

They're Back: The Public Plan, the Reincarnation of Harry and Louise, and the Limits of Obamacare

Marie Gottschalk
University of Pennsylvania

Many advocates of universal health care put competition and consumer choice at the center of the latest major push for health reform. Dozens of major organizations close to the Democratic Party, including the AFL-CIO, Moveon.org, and the Children's Defense Fund, fought on behalf of a remarkably modest solution: creation of a public health plan—essentially a nonprofit insurance company—to compete with the commercial health insurers. They largely abandoned the movement for a single-payer health system, which had been gaining ground since the demise of the Health Security Act during Bill Clinton's administration, fifteen years ago. This faith in market-led solutions for health care remained largely unshaken, despite the recent financial collapse. The final version of the Patient Protection and Affordable Care Act (ACA) did not include a provision for a robust public plan—or even a weak one. But the controversy over this issue has left a lasting mark on the course of health care reform.

The Public Plan Option

During the 2009–2010 health reform debate, private insurers charged that a public plan would not be competing on a level playing field and thus would ultimately drive them out of business. This subtly recast the debate. The focus shifted toward how to make the public plan a “fair” competitor and away from the enormous inequities of the underregulated

private insurance market in the United States that have contributed so significantly to the country's health care crisis. It also deflected attention away from the costly side deals that the administration cut early on with the pharmaceutical industry, the hospital sector, and others to garner support (Blumenthal 2010; Mundy and Meckler 2009).

Advocates of the public plan's hybrid approach to reform created highly stylized versions of the relative strengths and weaknesses of the public and private sectors in the delivery of health care (see, for example, Hacker 2008: 1). These advocates extolled the public sector for its reported ability to contain costs and to pursue innovations that improve the quality of care. At the same time, they applauded the private sector for offering a range of insurance products and for nimbly adjusting benefit packages to meet shifts in consumer demand. Meanwhile, they glossed over the enormous variations in how the public and private sectors actually deliver health care in the United States and abroad.¹

In short, public plans are not necessarily innately superior when it comes to developing cost-saving innovations.² The real question is, under what conditions do the political stars line up such that both the government and the public are willing to use their considerable powers as the prime purchasers of health care to rein in providers and insurers? The new public plan might have ended up looking like the largely unregulated Medicare program circa 1965 or today's semiregulated Medicare program or the grossly underfunded Medicaid program or the health care equivalent of Fannie Mae and Freddie Mac, the quasi-public mortgage companies that were leading culprits in the subprime fiasco and the foreclosure crisis.

Greater Regulation and the Single-Payer Option

The public plan option split organized labor and other key groups. Just like fifteen years ago, supporters of a single-payer plan were some of the fiercest opponents of a minimalist approach to health reform. The single-payer message had not changed much from the early 1990s, though supporters invested more effort this time around in mobilizing support from labor unions and other groups.

Single-payer advocates focused public attention on the extraordinary

1. See Grogan's essay in this issue for a broader discussion on the interdependence of the public and private sectors in the U.S. health care system.

2. For a more detailed critique of the public plan proposal, see Gottschalk 2010.

pathologies of the U.S. health system, notably the enormous costs amid gross lapses in care and coverage and the billions squandered on administrative costs. They also offered the most progressive tax proposals to finance universal health care. But their fixation on a Canadian-style solution over the years may have come at the cost of not seriously considering alternative European models of health care that have achieved affordable universal health care while retaining a sizable insurance industry. What most distinguishes health care systems is not necessarily whether the government pays all the bills directly to providers without third-party insurers but rather whether a country has the political will and institutional capacity to seriously regulate the health care and insurance industries.

