"Thanks, Obama: Political and Policy Lessons from the Quest for National Health Insurance"

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Abstract

Health care reform with the goal of universal coverage, or near universal coverage, in the United States, has been an objective of reform advocates and presidential administrations over the course of the last century. Incremental changes have been made to the system, primarily through the creation of Medicare and Medicaid, but historically, comprehensive reform has either failed or been deemed impossible. Why was President Obama the first president to successfully overhaul the system when the window for reform was open for one of his recent predecessors, President Bill Clinton? In this paper I argue that President Obama's leadership, and willingness to take a moderate stance on specific provisions of the Patient Protection and Affordable Care Act (ACA) during the negotiation process, allowed him to correct for the mistakes of the Clinton administration. I contend that the primary corrections made by Obama that secured passage of the ACA, while not exhaustive, are: timing, transparency, issue-framing, personality and leadership, and the inclusion of stakeholders. This paper highlights the importance of these corrections and uses them as an accessible set of lessons for policymakers and political scientists to consider during future reform efforts.

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Introduction

Health Care reform in the United States has been a salient policy issue in the minds of the public and policymakers over the course of the last century. Incremental changes to the system have been made, but the adoption of a national health insurance plan, or even a comprehensive overhaul of the system, has been deemed impossible, or met with fierce opposition, until the unlikely passage of the Patient Protection and Affordable Care Act (ACA) in 2010. The Obama administration found success in a policy arena where one of his more recent predecessors, Bill Clinton, failed. The question of why one attempt was successful and the other was not is one that many political scientists have recently attempted to answer, and through the set of already existing literature that analyzes health care reform in the United States, I hope to provide policymakers with an accessible set of lessons that were learned throughout the process.

Political Scientists Sven Steinmo and Jon Watts argue that the reason the Clinton administration failed to pass a health care reform bill is the same reason that a number of his predecessors, including Franklin Roosevelt, Lyndon Johnson, Richard Nixon, and Jimmy Carter, also failed to pass a health care reform bill: the institutional barriers that exist in the United States. The fragmented institutional dynamic in the U.S. gives interest groups enormous power in the legislative process, and makes it difficult for the majority party to act on larger pieces of legislation (Steinmo and Watts 1995). President Obama was able to use effective leadership and political procedure to successfully overcome the institutional barriers that stifled previous reform efforts.

Although health care reform appeared to be inevitable under President Clinton, never before in the history of the United States did conditions for reform prove to be

more favorable than they did in 2009-2010 (Peterson 2011). In highlighting the importance of President Obama's leadership, political scientist Mark Peterson notes, "advantageous contexts only matter if leaders exploit them effectively, and even then challenges remain (Peterson 2011)." I argue that through Obama's leadership style, and his willingness to take a moderate stance in negotiations with interest groups and relevant stakeholders, he was able to successfully overcome institutional challenges and correct for the mistakes of President Clinton to pass the Affordable Care Act. The corrections made by the Obama administration act as the set of five health care reform policy and political lessons that were imperative in passing health care reform, and will play an important role in future legislative initiatives.

The first lesson, the importance of *timing*, is key in politics, and played a huge role in reform efforts by both President Clinton and President Obama. Both had the ability to act under conditions favorable to health care reform, but inaction, or slow action, can result in lost opportunity. President Clinton took too long to move his legislation forward, while President Obama acted during the time that the window for reform was open. When the window for reform closes, policymaking on any particular issue becomes exceptionally challenging. The second lesson is the importance of *transparency*. President Clinton was often criticized for conducting operations regarding his health care bill behind the closed doors of the White House. This resulted in an alienated public and Congress, and a loss of trust that was needed to gain support for the bill. President Obama corrected for this by giving the responsibility to Congress in drafting the ACA, thus guaranteeing a level of transparency that did not exist under Clinton. The third lesson, *issue-framing*, highlights the importance of framing legislative

initiatives in a way that will gain the most support among the public, Congress, and relevant stakeholders and influential interest groups, while limiting the amount of perceived damaged or loss that will occur. President Obama relied on framing when he assured the public that if they liked their insurance they could keep it, whereas President Clinton framed his plan in terms of security and freedom.

The fourth lesson is the *power of personality*; President Obama's personality and leadership was central in passing the ACA. His charisma and reassuring attitude, juxtaposed with the media's portrayal of a "rigid" First Lady Hillary Clinton leading the charge in the 1990s, highlights the effects of personality in shaping public perception when garnering support for controversial legislation. The final lesson points to the importance of *the inclusion of stakeholders* in the negotiation process. President Obama was careful in his negotiations with relevant stakeholders, and was willing to make moderate decisions and compromises when it proved to be necessary. President Clinton was unable to mobilize important stakeholders in favor of his bill, and was unwavering in his devotion to vetoing any legislation that fell short of universal coverage.

The remainder of the paper begins by highlighting important aspects of the health care system in the United States. This section includes a brief discussion about why reform was deemed necessary and how health policy contrasts with other public policy areas. Altering health policy in the U.S. is not only difficult because of institutional barriers, and a complex design, but also because of the amount of government intervention that permeates the system. Part II provides a brief historical overview of health policy starting with the Franklin Roosevelt and the creation of the New Deal in the early 1930s. This section continues through President Johnson and the enactment of

Medicare and Medicaid in 1965 and ends at the start of the Clinton administration. Understanding the historical context is crucial in understanding how important future decisions were made.

The following two sections will sketch out the timelines and details of the two legislative attempts at the focus of the paper: those under President Clinton and President Obama. Then I discuss, in detail, the set of political and policy lessons learned: timing; transparency; issue framing; the power of personality; and the importance of the inclusion of stakeholders and interest groups. Lastly, the paper draws conclusions, discusses implications, and notes other important considerations that should be made in the conversation surrounding future reform efforts.

Part I: Why Health Care Reform?

Reforming the U.S. health care system is not a new idea. Moving toward universal coverage has been a goal of many presidents before Bill Clinton and Barack Obama, and will continue to play a prominent role in politics in the future. Incremental changes have been made to the system, the architects of which hoped would act as a stepping stone, and would eventually lay the groundwork for a health care system in the United States that would provide universal coverage. These changes will be discussed in further detail in the following section of the paper, but first, an important question should be addressed: what makes the United States health care system such a challenging but necessary area for policymakers to address and reform? The U.S. is known internationally for its various strengths, including its powerful military, technological and medicinal advancements, and being home to some of the world's greatest universities. The U.S. is also known internationally for its health care system, but the views are not positive.

In his book, a comparison of health systems across the globe, *The Healing of America,* T.R. Reid notes, "The one area where the United States unquestionably leads the world is in (health care) spending." Being the richest nation on earth comes with the expectation that health care spending would be higher in the United States than in other countries. This would be an acceptable justification if the return matched the output. The U.S. spends about 17 percent of GDP on health care, compared to just 11 percent in France and 10 percent in Germany and Canada (Reid 2010). In a comparative analysis of infant mortality rates, the United States is again ranked among the highest of the developed nations, with a rate of 6.37 deaths per 1,000 births in 2008 (Reid 2010).

Where the U.S. does not rank highest is in the areas of life expectancy at the time of birth, and of overall performance of health systems, where the World Health Organization gave the U.S. a ranking of thirty-seventh, just below Costa Rica and just above Slovenia and Cuba (WHO).

The United States has a mixed health care system, where the majority of citizens are covered through their employers. Government programs, like Medicare and Medicaid, exist to protect vulnerable populations who aren't eligible for employer-based coverage, such as the poor and elderly. Members of the public not falling into one of these groups are often left uninsured. Cost is one of the biggest issues facing the American health care system, but it is not the only issue. In its mostly private health care system, the U.S. still pays more in public spending than any other country that has entirely government-provided health care (Kliff 2015). The reason for the spending is usually attributed to high prices and lack of price controls, extremely high administrative costs, and the excessive use of new and expensive technology.

In the United States, people pay more for their visits to hospitals and doctors, prescriptions, and medical technology than anywhere else in the world. In comparing medications, treatments, and procedures, citizens in the U.S. pay significantly more than citizens of other developed countries with more efficient health care systems. For example, Sarah Kliff reports that Nexium, a medication used to treat heartburn, costs only $23 in The Netherlands compared to $215 in the U.S. (Kliff 2015). The same trend can be found in a comparison of medical procedures and testing. In the United States, a MRI costs approximately $1,000, where the same exact test costs only about $300 in Canada (Cutler 2014). Aside from high prices, another issue plaguing the system is the lack of

stability that an employer-based, private system provides. Losing their job puts the most vulnerable citizens, those who are now unemployed, in an even more compromising position as they, and in many cases their families, are left without health insurance. Other countries, like Germany, where an employer-provided health insurance system is in place, the government is willing to pay the premiums until the person finds work if they happen to lose their job. In the U.S., this same person would be left without health care and with the possibility of having to choose between accumulating large amounts of medical debt, or leaving illnesses untreated.

Any potential health care reform initiative would need to address rising costs and unsustainable spending, but cost isn't necessarily the issue with the system that has driven recent reform proposals. Cost has come and gone as a salient issue, but the amount of people unable to access the system has remained prominent. Many developed countries struggle with health care spending, but access is what truly sets the United States apart. The U.S. leaves many of its citizens without coverage, or vulnerable to losing coverage. The challenge for many families to access coverage, and the rising uninsured population, is what truly motivated President Clinton and Obama to overhaul the system. The combination of the access, quality, and cost issues leads to a disastrous result, where people's lives often depend solely on their income and ability to pay out-of-pocket for treatment costs.

This amalgamation of high prices and erratic coverage options leads to a fundamental problem of equality of access. The government cannot necessarily make someone healthier, but they can work to provide a system that grants more equal access to all of its citizens (Wildavsky 1977). According to David Cutler in his book *The*

Quality Cure "one-third of Americans worry about people who do not have insurance coverage or people whose coverage is not sufficiently generous, and twenty percent of people indicate that there was a time during the past year when they or a family member needed medical care but did not receive it (Cutler 2014)." The issue of access often leads to preventable deaths, which is a problem that no other developed country, with a health insurance system that provides universal coverage, faces.

