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The Affordable Care Act: How It Passed and Where to Go from Here

In March 2010, President Obama signed the Patient Protection and Affordable Care Act (ACA), effectively increasing coverage to millions of previously uninsured Americans. It is of interest that he was successful when earlier healthcare reform efforts, such as those made by President Clinton in the early 1990s, had failed. Obama's success depended on a myriad of factors including Democratic majorities in Congress, the Massachusetts model of healthcare reform, and compromises made with interest groups as well as pivotal Congress members.

One of the most straightforward reasons that healthcare reform was able to pass was the legislative make-up from 2009-2010. At the time, Democrats enjoyed majorities in Congress, with 59 members in the Senate, and 257 members in the House. Obama thoughtfully planned around the possibility of a less than three-fifths majority in the Senate (required to overcome a filibuster), something Clinton had failed to during his tenure. He did so by making sure reformers put reconciliation instructions for healthcare reform into the budget resolution. This loophole allowed the Senate to effectively pass the ACA without the threat of filibuster. Thus, only 51 senators were necessary to pass the bill in the Senate (Oberlander 1113).

However, the makeup of Congress and the utilization of the budget reconciliation process were not the only differences between Obama and Clinton's efforts that led to the former's success and the latter's defeat. In fact, the majorities enjoyed by Obama were not remarkably different from those at the time Clinton was in office (Oberlander 1113). So what was else was different? For one, Obama was proposing reform based on an already existent model. Massachusetts had passed comprehensive reform back in 2006, which included subsidies for

coverage, an individual mandate, expanded Medicaid, and an interface for individuals to compare coverage options (Oberlander 1114).

Having a model, however, would not be sufficient to pass such large-scale reform. Massachusetts may have provided a framework for change, but in order to get the ACA passed, Obama had to dedicate efforts to minimizing opposition from interest groups. These strategies included exempting small businesses from a mandate that would require them to provide insurance to their employees, as well as allowing Americans content with their current coverage to keep their plans (Oberlander 1113).

These kind of calculated considerations went beyond the interests of businesses and consumers to target industries as well. Big players that would naturally oppose reform, namely the health and insurance industries, were convinced by reformers to support it. Reformers argued that expanded coverage would increase the pool of patients from which pharmaceutical companies and hospitals could profit. To get these groups on board, reformers did have to make a significant concession: they had to agree that they would not utilize the federal government's bargaining power to drive down prices (Cohn 20). Getting the insurance industry on board was similarly challenging. While an expanded market generated by covering previously uninsured individuals would benefit insurance providers, the public option proposed by Obama remained a threat. Ideally, the public option would have provided competition with the private sector to drive down prices and make insurance more affordable. Insurance companies, of course, did not favor this. Giving up the public option became an unfortunate but necessary compromise that Obama was willing to make if it would get insurance companies on his side (Oberlander 1116).

Agreeing to remove the public option from the ACA was not just a concession to private insurers, but also to members of Congress who refused to approve of the bill while the public

option remained a part of it. More generally speaking, passing the ACA not only consisted of winning over interest groups, but also pivotal members in Congress who stood moderately on issues of healthcare reform. Removing the public option, for example, was key in gaining the support of the independent Senator Joe Lieberman (Cohn 24).

Political scientist Keith Krehbiel describes an applicable theory of pivotal politics, in which policy space can be effectively arranged on a line with liberal policies on the left and conservative ones on the right, on which key “pivotal players” lie based on their ideologies (Krehbiel 2). These pivotal players include the filibuster pivot, which is defined in relation to the president. We can think of moderate Senators such as Joe Lieberman and Bill Nelson as pivotal filibuster players. If reformers failed to win them over (or, more accurately, them and everyone to their left on the continuum), then there would be less than the three-fifths majority necessary to avoid filibuster. Thus, Obama and Senate Majority Leader Harry Reid had to make sure whatever bill they proposed was no further from filibuster pivotal players along the policy continuum than was the status quo in order to ensure those players’ support.

