Right-Wing Conspiracy? Socialist Plot?
The Origins of the Patient Protection and Affordable Care Act

Jill Quadagno
Florida State University

Abstract  On March 23, 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act (ACA). Did the ACA signify a government take-over of the health care system, a first step on the road to socialism, as conservative critics charged? Or was it, rather, a sellout to the right wing, as liberal single-payer advocates proclaimed? The ACA’s key provisions, the employer mandate and the individual mandate, were Republican policy ideas, and its fundamental principles were nearly identical to the Health Equity and Access Reform Today Act of 1993 (HEART), a bill promoted by Republican senators to deflect support for President Bill Clinton’s Health Security plan. Yet the ACA was also a policy legacy of the Clinton administration in important ways that rarely are acknowledged, notably Medicaid expansion and insurance company regulation. Although the ACA departed from the liberal vision of a single-payer plan and adhered closely to the objectives of those who believed that the health care system should encourage the free market, it included provisions that will make coverage more affordable, reliable, and accessible.

On March 23, 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act (ACA). For the first time in more than a century, the federal government made a commitment to provide universal coverage through a complex mix of private incentives and public support. Its main features include state insurance exchanges, stringent regulations on insurance companies, fines on employers who do not offer coverage, a mandate that individuals purchase health insurance, subsidies to help low-income people with the costs, and a substantial expansion of Medicaid. To liberal supporters of a single-payer plan, the ACA represented a disappointing concession to private insurance companies, a scheme that would
never achieve universal coverage. As Physicians for a National Health Program (PNHP 2010) reported, the legislation was like “seeing aspirin dispensed for the treatment of cancer.” For conservatives, however, Obamacare was a first step on the road to socialism (Grogan 2011). According to former House Speaker Newt Gingrich, a Republican presidential candidate in 2012, “The new law [is] a back door to socialized medicine that puts America at the edge of a possible catastrophic failure” (McDermott 2010).

Despite criticisms from both the Left and the Right, most analysts agree that the ACA represented a victory for the Democratic Party over Republican visions of limited government intervention. For Anne Beausier (2012), the victory resulted from congressional Democrats’ success in transcending institutional constraints. Hacker (2010) emphasizes the composition of the Democratic majority in Congress. As he explains, “The approach (of the ACA) was feasible only because so much intraparty agreement already existed about the proper direction forward. The three leading Democratic candidates in the presidential race endorsed not similar reform plans but essentially the same reform plan” (Hacker 2011: 440). Similarly, Lawrence Brown (2011: 421, 425) claims that “Congress’ accomplishment was not merely but entirely a triumph for the Democratic Party. . . . The ACA is a virtually pure Democratic product.”

These claims are correct in the narrow sense of votes in Congress. The ACA passed without a single Republican vote in either the House or the Senate. Yet they are also inaccurate in other respects. First, despite howls from the Right that the ACA signified the victory of socialized medicine, its provisions were nearly identical to the Health Equity and Access Reform Today Act of 1993 (HEART), a Republican plan that was promoted as an alternative to President Bill Clinton’s American Health Security Act of 1993. The HEART was consistent with a free-market approach and contained provisions, notably the employer mandate and the individual mandate, that had widespread Republican support in the two decades before the ACA was enacted. Second, contrary to conventional wisdom that President Clinton’s health care reform was an utter failure, a road to nowhere (Hacker 1997), policies his administration pursued were critical for the ACA’s eventual success. These include federal regulation of the private insurance industry through the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and incentives for states to expand Medicaid coverage beyond the very poor, to near-poor and working-class families. How was the ACA transformed from a conservative Republican plan to protect the private insurance industry into an ambitious proposal for universal
coverage favored by liberal Democrats? This article draws on archival research, congressional records, and secondary documents to elucidate the complex policy legacies that became the Patient Protection and Affordable Care Act.

The Origins of the Individual Mandate

Policy learning effects come from political actors’ experiences with past initiatives in which “the setting of a new agenda and the design of alternative responses may build on . . . past successes or may reflect lessons learned from past mistakes” (Pierson 1994: 4). For example, Hugh Heclo (2011), in his study of social policy in Britain and Sweden, emphasized an incremental policy-learning process in which past policies provided models for policy makers. What is initially puzzling about the ACA is that its policy legacy reflected neither conservatives’ favored proposal for expanding health savings accounts nor liberals’ proposal to extend Medicare to all (Quadagno and McKelvey 2010; Schlesinger and Hacker 2007). Rather, the ACA’s core provisions were a legacy inherited from other health insurance proposals over nearly half a century following the enactment of Medicare and Medicaid in 1965.