President Barack Obama and other would-be reformers attempted to skirt an axiom of medical economics that is at the heart of the politics of health care: “A dollar spent on medical care is a dollar of income for someone” (Marmor, Oberlander, and White 2009: 485). Health care reform to achieve universal, high-quality, affordable care is fundamentally a redistributive issue with high political and economic stakes. Meaningful cost control demands strong government leadership to set targets or caps on medical spending and regulate risk pools and administrative expenditures. Competition is a weak, indirect way to contain costs in the absence of strong regulatory institutions. Historically, the United States has been shockingly unwilling to seriously regulate its private insurance industry (Quadagno 2005: 169). Obama attempted to finesse the politically explosive issue of real cost containment by focusing on what one critic disparaged as “faith-based savings,” notably, expanding the use of electronic health records and investing more in preventive care and better disease management (Oberlander 2008).³

Supporters of the public plan solution conceded that the insurance industry needed tougher regulation, but this was not their main focus. Their emphasis on competition reinforced the idea that health care should be treated primarily as a private consumer good distributed by market principles. This undermined the idea of health care as a social good that needs to be organized around underlying principles of social solidarity, not market competition.

Advocates of the public plan risked squandering enormous political capital to get so little. They bent over backward to convince the public and critics in the insurance industry that they truly would create a level

3. For more detail on cost-control provisions (or the lack thereof) see essays by Oberlander, Rice, Gusmano, and Pauly in this issue.

playing field. This fostered the impression that the insurance industry has been playing fair and square all along. The terms of the debate shifted to the imaginary injustices that a mammoth public plan would inflict on a Lilliputian insurance industry that has historically been too weak and fragmented or too disinterested to put the cost-containment screws on providers. This is a revisionist portrait at odds with the historic role of the insurance industry in U.S. politics. The insurance industry has been a shrewd behind-the-scenes political operator for well over a century now. Since the Progressive era, each time health care reform has moved to center stage, outcries for more federal action have ended up further entrenching the private insurance industry (Quadagno 2005: 75; Klein 2003).

The Return of Harry and Louise

The public plan solution emerged out of the doldrums of the vanquished Clinton plan and out of a very particular reading of what went wrong fifteen years earlier. In the revisionist account, Harry and Louise, a fictional, white, middle-class couple featured in a series of commercials funded by the insurance industry, killed health care reform under Clinton. Harry and Louise because famous—or infamous—as they sat around their kitchen table, fretting that the Clinton plan would force them to change their current health benefits and maybe even switch doctors.

Elite policy and opinion makers then and now have persistently overestimated how much Harry and Louise represented heartfelt popular sentiment and how satisfied Americans are with the health care coverage they have (Brodie 2001). As the health care debate got under way in 2009, there was overwhelming evidence that Americans were profoundly dissatisfied with their health care system and were ready for major changes (Blendon, Kim, and Benson 2001: 16).⁴ Over the last fifteen years, in the wake of the demise of the Clinton plan, the wheels had come off job-based benefits (Gottschalk 2007). As the Great Recession settled in, it was no longer possible for most Americans to maintain six degrees of separation from the uninsured. The foreclosure crisis riveted public attention on the enormous number of Americans who had gone bankrupt and risked losing their homes because of medical debts. Many of them

4. One of the most surprising poll results came from a 2008 Harvard School of Public Health survey that directly asked whether a “socialized medical system” would be better than the current one. Among those who said they had some understanding of this historically inflammatory phrase (82 percent), a plurality (45 percent) said socialized medicine was preferable (Harvard School of Public Health 2008).

were middle-class people who'd initially had health insurance when they first became ill.

The minimalist approach to health reform premised on creating a modest public plan option did not tap into this smoldering public anger over the health system or into the explosive public outrage at the financial industry, the business sector, and their bipartisan political patrons in Congress in the wake of the economic meltdown. The time was ripe for an ambitious health care plan that fundamentally challenged the very insurance, financial, and health care industries that have repeatedly thwarted the creation of an affordable, high-quality, and just system of universal health care (Tomasky 2010). The economic meltdown rendered legislators on both sides of the aisle in Congress particularly vulnerable to charges of shilling for the business sector (see, for example, Toobin 2010). Obama's decision to seed his administration with many free-market protégés of Citigroup's Robert Rubin also made him vulnerable on this score, as did his choice of Nancy-Ann DeParle, who served as director of many large health care companies, to be his health czar.

