EDWARD BERKOWITZ

Getting to the Affordable Care Act

Congress finished with the Affordable Care Act late at night on March 21, 2010. Weary White House staffers watched the proceedings. When things concluded, President Obama invited some fifteen or twenty of them back to the White House for an impromptu celebration. They assembled after midnight in the White House residence, and the president served champagne and hors d'oeuvres on the Truman balcony. "No matter what you do," the president said, "this will be the hallmark of the rest of your careers." As one participant noted, "Everyone was humbled that we were part of this effort that had previously failed."[1]

The formal signing ceremony for the Patient Protection and Affordable Care Act occurred on March 23. It was the usual elaborate ceremony, celebrating a legislative triumph for the president and his party. The bill, according to the president, "set in motion reforms that generations of Americans have fought for and marched for and hungered to see." The Affordable Care Act (ACA), then, marked the end of a long process that stretched back at least as far as President Truman.[2]

In explaining a modern event like the passage of the Affordable Care Act, historians need to understand the technical complexity of modern public

This article originated as a talk given at the Institute for Health, Health Care Policy, and Aging Research on October 8, 2015, at Rutgers University. I am grateful to Professor David Mechanic for arranging the event. I also wish to make clear that the essay was written, peer reviewed, and rewritten while Barack Obama was still president and before it became evident that Donald Trump and the Republican Party would win the 2016 election. I would contend that, despite the change in the political landscape, the points made in the article remain relevant to the history of health-care policy, although that is up to the reader to decide.

THE JOURNAL OF POLICY HISTORY, Vol. 29, No. 4, 2017.
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doi:10.1017/S0898030617000252

https://doi.org/10.1017/S0898030617000252 Published online by Cambridge University Press

policy, such as the complicated formula for computing federal payments to hospitals in the Medicare program. Unlike other social scientists, however, they do not have to allow their theories to do all the heavy lifting. In particular, historians have the luxury of uncovering the large role of serendipity in the creation of policy. Random events color what happens and, in so doing, affect what will happen as well. An unexpected election result and an unanticipated Supreme Court decision influenced the passage and implementation of the Affordable Care Act.

Historians who write on the subject of national health insurance have tended to be critics of the status quo. Despite the idiosyncratic approach of historians to politics and policy, they typically identify an aspect of our health insurance system that is less than optimal—and there are many such aspects—and proceed to examine the historical roots of the deficiency.[3] Although this approach has much to recommend it, it tends to emphasize structural deficiencies, such as racism, sexism, or income inequality, and to omit other factors that are closer to the institutions that make health policy. This article takes an institutional rather than an ideological approach and highlights such things as bureaucratic politics that has motivated changes in the federal agency responsible for health insurance (from the Social Security Administration and Welfare Administration to the Health Care Financing Agency to the Centers for Medicare and Medicaid Services). These arcane details matter in such things as the dominance of Medicare over Medicaid that lasted for many years, the battle to be the score keeper for health-care legislation, and the way that private companies have been used for public purposes as in prescription-drug benefits. A similar bureaucratic politics applies to the congressional committees that have governed Medicare and Medicaid. This politics helps to account for things like the remarkable role that Congressman Henry Waxman (D-Calif.) played in the expansion of Medicaid.

This article uses a new data set, composed of interviews with former heads of CMS and its predecessor, to illuminate the contents of the Affordable Care Act. As an act of policy history, it tries to examine those contents by placing them in their historical contexts.

BARACK OBAMA AND PAST PRESIDENTS

If one were to ask a Washington insider, the key to final passage of the Affordable Care Act was Speaker Nancy Pelosi's (D-Calif.) ability to hold her caucus together and get the House to pass an identical bill to the one that the Senate had already passed in November 2009. That avoided a conference committee

https://doi.org/10.1017/S0898030617000252 Published online by Cambridge University Press

report, which was critical to the process because the election of conservative Scott Brown to the very liberal Edward Kennedy's seat had altered dynamics within the Senate.[4] In fact, the unusual procedure probably made the bill more liberal than it would otherwise have been. Veteran health policy observer Gail Wilensky, who followed legislation closely and who understood the convoluted workings of health-care policy, believed, for example, that "this infamous IPAB, Independent Payment Advisory Board, which gives enormous power to this group and the Secretary would not have survived" a conference.[5]

This inside-politics view put a premium on last-minute deals and other maneuvers and tended to take attention away from the contents of the Affordable Care Act itself. Despite the contentious politics of its passage, the Affordable Care Act represented an incremental expansion of the existing system for health-care finance, not a revolutionary change. As always in the policy process, the past exerted a heavy influence on the present. History mattered even in the way that President Obama framed the ACA's contents and presented it to Congress. In particular, he tried to avoid the perceived errors in political strategy that led to the failures of the Catastrophic Health Care Act of 1988 and the Clinton health-care reform initiative of the 1990s.

In the 1988 case, legislators made the mistake of initiating new taxes to pay for things like a new drug benefit before starting the benefits themselves. These new taxes, paid by senior citizens rather than working Americans, triggered a successful movement to repeal the new law. President Bush 41 made an unsuccessful effort to save the law before signing the repeal.[6] The moral for Obama was to load a health insurance bill with popular benefits that people wanted before the more controversial and expensive aspects of the measure kicked in. Hence, the Affordable Care Act started with new provisions that made it easier for people with preexisting conditions to get health insurance and parents to keep their children on their health insurance plan until the age of twenty-six.