The success of Medicare emboldened supporters of national health insurance regarding the prospects for universal coverage. As Dr. John Hogness, president of the Institute of Medicine, declared in 1973, “The feeling among experts is that it will take three to five years” (Hodgson 1973: 2). During the 1970s numerous bills were introduced in Congress, ranging from Senator Russell Long’s (D-LA) plan to subsidize basic private health plans with federal payment for catastrophic costs to Senator Ted Kennedy’s (D-MA) Health Security, which would fold all public and private health plans into a single federal program. When it appeared that Congress would enact some program, President Richard Nixon unveiled his own national health plan in 1974. Nixon’s plan consisted of two parts: the Comprehensive Health Insurance Plan, which included an employer mandate administered by private insurance companies, and the Assisted Health Insurance Plan, where states would contract with private insurers to cover low-income and high-risk individuals (Quadagno 2005). The employer mandate won the endorsement of the Washington Business Group on Health, an organization of two hundred corporation members whose mission was to help firms design benefit packages that reduced costs. Another business group, the National Leadership Coalition, composed of executives from large companies, also supported the employer
mandate. Although Nixon’s impeachment ended Republican support for health insurance legislation, President Jimmy Carter included an employer mandate in his health insurance plan, which gained no traction in Congress because of a stalled economy (Quadagno 2005). Thus, the employer mandate originated with Republicans but was not anathema to Democrats.

In the 1980s, rising costs and increasing numbers of uninsured revived interest in health care reform. Most proposals for universal health care, except the liberal single-payer model, were based on an employer mandate. Yet some conservatives warned that an employer mandate contained perverse incentives, which could lead to job lock and create inflation as employers passed costs onto consumers. Looking for an approach that would not interfere with a free market, conservatives began to evaluate an alternative approach, an individual mandate. The virtues of an individual mandate were that it would avoid job lock and discourage free riders. As Stuart Butler (1989: 6) of the conservative Heritage Foundation explained the rationale for the individual mandate:

Many states now require passengers in automobiles to wear seatbelts for their own protection. Many others require anybody driving a car to have liability insurance. But neither the federal government nor any state requires all households to protect themselves from the potentially catastrophic costs of a serious accident or illness. Under the Heritage plan, there would be such a requirement. This mandate is based on two important principles. First, that health care protection is a responsibility of individuals, not businesses. . . . Second, it assumes that there is an implicit contract between households and society, based on the notion that health insurance is not like other forms of insurance protection. If a young man wrecks his Porsche and has not had the foresight to obtain insurance, we may commiserate but society feels no obligation to repair his car. But health care is different. If a man is struck down by a heart attack in the street, Americans will care for him whether or not he has insurance. . . . A mandate on individuals recognizes this implicit contract. Society does feel a moral obligation to insure that its citizens do not suffer from the unavailability of health care. But, on the other hand, each household has the obligation, to the extent it is able, to avoid placing demands on society by protecting itself.

In 1991 a group of conservative economists charged with developing a health insurance plan for President George H. W. Bush laid these principles out in greater detail (Roy 2012). Their plan endorsed an individual mandate
as a counterpoint to either the employer mandate or the single-payer system favored by Democrats:

The allocation of resources to health care should rest on individuals’ choice of insurance in light of their different needs and desires. This will drive a competitive market and improve the efficiency of the health care system. . . . All citizens should be required to obtain a basic level of health insurance. . . . Permitting individuals to remain uninsured results in inefficient use of medical care, inequity in the incidence of costs of uncompensated care, and tax-related distortions. . . . [The individual mandate] avoids interfering with labor markets and employment contracts; it facilitates portability of coverage, employment mobility and a competitive market. (Pauly et al. 1991: 8)

Thus in its original formulation the individual mandate was consistent with conservative American values that favored a free market and limited state authority (Lipset 1996). It was incorporated into President Bush’s plan, the Comprehensive Health Reform Act of 1992, which mandated that each individual purchase a basic benefit coupled with tax credits and deductions to help cover the costs. The Bush plan also would have created health insurance networks (HINs) that would arrange for the purchase of health insurance and negotiate payment rates and selective contracts with providers (US Congress 1993: 25). Republicans tabled the plan, however, when it appeared they could not get enough Democratic support. Then Bush lost the 1992 election, and momentum shifted to the Democrats.

The Policy Legacy of the Clinton Administration

American Health Security Act

During the 1992 presidential election, Bill Clinton campaigned on a promise to enact legislation to guarantee universal coverage. Following his victory, he created an outside task force to draft a plan, ignoring ongoing work in congressional committees. The Clinton proposal, the American Health Security Act of 1993 (H.R. 3600, 103d Cong. 1st Sess. [1993]), was released seven months later. Its central feature involved the purchase of cooperatives called “health alliances.” Echoing aspects of Bush’s HINs, the alliances would hold down costs by bargaining directly with health care providers. Further, Health Security would create an independent agency that would certify private insurance plans and set guidelines for a standard benefit package that all insurers would have to offer (Hacker 1997). Health
Security also included federal regulations on insurance companies operating in the small-group and individual insurance market. These regulations would prohibit insurance companies from refusing coverage on the basis of age or health status (guaranteed issue) or terminating benefits for any reason. Firms with more than five thousand employees could self-insure but would have to pay a new payroll tax to expand the public program for the uninsured.

