

Why Is Health Reform So Difficult?

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Abstract This article examines the possibilities for health care reform in the 111th Congress. It uses a simple model of policy making to analyze the failure of Congress to pass the Clinton health plan in 1993–1994. It concludes that the factors that created gridlock in the 103rd Congress are likely to have a similar impact in the present.

Introduction

In November 1992 health care reform appeared to be a foregone conclusion. The country had elected a new, charismatic Democratic president and a Democratic Congress. Both the incoming president and members of Congress vowed to make health care reform a priority. Health insurance premiums were rising, and the economy was in recession. Yet, despite these favorable conditions, no major health care legislation passed the Congress.

A long literature has analyzed the failure of the Clinton health plan. Broder and Johnson (1996) provide an excellent description of the policy process but do not explicitly identify the causes of what was then considered a surprising outcome. Hacker (1997) argues that Bill Clinton and his advisers naively thought that managed competition would appear liberal

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to liberals and moderate to moderates. Skocpol (1996) argues that Clinton's health care plan failed because of Ronald Reagan's antigovernment legacy, the deficit, and the fact that Clinton spent critical time and energy on the North American Free Trade Agreement (an issue that antagonized liberals and labor groups).

Steinmo and Watts (1995) offer an institutionalist perspective that views the failure of the Clinton plan more broadly. They argue that the fragmented and federated political system in the United States gives enormous power to focused interest groups, which in turn inhibits large-scale change like health reform, even if such change were favored by a majority.

Although these works have contributed to an understanding of the politics of health reform, none focuses on the role of voters' preferences and how the interaction between these preferences and congressional institutions affected health reform in the 1990s—and could affect health reform in 2009. As one of us has written elsewhere (Brady and Buckley 1995), this type of model can explain the failure of reform in the early 1990s. It shows how supermajority institutions in the Congress, combined with incomplete information about the consequences of reform, favor gridlock (Krehbiel 1998; Brady and Volden 1998).

In this article, we first reexamine the failure of the Clinton health reform plan in light of this model. Then we discuss the prospects for reform at present. We consider how changes in public opinion, the composition of Congress, and macroeconomic conditions might lead the outcomes of the policy process in 2009–2010 to differ from those in 1993–1994.

Gridlock Theory

In this section, we describe how voters' preferences and congressional institutions put constraints on policy formation, even if policy makers have complete information about the consequences of reform. Then we expand the model to include the possibility of three forms of uncertainty: uncertainty about the economic effects of policy changes, uncertainty about constituents' reactions to a given economic effect, and uncertainty about the location of other legislators' preferences.

Our model makes three important assumptions. First, it assumes that each legislator takes account of the preferences of the voters she or he represents. For example, neither Democrats from conservative districts nor Republicans from liberal districts can (or need to) blindly follow the party line. Second, it assumes that, on any particular issue (health care included) the status quo and the preferences of each legislator and the president can

be characterized in a single dimension, ranging from most liberal to most conservative. Third, it assumes that all legislators know the preferences of their electorate and of other legislators with perfect certainty. We discuss the significance of these assumptions below.

Based on the position of the status quo relative to the position of members of Congress, the model predicts whether legislation will pass successfully through the institutional structure of lawmaking. If a bill is to become law, it must gain a majority in both houses and must not be killed by a filibuster or a veto.¹ In the context of health reform in 2009–2010, the filibuster is likely to be an important binding constraint, so we focus on it in the discussion below. The filibuster is an institution that allows a senator, once given the floor, to continue to speak for extended periods of time. When a senator's right to hold the floor indefinitely is used to slow or stop a bill's advancement, the action is commonly referred to as a filibuster. Obviously, filibusters could keep the Senate from acting on important legislation. As a result, the Senate has, over time, adopted rules limiting the use of the filibuster. Of great significance is Senate Rule XXII, allowing for a cloture vote to end debate. To invoke cloture, sixty senators must agree that the issue has been sufficiently discussed and that the Senate should continue with its business, often leading to a vote on the bill being filibustered. The cloture rule thus limits the power of any small group of senators who wish to talk an issue to death. But it still allows a minority to have significant power over an issue. If forty-one senators wish to kill a bill through a filibuster, they can do so by voting against cloture.

