a family, there is a tax set at 40% of plan value. The provision is effective as of 2013, and linked to inflation. Estimated revenue: \$210 billion. <sup>xvii</sup> | On most health plans valued at over \$8,500 for an individual or \$23,000 for a family, there is a tax set at 40% of plan value. The provision is effective as of 2013, and linked to inflation. Estimated revenue: \$149 billion. <sup>xviii</sup> | On most health plans valued at over \$10,200 for an individual or \$27,500 for a family, there is a tax set at 40% of plan value. The provision is effective as of 2018, and linked to inflation after 2020. Estimated revenue: \$32 billion. <sup>xix</sup> |

Strongest Provision  Weakest Provision

|   | <b>OBAMA PROPOSAL</b>  | <b>HOUSE BILL</b>   | <b>SENATE FINANCE</b>  | <b>SENATE BILL</b>   | <b>FINAL LAW</b>   |
|---|--|---|--|--|--|
| <p><b>Free-rider Penalty:</b><br/><i>Penalties on individuals without qualifying coverage and large employers not providing coverage.</i></p> | <p>Obama never explicitly endorsed an individual or employer mandate, calling only for a “plan that put the United States on a clear path to cover all Americans.”<sup>xx</sup></p> <p>In response to the Committees plans to introduce a mandate, Obama emphasized the need to make plans affordable to individuals and small businesses.<sup>xxi</sup></p> | <p>Uninsured would pay 2.5% of household adjusted income up to cost of national premium basic plan.</p> <p>Employers must cover 72.5% of premium for an individual or 65% for a family, or pay 8% of payroll into the Health Insurance Exchange Trust Fund. Employers with payroll less than \$500k are exempt, and fees are lower than 8% for businesses with a payroll less than \$750k.</p> <p>Estimated ten year revenue: \$168 billion.<sup>xxii</sup></p> | <p>Uninsured would pay a tax of \$750 per adult per year.</p> <p>Employers with more than 50 employees not offering coverage pay a fee based on the average national tax credit for each employee receiving a tax credit, or \$400 times the total number of employees in the firm.</p> <p>Estimated ten-year revenue: \$27 billion.<sup>xxiii</sup></p> | <p>Uninsured would pay a tax equal to the greater of 2% of household adjusted income or \$750 per person up to \$2250.</p> <p>Employers with more than 50 employees not offering coverage who have at least one employee receiving a tax credit pay \$750 per full-time employee. If employer does offer coverage, they must pay the lesser of \$3000 for each tax credit or \$750 per employee. Employers offering coverage must offer vouchers for employees below 400% of the federal poverty line who buy on the exchange. Additional fees for long waiting periods for coverage.</p> <p>Estimated revenue: \$39 billion.<sup>xxiv</sup></p> | <p>Uninsured would pay a tax equal to the greater of 2% of household adjusted income or \$695 per person up to \$2085.</p> <p>Employers with more than 50 employees not offering coverage who have at least one employee receiving a tax credit pay \$2000 times the number of full time employees minus 30. If employer does offer coverage, they must pay the lesser of \$3000 for each tax credit or \$2000 times the number of full time employees minus 30. Employers offering coverage must offer vouchers for employees below 400% FPL who buy on the exchange.</p> <p>Estimated revenue: \$65 billion.<sup>xxv</sup></p> |



## Endnotes

Unless otherwise noted, summary of provisions drawn from the Kaiser Family Foundation's Side-by-Side Comparison of Major Health Care Reform Proposals, available at the Kaiser Family Foundation website, [www.kff.org](http://www.kff.org).