Purchasing cooperatives, standard benefit packages, and insurance company regulation were at the forefront of Health Security and received the bulk of the critical attention. Health Security also included a little-noticed provision, however, mandating that individuals purchase health coverage. Section 1002 of the Health Security Act specified that “each eligible individual (1) must enroll in an applicable health plan for the individual and (2) must pay any premium consistent with the Act, with respect to such enrollment.” Eligible individuals according to Section 1001 included citizens, nationals, permanent alien residents, and long-term nonimmigrants. Thus virtually all Americans and people residing in the United States would be required to enroll in a health insurance plan.

The story of how a coalition of insurers, corporations, and small business groups mobilized against Health Security has been described in great detail elsewhere (Jacobs and Skocpol 2010; Quadagno 2011). Overall, the Center for Public Integrity estimated that 650 organizations spent at least $100 million to defeat the Clinton plan (Quadagno 2005; Skocpol 1997). Health Security never even came up for a vote. What is less well known is that Republican opponents of the Clinton plan adopted an alternative proposal that included a stringent employer mandate and a harsh individual mandate.

HEART

The Republican alternative, the Health Equity and Access Reform Today Act, was introduced in November 1993 by Senator John Chafee (R-RI). Chafee was the leader of a Republican task force that had met almost weekly for three years to develop a health care plan. When Chafee introduced his bill, Senator Robert Packwood (R-OR) called it “a culmination of these efforts [that] represents a cautious and sensible approach to reforming our health care system” (Cong. Rec. S16925 [November 22, 1993] [“Health Care Reform”]). The HEART would “guarantee every individual access to affordable and secure health coverage through substantial health insurance market reforms.” Insurance plans would have to
meet strict requirements, including guaranteed eligibility, no preexisting condition exclusions, guaranteed renewal, and a standard benefit package. Further, large employers would be required to offer coverage to all employees, and small employers (one hundred or fewer employees) would have to offer but not pay for a benefit package. Individuals would be required to purchase coverage or pay a substantial penalty “equal to the average yearly premium of the local area plus 20 percent” (Cong. Rec. E3078 [November 24, 1993] [Hon. William M. Thomas, “Introduction of the Health Equity and Access Reform Today”]). However, vouchers would be provided to make insurance affordable for low-income individuals.

The HEART alternative was supported by half of the GOP Senate, including such knowledgeable members as Senate minority leader Bob Dole (R-KS), Robert Bennett (R-UT), John Danforth (R-MO), Pete Domenici (R-NM), David Durenberger (R-MN), and Richard Lugar (R-IN). It also had the support of key House Republicans, including Representative Newt Gingrich (R-GA), who declared on Meet the Press in 1993, “I am for people, individuals—exactly like automobile insurance—individuals having health insurance and being required to have health insurance. And I am prepared to vote for a voucher system which will give individuals, on a sliding scale, a government subsidy so we insure that everyone as individuals have health insurance” (Gingrich 1993). Yet when Chafee attempted to move his bill forward, conservatives within his own party declared that mandates were out of the question. As Senator Trent Lott (R-MS) said, “Republicans have to make clear we are not signed on to any of this government control and mandate stuff” (Johnson and Broder 1996: 364). The HEART was never debated in the Senate, and it disappeared from the national policy agenda for the remainder of the 1990s.

Insurance Company Regulation

It is accepted wisdom that Health Security was a failed policy initiative that led to a Republican takeover of the House and Senate in 1994 and undermined support for the Democratic Party for more than a decade (Skocpol 1997). Lost in this interpretation are the Clinton administration’s policy legacies that paved the way for the ACA. One legacy was federal regulation of insurance companies. Ever since the McCarran-Ferguson Act of 1945 affirmed insurance regulation as a primary state responsibility, health insurance plans had been regulated by the states. In most states, legislatures enacted the laws under which insurance companies operated
and state insurance departments enforced those laws. Under Clinton that power shifted to the federal government.

During the early 1990s, the states responded to growing concerns about the disintegration of the insurance market for individuals and small groups by enacting numerous reforms (Hall 2000; Kail, Quadagno, and Dixon 2009). Many states enacted consumer protection policies that were designed to control the underwriting practices of insurance companies (Stream 1999). Rating restrictions compressed the range of prices insurers could charge to policyholders. Although insurers were allowed to vary premiums according to an individual’s or group’s risk profile, they could only do so to a defined extent within set “rating bands” (Hall 2000). Affordability and disclosure regulations required insurers to offer similarly priced plans with uniform benefits (Stream 1999). Guaranteed issue regulations required insurers to offer coverage to any individual or group, regardless of health.

