Health care reform was a top priority on the agenda of Obama's presidential campaign and the most important legislation during his first term as president of the United States. Right after his inauguration in January 2009, he started to work with the Democrats in Congress – who did win a majority in both chambers in the election 2008 – to get legislation on track and on March 23, 2010 President Barack Obama signed the Patient Protection and Affordable Care Act. The congressional approval of health care reform marked the most significant advance in health care policy since the Great Society and the passage of Medicaid and Medicare in 1965. In terms of social welfare legislation, it also ranked alongside the enactment of Social Security in 1935. For the first time since the 1970s this legislation will provide a massive redistribution of income from the top to the bottom. But beside all sense of excitement that accompanied the signing of the bill, not just in the United States but in Europe too, there was some kind of parallel reality at the time congress and the president discussed the reform bill. The public was highly divided in their assessment of the reform, and the passage of the bill was followed by one of the longest, most rancorous and most partisan debates Capitol Hill has seen in a long time. On the one hand this intense debate gave birth to the rise of a new grassroots-movement of activists that called themselves the 'Tea party movement'. On the other hand it conjured up fears of encroaching big government and sparked angry protests at town hall meetings all over the country.

In order to get the picture of those two parallel realities in the health care debate it is necessary to understand the structure and deficits of the US Health Care system as well as the political context at the time when
the reform law was enacted. The highly partisan polarization of US politics that started to some extent at least with Newt Gingrich's 'Contract with America' and the Republican victory in the congressional midterm election of 1994 led to a political gridlock in Washington, D.C. and consequently to a growing feeling of mistrust and anger within society over the political elites in Congress and the White House. In light of the reform legislation and the political battle surrounding it, this paper will evaluate the reform with regard to the policy output as well as the politics-dimensions and the way the reform bill will help Obama to continue his ambitious political agenda.

Structure and Crisis of the U.S. Health Care System

Health care reform was widely seen as necessary because of the deficits of the existing health care system in the United States. Unlike all other industrialized democracies the United States never implemented a universal public health care system. And the many failed efforts to pass national health care insurance since the 1930s have inspired social scientist to publish books with titles like *The Road to Nowhere*, *One Nation: Uninsured, Chronic Politics*, and *Dead on Arrival* (Hacker 1997; Quadagno 2005; Funigiello 2005; Gordon 2003). That doesn't mean that there is or was no health care system in the United States, but it was not a universal one organized like an insurance system or financed from the general budget, leaving millions of people without coverage against the social risk of being ill. Most of the working people have a private health insurance that is linked to their employment, and very few persons are able to buy a health insurance by themselves. Since the introduction of Medicare and Medicaid in the 1960s, two groups of people in the United States can get public help in case of being ill: Medicare, administered by the US government and financed by taxes, provides health insurance coverage to long-term residents 65 and older and the disabled; Medicaid, created in 1965, is a means-tested program for families with low-income and resources as well as for people with certain disabilities. And this complex health care system urgently needed reforming. Despite spending much more on health care than any other industrialized country in the West, the US does not enjoy health outcome commensurate with its high level of spending. The U.S. spends
about $7,400 per person on health care each year. Accordingly, nearly 17 percent of the U.S. economy was devoted to health care in 2007 (see for this and the following data: Kaiser Family Foundation 2009a). The Health care sector grows faster than any other sectors of the U.S. economy and its share of economic activity has increased dramatically over time, exceeding economic growth in every recent decade. Over the last four decades, the average growth in health spending has exceeded the growth of the economy as a whole by 1.3 and 3.0 percent points. Since 1970, health care spending has grown at an average annual rate of 9.6 percent or 2.4 percent points faster than the nominal GDP. Compared to other OECD countries the amount of health spending was 52 percent higher than in the next highest spending country, and about 90 percent higher than in many other OECD countries. On the other hand, the United States ranks in the lower third of advanced countries in major measures of health such as life expectancy and infant mortality (Medearis 2010). Without a reform, the burgeoning costs of the system will put unsustainable fiscal pressure not just on health care but on public finances in general. The non-partisan Congressional Budget Office predicts that the share of GDP devoted to health care will rise without reform from currently 17 percent to 25 percent of GDP in 2025 and 49 percent of GDP in 2082 (Congressional Budget Office 2007). Federal spending on Medicaid alone would rise from currently 4 percent of GDP to 19 percent in the same period. Here we do see a clear indication of market failure in the health care sector. The higher levels and the faster growing of health care spending in the United States compared to other OECD countries can be explained with several factors: 1. The US spends more on in-patient and out-patient care as a percentage of overall medical spending, and much more on administration. Advances in technology and medical science are another driving force in US health care spending. Also contributing to higher levels of spending are the proliferation of medical lawsuits, the relative high income of physicians and the higher prices for pharmaceutical drugs.