Basic Model

Figure 1 illustrates how the filibuster creates gridlock. It arrays each of the one hundred senators on a line from the most liberal to the most conservative. Three senators are labeled: the forty-first most liberal (i.e., the senator who has forty colleagues who are more liberal), the median senator, and the sixtieth most liberal (i.e., the senator who has forty colleagues who are more conservative). Senator A and the forty senators to his or her left could successfully filibuster a bill, as could C and the forty senators to the right.

Thus if the status quo is between the preferences of A and C, no policy

1. Rules in the Senate make certain legislation exempt from the use of the filibuster—for example, fast-track trade negotiation and reconciliation budgets. We discuss the significance of these exceptions below.

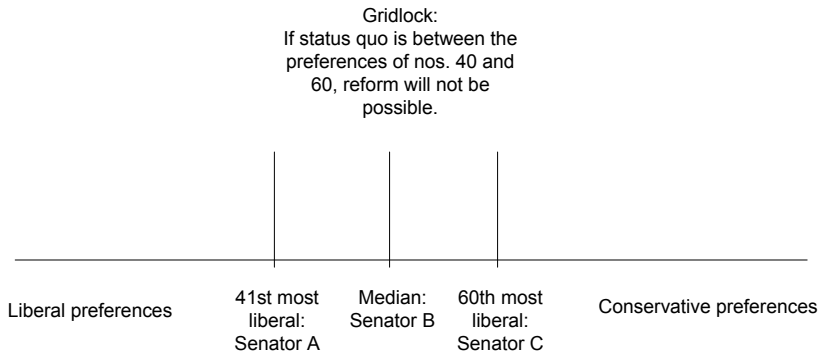


Figure 1 How the Filibuster Creates Gridlock

movement can occur. Consider a status quo just to the right of Senator A. A majority would prefer a more conservative policy, but A would have no reason to go along. If the majority to the right of the status quo attempts to enact legislation moving policy to the right, A and the forty senators to the left will filibuster to prevent any legislative movement. This does not mean that the minority on the left can dictate policy, however. Indeed, if they attempt to move policy any farther to the left, C and the forty senators to the right will filibuster to prevent that movement. Thus the status quo cannot be changed by the Senate, and gridlock occurs.

This “gridlock region” within which no policy change can occur is actually even larger than described above. The reason for this is found in a second institutional feature: the presidential veto. If the president adopts a position on an issue that is more conservative than C, the region of inaction is extended farther to the right. The logic here is much the same as with the filibuster. If the status quo policy is fairly conservative and Congress acts to make the policy more moderate, the president can veto that legislation. Instead of needing the forty-one conservative senators required to maintain a filibuster, the president only needs thirty-four conservatives to sustain a veto. Because a cloture vote requires three-fifths of the Senate and a veto override requires two-thirds, the veto provides a greater constraint on policy action. When the president is conservative and the senators are ranked along the main policy dimension, this region of inaction, or gridlock, stretches from the forty-first senator to the sixty-seventh. With a liberal president holding veto power, this region stretches more to the left, from the thirty-fourth senator to the sixtieth. If previous policy has positioned the status quo in this region, then Congress can

