

# HEALTH REFORM AND TED KENNEDY: THE ART OF POLITICS . . . AND PERSISTENCE

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*“On the domestic front, I committed myself to the issue that had already caught my passion. I recognized that improving health care, and ensuring Americans’ ability to pay for it, would be my main mission, and I would fight for it for however long it would take.”*

~ Edward M. Kennedy<sup>1</sup>

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1. EDWARD KENNEDY, *TRUE COMPASS: A MEMOIR* 299 (Twelve 2009).

*“Politics is moved less by new ideas than by the ability of politicians to bend the direction of history, even slightly.”*

~ Nicholas Lemann<sup>2</sup>

#### INTRODUCTION

Health care has become a core challenge for modern societies. Health care is increasingly effective in treating diseases, relieving pain, and extending life. This growing power, however, requires a massive deployment of resources, from hospitals to drugs and devices to providers, and the costs of these resources are rapidly increasing.<sup>3</sup> Market forces do not constrain this cost escalation, partially due to a lack of competition in the delivery of physician and hospital services.<sup>4</sup> Modern societies must decide how to finance health care, how to organize it, and how to handle the costly procedures that can bankrupt any ordinary citizen.

The models range from national health services, owned and operated by the state and employing providers, to purely private systems, where the rich pay for good service and the poor get little or nothing, except through public hospitals.<sup>5</sup> The variations among models are substantial, even within groups of sister countries, such as Ireland, Scotland, Wales, and England.<sup>6</sup> If access is the test of a successful,

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2. Nicholas Lemann, *Kennedy Care*, THE NEW YORKER, Sept. 7, 2009. Nicholas Lemann is Dean and Henry R. Luce Professor at the Columbia University Graduate School of Journalism in New York City. He is a journalist, editor, and author, and has served as an editor or reporter for major national magazines such as the Atlantic Monthly and the New Yorker, and has written for or served in editorial positions for papers such as the Washington Monthly and the Washington Post.

3. This story has been well-told by PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE: THE RISE OF A SOVEREIGN PROFESSION AND THE MAKING OF A VAST INDUSTRY (1982). Starr won a Pulitzer Prize for his brilliant work on health care in America, and much legal and health policy scholarship has built on his careful and thorough analysis of American health care history. For a recent review of the impact of his book, see Keith Wailoo et al., *Professional Sovereignty in a Changing Health Care System: Reflections on Paul Starr's The Social Transformation of American Medicine*, 29 J. HEALTH POL. POL'Y & L. 557 (2004).

4. The health reform debate that preceded the passage of ACA generated much writing on this topic, the best being Uwe Reinhardt's blog in the *New York Times*. See Archive of Columns by Uwe E. Reinhardt: Economix, N.Y. TIMES, <http://economix.blogs.nytimes.com/tag/uwe-e-reinhardt/> (last visited Nov. 12, 2010).

5. COMMONWEALTH FUND, INTERNATIONAL PROFILES OF HEALTH CARE SYSTEMS: AUSTRALIA, CANADA, DENMARK, ENGLAND, FRANCE, GERMANY, ITALY, THE NETHERLANDS, NEW ZEALAND, NORWAY, SWEDEN, SWITZERLAND, AND THE UNITED STATES 4 (2010).

6. An excellent summary account of how European countries have managed universal health care coverage using a variety of approaches is provided in Tim Reid, Address to the 2010 Catholic Health Assembly: Universal Coverage: 'They Did It. We Can Do It.' (June 15, 2010), in HEALTH PROGRESS, Nov.–Dec. 2009, at 55. He

ethical health care system, the United States does not rank well in comparison with other industrialized countries.<sup>7</sup> With 17.5% of our 2010 gross domestic product (GDP) spent on health care,<sup>8</sup> Americans pay a higher percentage of their income on health care services than the citizens of any other western country.<sup>9</sup>

The Patient Protection and Affordable Care Act of 2010 (ACA) has helped us progress further down the road toward universal coverage of all Americans.<sup>10</sup> The ACA is both an extension of existing programs like Medicare and Medicaid, and a reform of private employment insurance, intended to increase coverage for those who are currently uninsured. It promises to cover 32 million more Americans (while leaving 19 million uncovered), and it improves, but does not achieve, the true portability of coverage that universal health reform would achieve. This legislation is a significant movement toward universal coverage of health care expenses, building on existing statutory structures while redefining the ground rules under which they operate. This legislation bears the indelible mark of Senator Edward Kennedy, who acted for forty years as a strong tailwind, pushing health care reform forward and making contributions to insurance reform through HIPAA and the Massachusetts health reforms, which provided a partial template for the final version of the ACA.

Driven by personal tragedies and empathy for those who were denied access to health care for any one of a dozen reasons, from insurance discrimination to lack of eligibility for federal and state health programs, Senator Ted Kennedy made health care a central theme of his political life. Health care was personal for Kennedy be-

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elaborates on these ideas in TIM REID, *THE HEALING OF AMERICA: A GLOBAL QUEST FOR BETTER, CHEAPER, AND FAIRER HEALTH CARE* (2009).

7. WHO Health 2000 ranks the U.S. thirty-seventh among health care systems, with access problems driving our rank down. WORLD HEALTH ORG., *THE WORLD HEALTH REPORT 2000: HEALTH SYSTEMS: IMPROVING PERFORMANCE 200* tbl.10 (2000), [http://www.who.int/whr/2000/en/whr00\\_en.pdf](http://www.who.int/whr/2000/en/whr00_en.pdf).

8. Andrea M. Sisko et al., *National Health Spending Projections: The Estimated Impact of Reform Through 2010*, 29 HEALTH AFF. 1933, 1934 (Oct. 2010) (updating national health spending data to take into account the budgetary effects of passage of the Affordable Care Act).

9. See ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT, *HEALTH DATA 2010: HOW DOES THE UNITED STATES COMPARE?* 1 (2010), <http://www.oecd.org/dataoecd/46/2/38980580.pdf> (concluding that “Health spending accounted for 16% of GDP in the United States in 2008, by far the highest share in the OECD, and seven percentage points higher than the average of 9% in OECD countries. Following the United States were France, Switzerland and Germany, which allocated respectively 11.2%, 10.7% and 10.5% of their GDP to health.”).

10. Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 (to be codified as amended in scattered sections of 26 and 42 U.S.C.).

cause he, along with many members of his close family, had experienced serious injury and illness,<sup>11</sup> and he was well aware that his wealth allowed him access to top specialists that most Americans could not afford.<sup>12</sup> He often spoke of the medical crises that he and his family experienced, from his sister's mental illness to his own recovery from a small plane crash.<sup>13</sup> In the words of one of his biographers, "[h]is personal exposure to health care challenges only strengthened his determination to achieve his central goal in the Senate, the mission that drove both his daily schedule and his long-term agenda: he wanted every man, woman, and child in America to have access to decent health care."<sup>14</sup> The history of health reform in the United States, however, reflects embedded resistance to reform and a heavy reliance on employment-based insurance to provide coverage to most Americans. Kennedy faced a daunting political challenge in striving for any version of universal health coverage.

## I.

### THE BACKGROUND OF HEALTH CARE REFORM<sup>15</sup>

The political struggles of Senator Kennedy in the health reform arena are explained by the structural impediments to any version of health reform. The path to American health care reform has been impeded by differing ideologies; the history of our health care system and its resulting fragmentation;<sup>16</sup> and entrenched and often well-organized and well-funded interests that have mobilized to resist reform, from the American Medical Association (AMA) to insurers and employer groups. Some background information is in order.<sup>17</sup>

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11. THE BOSTON GLOBE, *LAST LION: THE FALL AND RISE OF TED KENNEDY* 322 (Peter S. Canellos ed., 2009).

12. *Id.*

13. See KENNEDY, *supra* note 1, at 300; EDWARD M. KENNEDY, IN *CRITICAL CONDITION: THE CRISIS IN AMERICA'S HEALTH CARE* 11 (1972).

14. THE BOSTON GLOBE, *supra* note 11, at 323.

15. I have based much of the historical discussion on the superb historical treatment of American medicine in STARR, *supra* note 3. A more detailed look at reform and its goals can be found in Paul Starr, *Transformation in Defeat: The Changing Objectives of National Health Insurance, 1915–1980*, 72 AM. J. PUB. HEALTH 78 (1982).

16. Jill Quadagno, *Why the United States Has No National Health Insurance: Stakeholder Mobilization against the Welfare Street, 1946–1966*, 45 J. HEALTH & SOC. BEHAV. 25 (2004).

17. See Anne-Emanuelle Bim et al., *Struggles for National Health Reform in the United States*, 93 AM. J. PUB. HEALTH 86 (2003) (examining popular political movements and forces that pushed for reform from 1901 to the 1990s); Beatrix Hoffman, *Health Care Reform and Social Movements in the United States*, 93 AM. J. PUB. HEALTH, 75, 75–85 (2003) (discussing grass roots movements for health reform in the 20th century).

### A. *The Stages of American Health Reform*

The history of U.S. health care reform can be divided into four periods. This Article will use Paul Starr's terminology to define the first three intervals: Progressive Health Insurance, Expansionary Health Insurance, and Containment Health Insurance.<sup>18</sup> The passage of the ACA marks the dawn of a fourth period, which I have termed Quasi-Social Insurance. Progressive Health Insurance, which took place in the early twentieth century, gets its name from the Progressives, who introduced health insurance as a method of income maintenance for wage earners, with secondary goals of promoting disease prevention and national efficiency. Progressive reformers passed workers' compensation statutes to protect workers and regulate food and water, with health care as a secondary issue to these other important social reforms of public health and worker protection.<sup>19</sup>

Expansionary Health Insurance refers to the period from the 1930s to the 1960s, during which we focused on improving access to health care services.<sup>20</sup> In this period, health insurance was viewed as a mode of medical care financing for increasingly expensive services, through the distribution of individual risks and the expansion of access to coverage for lower- and middle-income groups. Blue Cross plans developed, followed by the expansion of commercial insurance that competed with the Blues. Employment-based health insurance became the norm in the 1950s. An accident of wartime collective bargaining, mid-century health insurance was not primarily designed as a health care payment system. It foreshadowed future contemporary health care coverage problems, as insurance functioning as a fringe benefit of work meant that those who stopped working lost coverage. The model was a characteristically American approach in which the path to health care policy weaved among the landmines of the political landscape of the era.