States also attempted to restrict insurers’ risk selection practices through accessibility reforms (Stream 1999). Guaranteed renewal laws require insurers to continue to cover previously insured groups, even if the members of the group suffered a change in health. Preexisting condition limitations set a maximum period for which an individual could be excluded from a group plan because of a prior health condition. Finally, portability rules guaranteed that a person who changed jobs or changed insurers within the same workplace could retain coverage without being subject to a new exclusion period (Barrilleaux and Brace 2007; Hall 2000).

For the most part, these reforms did little to reduce the number of uninsured, and in some cases they had the opposite effect (Kail, Quadagno, and Dixon 2009). For example, the guaranteed issue requirement for all small-group products prompted insurers to drop plans they were unwilling to sell under these conditions. Rating restrictions appear to have had a similar effect (Hall 2000). The failure of regulation may also reflect the fact that in many states insurers control the state insurance commissioner’s offices. These offices have become a revolving door, with insurance industry executives often serving as commissioners and then returning to the industry (Bodenheimer 1990). As a result, at the state level insurers could influence legislation and insert loopholes to ensure that regulations were ineffective (Hall 2000; Light 1992).

Although states’ efforts to regulate insurance practices largely failed, they set the stage for greater federal control. In 1995 Senators Ted Kennedy (D-MA) and Nancy Kassenbaum (R-KS) drafted rigorous federal regulations including guaranteed renewal, guaranteed issue, prohibitions on experience rating, and tightening of preexisting condition exclusions.
Following a barrage of opposition from the insurance industry, however, the proposal was watered down considerably. The bill that President Clinton signed into law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), limited the ability of private health plans to impose preexisting condition coverage exclusions on plan participants (Medill 1998), allowed employees who lost group coverage because of a change in personal circumstances to convert to individual coverage, prohibited insurers from charging different premiums for individuals within groups, and required insurers to guarantee renewal to any group. HIPAA did not include any price restrictions, however, and this made continuing coverage unaffordable for many individuals (Quadagno 2005). Nor did HIPAA guarantee that people shopping for coverage would not be rejected because of health. Further, HIPAA had many loopholes and applied only to small groups (Hall 2000). Despite these limitations, HIPAA set an important precedent for federal regulation of the insurance industry.

**Medicaid Expansion**

A less publicized achievement of the Clinton administration was the expansion of Medicaid beyond the very poor to near-poor and working-class families. This expansion was made possible by Section 1115 of the 1965 amendments to the Social Security Act, which allows states to apply for waivers to conduct research and demonstration projects within their Medicaid programs, thus bypassing strict federal rules and regulations. Throughout the 1970s and 1980s there were many approved demonstrations, but they were small in scope and driven mainly by state rather than federal interests. Most expansions targeted pregnant women and children, groups generally viewed as morally deserving (Grogan 2008; Grogan and Patashnik 2003). In 1993 the Clinton administration began actively promoting states’ use of Section 1115 waivers to expand coverage beyond the very poor and issuing new guidelines that streamlined the process. States responded rapidly, raising income and asset limits and incorporating groups not categorically eligible (Schneider 1997). For example, Oregon extended Medicaid eligibility to all state residents with income below the federal poverty level (Gold et al. 2001). Tennessee’s TennCare program made Medicaid available to families with income up to 400 percent of the poverty level (Ku and Garrett 2000).

The expansion of Medicaid to new beneficiary groups and to the near poor and working class helped to transform public perceptions of the program. During the 1995–96 budget showdown between President
Clinton and Republicans, Clinton sought to rally support against the GOP budget by arguing that it would involve huge cuts in popular entitlement programs, not only Social Security and Medicare but also Medicaid. No longer was Medicaid merely a “welfare” benefit. This definition of Medicaid as an entitlement was incorporated into the 1996 Democratic Party platform, which promised to protect the program from “devastating cuts” (Grogan and Patashnik 2003: 845).

Medicaid was further entrenched as a popular entitlement when Congress enacted the State Children’s Health Insurance Program (SCHIP) of 1997. This new program increased the federal match to the states from 50 percent to 65 percent and covered children in families with income up to 200 percent of poverty level. In response, some states created quite generous SCHIP programs (Blewett, Davern, and Rodin 2004; Cunningham 2003). Others, as allowed by law, implemented separate non-Medicaid programs for low-income children with more restrictive benefit packages, a strategy that reduced costs and also avoided any stigma associated with Medicaid. Between 1998 and 2001 Medicaid and SCHIP enrollment grew on average by 30 percent (Grogan and Patashnik 2003). Further, SCHIP rules were subsequently amended to allow states to cover uninsured parents as well as their children (Cunningham 2003; Kaiser Commission on Medicaid and the Uninsured 2005). As Grogan (forthcoming) notes, “By the end of the Clinton administration, [Medicaid] looked like a broad entitlement more than a welfare program.”

