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A Conservative Case for Obamacare?

Are the individual mandate and health-insurance exchanges conservative ideas?

By Thomas P. Miller - OCTOBER 1, 2012 7:30 P.M.

J. D. Kleinke, my neighbor at the American Enterprise Institute, has written a *New York Times* op-ed that recycles a fact-challenged rewriting of health-policy history and combines flawed analysis with wishful thinking.

Kleinke argues that the individual mandate and health exchanges of the Affordable Care Act (ACA) were, and should remain, sound conservative ideas meriting Republican support. He imagines that, but for crass political calculations, Republican leaders would be taking credit for what President Obama borrowed from them.

To borrow the words of former president Clinton during another Obama-related political battle four years ago, “Give me a break. This whole thing is the biggest fairy tale I’ve ever seen.”

Dismantling Kleinke’s argument will require:

- coming to terms with the dalliance of a handful of Republican-affiliated figures with the individual mandate as a politically expedient defensive measure — two decades ago;
- understanding how grassroots conservatives have a better instinctive handle on health-policy issues than many of their timid, would-be “leaders”;
- seeing how the ACA’s health exchanges are designed primarily for heavy-handed government regulation and income redistribution rather than for choice and competition in health insurance;
- acknowledging the serious mistakes of Romneycare in Massachusetts but ensuring they don’t have to be repeated exponentially on a national basis; and
- moving beyond the thin rhetorical slices of conservative health-policy reform ideas toward more substantive “repeal and replace” details that can offer realistic hope and deliver sustainable change.

THE PATERNITY TEST FOR THE INDIVIDUAL MANDATE

I remember receiving, back in 1989, one of the Heritage Foundation's earliest briefings on the idea of a mandate requiring individuals to purchase health insurance. To the extent that any conservatives were paying attention to health policy back then, it was not broadly welcomed on the right. In 1991, AEI published a mandate-based proposal for "Responsible National Health Insurance." It was developed by four right-leaning health-policy analysts who gave it their best shot in an unfavorable political climate. In the early fall of 1993, most Capitol Hill Republicans were discouraged by the apparent popularity of the first wave of the Clinton plan. The response of roughly half of the Senate Republicans was to co-sponsor an alternative bill offered by Senator John Chafee that included an individual mandate. And about as many Senate Republicans (with some overlap) co-sponsored another pro-mandate bill advanced by Senator Don Nickles and essentially designed by the Heritage Foundation's health-policy team.

But then-senator Phil Gramm, along with Bill Kristol's Project for the Republican Future, rallied the troops. Almost all other conservative policy groups (such as the Cato Institute, the National Center for Policy Analysis, the Manhattan Institute, the Competitive Enterprise Institute, Citizens for a Sound Economy — a forerunner of FreedomWorks — and even parts of AEI) joined in, along with even stronger grassroots sentiment, against Hillarycare part I. I don't recall running into J. D. Kleinke at any of those meetings planning how to stop the Health Security Act, or his writing any papers for, or against, the Heritage-sponsored individual-mandate alternative that by the spring of 1994 was abandoned by most Capitol Hill Republicans.

From that time until President Obama took office, few elected Republicans supported the idea of an individual mandate. Why? Because they had learned that leaders need followers, and the mandate was vigorously opposed by conservatives around the country. Even the Heritage Foundation eventually found its way back to the front lines of opposition.

THE REBUKE FROM THE GRASSROOTS

In contrast with the strong resistance that the Clinton plan met from the health-care industry in 1994, a divide-and-conquer strategy by the Obama White House and its allies kept most of the key industry players at the table, hoping for scraps or even some early-bird specials at

the subsidy buffet line. Consequently, the first significant signs of opposition to Obamacare came from outside the Beltway at the grassroots level, during the summer recess of 2009.

Capitol Hill Republicans became more emboldened to oppose Obamacare when they learned that it was more unpopular than they had imagined. This is not to ignore the important roles of a handful of Hill Republican leaders, but the ACA would not have been held up until March 2010, after narrowly escaping several near-death experiences, without the strong signal originating from outside of Washington, primarily from many less-traditional activist groups.

We ignore at our peril the lesson that the most principled and politically effective, if not particularly sophisticated, signals on health policy (and other issues) don't usually start in Washington.