How Health Care is Different.

Aside from the issues facing the system that call for change, the obvious complications that have historically made health care reform difficult to achieve include the extremely complex nature of the system in general, out-of-control spending, and the interests of the various stakeholders involved who have viciously fought to prevent changes that might decrease their profits. However, one must also consider how different the task of changing health policy is compared to other policy areas. Health care reform is an enormous undertaking, more so than many other public policy initiatives, including ones that people come into contact with daily like tax and education policy.

One primary reason that accounts for why health policy is such a challenge to legislate can be attributed to the sheer enormity of government intervention that is involved in the system. Government presence exists more heavily in health care than in any other area, and this involvement is visible through the process of regulation, the government's role in setting and monitoring price controls, the ability to control who enters and exist the system, and even through involvement in the tax code (Phelps 2012). Beyond this, there is a large gap in the levels of knowledge between providers and the general public, and an externalities problem to take into consideration (Phelps 2012).

Another challenge that reformers and health policy advocates must face when pushing legislation is the history of notorious Congressional gridlock associated with health care reform bills. In their article "Breaking Gridlock: The Determinants of Health Policy Change in Congress" Craig Volden and Alan Weisman analyze all health-related legislation in the U.S. House of Representatives from 1973-2002. In doing this, they compare health policy legislation with legislation in other public policy areas and conclude that "health policy proposals were significantly more likely to fail overall, to die in committee, and to fail in resolving House-Senate differences than were other policy proposals before Congress (Volden and Weisman 2011)." They go on to say that health policymaking is often more polarized, with bill sponsors being at the far ends of the ideological spectrum, but note that even moderate sponsors of bills have trouble getting legislation passed. Finally, Volden and Weisman say that health policy experts, and strong leadership in Congress and the White House, is central in passing health care reform legislation, specifically when they build "coalitions with a strong majority party base, and then engage in limited (but sufficient) compromise with supportive minority party members (Volden and Weisman 2011)." Their emphasis on expertise, leadership, and coalition building as a path to success was key in President Obama's ability to correct for the mistakes of the past in securing passage of the Affordable Care Act.

Reforming health care, for many of the reasons noted above and for reasons that will continue to be brought up through the course of the paper, has clearly proven to be an extremely difficult task. Many presidential administrations considered the idea but no one genuinely made health care reform the center of their agenda, and attempted to implement a plan with the goal of universal coverage, until President Clinton in 1993.

The following section will detail the historical struggle for reform and will give a better conceptual understanding of the manifestation of President Clinton, and even President Obama's, obstacles.

Part II: Historical Overview

The creation of the New Deal, starting in 1933, could have potentially been an opportune moment to implement national health insurance, but the immediate needs of the country proved to lie elsewhere. One main component of the New Deal was Social Security, but due to its contributory nature with members of the public paying in to the system in order to receive benefits later, it did not bring immediate relief, and did not begin to enjoy immense popularity until the 1950s under President Eisenhower. The New Deal did assuage the urgent needs of the country through various public works, agricultural, and other relief programs, but a national health insurance plan would have involved risk that President Roosevelt did not believe the country could afford to take at the time (Starr 2011).

Aside from the profound suffering of the elderly during and after the Great Depression, part of the fundamental logic behind establishing Social Security as opposed to a universal health program was that Social Security had the luxury of being started completely from scratch on a blank canvas. From a public policy standpoint, health care reform could have potentially affected doctors and other stakeholders who were already involved in the system, but Social Security wasn't necessarily negatively affecting any one group. Stakeholders make reform challenging and our political institutions are not designed in a way that make it easy for majority parties to act on major reform or legislative initiatives.

Under President Truman there was more of a push to pass for long-term reform like health care because of the more favorable economic conditions of the country. But the favorable economic conditions of the country also worked against prioritizing

national health insurance. Employer-based insurance became more solidified, and coverage levels increased, because employers used health insurance as a way to attract domestic workers due to the high amount of the population fighting overseas. By the 1950s there was a highly educated population due to the implementation of the GI bill, and the country was also enjoying high levels of employment. These circumstances contributed to the belief that the employer-based system was working. However, the 1950s model left out two very vulnerable populations: the poor and the elderly.

After President Kennedy's assassination and the subsequent Democratic landslide in November of 1964, President Johnson was in the position to address the coverage gaps that left the poor and elderly to fend for themselves. The legislation that was passed in 1965 set the stage for health care debates about the inequalities and high costs of the system that we can still see playing out in the politics of the present. After a series of compromises among Democrats and Republicans, the Social Security Act of 1965 was passed, and established two of the most well-known and costly programs in the U.S. today: Medicare and Medicaid. The establishment of these two programs produced one of the most critically important dimensions of how health care reform would be viewed and approached in the future: a health care policy trap. Along with employer-based insurance, the creation of Medicare and Medicaid created "a costly, extraordinarily complicated system which nonetheless protected enough of the public to make the system resistant to change (Starr 2011)." The dynamics of this policy trap will become more evident in the discussion of how President Clinton and President Obama's legislative attempts played out, and will also provide a key answer as to why one of those legislative attempts was successful and the other was not.

Medicare, known sometimes known by health scholars as a "three-layered cake," was designed in compromise to have three separate parts that covered different aspects of health care and different groups of the population. The three layers are known as Part A, Part B, and Part C. Medicare Part A is essentially hospital insurance and was the original entirety of the Medicare proposals. With pushback from the Republicans and the American Medical Association, part B was eventually created to cover physicians costs in addition to the hospital visits (Starr 2011). Medicare Part C, or Medicaid, was an attempt to extend coverage from the indigent elderly (the Kerr-Mills program at the time was a program designed to cover this group) to other impoverished groups of the population including the disabled, blind, and low-income families with dependent children (Brecher and Rose 2013). The architects of the Medicare program of course wanted to address the major health care gap and concern that was persisting in the country, but they also had ulterior motives. One of the designers, Robert Ball, notes that Medicare was ultimately the choice because it would be the easiest program to pick up support (among the well organized and strong voting senior populations), and would also be the most arduous to attack. There was a strong sense of political plausibility and the creators were able to market Medicare via Social Security's prodigious popularity by calling it "health insurance through social security (Ball 1995)." The primary logic for choosing a program that would be easy to pick up support and difficult to criticize is that, at its core, Medicare was constructed as an incremental stepping stone for what liberals hoped would eventually become universal coverage.

Despite the many issues perpetuated by the establishment of Medicare and Medicaid, segments of the population that had been previously left out of the system are

now able to enjoy coverage and live longer and healthier lives. And despite being passed in the same piece of legislation, with the attempt to do the same thing (cover more people), Medicare and Medicaid have been both viewed and treated differently by policy makers and by the public since their inception. Medicare enjoys enormous support and popularity, partly because of its contributory nature and ties to Social Security. Medicare beneficiaries are generally regarded more positively because the benefits that they enjoy are seen as an "earned right" (Starr 2011). Although attitudes have shifted slightly more positively over time, Medicaid has a stigma attached because, unlike Medicare which is viewed as an earned right and an expansion of Social Security, it is associated with welfare and public assistance. In *Remedy and Reaction* Paul Starr remarks rightfully that Medicaid's lack to a "moral claim" leaves it politically vulnerable and insecure to negative legislative changes and funding cuts. Another primary difference between the two is that Medicaid beneficiaries are decided by income as opposed to age so Medicaid beneficiaries are the opposite from the static Medicare population group; this fact potentially incentivizes Medicaid recipients to stay poor in order to continue to receive health benefits for themselves and their families (Starr 2011).

Richard Nixon- George H.W. Bush

The election of Richard Nixon marked the beginning of the end of the height of liberalism in the United States. By the early 1970s, Medicare and Medicaid were booming and the health care system had become even more complex while costs were beginning to truly skyrocket. President Nixon supported a national health insurance plan and fully intended to pursue one, so the question that remained was largely about the form that his plan would take (Starr 2011). Despite being a conservative Republican,

many of Nixon's domestic achievements, including an expansion of affirmative action and the establishment of the Environmental Protection Agency, are decidedly liberal. President Nixon's more centrist approach to national health insurance meant that garnering sufficient support from both parties would pose a challenge. Democrats found his proposals to be too far to the right, while Republicans found them to be too far to the left (Wainess 1999).

After a failed proposal in 1971 that included a limited employer-mandate and subsidies for poor members of the population, Nixon relied on Caspar Weinberger, Secretary of the Department of Health, Education, and Welfare to develop a new proposal that would hopefully gain more traction on Capitol Hill. Secretary Weinberger used the 1971 plan as a blueprint for the new proposal, but also included new provisions as a result of consulting with many stakeholders and interest groups including the AFL-CIO, Chamber of Commerce, and the American Medical Association (Wainess 1999). Although this proposal cannot be deemed a legislative success, the importance of including key stakeholders in the discussion for health reform was a dominant theme in the quests made by Clinton and Obama. And despite his failure in passing health care reform, in part due to the distraction created by the Watergate scandal, President Nixon's legacy will include being the first president to actively pursue a plan for national health insurance.

Unfortunately for supporters of universal coverage, the resignation of Richard Nixon resulted in the beginning of an era of conservatism that would view plans for universal coverage as the onslaught of socialized medicine as opposed to a right that should be guaranteed to all citizens. President Ford did not send President Nixon's plan

to Congress, which highlights the importance of timing in public policy decisions. "If political leadership fails when the window for reform is open, the moment may pass and the window may close (Starr 2011)." The continued rising costs of health care became the dominant theme of Jimmy Carter's approach to reform when he took office. Instead of concerning himself mostly with a plan that expanded coverage, he instead focused solely on reform on the basis of cost-containment. The Democratic Party was split between Ted Kennedy's more liberal approach to universal coverage and the Carter administration's centrist approach that fixated primarily on the premise of introducing catastrophic insurance. Instead of a national health insurance plan, Carter decided to eventually propose a hospital cost-containment plan that would have done little to fix the issues plaguing the health care system and expand coverage, but a lot to exacerbate the issue of high-costs (Starr 2011). Eventually, the plan failed in the House of Representatives and the opportunity to change the health care system in the United States in the 1970s was over.