A second major challenge besides costs is the growing number of people without health insurance in the United States. In 2009, boosted by the economic and financial crisis, the number of people without health insurance rose sharply to 50.7 million, an all-time high according

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1 For a more detailed discussion of these factors see Medearis 2010.
to data from the Census Bureau (DeNavas-Walt 2010). That pushed the rate of uninsured Americans from 15.4 percent in 2008 to 16.7 percent in 2009. This is the largest single year increase since the Census started tracking these figures in 1987. The increase in people without insurance is mostly attributed to the loss of employer-provided insurances during the recession, either because employees lost their jobs or employers no longer provided health care plans, because of the rising costs and premiums. At the same time, the number of people with health insurance dropped for the first time in 23 years. According to the Census report, 253.6 million people had health insurance in 2009, down from 255.1 million in the previous year. Individuals below the poverty line are at highest risk of being uninsured, and this group comprises 40 percent of all uninsured. In total, nine of ten of the uninsured are in low- or moderate-income families, meaning they are below 400 percent of the poverty line. Uninsured workers typically are not offered employer-sponsored insurance and cannot access it through family. Most uninsured workers are self-employed or work for small firms where health benefits are less likely to be offered. Almost three-quarters of uninsured in 2005 were not offered employer-sponsored insurance, either through their own employer or that of a family member. Additionally, the rise in unemployment during the recent financial and economic crisis has put many people's employer-sponsored coverage at risk. In 2009, the number of people with Medicaid increased and helped to offset declines in private coverage. However, the program's structure has limited the ability to cover every low-income adult who does not fit into one of its eligibility categories. Despite these limits, Medicaid has been able to play a crucial role in maintaining coverage during the recession, party because of a temporary increase in federal funding to the states (Kaiser Family Foundation 2010b).

Another important and often unconsidered problem in the context of the US health care system are underinsured citizens, that is to say people who have health insurance but still struggle to pay their health care bills. Many of them are faced with rising health care premiums, deductibles, and co-payments, as well as limits on coverage for various services or other limits and excluded services that can increase out-of-pocket expenses. The Commonwealth Fund defines the underinsured as people who spend 10 percent or more of their income on medical expenses, or have deductibles that equal at least 5 percent of their annual family in-
come. According to the Commonwealth Fund (Schoen et al. 2008) in 2007 the number of underinsured people has grown by 60 percent to 25 million since 2003. The fastest growing segments of the underinsured are middle and upper income families. The rate of underinsured for those with incomes of $40,000 and more, nearly tripled to 11 percent in 2007. But the highest rate of underinsured is in families with incomes under the poverty line (31 percent). The same report also showed that nearly 45 percent of the adults in the Commonwealth survey reported that they had a hard time paying their medical bills, even with health insurance, and approximately every second personal bankruptcy is due to medical expenses (Schoen et al 2008). As a matter of course, illness in the United States is one of the highest risks of falling under the poverty line. Another financial problem results from the fact that health insurance premium increases consistently outpaced inflation and the growth in worker's earnings over the last decades. Whereas premium increase has been between 5 and 14 percent per year since 2000, inflation and chances in worker's earnings are typically in the 2 to 4 percent range. This usually means that workers have to spend more of their income each year on health care to maintain coverage. The average annual premiums for employer-sponsored health insurance in 2010 have been $5,094 for single coverage and $13,770 for family coverage. Since 2000, the average premiums for family coverage have increased by 114 percent (Kaiser Family Foundation 2010a).

