ARTICLE

HEALTH REFORM AND PUBLIC HEALTH: WILL GOOD POLICIES BUT BAD POLITICS COMBINE TO PRODUCE BAD POLICY?

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The enactment of the Patient Protection and Affordable Care Act (PPACA)[1] was an incomplete victory and will remain so even if the new Republican congressional majority does not curtail its provisions. The legislation has many shortcomings and compromises. Most importantly, it could have brought help sooner to millions of uninsured or under-insured Americans.

Despite these compromises, public health researchers and practitioners have reason to celebrate.[2] Simply put, PPACA fundamentally altered and improved the public health infrastructure of the United States. Fully implemented, PPACA promises to markedly improve clinical preventive services and transform our nation's response to traditional centerpiece public health concerns, including HIV/AIDS, substance abuse, mental health disorders, and other conditions.

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[1] Pub. L. No. 111-148, 124 Stat. 119 (2010) (to be codified as amended in scattered sections of 21, 25, 26, 29, and 42 U.S.C.).

[2] *See* Harold A. Pollack, *Prevention and Public Health*, 36 J. HEALTH POL. POL'Y & LAW (forthcoming 2011) (manuscript at 1) (on file with author) (describing improvements that PPACA makes to the U.S. public health system).

In this Article, I note several ways in which provisions of PPACA promise to improve population health.[3] But this Article is less sanguine regarding the *politics* of public health. I submitted the first draft in early January 2011, the very week PPACA's opponents assumed the majority in the House of Representatives.[4] The Speaker of the House has vowed to repeal PPACA,[5] and twenty-six states support constitutional challenges to the individual mandate, a central pillar of the new law.[6] PPACA's ultimate success depends on the executive branch's ability to implement successfully one of the most complex policy reforms in American history against a backdrop of fiscal constraint and partisan acrimony.[7]

As a sometime participant and advocate in this process,[8] I am struck in hindsight that the bill's fervent defenders did not focus more explicitly or effectively on these political matters in crafting the final bill. Many commentators noted that key provisions of PPACA would likely become politically impregnable once they became part of the fabric of American life.[9] On many of these provisions, PPACA proponents had less success in structuring the Act to ensure that these provisions would achieve such an embedded status.[10]

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[3] I do not address some other ways PPACA improves public health infrastructure, such as investments in the medical workforce and Federally Qualified Health Centers. For a discussion of these issues, see Lawrence O. Gostin et al., *Restoring Health to Health Reform: Integrating Medicine and Public Health to Advance the Population's Well-Being*, 159 U. PA. L. REV. 1777 (2011).

[4] *See* Carl Hulse, *Taking Control, G.O.P. Overhauls Rules in House*, N.Y. TIMES, Jan. 6, 2011, at A1 ("Jubilant Republicans took control of the House on [January 5, 2011] and installed Representative John A. Boehner of Ohio as the new speaker . . . .").

[5] *Id.*

[6] *See* Kevin Sack, *Second Judge Deals Blow to Health Care Law*, N.Y. TIMES, Feb. 1, 2011, at A1 (noting that twenty-six states joined a suit challenging PPACA, six of which joined after the Republican party took control of those states' governments).

[7] *See* Henry J. Aaron & Robert D. Reischauer, *The War Isn't Over*, 362 NEW ENG. J. MED. 1259, 1260-61 (2010) (detailing anticipated difficulties in implementing PPACA, such as information exchanges between state and federal agencies).

[8] *See, e.g.*, Harold A. Pollack, *The Ride of a Lifetime*, NEW REPUBLIC (Mar. 23, 2010, 4:53 PM), http://www.tnr.com/blog/the-treatment/the-ride-lifetime (commenting on my experience working for health reform).

[9] *See, e.g.*, Jonathan Cohn, *You Thought Passing Health Reform Was Hard? Try Repealing It*, NEW REPUBLIC (Dec. 2, 2010, 11:46 AM), http://www.tnr.com/blog/jonathan-cohn/79584/repeal-health-reform-difficult-1099 (describing the immense difficulty of repealing provisions of the statute).

[10] *See* Aaron & Reischauer, *supra* note 7, at 1259 ("Given the intensity of Republicans' opposition to the substance and manner of passage of this reform, if the GOP regains the presidency and control of Congress in 2012, implementation could be substantially delayed or the law could be . . . repealed before its major elements have been implemented.").

Perceptive PPACA supporters certainly understood from the start that back-loading implementation was a fundamental political problem.[11] Executive branch and congressional advocates, along with outside activists, worked hard to win passage of the best possible bill consistent with political constraints. However, supporters appear to have been less effective in considering how PPACA might be optimally structured to withstand likely attack should its critics win an emboldening majority. As a result, the reformers missed opportunities to enact and defend effective public health policies.

I. PUBLIC HEALTH GAINS IN HEALTH REFORM[12]

The contributions of PPACA to population health are easily overlooked. PPACA, like most health policy legislation, was not primarily designed to address public health services or public health concerns.[13] In this, the bill reflected the unbalanced political economy of American health care, which devotes a disproportionate share of public and private resources and political attention to personal medical services and tertiary care.[14] Although elected officials across the ideological spectrum cite the importance of public health,[15] public health investments often fare poorly in legislative bargaining over scarce resources.

Moreover, many analysts who recognize the centrality of social determinants of health argue that expanded access to medical services is likely to have minimal impact on population health. Distinguished health economists Dana Goldman and Darius Lakdawalla argue with particular force that PPACA may be overpromising health improvement:

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[11] Paul Starr, *The Next Health-Reform Campaign*, AM. PROSPECT, Sept. 2010, at A3, A5-A6 (outlining PPACA's vulnerability to political obstacles to implementation).

[12] This Part is an expanded and modified version of my article on the improvements to U.S. public health resulting from PPACA. *See* Pollack, *supra* note 2.

[13] *See* Gostin et al., *supra* note 3, at 1766-1767 (arguing that PPACA is not focused on public health, and providing suggestions for how it could achieve greater public health at a lower cost).

[14] *See* Paula M. Lantz et al., *Health Policy Approaches to Population Health: The Limits of Medicalization*, 26 HEALTH AFF. 1253, 1256 (2007) (noting that health policy usually focuses on expanding access to personal medical services to the exclusion of expanding access to other services that affect an individual's health).