The Reagan administration did not support universal coverage, and during the process of adopting Medicare in the 1960s Reagan vehemently expressed his disapproval. Regarding Medicare, Reagan was quoted as saying that the program would "invade every area of freedom as we have known it in this country until we wake to find that we have socialism (Ubel 2014)." Despite his fervent opposition to the program at its onset, he ultimately resigned himself to the need for an expansion of the program, similar to what was supported by his predecessor, in the form of catastrophic coverage. However, Reagan's proposal to control costs and pay for the program was unprecedented in the sense that it, for the first time ever, would make seniors responsible for a share of the

costs. The catastrophic coverage plan was designed to protect the elderly from the profoundly burdensome costs of long-term care, and also contained provisions to cover skilled nursing care and the costs of drugs (Ubel 2014). Though these policies would seem to help the elderly being crushed by the costs of long-term hospital stays, the legislation was met with brutal contempt. Just sixteen months after the passage of "Medicare Catastrophic" the law was repealed under the presidency of George H.W. Bush.

Approximately forty percent of Medicare beneficiaries were charged with a surtax to pay for the Medicare Catastrophic program, with the average beneficiary paying approximately $145 annually for benefits that they could have already accessed via the market for approximately $62 (Tolchin 1989). This effort to put cost-containment on the shoulders of seniors led to a "well-organized protest campaign that ultimately buried members of Congress under an avalanche of angry mail (Tolchin 1989)." Paul Starr calls this passionate revolt by seniors, and the subsequent repeal of the legislation under President Bush, "one of the most dramatic reversals in national policy" that the nation had ever seen, and also notes that it has continued to serve as a "cautionary tale" against political hazards that can be incurred when attempting to alter health policy (Starr 2011).

Part III: The Clinton Moment: The Health Security Act

With the close of another decade and the country no closer to adopting a national health insurance plan, the complications facing the system were continuing to grow at a rapid rate. Issues surrounding coverage, access, and costs became impossible to ignore and health reform seemed to be inevitable under the newly elected President Clinton. Between 1989 and 1992 the uninsured population grew by 5.2 million to reach an approximate total of 38.6 million (Starr 2011). With previously enacted cost controls proving to be ineffective, there was a growing concern among the public about health care, more people were falling through the cracks as the poor were still largely without coverage, and the gap between the upper and lower classes became more glaring.

Aside from the issues with the system more broadly, economic conditions were also favorable in re-opening a window for reform. In the early 1990s, workers faced high unemployment due to a brutal economic recession. High unemployment under an employer-based health care system results in a large increase in the uninsured population. Foreign affairs was a strong focus during preceding decades, and with the Cold War coming to an end, policymakers would be able to begin shifting focus toward domestic policy in the 1990s.

President Clinton was the first president to make health care reform a primary focus of his agenda, and his policy inspiration came from a recently elected senator in Pennsylvania. After being appointed to the Senate by Pennsylvania's governor, Democrat Harris Wofford was facing a difficult special election that he was largely expected to lose. In the summer of 1991, at the beginning of the race, Wofford was down by forty points in the polls. His staff, consisting of Paul Begala and James Carville, knew

they needed to do something immediately to gain momentum, and they chose to focus heavily on Wofford's domestic policy plan. The heart of the plan was growing the economy, assisting the middle class, and implementing national health insurance.

The introduction and subsequent marketing of Wofford's new focus on domestic policy was directly correlated with an increase of support in the polls. Eventually Wofford went on to win the first Democratic Senate seat in Pennsylvania since 1962 by ten percentage points (Hinds 1991). This victory was the turning point that many Democrats needed to begin moving away from the conservatism of the previous two decades. A chairman of a social research firm in New York named Daniel Yankelovich was quoted by The New York Times, following the election in 1991, as saying that Wofford's victory " sends a very dramatic message, first to the White House that Bush is not invincible and that health care is one of the cutting edge issues of the 1992 elections. This race in Pennsylvania is a rehearsal of it (Hinds 1991)." Mr. Yankelovich was correct.

Explaining the specific details of the Clinton health plan in-depth would require a specific level of expertise, as the plan was seen as being notoriously abstruse. The extremely complex nature of Clinton's proposal was one of the many weaknesses perceived by Congress and the public at the time. When President Clinton assumed office in 1993, health care reform was imminent, and the Wofford election gave Clinton and his advisers the momentum that they needed to initiate the process. Within a matter of days post-inauguration, Clinton named First Lady Hillary Rodham Clinton as the head of the White House Task Force that would develop the health policies that Clinton himself supported. Paul Starr stresses in *Remedy and Reaction* that the common misconception

that Ms. Clinton was solely responsible for the health plan is one that will likely always exist but that it could not be further from the truth. President Clinton was present in the Roosevelt Room for virtually all of the long meetings that were held regarding the health care plan, and Ms. Clinton's role was to simply develop the policy that the President was controlling (Starr 2011).

After naming the First Lady as the head of the White House Task Force, Clinton was required to make important decisions about how he should approach health reform and what core principles would be the governing force behind his proposals. This would prove to be an especially difficult decision given the lack ideological heterogeneity among the Democratic Party; the more progressive left wing of the Party had ideas about how health care reform should play out that differed significantly from the more conservative views of the right wing of the Party.

The progressive Democrats were mostly in favor of a Canadian-style system to implement universal coverage and contain costs (Starr 2007). This "single-payer" approach lacked support from both the rest of the Party, the majority of the public, and the Republicans. The policy trap was the strongest influence behind this lack of support. Although the number of uninsured Americans was continuing to grow by the day, there was still a large enough percentage of the public who were happy with their existing coverage to firmly resist change. The protected public, namely those enjoying comprehensive benefits from their employer-based insurance, and Medicare beneficiaries, were not supportive of programs or initiatives that they thought might jeopardize their current coverage.

In his article, "The Rationale Behind The Clinton Health Care Reform Plan," Walter Zelman presents a concise and clear explanation of the "guiding principles" behind the Clinton reform plan, formally known as the Health Security Act (HSA). Zelman points to six fundamental guiding principles that influenced Clinton's approach to policymaking and the development of his plan. The principles are: universality; savings; choice; quality; simplicity; and responsibility (Zelman 1994). The universality principle was an obvious one for Clinton. He did not want to work hard on a reform plan that would not be universal, and he even threatened to veto legislation that did "not guarantee every American health insurance that can never be taken away (Raum 1994)." He strongly believed in the principle of equality and making the system available to the poorest and most disadvantaged members of the public all the way through the middle class and up to the top one percent.

The second guiding principle that Zelman notes was a top priority for President Clinton, savings, was one that originally inspired Clinton to undertake reform to begin with. Costs that were spiraling out of control put pressure on policymakers to act, so any effort to change the system would need to include cost-savings and cost-containment measures. Not only would savings be required in the aggregate, they would also need to be seen at the individual level. Many families had the ability to access the system but out-of-control costs stood in their way. The plan would need to make the system cost-friendly and accessible to everyone. Choice is also a principle emphasized by Zelman. National values play an important role in shaping public opinion and support (or lack thereof) for issues, and removing the ability for Americans to choose their health plans or doctors would have been detrimental to the plan's success.

Ironically, Zelman also points to simplicity as one of Clinton's guiding principles. President Clinton wanted to simplify the system, including the complicated administrative aspects that continued to play a dominant role in health spending. Despite a commitment to simplifying the system as a whole, lack of simplicity is partially responsible for dooming Clinton's plan more generally. The guiding principles that Clinton based his plan around are the more obvious pieces of the plan's components. How to structure and implement the plan was the bigger challenge. President Clinton had to decide how he would incorporate a universal plan that contained costs, improved quality, simplified the system, and allowed for competition, into an overarching proposal that would satisfy liberals and conservatives alike while still preserving the chance to advance in Congress. This is where things got complicated.

President Clinton decided to forgo pursuit of a single-payer system supported by progressives, and a price control, "play or pay" model that he had previously pondered support for, in favor of a managed competition approach. Managed competition was a fairly new model that was not widely understood at the time. The New York Times described managed competition as being "a structured competition among health maintenance organizations" (The New York Times 1992). President Clinton was quoted as saying that he supported managed competition over certain price control options because he believed that it would be the best for the national budget while maintaining the guiding principle of quality that was dedicated to improving (The New York Times 1992).

The expectation in the Clinton administration was that the managed competition approach would be a way to unite the differing ideologies in Congress in the hopes that it

would contain just enough provisions to appease everyone. However, the opposite happened and the approach fell short for both sides. In his article "The HillaryCare Mythology" Starr describes the managed competition approach as a plan "for universal coverage based on consumer choice among competing private health plans, operating under a cap on total spending (Starr 2007)." These goals reflected a spirit of compromise that Clinton had hoped to invoke: universal coverage for the progressives and choice and competition in the marketplace for conservatives. Ira Maganizer, senior health policy adviser to President Clinton, said of the decision that "If we were serious about universal coverage, we felt, then the single-payer people would buy off even if they didn't like managed competition. We felt we were doing enough of the market reforms that the reform people would buy off too. And, by the way, we also thought that that was the best policy (Fallows 1995)."