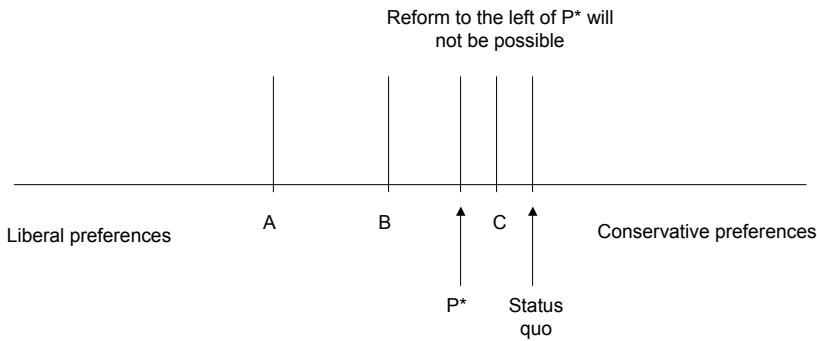


Figure 2 How the Filibuster Constrains Policy, Even When Change Is Possible

Notes: A = Senator A; B = Senator B; C = Senator C; P* = the most liberal policy in Senator C's interest

successfully undertake no further policy action. Successful filibusters or vetoes will halt movement to the left or the right.

The gridlock region described above is important with regard to both policy action and policy inaction. Figure 2 shows how the filibuster constrains policy outcomes, even when the status quo lies outside the range of preferences between A and C. In this case, the status quo policy is to the right, so the pivotal Senator C allows a shift to the left just so far as is in that senator's interest. The policy that satisfies this condition is located at P*, which is the same distance to the left of C as the status quo is to the right. The pivotal senator will join the forty colleagues to his or her right to filibuster bills that go farther left. We refer to this senator as the *filibuster pivot*, as this lawmaker plays a pivotal role in deciding which bills are satisfactory and which should be filibustered. The policy will end up between P* and the status quo; the bill's exact position in this region is subject to agenda setting and political bargaining. In this range, the model is indeterminate.

The above discussion has concentrated mainly on the Senate. There similarly exists a gridlock region for the House. As filibusters are not allowed in the House, this region only stretches from the House median to the House *veto pivot*, that is, the legislator nearest the president who has one-third (145) of House colleagues to his or her right (or left). With a liberal president, status quo policies in this region cannot be shifted to the left because a majority would not vote for such a shift, and policies cannot be moved to the right because such a shift would be vetoed and the veto

sustained. Because this region is smaller than in the Senate, it is often less of a constraint on policy. The need for a supermajority to override a veto, however, is a serious constraint in both the House and the Senate.

As mentioned above, reconciliation legislation cannot be filibustered. Many analysts of the current debate have noted that circumventing the supermajority requirement might be used for health care reform. Although consideration of health care reform under reconciliation rules would allow Democrats to pass a bill with fewer votes, reconciliation would impose other constraints on what the bill could or would have to contain. Most important, health care reform considered under reconciliation would have to be roughly deficit-neutral. Although there is some disagreement, reasonable estimates of the cost of the bills currently under consideration are at least \$1 trillion over a ten-year budget window. Thus the requirement of deficit-neutrality would imply that the bill would have to contain either broad-based tax increases or large spending cuts, which might reduce the number of senators willing to support it.

In addition, the “Byrd rule” allows a senator to raise a point of order and strike any provision of a reconciliation bill that increases the deficit for a fiscal year beyond the budget window covered by the bill (Keith 2008). Given that many of the current health reform proposals have the feature that their net costs are rising over and positive by the end of the budget window (e.g., see Congressional Budget Office 2009), they are likely to fall afoul of this provision. Although the Byrd rule can be waived, doing so requires a three-fifths vote—the same supermajority required to end a filibuster.

Incomplete Information

The model above assumes that legislators can perfectly predict the economic effects of a policy change, their constituents’ responses to these effects, and the preferences of other legislators and their constituents. In practice, of course, this is rarely the case. Members of Congress take many steps to collect as much information as possible. They listen carefully to constituents, paying attention to surveys and polls. They take advice from experts, whether they are committee members who have specialized in a policy area or authorities who give testimony in hearings. Still, the fact that the consequences of a change in policy are never fully known *ex ante* tends to increase gridlock for three reasons.

First, there is uncertainty over the actual policy results of passing a bill.