[15] For example, Senator John McCain's 2008 campaign platform supported creating public health infrastructure, such as smoking-cessation programs. *See Straight Talk on Health System Reform*, JOHN MCCAIN 2008 (Oct. 17, 2007), http://replay.web.archive.org/20081219070603/http://www.johnmccain.com/content/default.aspx?guid=8475c713-a541-4b97-a2aa-800e35da37bb (accessed by entering the McCain campaign's website address in the Internet Archive index).

> Advocates of universal coverage often get confused on this point. They equate good health with having health insurance, and cite myriad academic studies. The problem is that these studies don't account for all the other differences between the insured and uninsured—what they eat, where they live, whether they smoke or drink, the amount of stress in their lives, and even their genetic predisposition to disease. No healthcare system is good enough to fully compensate for bad behavior and poor environmental factors.
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> Perhaps the strongest and earliest such evidence came from the RAND Health Insurance Experiment (HIE), which randomly assigned families to health insurance plans of varying generosity. One of the main findings of this experiment was that families in the least generous plan (95 percent coinsurance) spent nearly 30 percent less on medical care—with little or no difference in their health.[16]

These authors do not identify specific advocates who equate good health with having health insurance, or who deny the importance of behavioral or environmental risk factors. As a result, it is unclear how many advocates of universal coverage are actually confused or naïve on these basic points.

Still, the authors' point is well-taken. Health insurance coverage does not address many threats to individual and population health. Balanced policies must attend to social determinants of health—education, housing, accidents and violence, public safety, workplace safety, environmental protection—as well as to reducing barriers to personal medical services. Social policy *is* health policy in each of these areas.[17]

Health policy researchers are increasingly aware of the dangers in overstating the link between insurance and health. At the same time, it is tempting to misapply social epidemiology to wrongly dismiss the importance of expanded health coverage. There is substantial evidence, much of it compiled in the Rand Health Insurance Experiment (HIE), that expanded access to care improves health outcomes, particularly in patients with cardiovascular risk-factors and hypertension.[18]

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[16] Dana P. Goldman & Darius N. Lakdawalla, *Can the ACA Improve Population Health?*, ECONOMISTS' VOICE, no. 5, art. 4, 2010, at 1, 1-2, http://www.bepress.com/ev/vol7/iss5/art4.

[17] *See* ROBERT F. SCHOENI ET AL., MAKING AMERICANS HEALTHIER: SOCIAL AND ECONOMIC POLICY AS HEALTH POLICY 3-23 (2008) (considering the general health effects of social economic policy); Lantz, *supra* note 14, at 1254 (describing the need to incorporate social policy into health policy considerations).

[18] *See, e.g.*, Emmett B. Keeler et al., *How Free Care Reduced Hypertension in the Health Insurance Experiment*, 254 JAMA 1926, 1926 (1985) (finding that hypertensives with free care had more visits with their physicians, which led to higher rates of diagnoses).

The experiment was too short to directly investigate mortality differences across the different treatment plans.[19] However, study investigators were able to explore statistical models of human mortality attributable to basic measurable risk factors.[20] Within these analyses, low-income HIE participants enrolled in high-deductible plans displayed notably higher predicted mortality than did their otherwise comparable peers enrolled in a free care plan.[21]

Almost all of the predicted mortality reduction reflected improved hypertension detection and treatment.[22] Subsequent studies support these findings.[23] Goldman and Lakdawalla themselves note that "poor people with high blood pressure had slightly higher [predicted] mortality rates" when assigned to high-deductible rather than free health care plans.[24]

As these studies demonstrate, health insurance coverage facilitates the receipt of basic health services, which in turn enables primary care providers or others to detect hypertension and to provide accompanying treatment through inexpensive medications. Access to such care rarely produces large changes in health behavior or in social determinants of health,[25] but it does give individuals access to basic, effective treatments that improve health and prolong life.

Using nationally representative longitudinal data from the Health and Retirement Study, J. Michael McWilliams and colleagues found substantially higher eight-year mortality rates among uninsured individuals ages fifty-five to sixty-four than among facially similar insured peers.[26] Mortality differences were especially stark within the lowest

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[19] JOSEPH P. NEWHOUSE & THE INS. EXPERIMENT GROUP, FREE FOR ALL? LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT 204 (1993).

[20] *Id.* at 210-11.

[21] *Id.* at 211 tbl.6.13.

[22] *See* Robert H. Brook et al., *Does Free Care Improve Adults' Health? Results from a Randomized Controlled Trial*, 309 NEW ENG. J. MED. 1426, 1429-33 (1983) (finding that free care benefits those with "specific conditions," such as hypertension, and is likely to lower their mortality risk).

[23] *See, e.g.*, Joseph D. Freeman et al., *The Causal Effect of Health Insurance on Utilization and Outcomes in Adults: A Systematic Review of U.S. Studies*, 46 MED. CARE 1023, 1030 (2008) (summarizing studies indicating that insurance is associated with decreased mortality rates).

[24] Goldman & Lakdawalla, *supra* note 16, at 2.

[25] *See* E.B. Keeler et al., *Effects of Cost Sharing on Physiological Health, Health Practices, and Worry*, 6 HEALTH SERVICES RES. 279, 302-03 (1987) (finding that increased access to free care does little to create better health habits).

[26] J. Michael McWilliams et al., *Health Insurance Coverage and Mortality Among the Near-Elderly*, 23 HEALTH AFF. 223, 228 exhibit 2 (2004) (reporting a three to five percent difference in mortality rates).

quartile of household income as well as among adults with diabetes, hypertension, or heart disease.[27] Mortality hazard rates among the uninsured were more than fifty percent higher than those observed among the insured in both the low-income and the cardiovascular-illness groups.[28]

Given the non-experimental nature of these analyses, it is possible that unobserved factors account for the observed mortality differences. Yet the authors conducted sensitivity analyses which suggest that complete confounding is unlikely:

> [A]n unobserved factor similar to smoking in prevalence (approximately 25 percent of the study cohort) and its association with insurance status (relative risk of being uninsured equal to 1.66) would have to be associated with a relative eight-year mortality risk of 2.65 for the association between insurance status and mortality to become non-significant when further adjusted for this unobserved factor. In comparison, smoking was associated with a relative eight-year mortality risk of 2.48.[29]

Medicare studies provide further support for the causal importance of health coverage. In a series of other studies, the same researchers documented improvement in many health measures when individuals reached the age of Medicare eligibility, along with surprisingly large reductions in racial, ethnic and educational disparities.[30] Racial disparities in systolic blood pressure decreased by approximately sixty percent.[31] Educational, racial, and ethnic disparities in blood glucose control decreased by more than seventy-five percent.[32] Educational disparities in total cholesterol levels became negligible.[33] Receipt of key preventive services, such as mammography and prostate

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[27] *See id.* at 229 exhibit 4 (demonstrating a difference of approximately six percent between insured and uninsured individuals).