Both Starr and Magaziner felt that by starting with a large plan under this approach, that they would eventually be able to compromise and negotiate toward the center. Starr describes this as the "onion approach" where starting left of center would allow them to negotiate off different layers in the hopes of eventually arriving at a center that most people could agree on (Starr 2007). Ira Maganizer also strongly believed that this approach was key to victory. He acknowledged that they knew "that the only way we could try to bridge the chasm was to start a little bit left of center and try to negotiate toward the center (Fallows 1995)."

The problems for the Clinton were numerous and didn't just involve the attempt to find an approach that would appease various ideological factions. These issues started almost immediately and didn't let up until the plan's ultimate death. The task force that

President Clinton put First Lady Hillary Clinton in charge of, in cooperation with Ira Maganizer, received harsh and incessant criticism that led to messy lawsuits and damaged public perception about White House operations. Many felt that the task force involved a layer of secrecy and opaqueness that kept Congress and the public locked out of the process. Paul Starr pushes back on this claim by saying that the reason the task force received such intense criticism was because Ms. Clinton was responsible for leading it. By putting the First Lady in charge, it publicized the negotiations in a way that wouldn't have existed had Clinton worked with staff privately behind closed doors like many administrations had done before him. The task force that was comprised of over 500 members, including policy consultants, Cabinet members, and federal employees, was accused of violating disclosure laws and was eventually disassembled by Clinton months after its inception (Pear 1993). Although the White House won the lawsuit several years later, the reputation of secrecy and feelings of public distrust had already been set in stone.

When the legislation finally reached Congress, partisanship was intense and it became more apparent that striking a deal would be particularly arduous. The struggle that would exist in Congress was exacerbated by the news that Senator Byrd ruled against allowing health care reform to be included as part of the reconciliation process, by saying that it was not budget-related. Reconciliation has historically been used to pass large, and often controversial, bills as part of the budgetary process. Often, the reason for choosing reconciliation as the legislative vehicle of choice is because it is immune from the filibuster in the Senate, and is one of the only instances that allows for ease of passage by a simple majority vote. However, any piece of the bill that is not considered budget-

related is banned from being included in the reconciliation process. Ironically, reconciliation proved to be vital in passing two massive pieces of health care legislation by two of President Clinton's immediate successors: Medicare pt. D under President Bush and the Affordable Care Act under President Obama.

The various congressional committees involved in the process ultimately passed different versions of Clinton's proposal. This prompted numerous members of Congress, including members of the leadership, to draft their own version of Clinton's plan combining aspects of the original proposal with the versions that came out of the committees. This convergence resulted in watered-down legislation that didn't meet Clinton's original standards for universal coverage. One particular area of controversy that prevented a plan for universal coverage to move forward was the employer-mandate that would require employers to purchase insurance for their employees (Hamburg 1995).

Despite the contentiousness promulgated by the employer mandate, it had originally garnered support from members of the Republican Party, and various interest groups and stakeholders including the Chamber of Commerce and the American Medical Association (Starr 1994). Some of the eventual Republican alternatives to the employer mandate included support for an individual mandate that required individuals to purchase insurance as opposed to placing the burden on employers. One notable proponent of the individual mandate was Newt Gingrich, leader of the Republican Revolution during the midterm elections in 1994. This is the same individual mandate that Republicans would vehemently oppose in the debates over the ACA in 2010.

Many Republicans, including Gingrich, refused to budge on the employer mandate and their voices became a powerful mechanism in their quest to put the brakes

on health care reform. In an effort to fight back against the growing pressures, Clinton had been willing to compromise on various aspects of the employer mandate in order to appease the different interests, but it proved to be a futile attempt. Even with Senate Majority Leader George Mitchell's attempt to introduce a bill that phased in the employer mandate aspect of the legislation years later, they still couldn't muster the required support (Hamburg 1995). The growing lack of trust in the government mixed with the unwillingness to compromise by the Republican Party was too big of a hurdle for the Clinton administration to overcome, and ultimately resulted in the bill's failure in Congress. Health care reform in the 1990s was dead and the Republican Party knew that they were partially responsible. Paul Starr mentions in many of his publications that Republican Senator Bob Packwood was quoted as saying that "now that they had killed health care reform, they had to make sure that their fingerprints weren't on it (Starr 1994)."

Part IV: The Affordable Care Act

The election of President Barack Obama in 2008 was undoubtedly historic. For the first time in the United States, an African American won the presidency. But race wasn't the only thing that made this election special: the long and hard-fought primary battle against Hillary Clinton added to the historic nature of the election, as did the grassroots mobilization efforts by the President's campaign staff, and the unprecedented levels of fundraising by both Republicans and Democrats. When Barack Obama took office, hopes and spirits were high across the nation. There was an overwhelming sentiment that the President would bring the change that the nation needed to again begin experiencing prosperity and growth. Despite the sense of optimism, President Obama had a taxing road ahead of him. He took office under the grimmest economic conditions since the Great Depression. The U.S. had experienced a severe financial crisis in 2007-2008 under the leadership of President Bush. The value of the dollar decreased while the debt and unemployment increased. The country was involved in two expensive wars in Afghanistan and Iraq, the conditions of which, and reasoning for, were mostly unclear. The poor were getting poorer and the rich were getting richer as the tax code was biased in favor of the wealthy. It would not be easy for newly elected President Obama to reverse the direction that the country was headed in, and the tough decisions he was forced to make would firstly require him to prioritize his policy agenda.

One of the first major pieces of legislation enacted by President Obama was the American Recovery and Reinvestment Act (ARRA or "the Stimulus), the goal of which was to stimulate economic activity and lower unemployment. Included in the Stimulus package were a number of relief programs that were designed to bring temporary aid to

people in need, states and localities, and small businesses (CBO 2012). The cost and size of the Stimulus was contentiously debated, with many liberals arguing that it didn't go far enough, and many conservatives arguing that it was the wrong approach more generally. Although the President had originally intended for the Stimulus would be a bipartisan effort, the vote was split along mostly partisan lines, and the very polarized nature of Congress that would drive the future health care debate became glaringly apparent.

The Stimulus was an obvious first step for the President. Similar to FDR in the 1930s following the Great Depression, President Obama decided that he couldn't act on other priorities like health care, immigration, or climate change, until he addressed the ailing economic state of the country. After the Stimulus passed though, the President decided it was health care's turn. His predecessor was strongly opposed to implementing a national health insurance plan, and the problems that prompted President Clinton to act almost two decades prior had only been exacerbated. Quality, coverage, and costs were still problems within the system and any plan proposed by the President needed to address all three. By 2009 the uninsured population had reached a total of about 16.7 percent of the population, or 50.7 million Americans; this was an increase from 46.3 million the year prior (Census 2010). For the first time since 1987, the number of people with insurance *decreased* from the previous year. Employer-based coverage had also experienced its largest drop since 1987, whereas the number of citizens relying on government insurance, including Medicare and Medicaid, was the highest that it had been since 1987 (Census 2010).

The cost of health care was soaring at an alarming rate that wasn't sustainable. By 2009, the U.S. was spending 17.6 percent of GDP on health care, compared to about

15 percent in 2006 (Kaiser 2009). This figure equated to about $2.5 trillion in 2009 alone, or about $8,160 per resident; this was an increase from the $356 that the U.S. spent per resident in the 1970s. Even those with coverage were being burdened by these rising costs. Premiums were skyrocketing, many families and individuals were forced to pay high out-of-pocket costs associated with their plans, one in five members of the public reported experiencing extreme financial difficulty related to health care costs, and the average family devoted about 10 percent of their non-taxable income to paying for health care (Kaiser 2009). The impact of these rising costs percolated from the micro to the macro level with businesses experiencing profit-loss and the economy experiencing less activity as consumers had less disposable income to spend.

President Obama was able to prioritize health care because of the favorable makeup of Congress. In 2008 the country experienced Democratic landslides that gave the Democrats control of both the House and the Senate. Although the Senate Democrats held 58 of the 100 seats, they were still two seats shy of a filibuster-proof majority. This changed soon when Joe Lieberman, an Independent from Connecticut, announced his support for reform, and when Al Franken eventually won a contested Senate seat in Minnesota (Starr 2011). President Obama did not ignore the importance of timing, and moved to pass a bill while the window for reform was open. Moving too slowly would have meant that the window for reform could have potentially closed, especially with the quickly approaching midterm elections in 2010. Also invaluable was the support that President Obama had from the well-organized and powerful Democratic leaders in Congress, Speaker of the House Nancy Pelosi and Senate Majority Leader Harry Reid. Max Baucus, chairman of the Senate Finance committee, was also a vocal and active

supporter of health care reform, and a week after President Obama won the election he cited it as being the "duty of the next Congress" (Starr 2010). Another notable proponent for health care reform was a figure who had been involved in almost every debate of the previous several decades: Senator Ted Kennedy.

With strong support from Congressional leadership and the legislative majorities that he needed to get a bill passed, the President had to decide how to structure a reform plan that would cover the majority of the population while also addressing costs and quality. Despite his commitment to getting health care reform passed, it was unlikely that the President was going to present legislation that would appease the more progressive wing of the Democratic Party. Starr concludes that as early as the beginning of the election "Democrats had decided to settle for reforms that would be minimally disruptive" but he also noted that despite making several concessions that they would typically find ideal, Republicans would still view their reform efforts having "broad ideological implications" and as a "government takeover" (Starr 2010). Even though the health care reform model wouldn't necessarily be as liberal as some Democrats might have liked, there was still a general consensus of what needed to be included. The ability to agree within the Party gave President Obama the freedom to hand over the responsibilities of drafting the bill, and hashing out the details, to members of Congress.

The bill that was eventually passed included several parts designed to work in tandem to reduce the uninsured population. In an effort to appease the Republicans, the bill included provisions that gave states the responsibility to implement several main components, including Medicaid expansion, and creating health care exchanges that the public would be able to use to navigate through various plans. If states chose not to

create an exchange, the federal government would step in and create it for them. The exchanges were to be used as a way for citizens to compare plan benefits and pricing, and the plans would be ranked from catastrophic, to bronze, to silver, to gold. The ACA also included a provision that would provide subsidies for people who could not afford their chosen plan in the exchange.