Although the 1990s transformed Medicaid, both in regard to coverage expansions and in ideological terms, these changes also highlighted the limitations of state responsibility. TennCare provides an example of some of the challenges the states faced. Originally TennCare expanded subsidized coverage to all uninsured residents and allowed those ineligible for the subsidy to buy into what was essentially a public option. In its first year of operation, TennCare enrollment quickly grew close to the federal cap of 1.5 million people, meaning the federal government would not share in the cost of the number above that. In 1995, however, the fiscal strain caused by the growth in enrollment forced Tennessee to close eligibility to uninsured adults. Another budget crisis in 2005 resulted in the removal from TennCare of more than 160,000 people who were not Medicaid eligible, and the program’s benefits were trimmed (Kaiser Commission on Medicaid and the Uninsured 2005). Thus the waiver experiments demonstrated the limits on what can be achieved at the state level and pointed to the need for a federal solution.
The Massachusetts Health Care Plan

One of the state experiments with coverage expansion was a rousing success. In 2006, after a six-month debate and a series of compromises between Democrats and Republicans, the Massachusetts legislature adopted the Massachusetts Health Care Reform Plan, with only four nay votes out of two hundred House and Senate members. On board was Senator Ted Kennedy, the single-payer advocate who became convinced that this approach could achieve his lifelong goal of universal coverage (Cooper 2012). Designed in large part with the assistance of the Heritage Foundation, the plan was “a hybrid approach that incorporated ideas from across the political spectrum” (Hyman 2007). The law included a state insurance exchange, which Governor Mitt Romney touted as “a single consumer-driven marketplace for health insurance for small businesses, their employees and individuals” (quoted in Owcharenko and Moffit 2006: 1). It also contained an employer mandate requiring that all employers with more than eleven full-time employees make a “fair and reasonable” contribution toward their workers’ health plans or face penalties. And for the first time, health insurance legislation included an individual mandate. In signing the bill, Romney (2006) explained its virtues: “No longer can individuals free ride [sic] by seeking healthcare and expecting society to bear the cost.” To ensure that all residents could afford the premiums, health insurance was fully subsidized for adults earning up to 150 percent of the federal poverty level and for children of parents earning up to 300 percent of that level. Thus these provisions borrowed many features in HEART but also incorporated the Medicaid expansions that the Clinton administration had made possible.

Some observers believed that the Massachusetts plan would be as futile as other state-level reforms and, more worrisome, likely to detract from efforts for federal reform (Jacobson and Braun 2006–7). Yet such dire predictions proved unfounded. Before the law took effect in 2006, about 94 percent of state residents were insured. By 2010 more than 98 percent were insured, including 99.8 percent of all children, making Massachusetts’s rate of uninsured the lowest in the United States (Kahn 2011). Thus Massachusetts provided the blueprint and the evidence that the individual mandate was a workable solution that could be achieved with bipartisan support.

Healthy Americans Act

The success of the Massachusetts plan encouraged members of Congress to consider moving toward universal coverage through an individual...
mandate, an option was gathering support among Democrats as well as Republicans. In 2004 Senator Ron Wyden (D-OR) began developing a proposal around the individual mandate, testing it out on both Democrats and Republicans. “Between 2004 and 2008, I saw over eighty members of the Senate, and there were very few who objected” (quoted in Klein 2012). In December 2006, he unveiled the Healthy Americans Act (S. 334, 110th Cong. [2007]), and in May 2007, Robert Bennett (R-UT), who had been a sponsor of the 1993 Chafee bill, joined him. Two related House bills, H.R. 3163 and H.R. 6444, were introduced simultaneously.

The Healthy Americans Act was designed to transition away from employer-provided health insurance to employer-subsidized health insurance. It would do this by eliminating entirely the tax break for employer health insurance. This was a highly controversial feature because it meant abandoning the employer-based system, which had been the mainstay of health coverage since the 1940s. The Healthy Americans Act would also require those who did not have insurance coverage to enroll in Healthy American Private Insurance Plans (HAPIs). Individuals would choose their health care plan from state-approved private insurers. Endorsed by seventeen co-sponsors, including nine Republicans and seven Democrats, the bill won more bipartisan support than any universal health care proposal in the history of the Senate but died in the Senate Finance Committee.