[28] *Id.*

[29] *Id.* at 228-29.

[30] *See, e.g.*, J. Michael McWilliams, *Health Consequences of Uninsurance among Adults in the United States: Recent Evidence and Implications*, 87 MILBANK Q. 443, 470 (2009); J. Michael McWilliams et al., *Health of Previously Uninsured Adults After Acquiring Medicare Coverage*, 298 JAMA 2886, 2892 (2007); J. Michael McWilliams et al., *Impact of Medicare Coverage on Basic Clinical Services for Previously Uninsured Adults*, 290 JAMA 757, 761 (2003) [hereinafter McWilliams et al., *Impact of Medicare Coverage*]; J. Michael McWilliams et al., *Use of Health Services by Previously Uninsured Medicare Beneficiaries*, 357 NEW ENG. J. MED. 143, 149-50 (2007).

[31] J. Michael McWilliams et al., *Differences in Control of Cardiovascular Disease and Diabetes by Race, Ethnicity, and Education: U.S. Trends from 1999 to 2006 and Effects of Medicare Coverage*, 150 ANNALS INTERNAL MED. 505, 512 fig.3 (2009).

[32] *Id.* at 511 fig.2.

[33] *Id.* at 512 fig.3.

cancer screening, also sharply increased at age sixty-five among the previously uninsured.[34]

Expanded Medicaid eligibility is an especially important *institutional* shift.[35] Although expanded Medicaid is usually discussed as a vehicle to reduce the number of uninsured, it has particular implications for the patchwork of providers and services in safety-net care.

Medicaid is currently a means-tested categorical program which only covers certain types of low-income individuals—for example, children under the federal poverty level, or those who are eligible for specific programs such as Temporary Assistance for Needy Families (TANF) or Supplemental Security Income (SSI).[36] Many poor working parents or single adults are not eligible for Medicaid.[37] In particular, unattached adults who are drug-dependent or HIV-infected are often ineligible.[38] These individuals, therefore, rely on a patchwork of safety-net providers to finance substance-abuse treatment and other essential services.[39]

By 2014, PPACA will extend Medicaid eligibility to every American with a household income below 133% of the poverty line.[40] These individuals will gain access to the full apparatus of Medicaid-funded services for their primary conditions, while their providers will gain access to more generous and secure funding. They will also have Medicaid coverage to treat the physical and psychiatric co-morbidities that now often go unaddressed.

This change will require significant adjustments within both the public and private sectors. Existing federal programs such as the Ryan White CARE Act and the Substance Abuse Prevention and Treatment

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[34] McWilliams et al., *Impact of Medicare Coverage*, *supra* note 30, at 761 tbl.2.

[35] *See* ERIC M. PATASHNIK, REFORMS AT RISK: WHAT HAPPENS AFTER MAJOR POLICY CHANGES ARE ENACTED 163-67 (2008) (discussing institutional change as a mechanism for sustained policy reform).

[36] *See* INST. OF MED., PUBLIC FINANCING AND DELIVERY OF HIV/AIDS CARE: SECURING THE LEGACY OF RYAN WHITE 109-17 (2001) (describing barriers to eligibility and the special programs that provide coverage).

[37] *Id.* at 109.

[38] *See id.* (noting that many needy, working individuals earn incomes above the Medicaid eligibility level).

[39] *Id.*

[40] KAISER COMM'N ON MEDICAID & THE UNINSURED, KAISER FAMILY FOUND., OPTIMIZING MEDICAID ENROLLMENT: PERSPECTIVES ON STRENGTHENING MEDICAID'S REACH UNDER HEALTH CARE REFORM 3 (2010), *available at* http://www.kff.org/healthreform/upload/8068.pdf.

Block Grant must be redesigned for an era of near-universal coverage.[41] Moreover, traditional providers such as methadone clinics will face new competition from Federally Qualified Health Centers and accountable-care organizations, which have new incentives and resources to expand their reach into mental and behavioral health services.[42]

PPACA also enhances the financing of clinical preventive services by requiring insurers to reimburse evidence-based preventive services without patient cost-sharing. In particular, insurers will be required to cover services that either have received an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF), or that are supported by other selected public health guidelines released by federal agencies.[43]

The USPSTF attracted controversy when it declined to endorse routine mammography screening for women in their forties, leading many citizens and advocacy groups to argue that these provisions of PPACA will be used to ration care.[44] The more important change is to ensure that evidence-informed services are fully covered for populations in which there is documented need.[45] Many of these services focus on politically marginalized or obscure populations that have important yet unmet needs.

Finally, PPACA establishes a Prevention and Public Health Fund to support preventive services and public health infrastructure.[46] The

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[41] *See, e.g.*, Harold Pollack, *Progress on HIV, but Will It Last?*, NEW REPUBLIC (July 16, 2010, 12:00 AM), http://www.tnr.com/blog/jonathan-cohn/76312/progress-hiv-will-it-last (noting that PPACA will have an enormous impact on long-standing federal programs, many of which will need to be modified as a result).

[42] *See* Harold Pollack, *Rehab: America's Drug Policies Just Got a Whole Lot Better*, NEW REPUBLIC (May 14, 2010, 12:00 AM), http://www.tnr.com/article/politics/rehab (discussing federally funded addiction-treatment services affected by PPACA).