The poorest of Americans who were previously ineligible for Medicaid would be covered through the voluntary state Medicaid expansion. For example, in Virginia, as is the case for many other states, only pregnant women, poor families with dependent children, the impoverished elderly, and the blind were eligible for Medicaid prior to expansion. The ACA would provide federal funds that would allow the states to expand coverage to those falling under 100% of the poverty level that are also ineligible for employer-based insurance. Between the subsidies provided for those making over 100% of poverty level that purchase through the exchange, and Medicaid expansion, health care coverage would now be accessible and affordable to millions of Americans who could otherwise not be able to afford coverage.

There was a mostly partisan public opinion split regarding the Affordable Care Act with Democrats reporting in favor of the bill and Republicans reporting as being mostly against it (Brodie 2010). Although many reported being unhappy with choices that President Obama made, or health care reform in general, the majority of the public reported support for more popular pieces of the package (Brodie 2010). The two most popular provisions of the ACA banned insurance companies from denying coverage to people with pre-existing conditions, and allowed children to stay on their parents' insurance until age 26.

The provision that prevented insurance companies from denying people with pre-existing conditions received mostly high levels of support on its own, but the cost-saving mechanism put in place, that allowed it to even exist, proved to be extremely controversial. The only way for the President to accomplish this part of his plan would be to enact part of the Republican Party's alternative to the Clinton plan in 1993: the individual mandate. The individual mandate would require everyone to purchase health insurance or face a penalty. Because Medicaid expansion was a voluntary component and discretion was left up the states, those living in states that chose not to expand could claim financial distress that would allow them to avoid paying the penalty from the individual mandate.

The reasoning behind the decision to include the individual mandate was simple: it was the only way the insurance companies would be able to avoid adverse selection from a high-risk pool and agree to cover everyone. If people weren't required to purchase insurance, then those who actually did would be heavily skewed toward the unhealthy portion of the population. If insurance companies were flooded with unhealthy applicants then everyone else's premiums would rapidly increase and most people would wait until they got sick to buy insurance. The only way that covering people with pre-existing conditions would be possible would be for there to be enough healthy members paying into the system to off-set the costs posed by the unhealthy people who would now be covered. Without the individual mandate, the insurance companies would have severely lost profits, and been unduly galvanized. This would have resulted in President Obama and Democrats facing insurmountable backlash. Democrats had not anticipated the pushback that they received over the individual mandate. After all, this was a

Republican idea, and the Republican Governor of Massachusetts, Mitt Romney, successfully enacted it at the state level.

Although the individual mandate has proven to be the most polarizing provision of the ACA, it did end up making it in the final version of the bill and thus signed into law. The other contentious provision that received large amounts of attention from the public did not prove to be as lucky as the individual mandate. The public option, which would have added a government-provided insurance plan, similar to Medicare, to the exchange alongside the private plans, was a piece that many Democrats considered non-negotiable, while more conservative members of the caucus were adamant that they wouldn't support a final version of the health care reform bill if the public option was included. Many of the arguments against a public option were centered on "big government" and the losses that the insurance companies might experience if people chose to forgo private insurance plans or employer-based insurance in favor of a government plan. Conservative Democrat who opposed the public option, Senator Ben Nelson, said to ABC "I don't want a big-government, Washington-run operation that undermines the private insurance that 200 million Americans now have" Murray 2009).

Although Democrats faced opposition regarding the public option, they made it clear that they would support a version of the public option drawn in compromise by abdicating some of the cost-containment measures that were originally included. Jacob Hacker, health policy scholar in favor of the public option, argues that in order for health care reform to experience optimal success the public option should still be a goal and should be included in future reform discussions regardless of the political woes that might lie ahead. He calls the public option a "clear and simple goal that links concerns

about health security, the affordability of coverage, and the nation's larger fiscal challenge" and also argues that it could potentially act as an accountability tool for insurance companies who could risk losing customers if they didn't act in lowering rising costs (Hacker 2010). The public option did not make the final version of the bill despite the willingness to compromise by progressive Democrats, and serves as an example of how split the debate was throughout the process, even among Democrats, and also is representative of one of many concessions that Democrats made in order to finally get a bill passed.

"The single most important thing we want to achieve is for President Obama to be a one-term President" – Senate Minority Leader Mitch McConnell. This is the quote that accurately sums up the response President Obama received from Republicans during virtually every legislative attempt that he made. Many of the provisions in the Affordable Care Act were inspired by Republican ideas that had garnered bipartisan support in previous years and Democrats had been willing to compromise on the more liberal aspects of the bill. The ACA was more similar to proposals and alternatives presented by the GOP than anything that progressives had advocated for in previous attempts. Regardless of any desire for bipartisanship that existed among Democrats in the beginning, the process strongly demonstrated that the partisan and polarized nature of Congress would dictate the end results. The final vote fell along predictable Party lines, without a single Republican siding with the Democrats in either the House or the Senate.

The resistance from the Republicans was fueled by many misconceptions and misunderstandings that circulated through the media and eventually went on to shape the attitudes and opinions of the public. Perhaps the most notable misconception during the

debate over the Affordable Care Act was the declaration perpetuated by former Governor of Alaska and Vice Presidential nominee Sarah Palin that the bill would implement what she referred to as "death panels." The "death panels" were a reference to a section of the Affordable Care Act that included optional counseling sessions designed to help Medicare beneficiaries appropriately plan for end-of-life care. Under this provision, physicians would be reimbursed for doing work that they had already been doing without specific allocated payments: advising patients on how to prepare living wills, make decisions about what to do in life-threatening situations, provide information about hospice care, and educate about other end-of-life services that need consideration.

The Republican view, that this provision might lead to rationing, framed the issue in a way that was simply not true. This framing presented the optional end-of-life counseling appointments as mandatory sessions that would give bureaucrats the opportunity to tell elderly people how and when to die. According to Brendan Nyhan, the "death panels" myth started when politician Betsy McCaughey made the claims on Fred Thompson's radio show in early 2009. McCaughey was quoted as saying:

> And one of the most shocking things I found in this bill, and there were many, is on Page 425, where the Congress would make it mandatory—absolutely require—that every five years, people in Medicare have a required counseling session that will tell them how to end their life sooner, how to decline nutrition, how to decline being hydrated, how to go in to hospice care. And by the way, the bill expressly says that if you get sick somewhere in that five-year period—if you get a cancer diagnosis, for example—you have to go through that session again. All to do what's in society's best interest or your family's best interest and cut your life short. These are such sacred issues of life and death. Government should have nothing to do with this. (Nyhan 2010).

The "death panels" myth is the most popular example of extensive and widespread hysteria that was unfounded during the health care debate. Although the claims were

proven false, they continued to influence the way the legislation was perceived by the public, and ultimately increased pressure on Congress to either vote against the bill or attempt to fight back against the myths dominating public perception.

The health care debate took a sad turn when advocate of the cause Senator Ted Kennedy died from brain cancer in August of 2009. Senator Kennedy had been involved in all of the health care debates that occurred during his near fifty-year tenure in the Senate. He was recorded as having called health care reform the "cause of his life" but his death unfortunately preceded the change that he had so intensely fought for (CNN 2009). The death of Senator Kennedy represented the loss of an outstanding champion of health care reform, a loss in Congress and for Democratic Party, a loss for the citizens in his home state of Massachusetts, and the loss of the filibuster-proof majority that the Senate Democrats had planned to rely on in order to pass the ACA. Following his death, Massachusetts eventually called for a special election to fill the vacant Senate seat, and in a stunning upset, Republican Scott Brown defeated Democrat Martha Coakley. This victory gave the Republicans another vote against health care reform and put the Democrats in a compromising position. They had to either convince a Republican to vote alongside them, or find another way to get the bill passed.

The institutional barriers that make it challenging to legislate with a simple majority resulted in President Obama and Congressional Democrats using less conventional measures to pass the Affordable Care Act. In order to pass the ACA with a simple majority in the Senate, and to pass a version of the bill more in-line with their priorities, Democrats opted to use a parliamentary procedure known as reconciliation. Reconciliation was originally introduced as part of the Congressional Budget and

Impoundment Act of 1974. The purpose of reconciliation was intended to be used by Congress to alter existing laws in order to meet specified spending caps or revenue targets as set forth in the budget resolution. However, as time went on reconciliation became more and more institutionalized for its use as a vehicle to pass controversial bills with a simple majority. A common misconception is that the Democrats' use of reconciliation to aid in the passing of health care reform was somehow an isolated or extreme incident and that the use of it was a usurpation of regular order in Congress. This is not exactly the truth.

In 2009, the Senate and House both passed similar versions of the Affordable Care Act through regular order, despite the existent of stringent House rules and the filibuster in the Senate (Burgin 2012). The loss of Kennedy's seat forced Democrats and President Obama to re-think their legislative options. After forcing Harry Reid to invoke cloture three times under regular order, the Senate was finally able to pass their version of the ACA which ended up, according to Kaiser, being approximately 85 percent in line with the House version of the bill (Burgin 2012). However, the 15 percent of differences, including how to pay for reform, required some sort of compromise between the two chambers. Speaker of the House Nancy Pelosi agreed to pass the Senate version of the bill on the condition that she could amend it to make it "more attractive to liberals" in her caucus through the reconciliation process, and with the guarantee that the Senate would pass the reconciliation measure (Burgin 2012). By the end of March in 2010, and without a single Republican vote, President Obama signed both the Affordable Care Act and the accompanying amendments that were passed through the reconciliation process, into law.