In the rear-view mirror of President Obama and his advisers, the Clinton initiative loomed large. It had become the poster child for an ill managed health-care campaign. The received wisdom was that Clinton took too long to introduce a bill, that he had written too much of that bill in the White House rather than allowing Congress to write its own bill, and that the process was conducted in secret without sufficient consultation of the major players who would be affected by the bill. As one participant recalled, "I got a call one day very shortly after the President took office to join the Health Care Task Force, and I became one of the 500 who hung out for three months in the old Executive Office Building, working on health care reform." He found that

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many committees had been created. "There were . . . 39 different committees, work groups, whatever, and I show up and say, 'You don't have anything here about antitrust?' So Ira (Magaziner, the White House staff member in charge) says, 'Good, you can head up the 40th committee.'" "The whole thing was just terribly managed."[7]

Obama vowed to do better. He made a point of leaving the drafting of his bill to the key members of Congress and their staffs and holding widely publicized meetings with representatives of the health-care industry. A small White House staff, notably Nancy Ann DeParle, who was a veteran of the Office of Management and Budget (OMB) and the Health Care Financing Administration (HCFA) in the Clinton administration, shadowed the process and lent what support it could, trying to demonstrate a conciliatory manner and still get Congress to pass a bill.[8]

Beyond matters of presidential style and avoiding past mistakes, the content of Obama's bill reflected the conventional wisdom on national health insurance in the first decade of this century. Everyone conceded that the system was too expensive, and most believed that the system excluded too many people. America spent more than 15 percent of its gross domestic product on health-care and still left some 38 million without coverage. Even those with health insurance experienced serious and often expensive problems as they became ill in the course of their working lives.[9] Providers received reimbursement from public and private insurers for the quantity of the work they did rather than the quality (or success) of their patients' outcomes. As Kerry Weems, who served in the Health Care Financing Agency during the second Bush era, put it, "We buy Medicare services by the yard and we shouldn't." Another prominent Bush 43 official said that Medicare should shift from being "a big dumb payer" and instead "pay for value or pay for quality."[10]

GETTING TO MEDICARE AND MEDICAID

In the Obama era, the Medicare and Medicaid programs, enacted in 1965, remained the centerpieces of a public health insurance system. Kennedy and Johnson, who had created Medicare and Medicaid, in turn looked back on Harry Truman's experiences. Truman had made formal health insurance proposals in 1945 and 1948 without political success. The usual way of explaining Truman's defeat—a staple of American political history—was that he was "stymied by the conservative coalition of Republicans and Southern Democrats that controlled Congress, fierce resistance of the American Medical Association and the Cold War stigma of socialized medicine."[11]

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This explanation, true as far as it goes, misses a key historical detail that helped to shape Medicare and Medicaid and, ultimately, the Affordable Care Act. The Truman administration hoped to make the Social Security system a delivery platform for national health insurance. At the time, however, Social Security was far from popular, covered less than half the population, and paid old-age benefits that were lower than the welfare benefits paid in most states. As such, it provided a very wobbly platform and demonstrated that straightforward political history obscured important points of policy history.[12]

The post-Truman wisdom held that one should expand Social Security first and only then press for national health insurance. The strategy proved very successful, calling into question the usual historical narrative of national health insurance as a series of reversals and defeats. In 1950, Congress expanded Social Security coverage and raised benefit levels, which provided a more secure base of support for the program. In 1956, Congress broadened the range of Social Security benefits to include disability. Only then did health insurance proponents turn to health insurance itself, and even then they adopted the conservative approach of limiting their proposals to cover people on Social Security: the elderly but not prime-aged workers.[13]

The delay from Truman to Kennedy mattered because it allowed for the continued growth of the private health insurance system and decreased the urgent need to pass public health insurance. As political scientist Chris Howard has noted, the use of tax expenditures to fund private health insurance occasioned much less debate compared to the heated battles over national health insurance in the Truman era. The reliance on tax expenditures had relatively little to do with health insurance itself but stemmed instead from the need to recruit workers and reduce turnover and disruptive strikes during World War II (a good example of one policy stream affecting another). Once in place, however, this arrangement tended to stay in place right up the age of Obama, and the federal government, in its drive to expand health insurance, had to work around it.[14] The Affordable Care Act built on the foundation of private health insurance for working Americans and their dependents.

National health insurance as understood in the Sixties—which turned out to be a crucial time in the system that Obama would inherit—meant special provisions for elderly Social Security beneficiaries. In the short run, Kennedy's efforts failed largely because he could not get Medicare past Wilbur Mills (D-Ark.) and the Ways and Means Committee. In explaining the passage of Medicare, a common convention is to contrast Lyndon Johnson's legislative acumen with Kennedy's less-sure handling of Congress. This explanation fails to account for the fact that LBJ tried very hard and

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failed to pass Medicare in 1964. It took the Democratic landslide of 1964 to get Medicare through Ways and Means and into the statute books.[15]

In retrospect, Medicare looked inevitable, but, just as in the Obama era, its contents remained fluid until final passage (a good example of how historical particulars influenced policy outcomes). Once in place, however, the three programs created in the era of Lyndon Johnson became permanent fixtures in the debate over national health insurance from 1965 to the passage of the Affordable Care Act. Anyone who coped with health-care policy needed to know the basic details of the three programs.