This diagnosed market failure is the main reason that health care reform was such a big issue in Obama's election campaign and during his first two years in office. The two problems taken together – the un- and underinsured people and the rising costs in the health sector – made the reform possible. In the context of rising public deficits the cost argument must be seen as the trigger of the reform process under the Obama administration.
The Health Care Reform Act

In this section the major elements of the 2010 health care reform will be outlined. One of the top priorities that Obama already mentioned in his election campaign was the reduction of people without health insurance; consequently, the legislation contains several measures to reduce this number significantly. So the overall approach of the reform bill is to expand access to health care coverage. And this is mainly done by the individual mandate that requires most US citizens and legal residents to have health insurance starting in 2014. This proposal is argued as necessary, as a functioning insurance system is based on the principle of solidarity. Under the new system, even healthy people (who under the current law don't have to buy a health insurance) are forced to buy health insurance and that will help the insurance companies to reduce the premiums. Another major element of the reform is the implementation of so-called state-based "Health Benefit Exchanges" where individuals can purchase coverage, with premium and cost-sharing tax credits available to individuals with an income between 133-400 percent of the federal poverty line (currently $29,326 to $88,200). Policies and premiums purchased through these new exchanges would have to meet several requirements and would be subject to oversight of newly established state insurance commissions that will control the new markets with regard to consumer protection, rate review and solvency. Separate Exchanges will be created through which small businesses can purchase coverage for their employees. In these new markets, insurance companies will have to accept all applicants and are no longer allowed to limit or refuse coverage because of pre-existing medical conditions. Moreover insurance companies are not allowed to vary premiums to reflect differences in enrollees' health. One of the most controversy parts of the health care debate is not included in those new markets: a government-offered insurance plan, or as it was called in the debate, the "public option."

Incomes under 133 percent of the poverty line will be eligible for Medicaid under the new law and this is the largest expansion of Medicaid since its implementation in 1965. All newly eligible adults will be entitled to Medicaid care. The text of the bill and a summary can be retrieved at: http://thomas.loc.gov/cgi-bin/bdquery/z?d111:H.R.3590:.
guaranteed a benchmark benefit package that provides at least essential health benefits. To finance coverage for the newly eligible, states will receive 100 percent federal funding for 2014 through 2016, down to 90 percent federal financing in 2020. To "encourage" enrollment of the up to now uninsured and to help finance the expansion, individuals and businesses that do not fulfill the insurance mandate will be penalized. Individuals who do not purchase health insurance and whose income is over the tax filing threshold, will be assessed a penalty of 2.5 percent of their incomes by 2016. Exemptions will be granted for financial hardship, religious objections, American Indians, those without coverage for less than three months, undocumented immigrants, incarcerated individuals, those for whom the lowest cost plan option will exceed 8 percent of an individual's income, and those with incomes below the tax filing threshold. Firms with more than 50 workers that do not offer coverage will have to pay a penalty of $2,000 for each full-time employee. In order to help small business to offer health care plans, the government will provide tax credits that took take effect already in 2010, well before the launch of the exchanges and the penalty system in 2014. Small business with less than 25 full-time employees will be eligible to receive a tax credit for 35 percent of their costs in health care premiums. After the start of the exchanges in 2014, these tax credits will increase to 50 percent.

Insurance companies will face a number of new restrictions and regulations under the new law in exchange for the additional clientele they will be able to insure as a result of millions of new customers entering the established health insurance market and the new exchanges. Until the final regulation of the private health insurance plans will take place, a temporary high-risk pool will be established, to provide health coverage to individuals with pre-existing conditions. U.S. citizens and legal immigrants who have a pre-existing condition and who have been uninsured for at least six months will be eligible to enroll in the high-risk pool and receive subsidized premiums. Starting in 2014, under the new law it is not allowed for insurers to drop people from insurance plans if they become ill (in the discussion referred to as "rescission") or deny coverage on the basis of a pre-existing medical condition (or gender, or race, or income). All health insurance companies will additionally be subject to the decisions of a new, independent 'claims appeals process' for consumers. The new law will prohibit individual and group
health plans from placing lifetime limits on the dollar values of coverage and prohibit insurers from rescinding coverage except in case of fraud. Starting already since September 2010, insurance companies are no longer allowed to exclude children from health insurance because of pre-existing conditions. Beginning in 2014, the reform bill will prohibit individual and group health plans from placing annual limits on the dollar value of coverage. Consumer protection in the field of health care will be extended. In July 2010, the Obama administration established an internet website to help residents to identify health coverage options and develop a standard format for presenting information on coverage options. Additionally, the law will develop standards for insurers to use in providing information on benefits and coverage.