In the above section, we assumed that the status quo policy and the alternative proposed were known and were easily placed on a one-dimensional line. Legislators then simply pick whichever policy is closer to their preferred outcome. In reality, policy making is an uncertain activity. Budget estimates made over a five-year period will undoubtedly become less accurate over time. Members of Congress cannot perfectly predict which interpretations and actions government agencies and bureaus will take. Policy makers and policy analysts are unsure of just how many people will qualify for programs, find loopholes, or be indirectly affected by a policy change.

In addition to being uncertain about where the policy outcome of a bill will lie, members of Congress face a second uncertainty: how their constituents will react to how they vote. In the above section, we argued that members of Congress are aligned from liberal to conservative. Their positions on various issues can be determined by observing how they vote over time. When they vote, members of Congress seeking reelection must be aware of how their constituencies view their votes on the issues at hand. And yet these members are uncertain as to what the reaction will be back home. Many policy votes will simply be ignored by constituents; others will be observed but play little or no role in swaying voters; and still others will become major campaign issues. Because legislators are risk averse, increases in the scope of possible outcomes leads them to be less willing to support change.

Imperfect information on voters' preferences for change increases gridlock for a third reason: legislators may not know precisely where their colleagues' preferences lie, which makes bargaining over policy alternatives more difficult. This is simply a special case of the more general classic result from game-theoretic bargaining models. Given two parties with private valuations of a policy change, agreement is possible only if it is common knowledge that "gains from trade" exist—that is, if each party knows *ex ante* that it is in the other party's interest to compromise (Ausubel, Cramton, and Deneckere 2002: chap. 50). As the range of possible outcomes of a policy reform increases, voters' potential for dissatisfaction with change increases, which makes it increasingly difficult for legislators on one side of an issue to know how far off of the status quo their colleagues will be willing to move. It is this form of imperfect information that leads to the gridlock that Pauly (2004) describes as Altman's conundrum. As Pauly puts it, liberals in the health policy realm are uncertain about conservatives' valuation of reforms. Thus liberals' uncertainty

about how much they will need to compromise from their ideal policy leads them to be unable to reach a compromise with conservatives, who view the status quo more favorably.

The Clinton Health Reform Plan

Electoral change and public opinion surveys seemed to set the stage for reform when President Clinton took office. The 1992 election ended twelve years of Republican presidents; in addition, the Democrats controlled Congress and public opinion favored change. In May of that year, 82 percent of Americans agreed that the government should guarantee everyone health care coverage (Jacobs, Shapiro, and Schulman 1993: 408). In September 96 percent of Americans said when asked a closed-ended question about health care that they thought health care was very important or somewhat important (*ibid.*: 399). Americans in the 1992 elections by margins of 3 and 4 to 1 thought Clinton and the Democrats were better able to handle health care policy (*ibid.*: 401).

In response, Clinton proposed a far-reaching set of reforms designed to address the dual challenges of incomplete coverage and high cost. The Clinton plan would have provided universal coverage through an employer mandate and a system of government subsidies to help those who were not working afford insurance. Costs would be controlled by a cap on premiums, which would not only make health care more affordable for those who purchased it privately but also reduce the rate of growth in the government's health care liabilities.

Yet a closer examination of public opinion data paints a murkier picture (e.g., see Bundorf and Fuchs 2007). First, most Americans were happy with the health care they were receiving. The 1991 Gallup poll reported that 88 percent of respondents were very or somewhat satisfied with the quality of health care they received (*ibid.*: 420). Depending on the specific question that was asked, respondents were satisfied with their insurance coverage as well—between 69 and 81 percent were very or somewhat satisfied in the 1991–1992 period. Second, when polls put a price on health care reform, respondents were far less likely to support it; the typical outcome of these polls was that voters were simply unwilling to pay anything close to the cost of reform. One poll, for example, found that only 26 percent of respondents were willing to pay \$250 or less in increased taxes to support universal coverage; majority support could be obtained for a tax increase of \$100 (Associated Press Poll 1993). Third, in addition to saying they would not pay more in taxes for increased health care coverage,

majorities at this time rejected any change that would increase waiting times for treatment, even if it saved money. When asked in 1990, 1991, and 1992 if they would rather pay less for medical care but wait longer to get it, or pay more and get it right away, about 80 percent said pay more (Jacobs, Shapiro, and Schulman 1993: 424).