Medicare Part A or hospital insurance relied on payroll taxes to finance a new program that included such benefits as sixty days of hospital care and one hundred home visits by a nurse. As in a private insurance plan, out-of-pocket consumer costs, such as deductibles and co-pays, applied.

The second of the three programs, Medicare Part B or Supplementary Medical Insurance, helped beneficiaries with such things as laboratory tests, physician visits, and surgery. Voluntary in that beneficiaries needed to elect this coverage, it paid 80 percent of "reasonable charges" for all physician services, after a $50 yearly deductible and payment of a flat premium. In one version of Medicare's history, one endorsed by participants Wilbur Cohen, a high official in the Department of Health, Education, and Welfare (HEW), and Robert Ball, the commissioner of the Social Security Administration (SSA), Wilbur Mills, the chairman of the House Ways and Means Committee, essentially created Part B on the spot on the afternoon of March 2, 1965. "Without any advance notice," according to Wilbur Cohen, "Mills asked why we could not put together a plan that included the administration's Medicare plan with a broader voluntary plan covering physician or other services."[16]

Medicaid, the third of the 1965 programs, became the most misunderstood of the three, but it evolved into one of the most important building blocks of the Affordable Care Act. It involved an expansion of the Kerr-Mills program. Passed in 1960 and bearing the names of two of the most powerful legislators in Congress, Senator Robert Kerr (D-Okla.) and Representative Wilbur Mills, this program provided federal grants for state health insurance plans that served the elderly on welfare (understood as a program intended for only a particular segment of the poor) or the elderly who were medically indigent (poor but not poor enough to qualify for welfare). Medicaid expanded the Kerr-Mills coverage to those in the other welfare categories: dependent children, the blind, and the permanently disabled. Of these three groups, dependent children were the most important because they were the most numerous.[17]

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CONSEQUENCES OF MEDICARE

In the subsequent history of Medicaid, an obscure bureaucratic detail mattered. This program came not from the Social Security Administration, which controlled most of the bureaucratic action surrounding Medicare, but, rather, the Welfare Administration, a relatively new agency in the Department of Health, Education, and Welfare that had been split off from the SSA in 1963. That meant that, until Jimmy Carter changed the arrangement, two different parts of HEW ran Medicare and Medicaid. As a direct consequence of the sort not often considered by historians, health insurance advocates favored Medicare over Medicaid as the agent for the creation of national health insurance. Medicare, which already contained Parts A and B, might acquire a new Part C, which would expand coverage from the elderly to people of all age groups. Although that never happened, the effort to expand Medicare left a permanent imprint on the Affordable Care Act.[18]

At first, many of those in favor of national health insurance envisioned a series of incremental steps, rather than one grand leap. For Wilbur Cohen, who played the key role in the creation of Medicare as an HEW administrator, that view reflected his experience with Social Security and his expectations for Medicare. In 1968, Cohen, newly appointed as Secretary of HEW, took the first step and floated what became known as kiddy care, in which the federal government would pay for prenatal care and the baby's care through the first year of life. Although kiddy care did eventually become part of the arsenal of public programs, it took a far different form than that envisioned by Cohen. For Robert Ball, a Social Security bureaucrat and another key health insurance advocate, the first things on the incremental expansion list were health-care benefits for people on the Social Security disability program and prescription drug coverage.[19]

Wilbur Cohen never got kiddy care as an extension of Medicare, but the two expansions mentioned by Ball—coverage of disabled beneficiaries and prescription drug coverage—both came to pass. The first happened relatively quickly. Congress legislated Medicare coverage for people with disabilities in 1972. It did impose a special waiting period on disabled beneficiaries, but it made no changes in the program in order to accommodate people with disabilities. They were simply swept into the program as it existed in 1972, an almost incidental part of an omnibus bill that created a whole new welfare program and liberalized many aspects of Social Security.[20]

The second of Ball's expansions awaited the passage of the Medicare Modernization Act in 2003. The 1972 addition of people with disabilities was rather simple; it expanded the existing Medicare program. By way of contrast,

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the 2003 prescription drug program marked an effort to reorient the Medicare program—reform it in a fundamental way so that it utilized private companies, stimulated competition, and facilitated the use of managed care. In this new version of Medicare, recipients could choose a privately managed drug plan, and the Bush 43 administration hoped to direct Medicare recipients away from single-payer "traditional Medicare" into managed-care plans—known as Medicare Advantage—that would drive down the cost of care.[21]

PREDICTING THE COST OF PUBLIC PROGRAMS

In a sense, President Obama needed to cope with the both the traditional Medicare program of 1965 and 1972 and the reformed program that developed after 1972 and produced the Medicare Modernization Act of 2003. One key development that might serve as a case study of changes in the policy-making system for Medicare occurred in the way that policymakers estimated the program's future costs.