Despite the failure of the Healthy Americans Act, a bipartisan consensus on the individual mandate seemed to be emerging. Not only did congressional members of both parties support the concept, but in the 2008 presidential election campaign, two Democratic candidates, Senators John Edwards (D-NC) and Hillary Clinton (D-NY), highlighted the individual mandate in their health care plans (Jacobs and Skocpol 2010). The holdout was Senator Barack Obama. Thus what began as a conservative, free-market approach to health care reform was beginning to morph into the liberal blueprint for change.

The Patient Protection and Affordable Care Act of 2010

Immediately after his victory in the 2008 election, President Obama urged committees in Congress to assemble the legislative specifics and the votes to pass a bill. In contrast to President Clinton, who involved a task force of outsiders to draft his plan and delayed release for seven months, Obama did not attempt to reinvent the wheel but turned to policy options already on the agenda. Initially, it seemed that the Healthy Americans Act would
provide the solution. Immediately after Obama became president-elect, Wyden and Bennett wrote a letter on November 20, 2008, recommending legislative goals reflected in the Healthy Americans Act. They reintroduced their bill on February 5, 2009, with fourteen co-sponsors—nine Democrats and five Republicans (S. 391). A companion bill (H.R. 1321) was introduced in the House with ten co-sponsors. Wyden-Bennett was also endorsed by Republican presidential aspirant Mitt Romney (2009a), who in a June 2009 interview on *Meet the Press* called it a plan “that a number of Republicans think is a very good health-care plan—one that we support.” Yet in an interview on July 2009, President Obama said that although he agreed with many of the principles in Wyden-Bennett, he felt that the plan, like the plan promoted by single-payer advocates, was too radical. In theory, he said, those plans work, but “the problem is, we have evolved partly by accident into an employer-based system.” Not only would a “radical restructuring” meet with “significant political resistance”; in addition, “families who are currently relatively satisfied with their insurance but are worried about rising costs . . . would get real nervous about a wholesale change” (Lane 2009).

Another obstacle was that a key Democratic constituency, organized labor, was opposed to the Healthy Americans Act. The trade unions were concerned about whether employment-based coverage could be sustained over the long run, but they were unwilling to support legislation that would undo it completely. In 2009 three large unions—the American Federation of State, County and Municipal Employees; the United Food and Commercial Workers; and the National Education Association—ran ads against the Healthy Americans Act, charging that it would unfairly tax health benefits (Robertson 2009).

A key constituency was the private insurance industry. Insurers were willing to accept stricter regulations, including price controls and guaranteed-issue without preexisting condition exclusions, as long as these regulations were accompanied by an individual mandate (Hacker 2011). An individual mandate would bring young, healthy people into the system to help pay the costs of older, sicker people. Insurers also supported Medicaid expansion. Indeed, a decade earlier the Health Insurance Association of America had endorsed a proposal that would use Medicaid as the cornerstone to expand coverage. Under this plan Medicaid would cover all individuals with income below 133 percent of the poverty level (Grogan and Patashnik 2003). What was unacceptable to insurers, however, was the public option, which would have offered an alternative to private insurance.
Fearing that a new public program could out-compete private insurance on price and quality, insurers launched a campaign against it (Harwood 2009). Physician organizations were less influential in 2010 than in previous health care reform debates (Quadagno 2005). The reason was that physicians were divided into multiple organizations and did not speak with a single voice. The liberal PNHP wanted to eliminate the private insurance industry entirely and opposed any solution other than a single-payer system. In contrast, the AMA favored expanding tax advantages for health savings accounts. Physicians’ opposition was reduced by a concession that abrogated a 1997 provision that would have cut Medicare reimbursement rates by the end of the year (Beaussier 2012).

On July 14, 2009, three House committees reported out the House Tri-Committee America’s Affordable Health Care Act (HB 3200). The following day the Senate Health, Education, Labor and Pension Committee, of which Obama had been a member when he was a senator, passed its own version, the Affordable Health Choices Act (S 1679). The legislation that emerged was much more comprehensive than the Healthy Americans Act and less committed to eliminating employer-based coverage. A key provision was the individual mandate, which the president now supported: “I was opposed to this idea because my general attitude was the reason people don’t have health insurance is not because they don’t want it. It’s because they can’t afford it. I am now in favor of some sort of individual mandate” (quoted in Klein 2012). His change of heart was a pragmatic choice. Given the extensive bipartisan support won by previous health care reform plans based on an individual mandate, the president had reason to believe that he might receive a favorable response from Republicans. Romney, in fact, heralded the individual mandate’s merits: “Our experience also demonstrates that getting every citizen insured doesn’t have to break the bank. First, we established incentives for those who were uninsured to buy insurance. Using tax penalties, as we did, . . . encourages free riders to take responsibility for themselves rather than pass their medical costs to others” (Romney 2009b). This optimism proved unfounded, however, for the final bill that made it through the House and Senate on March 21, 2010, had no Republican support. Republicans united against it, hoping for the complete victory they had achieved against the Clinton plan (Hacker 2010).