As the details of the Clinton plan were brought to light, it became evident that the proposal did not reflect the preferences of the majority of citizens or members of Congress. To succeed, a Clinton proposal would have had to appeal to conservative Democrats and moderate Republicans at the filibuster pivots. As one of us has written elsewhere (Brady and Buckley 1995), given the position of the status quo, a successful proposal could not be to the left of the median voter. Yet the fact that several Democrats proposed plans to the right of Clinton just after his plan was introduced suggests that this was the case.

A more moderate plan was proposed by Representative James Cooper (D-TN), but, like the Clinton plan, it proved too costly to attract the necessary votes. Significant doubts about the effectiveness of price controls in reducing health care cost growth led to uncertainty about the true budget implications of a vast coverage expansion. Various House committees (such as Energy and Commerce) had even more difficulty producing proposals with broad appeal and thus were unable to bring bills to the floor.² Even if such bills had reached the floor, their passage in the House was unlikely. Representatives were reluctant to vote on health care prior to the more conservative Senate. House members did not want to repeat their performance on the budget bill, when they were forced to vote on the BTU tax only to have it later stricken from the Senate version. Given the dim prospects for passing health care legislation in the House, attention turned back to the Senate.

The Senate Finance Committee was expected to produce the bill with the greatest chance of success. This committee, chaired by Senator Daniel Patrick Moynihan, was viewed as the most representative of the Senate, including both moderate Democrats and Republicans—the key to building a majority. Moynihan's attempt, put forward as a chairman's mark, was a diluted version of the Clinton plan: a 45 percent increase in the tobacco tax, full deductibility for the self-employed, a requirement that insurance companies cover preexisting conditions and people who change

2. All of the crucial committee members were moderate Democrats from southern or border states. The crucial member on the most important committee was Mike Andrews of Houston, Texas, who ultimately did not vote for the bill in committee, and it was never reported to the floor.

jobs, and increases in the number of pregnant mothers and children covered by Medicaid. The Moynihan plan sacrificed universal coverage, but increased the funds available to the plan through taxes and greater costs to employers. As information became available on the cost and complexity of Moynihan's plan, it too was eliminated as a viable challenger to the status quo. In many ways, it appeared as if no plan could actually pass Congress.

As the chances of passing a health care bill in the 103rd Congress diminished, Majority Leader George Mitchell (D-ME) called for a bipartisan coalition to salvage reform. The group of moderates, headed by Senator John Chafee (R-RI), proposed expanding coverage without requiring employer mandates. Even this bipartisan compromise failed to make it to the floor. The Chafee plan may have been more attractive to the median voters in Congress than the other proposals, but two factors ensured its defeat: (1) the probusiness filibuster pivot voters in the Senate and (2) the plan's late entrance into the debate. By the time the Chafee bill had been introduced, members were uncertain whether voters even wanted substantial reform. The role of uncertainty is one of the least-appreciated aspects of the Clinton plan's failure. The "Harry and Louise" advertising campaign, for example, raised the possibility that the Clinton plan would require large numbers of people who were happy with the status quo to change how they obtained care. In late 1994, after a year of debating the Clinton plan and its less-complicated alternatives, Congress officially abandoned health care reform without so much as a floor vote.

Prospects for Reform in the Present

The above model predicts the viability of reform as a function of voters' preferences and congressional institutions. From the 1990s to today, congressional institutions have remained much the same. In the remainder of this section, we explore whether this is also true of proxies for and determinants of voters' preferences. We consider how changes in the location of the status quo and public opinion of it, the composition of Congress, and macroeconomic conditions might lead the outcomes of the policy process in 2009–2010 to differ from those in 1993–1994.