ACA EXCHANGES: MORE POLITICS THAN MARKETS

Kleinke argues in his op-ed that health-insurance "exchanges" are a conservative idea, but the same term often has very different definitions. When liberals talk about exchanges, they highlight standard benefits, regulatory policing of market variation, active purchasing roles by government officials to control prices, and large cross subsidies from younger, healthier, and more self-sufficient Americans to older, unhealthier, and more dependent ones. Conservatives talk about more choices, stronger incentives to stay healthy and make smarter decisions, "market" competition with willing buyers and sellers, and privately managed exchange options.

The conservative approach to health exchanges includes:

- opposing federally run exchanges (both for policy and legal reasons; for the latter, see last month's amended lawsuit by the State of Oklahoma);
- restructuring any state-administered ones to emphasize open competition and approaches that are both information-heavy and regulation-light and that would *not* comply with the ACA's designs; and
- focusing more on improving the non-exchange market for individual and small-group insurance.

Health-insurance exchanges have a checkered and incomplete history at best. Theoretical concepts for new health-benefits marketplaces have come and gone in different forms for at least a couple of decades, but the goal of establishing marketplaces that would be sustainable has been elusive. The Federal Employees Health Plan offers some possible lessons, but it operates differently than non-employer-based exchanges do. Other business-group purchasing ventures have lacked either the scale or the time frame to allow us to draw conclusions about how larger exchanges would work in practice.

Government-run exchanges also have a mixed record. Massachusetts Health Connector's subsidiaries have failed to gain much market share among populations for which it does not serve as a source of subsidies. The early versions of Utah's exchanges are much more market-oriented, but they have yet to demonstrate substantial appeal to new customers.

The ACA version of full-strength, HHS-sanctioned exchanges looks like a political "solution" that will create bigger political and market problems than it will solve. Moreover, the traces of conservative Republican DNA within exchanges (outside of Utah) are too minuscule to show up in falsifiable lab tests. Just look at decisions made by most states run by Republican governors, who continue to balk at signing on to the ACA-compliant state exchanges.

WHAT TO DO ABOUT ROMNEYCARE?

Mitt Romney presided over a four-year period of health policy in the Bay State that may have technically been "Republican" but certainly wasn't conservative or market-based. The best that can be said is that although Governor Romney won't admit he was wrong, he has promised (at least during most days on the campaign trail) not to do it again on a national scale.

Our motto should be "What happened in Massachusetts should stay in Massachusetts." The alternatives ahead in health policy offered by the current White House team are too disastrous to countenance. To revise the infamous Lincoln Steffens quote from 1919 about Soviet Russia, "I have seen the future of Obamacare, and it does not work." So, instead of investing too heavily in health-policy change that originates from the Oval Office, more effort should be placed on changing the broader political context within which our next president will act, in the hope that he will be compelled to ratify the better policies advanced by others.

BEYOND REPEAL

Is there really a replacement plan that goes beyond new ways to say “no”? Yes, there are a number of elements out there, but don’t expect to see them advanced immediately by Republican leaders who are focused on the negative case against Obamacare and on the soothing platitudes of “the market and the states will do it” but who don’t bother much to figure out *how*. The real centerpiece of conservative health reform over the past decade was health-savings accounts and consumer-driven health care. They remain necessary but are far from sufficient. The frequently recycled association-health-plan proposals were not terrible ideas, but they remained extremely limited, appealing to too narrow a constituency while bypassing the more fundamental problems of our health-care system. Not surprisingly, they faded away quietly from the front lines of the debate.

The conservative case for health reform doesn’t appear on the editorial pages of the *New York Times*. It includes defined-contribution financing of all taxpayer subsidies for health coverage, premium support for Medicare, accountable block grants to the states for Medicaid, retargeted subsidies for a sustainable safety net, health-insurance regulation that relies on enhanced information and vigorous competition instead of mandates, and many other less-well-known items. But most of all, it involves restoring and strengthening accountability in health-care decision-making. Not one-way accountability to the wishes of vote-buying politicians and their interest-group allies, but the two-way responsiveness that mediates the personal choices and complex trade-offs made every day by individual patients and the providers who serve them.

That’s a case we can believe in and should act on, rather than dreaming that the imminent nightmare of Obamacare will end on its own.

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