Once again, in a major motif of this essay, bureaucratic details mattered. A key part of the 1972 arrangement centered on the Office of the Actuary in the Social Security Administration. The actuary made estimates of the costs of legislative proposals on which the President's Office of Management and Budget in the executive branch and the Ways and Means and Finance Committees in the legislative branch relied. The actuary was supposed to operate at some remove from political considerations in order to serve as an impartial umpire and produce the best estimates possible.[22] That always mattered because each side in the political conflict wanted the estimates to come out in a certain way. Those who favored expansions sought evidence that they were within the nation's means. Those who opposed the expansions wanted data to show that the new initiatives would break the bank.

In fact, the relationship between the actuary and the rest of the Social Security Administration had often been tense, even in the placid days before the SSA took on the task of administering Medicare. One actuary who served at the beginning of the program in the 1930s would on occasion simply refuse to give a firm estimate on how much a program, such as disability insurance, would cost. Robert Myers, who served in the position from 1948 to 1970, lacked this sort of diffidence. He did his best to provide Congress and anyone else who was interested with the most accurate estimates, and he was not hesitant to put a firm number on a particular proposal. But even he ended up being fired by Commissioner Robert Ball for refusing to go along with the program to expand Social Security and Medicare.[23]

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By the time of the Medicare Modernization Act, the entire arrangement of making cost estimates for legislative proposals had changed. For one thing, Medicare now resided in a different agency than Social Security (bureaucratic details again). President Carter or more particularly Joseph Califano, his secretary of Health, Education, and Welfare, who thought himself particularly wise in the ways of Washington, created a new agency, called the Health Care Financing Agency in 1977. The new agency took Medicare, which had been housed in something called the Bureau of Health Insurance, from Social Security and united it with a successor to the Welfare Administration that was running the federal end of Medicaid. It put them both in a new bureaucratic entity that concentrated on health-care finance.[24] That meant there was now a Medicare actuary who worked at the Health Care Financing Agency.

For another thing, in the years between putting people with disabilities on the Medicare rolls and creating a new prescription drug benefit, Congress had acquired a greater capacity to act independently of the executive branch (yet another bureaucratic detail). The Medicare actuary might estimate the cost of a particular proposal from HCFA, but Congress relied on a new (1974) agency called the Congressional Budget Office (CBO). This office owed its existence to budget battles between the Democratic Congress and the Nixon administration at a time of particular ill will between the two branches of government. Once in place, it became the official scorekeeper for Congress. As the search for budget-neutral programs intensified in the late 1970s and throughout the 1980s, the scorekeeper function emerged as a vital part of the legislative process.[25]

After 1968 a prescription drug benefit for Medicare had become a perennial legislative proposal. In these years, the importance of pharmaceuticals in the practice of medicine increased, in part because of the efficacy of an expanding array of drugs, but in part because pills cost less than did a stay in the hospital. And just as medicine had become too expensive for many people to pay out of pocket, so the cost of prescription drugs stressed peoples' budgets.[26]

The Bush era initiative began in earnest in 2002, after 9/11 but before the Iraq War and at a time when there were "still surpluses as far as the eye could see." Bush had already enacted a tax cut, leading some administrative figures to argue that the right thing to do with these surpluses was "to come up with a market oriented, fairly conservative, fairly cheap drug benefit that will cover poor people." The president, who took an active interest in the discussion in a way that belied his reputation as a passive figure in the policy process, agreed. As always, though, the Republicans, who hoped to make inroads among

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elderly voters, faced competition from Democrats who had been seeking a prescription drug benefit from the beginning of the program. One key difference was that the Democrats favored a relatively expensive plan that covered all Medicare beneficiaries. The Republicans tended to think of prescription drug benefits as an adjunct of managed care. If one joined a prepaid health plan, one of the benefits would be prescription drug coverage. The president decided that he wanted to spend $400 billion over ten years "and not a penny more."[27]

Estimating the cost of a new benefit over a ten-year period was not a straightforward exercise for any actuary. The annals of social policy were filled with programs that greatly exceeded their initial cost estimates, including disability insurance and Medicare itself. As one insider described the new prescription drug benefit, "Nobody had any idea that it was going to work. It was all guess work."[28] Not surprisingly, then, the Congressional Budget Office and the Medicare actuary did not come up with the same scores for Bush's bill. Bush administration officials even anticipated this contingency, predicting that the CBO would score the proposal lower than the Medicare Actuary. Congress would then take Bush's bill and fill it up until the cost reached $400 billion, the president's limit, according to the CBO scores. The Bush administration, in other words, decided to work around its own actuary in the executive branch under the rationale that the CBO score, the one that favored the administration, was the only one that counted.

The bill as passed in December 2003 had a CBO score of $399 billion. But the administration's budget that came out at the beginning of 2004 used HCFA rather than CBO numbers. The media accused the administration of lying to Congress about the cost of the prescription drug benefit and trying to sell a $500 billion program for $400 billion. When Center for Medicare and Medicaid (CMS) officials (CMS was the bureaucratic successor to HCFA as a result of a name change in the Clinton era) refused to let the Democrats on the Ways and Means Committee see the Medicare actuary's scores, the Democrats charged that the Republicans were trying to muzzle the presumably independent Medicare actuary. Pete Stark (D-Calif.), a particularly partisan Democrat, put out a press release that said the CMS Administrator was threatening to fire the actuary.[29]

Hence the new prescription drug program began with considerably more acrimony than did the extension of Medicare to people with disabilities. Because 2004 was an election year, the political jockeying became particularly intense. Still, partisan bickering that impeded the policy process appeared to be a permanent fixture of health-care policy, in stark contrast to

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earlier periods. The incident showed just how hard it would be to pass even more fundamental health-care reform in the Obama era.