The transformation of health care reform from a bill into a law did not mean that the Republican Party had any intention of reigning in their opposition. Many Republicans expressed that the law was a strong violation of their ideology and how they believed that government in America should be run. The most divisive element of the ACA continued to be the individual mandate, with Medicaid expansion (despite the ability to opt out by the states) coming in a close second. Immediately after President Obama signed the law, starting with Florida, states began filing federal lawsuits challenging the constitutionality of both of the controversial provisions. After Florida filed their initial lawsuit, an additional 24 states followed their lead and eventually the future of the Affordable Care Act was in the hands of the Supreme Court. The Court would consider the constitutionality of the individual mandate, and also the premise that the Secretary of Health and Human Services could withhold federal Medicaid funds for states who chose to opt out (Kaiser 2012).

The Court ruling loomed over the nation for months, and would ultimately be announced during a crucial time for President Obama- the heart of his re-election campaign. The elections in 2012 were significant for the Democrats for several reasons. The midterm elections of 2010 proved to be successful for the Republican Party who mostly ran on an "anti-Obamacare" agenda. The Democrats who won in swing districts in 2008, mostly due to the momentum that sharing a ticket with President Obama provided them, weren't nearly as lucky in 2010. The Republican Party to took a sharp turn to the right with the rise of the "Tea Party," who staunchly opposed the majority of the President's policies, *especially* the Affordable Care Act. This wave of conservatism resulted in a Republican takeover of the House, and a loss of important seats in the

Senate for the Democrats. Partisanship was reaching new heights, and the most policy decisions were contingent on the future of the ACA. The President needed another landslide victory in 2012 in order to secure, and potentially win back, some seats in Congress, and to keep the ACA alive.

Ultimately the Court ruled in favor of the ACA, with the hand of Chief Justice John Roberts, which came as a surprise to most Republicans. In regard to the individual mandate, the Court upheld the provision completely, saying that it was in line with the constitutional exercise of Congress' power to tax (Kaiser 2012). The decision about Medicaid expansion was slightly less clear. According to Kaiser, "The Court ultimately held that the Medicaid expansion is unconstitutionally coercive of states because states did not have adequate notice to voluntarily consent, and the Secretary could withhold all existing Medicaid funds for state non-compliance." They decided that the remedy for this would be to prevent the Secretary from withholding all of a state's federal Medicaid funds if they chose not to expand to populations covered under the ACA. The decision by the Supreme Court still didn't slow the wind in the Republican's sails. Heated debates continued, the debt ceiling and the federal budget was held hostage, and the government was eventually shutdown for 16 days in 2013, all due to the Republican's opposition of the ACA. Although many members of the GOP still vehemently oppose the legislation, the government shutdown did inflict temporary damage to their reputations, which eventually resulted in an apparent shift of focus. They went on to win a majority in the Senate in the midterm elections of 2014, giving them control of both Houses for the first time during the Obama administration.

Even though the content of the Affordable Care Act will continue to provoke heated reactions on both sides, and many Democrats feel it didn't go far enough, it has significantly reduced the percentage of the uninsured population since the phasing in of most major provisions. According to numbers released by the government in March of 2015, less than two years after the health insurance exchanges went live, 14.1 million adults gained health insurance coverage, dropping the uninsured rate from 20.3 percent to 13.2 percent, which is an overall 35 percent reduction in the uninsured rate (HHS 2015). These numbers can be attributed to Medicaid expansion, the provision of the ACA that allows children up to age 26 to remain on their parent's insurance plans, the subsidies provided for low-income people wishing to purchase through the exchange, and people suffering from pre-existing conditions no longer being denied coverage. These numbers point to the "largest drop in the uninsured rate in four decades (CNN 2015)."

Despite their brief shift of focus through the midterm elections in 2014, Republicans continue to challenge aspects of the law, now shifting to the subsidy provisions, which is expected to receive a Supreme Court ruling by sometime in the summer of 2015 (CNN 2015). The future of the Affordable Care Act is unclear: President Obama's final term is up in two years and the person chose to fill the vacancy in the White House will likely be key in determining any new paths that health care reform might take. Regardless of what happens in the future, the ability for President Obama to pass health care reform was nothing short of historic, and provides academics and policymakers with a blueprint for the future.

Part V: Lessons Learned

Thus far I have detailed the political and policy experiences of both Bill Clinton and Barack Obama in their respective quests to implement comprehensive health care reform. This section will take those experiences and draw lessons that public policy advocates, policymakers, and political scientists can use as a guide for important considerations to make during future reform efforts, and to perhaps gain a better understanding of why one administration found success in an area where another was met with failure. However, this set of lessons does not claim that the efforts of the Obama administration were perfect, nor that the efforts of the Clinton administration were exclusively wrong. In both cases there were an abundance of achievements and roadblocks, and I hope to bring attention to both.

Lesson #1: Timing is Everything.

Timing is a crucial aspect of the political and public policy decision-making process. Politicians, and those with political ambitions who have experience working in the business sector, often tout their business experience in arguments about how government should be run. This implies effectiveness and efficiency with a goal to drive profits and cut fraud and waste. Republican candidate for President in 2012, Mitt Romney, often made this comparison.

While many debate the merits of running government like a business, valuable comparisons between the two can be made. When a business is considering a product launch, timing is absolutely crucial. Development and marketing teams work tirelessly in conjunction in order to make sure that consumers will desire and purchase the product. If something goes wrong in developing the product, or the marketing strategy fails to target

the correct audience within a certain time, it is possible that the window of opportunity for that product to be successful in the market might close. The potential for this to happen could have detrimental reputational and financial effects on the business.

Timing is also imperative in the decision to launch a business. Prospective business owners must consider timing when attempting to own a business because the ultimate success or failure of their business is up to them, regardless of external conditions. Contributor to Forbes and CEO of Swiftpage, John Oechsle, says that timing is indeed everything, and in determining whether or not the timing is right to start a business, owners should ask themselves an important set of questions. Are economic and market conditions favorable to the respective business launch? Essentially, if there is no demand for the product that the business will provide, and the local entrepreneurial environment is hostile, then failure is likely imminent. He also stresses the importance of ensuring that personal timing is right, understanding the timing involved in customer outreach, and evaluating the position of the competition (Oeschle 2014). Clearly, if timing isn't on your side it might not be worth it to put in the time, effort, and financial commitment that it takes for a successful business launch. If timing is indeed on your side, then monopolizing on the favorable conditions in a timely manner becomes a priority. This premise is the same for most domestic and foreign political and public policy initiatives.

As previously discussed, favorable economic and political conditions contributed to President Clinton's desire to pursue health care reform in the beginning of his first term. The country was in a position to take on a massive domestic policy initiative, and with the recession forcing people into unemployment, and the dreadful state of the health

care system, taking the road *sort of* traveled toward health care, with a goal of universal coverage, appeared to be the natural and obvious course of action. Health care reform was a central theme of the debates between President Bush and then-Governor Clinton. Clinton had support for reform in Congress, even among Republicans who initially agreed that the current system was unsustainable, and, despite the dangerous policy trap that exists in America's health care system, public opinion also proved favorable. If there was ever a time that health care reform was going to pass, many believed that it was then. The "window for reform" was open and according to the American Medical Association, it was inevitable (Starr 2007).

One of Clinton's primary mistakes was not appearing cognizant regarding the importance of acting when the timing was right. It took a painfully long time for the administration to move legislation forward. The inability to forge important compromises significantly slowed the process down. When President Obama took office and decided to act on health care reform, he had the luxury of a general agreement between the various liberal and conservative factions of his Party with respect to how reform would be structured. This was not necessarily the case for President Clinton. His managed competition approach was new, complex, and didn't appeal to liberal Democrats. Paul Starr writes that Ira Magaziner and various other health policy advisers to Clinton believed that the managed competition approach had political advantages, including that "managed competition was a better fit with Clinton's general appeal as a New Democrat willing to break with the liberal orthodoxy (Starr 2011)." But this approach, along with Clinton's threat to veto any legislation that didn't result in universal coverage, reflected a lack of a spirit of compromise that exacerbated the slow process that

reform often takes. Clinton's promise to enact reform within his first 100 days in office quickly became impossible.

In comparison, President Obama took a much different approach. He also had a window for reform. The country was experiencing another recession, unemployment was high, the uninsured population was rising, and there were Democratic majorities in Congress. Along with those majorities came Congressional leadership capable of mobilizing and uniting their caucuses in favor health care reform. The consensus among Democrats gave the President the ability to hand over the responsibility to draft legislation, and even in spite of unexpected variables (the death of Ted Kennedy, an extreme commitment to obstructionism, etc.) the Democrats moved quickly. Swift action taken by President Obama and Congressional Democrats demonstrated the importance of timing in policy decisions, especially ones that involve sweeping and comprehensive changes. The time that it took the House and Senate to enact their respective versions of the health care bill under President Obama, was the same amount of time that it took for Clinton to begin introducing the Health Security Act (Peterson 2011). The failure to act in a timely manner closed, locked, and put bars up, on Clinton's window for reform.

Politicians and policy advocates can work tirelessly on an issue for years without ever seeing a hint of progress, and then suddenly the timing is right and their issues of passion become national priority. Inaction could cause them to lose ground on their respective battles again for decades. We have seen both positive and negative examples of this among advocates for marriage equality, pro-life causes, environmentalists, and proponents for health care reform. Putting in the work necessary to birth change must always remain salient and when the timing is right action must be taken, because it is

unlikely that those conditions will exist again in the near future. The rapid action taken by President Obama in comparison to the sluggish movements of President Clinton should serve as an important lesson about the effects of timing for policymakers in the future.

Lesson #2: The Importance of Transparency.

Lack of a trust in government has permeated American culture since the country's inception, and the perceived opaqueness of the Clinton Administration's approach to develop the framework and content of it's health care reform legislation exacerbated this concern among members of the public, Congress, and various stakeholders. President Clinton won his election with only 43 percent of the vote, and a record from his time as Governor of Arkansas emerging with rumors of scandalous personal endeavors, which meant that his margin of error for losing public trust was relatively low. When the White House task force emerged, led by Hillary Rodham Clinton, the media and the public erupted with cries of "secrecy." In fact, virtually every news article, opinion piece, and academic journal written during and about this time includes the word secrecy as part of an overall negative context.