The Containment Health Insurance era began in the 1970s, when the recently enacted Medicare program began to drive up costs. Con-

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18. Paul Starr describes the first three eras, while the fourth is purely my invention. Starr, *supra* note 15, at 78.

19. See e.g., DONALD W. ROGERS, MAKING CAPITALISM SAFE: WORK SAFETY AND HEALTH REGULATION IN AMERICA, 1880-1940 4, 66 (2009) (describing Progressive contributions to the development of workers' compensation laws in Wisconsin and elsewhere). See generally MICHAEL MCGERR, A FIERCE DISCONTENT: THE RISE AND FALL OF THE PROGRESSIVE MOVEMENT IN AMERICA, 1870-1920 (2003).

20. For a more elaborate discussion of the struggles for health care from 1929 to 1945, including the emergence of the Blue Cross plans, see STARR, *supra* note 3, at 290-335.

gress passed the Health Maintenance Organization Act (HMO Act)<sup>21</sup> to make health insurance a tool of cost control. The passage of Medicare in 1966 and Medicaid shortly thereafter meant that the federal government became the dominant payer for two categories of Americans with expensive health care needs: the elderly and the poor. The spigot of federal money was opened wide, and Medicare became a source of health care cost inflation, pouring federal dollars into the health care marketplace as ten percent of the American population became Medicare- and Medicaid-eligible in the mid-1960s.<sup>22</sup> Between 1966 and 1983, when the prospective payment, or diagnosis-related groups (DRG) system,<sup>23</sup> was instituted to control Medicare hospital costs, the health care system was arguably free of financial regulation. National health expenditures increased by a factor of ten, from \$42 billion in 1965 to \$420 billion in 1985, adjusted for inflation. Cost inflation in health care, and its demands on public and private payers, led to renewed health reform efforts in the mid-1970s by three consecutive administrations: Nixon, Ford, and Carter.<sup>24</sup> Health care cost inflation was fueled by economic drivers created by earlier federal policy decisions: biomedical research funded at a high level, rapid expansion of the physician supply, federal subsidies for the construction and renovation of hospitals, and restructuring of health care financing. Hospitalization costs grew, and consequently, so did private health insurance.<sup>25</sup>

During this period, the Medicare and Medicaid programs faced rapidly growing costs. At the same time, critics noted that American health care was unevenly distributed, marked by limited access for poor and rural residents, inefficient administration, and the inferiority

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21. Health Maintenance Organization Act of 1973, 42 U.S.C. § 300e.

22. See THEODORE H. TULCHINSKY & ELENA A. VARAVIKOVA, *THE NEW PUBLIC HEALTH* 471 (Elsevier 2d ed. 2009).

23. The diagnosis-related groups (DRG) prospective payment system was mandated by Congress in 1982 to control Medicare costs. This system changes payment from a highly inflationary fee-for-service approach to a per-case reimbursement mechanism, which divides inpatient admission cases into categories called diagnosis-related groups. Medicare then pays hospitals a flat rate per case based on the particular DRG. The goal is to reward efficient hospitals and create incentives for inefficient hospitals to improve. See generally OFFICE OF INSPECTOR GEN., *MEDICARE HOSPITAL PROSPECTIVE PAYMENT SYSTEM: HOW DRG RATES ARE CALCULATED AND UPDATED* (Aug. 2001).

24. The history of health reform from the perspective of American presidents is well summarized in *American Presidents and Health Reform: A Chronology*, HOSPITALS AND HEALTH NETWORKS, [http://www.hhnmag.com/hhnmag\\_app/jsp/articledisplay.jsp?dcrpath=HHNMAG/Article/data/02FEB2009/0902HHN\\_CoverStory\\_WebExtra&domain=HHNMAG](http://www.hhnmag.com/hhnmag_app/jsp/articledisplay.jsp?dcrpath=HHNMAG/Article/data/02FEB2009/0902HHN_CoverStory_WebExtra&domain=HHNMAG) (last visited Feb. 24, 2011).

25. See STARR, *supra* note 3, at 381–82.

of many of its delivery components.<sup>26</sup> In 1970, the country faced a national “crisis” in health care, driven by escalating costs for “usual, customary, and reasonable”<sup>27</sup> reimbursement and fee-for-service medicine. As costs skyrocketed, health care regulation focusing on cost control began in earnest, with the enactment of the following pieces of legislation: price stabilization programs in 1972, the HMO Act in 1973, and the Health Planning and Resource Development Act and its Certificate of Need requirements in 1974. At the same time, private insurance costs escalated, leading private employers to restructure work-related health insurance programs: they began to cost-shift from themselves to their employees by narrowing plan choices, imposing deductibles on coverage, and dropping dependents from employee coverage.<sup>28</sup> This restructuring laid the foundation for access problems for the next three decades.<sup>29</sup>

During the next phase of health insurance regulation, in the late 1990s and the first decade of the 2000s, smaller companies began to either drop insurance altogether or shift employees to part-time status to reduce insurance costs.<sup>30</sup> The late 1980s and early 1990s had also seen hyper-entrepreneurship among health care providers, with for-profit hospitals acquiring non-profits, and for-profit managed care plans expanding rapidly.<sup>31</sup> In addition, the health care delivery model of the hospital as the hub of health care began to fade. One of the secondary consequences of the DRG program’s fixed prices for groups within the hospital was to move procedures out of the hospital and into unregulated settings. Most medical encounters now occurred in non-hospital settings, and many surgical procedures were shifted to outpatient surgery settings. Group practices, ambulatory care centers, home health agencies, sub-acute units, and hospices grew in part as a

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26. *See id.* at 381.

27. Prior to 1989, physicians were compensated by both private insurers and Medicare by the usual, customary, or reasonable (UCR) method, with payment determined based on the lowest of either the bill submitted, the customary charge of the physician, or the prevailing rate in the area for those services. This mode of payment was inflationary, since physicians had a strong incentive to increase their fees over time to raise the reasonable rate calculation in the future. REXFORD E. SANTERRE & STEPHEN P. NEUN, *HEALTH ECONOMICS: THEORY, INSIGHTS, AND INDUSTRY STUDIES* 300 (5th ed. 2010).

28. *See* GERALD R. LEDLOW & M. NICHOLAS COPPOLA, *LEADERSHIP FOR HEALTH PROFESSIONALS: THEORY, SKILLS, AND APPLICATIONS* 292 (2011).

29. *See* Barry R. FUITOW, *Access to Health Care and Political Ideology: Wouldn't You Really Rather Have a Pony?*, 29 W. NEW ENG. L. REV. 405, 407 (2007).

30. *Id.* at 409.

31. The description “hyper-entrepreneurship” is used by Robert Kuttner to describe the frenzy of market forces during these last two decades. *See* ROBERT KUTTNER, *EVERYTHING FOR SALE: THE VIRTUES AND LIMITS OF MARKETS* 134 (1996).

response to this shift in location of patient care.<sup>32</sup> There were also casualties: almost a thousand hospitals have closed since the early 1980s, a trend that the ACA will only accelerate.<sup>33</sup>

The United States has resisted a universal model of health care delivery under which all Americans would enjoy the same access rights and benefits. Instead, we developed over time a highly fragmented system, with Medicare for the elderly, private insurance for working adults, and means-based programs, like Medicaid, for the poor. This complex system has managed to cover health care costs for most employees for decades, as well as for the old and the poor. Employment-based insurance has decayed as smaller employers have found it too difficult to pay the high premiums for small group coverage, and even workers with good insurance often found themselves barred from coverage due to predatory private insurance practices.<sup>34</sup> This deterioration has a lengthy history, one that existed even as Senator Edward Kennedy was chairing congressional hearings on these questions as far back as the 1970s.<sup>35</sup>

The history of American public health programs—Medicare and Medicaid in particular—offers one explanation for health reform struggles. This history is one of a progressive fragmentation of care.<sup>36</sup> In the 1960s, the idea of universal health coverage was resisted by organized medicine, subordinated to Medicare (which was considered old-age insurance) and then crowded out by cost inflation of Social Security and Medicare.<sup>37</sup> This history made large-scale, comprehen-

32. See HARRY A. SULTZ & KRISTINA M. YOUNG, *HEALTH CARE USA: UNDERSTANDING ITS ORGANIZATION AND DELIVERY* 114 (2011).

33. In 1990 the Census Bureau reported 6,649 hospitals, and in 2007 5,708. U.S. CENSUS BUREAU, *STATISTICAL ABSTRACT OF THE UNITED STATES: 2010, SECTION 3, HEALTH AND NUTRITION* 115 (2010), available at <http://www.census.gov/prod/2009pubs/10statab/health.pdf>.

34. I have recounted elsewhere some of the factors that have led to and reinforced our fragmented system. See Furrow, *supra* note 29, at 405, 407–08 (describing shrinking of employment-based insurance coverage).

35. See KENNEDY, *supra* note 13, at 13–14 (discussing health subcommittee hearings in which witnesses testified to access problems they had faced).