Technological changes in the delivery of benefits affected the development of health-care policy almost as much as changes in the policymaking environment. The fight over drug benefits lasted a long time, and as a result the measure that was finally passed in 2003 benefited from advances in technology that had not been so readily available in 1988 (the timing of a policy event matters). In that year Congress had passed a prescription drug benefit as part of the ill-fated Medicare Catastrophic Coverage Act. When the act was repealed in 1989, these drug benefits disappeared.

Some thought that might have been just as well. The HCFA employees who would have had to implement the 1988 benefit had serious doubts about their ability to administer it. The man in charge of the agency envisioned what he called the "shoebox approach." Under this arrangement, people would keep the receipts of their prescription drug expenditures and when those expenditures reached a certain level, "somehow they would make their claim to be reimbursed, which would obviously be horribly complicated and inefficient." By 2003 the available technology had improved.[30]

DRGS AND OTHER STATISTICAL MANIPULATIONS

Partisan politics and technology helped to create the environment that created the Affordable Care Act, but so did the more fundamental problem of rising costs in Medicare and Medicaid. The ascendancy of cost concerns over competing concerns related to the expansion of coverage was neither natural nor automatic. The fact remained, however, that slower rates of economic growth in contrast to the prosperity that had facilitated the creation of Medicare, the rising costs of medical care, and the nation's continuing defense needs all put pressure on the federal health-care budget. One indication of the changed policy environment was reflected in the career of William Roper, who worked in the Reagan administration at the beginning of a distinguished career that would take him to HCFA, the Centers for Disease Control, and ultimately to the University of North Carolina. Roper said that one of his regular activities at the beginning of the Reagan era was to go to the White House library and pull copies of the *National Journal* off the shelf. Reading the articles about health policy, he noticed that those from the early 1970s "were about how we can go further to add other populations to Medicare, ultimately to get national health insurance." By the end of the 1970s, "there were many more articles in the *National Journal* about the cost of the programs." As a result, "talk of expanding Medicare was lost."[31]

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Instead of adding new populations to Medicare, policymakers implemented new methods of reimbursing the expenses of doctors and hospitals that treated the old populations. Diagnosis Related Groups (DRGs) for hospitals and the Resource Based Relative Value Scale (RBRVS) for doctors, two new statistical concepts, provided more cost-conscious approaches to reimbursement than did the original, more permissive system.[32]

Bureaucratic capability, technological developments in computing, and partisan politics all mattered in the creation and implementation of DRGs. The Health Care Financing Agency, a small agency of some five thousand people, used some fifteen times that number to carry out its basic functions. It therefore farmed out major projects.[33] Hence the DRGs began with experiments in the states, such as New Jersey.

Bruce Vladeck, a distinguished figure in the health policy field, recalled that the New Jersey system required the calculation of 394 prices for one hundred separate hospitals from data that the hospitals submitted that needed to be key punched. At the time (the early 1980s), the New Jersey Department of Health did not even own a computer. The necessary computations were done at Yale University, at mainframe computers controlled by the state's Department of Transportation, and at Rutgers University. When the 1982 law that paved the way for the 1983 adoption of DRG's in Medicare was being debated in Congress, "there just wasn't a whole lot of actual data from New Jersey."[34]

With or without much evidence, Congress readily approved the introduction of the DRG system in 1983. It arrived as part of a Social Security rescue package that had the blessing of President Reagan and Speaker Tip O'Neill and thus passed Congress without much scrutiny. "There was no serious debate," one political insider noted.[35]

In fact, DRGs represented a politically astute way to handle Medicare's problems. Medicare benefits remained the same so far as the beneficiaries were concerned. What changed was the amount of money that hospitals received.[36] Hospitals would now be reimbursed a set amount of money by the diagnosis, rather than being allowed to charge for all of the costs a patient accrued during a hospital visit. It was a very complex procedure, but the basic idea was to substitute limited prospective for unlimited retrospective payments.

Both parties saw DRGs as a way of advancing their ultimate objectives. Mac Haddow, who was an assistant to Reagan-era Health and Human Services Secretary Margaret Heckler, a HCFA administrator, and someone well connected to Senator Orrin Hatch (R-Utah), said that some of his associates viewed DRGs "as a transitional step to a capitated system" (in which, for

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example, a person might receive a voucher and be expected to cover his health costs with that.) Liberals regarded DRGs as a common-sense way to squeeze money from the system that could be spent on national health insurance or some worthy cause. Both sides realized that the liberal reimbursement patterns of 1965 would have to give way to what Haddow described as a "budget-driven health care delivery system."[37] The Resource Based Relative Value System, another product of health services research, replaced the old way of reimbursing doctors at the end of the 1980s. It functioned in much the same way.[38]