The Status Quo and Public Opinion

Since the 1990s two opposing forces have affected the location of the status quo. On the one hand, the median voter's cost of health care rela-

tive to wages has increased, which makes the status quo less attractive. From 1999 to 2007, the cost of an employer-sponsored health insurance plan more than doubled, from \$5,791 to \$12,106 (Kaiser Family Foundation and Health Research Educational Trust 2008), while the median household income remained roughly constant (DeNavas-Wait, Proctor, and Smith 2008).

On the other hand, policy on health care has moved incrementally to address some of the concerns that may have motivated reformers in the early 1990s, making the status quo more attractive to would-be reformers. The Health Insurance Portability and Accountability Act (HIPAA), passed in 1996, seriously restricted the ability of group health plans to excluding preexisting conditions from coverage. The State Children's Health Insurance Program (SCHIP), created in 1997, extended insurance coverage to children from families with too much income to qualify for Medicaid but too little to afford private insurance. More recently, the Medicare Prescription Drug, Improvement, and Modernization Act extended coverage for outpatient pharmaceuticals to the elderly.

Thus, given these countervailing trends, it is not surprising that public opinion on this issue has remained generally supportive of the status quo. The Gallup poll has asked similar questions about public opinion about health care quality and coverage since the 1990s. As discussed above, vast majorities in the early 1990s were satisfied with the quality of health care they received and with their health coverage. Although satisfaction has declined slightly since the 1990s, the status quo still has majority support. The 2007 and 2008 Gallup polls found that 83 percent of respondents rate the quality of the health care they receive as excellent or good (Gallup Poll 2007, 2008), as compared with 87 percent expressing high or some level of satisfaction with their care in 1991. Similarly, the recent Gallup polls found that 70 percent in 2007 and 68 percent in 2008 rate the quality of their health care coverage as excellent or good, as compared with 69–81 percent in the early 1990s.

One component of public opinion that has changed is the perception that “access” has become the country's top health policy issue. Each year, the Gallup survey asks Americans to name, without prompting, the country's most urgent health problem (Gallup Poll 2007, 2008). In the early 2000s access was rated below the cost of health care in urgency. In 2008, however, access was offered by 30 percent of respondents as the most urgent problem, whereas cost was offered by only 25 percent of respondents. The extent to which this can be interpreted as a change in public opinion (or a change in the extent to which voters feel that they can count

on their own coverage in the future) is a difficult question. If it can, then the policy debate may shift in favor of reforms; if, however, the shift just reflects a temporary increase in the salience of the issue because of the presidential campaign, then that is another matter. Our general conclusion is that public opinion does not differ significantly from the 1992 situation. Although this would suggest that major reform, along the lines of the Clinton plan, is unlikely, it certainly leaves open the possibility of more incremental change.

Composition of Congress

Going into the 2008 elections, President Bush's low approval rating, the state of the economy, and an unpopular war signaled a major Democratic Party victory. Yet the composition of Congress in 2009 is similar to that of 1993. In 1993 the Senate was 57 Democrats and 43 Republicans; the House was 259 Democrats and 176 Republicans. In 2009, after the death of Senator Edward Kennedy (D-MA), the Senate is 57 Democrats, 2 independents who caucus with the Democrats, and 40 Republicans; the House is 258 Democrats and 177 Republicans. We know in retrospect that the signals from the Democratic victory in 1993 were overrated and the signals that the status quo would prevail underrated. How different, if at all, is 2009 from 1993?