36. See *THE FRAGMENTATION OF U.S. HEALTH CARE: CAUSES AND SOLUTIONS* 11–12 (Einer Elhauge ed., 2010) (citing, among other causes of such fragmentation, the law and legal doctrines that thwart efficiencies, and the payment system of Medicare).

37. See Theodore R. Marmor, *Is Fragmentation a Helpful Category for Understanding Health Reform Experience and Prospects?*, in *THE FRAGMENTATION OF U.S. HEALTH CARE: CAUSES AND SOLUTIONS* 342, 346 (“In the 1980s the picture was different, politically, economically, and intellectually. Few prominent figures promoted government-financed universal health insurance, either for the nation or for a particular state. Following the 1980s, the deficits of the Reagan and Bush years continued to dominate political discourse . . .”).

sive reform more difficult.<sup>38</sup> This is largely so because by the beginning of the new millennium, Americans faced a deeply entrenched infrastructure of private, tax-subsidized, employer-based programs, along with public programs that covered only specific groups (Medicare for the elderly, Medicaid for the poor, the Veterans Affairs (VA) system for veterans) and nothing for those in the gaps.<sup>39</sup> This left large numbers of citizens uninsured, either because they were too young, they earned too much money to qualify for subsidized health care, or they were unemployed or underemployed.

Quasi-Social Insurance, which commenced in 2010, is the era of the ACA, which was signed into law by President Obama on March 23, 2010. One week later, the president signed the Health Care and Education Affordability Reconciliation Act,<sup>40</sup> which amended some of the spending and revenue provisions of the ACA.

Together, these statutes represent the most significant change in the American health care system in a generation. The ACA promotes access to health care through a change in the core definition of private insurance and the decoupling of poverty and Medicaid, while also shifting some responsibility to individuals to improve their own health.<sup>41</sup> The ACA will harmonize health care in the United States with the idea of universal coverage of all citizens as a right, in large

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38. See RICK MAYES, *UNIVERSAL COVERAGE: THE ELUSIVE QUEST FOR NATIONAL HEALTH INSURANCE* 142 (2004).

39. See *id.*

40. Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (to be codified as amended in scattered sections of 26 and 42 U.S.C.).

41. Insurance reforms in ACA have been the focus of most discussion, but the scope of the legislation is broad. The Medicare and Medicaid provisions of the bill, for example, encourage new forms of health care organization, such as accountable care organizations and health homes, that may in the long run further transform hospital-physician relationships and the organization of health care institutions. The ten titles of the ACA illustrate the range of issues addressed by the statute. A list of these titles follows, together with a brief description of each:

Title I: Quality, Affordable Health Care for All Americans, contains both immediate and longer-term insurance reforms, establishes exchanges for the sale of health insurance in the individual and small group market, provides subsidies for the purchase of health insurance for Americans with household incomes below 400% of the poverty level, requires uninsured individuals to purchase health insurance or pay a penalty, and mandates that employers who do not adequately insure their employees pay a penalty if their employees end up receiving public subsidies. The insurance reforms attempt to end underwriting based on health status and to limit a number of restrictive or exclusionary practices of health insurers.

Title II: Role of Public Programs, dramatically expands the Medicaid program to cover all Americans with household incomes not exceeding 133% of the federal poverty level. It also provides some additional benefits for Medicaid recipients, increases Medicaid payments for primary care services, and extends the funding of the Children's Health Insurance Program.

part by moving private health insurance closer to quasi-social insurance.

The ACA mandates that employers provide insurance for their employees, under threat of penalties, and the insurance exchanges set up under the act require that insurance offerings be transparent in their design and easily available, and that the price of such policies bear some relation to the insured's ability to pay.<sup>42</sup> Prior to the ACA, the U.S. health insurance system already had significant social insurance features, including Medicare, Medicaid, and workers' compensation. As opposed to private health insurance, the social insurance system already in place was and continues to be mandatory for the relevant group, imposed by government, and funded by taxpayers and the government.<sup>43</sup> Such insurance offers guaranteed benefits to qualified

Title III: Improving the Quality and Efficiency of Health Care, amends the Medicare program. The provisions of Title III are primarily intended to encourage quality and control cost, but the title also contains benefit enhancements and provider payment reductions.

Title IV: Prevention of Chronic Disease and Improving Public Health, contains provisions reducing barriers to the receipt of clinical preventive care and encouraging community prevention and wellness programs.

Title V: Health Care Workforce, provides additional support for educating and training health care workers and for community health centers. What kind of support for these health centers? Building them? Pure financial support?

Title VI: Transparency and Program Integrity, contains a host of fraud, abuse, and conflict of interest disclosure provisions, as well as provisions for outcomes research.

Title VII: Improving Access to Innovative Therapies, provides a track for the approval of biosimilars (generic biologics) and for the expansion of the affordable medicines program.

Title VIII: The Community Living Assistance Services and Supports Act (CLASS Act), establishes a national voluntary insurance program for purchasing community living assistance services and support.

Title IX: contains the Revenue Provisions of the legislation. It also includes provisions amending the requirements that apply to tax exempt hospitals.

Title X: Strengthening Quality, Affordable Health Care for All Americans, includes the manager's amendment and provisions relating to all of the subjects discussed above. See BARRY R. FURROW ET AL., *HEALTH LAW: CASES, MATERIALS AND PROBLEMS* 1–2 (6th ed. Supp. 2010).

42. See generally Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, §§ 1301–04, 124 Stat. 119, 162–72. The term “Essential Health Benefits Package” is defined as coverage that “limits cost-sharing for such coverage.” *Id.* § 1302(a)(2). Section 1302(b) defines the essential health benefits that must be provided. *Id.* § 1302(b). A separate section prohibits discrimination based on salary in the provision of insurance. *Id.* § 2716.

43. Beth Wankel, *Social Insurance Definition*, eHow.COM, [http://www.ehow.com/facts\\_5771028\\_social-insurance-definition.html#ixzz13JLY1umx](http://www.ehow.com/facts_5771028_social-insurance-definition.html#ixzz13JLY1umx) (last visited Feb. 24, 2011); see also Anthony B. Atkinson, *Social Insurance*, in 16 GENEVA PAPERS ON RISK AND INSURANCE THEORY 113, 113–14 (1991) (noting that social insurance involves at least mandatory coverage and no means testing for the social benefit).

members of large groups. In recent years, even employment-based insurance provided strong incentives, through income tax rules and employment law, for employers to offer insurance. However, the legal choice to offer health insurance was still the employer's, and individuals' only health insurance obligations until recently were to pay Medicare taxes and to participate in the financing of Medicaid through the payment of their ordinary state and federal taxes. The ACA changes all of this.

### B. *The Affordable Care Act of 2010*

The ACA changes the status quo by mandating large employers' obligations, starting in 2014, and by requiring individuals to obtain health insurance for their entire lifetimes, not just for old age or in the event of total disability.<sup>44</sup> These mandates move the paradigm from discretionary employment insurance to a form of social insurance requiring total participation. The ACA thus creates an expanded version of health care solidarity—a “society united on the basis of mutual insurance,” as early reformers described it.<sup>45</sup> The ACA will significantly transform the private health insurance market. One of its main goals is to repair the small group and individual insurance markets—markets in which small businesses and people who are not covered through

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44. Prior to the enactment of the ACA, federal law did not specify a standard minimum benefit package that must be covered by private health insurance and group health plans. The ACA not only bars discrimination in enrollment or the availability of coverage based on health status, but also establishes a minimum standard of coverage that must be satisfied by individual and small group health plans sold in both exchange and non-exchange markets, as well as by any qualified health plan sold in the state exchange market, regardless of group size. See Patient Protection and Affordable Care Act of 2010 § 1302. Katherine Jett Hayes, *Essential Benefits*, HEALTH REFORM GPS, <http://www.healthreformgps.org/resources/essential-benefits/> (last visited Feb. 24, 2011).

45. D.R. Jacques, *Mutual Life Insurance: Society on the Basis of Mutual Life Insurance*, 16 HUNT'S MERCH. MAGAZINE & COMMERCIAL REVIEW 152, Feb. 1849, at 158. Jacques writes:

By a system of mutual insurance thus generally established, embracing all callings, a great fund, as it were, for the benefit of society, would be created; a fund to which none could be said to contribute gratuitously, from which none but the needy should be aided; a great reserve fund, held in readiness for the uncertain case of want. We thus have the mechanic, the laborer, and the merchant, joined hand in hand in mutual protection against the risks of their callings: we have the masses, above all, shielded from the most blighting evil of the inequality of human condition, the danger of destitution: we have society united on the basis of mutual insurance.

For a full discussion of the uses of private insurance and its limits as a tool of social insurance, see Tom Baker, *Embracing Risk, Sharing Responsibility*, 56 DRAKE L. REV. 561 (2008).

their jobs can purchase health insurance. Insurance prices in these markets are currently very high, and many individuals who are ill may not be able to afford coverage. The ACA takes a three-pronged approach to reforming these markets: (1) instituting new rules that prevent insurers from denying coverage or raising premiums based on preexisting conditions, (2) providing requirements for everyone to buy insurance, and (3) offering subsidies to make that insurance affordable.<sup>46</sup>

Single-payer public ownership, public financing, or complete tax-based financing are technically easier and almost certainly cheaper routes to health care solidarity, but they come at a political cost that Congress was not prepared to pay. The ACA continues a long-term trend in U.S. health care financing away from the ordinary market-based approach, according to which people pay for their own health care services at the point of consumption. It asks people to pay their fair share of the overall cost of health care, primarily through taxes and insurance premiums, and also through cost-sharing at the point of consumption. The ACA expands the private insurance market by instituting mandates and subsidies, expanding Medicaid, reducing some of the cost-sharing in Medicare, and placing new limits on the cost-sharing permitted in the insurance market. The ACA also requires insurance availability in the small group and individual markets.<sup>47</sup> Many states have enacted reforms to improve small group access to affordable insurance, but such reforms have had only a limited effect, as insurers have creatively evaded regulation and limited their exposure.<sup>48</sup> It remains to be seen whether insurers can manipulate the ACA requirements to avoid insuring some high-cost subscribers.