Despite the political consensus that facilitated congressional passage of these changes, they were not without controversy. Providers and HCFA bureaucrats had many reservations about a system that would be difficult to implement and might lead to substantial reductions in the money doctors and hospitals received from Medicare (which had grown into the single largest payer in the health-care system). Henry DesMarais, who worked at HCFA in the period just after the start of the prospective payment system, served a short stint as acting administrator of the agency. He faced the most stressful situation of his short tenure in March 1986. Reporters including Joel Brinkley of the *New York Times* demanded the release of agency data that reported on mortalities by hospital. The agency regarded the data as preliminary and had no desire to embarrass particular hospitals. The General Counsel told DesMarais that he had no choice but to release the data. What motivated the frenzy over this data stemmed from the controversy over whether the newly installed DRG system caused patients to be released quicker and sicker from the hospital and possibly caused more of them to die. Receiving a set amount of money for a particular diagnosis, hospitals made more money if they released a Medicare beneficiary as quickly as possible than they would if they kept the patient longer. What made the data particularly sensitive was that it concerned the welfare of Medicare beneficiaries and not just the reimbursement patterns for particular hospitals or doctors. Prospective payment, however rational it seemed to policymakers, unsettled people and institutions used to the older system.[39]

THE UNANTICIPATED RISE OF MEDICAID

Although much public and congressional attention centered on Medicare, Medicaid became the key vehicle for the expansion of health-care coverage beginning in the 1980s. In expanding Medicaid, the Affordable Care Act therefore followed an established pattern of the late twentieth century. The new

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act proposed to widen Medicaid eligibility to include adults without children (who were the least likely to fall into the traditional welfare categories and hence receive Medicaid) and raise the eligibility across the nation to 133 percent of the federal poverty line. Income level, rather than the receipt of welfare benefits, would determine Medicaid eligibility.[40]

That development would have come as something of a surprise to policy observers in 1965. Both Medicaid and Medicare began with the notion that social insurance represented a better form of social protection than welfare or public assistance. The mantra at the Social Security Administration was that programs for poor people made poor programs. Medicare was tied to the Social Security program and the respected Social Security Administration and Medicaid to the welfare system and the much less well respected welfare and rehabilitation bureaucracy. When President Carter put Medicare and Medicaid together in a new agency, Medicare quickly established itself as the "dominant partner."[41]

Federal administrators favored Medicare in part because they had more control over it. One set of Medicare rules, at least in theory, applied to the entire nation (although these rules were interpreted by widely dispersed "fiscal intermediaries" and "carriers" and after 2003 by Medicare Administrative Contractors). Hence Congress could create something like the diagnosis-related groups and expect them to govern Medicare expenditures across the nation. These same sets of fiscal controls did not operate in Medicaid. The common wisdom was that, in the words of CMS administrator Michael McMullen, "Medicaid was a different program for every state." Another former CMS administrator noted, "There is not just one Medicaid program; all of them are different in the states and territories." In a typical lament, one federal official, who worked in the New York regional office of the Department of Health and Human Services, complained that in the 1970s "we lacked clear rules."[42]

Based on that sort of evidence, one would have expected Medicare to expand at a greater rate than Medicaid and eventually subsume Medicaid. There was historical precedent for that. The old-age insurance program largely replaced the old-age assistance welfare programs in the states during the 1950s. Despite much discussion, particularly in the Reagan era, however, Congress did not take the step of federalizing the Medicaid program. It remained a separate and a growing entity. By the time the Affordable Care Act came along, Medicaid had 20 percent more people than Medicare on its rolls. More people received Medicaid than received Social Security.[43]

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If one were to judge by expenditures and the number of people covered, Medicaid was a great success. It cost less than $1 billion in 1966 and more than $200 billion in 2000. At the beginning the program had something like four million people on its rolls and spent about $200 on each person enrolled. By the end of the century, the rolls had swelled to 33 million and the program spent $750 per capita.[44]

Medicaid owed its survival and eventually its inclusion in the Affordable Care Act in part to the way that Congress protected the program at critical junctures. In 1996 the battle over welfare reform reached a climax and the largest welfare program—Aid to Dependent Children—became incorporated into a federal block grant. The states got considerably more leeway to deal with dependent children on welfare in their particular state, and welfare as an entitlement, in which everyone who qualified received benefits, ended. Instead of allowing the states a similar leeway to end the Medicaid entitlement of dependent children and their parents, Congress created the State Children's Health Insurance Program (SCHIP) in 1997, which broadened health insurance protection for children. Kiddy care, the desired policy objective of liberals in the 1960s, had morphed into the means-tested SCHIP Program.[45]

A second critical juncture occurred in 1988 and 1989, when the Medicare Catastrophic Coverage Act was passed and then repealed. In 1989 Congress repealed all of the social insurance aspects of the 1988 bill. At the same time, it left intact the Medicaid aspects of the 1988 bill, such as a provision that required states to use their Medicaid programs to pay Medicare deductibles and co-insurance for people with incomes below the poverty line.[46] Previous state options were converted into mandates. Medicaid came out of the experience strengthened rather than weakened.