The way the reform will be financed was one of the controversial aspects in the debates of the Senate and the House of Representatives. The Senate legislation relied on a tax on high-cost health insurance plans, while the House legislation included a tax on wealthy Americans. In the end, the Senate's excise tax on high cost plans provided the basis for offsetting revenues. But the introduction of the tax was postponed until 2018 and its threshold amounts were raised. The final legislation imposes a 40 percent excise tax on employer-provided insurance plans worth more than $10,200 for individuals and $27,500 for families. Additionally a tax increase for higher income earners will help to carry the costs of the reform. Specifically, families earning over $250,000 (individuals over $200,000) will be subject to an increased Medicare Part A (Hospital Insurance) payroll tax. In addition, the investment income of these high-income earners will also be subject to a Medicare tax of 3.8 percent.

The reform will result in a sharp reduction of the number of uninsured. The Congressional Budget Office and the Joint Committee on Taxation estimate that the legislation will reduce the number of uninsured by about 32 millions, leaving approximately 23 millions non-elderly residents uninsured, about one third of those uninsured illegal immigrants, who are not permitted to take part in the new insurance markets. But altogether under the new law 94 percent of the legal non-elderly residents, compared to 83 percent right now, will be covered by a health insurance plan.
A difficult debate: the economic and political context

The passage of the health care reform was a remarkable policy breakthrough, especially taking into account the extreme difficult contextual setting of the reform debate: the worst economic and financial crisis in the United States since the Great Depression in the 1930s, accompanied by a deep partisan polarization of US politics that led to a political gridlock in Washington, D.C. and a growing distrust in US politics and its major institutions. The reform involves massive new regulation of private health insurance, the public creation of new insurance-purchasing organizations, called 'exchanges', a major reorganization and massive expansion of Medicaid and major reductions in spending growth within and substantial changes to Medicare. In light of the long history of failed health reforms in the United States from Roosevelt to Clinton, the Affordable Care Act represents a decisive departure from the past politics and policy of American health care. (Hacker 2010, 863). There are two important factors in the first place that are essential for this departure: The election of Barack Obama and the Democratic victories in the congressional elections 2006 and 2008, the last one giving the Democrats a clear majority in the House and a 60-vote majority in the Senate. But it was not just the size but also the composition of the Democratic victory that mattered. After the loss of more seats in the conservative Southern region and the strengthening of the Democrats in more liberal regions, a far more homogenous and less conservative Democratic caucus made it at least a little bit easier for President Obama to push his progressive agenda in health care policy.

One of the decisive factors that made the reform possible was the economic climate in 2009/2010. The economic crisis heightened public anxiety about losing coverage or paying more for care in difficult economic times. Widespread economic fear bolstered the electoral standing of the Democratic Party as well as the Democratic Candidate for President in 2008 and fuelled continuing public concern about health and economic security during the health care debate. Interestingly, as different surveys showed, the economic context causes a conflicting public view on health care reform: on the one hand, a clear majority of Americans had serious concerns about the Democratic reform bills but one the other hand, a majority also said they would be "angry" or "disappointed" if nothing were done. And nearly two-thirds of the people said that the
economic crisis made it more important to "take on health care right now" (Hacker 2010, 864). Many Americans also expressed concern that the health care system as a whole does not cover everyone and that many people are under-insured. A majority of the citizens even supported the creation of a government-run insurance plan to compete with the private insurers and a significant majority even supported a single-payer health care system like Canada has (Kaiser Family Foundation 2009). Hence, there seemed to be public justification for reform in general and on some specific aspects of the reform, but not on the content of the reform proposal and the way Washington elites were dealing with the problem.