The insurance reforms in the Affordable Care Act change health insurance from a model based on individual actuarial assessment of

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46. See Jonathan Gruber, *Health Care Reform Is a "Three-Legged Stool": The Costs of Partially Repealing the Affordable Care Act*, CENTER FOR AMERICAN PROGRESS, Aug. 10, 2010, [http://www.americanprogress.org/issues/2010/08/three\\_legged\\_stool.html](http://www.americanprogress.org/issues/2010/08/three_legged_stool.html).

47. The ACA accomplishes this in Title I in several critical ways by mandating fair premiums, guaranteed availability and renewability of insurance coverage, prohibition of preexisting condition exclusions, prohibition of health status discrimination, comprehensive coverage, and limits on waiting periods. Patient Protection and Affordable Care Act §§ 2701–05, 2707, 2708.

48. See BETH FUCHS, EXPANDING THE INDIVIDUAL HEALTH INSURANCE MARKET: LESSONS FROM THE STATE HEALTH INSURANCE REFORMS OF THE 1990s, THE ROBERT WOOD JOHNSON FOUND. 6 (2004). For a comparative perspective, see Timothy S. Jost, *Private or Public Approaches to Insuring the Uninsured: Lessons from International Experience with Private Insurance*, 76 N.Y.U. L. REV. 419 (2001) (discussing the experience of Germany, Switzerland, and other European countries that use private insurance as part of their provision of national health care coverage).

health risks to what can be called a new concept of “fair share” in health care. Under the new model, insurance discrimination is largely eliminated in favor of determining an individual’s share of health care costs according to an individual’s ability to pay rather than on the volume of services consumed, and more on individual choices than on genetic or preexisting health risks.<sup>49</sup> The ACA also fosters wellness and prevention programs by eliminating cost-sharing for preventive health services.<sup>50</sup> This continues the non-discrimination focus of Title I of the ACA: the wellness program subsection of one of the non-discrimination sections prohibits “discrimination against individual participants and beneficiaries based on health status.”<sup>51</sup> This key provision is placed in a non-discrimination section, along with the prohibition of wellness programs that are a “subterfuge for discriminating based on a health status factor.”<sup>52</sup> This is meant to prevent insurance plans from limiting coverage based on a subscriber’s inability to be completely healthy. The ACA only requires that individuals “be as healthy as they can be.”<sup>53</sup>

The Affordable Care Act thus turns the private insurance model into a much fairer regime in which access to insurance is promoted strongly, and the risk of exclusion is eliminated. This bears more than a passing resemblance to a typical national health system; in those systems, once citizenship and residency is proven, coverage ensues. The Affordable Care Act comes much closer than past reforms to creating the kind of universal health insurance that advocates like Senator Kennedy have consistently promoted.

## II.

### UNIVERSAL HEALTH CARE AS SENATOR TED KENNEDY’S CAREER PASSION

Senator Edward Kennedy was a major force behind health care reforms throughout his political career. Kennedy’s 1972 book *In Criti-*

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49. Tom Baker, 2010 Hawley Lecture: Health Insurance, Risk, and Responsibility after the Patient Protection and Affordable Care Act (Oct. 21, 2010), *available at* [http://www.uiowa.edu/~ibl/documents/Health\\_Insurance\\_Risk\\_and\\_Responsibility\\_after.pptx](http://www.uiowa.edu/~ibl/documents/Health_Insurance_Risk_and_Responsibility_after.pptx) (last visited Feb. 24, 2011) (partial draft prepared for the University of Pennsylvania Law School’s health law symposium).

50. Section 2716 of the ACA prohibits discrimination based on salary, and section 2717(a)(1)(D) requires insurers to implement wellness and health promotion activities. Patient Protection and Affordable Care Act §§ 2716–17.

51. Baker, *supra* note 49, at slide 22.

52. *Id.*

53. This is Tom Baker’s analysis of the ACA, teasing out the policy threads that link the anti-discrimination components of the insurance provisions with the wellness features that ACA promotes. Baker, *supra* note 49.

*cal Condition: The Crisis in America's Health Care* illustrates his approach to health care reform.<sup>54</sup> Published thirty-eight years before the ACA, it identifies the fundamental problems that have plagued the American health care system up to today. The list is both sad and familiar: sickness and bankruptcy,<sup>55</sup> insurance coverage denials,<sup>56</sup> gaps in charity care,<sup>57</sup> poor access in the inner city and rural areas,<sup>58</sup> fragmentation in the delivery system,<sup>59</sup> unnecessary and expensive care, and the United States' poor performance on access compared to our peer countries.<sup>60</sup> The book also reveals Kennedy's empathy towards those who were refused health care, his egalitarian sense that Americans should treat each other better, his simultaneous search for value in the market model as applied to the health care delivery system and rejection of that model's extremes, and his frustration with the lack of evidence of the efficacy of many treatments and the money wasted as a result.<sup>61</sup>

Kennedy was the chairman of the Senate Health Subcommittee at the time his book was published. The subcommittee took testimony from dozens of Americans with health care disaster stories, and Kennedy wrote:

I am shocked to find that we in America have created a health care system that can be so callous to human suffering, so intent on high salaries and profits, and so unconcerned for the needs of our people. American families, regardless of income, are offered health care of uncertain quality, at inflated prices, and at a time and in a manner and a place more suited to the convenience and profit of the doctor and the hospital than to the needs of the patient. Our system especially victimizes Americans whose age, health, or low income leaves them less able to fight their way into the health care system.<sup>62</sup>

Kennedy's political perspective was also clear: health care was a fundamental right, and universal health care was the best solution for the many problems the subcommittee observed in 1970. Guided by the belief that every man, woman, and child in America deserved access to decent health care, his determination to achieve his goal drove both

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54. KENNEDY, *supra* note 13.

55. *See id.* at 25–26.

56. *See id.* at 54–74.

57. *See id.* at 96–101.

58. *See id.* at 103–22.

59. *See id.* at 94–95.

60. *See id.* at 219–33.

61. *See id.* at 167–70.

62. *See id.* at 15.

his daily schedule and his long-term agenda in the Senate.<sup>63</sup> It was a goal that could be accomplished with one big national health program—a plan that would ensure pregnant women of prenatal care, children of vaccinations, sufferers of rare diseases of access to the medicines they needed, workers of the ability to change jobs without worrying about losing their health insurance, and seniors of access to affordable prescription drugs.

Kennedy developed his focus on health care early in his senatorial life. In 1966, he was intrigued by the concept of local health centers, which were modeled on the nation's first comprehensive neighborhood health center established by Tufts University at the Columbia Point Housing Project in Dorchester, Massachusetts. Kennedy won expansion of the Economic Opportunity Act in 1964, which created a national health center system.<sup>64</sup>

#### A. National Health Reform Proposals

National health reform—a universal coverage model with the federal government as payer—was Kennedy's ambition for a major system change. In 1971, Kennedy proposed a plan for a national health care system with universal coverage.<sup>65</sup> The Health Security Act<sup>66</sup> represented a liberal vision of health care, financed outside the framework of employment-based insurance. Kennedy and Representative Martha Griffiths of Michigan proposed a government-run single-payer system, based on the idea that health care was a fundamental right for every American. Kennedy and liberal House Democrats formed an alliance with numerous groups, including the AFL-CIO and the United Auto Workers, which worked through the Committee for National Health Insurance, and pushed for restructuring of the nation's health care financing system. Their proposed solution, the Health Security Act, also known as Senate Bill 3, sought to insure all Americans under a single-payer health care system with the federal government as sole insurer, financed primarily through payroll taxes.<sup>67</sup>

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63. KENNEDY, *supra* note 13, at 17 (“I believe good health care should be a right for all Americans. Health is so basic to a man's ability to bring to fruition his opportunities as an American that each of us should guarantee the best possible health care to every American at a cost he can afford.”).

64. See 1 ENCYCLOPEDIA OF HEALTH SERVICES RESEARCH 201 (Ross M. Mullner ed., 2009).

65. 116 CONG. REC. 30,142 (1970) (statement of Sen. Kennedy) (introducing the Health Security Act).

66. S. 4297, 92d Cong. (1971).

67. See NATIONAL HEALTH INSURANCE—A BRIEF HISTORY OF REFORM EFFORTS IN THE U.S., THE HENRY J. KAISER FAMILY FOUND. (Mar. 2009), available at [www.kff.org/healthreform/upload/7871.pdf](http://www.kff.org/healthreform/upload/7871.pdf).

The Kennedy-Griffiths Health Security Act had several key features.<sup>68</sup> First, the federal government would be the health insurer for the country.<sup>69</sup> In Kennedy's words, ". . . the program calls on the federal government to make sure that every American can pay for health care, that every American has good health care offered to him in ways suited to his needs, and that enough providers, facilities, and equipment are available to do the job."<sup>70</sup> Second, the coverage would be identical for all, regardless of employment status, preexisting conditions, or income. "Every American would have a comprehensive policy with the federal government from the moment he is born until the day he dies. . . . [T]he program covers all medical care to all Americans without limit."<sup>71</sup> Third, the act would put providers within a budget set by the federal government, with controlled increases in physician incomes to match cost-of-living increases. Hospital budgets would be negotiated by local health security offices. Efficiencies and cost controls would be created by these annual budgets, since pressures to fill hospital beds would be eliminated, and physicians would be provided with financial incentives ". . . to form comprehensive health service organizations."<sup>72</sup> These prepaid group practice organizations would offer care for a fixed amount per person per year and were clearly health maintenance organizations (HMOs) in conception and design. Fourth, payment would be based on individual payroll and income taxes, in addition to an employer tax on payrolls, though employers would be relieved of the burden of private health insurance premiums.<sup>73</sup> Fifth, health service organizations would offer coordinated care to all enrollees. Sixth, health planning would be imposed "for all areas and regions of the country," with a special fund set up to build the facilities and educate personnel. The Health Resources Development Fund would take on these tasks, along with setting up health service organizations and improving rural and inner city health care. Seventh, Kennedy predicted, "Medicare, Medicaid and other programs will be absorbed in this more comprehensive plan, and thousands of private insurance plans will cease to exist."<sup>74</sup>

Federal financing, elimination of private health insurers, comprehensive planning, and negotiated budgets were dramatic proposals for

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68. Kennedy describes the Health Security Act in detail in KENNEDY, *supra* note 13, at 238–51.