Because of the wide variety of state plans and the freedom of states to experiment, Medicaid, although widely criticized as inadequate, became known as a center of health innovation. For example, states began to experiment with health maintenance organizations and other health delivery systems that were touted as more efficient and inclusive than traditional health insurance. Earlier than Medicare, Medicaid, to the extent that one could talk about a national program, changed "from merely paying claims to managing services and the costs of care as well." By the year 2000, more than half of all Medicaid clients were in some sort of managed-care plan.[47]

Medicaid also profited from the fact that it filled a key niche in the nation's safety net. Medicaid became the major vehicle for financing long-term care, paying nearly half of the nation's total costs. When the program

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began, the bias among policymakers was that the federal government should not support custodial care, such as the large insane asylums that could still be found in many states. No one wanted hospitals, widely hailed as places where people went to be cured, to become, in health expert Judy Feder's words, "warehouses for frail elderly people."[48]

Here Medicaid's loose structure facilitated its growth. Congress, reflecting the fashions of the day, explicitly prohibited Medicare from covering custodial care. Instead, the program limited its long-term-care benefits to post acute care that followed a hospital stay and would lead to the recovery of the patient. Medicaid, from the beginning, had fewer constraints and quickly became a major supporter of nursing homes. Nursing home care for individuals over twenty-one was one of five basic benefits that the federal government required the states to have in their Medicaid programs. As early as 1971, Medicaid was disbursing more money on nursing homes "than had been spent in the entire industry five years earlier." The creation of intermediate care facilities, which offered fewer services than so-called skilled nursing facilities, also facilitated both the growth of Medicaid and the growth of nursing homes.[49]

Long-term care brought a new clientele to Medicaid. The residents of nursing homes were not traditional welfare recipients. Instead they might be elderly women who had outlived their husbands and spent down their assets. The nursing homes themselves became a powerful political force—supposedly the most influential force in twenty-one states according to Medicaid authority Laura Olson. That changed the configuration of health-care politics. Republicans interested in ending federal matching grants in Medicaid and returning the program to the states needed to counter the argument that most of the money would go to nursing homes.[50]

CONGRESSIONAL POLITICS AND HENRY WAXMAN

Beyond these important structural factors, Medicaid benefited from congressional champions who knew how to use the budget reconciliation process to expand Medicaid. The most prominent was Congressman Henry Waxman, who came into Congress as one of the Watergate babies in 1975 and held a safe seat in the Los Angeles area. His main committee assignment was the Interstate and Foreign Commerce Committee (now called the Energy and Commerce Committee), which came to play an important role in health-care policy.[51]

Once again, otherwise unimportant bureaucratic history mattered. In 1935 someone decided that the programs created by the Social Security Act, such as Social Security and welfare, should fall under the jurisdiction of the

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congressional tax committees. That followed from the fact that Social Security, if not welfare, depended on payroll deductions—taxes, in other words—as its means of finance. That meant that the Ways and Means Committee in the House and the Finance Committee in the Senate controlled the Social Security program.[52] Since Medicare was another program financed in part by payroll taxes, it too came under the jurisdiction of these important committees.

Urban liberals, who typically served on committees concerned with labor and education, represented a countervailing force that challenged the control of the tax committees, often controlled by southerners, over social legislation. Senator Robert Wagner (D-N.Y.), for example, used the Committee on Education and Labor to advance the cause of national health insurance. Senator Edward Kennedy (D-Mass.) made the Labor and Human Relations Committee his base of operations. In the House, John Dingell (D-Mich.), the head of the Interstate and Foreign Commerce Committee, had inherited his Detroit-area seat from his father, whose name was practically synonymous with national health insurance in the 1940s. When Medicare passed the House in 1965, John Dingell, who served in Congress from 1955 to 2015, held the gavel in homage to his dad, who had represented the same Michigan district from 1933 to 1955. Dingell led a move to take the health programs that were not directly financed by payroll deductions away from the Ways and Means Committee. In 1974, a year of considerable upheaval in Congress after the Watergate scandal, he succeeded in having his committee gain jurisdiction over Medicaid and to share jurisdiction with Ways and Means over Medicare Part B.[53]

Henry Waxman, who headed an important health subcommittee of the Commerce Committee, led the way in the incremental expansion of Medicaid in the 1980s. Each year after 1984, Congress passed laws that expanded Medicaid coverage in the states. Even before that, in 1981 Congress allowed the states to pay additional compensation to hospitals serving a disproportionate share of Medicaid or uninsured patients. States learned how to use this program to expand greatly the federal contributions to their state Medicaid program. A state could, if it wished, increase the so-called DSH payments to a hospital to any level it chose and recoup the increased payment through a donation from or tax on that provider. In that way the state received, in the words of one expert, "essentially unlimited Federal matching funds with little or no increase in net State spending." Thirty states took advantage of this practice.[54]

More conventional Medicaid expansions of the era affected infants, children, pregnant women, low-income Medicare beneficiaries, and other disabled

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and aged enrollees. Washington insiders, like Michael Hash, who worked on the Affordable Care Act from the White House, called it "the Waxman wedge," which over a period of eight or nine years changed Medicaid from a program that served welfare beneficiaries to one that brought care to low-income individuals. States provided Medicaid, for example, to children in families that earned too much to qualify for welfare programs, such as AFDC or, later, Temporary Aid to Needy Families. A former head of CMS called Henry Waxman and John Dingell "raging incrementalists," who fundamentally changed the Medicaid program in the 1980s.[55]

AFTERMATH

In this very disjointed way, the nation progressed from Medicare to the Affordable Care Act in some forty-five years. When national health insurance arrived, it looked very much like the existing health-care system, with various parts, such as private health insurance and Medicaid, tweaked and extended. Still, given the political and technical difficulties involved, President Obama had every reason to celebrate passage of the ACA.