[43] PPACA sec. 1001, § 2713, 42 U.S.C.A. § 300gg-13 (West Supp. 1A 2010); *see also* Timothy Jost, *Implementing Health Reform: Preventive Services*, HEALTH AFF. BLOG (July 15, 2010, 11:48 AM), http://healthaffairs.org/blog/2010/07/15/implementing-health-reform-preventive-services (summarizing some of the requirements of section 1001).

[44] *See* Eric M. Patashnik & Alan S. Gerber, *Problem Solving in a Polarized Age: Comparative Effectiveness Research and the Politicization of Evidence-Based Medicine*, THE FORUM no. 1, art. 3, 2010, at 7, 7, n.1, http://www.bepress.com/forum/vol8/iss1/art3 ("The Obama Administration responded to the public outcry . . . by promising that government insurance programs would continue to cover mammograms for women starting at age 40.").

[45] *See U.S. Preventive Services Task Force Recommendations*, HEALTHCARE.GOV, http://www.healthcare.gov/center/regulations/prevention/taskforce.html (last visited Mar. 15, 2011) (listing various types of preventive actions and the populations that would benefit the most from them).

[46] PPACA § 4002, 42 U.S.C.A. § 300u-11; *see also Public Health Provisions of the Patient Protection and Affordable Care Act*, PUB. HEALTH L. NETWORK, http://

Fund will allocate approximately $15 billion over the next decade.[47] Funded activities include diabetes, HIV, and violence prevention; infrastructure development of epidemiological surveillance systems; and case-finding for sexually-transmitted infections, tobacco control, obesity and more.[48]

In some areas, such as smoking cessation, a wide range of evidence-based programs are available.[49] In others, such as obesity prevention, the field is at an earlier, more tentative point.[50]

II. THE POLITICAL CHALLENGE

Each of the above public health provisions promises to be an important substantive accomplishment. Each is also potentially threatened by the changed legislative landscape, by political vulnerabilities created by the design of the new law, and by the state and local fiscal crisis. PPACA was carefully crafted, from a political perspective, to win legislative enactment.[51] Its backers also carefully crafted its provisions to maximize the chances that it would eventually become part of the fabric of American political life.[52]

The fact that PPACA was passed at all represented a historic accomplishment—one that testifies to the determination and political skills of its backers. Yet its backers now face a more immediate challenge: implementing, preserving, and defending a relatively unpopular bill in the face of a hostile congressional majority.

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www.publichealthlawnetwork.org/wp-content/uploads/ACA-chart-formatted-FINAL2.pdf (last visited Mar. 15, 2011) (noting that PPACA section 4001 establishes the Prevention and Public Health Fund).

[47] PUB. HEALTH L. NETWORK, *supra* note 46.

[48] *See* Georges Benjamin & Larry Cohen, *The Prevention and Public Health Fund: Good for Our Health, Good for Small Business*, KAISER HEALTH NEWS (Sep. 13, 2010), http://www.kaiserhealthnews.org/Columns/2010/September/091310benjamincohen.aspx (describing the benefits likely to result from the Fund's screening programs).

[49] *See* Michael C. Fiore, *A Clinical Practice Guideline for Treating Tobacco Use and Dependence: A US Public Health Service Report*, 283 JAMA 3244, 3244 (2000) (providing an "evidence-based, updated guideline" with "specific recommendations regarding brief and intensive tobacco cessation interventions").

[50] *See* John Cawley, *The Cost-Effectiveness of Programs to Prevent or Reduce Obesity: The State of the Literature and a Future Research Agenda*, 161 ARCHIVES PEDIATRICS & ADOLESCENT MED. 611, 612 (2007) ("[T]he research literature [regarding obesity] is still at the earlier stage of determining whether specific interventions work at all.").

[51] Mark A. Peterson, *It Was a Different Time: Obama and the Unique Opportunity for Health Care Reform*, 36 J. HEALTH POL. POL'Y & L. 429, 435-36 (forthcoming June 2011) (describing the strategic choices leading led to PPACA's successful passage).

[52] *See, e.g.*, Cohn, *supra* note 9 (noting that PPACA's provisions are difficult to repeal because of the financial costs involved).

Had they foreseen the outcome of the 2010 election, PPACA supporters might have fashioned this legislation rather differently. Of course, hindsight offers greater clarity than can be expected in the moment. But some political challenges and strategic missteps could have been readily anticipated based on the history of other reforms.

Eric Patashnik's *Reforms at Risk* provides an especially valuable framework to explore these questions.[53] Patashnik examines the political feasibility of "general-interest reforms" that provide broad-reaching social value but which may not advance the interests of specific constituencies.[54] Some general-interest reforms, such as airline deregulation, endure.[55] Others, such as the 1986 tax reform, were passed with great fanfare but then gradually unraveled.[56]

Patashnik anticipated one fundamental political concern facing supporters of health reform: its back-loaded implementation. As Patashnik argues, "It takes time for reforms to embed themselves in governing routines, but time is a luxury reform advocates may not have."[57] Moreover, Patashnik adds, "Reforms endure not because they are 'frozen in place' . . . . Rather, they endure because they reconfigure the political dynamic."[58]

As previously noted, the fact that key provisions will not be operational until 2014 or later is the greatest and most obvious shortcoming of the health reform. Its key features may eventually reconfigure the political dynamic surrounding health insurance and health policy. Yet many of the most important political and policy outcomes will be determined before this occurs. PPACA was enacted in March 2010, and the 2010 and 2012 elections—and in some cases the 2014 or later elections—will occur before its most costly and important elements take force.[59]

In the meantime, states and localities are experiencing profound fiscal retrenchment, with an accompanying retrenchment of public

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[53] PATASHNIK, *supra* note 35.

[54] *Id.* at 155.

[55] *See id.* at 133 (contending that airline deregulation has been a long-lasting policy because important private parties adapted to the reform instead of trying to drive reform).

[56] *See id.* at 54 (noting that, from the beginning, commentators "warned that reform might not stick" because the act did not force any actors to change their behavior).

[57] *Id.* at 155.

[58] *Id.* (emphasis omitted).