69. *Id.* at 238–39.

70. *Id.* at 239.

71. *Id.* at 240–41.

72. *Id.* at 243.

73. *Id.* at 245.

74. *Id.* at 248.

reform. An army of proponents of the status quo resisted such radical changes—adversaries such as the insurance industry which would disappear under the plan, and providers whose incomes would be constrained. Indeed, the opponents to such a large-scale change were many, public support was weak, and the bill did not succeed in passing.<sup>75</sup> It was Kennedy's first, and last, attempt at a broad vision for reform of the system.

Immediately after this unsuccessful attempt, Kennedy debated compromising with President Nixon, whose 1971 proposal was to expand health care coverage through employment, with the federal government subsidizing insurance premiums for the poor. Nixon's was a compromise approach that would foreshadow later proposals, including several aspects of the ACA. Ultimately though, Kennedy decided not to compromise.<sup>76</sup> Kennedy abandoned the single payer model of reform after 1971, following his bruising failure to achieve large-scale reform of the fragmented U.S. health care system. He moved instead toward a more politically palatable model, building on private insurance. The 1974 Mills-Kennedy bill, co-sponsored with Representative Wilbur Mills, represented a compromise approach, preserving the role of the private insurance industry in the health care sector. The Mills-Kennedy bill kept employment-based insurance, did not promise universal coverage, and moved toward a high-deductible model. For liberals, this was too big of a concession. Organized labor refused to endorse the Mills-Kennedy bill. Ralph Nader and his organization

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75. John F. Seiberling, *Health Care Reform—A Symposium*, 26 AKRON L. REV. 135, 135 (1992). He writes:

In 1971, as a “freshman” Member of Congress, and following what I thought to be the inescapable logic of the situation, I signed on as a co-sponsor of Senator Ted Kennedy's bill to set up a national health insurance program. The bill would have offered universal health care coverage paid for by a payroll tax, with the Federal government as the sole insurer.

As I quickly found out, the issue was far less simple than it seemed. The bill had a formidable set of opponents, including not only the insurance industry but also the health care provider “industry”—doctors, hospitals, pharmaceutical manufacturers, and their respective trade associations. Some labor organizations and a few employers favored it, but the voting public was largely apathetic. Faced with powerful opposition and lacking any strong public pressure or Presidential leadership, Congress, as might be expected, took no action.

76. See ADAM CLYMER, EDWARD M. KENNEDY: A BIOGRAPHY 219 (1999) (describing discussions between the White House and Kennedy regarding a health care compromise. Caspar Weinberger, Nixon's Secretary of the Department of Health, Education, and Welfare “. . . had already moved about as far as he could go, and Kennedy had gone out on a limb with labor and also had little room left”).

Public Citizen Research Group also criticized Kennedy for selling out to the insurance industry.

Having learned his lesson early in his political career, Kennedy was flexible on the means to achieve the goal of national health care reform. He was open to a range of strategies, including free market techniques, so long as access to health care was thereby increased. In 1978, Kennedy was a pioneer as he suggested ideas rooted in competition among insurer plans, ideas that would later shape the approaches to health care reform adopted by both the Clinton and Obama presidential administrations.<sup>77</sup> As Paul Starr writes, “Kennedy was very flexible on health care and many other issues . . . . He was not an ideological left-winger. It’s just not correct. He was much more market-oriented than people understand.”<sup>78</sup>

Kennedy’s willingness to postpone large scale reforms in favor of incremental half-measures was part of a larger shift in the ambition and scope of liberal legislative leaders, as they began to feel the assault of the conservative ascendancy of the 1970s and 1980s. During this period, organized labor was blamed for killing reform with its unwillingness to compromise, even though organized labor’s supporters in Congress did not reject the various National Health Insurance bills in committee. Nonetheless, a reputation of intransigence was something to avoid, as holding out for more expansive legislation is often risky in American politics. Some observers note that Senator Kennedy exemplified the politics of possibility in 1974, as he helped craft the Mills-Kennedy bill even though he disagreed with certain portions of it.<sup>79</sup>

The lessons of health care reform are often more complicated than analysts realize. For example, the 1974 experience does not necessarily mean that incrementalism is the only political strategy available to liberals. Rather, as Wainess has argued, legislation is a creature of the political moment—with a little serendipity and a longer congressional session, health reform might well have succeeded in 1974. As he writes, “In this sense, the model of health politics in 1974 is not one to reject but to embrace.”<sup>80</sup> Incrementalism is often seen as the

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77. Mary Agnes Carey, *Recalling Kennedy: Health Care Players Reflect on His Career*, KAISER HEALTH NEWS, Aug. 26, 2009, <http://www.kaiserhealthnews.org/Stories/2009/August/26/Kennedy-React.aspx>.

78. *Id.*

79. See Flint J. Wainess, *The Ways and Means of National Health Care Reform, 1974 and Beyond*, 24 J. HEALTH POL. POL’Y & L. 305, 318–19 (1999) (explaining that Kennedy disagreed with the bill’s cost-sharing provisions).

80. *Id.* at 329.

enemy of the idea in health care reform, and it can be.<sup>81</sup> On the other hand, it can also lay the foundation for broader future reforms. Ted Kennedy's role in the history of health care reform and his contribution to the ACA suggest as much. Small steps that address real needs and are politically palatable can be legislated more easily than wholesale reform. It may not be ideal, and it is certainly slower, but it may lead to the same end point.<sup>82</sup> And sometimes it moves the ideological ball a few squares ahead as well.<sup>83</sup>

The politics of health care were changing as early as the 1970s, as discussed above. What Kennedy had believed to be possible in 1972—expanding Medicare to cover all Americans—became unlikely. Kennedy knew he had missed a reform opportunity early in his career. In 1971, President Richard Nixon had unveiled a plan to expand health care to nearly all Americans through their employers, with the federal government subsidizing insurance premiums for the poor. The plan was strikingly similar to those that Democrats would put forth in subsequent years. “[I]n the early 1970s, the then 39-year-old senator wanted more. He stubbornly held out for a straight-up, national health care system funded through general revenues and Social Security taxes.”<sup>84</sup>

Senator Kennedy and President Carter were at odds in 1977 over the shape of health insurance reform. Kennedy wanted to use national health insurance to restructure the system with a new framework of incentives and bargaining relationships, combining improvements in both cost control and access. Carter, however, regarded national health insurance as undesirable unless cost controls were first set in place legislatively, and the economy recovered from recession.<sup>85</sup> He was unwilling to accept Kennedy's leadership on health care reform and proposed a phase-in of national health insurance, with some cost control devices. Neither proposal succeeded in Congress, and Carter still blames Kennedy for stalling health reform.<sup>86</sup>

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81. For a discussion about the benefits and limits of incrementalism, see Thomas Bodenheimer, *The Movement for Universal Health Insurance: Finding Common Ground*, 93 AM. J. PUB. HEALTH, 112, 112–15 (2003); David U. Himmelstein & Stefie Woolhandler, *National Health Insurance or Incremental Reform: Aim High, or at Our Feet?*, 93 AM. J. PUB. HEALTH, 102, 103–04 (2003).

82. See Wainess, *supra* note 79, at 329–30.

83. See *supra* note 81.

84. THE BOSTON GLOBE, *supra* note 11, at 323.

85. Starr, *supra* note 15, at 85.

86. “‘The fact is that we would have had comprehensive health care now, had it not been for Ted Kennedy's deliberately blocking the legislation that I proposed,’ Mr. Carter told Leslie Stahl. ‘It was his fault. Ted Kennedy killed the bill.’” Michael D. Shear, *Jimmy Carter Attacks Ted Kennedy*, THE N.Y. TIMES: THE CAUCUS (Sept. 16,

Kennedy, in an address in 1978, again articulated the need for health care reform:

Our workshop here on health care will clarify this crucial point about priorities in spending federal dollars. One of the most shameful things about modern America is that in our unbelievably rich land, the quality of health care available to many of our people is unbelievably poor, and the cost is unbelievably high.

That is why national health insurance is the great unfinished business on the agenda of the Democratic Party. Our party gave Social Security to the nation in the 1930's. We gave Medicare to the nation in the 1960's. And we can bring national health insurance to the nation in the 1970's.

One of the saddest ironies in the worldwide movement for social justice in the twentieth century is that America now stands virtually alone in the international community on national health insurance. It seems that every nation is out of step but Uncle Sam. With the sole exception of South Africa, no other industrial nation in the world leaves its citizens in fear of financial ruin because of illness.<sup>87</sup>

In 1979, Kennedy submitted to Congress the Health Care for All Americans Act, which became known as the Kennedy-Waxman bill.<sup>88</sup> In the interest of cost control, both parties offered proposals to combine national health insurance with a more general reorganization of the medical industry. Kennedy—this time with the support of the AFL-CIO and other liberal organizations—introduced a compromise proposal that would have provided universal coverage while retaining private insurance plans. The new Kennedy bill incorporated market-oriented reforms to foster greater competition, along with redistributive and planning mechanisms to achieve equity as well as cost containment. The bill failed to be enacted, just as Kennedy's previous attempts at systemic reform had failed.