Regardless of who was included in the talks at the White House, public perception mattered most, and the widespread criticism (and subsequent lawsuits) were insurmountable. The Task Force consisted of 500 government officials, health policy experts and scholars, and cabinet members, all of whom were brought together to assist President Clinton in the development of his plan. Hillary Clinton was quoted as saying "we listened to everybody- and then made recommendations based on what we thought made the most sense (Fallows 1995)." A primary criticism of the Task Force was that a majority of the members were unable to be publicly identified, and the lack of inclusion

of members of the business community who would eventually be a central part of the proposal under the employer-mandate (Blendon et al 1995). Other groups who appeared to largely be left out of the discussions were "private-sector leaders, such as major employers, unions, distinguished physicians, and others who had gained considerable national or regional recognition for their own work on health care reform (Blendon et al 1995)."

Pushing back on the notion of secrecy, or at least the reason for its rise in popularity, James Fallows places the majority of the blame on the Clinton's exclusion of the Washington press throughout the process. Fallows argues that representatives from most interested groups were included in the deliberation process, but that the White House communications team advised Ira Magaziner and Hillary Rodham Clinton against discussing potential ideas or provisions of the plan with the press. This resulted in the media painting a picture of secret operations, usurping any outlying trust that the public had in the Clinton Administration. He goes on to say that "secrecy toward reporters was stupid. But reporters are now acting as if it were something worse: closed-mindedness about ideas (Fallows 1995)." Regardless of whether or not the exclusion of business owners or the exclusion of the media doomed the plan's reputation, the apparent lack of transparency had already impregnated the minds of the public and still exists today.

Unlike President Clinton, President Obama decided to make the development of his proposal completely transparent by giving full responsibility of drafting the ACA to Congress. As noted above, this was more easily accomplished because of the existence of a more cohesive Democratic Party and strong Congressional leadership. There were several advantages to this approach. President Obama couldn't afford to lose public trust

the way that Clinton did, and he also knew that if the public didn't like various elements of the plan, the blood wouldn't necessarily be on his hands. However, the Republican idea to refer to the ACA as "Obamacare" kept his role salient in the minds of the public. Even despite his strong association with the legislation, people were unable to complain that the President was possibly hiding something. This distanced President Obama from this affiliation with the Clinton years and gave him a stronger claim to credibility.

Transparency has the ability to shape long-lasting public attitudes about various pieces of legislation and the politicians responsible. Although the Obama administration did a better job of hashing out the details of their plan in an open environment, they didn't execute their strategy perfectly. Speaker of the House Nancy Pelosi made a famous quote during the deliberations over the bill that Congress would "have to pass the bill so you can find out what's in it, away from the fog of controversy (Roff 2010)." While Speaker Pelosi didn't intend the quote the way many chose to interpret it, it still managed to fuel the opposition. Coupled with the length of the ACA and the lack of time that members of Congress had to properly navigate through the bill, a message was sent that President Obama was simply trying to force a bill through Congress, the content of which was mostly unknown. Still fighting against allegations of secrecy and working behind closed doors is Hillary Clinton who is running for President again in 2016. Stories of Mrs. Clinton using a personal email during her time in the State Department have been perpetuated with headlines about her "history of secrecy." This mistake will continue to live on and should serve as a strong warning for policymakers in the future.

Lesson #3: Choose the Right Frame.

The importance of issue-framing is rarely lost on scholars of politics, particularly those interested in American political behavior, as evidenced by the massive set of literature designed to measure the intentions and effects of issue-framing on public opinion. Framing is a psychological tool, frequently used by researchers, politicians, and policymakers, designed to shape attitudes by implicitly sending a message to the public about the nature in which they should be thinking about particular issues. Political Scientist James Druckman argues that citizens frequently base their opinions on arbitrary information, and that elites use framing to manipulate citizen judgments; he also says that experts use frames explicitly as an intentional way to form issues (Druckman 2001).

In *The Nature and Origins of Mass Opinion*, John Zaller argues that people often have predispositions and considerations that they connect to when confronted with a political issue. These people are said to reach into the "bucket" that exists in their head, and pull out the most salient considerations that are near the top of the bucket, in order to form their opinion. In this model, the role of the elite (primarily politicians and media sources) becomes crucial. When politicians take sides on issues, they often choose the frame that will appeal to their base and the majority of Americans. The media has the opportunity to report on those issues, and alter the frames to suit their audience if they desire. This system of administering information is an extremely powerful tool in influencing public opinion: reporting on an issue framed in a particular way tells the public how to think about that issue, and subsequently primes them, and the issue becomes more salient in their "thought bucket" that they reach into in order to form

opinions. Framing was a central part of the health care debate, on both sides, and worked for and against both President Obama and President Clinton in numerous ways.

When a politician takes a side on an issue, framing is one of the first considerations that they must make. President Clinton framed his health care proposal as being an issue of freedom and security. What American doesn't love freedom? In this case, universal coverage would provide Americans with the freedom to live their lives securely without the fear that their insurance would be taken away, or with the fear that one day medical bills would bankrupt them because they couldn't afford insurance. The logic of choosing this way to frame his proposal was likely fueled by various considerations, but the dangerous policy trap that exists in the health care system had significant influence.

President Clinton needed to appeal to those who were already covered, as well as those who were uninsured, in order to alleviate the different dynamics of the fear that pervades public opinion when the sense that massive change is imminent. Of security, President Clinton said in a speech to a joint session of Congress in 1993 that under his plan "if you lose your job or you switch jobs, you're covered. If you leave your job to start a small business, you're covered. If you're an early retiree, you're covered" and continued to cite similar examples of groups that would be covered under his plan but didn't already enjoy that sense of security through the current system (Starr 2011). Paul Starr compares Clinton's efforts to frame his proposal as an issue of freedom as being similar to Franklin Roosevelt's effort to pass Social Security through the New Deal.

The main problem with Clinton's framing wasn't necessarily that American's couldn't identify with added freedom or security, because those are two prominent

national values, but that because of the complexity of his plan, his efforts to positively frame did him little good. By developing an extremely complex plan, without including the press, Clinton gave his opposition a powerful and influential tool: the ability to frame his proposals for him. Without many having a strong grasp of what exactly the Health Security Act entailed, the Republicans were able to use that to their advantage to shape the message that the public received, and to frame the proposals as big and bad government.

President Obama also heavily relied on framing throughout the health care debate, but, like Clinton, it didn't always work for him in the ways that he had intended. One of his more famous quotes, which ended up being mostly true, brought comfort to many Americans in 2009-2010. In a speech to the American Medical Association President Obama said:

> "That means that no matter how we reform health care, we will keep this promise to the American people: If you like your doctor, you will be able to keep your doctor, period. If you like your health-care plan, you'll be able to keep your health-care plan, period. No one will take it away, no matter what. (Kessler 2013)"

The President emphatically stated and re-stated this promise publicly at virtually every appearance that he made on behalf of the Affordable Care Act, and continued to do so after the bill was signed into law. This was used as a blatant way to ameliorate the same concerns brought forth by the policy trap that President Clinton had attempted to ameliorate. The majority of the country has either been guaranteed insurance via employer-provided plans, or through a government plan like Medicare or Medicaid. Without support from these groups, the ACA would have been doomed, and many had expressed concerns that they would perhaps be required to switch plans or doctors as a

result of certain provisions. Ultimately this ended up being a controversial promise. The President's plan *did* allow certain plans to be grandfathered, but overtime it became apparent that those plans would not continue to meet the minimum coverage requirements as specified in the Affordable Care Act. Those people would then be required to obtain coverage through a more comprehensive plan.

The public was in an uproar when they found out that Obama had "lied" and while this framing had potentially alleviated some concerns throughout the process, most of that deteriorated when these revelations were made. The President would have likely been met with less anger had he made an altered version of his original statements that insinuated that people could either keep their plans temporarily, or that the only changes to their plans would be positive ones. However, while this was certainly the most controversial issue-frame that Obama relied on throughout the health care debate, it wasn't the only one. T.R. Reid points out that the President spent the majority of his time discussing the economic concerns surrounding the ACA, and waited until the final push to focus on the "plight of the uninsured" and the nation's moral obligation to provide universal coverage (Reid 2010). Had President Obama more decidedly marketed the bill around the issues that the uninsured population was facing then it could have potentially sent a message to Americans that this was less about an economic or big government issue, and more about a moral obligation to protect their fellow citizens. Issue-framing played a consequential role in both health care debates and will continue to remain a powerful political tool used by politicians, the media, and policymakers well into the future. Anyone considering future reform efforts, or wishing to develop a greater

understand of the politics of the HSA or the ACA would benefit greatly from paying specific attention to framing effects.

Lesson #4: The Power of Personality.

One of the most prominent perceptions, and perhaps misconceptions, about the process in which Bill Clinton developed his health care plan was that he had relinquished the majority of control and direction of the proposals to his wife Hillary Rodham Clinton. The First Lady, who did indeed head the White House Task Force, was at the center of media reports and speculation, the lawsuit that emerged against the White House, and continued to be blamed as a Senator from New York and a candidate for President. Like other aspects of the health care debate under President Clinton, charges made against Hillary are likely to continue to roar back into the public spotlight given her prospective candidacy in 2016.

In politics, personality matters. Personality sells. A "good" politician will of course be charismatic and empathetic, but even more important is their ability to win the trust of the public. President Clinton was simply a Governor from Arkansas when he took office, which meant that there wasn't an automatic rapport with Congress and the public that might have existed had he already spent a significant amount of time in the national spotlight. This was also true for the First Lady. Combined with her strong personality, personal successes, and commitment to Democratic policies, putting her at the forefront of such a highly contentious legislative push engendered controversy.