[59] See Henry J. Aaron, *The Midterm Elections—High Stakes for Health Policy*, 363 NEW ENG. J. MED. 1685, 1687 (2010) ("Since most major provisions of the [PP]ACA do not take effect until January 1, 2014, delaying tactics might eventually enable repeal.").

health efforts.[60] Thousands of public health workers have been laid off over the past two years and many health departments have reduced services, despite growing needs for those services.[61] Retrenchment may worsen as states and localities experience continued fiscal difficulties. PPACA does little to address these losses directly. Moreover, proper implementation of PPACA depends at many points upon state lawmakers' skills, resources, and desire to cooperate with federal authorities.

It is unclear whether these state budget challenges politically help or hinder PPACA's implementation. Governors fear that it will impose additional costs through Medicaid and other programs.[62] However, PPACA also makes available additional resources for Federally Qualified Health Centers, workforce training, and other activities of great value to cash-strapped states.[63]

PPACA is also vulnerable because key provisions rely upon the appropriation decisions of future Congresses.[64] The Prevention and Public Health Fund may be the single most vulnerable item:

> One aide said health reform's preventive health spending is one of the "top three" offsets in the law that congressional Republican staffers are eyeing, with the idea that a few moderate Democrats facing tough races in 2012 could eventually be brought on board. . . . Republicans have long derided the multibillion Prevention and Public Health Fund as wasteful spending, scoffing at its investment in bike paths and farmers' markets. One Republican Senate aide quipped that it was a "slush fund for jungle gyms."[65]

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[60] *See, e.g.*, Julie Appleby, *Groups Vie for a Piece of Health Law's $15 Billion Prevention Fund*, KAISER HEALTH NEWS (May 7, 2010), http://www.kaiserhealthnews.org/Stories/2010/May/08/prevention-money-fight-health-reform-law.aspx ("Eighty-five percent of health departments surveyed by association[s] of health officials say they have reduced services since July 2008, often because of state budget shortfalls.").

[61] *See LHD Budget Cuts and Job Losses*, NACCHO, http://www.naccho.org/topics/infrastructure/lhdbudget/index.cfm (last visited Mar. 15, 2011) (reporting that roughly 29,000 local health jobs were lost from January 2008 to December 2010).

[62] *See* Harold Pollack, *Forget About Boehner. Try Republican Governors*, NEW REPUBLIC (Oct. 29, 2010, 12:00 AM), http://www.tnr.com/blog/jonathan-cohn/78760/health-care-obama-congress-republican-governors (noting that some governors have expressed concerns about how to finance PPACA's mandated programs and arguing that those governors may provide valuable political support for the Act in return for financial aid for those programs).

[63] *See id.* (noting that PPACA "expands funding for community health centers. . . . [that] also provide thousands of jobs.").

[64] *See generally* PATASHNIK, *supra* note 35, at 155 (arguing that reforms often fail because future governmental actors lack the same vision as those who enacted the reform).

[65] Sarah Kliff, *Doc Fix New Weapon vs. Health Reform*, POLITICO (Dec. 5, 2010, 5:09 PM), http://www.politico.com/news/stories/1210/45976.html.

Republicans have proposed to zero out the Prevention and Public Health Fund in two legislative battles: the first is a proposed amendment by Nebraska Republican Senator Mike Johanns to repeal a small-business tax reporting requirement,[66] and the second is a proposed measure to finance one year of Medicare's proposed "doctor fix."[67]

At first glance, the fund's political predicament is rooted in ideological disagreement about the value of preventive services, fraught with problematic symbolism evocative of such past efforts as "midnight basketball" for urban youth.[68] Some fund activities concern HIV prevention and reproductive health services that have traditionally attracted congressional concern.[69]

Yet the Fund's fundamental difficulty is that it rests on a simple appropriation, which can be readily eliminated or cut by congressional majorities that oppose specific program activities or that simply wish to reallocate $15 billion to other purposes in a constrained fiscal environment. Although the Fund provides money for valued services, it was not structured to maximize its likelihood of survival in unfavorable political conditions. These portions of PPACA did not create institutional changes or legal obligations that would raise the costs of future budget cuts. Individuals receiving Fund-financed services have no specific legal right to continued benefits. States that administer Fund-financed programs have no similar continued legal claim to federal monies.

Ironically, the Fund might have stronger political prospects if it were a "slush fund" for specific constituencies. Unlike programs to promote agricultural subsidies, specific weapons systems, small business owners, home mortgages, health coverage, or higher education, the Fund is not structured to serve or cultivate concentrated constituencies who could then lobby for continued appropriations.

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[66] *See* Harold Pollack, *For THIS Congress Might Defund Public Health?*, NEW REPUBLIC (Sept. 12, 2010, 8:31 PM), http://www.tnr.com/blog/jonathan-cohn/77604/republicans-tax-evasion (describing Senator Johanns's proposal to eliminate the Prevention and Public Health Fund in order to fund a tax measure).

[67] *See* Kliff, *supra* note 65 (discussing Republicans' use of the Medicare "doc fix" to take funding from health reform).

[68] Darren Wheelock & Doug Hartmann, *Midnight Basketball and the 1994 Crime Bill Debates: The Operation of a Racial Code*, 48 SOC. Q. 315, 316 (2007) (describing interest-group agitation that led to the evisceration of the Violent Crime Control and Law Enforcement Act of 1994).

[69] *See* Nancy Folbre, *Sex and the Stimulus*, N.Y. TIMES ECONOMIX BLOG (Feb. 5, 2009, 4:16 PM), http://economix.blogs.nytimes.com/2009/02/05/sex-and-the-stimulus (describing opposition from many quarters to a family planning funding element in a stimulus package).

Almost by definition, the Fund serves critical, frequently disorganized, and politically marginal constituencies. Consumers of smoking-cessation quit lines, or individuals requiring treatment and screening for sexually transmitted infection or substance abuse, for example, are poorly positioned to advocate for their programs. But the Fund does have a strong ideological constituency within the public health community. Given the perceived alignment between the public health community and politically liberal causes,[70] such advocacy may be more effective when Democrats rather than Republicans are politically ascendant in Congress.

