



Reforming Health Care Reform in the 112th Congress

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The results of the 2010 midterm elections represent a wake-up call for Democrats and Republicans alike. Thanks in large part to widespread dissatisfaction with the country's economic perfor-

mance and a lack of public confidence in the Patient Protection and Affordable Care Act (ACA), Republicans gained control of the House of Representatives and will have additional votes in the Senate. This return to two-party government creates a tougher political climate for the White House in implementing health care reform.

It also poses a challenge to Republicans. Knowing that outright repeal of the ACA is impossible, they must decide on a legislative strategy that can win votes in 2012. How far could Republicans go in modifying the health care legislation without making the remaining provisions unworkable or losing an important political talking point? Do

the early signs of flexibility on the part of executive-branch agencies in interpreting and enforcing new rules make it more difficult to convince private-sector decision makers that the ACA is unworkable? Does the focus on Washington politics overlook the actions already being taken by states and private firms to prepare for a new way of doing business in health care?

The Republican gain of 63 seats in the House marks a sea change in policy perspective but may not produce major substantive changes in law. Although the new leadership will probably have little difficulty passing bills out of the House, the fate of those bills lies in the hands of the

Senate. Efforts to repeal or make major changes to the ACA will probably never reach President Barack Obama's desk for his veto.

The question of who will lead in the House has been settled after considerable debate. Despite his long earmarking history, Hal Rogers (R-KY) will chair the Appropriations Committee, where anti-earmark sentiment and the demand to "defund" health care reform will play out. Fred Upton (R-MI) takes over the Energy and Commerce Committee despite concern on the part of conservative members about his less-conservative voting record, with pro-life Joe Pitts (R-PA) heading the health subcommittee. The new House lineup offers a sharp contrast with the old-line liberalism of Nancy Pelosi (D-CA) and the current leadership.

The Senate, with its requirement of 60 votes to end a filibuster, remains a barrier to House

Who's In, Who's Out — Major Leadership Positions in the House of Representatives.		
Position or Committee	In	Out
Speaker	John Boehner (OH)	Nancy Pelosi (CA)
Appropriations	Hal Rogers (KY)	Dave Obey (WI)
Budget	Paul Ryan (WI)	John Spratt (SC)
Energy and Commerce	Fred Upton (MI)	Henry Waxman (CA)
Health Subcommittee	Joe Pitts (PA)	Frank Pallone (NJ)
Oversight and Government Reform	Darrell Issa (CA)	Edolphus Towns (NY)
Ways and Means	Dave Camp (MI)	Sandy Levin (MI)*
Health Subcommittee	Wally Herger (CA)	Pete Stark (CA)

* Charles Rangel (D-NY) relinquished the chair of the Ways and Means Committee on March 3, 2010. Sandy Levin became acting chairman on March 4, 2010.

legislative ambitions. Indeed, the need to obtain a supermajority on contentious pieces of legislation is the reason the House passed the Senate version of health care reform without change, later enacting a narrower reconciliation bill that needed only a simple majority for passage. That action averted the need to work out policy differences in a conference committee, but it left in the statute a variety of provisions (including the notorious requirement that businesses file tax forms for as little as \$600 in purchases) that otherwise would not have survived.

All this leaves Republican opponents of the ACA with few options. The House will be able to pass repeal legislation, but the Senate will not approve it. House committees will hold frequent oversight hearings to reinforce their political message and require in-depth answers to many questions about the ACA and its implementation as a way of disciplining the process, although not changing policy. The Republican leadership must make a strategic decision about whether to advance legislation that would alter major provisions of health care reform. It is conceivable that

some substantial changes will be made, but that would require compromises by Republicans and Democrats that may be impossible in today's polarized political climate.

The outgoing 111th Congress will be leaving unfinished business when it adjourns in mid-December. Now that an agreement on taxes has been made between the President and congressional Republicans, it is clear that the Bush tax cuts will be extended in some form, but the Democrats may be happy to push off funding the government to the next Congress.