According to Brady and Buckley (1995), the median voters in the 103rd House were individuals like Charles Wilson (D-TX), Mike Andrews (D-TX), and Lee Hamilton (D-IN); the medians in the 103rd Senate were individuals like David Boren (D-OK), Sam Nunn (D-GA), and John Breaux (D-LA). These centrist Democrats could not and did not vote for the Clinton health care plan. The senators at or about the filibuster pivot were moderate Republicans such as Robert Packwood (R-OR), Arlen Specter (R-PA), William Cohen (R-ME), and Chafee.

According to Woon (2009), the medians in the 111th House and Senate are to the left of the medians in the 103rd. These differences, however, may not translate into a significantly greater probability of major reform. First, 52 of the 258 House Democrats are members of the fiscally conservative Democratic Blue Dog coalition, which has been skeptical of the party's current reform proposals. Given that 218 votes are required for a bill's passage, the median of the chamber is undoubtedly a member of this group. Second, Woon also shows that the gridlock region in the 111th Congress is similar to that in the 103rd. This seeming anomaly arises out of the fact that the filibuster pivot in the Senate is once again a moderate.

Woon lists Specter (now a Democrat), Olympia Snowe (R-ME), and Susan Collins (R-ME) as the 59th, 60th, and 61st most liberal in the chamber. In short, as in 1993, any bill passed by the present Congress will have to appeal to members who are moderates.³ This leads us to predict that there has been no obvious substantive shift in preferences because of electoral differences between the two periods.

Macroeconomic Conditions

What has shifted are the exogenous economic conditions in 2009 relative to 1993. First, and most important, the vast fiscal crisis of the U.S. government has made it extremely difficult to predict the extent to which voters and legislators will support expanded public spending on subsidies for health insurance. While creation of a new \$100–\$200 billion per year entitlement program for the middle and lower middle class could be seen as a “fair” counterpart to the multi-hundred-billion dollar bailout of the nation’s financial firms, the tightness of public budgets resulting from the bailout, combined with the current recession, could lead to reduced support for health reform. Thus the effect of macroeconomic conditions is an open question.

Conclusion

If only exogenous factors are considered, 2009–2010 looks much like 1993–1994. Neither public opinion nor electoral conditions have changed much from their state in 1993–1994, and the effects of changes in the macroeconomy are at best uncertain. The factors that created gridlock in the 103rd Congress are likely to have a similar impact in the present.

Nonetheless, there are several possibilities for reform in 2009–2010. First, the expansion of SCHIP in February 2009 with some Republican support suggests that further expansion of it or Medicaid could obtain enough votes for passage. Second, helping people who are “high risks”—that is, with high expected health expenses—obtain insurance also has both liberal and conservative support. In his plan for health

3. While the distribution of preferences around the median in 2009 is similar to that in 1993, there are two potentially relevant differences. First, in 1993, about one-third of House Democrats and one-quarter of Senate Democrats were from the South, whereas in 2009 the comparable numbers are one-quarter and about one-tenth. Second, in 1993, many of the Southern Democrats were committee chairs who often voted with the conservative coalition (which no longer exists).

reform, president-elect Barack Obama offered subsidies to insurance pools to cover the costs of high-cost people. In his presidential campaign, Senator McCain offered subsidies to state high-risk pools with a Guaranteed Access Plan. More recently, Senator Snowe has described such a proposal as “worth exploring” (Hulse 2009). In other work (Kessler and Brady 2009) we show that there is majority support for exactly this sort of proposal, even when prospective voters are informed about the proposal’s true costs. Third, the use of nonprofit insurance cooperatives to provide low-cost competition to conventional private insurance has emerged as an alternative to an expansion of government insurance. Finally, both liberals and conservatives support increased public investment in comparative effectiveness research—research that would help both public and private purchasers of health care get better value for money.

Of course, these options are only possibilities; the outcome of a process as large and complex as the American political system is impossible to predict precisely. But until the status quo becomes significantly unattractive to a larger number of voters, proposals of the scope of the Clinton plan that seek to achieve major coverage expansions and cost control, all in one bill, are unlikely to become law. As was the case in 1993, a radical transformation of health care in the United States will likely have to wait.

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