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2010, 5:34 PM), <http://thecaucus.blogs.nytimes.com/2010/09/16/jimmy-carter-attacks-ted-kennedy/>. Kennedy also blamed Carter for dragging his feet on health care, writing that Carter viewed Kennedy's health care efforts as a platform to challenge his presidency. "If that's why he slowed things down, then he made a poor political calculation," Kennedy wrote. "If we had passed comprehensive national health insurance together, it would have been a huge victory for Carter." *Carter Blames Ted Kennedy for Delay in Passing Health Bill*, KAISER HEALTH NEWS, Sept. 17, 2010, <http://www.kaiserhealthnews.org/Daily-Reports/2010/September/17/Carter-and-Kennedy.aspx>.

87. Senator Edward M. Kennedy, Remarks at the Workshop on Health Care, Mid-Term Nat'l Convention, Democratic Nat'l Committee (Dec. 9, 1978).

88. Health Care for All Americans Act, S. 1720, 96th Cong. (1979).

*B. The Movement Away from National Health Reform*

The prospects for national health insurance shrank as conservative ideology moved further into the mainstream, inflation continued, and economic anxieties grew. As commentators observed, “for most of the 1980s there existed little possibility of rekindling a campaign for national health insurance.”<sup>89</sup> After the 1980 election, the Reagan administration arrived with an ambitious agenda to reduce the role of the federal government and social programs. Medicaid was cut, and Medicare survived only because of the mobilization of senior citizens in opposition to the Reagan agenda.<sup>90</sup>

By the 1990s, a grassroots movement for universal health care had been energized, as epitomized by the Health Care for All movement. Throughout the 1980s, Democratic candidates increasingly focused on national health care reform. Jesse Jackson’s presidential campaigns made health care an issue, the 1988 presidential campaign of Michael Dukakis included a health reform plank, and in 1991 Harris Wofford won a Senate election based on national health reform ideas.<sup>91</sup> In light of the momentum for some form of universal health care, President Clinton made reform a central issue during his presidency. By 1993, Kennedy had become an ardent supporter of the ambitious and complicated Clinton health care reform overhaul.<sup>92</sup> The proposal was ultimately blocked, its complexity used against it in a deadly series of ads by the Health Insurance Association of America.<sup>93</sup>

Health care reform lay dormant from 1993 until President Obama made it a core part of his presidential reforms in 2008. Kennedy was nonetheless busy during this long period in the health reform wilderness, working to pass smaller pieces of legislation that addressed the many failures of the health care marketplace—discrimination against vulnerable high cost groups, insurance predatory practices, and resource needs. If he couldn’t pass national health reform legislation, he could at least solve some of the access problems of the insurance mar-

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89. Bim et al., *supra* note 17, at 90.

90. *Id.* (“[F]or most of the 1980s there existed little possibility of rekindling a campaign for national health insurance.”).

91. *Id.*

92. See CLYMER, *supra* note 76, at 523–25 (describing Kennedy’s enthusiasm for the Clinton approach to comprehensive reform, while noting his doubts about the cumbersome task force process designed by Ira Magaziner); see also Health Security Act, H.R. 3600, 103d Cong. (1993).

93. See CLYMER, *supra* note 76, at 531. Insurers were unhappy with price controls on premiums and restrictions on their underwriting tools such as denials of preexisting conditions. See *id.*

ket and legislate against discriminatory practices by insurers, employers, and others.<sup>94</sup>

### III.

#### HEALTH CARE IN INCREMENTS: THE STRATEGY OF PRAGMATISM

After suffering failure in his early attempt to bring Americans universal health care reform, Kennedy spent decades trying to make the component parts of his original vision happen piece by piece.<sup>95</sup> He was in many ways *the* senator of health care, as he always pushed health reform onto the national political agenda. As Robert Blendon explains:

You couldn't run as a candidate without knowing he would be there or raise the issue or highlight it in a way that had to be taken seriously by Democratic presidential candidates. And, as far back as Richard Nixon, even Republican candidates . . . . Although people in the health field think it's obvious that presidents will talk about health reform, it has always had political problems for major leaders. Kennedy made it almost impossible for Democrats not to take this issue on.<sup>96</sup>

Kennedy, using his unique ability to collaborate with Republicans, was able to achieve at least piecemeal progress in earlier and less contentious political eras.<sup>97</sup> His skills led to remarkable results in an evolving American political system where Republicans and conservative ideology pushed the country to the right. In the face of increasing opposition to universal health care, his legislative accomplishments are an impressive list of solutions to specific access problems, from AIDS treatment programs to insurance coverage.<sup>98</sup>

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94. EDWARD KLEIN, *TED KENNEDY: THE DREAM THAT NEVER DIED* 184 (2009) (“Learning to settle for half a loaf, Ted had compiled a legislative record unsurpassed by any other living senator.”).

95. See *THE BOSTON GLOBE*, *supra* note 11, at 323.

96. Carey, *supra* note 77 (citing comments by Robert Blendon, Professor of Health Policy and Political Analysis at Harvard School of Public Health).

97. For a useful chronology of Senator Kennedy's health care legislative contributions, see Jennifer Evans & Jaclyn Schiff, *A Timeline of Kennedy's Health Care Achievements and Disappointments*, KAISER HEALTH NEWS, Sept. 17, 2010, <http://www.kaiserhealthnews.org/Stories/2009/August/26/Kennedy-health-care-timeline.aspx>.

98. Carey, *supra* note 77 (citing comments by Diane Rowland, Executive Vice President of the Kaiser Family Foundation: “His contribution was broader than just providing services to low income or disadvantaged populations. It was really how to improve the overall health of the nation, whether it was through better regulation through the FDA or better improvements in the way we handle immunizations and vaccinations.”).

Senator Ted Kennedy became a master at incremental reform out of political necessity. That was not his vision—as is evident from his early commitment to health care legislation, he believed in the superiority of single payer coverage as the most comprehensive and efficient approach to delivering health care. Defeated in achieving that goal, he became the consummate senator, doing what he had to do to improve coverage for the disadvantaged, expand research to improve the scientific basis of medical treatments, and reduce discrimination in health care.

Kennedy's political career is a story of a liberal politician who moved to the center, as American liberalism declined, in order to achieve parts of a dream of social reform, adapting to a changing political culture in which even a mild "public option" in a health care reform bill became unacceptable. Unable to persuade Congress and the White House to create a sweeping national plan, Kennedy painstakingly went about expanding health care on a piecemeal basis.<sup>99</sup> As Diane Rowland writes:

His contribution was broader than just providing services to low income or disadvantaged populations. It was really how to improve the overall health of the nation, whether it was through better regulation through the FDA or better improvements in the way we handle immunizations and vaccinations. It was a broad sweep of saying that health care is essential to the way a country takes care of its citizens and improving the health of the American public ought to be a priority. One of the things about Kennedy that you always remember is how he used the hearing process to bring the voices of the American people and their concerns to the Senate. It was a very people-oriented approach to politics.<sup>100</sup>

Kennedy's legislative successes in this area represent his steadfast focus on health care as an essential governmental obligation aimed at improving the health of Americans. These legislative accomplishments can be grouped as private insurance regulation, incentives for drug production, protections against discrimination targeting vulnerable populations, and the provision of core services for the poor, such as meals, vaccinations, and other necessities for life and health.

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99. See generally *A Lifetime of Service*, COMM. FOR A DEMOCRATIC MAJORITY, [http://tedkennedy.org/service/item/health\\_care](http://tedkennedy.org/service/item/health_care) (last visited Jan. 21, 2011) (describing some of Kennedy's many legislative accomplishments).

100. Carey, *supra* note 77 (citing comments by Diane Rowland, Executive Vice President of the Kaiser Family Foundation).

### A. *Private Insurance Reforms*

One of Kennedy's major accomplishments was the Health Insurance Portability and Accountability Act of 1996 (HIPAA), co-sponsored by Republican Senator Nancy Landon Kassebaum.<sup>101</sup> HIPAA was designed to narrow conditions under which insurers could refuse coverage. It began as an attempt to enact the least controversial elements of the much more ambitious Clinton health insurance reform proposals of 1993 and 1994, but became a grab bag that addressed a variety of topics, including medical privacy.<sup>102</sup> HIPAA was named, however, after its core provisions, which amended the Employee Retirement Income Security Act (ERISA), the Public Health Services Act, and the Internal Revenue Code to increase the portability and accessibility of health insurance. Prior to HIPAA, preexisting conditions clauses were believed to have resulted in job-lock, as employees could not change employers without losing coverage for "preexisting conditions."<sup>103</sup> HIPAA increased the portability and accessibility of health insurance by limiting insurers' use of preexisting conditions requirements.

HIPAA also imposes other requirements on ERISA-qualified health plans. First, it prohibits group health plans from discriminating against individuals in determining eligibility to enroll. The legislation also attacks discrimination by setting premiums on the basis of health status-related characteristics of the insured individual, including medical conditions (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), or disability.<sup>104</sup> HIPAA also requires insurers that sell insurance in the individual market to make insurance available to all applicants with eighteen months or more of creditable coverage who have lost that coverage and exhausted COBRA<sup>105</sup> coverage

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101. HIPAA also protects the security of health records and the privacy of patients. Pub. L. No. 104-191, 110 Stat. 1936 (codified as amended in scattered sections of 26 U.S.C.).