To keep programs operating until a new budget is approved, Congress must pass a continuing resolution (CR) — a stop-gap measure used to extend last year's funding levels into the new fiscal year, until the House and Senate can agree on specific funding decisions.¹ The federal government has been operating under a CR since October 1, and the current Congress will probably pass a new CR that will expire early in 2011. That would force the new Congress to set spending levels for both 2011 and 2012.

Rather than attempting to develop detailed appropriations bills

for 2011 midway through the fiscal year, the next Congress will probably enact a CR for the remainder of the year. In its least complicated form, a year-long CR means that no funds beyond the amount allocated in the 2010 budget can be used to implement reform. Although more complicated arrangements limiting the way some funds are spent could be included in a CR or an appropriations bill,² the Senate would block any language that cut off funds for major implementation activities.

Democrats may argue that the Republican House is starving health care reform through the appropriations process. In fact, Democrats had an opportunity, with majorities in the House and Senate, to fully fund the 2011 budget and failed to do so.

If Republicans expect to fundamentally alter the direction of health care reform, they must look beyond Capitol Hill. With at least 29 Republican governors taking charge in January, states will be a powerful force for promoting innovative, market-based reforms in place of a top-down approach directed by Washington. States must implement major sections of the new law, but many are fi-

nancially strapped and concerned about the cost of reform and its ability to meet their population's needs.

Maine, Florida, Iowa, and other states have already indicated that they will seek waivers for some insurance rules that could destabilize local insurance markets. A recent proposal by Senators Ron Wyden (D-OR) and Scott Brown (R-MA) would grant states additional flexibility but falls short of giving them full authority to develop their own reform approaches. Since reform cannot be implemented without them, states could choose to take a more independent role even if Washington is slow to give it to them.

Will the President's health care reform look burdensome and unworkable 2 years from now? Reform is no longer a 2000-page bill sitting on the desk of a senator or representative. The executive branch has been issuing guidance and regulations that are beginning to fill holes in the

legislation and will change the way the law works in practice. Much to the chagrin of the legislation's most ardent supporters, Secretary of Health and Human Services Kathleen Sebelius has been granting waivers when the rules don't work for everyone, albeit on a selective basis designed to avoid the worst political heat.³ Although such decisions will soften the impact of reform, they neither alter the shift toward greater government control nor slow the growth of health care spending.

Despite the talk of repeal, Congress will not pass any major health legislation over the next 2 years, and the health sector and private employers will be hard at work preparing for 2014, when many ACA provisions take effect. That does not make health care reform a *fait accompli*. Absent a miracle, the country will still face crushing budget deficits when the next president takes office. A Republican president,

backed by a Republican Congress, would be wise to delay enrollment in the health insurance exchanges, using the time and money to develop a more targeted plan that closes off open-ended subsidies for health insurance and gets the economic incentives right. A Democratic president would do the same thing out of necessity — but it would take longer.

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Responding to Cholera in Post-Earthquake Haiti

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The earthquake that struck Haiti on January 12, 2010, decimated the already fragile country, leaving an estimated 250,000 people dead, 300,000 injured, and more than 1.3 million homeless. As camps for internally displaced people sprang up throughout the ruined capital of Port-au-Prince, medical and humanitarian experts warned of the likelihood of epidemic disease outbreaks. Some organizations responding to the disaster measured their success by the absence of such outbreaks, though

living conditions for the displaced have remained dangerous and inhumane. In August 2010, the U.S. Centers for Disease Control and Prevention (CDC) announced that a National Surveillance System that was set up after the earthquake had confirmed the conspicuous absence of highly transmissible disease in Haiti.

However, on October 20, more than 55 miles from the nearest displaced-persons camp, 60 cases of acute, watery diarrhea were recorded at L'Hôpital de Saint Nicolas, a public hospital in the

coastal city of Saint Marc, where Partners in Health has worked since 2008. Stool samples were sent to the national laboratory in Port-au-Prince for testing. The hospital alerted Ministry of Health representatives in the region and in the capital, as well as World Health Organization representatives managing the Health Cluster, a coordinating group formed after the earthquake. In the next 48 hours, L'Hôpital de Saint Nicolas received more than 1500 additional patients with acute diarrhea.