It wasn't necessarily Mrs. Clinton's personality that was a problem, but the media portrayal of her personality not only helped to shape public perceptions and attitudes about her, but also reeked of sexism. The country wasn't used to having such a powerful

first lady and sexist charges made against Hillary began during the campaign, with the media often speculating whether or not she would hurt or help Bill Clinton's chances at the presidency. The press often referred to her "rigidity" and unwillingness to compromise as an issue during the health care debate. Starr even points out that many articles said that it was supposedly "Hillary's secretiveness and rigidity that led to fatal decisions about the White House health plan and political strategy (Starr 2007)."

Even if those reports were incorrect and the terminology perhaps offensive, reporters frequently exceeded the sexist nature of those terms; U.S. News & World Report called her an "overbearing yuppie wife from hell" and numerous news outlets made comparisons to Lady Macbeth (Corcoran 1993). These types of headlines followed Hillary into the health care debate and likely influenced the way she was perceived by the public and Congress, and was used as a way to shift the frames in which people viewed her role in the process.

President Obama faced an entirely different host of issues, including false and negative charges from the opposition about his personal life. However, he did enter office being known as one of the most charismatic presidents to ever hold the job. President Obama had the extraordinary ability to forge seemingly "personal" relationships with his supporters through his genuine and inspiring messages of hope and change. Harvard Business Review calls him the "man whose silver tongue had moved many to the point of tears, had moved them to move mountains to make him president" and goes on to say that no president "in our lifetimes have forged with their followers a bond so tight it transcends the ordinary (Kellerman 2009)." This is not to say that Barack Obama was simply able to pass health care because of his ability to give a powerful and

moving speech. However, it does highlight the vigor in which his supporters would dedicate themselves to his defense, being the champions that his movement required to move forward in a hostile environment.

President Obama wasn't the only leader in the spotlight. He had two strong (albeit different) personalities backing him in the Congressional leadership. Nancy Pelosi frequently gets hit with the same sexist charges as Hillary Clinton, frequently being portrayed as an uncompromising advocate for the liberal agenda. However, as Speaker of the House she was able to persuade and attenuate the needs of her caucus in unprecedented ways. Harry Reid, with a style different from Pelosi's, knew the procedural and parliamentary procedures of the Senate and was able to use that to his advantage. Their unwavering support for passing health care reform was an essential component of President Obama's ultimate success. And while Bill Clinton is also portrayed as charismatic, and Hillary Clinton faced unfair and sexist allegations by people uncomfortable with her success, public support and perception can sometimes be everything.

Lesson #5: The Inclusion of Stakeholders.

In politics there are always outside stakeholders that have an interest in prospective policies and policy decisions. Oftentimes these stakeholders come in the form of large, wealthy interest groups, who are willing to spend enormous sums of money in support of, or against, specific proposals. Stakeholders in health care can include the protected public, physicians, insurance companies, pharmaceutical companies, and groups representing specific factions of the population like the AARP. Having support from various stakeholders can potentially make passing legislation a much easier process,

whereas facing tough opposition results in the opposite effect. It is difficult to please the varying and competing interests, but remaining flexible and willing to compromise is usually the most promising approach. Interest groups have been at the forefront of the health care debate since its inception, and can be attributed as part of the reason Franklin Roosevelt didn't include a national health plan as part of the New Deal. While the country still didn't have a solid health system in place, as many aspects of the current system came into existence later, there were still interests (doctors, etc) that would have been affected by implementing some sort of universal coverage. In developing their respective health care plans both President Clinton and President Obama took significantly different approaches.

Initially, President Clinton and his staff gained endorsements from unlikely supporters, including the American Medical Association and the Chamber of Commerce, who both announced positions in favor of universal coverage. Along with these two groups, who had previously opposed health care reform, Clinton found support with "The American College of Physicians, the pediatricians, neurologists, and family practitioners, as well at the American Nursing Association (Starr 2011)." Having support from the Chamber of Commerce was especially improbable given their representation of many small businesses who might have been affected by Clinton's employer mandate. Although there was strong initial support for Clinton's plan, the support wasn't comprehensive and he was met with fierce opposition from interest groups like the National Federation of Independent Business, and the Health Insurance Association of America. Both made every effort to warn their relevant audiences of the supposed

dangers that President Clinton's health plan, and more specifically the employer mandate, would cause (Starr 2011).

The support for the HSA didn't last long as the Republicans united together to convince the stakeholders involved, primarily the Chamber of Commerce, that their support should be retracted. Within a matter of three days, the majority of the organizations who had previously endorsed Clinton's plan "reversed direction" and withdrew their support (Starr 2011). President Clinton and the White House were unable to convince them that they were willing to compromise on the more controversial aspects of the bill, which resulted in pushing legislation without support from the majority of business groups and organizations. Including stakeholders in the process and giving them a seat at the table would have likely benefited President Clinton in numerous ways, and learning from this mistake, President Obama decided to give that his best shot when it became his turn.

The controversy that the employer mandate generated under President Clinton was similar to the controversy that the individual mandate generated under President Obama. But the individual mandate was a crucial aspect in getting support from the insurance companies. Insurance companies would have found back vehemently against a plan that required them to cover pre-existing conditions without expanding the healthy pool of applicants. The individual mandate fixed this issue and resulted in millions of newly insured patients arriving in the marketplace. The Chamber of Commerce had not changed direction since finally declaring opposition to Clinton's health plan in the 1990s, but the ACA managed to gain support from the American Medical Association and the Pharmaceutical Research and Manufacturers of America (PhRMA) (Oberlander 2010).

Some of the support for the ACA was gained at a specific cost. The exchange for having new patients in the marketplace was rewarded by groups like PhRMA and the American Hospital Association by their agreement to lower Medicare and Medicaid payments (Oberlander 2010).

Another difference between President Obama and President Clinton's efforts was the successful mobilization of pro-reform groups in 2010. While lobbying efforts against the ACA remained fierce, President Obama's ability to mobilize endured. Eventually, various groups expressed their favorability toward the ACA, and endorsed the comprehensive legislation. The support from stakeholders was crucial in the fight against the millions of dollars in attack ads spent by the opposition. Jonathan Oberlander points to costs that the Democrats had to relinquish in their accommodation of stakeholders, saying that it "limited the amount of savings that reformers could obtain from the health care industry, sparing the pharmaceutical industry the prospect of drug reimportation, or negotiated prices from Medicare (Oberlander 2010)." While some of the bargaining decisions made by Democrats proved to be costly, the end result demonstrated their necessity.

Successful reform efforts should find ways to compromise with interest groups without sacrificing the themes central to their legislative endeavor. President Clinton successfully mobilized his opposition, which resulted in insuperable resistance that he was incapable of surmounting. There will always be competing interests in politics, and abdicating core values that are central to specific proposals is not effective, but being flexible and moving toward the center through willingness to bargain can often help circumvent failure. President Obama and pro-health care reformers fought hard to

include interest groups in their negotiations in ways the President Clinton was unable to do, which gave momentum and power to the Democrats in passing the Affordable Care Act.

Summary and Conclusions

Through this paper, I attempted to highlight several political and policy lessons that can be learned from the two most recent efforts at health care reform in the United States. While this set of lessons learned will hopefully prove to be useful for those interested in health care policy, it is by no means a comprehensive list of the differences between President Obama and President Clinton's respective actions, nor does it provide an exhaustive list of reasons as to why passing health care reform in the United States has historically been such a struggle. Various scholars point to other reasons that perhaps have either created the dynamic of struggle, or exacerbated it. Some of these reasons include federalism and America's historical institutional background, as well as the varying makeup and dynamic of Congress.

Issues of cost, quality, and access have plagued the health care system in the U.S. for years, and these specific issues, primarily the issue of access, are what have prompted action over the course of the previous several decades. Costs have risen, and continue to rise, dramatically, as have the numbers making up the uninsured population, and the reports of those feeling disappointed with the quality of services that they receive. Many political scientists and policy analysts have questioned why Franklin Delano Roosevelt didn't include health care reform in the New Deal when problems started to become evident. The same question can be asked regarding subsequent presidents who had either announced support of a national insurance plan, or attempted to draft their own form of legislation, ranging from Lyndon B. Johnson to Richard Nixon. The presence of stakeholders, political and economic conditions, and the dangerous policy trap that was

created alongside Medicare and Medicaid can be pointed to in attempting to reason the lack of universal coverage in the richest and most powerful democracy in the world.

When President Clinton took office he decided that, due to the inevitability of health care reform, he would make it a priority of his policy agenda. However, a range of problems presented themselves and the President was unable to surmount them which resulted in his notorious failure to secure reform, and his successful wife often being forced by the public and Republicans to take a significant amount of the blame. Slowly moving the complex legislation after drafting it under seemingly opaque conditions, coupled with a partisan Republican party and the lack of inclusion of important stakeholders, President Clinton was forced to give up on a plan that he had believed would control costs and cover millions of additional Americans not benefiting from the current system.

President Obama was thoughtful and strategic in his push for health care reform, and proved to learn valuable lessons from Clinton's policy failures. His leadership and willingness to move toward the center built a strong foundation that he would rely on in correcting for President Clinton's prior mistakes. He corrected for these mistakes by giving Congress the responsibility in drafting the legislation, moving quickly, carefully framing how specific provisions of his proposal would be presented to the public, leading the charge alongside his powerful Congressional leadership, and including the groups who had consequential interests hinging on the details of the ACA. The Obama administration didn't execute strategy perfectly from either a political or policy standpoint, but they were met with success in an area that had largely been met with failure during years prior. The two most recent debates over health care reform highlight

the importance of timing, transparency, framing, personality, and stakeholders in making political and policy decisions. These political tools and policy considerations should provide the context for a better understanding of the previous two health care reform efforts in the United States, and should transcend those efforts by giving politicians and policymakers a set of lessons to apply in future legislative endeavors.

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