102. See generally BARRY R. FURROW ET AL., *HEALTH LAW: CASES, MATERIALS AND PROBLEMS* 749–52 (6th ed. 2008) (explaining that HIPAA's Medical Privacy Rules are now a significant legacy of HIPAA generally, which require providers to satisfy extensive patient privacy protections).

103. See U.S. GOV'T ACCOUNTABILITY OFFICE, *GAO-92-125, EMPLOYER-BASED HEALTH INSURANCE: HIGH COSTS, WIDE VARIATION THREATEN SYSTEM* 31 (1992).

104. 29 U.S.C. § 1182(a)(1) (2006).

105. Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, 100 Stat. 82 (codified as amended in scattered sections of 7, 16, 45, 47, and 49 U.S.C.). The original health continuation provisions were contained in Title X of COBRA, which was signed into law on April 7, 1986. *Id.*

and who have not had a gap of more than sixty-three days between the end of their insurance coverage and their application for extension coverage. Under HIPAA, insurers could not impose preexisting condition clauses on such individuals,<sup>106</sup> and HIPAA also required insurers selling insurance in the individual market to renew coverage at the option of the insured at the expiration of a policy, except under certain circumstances, such as where the insured has failed to pay premiums.<sup>107</sup>

Finally, HIPAA also required insurance companies that sell insurance in the small group market to guarantee availability and renewability to all employers who apply for small group coverage, and to all individuals employed by such employers who opt for coverage, on a timely basis.<sup>108</sup>

HIPAA began the process of federalizing the regulation of private health insurance by restricting predatory practices of some in the industry. It did not, however, regulate the rates that insurers could charge employers. It also did not mandate that a policy be offered at an affordable rate, and it contained enough loopholes to allow insurers to avoid covering people with chronic and expensive health conditions.<sup>109</sup> As a first step toward the social insurance model, however, HIPAA provided ideas and a foundation for the ACA's insurance regulation provisions.<sup>110</sup>

### *B. Extended Health Benefits for Vulnerable Populations*

The Children's Health Insurance Program (CHIP), formerly the State Children's Health Insurance Program (SCHIP), was one of the

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106. 42 U.S.C. § 300gg-41(a)(1)(B) (2006).

107. 42 U.S.C. § 300gg-42(b).

108. 42 U.S.C. §§ 300gg-11 to -12.

109. Even complying insurers have charged very high rates for HIPAA policies, sometimes exceeding 200% of the rates charged for non-HIPAA policies. *See* U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-99-100, PRIVATE HEALTH INSURANCE: PROGRESS AND CHALLENGES IN IMPLEMENTING 1996 FEDERAL STANDARDS 3 (1999); U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-98-67, HEALTH INSURANCE STANDARDS: NEW FEDERAL LAW CREATES CHALLENGES FOR CONSUMERS, INSURERS, REGULATORS 6 (1998).

110. COBRA's features are described in U.S. DEP'T OF LABOR, AN EMPLOYEE'S GUIDE TO HEALTH BENEFITS UNDER COBRA: THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1986 (2006), available at [http://www.dol.gov/ebsa/pdf/cobra\\_employee.pdf](http://www.dol.gov/ebsa/pdf/cobra_employee.pdf). COBRA was the predecessor act to HIPAA, a first step in reforming the insurance market. *Id.* COBRA gave workers and their families the opportunity to continue their group health insurance for a limited time when they left their job under certain circumstances. *Id.* Passed in 1986, it was a modest attempt to create limited portability of coverage for eighteen months on average, although the premiums charged by insurers were typically much higher for COBRA coverage. *Id.*

most impressive examples of Kennedy's incremental approach, which was the product of collaboration with conservative Republican Senator Orrin Hatch.<sup>111</sup> The CHIP program expanded federal coverage for poor children. In March 1997, Kennedy brought conservative Utah Republican Senator Orrin Hatch on as a co-sponsor of the legislation. Hatch was sympathetic to the health needs of poor children.<sup>112</sup> As he said, "Children are being terribly hurt and perhaps scarred for the rest of their lives . . . [A]s a nation, as a society, we have a moral responsibility to provide coverage."<sup>113</sup> This collaboration cemented a relationship between Hatch and Kennedy that would turn into both a genuine friendship and a powerful political alliance. Hatch valued Kennedy, and they found ways to collaborate on health care problems despite their generally opposing ideologies, due to the pressing nature of the problem before them.<sup>114</sup> Hatch wrote:

We disagreed on nearly every issue, and continued to do so for all the years we served together in the Senate. But to our mutual surprise, during our service on the Senate Labor, Judiciary, and other committees, we soon realized that we could work well together. If the two of us—positioned as we were on opposite sides of the political spectrum—could find common ground, we had little trouble enlisting bipartisan support to pass critical legislation that benefited millions of Americans.<sup>115</sup>

CHIP provides health insurance to children of thousands of working poor parents. Created by the Balanced Budget Act of 1997, the program allocates billions of dollars to help states insure low-income children who were ineligible for Medicaid but could not afford private

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111. See CLYMER, *supra* note 76, at 585–92 (discussing the process by which Kennedy, working with Hatch, got the SCHIP insurance program, which provides health insurance for children, passed).

112. Senators Kennedy and Hatch co-sponsored several bills in 1997 in attempts to create the SCHIP program, including Child Health Insurance and Lower Deficit Act, S. 525, 105th Cong. (1997). The SCHIP was created as part of the Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4901, 111 Stat. 251, 552 (codified at 42 U.S.C. §§ 1397aa–1397jj).

113. Robert Pear, *Hatch Joins Kennedy to Back a Health Program*, N.Y. TIMES, Mar. 14, 1997, at A24.

114. Orrin Hatch, *God Bless My Friend*, NEWSWEEK, Aug. 27, 2009, at 82. I once was at dinner with Senator Hatch after he gave a commencement address at the Widener University School of Law. Senator Hatch talked about his political life throughout dinner. It was striking how often Hatch talked about his partnership with Senator Kennedy, and how proud he was of their major legislative accomplishments.

115. *Id.*

insurance. States receive an enhanced federal match (greater than the state's Medicaid match) to provide for this coverage.<sup>116</sup>

Kennedy also worked on a host of other specialized pieces of legislation to provide benefits to vulnerable population groups. One such effort was the Ryan White Comprehensive AIDS Resources Emergency Act of 1990.<sup>117</sup> Kennedy's AIDS program, co-sponsored again by Orrin Hatch, established a federally funded program for people living with HIV/AIDS, with an emphasis on providing funding to improve the availability of care for low-income, uninsured, and underinsured victims of AIDS and their families. Another Kennedy initiative was the Health Centers Renewal Act of 2007. This act, a continuation of the first health initiative Kennedy sponsored as a senator, reauthorized the health center program for five additional years and provided people with essential health care services.<sup>118</sup> Senator Kennedy was a strong supporter of early childhood education and the value of the national Head Start program, which provides pre-school children from low-income families with meals, education, and health and human services.<sup>119</sup> Kennedy also assisted in the expansion of the Head Start program, increasing the number of low-income children served by twenty-five percent, and he championed the Head Start Improvement Act, which aimed to maintain quality and extend the services of the program.<sup>120</sup> In 1972, Kennedy worked on the Meals on Wheels program providing nutritious delivered meals for house-bound senior citizens.<sup>121</sup> In an effort to aid families in need of short-term assistance, Kennedy sponsored the Family Medical Leave Act of

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116. In 2006, Senator Kennedy and Senator Chuck Grassley proposed the Family Opportunity Act, which allows states to expand Medicaid coverage to children with special needs, giving low- and middle-income families with disabled children the opportunity to purchase health coverage under Medicaid. It enables parents to work and earn above-poverty wages without fear of losing Medicaid coverage for their children. For many children with disabilities, Medicaid is the only health insurance program offering sufficient benefits to cover the required care, such as physical therapy and medical equipment. *A Lifetime of Service*, *supra* note 99.

117. Ryan White Comprehensive AIDS Resources Emergency Act of 1990, Pub. L. No. 101-381, 104 Stat. 576 (codified in scattered sections of 42 U.S.C.).

118. H.R. 1343 from 2007 was called Health Centers Renewal Act of 2007. A related law, the Health Care Safety Net Act of 2008, became Pub. L. No. 110-355, 122 Stat. 3988 (codified as amended in scattered sections of 42 U.S.C.).

119. The Head Start program was started in 1964 as a part of the Economic Opportunity Act of 1964, Pub. L. No. 88-452, 78 Stat. 508.

120. See *Edward M. Kennedy*, JOHN F. KENNEDY PRESIDENTIAL LIBRARY AND MUSEUM, <http://www.jfklibrary.org/JFK/The-Kennedy-Family/Edward-M-Kennedy.aspx?p=2> (describing Kennedy's legislative accomplishments on a year-by-year basis).

121. The Meals on Wheels program was created by the 1972 amendment to the Older Americans Act of 1965, Pub. L. No. 92-258, 86 Stat. 88.

1993. The act provides qualifying employees unpaid leave for up to twelve weeks when a serious health condition makes that employee unable to work, or when the employee cares for a new baby (by birth, adoption, or foster care) or an ill family member.<sup>122</sup>

Kennedy also worked to extend prescription drug benefits to Medicare recipients, and he was a powerful force behind the Prescription Drug Improvement and Modernization Act of 2003,<sup>123</sup> an act that brought prescription drug coverage to Medicare subscribers by creating Medicare Part D. This legislation was the biggest change to Medicare since it was first enacted. Kennedy ultimately did not vote for the act, however, because of its provisions to create Medicare Advantage Plans,<sup>124</sup> which he opposed.