During the campaign, Obama said, "It's time to let the drug and insurance industries know that while they'll get a seat at the table, they don't get to buy every chair" (Newton-Small and Marcus 2007). He also promised that if the insurance industry sought to block reform with another Harry and Louise blitzkrieg, he would go on the offensive. But in the formative months of the health care debate, Obama and his key advisers gave no public indication of their readiness to defend certain first principles—or even to define what those first principles were, besides seeking a quixotic bipartisanship at all costs.⁵ The administration and leading Democrats in Congress did not wield the threat of the reconciliation process to keep conservative senators like Max Baucus (D-MT), Ben Nelson (D-NE), and Joe Lieberman (I-CT) from becoming health care kingmakers. They also did not seriously consider mobilizing on behalf of a long-overdue institutional reform of the Senate to eviscerate the filibuster, which has become so deleterious to democracy and to enactment of comprehensive, progressive social-welfare legislation (Geoghegan 2009, Packer 2010).

The Obama administration and much of the leadership of the Democratic Party responded to the health care crisis much as they responded to the financial crisis. They took extreme care not to upset the basic interests of the powerful insurance industry and segments of the medical industry and not to raise fundamental questions about the political and economic

5. See, for example, Wolf 2009.

interests that have perpetuated such a dysfunctional health system. They sought a minimalist solution rather than seizing the exceptional political moment to strike out in a bold new direction in health policy.

After the public plan was left by the wayside, in tatters, its supporters in organized labor and elsewhere rallied around a strikingly conservative solution. The ACA is remarkably similar in spirit to the controversial Medicare Part D prescription legislation pushed through by the George W. Bush administration in 2003, which was based on federal subsidies and loosely regulated private insurance plans and which imposed no serious cost controls on the pharmaceutical industry. A centerpiece of the ACA is an individual mandate requiring everyone to have health insurance coverage or else pay a penalty tax. This was a key feature of the plan introduced fifteen years earlier by the late Senator John Chafee (R-RI) and has been a darling of the conservative Heritage Foundation for years.

The ACA imposes an individual mandate on all Americans but does not impose serious cost controls that have worked in other countries to contain the medical and insurance industries. As health care costs continue to escalate, more Americans will be unable to afford insurance and will be forced to pay the penalty tax in these hard economic times. The ardent supporters of the ACA thus are at risk of a fierce political backlash and of being tarred once again as big tax-and-spend Democrats. This helps explain why the Republican Party's recent push to repeal the health care bill has had such traction.

The achievements of the ACA are considerable. But they have been bought at considerable cost. An additional 16 million uninsured Americans will be eligible for Medicaid, by some estimates, and millions more will qualify for government subsidies to purchase health insurance (Ku 2010: 1173). But this highly compromised legislation was born out of a strategy of top-down insider politics that did not fundamentally realign the politics of health care or of U.S. politics more broadly. It neither solidified a durable reform coalition to redistribute health dollars more equitably and efficiently nor fundamentally challenged the insurance and medical industries. Now that health reform has moved to the implementation phase, where lobbyists for these industries are greatly advantaged, this is a potentially fatal flaw.

Obama and the Democrats may have squandered an exceptional political moment.⁶ There are not many times in U.S. history when the previous

6. For more discussion of how 2009–2010 represented a unique political opportunity for health reform, see essays in this issue by Brown, Peterson, and Hacker.

administration, the ruling party, and the financial sector have been so thoroughly discredited. The Great Recession is one of them. The Depression was another. President Franklin Delano Roosevelt came into office at an exceptional moment in 1933. Four years into the Depression, the Hoover administration was thoroughly discredited, as was the business sector. FDR recognized that the country was ready for a clean break with the past as he symbolically and substantively cultivated that sentiment. But the break did not come from FDR alone. Massive numbers of Americans mobilized in unions, women's organizations, veterans' groups, senior-citizen associations, and civil-rights organizations to push FDR to switch course in the face of deep public mistrust and contempt of business after the 1929 stock market crash.