Since it was incremental reform, however, it meant that not everyone, even after the passage of the ACA, received health insurance coverage. It also meant that this legislation of many parts contained many things that its opponents could try to strip from the law even after it had been passed. As the third enrollment season got under way in September 2015, the *Washington Post* could report that 10.5 million Americans—disproportionately young adults or minorities, many from northern New Jersey—were eligible to purchase health care through the health insurance exchanges but had not yet done so.

At the same time, the Department of Health and Human Services claimed that 17.6 million Americans had gained health insurance coverage because of three aspects of the ACA. These included the change in insurance regulations that enabled young adults to remain on their parents' health insurance policies, one of the early benefits intended to create a favorable climate for the law's implementation—a vaccine, only partially successful, against repeal of the act. The exchanges maintained by the federal government and many of the states, intended to make private health insurance more accessible to Americans, constituted a second aspect of the act that promoted the expansion of private health insurance coverage. The third aspect of the ADA that promoted more health insurance coverage was the expansion of Medicaid.[56]

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The Medicaid expansion did not go quite as far as the Obama administration had hoped it would. In July 2012, the Supreme Court, in a decision upholding the basic constitutionality of the ACA, ruled that the states did not have to expand their Medicaid programs, with the result that only twenty-nine did. Judicial review thus affected the ACA just as it had earlier social reforms, such as the National Industrial Recovery Act during the 1930s. In addition, Congress, with its Republican majority in the House of Representatives beginning in 2011, sought to repeal the act. By March 2014, the House had voted six times to overturn the act.[57] The 2016 election only increased the pressure to repeal the law.

Incremental reform had the advantage that many people had bought into its components along the historical path that led up to it. As William Roper explained, the Affordable Care Act contained "many of the elements of health reform that I worked on in the Reagan and then Bush 41 administration." Nonetheless, it was not, despite all of Obama's efforts, a bipartisan bill. Republicans voted unanimously against it (unlike the Social Security Act of 1935 or the Social Security amendments that created Medicare in 1965). Roper noted that "a number of people on the far right have described it as socialized medicine or a takeover of health care by government."[58]

The result was that in a state like Missouri, described by its hospital association director as a "very red state," the state legislature failed to approve the Medicaid expansion, much to the chagrin of many hospitals in the state. Since so much of the new money was federal, it did not seem like rational behavior on its face. The hospital director explained that "the larger issue here is that it's part of the ACA. It's part of Obamacare. And if you're a politician who's campaigned against Obamacare, have campaigned for the repeal of it, the whole notion that you might move to implement any part of it becomes a real challenge."[59]

William Roper believed that the "simplification that the ACA sought to do . . . to make it a program that served low-income Americans and not categorically eligible low-income Americans, is something we simply need badly to do in a uniform way all over the country. But it suffers from the fact that it is not just a federal program but a federal and state program and therefore we have 50-plus state-like entities dealing with it and we've reached a stalemate about the ability to do full-scale overhaul of Medicaid."[60] In other words, there were limits, despite all of the incremental efforts by Henry Waxman and others, in the ability of the Medicaid program to transcend its historical identity as a state-run welfare program and become something else.

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That was one of the prices of the incremental approach to comprehensive reform. On the one hand, the approach made it possible to pass a comprehensive program that was composed of incremental changes in existing programs or approaches. On the other hand, the approach limited the nature and scope of the reform. Before and even during its late twentieth-century expansion, Medicaid had never been a major concern of many health-care reformers or of CMS. As Obama's CMS administrator explained, "Medicaid had never been front and center in the CMS world. And all of a sudden it's front and center. And then after the Supreme Court it's front and center and complicated."[61] Maybe it could not bear the weight of its newfound prominence.

CONCLUDING COMMENTS

A short, elliptical piece, this essay hardly substitutes for a deeply researched historical monograph, but it does suggest some approaches that future chroniclers of the ACA might take.

Historians need to remember that presidents have the images of the perceived successes and failures of their predecessors in their heads as they produce new legislative proposals. Obama had Clinton, and Kennedy had Truman in the rear-view mirror. Even as they look backward, however, these presidents and the people who advise them cannot escape from the conventional wisdom of their own times. In Obama's case, for example, the notion that somehow the idea of quality needed to be incorporated in Medicare reimbursement had wide currency. The very ambiguity and imprecision of the term "quality" added to its widespread appeal. In the Obama era, another unquestioned assumption was the need for some sort of cost-control mechanism, such as the diagnosis-related groups that affected the federal government's reimbursement of hospitals in the Medicare program. DRGs, like the other ideas that produced the ACA, had intellectual origins that were independent of electoral politics. Ideas mattered, but they had political consequences when placed into an overtly political setting.

Although this article is not exhaustive and reflects its origins in the Obama rather than the Trump era, I hope it has exposed some new approaches and introduced new topics to the historiography of national health insurance. For better or worse, the Affordable Care Act adds another piece to the institutional landscape that will have a permanent effect on the history of national health insurance whatever the ultimate result of the

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campaign to repeal it. In the end, the only way to tease out its lessons is to live through them, aware of the fact that policymakers are always indebted to the past as they legislate for the future.

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the Clinton administration. Gawande called health care "at once our most ambitious and treacherous project."

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