Senator Kennedy was also interested in writing legislation that would protect against discriminatory practices in the health care market. The prime example of Kennedy's anti-discriminatory legislation is the Americans with Disabilities Act of 1990, which provides disabled Americans with protections against discrimination due to their disability.<sup>125</sup> This important legislation, prompted by the acute problem of discrimination by employers and landlords against individuals with AIDS, was typical of Kennedy's initiatives to protect vulnerable subsets of the population, in this case when a stigmatizing disease caused the discrimination.<sup>126</sup> Kennedy was a protector of the underdog; as Edward Klein writes in his biography of Kennedy: ". . . Ted Kennedy's expressions of empathy with the underdog were more than empty platitudes; his ability to understand and share the feelings of others was woven into the narrative of his life."<sup>127</sup>

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122. Family and Medical Leave Act of 1993, 26 U.S.C. § 2601.

123. Medicare Prescription Drug Improvement and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (codified in scattered sections of 42 U.S.C.).

124. Medicare Advantage Plans were originally known as Medicare+Choice plans, created by the Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251. Medicare recipients were allowed to get their Medicare benefits through these private plans instead of the original Medicare plans (Parts A and B). The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066, made such plans more attractive to Medicare beneficiaries by adding prescription drug coverage and then were known as "Medicare Advantage" (MA) plans. The plans were paid a substantial subsidy by Medicare, and Kennedy and other Democrats were concerned that such plans would weaken support for Medicare generally by moving more seniors into the private insurance market.

125. Americans with Disabilities Act of 1990, 42 U.S.C. § 12101.

126. See CLYMER, *supra* note 76, at 445-74 (describing the political story of the ADA).

127. KLEIN, *supra* note 94, at 191.

### C. *Legislation to Foster Production of Useful Medicines*

Kennedy sponsored an incredible variety of legislation that provided incentives for the production of pharmaceuticals and the improvement of the regulatory drug pipeline. Examples include the Orphan Drug Act,<sup>128</sup> which provided tax credits for encouraging the development of medicines for rare diseases; the FDA Revitalization Act of 2007, which addressed many critical issues including the need to provide proper incentives and support for the development and review of pharmaceuticals and medical devices, and the need for heightened efforts to assure the safety of medications;<sup>129</sup> the Prescription Drug User Fee Act of 1992,<sup>130</sup> which authorized the FDA to collect fees from companies that produce certain human drug and biological products; and the Food and Drug Administration Modernization Act of 1997,<sup>131</sup> which regulates prescription drug advertising and food safety, and which codified the requirements for access to life-saving medicines. One can also include in this category the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, which aims to strengthen the security of the nation's drinking water, food and drug supply, and biological agents.<sup>132</sup>

### D. *The Massachusetts Health Reform: The Bridge to the Affordable Care Act*

From 1997 to 2008, Senator Kennedy was a driving force behind a sustained bipartisan effort to expand affordable health care to more than 750,000 previously uninsured Massachusetts residents. Kennedy worked with the state officials to get four "Section 1115" Medicaid waivers from the federal government in 1997, 2002, 2005, and 2008, thereby permitting Massachusetts to vary from the strict Medicaid rules. The waivers allowed for an expansion of coverage to previously uninsured persons.<sup>133</sup> Although three out of four governors in Massa-

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128. Orphan Drug Act, 21 U.S.C. § 360dd (1983).

129. Kennedy's bill, S.1082, didn't become law. A related bill, Food and Drug Administration Amendments Act of 2007, H.R. 3580, became Pub. L. No. 110-85, 121 Stat. 823.

130. Prescriptive Drug User Fee Act of 1992, Pub. L. No. 102-571, 106 Stat. 4491 (codified in scattered sections of 21 U.S.C.). The act continues to be reauthorized.

131. Food and Drug Administration Modernization Act of 1997, 21 U.S.C. § 301.

132. Bioterrorism Preparedness and Response Act of 2002, Pub. L. No. 107-188, 116 Stat. 594 (codified in scattered sections of 42 U.S.C.).

133. Governor Deval Patrick, *Governor Patrick Announces \$21.2 Billion Medicaid Waiver Agreement*, COMMONWEALTH OF MASSACHUSETTS, [http://www.mass.gov/?pageID=gov3pressrelease&L=1&L0=Home&sid=Agov3&b=pressrelease&f=093008\\_waiver&csid=Agov3](http://www.mass.gov/?pageID=gov3pressrelease&L=1&L0=Home&sid=Agov3&b=pressrelease&f=093008_waiver&csid=Agov3) (last visited Jan. 25, 2011).

chusetts during this period were Republicans, Senator Kennedy worked diligently across party lines and with state and national leaders to secure the waivers.

Massachusetts became the test case for a three-pronged approach to reform the health insurance market. In typical insurance markets, prices are often so high as to be unaffordable, and those with certain diseases simply cannot get coverage.<sup>134</sup> The Massachusetts reform, like the ACA for which it is a prototype, aimed to fix the failed markets for small groups and individuals, and it covers small businesses and the increasing number of working adults who do not get health insurance coverage through their jobs. The goal was to promote access by implementing a form of community rating under which individuals could not wait until they were sick to buy insurance. The state required its residents to buy insurance in order to make sure that community rating pricing was available, and it gave subsidies to those for whom premiums were too high. The result was a tremendous drop in the uninsured population. Indeed, reports indicate that Massachusetts has the lowest percentage of uninsured citizens in the country, with over 400,000 residents newly enrolled in health insurance. Cost increases have also been manageable. For instance, the Health Connector claims to have kept annual premium increases below five percent from 2007 through 2010, half of the increases in the private insurance market generally.<sup>135</sup>

The ACA adopted this strategy, recognizing the inexorable forces in insurance markets and developing legislative solutions to make the market work. It uses a three-pronged strategy to reform these cruel markets: (1) it bars insurers from using preexisting conditions to deny coverage or raise premiums, (2) it mandates that everyone buy insurance, and (3) it subsidizes those for whom premiums might still be too high. All three strategies are needed to avoid the adverse selection problem of the traditional American health care system, in which premiums go up because many avoid insurance unless they are sick.

#### CONCLUSION

Early in his presidential campaign, Barack Obama did not push universal health care particularly forcefully. Once Kennedy endorsed

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134. See Gruber, *supra* note 46.

135. HEALTH CONNECTOR, REPORT TO THE MASSACHUSETTS LEGISLATURE: IMPLEMENTATION OF HEALTH CARE REFORM, FISCAL YEAR 2009 (Oct. 23, 2009), <https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/How%2520Insurance%2520Works/Connector%2520Annual%2520Report%25202009.pdf>.

him, Obama put forth a first-year push for universal health care, a goal that had eluded five of his Democratic predecessors.<sup>136</sup> Kennedy was, at a minimum, a strong tailwind, combining with grass roots pressures<sup>137</sup> to push Obama in the direction of tackling major health care reform.<sup>138</sup>

Kennedy remained in the forefront of reform during the effort to pass the Affordable Care Act. He recognized that the Obama administration's strong position as a new administration presented the best chance in fifteen years to pass health care reform. Kennedy was close to Obama, had a large, capable staff familiar with the issues, and maintained a tremendous network of health policy experts involved in the discussions. Despite his cancer, diagnosed in May 2008, Senator Kennedy directed his staff in the summer of 2008 to pursue health reform aggressively. His staff met with representatives from constituency groups, and Kennedy stayed in touch with his staff and colleagues via telephone and videoconferences. After the election, Kennedy divided his committee into three working groups: Prevention and Wellness, led by Senator Tom Harkin; Delivery System Reform, led by Senator Barbara Mikulski; and Coverage, led by Senator Jeff Bingaman. He asked his friend Senator Christopher Dodd of Connecticut to prepare a health care bill for the next administration.

Kennedy maintained the national focus on health care reform by giving a speech at the 2008 Democratic National Convention in Denver about the issue, against his physicians' orders. In a letter to President Obama, delivered by his wife after his death, he wrote: "You will be the president who at long last signs into law the health care reform that is the great unfinished business of our society. For me, this cause stretched across decades; it has been disappointed, but never finally defeated. It was the cause of my life."<sup>139</sup>

In July 2009, the Health, Education, Labor, and Pensions Committee was the first congressional committee to pass the Affordable Health Choices Act, which became in significant part the Affordable

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136. See Lemann, *supra* note 2.

137. Johnathon S. Ross, *Health Reform Redux: Learning From Experience and Politics*, 99 AM. J. PUB. HEALTH 779, 783 (2009) (arguing that the constituency for universal access is growing as changes in the health care system break down some of the forces that have fragmented popular support for reform, including losses in employment-based insurance, state Medicaid budget reductions, and increased refusals of physicians to accept Medicaid patients).

138. See Lemann, *supra* note 2.

139. Letter from Edward M. Kennedy, U.S. Senator, to Barack Obama, U.S. President (May 12, 2009), available at [http://www.whitehouse.gov/the\\_press\\_office/Text-of-letter-to-the-President-from-Senator-Edward-M-Kennedy/](http://www.whitehouse.gov/the_press_office/Text-of-letter-to-the-President-from-Senator-Edward-M-Kennedy/) (last visited Feb. 24, 2011).

Care Act of 2010. The public option was removed, but the insurance market was regulated in a wide variety of ways, and access to health care was expanded to an additional 32 million Americans. Senator Kennedy's lifelong dedication to health reform was one of the forces that brought the Affordable Care Act into being. In the words of Nicholas Lemann, ". . . Kennedy's relentless support for universal health care kept it in a kind of incubated state, ready to reemerge whenever the political climate shifted again."<sup>140</sup> Access to health care was expanded by disciplining the private insurance market and expanding both Medicare and Medicaid coverage. Such improved access, a core value that Senator Kennedy had expressed as early as 1971 and championed throughout his career, was a victory for the uninsured. The only regrettable aspect of this great triumph is that it took so long to achieve Senator Kennedy's lifelong goal of health care for all.

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140. Lemann, *supra* note 2.