Another important factor that prevented health care reform in the past was the massive opposition from interest groups like the American Medical Association (AMA), the Health Insurance Association of America (HIAA) and business groups from the pharmaceutical and medical sector. The AMA, for instance, opposed national health insurance as early as 1920 and impeded its inclusion in the New Deal legislation (Hacker 2002, 188, 207), whereas health insurance companies achieved special tax exempt status in the early twentieth century, and later on worked to strengthen and expand their government-subsidized role successfully (Mettler 2010, 816). And even labor unions have opposed a reform of the health care sector for a long time or became a lukewarm supporter at best, because they found greater leverage in negotiating with employers for private health-insurance benefits than in seeking government-sponsored coverage (Gottschalk 2000). The context and interests of the interest group environment in US-politics changed on the one hand as result of the market failure in the health care sector and the economic and financial crisis. The Obama-administration and congressional Democrats on the other hand achieved significant success in working together with major interest groups to create a stronger coalition in favor of health care reform. The AMA even supported the House plan, that included a 'public option' and organized labor played a more pro-active role in pushing for health care reform and they strongly supported the public option too (Mettler 2010, 816). While the degree of cooperation among stakeholders brought reform closer to being realized than ever before, some powerful interests remained opposed. Especially insurance companies and business groups, which continued to benefit most from the existing arrangement, allied themselves and mobilized
against the different reform proposal. In order to accept any kind of reform legislation, health insurance companies demanded the individual mandate. To shorten the argument here: fewer Americans with health insurance meant not just fewer insurance subscribers, but also fewer paying patients for hospitals, doctors, and drug companies (Hacker 2010, 865). Additionally, all the key private actors in health care sector had become much more reliant on government for their revenues in the context of Medicare and Medicaid. Those two factors might explain the more cooperative approach of the key interest groups in the health care reform discussion. The compromise between the health care industries and the government was a simple quid pro quo: the acceptance of greater public regulation and involvement in return for greater guaranteed financing mainly provided through the individual mandate.

So those three factors mentioned – the victory of the Democratic Party in the 2008 elections, the general public support of health care reform in the United States and a more cooperative policy-approach of major interest groups – changed the political context of health care reform in the United States. The economic and financial crisis in 2008 further amplified those changes and made reform possible. Then again, the reform bill is undoubtedly limited – whether compared to European standards of health care provision or to the expectations of the political left and the progressive wing of the Democratic Party. Several factors might explain this restricted reform approach, structural conditions as well as short-term developments in the United States. First of all, we have to mention the fragmented political institutions and the distinctive health policy path in the United States that still affect the conditions of reform policy in the US (Hacker 2010, 867; Mettler 2010) America's longstanding reliance on a distinctively privatized system of health care gave rise to powerful interest groups that fought to preserve their interests. Due to the mentioned deficits in health care policy, there was a general willingness to reform health care policy by interest groups of the pharmaceutical and medical lobby. But they put immense pressure on some elements of the reform like the introduction of a 'public option' and were able and still strong enough to prevent those elements that might have threatened their competitiveness in the health care sector while fostering those elements – like the individual mandate – that were in their interest.
Another rather long-term factor that limited the chances for comprehensive health care reform is the public opinion. Although there was a general agreement in the public that reform was necessary, a majority of the people in the United States rejected the major reform bills that had been discussed in both chambers of the congress, even though public opinion polls could show that central elements of the reform like the public option or a stronger regulation of health insurances had been very popular. The general public reaction to the legislation was characterized mainly by anxiety about the effects of reform on the coverage and care of the people, by generalized mistrust of government and by a deep confusion about what the law would actually do. Those conflicting views in the public can be explained with the basic reality that most American citizen's had health care coverage, however costly and insecure. Those people could be easily frightened by the Republican Party and major interest groups into believing that reform would impose losses on them. The discussion on the so called 'death panels' (Nyan 2010) as well as the protests of the 'Tea Party Movement' are the most illustrative and successful examples of freighting the American people.

Public opinion polls provide arguments for that confusing appraisal among the citizens. In those polls, the core elements of the different bills – with the exception of the individual mandate, the insurance tax, and the slow implementation process – were quite popular, with positive assessments outweighing negative assessments. For example, polls during the health care reform debate by the Kaiser Family Foundation (Health Tracking Polls) and Newsweek showed that more than 75 percent of the public thought that it was important or preferred that insurance companies cover people with pre-existing medical conditions, and more than 70 percent supported the new health insurance exchanges (Shapiro and Jacobs 2010). The public also supported largely the "public option", which majorities of legislatures blocked. Measurement of public opinion toward a government-sponsored plan to compete with private insurance companies was affected by questioning wordings and framing such as those indicating that the survival of private insurances might be threatened or that it would produce a full single payer system. But the general assessment of Obama Health care plan hovered just around 50 percent or less (Kaiser Family Foundation 2010). And that’s not enough for a presidential ‘going public’ strategy. Some portion of this opposition was not made up of opponents, but of supporters of a more compre-
hensive reform in the health care sector who felt that the debated bills did not go far enough (Hacker 2010, 870). It is interesting to see that the Obama administration witnessed a noticeable decline in support over time, leading to a majoritarian opposition to the proposed health care reform. Much of the initial support for health care reform after Obama's election had flipped by 2010. And this development was accompanied with an increase in the perceptions of the public that the reform plan would change the health care situation to the worse nationally as well as individually. Specifically, based on the Kaiser Health Tracking Polls, the proportion of the public who thought that health care reform would make the country as a whole worse off nearly tripled from 12 percent in early 2009 to 34 percent in March of 2010. The percentage, that thought that they and their families would be worse off, increased as well from 11 percent to 32 percent (Shapiro and Jacobs 2010, 8).