If Obama, leading Democrats, and their allies calculated that the political conditions were not fortuitous to secure a single-payer plan, at least they might have pushed for a seriously regulated insurance system. Their failure to do so may have jeopardized their political fortunes, the cause of universal health care over the long term, and other efforts to defend and extend the safety net. Obama and other would-be reformers, including those who fought so doggedly to essentially create a nonprofit health insurance company, did not recognize the potential of the political moment in early 2009. It was not 1993–1994 all over again.

References

- Blendon, R. J., M. Kim, and J. M. Benson. 2001. The Public versus the World Health Organization on Health System Performance. *Health Affairs* 20 (3): 10–20.
- Blumenthal, P. 2010. The Legacy of Billy Tauzin: The White House-PhRMA Deal. Sunlight Foundation blog. Feb. 12. blog.sunlightfoundation.com/2010/02/12/the-legacy-of-billy-tauzin-the-white-house-phrma-deal/.
- Brodie, M. 2001. Impact of Issue Advertisements and the Legacy of Harry and Louise. *Journal of Health Politics, Policy and Law* 26:1353–1360.
- Geoghegan, T. 2009. The Case for Busting the Filibuster. *Nation*, August 31. www.thenation.com/issue/august-31-2009.
- Gottschalk, M. 2007. Back to the Future? Health Benefits, Organized Labor, and Universal Health Care. *Journal of Health Politics, Policy and Law* 32:923–970.
- . 2010. U.S. Health Reform and the Stockholm Syndrome. In *Morbid Symptoms: Health Under Capitalism*, ed. L. Panitch and C. Leys, special issue, *Socialist Register* 46:103–124.
- Hacker, J. 2008. *The Case for Public Plan Choice in National Health Reform: Key to Cost Control and Quality Coverage*. Berkeley, CA: Institute for America's Future.

- Harvard School of Public Health. 2008. Poll Finds Americans Split by Political Party over Whether Socialized Medicine Better or Worse Than Current System. News release, February 14.
- Klein, J. 2003. *For All These Rights: Business, Labor, and the Shaping of America's Public-Private Welfare State*. Princeton, NJ: Princeton University Press.
- Ku, L. 2010. Ready, Set, Plan, Implement: Executing the Expansion of Medicaid. *Health Affairs* 29:1173–1177.
- Marmor, T., J. Oberlander, and J. White. 2009. The Obama Administration's Options for Health Care Cost Control: Hope versus Reality. *Annals of Internal Medicine* 150:485–489.
- Mundy, A., and L. Meckler. 2009. Drug Makers Score Early Wins as Plan Takes Shape. *Wall Street Journal*, July 17.
- Newton-Small, J., and A. Marcus. 2007. Obama, Following Rivals, Unveils Health Plan. Bloomberg.com, May 29. www.bloomberg.com/apps/news?pid=20601070&sid=a5FINBWWfSDc.
- Oberlander, J. 2008. Miracle or Mirage? Health Care Reform and the 2008 Election. Invited lecture, University of Pennsylvania, Leonard Davis Institute, October 10.
- Packer, G. 2010. The Empty Chamber: Just How Broken Is the Senate? *New Yorker*, August 9.
- Quadagno, J. 2005. *One Nation Uninsured: Why the U.S. Has No National Health Insurance*. New York: Oxford University Press.
- Tomasky, M. 2010. The Money Fighting Health Care Reform. *New York Review of Books*, April 8, 10–14.
- Toobin, J. 2010. The Senator and the Street. *New Yorker*, August 2, 51.
- Wolf, R. 2009. Ready to Tackle Health Care Overhaul. *USA Today*, June 1. www.usatoday.com/news/health/2009-06-01-health-care-team_N.htm.

Copyright of Journal of Health Politics, Policy & Law is the property of Duke University Press and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.