Yet the ACA’s main provisions were nearly identical to the Republican-supported HEART plan. As table 1 shows, both the HEART plan and the ACA included an individual mandate, an employer mandate, a standard benefit package, state-based purchasing exchanges, subsidies for low-income people, efforts to improve efficiency, controls on Medicare spending growth,
and controls on high-cost plans. Both measures also included stringent regulations on insurance companies, including a ban on denying coverage because of preexisting conditions, and prohibited insurers from canceling coverage because of health.

The HEART plan and the ACA also differed on a few provisions that, to a large degree, reflected changes that had occurred in the health insurance system during the Clinton administration. One difference was that the ACA

<table>
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<tr>
<th>Major Provisions</th>
<th>ACA 2010</th>
<th>HEART Bill 1993</th>
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<tbody>
<tr>
<td>Individual mandate</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Fines on employers</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Standard benefits package</td>
<td>Yes</td>
<td>Yes</td>
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<td>Bans on denying medical coverage for preexisting</td>
<td>Yes</td>
<td>Yes</td>
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<td>conditions</td>
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<td>Establishes state-based</td>
<td>Yes</td>
<td>Yes</td>
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<td>exchanges/purchasing groups</td>
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<td>Offers subsidies for low-income people to buy</td>
<td>Yes</td>
<td>Yes</td>
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<td>insurance</td>
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<tr>
<td>Improves efficiency of health care system</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Equalizes tax treatment for insurance of self-employed</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Reduces growth in Medicare spending</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Controls high-cost health plans</td>
<td>Yes (taxes plans over $8,500 for single coverage, $23,000 for family plan)</td>
<td>Yes (caps tax exemption for employer-sponsored plans)</td>
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<tr>
<td>Prohibits insurance company from canceling coverage</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Prohibits insurers from setting lifetime spending caps</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Expands Medicaid</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Extends coverage to dependents</td>
<td>Yes (up to age 26)</td>
<td>No</td>
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Source: Adapted from Henry J. Kaiser Family Foundation 2010
but not HEART prohibited insurers from setting lifetime limits on health benefits. In 1996 Representative Anna Eshoo (D-CA) had first introduced a bill, the Christopher Reeve Health Insurance Reform Act (H.R. 3030), banning lifetime caps, which had been set at $1 million in the 1970s but had failed to keep pace with inflation. Her bill failed to win support in the Republican-controlled House, and it died in committee. By 2007 more than half of all health insurance plans had a lifetime cap, often buried in the fine print (Henry J. Kaiser Family Foundation 2007). With Democrats in control of the House in 2008, Representative Eshoo reintroduced the bill (H.R. 6228), while Senator Byron Dorgan introduced a similar bill in the Senate. That provision was included in the ACA.

Another difference was that the ACA but not HEART extended coverage on private plans to dependents up to age twenty-six. This age group stood out because young adults had the lowest rate of insurance coverage and, unlike children under age eighteen, were ineligible for SCHIP benefits (Sommers et al. 2013). Allowing young adults to remain on their parents' plans would immediately reduce the number of uninsured.

Both HEART and the ACA included an employer mandate, but whereas it was stringent under HEART, it was watered down under the ACA to a fine of $750 for each full-time employee. The individual mandate was also more modest. Under HEART individuals who failed to purchase coverage would pay a penalty equal to the average yearly premium in the area plus 20 percent. Under the ACA the penalty for those who failed to purchase coverage was $95 in 2014, rising to $750 in 2016 and indexed thereafter. Another difference was that HEART would have equalized the tax treatment of premium costs for the self-employed with workers who received benefits through their jobs, a provision not included in the ACA.

The ACA also expanded Medicaid by universalizing a process that had escalated in the states throughout the 1990s, thus eliminating the need for waivers. Specifically, the ACA extended Medicaid to all children, parents, and childless adults with family incomes up to 133 percent of federal poverty level. As an incentive to participation, the federal government would pay for 100 percent of the expansion for three years and 90 percent thereafter, plus a 23 percent increase in the SCHIP federal match.