Another issue in public opinion with regard to health care reform concerns the deep partisan division and its influence on the Republican opposition to the reform proposal. People in 2008 were asked by the Cooperative Congressional Election Survey: "Do you favor or oppose the US government guaranteeing health insurance for all citizens, even if that means raising taxes?" About 62 percent of respondents said that they support the idea. So it was generally popular during Obama's election campaign. But partisan divisions were substantial from the beginning of the reform debate, with 88 percent of Democrats, 61 percent of independents and just 23 percent of Republicans supporting the reform proposal. Such a distribution of opinion across House voters and districts provided little reason for congressional Republicans to cooperate with the Democrats on health care reform. And partisan views did not change appreciably over the months the legislation was working its way through Congress. Republicans were overwhelmingly opposed to the legislation, Democrats predominantly but somewhat less lopsidedly in favor of it. The most noteworthy response was from self-identified independents, whose opposition accounts for the lack of majority support for the bill.3

The contradictorily views of the public in favor and against the reform might in part be explained with the partisan polarization on the topic, the complexity of the matter and the great amount of misinformation in the public about the different reform proposals (Nyhan 2010). The interesting point here is that those misinformation were in part intentionally created by political elites to influence the outcome of the debate. The illustrating example in the 2009/2010 health care debate is the so-called "death panel" myth. The debate started with comments from Betsy McCaughey, who published a commentary in Bloomberg News in February 2009 falsely claiming that a provision in the stimulus bill would lead to governmental control of medical treatment (McCaughey 2009). Later in the summer of 2009 she made the false assertion that the health care legislation in Congress would result in seniors being directed to "end their life sooner". Her statement was a reference to a provision in the Democratic reform bill that would have provided funding for an advanced and voluntary care planning consultation for Medicare recipients once every five years. Although different newspapers would prove that McCaughey's statements were false, she repeated the argument in subsequent op-eds and the statement was quickly parroted by numerous pundits and Republican members of Congress. For instance, Rep. Virgina Foxx suggested during a House floor speech that the Democratic reform plan would "put seniors in a position of being put to death by their government" (Nyhan 2010). The myth reached its peak with former Alaskan Governor and Republican Vice-presidential candidate Sarah Palin's comment on government "death panels." On facebook she wrote: "The America I know and love is not one in which my parents or my baby with Down Syndrome will have to stand in front of Obama's death panel so his bureaucrats can decide based on a subjective judgment of their level of productivity in society, whether they are worthy of health care. Such a system is downright evil" (Nyhan 2010). In trying to explain why those misinformation where so successful, Jacob Hacker (2010, 870) quoted an article in Harper's Magazine

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4 Betsy McCaughey was the Lieutenant Governor of the State of New York from 1995 to 1998 and later on fellow at the Conservative Manhattan Institute and an opinion columnest for different newspapers.
American Politics has often been an arena for angry minds. In recent years we have seen angry minds at work mainly among extreme right-wingers, who have demonstrated...how much political leverage can be go out of the animosities and passions of a small minority...I call it the paranoid style simply because no other word adequately evokes the sense of heated exaggeration, suspiciousness, and conspiratorial fantasy that I have in mind (Hofstadter 1964).

The article was written by Richard Hofstadter in 1964 and tried to explain these kinds of phenomena with a paranoid style in American politics, not very sophisticated, but accurate.