Other PPACA provisions face political risks due to poor program design. As noted above, Nebraska Senator Mike Johanns sought unsuccessfully to defund the Prevention and Public Health Fund to finance repeal of a tax compliance measure included in PPACA.[71] That PPACA provision required small businesses to file 1099 income tax forms for a range of additional transactions exceeding $600.[72] In the aftermath of PPACA's passage, lawmakers received intense lobbying from representatives of small businesses who found this provision to impose unreasonable burdens.[73]

Republicans sought to eliminate this provision entirely, while Democrats sought to exempt purchases of less than $5000 (and firms employing less than twenty-five people) from the new requirement.[74] Although Democrats assembled fifty-six Senate votes for their preferred modification, they could not assemble a cloture-proof majority.[75]

Thus, the original unpopular tax provision remains settled law, leading to great anger within the key constituency of small-business owners directed towards PPACA. The vast unpopularity of this measure provides critics with little political incentive to help the Obama administration or congressional Democrats correct its technical de-

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[70] *See* SALLY SATEL, PC, M.D.: HOW POLITICAL CORRECTNESS IS CORRUPTING MEDICINE 17 (2001) (arguing that public health has moved away from finding scientific means for disease prevention towards social justice advocacy).

[71] *See supra* note 67 and accompanying text; *see also* Ezra Klein, *Senate Fails Small-Business Owners on 1099 Reform*, WASH. POST BLOG (Sept. 14, 2010, 1:26 PM), http://voices.washingtonpost.com/ezra-klein/2010/09/the_senate_fails_small_business.html (noting the failure of Senator Johanns's proposal).

[72] *Id.*

[73] *See, e.g.*, Bob Graboyes, *1099 Collation Calamity*, NFIB HEALTHCARE BULL. (Nat'l Fed'n of Indep. Bus., Nashville, Tenn), Aug. 10, 2010, at 11 (arguing forcefully that PPACA would "drown[] small business under an ocean of IRS Form 1099s").

[74] Klein, *supra* note 71 (describing the Senate's failed attempt to amend PPACA).

[75] *Id.*

fects. Indeed the National Federation of Independent Business and others have made "the 1099 Collation Calamity" a centerpiece of an effective anti-PPACA political campaign.[76] *The Wall Street Journal* editorialized in favor of NFIB's position, making no mention of Democrats' attempted, but filibustered, fix.[77]

The newly established Pre-existing Condition Insurance Plan (PCIP)[78] provides a second example of a problematic program design causing broader difficulties. This program allocates $5 billion between 2010 and 2014 to provide health insurance coverage for individuals with pre-existing conditions who lack health insurance coverage.[79] PCIP appears to suffer from all three difficulties identified in a December 2010 analysis by Patashnik and Zelitzer of the political sustainability of policy reforms: "[w]eak policy design, inadequate or conflicting institutional supports, and poor timing."[80]

As I describe in greater detail elsewhere,[81] this program faces serious operational and design challenges. The most serious of these challenges is the simple fact that available funding appears adequate to serve less than ten percent of Americans who face the dual challenge of chronic illness and the lack of health insurance coverage.[82]

Such design defects place these specific programs at risk and create broader political vulnerabilities for the entire bill. As *New York Times* columnist David Brooks asserted in a January 2011 essay:

> The health care reform law was signed 10 months ago, and what's striking now is how vulnerable it looks. Several threats have emerged—some of them scarcely discussed before passage—that together or alone could seriously endanger the new system. These include:
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> . . .

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[76] Graboyes, *supra* note 73, at 11.

[77] *The 1099 Stonewall*, WALL ST. J. ONLINE (Sept. 20, 2010), http://online.wsj.com/article/SB10001424052748703904304575498071550034964.html (opining that "Democrats slammed the door on a bipartisan attempt to repeal" the 1099 reporting requirement).

[78] *See, e.g.*, Harold A. Pollack, *High-Risk Pools for the Sick and Uninsured Under Health Reform: Too Little and Thus Too Late*, 26 J. GEN. INTERNAL MED. 91, 91-92 (2011).

[79] *Id.*

[80] Eric M. Patashnik & Julian E. Zelizer, When Policy Does Not Remake Politics: The Limits of Policy Feedback 5 (2009) (unpublished manuscript), *available at* http://ssrn.com/abstract=1449996.

[81] *See* Pollack, *supra* note 78, at 91 (arguing that "[t]o provide adequate health care for uninsured individuals with chronic diseases, the federal PCIP appropriations would need to be many times higher . . . .").

[82] *See* Patashnik & Zelizer, *supra* note 80, at 5.

> *False projections.* The new system is based on a series of expert projections on how people will behave. In the first test case, these projections were absurdly off base. According to the Medicare actuary, 375,000 people should have already signed up for the new high-risk pools for the uninsured, but only 8,000 have.
>
> More seriously, cost projections are way off. For example, New Hampshire's plan has only about 80 members, but the state has already burned through nearly double the $650,000 that the federal government allotted to help run the program. If other projections are off by this much, the results will be disastrous.[83]

For technical reasons, the design and forecasting problems with PCIP are less severe than Brooks implied. However, the inherent difficulty of designing and implementing this complex and temporary program poses many political challenges which might have been avoided through more carefully crafted provisions in the original bill.

More complex issues have been raised regarding the Community Living Assistance Services and Supports (CLASS) disability insurance program. Experts disagree about the actuarial soundness of CLASS's current program design, with the Congressional Budget Office taking a more optimistic view[84] than the chief actuary of the Center for Medicaid and Medicaid Services (CMS).[85] Should the most serious concerns be borne out, CLASS's challenges provide another potential area of political vulnerability for health reform.

III. SUCCESSFUL MODELS OF POLITICALLY SUSTAINABLE PUBLIC HEALTH MEASURES

Although some public health measures (enacted within PPACA or other legislation) appear politically vulnerable, others appear likely to be sustained under both Democratic and Republican majorities.

Tobacco excise taxes may be the most successful public health measure in terms of cultivating powerful supportive constituencies

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[83] David Brooks, Opinion, *Buckle Up for Round 2*, N.Y. TIMES, Jan. 7, 2011, at A19.

[84] *See* Letter from Douglas W. Elmendorf, Dir., Cong. Budget Office, to George Miller, Chairman, House Comm. on Educ. & Labor, at 1 (Nov. 25, 2009), at 1, *available at* http://www.cbo.gov/ftpdocs/107xx/doc10769/CLASS_Additional_Information_Miller_letter.pdf ("For both the House and Senate versions of CLASS, the Congressional Budget Office (CBO) estimates that the cash flows under the new program would generate budgetary savings (that is, a reduction in net federal outlays) for the 2010—2019 period and for the 10 years following . . . .").