- <sup>i</sup> Candidate Obama's full health care plan was outlined in a document called "Barack Obama's Plan for a Healthy America," available online at <http://www.barackobama.com/pdf/HealthPlanFull.pdf>.
- <sup>ii</sup> Jackie Calmes and Robert Pear, "To Pay for Health Care, Obama Looks to Taxes on Affluent," *New York Times*, February 25, 2009.
- <sup>iii</sup> Douglas W. Elmendorf, Director of the Congressional Budget Office, letter to the Honorable John D. Dingell, U.S. House of Representatives, November 20, 2009.
- <sup>iv</sup> Jeanne Sahadi, "Medicare tax hikes: What the rich will pay," *CNN Money*, March 25, 2010.
- <sup>v</sup> Ibid.
- <sup>vi</sup> James R. Horney and Paul N. Van de Water, "House-Passed and Senate Health Bills Reduce Deficit, Slow Health Care Costs, and Include Realistic Medicare Savings," Center for Budget and Policy Priorities, December 4, 2009.
- <sup>vii</sup> Laura Meckler, "\$318 Billion Tax Hit Proposed," *Wall Street Journal*, February 26, 2009.
- <sup>viii</sup> Letter from the President to Senator Edward M. Kennedy and Senator Max Baucus, June 2, 2009. Available at [whitehouse.gov](http://whitehouse.gov).
- <sup>ix</sup> Kathleen Masterson and Mary Agnes Carey, "Charting the Future of the Health Overhaul Bill," *NPR*, December 24, 2009.
- <sup>x</sup> Douglas W. Elmendorf, Director of the Congressional Budget Office, letter to the Honorable Max Baucus, Chairman of the Senate Committee on Finance, October 7, 2009.
- <sup>xi</sup> Slightly differing numbers are available. See: Patricia A. Davis, Paulette C. Morgan, Holly Stockdale, Sibyl Tilson, and Jim Hahn, "Medicare: Changes Made by the Reconciliation Act of 2010 to Senate-Passed H.R. 3590," Congressional Research Service, March 19, 2010. Kathleen Masterson and Mary Agnes Carey, "Charting the Future of the Health Overhaul Bill," *NPR*, December 24, 2009.
- <sup>xii</sup> Patricia A. Davis, Paulette C. Morgan, Holly Stockdale, Sibyl Tilson, and Jim Hahn, "Medicare: Changes Made by the Reconciliation Act of 2010 to Senate-Passed H.R. 3590," Congressional Research Service, March 19, 2010.
- <sup>xiii</sup> Douglas W. Elmendorf, Director of the Congressional Budget Office, letter to the Honorable Nancy Pelosi, Speaker of the House of Representatives, March 20, 2010.
- <sup>xiv</sup> Ceci Connolly and David Hilzenrath, "Obama Endorses Health Industry's Goal," *Washington Post*, May 12, 2009.
- <sup>xv</sup> Greg Hitt, Janet Adamy, and Jonathan Weisman, "Senate Bill Sets Lines for Health Showdown," *Wall Street Journal*, September 17, 2009.
- <sup>xvi</sup> "H.R. 4872 – Health Care and Education Affordability Reconciliation Act of 2010," U.S. Senate Republican Policy Committee Legislative Notice No. 35, March 22, 2010.
- <sup>xvii</sup> Congressional Budget Office letter to Sen. Max Baucus, October 7, 2009.

Strongest Provision  Weakest Provision

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<sup>xviii</sup> Douglas W. Elmendorf, Director of the Congressional Budget Office, letter to the Honorable Harry Reid, Senate Majority Leader, March 11, 2010.

<sup>xix</sup> Congressional Budget Office letter to Speaker Nancy Pelosi, March 20, 2010.

<sup>xx</sup> See the President's FY2010 budget proposal, "A New Era of Responsibility," p. 27.

<sup>xxi</sup> Letter from the President to Senator Edward M. Kennedy and Senator Max Baucus, June 2, 2009. Available at [whitehouse.gov](http://whitehouse.gov).

<sup>xxii</sup> Congressional Budget Office letter to Rep. John D. Dingell, November 20, 2009.

<sup>xxiii</sup> Congressional Budget Office letter to Sen. Max Baucus, October 7, 2009.

<sup>xxiv</sup> Congressional Budget Office letter to Sen. Harry Reid, March 11, 2010.

<sup>xxv</sup> Congressional Budget Office letter to Speaker Nancy Pelosi, March 20, 2010.

Strongest Provision  Weakest Provision