Although many Republicans had previously supported the core provisions of the ACA, once it was enacted, they launched an assault against it. Republican governors in several states refused to set up insurance exchanges and said that they would refuse to expand their Medicaid programs (Cohen 2012). The individual mandate, in particular, came under the heaviest fire, as polls showed that this was the most unpopular element of
the law (Klein 2012). On the day that President Obama signed the ACA into law, fourteen Republican state attorneys general filed suit against it on the grounds that it was unconstitutional. Heritage’s Butler (2012) also repudiated his previous support for the individual mandate:

I headed Heritage’s health work for 30 years. And make no mistake; Heritage and I actively oppose the individual mandate. Nevertheless, the myth persists. . . . The confusion arises from the fact that 20 years ago, I held the view that as a technical matter, some form of requirement to purchase insurance was needed in a near-universal insurance market to avoid massive instability through “adverse selection.” At that time, President Clinton was proposing a universal health care plan, and Heritage and I devised a viable alternative. . . . But the version of the health insurance mandate Heritage and I supported in the 1990s had three critical features. First, it was not intended to push people to obtain protection for their own good but to protect others. . . . Second, we sought to induce people to buy coverage through the carrot of a generous health credit or voucher. . . . And third, in the legislation we helped craft that ultimately became the preferred alternative to ClintonCare, the mandate was actually the loss of certain tax breaks for those not choosing to buy coverage, not a legal requirement. . . . Heritage-funded research . . . caused me to conclude that we had made a mistake in the 1990s. . . . Changing one’s mind about the best policy to pursue—but not one’s principles—is part of being a researcher at a major think tank.

On June 28, 2012, the Supreme Court upheld the constitutionality of the ACA but gave the states the right to opt out of the Medicaid expansion. As of February 2013, eleven states with Republican governors had announced they would not participate. However, some Republican governors, responding to pressures from Latino voters and the potential loss of billions in federal matching funds and health care jobs, did decide to expand their Medicaid programs. A prime example is Arizona, historically a welfare laggard, which did not participate in Medicaid at all until 1982. Yet in January 2013 Governor Jan Brewer, an outspoken critic of Obamacare, nonetheless announced that Arizona would expand its Medicaid program. In 2014, the first full year of expansion, Arizona would gain $1.6 billion in federal matching funds. It is likely that such fiscal concerns, coupled with hard lobbying by the health care industry, will eventually result in universal participation (Burton, Dooren, and Lippman 2012). Thus what began as a program of welfare medicine will probably play a major role in the move toward universal coverage. As Grogan (forthcoming)
explains, “The ACA . . . puts Medicaid on par with Medicare and Social Security—our sacrosanct middle-class entitlements.”

Conclusion

When Bill Clinton was elected president, he set the ambitious but ultimately unsuccessful goal of providing health insurance for all. His Health Security proposal is usually viewed as a total failure, a presidential initiative that foundered “quickly and completely” (Hacker 1997: xi). What is often not recognized is that the Clinton administration left a policy legacy that made possible the success of an equally ambitious plan for health care reform nearly two decades later. Specifically, Clinton encouraged states to apply for waivers to extend their Medicaid programs to new groups and enacted SCHIP, which expanded coverage for children and some adults. He also signed into law the HIPAA, which incorporated into federal law many of the state regulations on insurance companies that had been enacted in the early 1990s. This legacy of insurance company regulation and Medicaid expansion paved the way for core provisions of the ACA.

Yet the policy legacy of the ACA extends beyond the Clinton plan to Republican proposals from the 1970s to the 1990s, notably the employer mandate and the individual mandate developed in opposition. The employer mandate was initially introduced during the Nixon administration and remained favored by Republicans under the Bush administration and in HEART. The individual mandate first made a formal appearance in the Bush plan, was revived under the Republican-sponsored HEART in 1993, then reappeared under the bipartisan Healthy Americans Act of 2006. It appeared to have bipartisan support until 2009, when Republicans turned against it. Instead, it became the favored option of Democrats.

The ACA represents a curious stew of provisions that simmered for nearly four decades. Those who claim it represents a liberal takeover of the health care system, a major step on the road to socialism, ignore the fact that the employer mandate and the individual mandate were both devised by conservatives who claimed these provisions were consistent with free-market principles and conservative ideals. At the same time, liberal supporters of a single-payer plan who view the ACA as a right-wing victory should take comfort in the Medicaid expansion, low-income subsidies, and opportunity for states to introduce a public option down the road. The ACA does adhere to the objectives of those who believe that the health care system should encourage market competition. Yet the subsidies will make coverage more affordable for low-income individuals and families, and the insurance company regulations will make coverage more accessible and reliable.
Jill Quadagno is professor of sociology at Florida State University, where she holds the Mildred and Claude Pepper Eminent Scholar Chair in Social Gerontology. Her research interests include health policy, aging, and political sociology. She and Joellen Pederson have recently published “Has Support for Social Security Declined? Attitudes toward the Public Pension in the United States, 2000 and 2010” in the International Journal of Social Welfare. Her most recent book is One Nation, Uninsured: Why the US Has No National Health Insurance. A past president of the American Sociological Association, in 2010 she was elected to the Institute of Medicine.

References