[85] *See* Memorandum from Richard S. Foster, Chief Actuary, Ctr. for Medicare & Medicaid Servs., at 2 (Apr. 22, 2010), *available at* https://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf (finding that the CLASS program will generate net losses every year from 2010—2019, for a total of $37.8 billion).

over time. The Institute of Medicine and other expert bodies have identified excise taxes as important tools to reduce smoking.[86] These policies have proven especially sustainable for the obvious reason that they yield valuable revenue at every level of American government.[87] Between 1995 and 2009, federal cigarette excise taxes increased 321%, while the average state excise tax increased by 267%.[88] These tax increases finance a variety of medical and public health interventions, ranging from the Children's Health Insurance Program to smoking-cessation quit lines. These revenues are also used to reduce state and local budget deficits or to meet other important social needs.[89]

From a public health perspective, it is ideal when such revenues finance measures to directly improve population health. The mere fact that all levels of government depend on these revenues for popular activities helps to sustain these policies politically, even—or especially—during hard economic times when many public health services and expenditures are curbed.[90]

Other public health measures have also proved politically effective. As noted above, PPACA greatly expanded coverage of preventive services that are given high ratings by the USPSTF.[91] Viewed through the lens of Patashnik's analysis, this provision's institutional shift makes it especially politically generative.[92]

USPSTF, a rather marginalized expert body, now has explicit authority in the design and reimbursement of clinical preventive servic-

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[86] *See* DEP'T OF HEALTH & HUMAN SERVS., HEALTHY PEOPLE 2010: MIDCOURSE REVIEW (2010), at 27-7, *available at* http://www.healthypeople.gov/2010/Data/midcourse/ (describing the successes of Michigan, New Jersey, and Rhode Island in using excise taxes to combat smoking).

[87] *See 2009–2010 Proposed State Legislation for Tobacco Tax Increases*, NAT'L CONF. ON STATE LEGIS.), http://www.ncsl.org/default.aspx?tabid=13862 (last visited Mar. 15, 2011) (listing various states' expected revenues from tobacco taxes and how those revenues will be distributed across various levels of state government).

[88] *Federal and State Cigarette Excise Taxes—United States, 1995–2009*, 58 MORBIDITY & MORTALITY WKLY. REP. 524, 524 (2009).

[89] NAT'L CONF. ON STATE LEGIS., *supra* note 87.

[90] Curiously, the same trend has not applied to alcohol taxes. The real value of excise taxes on beer and spirits has markedly declined since the 1950s, despite strong evidence that such taxes are below the levels required for drinkers to internalize fully the economic costs of alcohol-related harm. *See* PHILIP J. COOK, PAYING THE TAB: THE ECONOMICS OF ALCOHOL POLICY 165 (2007) ("[L]ooking back fifty years from 2005, the federal excise tax on liquor (adjusted for inflation) was 5.7 times as high, and the excise tax on beer 3.6 times as high.").

[91] *See supra* note 43 and accompanying text.

[92] *See* PATASHNIK, *supra* note 35, at 155 (discussing how the most enduring reforms are politically dynamic).

es.[93] This immediately fosters improved reimbursement and utilization of specific services that are unlikely to be the target of focused political advocacy, such as chlamydia screening.

Some services, such as Screening, Brief Intervention, and Referral to Treatment (SBIRT) for alcohol disorders, have been subject to prolonged legislative and regulatory debate. Because these services have earned a "B" rating from USPSTF,[94] they will now be reimbursed. Other forms of screening yield high marks from USPSTF, yet are often excluded from public or private insurance coverage if they are proposed under the umbrella of population screening rather than as clinically indicated diagnostic tests for particular patients.

Over the long term, this provision may prove important in other ways. USPSTF is acknowledged as a central player in health policy. Clinicians, researchers, and funders now have much greater incentives to conduct clinical trials of promising services that might receive favorable USPSTF ratings. Prevention trials financed by the National Institutes of Health, the Agency for Healthcare Research and Quality, the Centers for Disease Control and Prevention, and others suddenly have direct policy relevance if they satisfy USPSTF's rigorous criteria for prevention trials.

The full implications of this change remain to be seen, but this major policy change commands attention. Although USPSTF decisions are occasionally controversial, Congress is less likely to curb USPSTF's authority to expand access to clinical services than it is to approve more expansive coverage of specific popular services that fail to pass USPSTF muster, such as mammography for young women who have no indicated risk factors.[95]

Other regulatory elements of PPACA are also politically generative. The language specifying health insurance exchanges provides significant protections for individuals with mental health and substance abuse disorders. By including these disorders in the language governing medical homes, PPACA encourages Federally Qualified Health Centers, as well as other kinds of organizations, including the Mayo Clinic, to address concerns that have traditionally been viewed within the province of safety-net care.

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[93] PPACA, sec. 1001, § 2713, 42 U.S.C.A. § 300gg-13 (West Supp. 1A 2010).

[94] *See* U.S. Preventive Servs. Task Force, *Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse: Recommendation Statement*, 140 ANNALS INTERNAL MED. 554, 554 (2004).

[95] U.S. Preventive Servs. Task Force, *Screening for Breast Cancer: U.S. Preventive Services Task Force Recommendation Statement*, 151 ANNALS INTERNAL MED. 716, 716 (2009).

IV. DESIGNING MORE SUSTAINABLE PUBLIC HEALTH POLICIES

The legislative and implementation battles that surround PPACA challenge public health activists, researchers, and practitioners to construct more durable policies. Sustainable policies must nurture the conditions for future political success. Such policies are politically generative when they attract new political allies and friendly interest groups, or when they create lasting institutional shifts that favor continued public health investment.

In tangible ways, PPACA might have been designed to be more robust in the face of a hostile majority. PCIP provides an egregious example. Although this program builds on traditional Republican proposals and is ideologically moderate, its cumbersome program design, combined with its low level of funding, makes it unlikely to win strong political support. PCIP's avowedly temporary structure gives potential allies especially little reason to embrace it or to expend political capital on its behalf.