To effectively play this game of pivotal politics, Obama and Reid had to compromise. To conciliate Lieberman, the public option was taken out of the bill. For Nelson, Nebraska was granted additional Medicaid money in exchange for his support (Cohn 24). In addition to catering the ACA to the needs of pivotal senators, Speaker of the House Nancy Pelosi had to accommodate pro-life Democrats in the House (led by Representative Bart Stupak) in order to maintain a majority support. In the House’s version of the bill, she was resigned to ban abortion procedures in new insurance exchanges (Cohn 23). These compromises made in both the Senate and the House, while not ideal from the perspective of reformers seeking universal healthcare, represented Obama’s dedication to politically feasible healthcare reform.

This complex combination of factors, namely the Democratic majority in Congress, Massachusetts as a readily available model for reform, as well as efforts to minimize opposition from both interest groups and pivotal Congress members, allowed Obama and reformers to pass the Affordable Care Act, thereby expanding access to millions of Americans. But while coverage has undoubtedly increased, 23 million people remain uninsured (Oberlander 1116). As senior advisor to MoveOn.org, a liberal interest group that supports the ACA, I recommend the following strategies to expand access to affordable healthcare.

One route for change is grassroots advocacy for voter participation. On one hand, it has been theorized that reelection is the dominant goal of most Congress members (Arnold 5). On the other hand, the ACA primarily benefits low-income individuals who previously were unable to be covered by health insurance, but also happen to be the least likely to vote in elections (Campbell 5). If MoveOn generates campaigns to increase voter participation amongst young and poor Americans who are most positively affected by healthcare reform, members of Congress will be incentivized to support expanded access in the future.

Another potential pressure point for change is provider capacity. It has been shown that affordability is only one strand in a web of difficulties that prevent people from accessing health insurance. An additional key factor is the availability of physicians and health care facilities (Citizens' Health Care Working Group 15). In its own reforms, Massachusetts introduced "initiatives to increase provider capacity including, primary care physician recruitment programs, expanded medical school enrollment for students committed to primary care, and a public-private program to repay loans for physicians and nurses who agree to practice in underserved areas" ("Massachusetts Health Care Reform" 6). MoveOn should lobby for these kinds of

initiatives at a federal level. This way, coverage could be increased without attempting to reintroduce more controversial portions of the bill such as the public option.

Additionally, MoveOn should address state-by-state discrepancies. Firstly, they should create awareness campaigns to promote exchange in states where officials are reluctant to inform their constituents about the ACA. For example, states like Texas are refusing to set up insurance exchanges (Luthra 1). MoveOn can either publicize the federal exchange in these states, or lobby state officials to set up state exchanges and publicize the federal exchange themselves. Secondly, MoveOn should try to appeal to insurers to reach more states. Some states, such as California, have a plethora of insurance providers offering coverage. Yet other states like Maine are limited to only a small number of options (Abelson 1). States with few choices fail to generate the kind of competition necessary to drive down prices. Thus, MoveOn would benefit from encouraging insurers to offer plans in states that lack competitive markets.

Moving forward with these recommendations, it should be kept in mind that the ACA was “probably as good as it gets” given the constraints (Oberlander 1116). Thus, future efforts to expand coverage would probably be best spent maximizing the efficiency of current legislation via the previously mentioned recommendations as opposed to trying to pass those elements of the bill that were considered too liberal to pass initially. Despite the ACA’s limitations, individuals with pre-existing conditions, as well as many low-income people of color now have better access to healthcare because of it. Yet, 23 million people still do not have coverage. Therefore, groups like MoveOn must continue to push for expanded coverage in creative ways so that we as Americans can move towards a more equitable, healthier society. Fortunately, Obama was able to pass healthcare reform when previous efforts had failed. If MoveOn utilizes the political strategy outlined here, reform will hopefully prove to be even more successful.

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