But the limits of the reform bill also had contemporary roots, like the partisan polarization in congress and the rules and practice of the Senate filibuster. Generally characterized in the public mind as a non-stop speech, a filibuster in the fullest sense employs every parliamentary maneuver and dilatory motion to delay, modify, or defeat legislation. It is taken for granted since a couple of years, that any legislation in the Senate that does not have any special procedural protection will need at least 60 votes to overcome the so called filibuster (cloture vote). The filibuster has become a normalized tool of minority obstruction in the Senate, used not just by the Republican Party. At the same time, Democratic Majority Leader in the Senate Harry Reid adopted an explicit strategy of relying on cloture – a motion or process aimed at bringing a debate to a quick end – as the standard way of doing business on any piece of legislations where Democrats faced the prospect of Republican opposition (Moscardelli 2010). This trend leads to a growing acceptance of the idea that any controversial legislation in the Senate must garner 60 votes instead of 51 before it can even be debated on the Senate floor. The election of 2008 provided the Democrats with such a 60 vote filibuster-majority in the Senate – 58 Democratic senators and two independents who regularly voted with the Democrats – but after Senator Ted Kennedy's death and the Republican victory in the by-election in Massachusetts, Republicans had enough votes in the Senate to block every legislative initiative. The dramatic polarization of the parties in Congress is the main reason for the extensive use of the filibuster and a radical opposition from the Republicans in both chambers of Congress. Conservative leaders delayed any vote on health care reform to capitalize on the growing tide of opposition to reform measures. Opposing
health care reform was a central element in the Republican strategy to work against the Obama-administration in general. South Carolina Republican Senator Jim de Mint said during the reform debate: "If we're able to stop Obama on this it will be his waterloo. It will break him." (Wilson 2009).

Obama's Health Care Reform: Mission Accomplished?

But it remains to be seen if Obama's health reform package will really fix the cost, control and coverage problems in the health care sector. The new law will at best cover three-fourth of the uninsured and cut costs by approximately $143 over the next decade. Half of those cost savings will come from cuts in Medicare to be implemented in 2018. And that would mean heavy cuts in fees to hospitals and doctors (Weissert and Weissert 2010). Opponents of the health care reform have criticized the Congressional Budget projections as too optimistic. (Medearis 2010, 20). Taking into account other additional costs like discretionary spending and cost for various departments to implement the proposed changes in Medicare and Medicaid and questioning other predicted revenues like the $70 billion of revenues from a new voluntary long-term care program (The Community Living Assistance Services and Supports), the federal deficit in 2019 will be unchanged or even slightly higher. A far greater financial risk is connected to the political uncertainty associated with the reductions in Medicare spending. The Congressional Budget Office estimates that cuts in Medicare payment will slow the growth in federal spending to 6 percent annually in the coming two decades (CBO 2009). Those cuts in Medicare and in fees to doctors and hospitals may prove politically difficult to implement given the lobby power of physicians and hospitals and their interest groups. Overall, the measures implemented to reduce the costs in health care are important ones, but it is questionable if they go far enough to solve the financial problems in the health care sector. Another challenge will be the growing number of illegal immigrants in the United States, who are – even under the new law – not allowed to purchase health care insurance.

Health care reform was the top legislative priority during President Obama's first term and a successful reform should give him and the
Democratic Party an electoral push and Obama's chances for a second term in 2014. But even several months after the passage of the health care reform bill, more than half of the Americans are still confused about it. And misperceptions also bound – three in ten seniors polled believe by mistake that the new law will permit government panels to make decisions about their end-of-life care. However, favorable views of reform have regained a small upper hand over unfavorable views, by 49 to 40 percent. During the congressional election campaign, health care still is largely overshadowed by the economic problems and the high rates of unemployment in the United States. Only 30 percent of the Americans say they are more likely to go to the polls in November 2010 because of the health care law, while 60 percent say that the law's passage doesn't really change their interest in voting. The poll from the Kaiser Family Foundation (2010) also bears positive aspects for the Democrats: Nearly 50 percent of the people say they trust the Democrats to do a better job handling health care reform, compared to 32 percent who say they trust the Republicans. This is especially important, as Republicans are pushing for a full repeal of the law, but only 26 percent of Americans say the law should be repealed as soon as possible. So in general, the passing of the health care reform won't give the Democrats and President Obama a boost in the public opinion polls and in the coming elections, but a failure of the reform would indeed have been a waterloo for the Obama administration and the Democrats in Congress, as Senator deMint had said during the reform debate. A clear winner of the reform are the aforementioned 30 million people who might finally be able to buy private coverage. Coming back to the question: Mission accomplished? The answer is: not really, but an important first step is taken with Obama's health care reform. Cost control, coverage and Republican opposition will still pose major problems in health care policy. Future initiatives for reform and the willingness to expand the public element in the health care sector will determine the success of Obama's reform approach in the long run.
Works Cited


Funigiello, Phillip. Chronic Politics: Health Care Security from FDR to George W. Bush. Lawrence: Lawrence UP.