Other strategies were available that provided simpler and more politically sustainable models to more quickly help the medically uninsured. Early in the health reform process, Senator Max Baucus proposed shortening the required Medicare waiting period for individuals deemed eligible for federal disability programs.[96] Several hundred thousand uninsured individuals with disabling conditions now endure this waiting period and could be helped through modifying the program rules.[97]

Expanding Medicare eligibility to this group represented a more administratively feasible change that could have quickly mobilized an organized constituency within the disability community. Moreover, the government could initiate this program through an expansion of the Medicare entitlement that would be difficult for future legislators to repeal and that would not require explicit appropriations from a future Congress. Ironically, the key drawback of this policy change is financial. Complete elimination of the Medicare waiting period

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[96] MAX BAUCUS, CALL TO ACTION: HEALTH REFORM 2009, at 14 (2008).

[97] *Id.* at 22; *see also* STACY BERG DALE & JAMES M. VERDIER, COMMONWEALTH FUND, ELIMINATION OF MEDICARE'S WAITING PERIOD FOR SERIOUSLY DISABLED ADULTS: IMPACT ON COVERAGE AND COSTS 1 (2003), *available at* http://www.commonwealthfund.org/usr_doc/660_Dale_elimination.pdf (estimating that disabled individuals' two-year waiting period affected about 1.26 million people as of January 2002).

would require much greater federal expenditures than are now being provided through PCIP.[98]

There are sometimes real tensions between good politics and good substantive policy. The Prevention and Public Health Fund might have better political prospects if it had a broader circle of constituencies outside the traditional public health community with a vested interest in its survival. For example, Democratic and Republican governors would have a greater stake in continued appropriations if fund resources were explicitly provided through state governments.

Such shared state-federal ownership brings a real price. Some governors may oppose evidence-based interventions such as a syringe exchange.[99] Others may demonstrate corresponding enthusiasm for popular programs such as abstinence-only education that lack demonstrated effectiveness.[100] Centralized federal control would likely focus resources more effectively on evidence-based public health interventions. When the executive branch and congressional majorities are strongly committed to public health, such centralized authority has many advantages. Under less favorable political conditions, however, such shared ownership may be more sustainable. Although some ineffective programs are likely to receive funding, overall public health funding might be greater and more secure.

PPACA also could have been structured more imaginatively to support state and local public health infrastructure. For example, local health departments can receive Medicaid reimbursement for prenatal care, HIV treatment, and other clinical services.[101] They cannot bill Medicaid for equally important services such as epidemiological case-finding or partner-notification services.[102] Expanding the scope

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[98] Compare figures from DALE & VERDIER, *supra* note 97, at 2, which estimate that the change would cost approximately $8.7 billion annually, with those discussed by Pollack, *supra* note 78, at 91, which note that PPACA provides $5 billion for PCIP funding between 2010 and 2014.

[99] *See* INST. OF MED., NO TIME TO LOSE: GETTING MORE FROM HIV PREVENTION 114-16 (Monica S. Ruiz et al. eds., 2001) (discussing political barriers to needle exchange programs).

[100] *See* CHRISTOPHER TRENHOLM ET AL., MATHEMATICA POLICY RESEARCH, INC., IMPACTS OF FOUR TITLE V, SECTION 510 ABSTINENCE EDUCATION PROGRAMS 59 (2007) (finding that abstinence education programs have no impact on rates of sexual abstinence).

[101] *See* Email from Sherry Glied, Assistant Sec'y for Planning & Educ., Dep't of Health & Human Servs., to author (Oct. 4, 2010) (on file with author) (describing the types of preventative services for which PPACA provides funding).

[102] *See id.* (explaining that these types of services are generally not billable to Medicaid under PPACA).

of Medicaid reimbursement to include a greater range of public health services would provide valuable financial assistance to state and local governments. It would also allow the federal government to more effectively promote and nurture vulnerable services that enhance population health.

The political science literature offers one more sobering lesson in formulating politically sustainable policy. Many within the public health community seek to address a central political challenge: crafting persuasive messages to convince voters and policymakers of the value of preventive services and measures that improve population health.[103] The good news is that the American public embraces the value of public health as a general policy goal. In a November 2009 survey, seventy-one percent of registered voters polled indicated that they support increased investments in prevention "to help people stay healthy and reduce diseases such as diabetes, cancer and heart disease."[104]

The bad news is that such generalized public support means much less than one might hope. In the first place, public opinion regarding public health can markedly shift when the underlying policy issues are linked with broader partisan and ideological disputes.[105] More fundamentally, the history of general-interest reforms suggests that such favorable polls are far less important to political outcomes than one might suppose.[106]

Sustainable public health policy requires more than the passive support or the momentary acquiescence of a political majority. One must design policies to nurture the loyalties and investments of specific interest groups and constituencies who have reason to support and defend these new policies. One must create organizational changes that are difficult, costly, or unattractive for future majorities to undo.

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[103] Robert J. Blendon et al., *Americans' Conflicting Views About the Public Health System, and How to Shore Up Support*, 29 HEALTH AFF. 2033, 2038 (2010) (noting that to continue to provide support for health care, Americans will want to see examples of successful programs).

[104] GREENBERG QUINLA, ROSNER RESEARCH & PUB. OPINION STRATEGIES, AMERICAN PUBLIC SUPPORTS INVESTMENT IN PREVENTION AS PART OF HEALTH CARE REFORM: SOLID MAJORITIES FAVOR TRUST FOR AMERICA'S HEALTH'S PROPOSALS 2 (2009), *available at* http://www.greenbergresearch.com/index.php?ID=2416.

[105] *See* Sarah E. Gollust et al., *The Polarizing Effect of News Media Messages About the Social Determinants of Health*, 99 AM. J. PUB. HEALTH 2160, 2165 (2009) (finding that Republicans' and Democrats' opinions on health care can diverge even when exposed to neutral social determinants messages).

[106] *See generally* PATASHNIK, *supra* note 35, at 155-71 (noting that popularity at the time of enactment has little to do with a reform's sustainability and discussing the factors that do impact the long-term survival of reforms).

Political durability is no guarantee of policy success. Yet good policy that rests on poor political foundations rarely remains good policy for very long. Bolstering these foundations is a critical challenge for both public health politics and public health policy.