The Hillarycare Mythology

Did Hillary doom health reform in 1993? It's time to get the facts straight about the Clinton plan and why compromise failed. Here's the real story.

BY PAUL STARR

FIVE DAYS AFTER HIS INAUGURATION IN 1993, BILL Clinton named his wife to chair a newly established President's Task Force on National Health Care Reform. From that moment, the public had the impression that Hillary Clinton and the task force under her direction were responsible for coming up with the administration's reform plan. And when that plan went down to defeat, many people assigned her a large share of the blame.

Now that Hillary Clinton is a candidate for president, the health-reform debacle is again receiving attention, this time as a basis for judging what kind of a president she might be in her own right. The trouble with such judgments, however, is that they are usually rooted in a series of misunderstandings about the Clinton health plan, Hillary's role in the reform effort, and the reasons for its failure. The mythology of "Hillarycare," as the Republicans like to call it, is only partly the result of right-wing misrepresentations of the plan as a "government takeover" and malicious personal attacks on Hillary. The press never got the story right in the first place, and recent biographies and articles about Sen. Clinton have added to the misconceptions.

By the time Hillary became involved in health-care reform in late January 1993, Bill Clinton's thinking about the problem was already well advanced. The previous September during his campaign, he had settled on the basic model for reform—a plan for universal coverage based on consumer choice among competing private health plans, operating under a cap on total spending (an approach known, in the shorthand of health policy, as "managed competition within a budget"). Though the media scarcely registered it at the time, Clinton had described this approach in a speech and referred to it in the presidential debates. Moreover, he saw health-care reform through the prism of economic policy, believed that reducing the long-term growth in health costs was a national imperative, and insisted that even while making coverage universal, health-care reform had to bring down future costs below current projections for both the government and the private economy. Among Clinton's close advisors, Ira Magaziner championed the view that these aims were achievable. When he became the director of the health-reform effort and Hillary the chair, their job was not to choose a policy, but to develop the one that the president had already adopted.

Despite all the attention it received, however, the President's Task Force—consisting of members of the cabinet and several other senior officials—proved to be useless for reaching decisions and drafting the plan. It immediately became the subject of litigation and dissolved at the end of May without making any recommendations. Bill Clinton actually never gave up control of the policy-making process, and the work fell to a small team of advisors and analysts that Magaziner directed. Beginning in March and continuing in a stop-and-go fashion until September, the decision meetings about the plan took place outside the formal structure of the task force, usually in the Roosevelt Room of the White House, and the president ran the meetings himself.

My knowledge of this process is first-hand. Magaziner first brought me into the internal discussions of health policy during the 1992 campaign after reading the manuscript of a book I had written, *The Logic of Health Care Reform* (Grand Rounds Press, 1992), which developed the idea of managed competition within a budget. As a senior White House health-policy advisor working under Magaziner, I took part in the decision meetings and presented some of the issues to the president. The first lady was an active force in these discussions, but there was never any question that the president was in charge. We took our guidance from him. That, of course, was how it should have been (who else but the president ought to make such decisions?), except that many reporters and the public thought that Bill Clinton had handed over the policy to Hillary and that she would report back to him, which was not the case.

Presidents often downplay their own direct involvement in decision making to put some distance between themselves and policies that may eventually prove to be unsuccessful. Part of the job of cabinet members and advisors is to take the blame when things go wrong. Clinton's appointment of his wife to chair the task force did not, however, create the necessary distance and deniability. Not only did the fiction of Hillary's personal responsibility for the health plan fail to protect the president at the time, it has also now come back to haunt her in her own quest for the presidency. According to

Gal With the Plan: Hillary at Johns Hopkins University in Baltimore, October 1993, touting the plan the public assumed was hers.

recurrent accounts—most recently in Carl Bernstein's shoddily researched biography *A Woman in Charge*—it was supposedly Hillary's secretiveness and rigidity that led to fatal decisions about the White House health plan and political strategy. Careful reporting after the failure of the health plan showed these charges were false, but Bernstein and other writers continue to recycle them. Misunderstanding the politics behind the plan, they give a distorted account of why it was defeated. The health-reform debacle was critical in framing Hillary's public image, and despite her years of accomplishment in her own right, she still carries the burdens of that failure. It is time to get the facts right and clear the air for the discussion of health-care reform in what may be another Clinton administration.

ALTHOUGH IN RETROSPECT IT WAS CLEARLY A MISTAKE, BILL CLINTON had good reasons in his first days in office to make comprehensive health-care reform an immediate goal of his presidency and to keep direct control over the reform effort. There appeared to be exceptional political forces aligned in support of reform and strong pressures to move quickly, and these considerations argued for an accelerated timetable. Originally, the president asked for a reform plan to be ready within the first 100 days.

Yet the kind of reform that Clinton believed necessary was alien to the Washington health bureaucracy and unfamiliar to members of his own cabinet. Ironically, the same concern that would motivate so much of the opposition—distrust of the Washington bureaucracy—probably also influenced the president's decisions to locate policy development in the White House and to put his wife and Magaziner, one of his old and trusted friends, in charge. Internal conflicts over the health plan, particularly with top officials at Health and Human Services and the Treasury, would become a consuming preoccupation inside the White House. It was partly these tensions that led to persistent and damaging leaks and the appearance of disarray in the reform effort and to the countervailing efforts to maintain confidentiality and discipline that Hillary's critics have mistakenly attributed to her allegedly controlling and rigid personality.

As 1993 began, there seemed to be a historic opportunity to complete what Democrats had long regarded as the chief unfinished business of the New Deal—national health insurance. Running for a Senate seat in a special election in Pennsylvania in November 1991, Harris Wofford had come from 40 points behind to win an upset victory after making universal health coverage a central issue in his campaign. Health-care costs were increasing at double-digit rates, rising unemployment threatened health insurance coverage for many in the middle class as well as the poor, and companies in manufacturing and other industries with generous health plans for workers and retirees saw themselves at a growing competitive disadvantage. Public opinion surveys showed that by wide majorities, both business executives and the public at large thought that health care needed fundamental reform. After Wofford's victory catapulted health care into the 1992 presidential race, even President George H.W. Bush felt obliged to put forward his own program, albeit a modest one and without any provisions

JOE MARQUETTE / AP IMAGES

for financing it. In a striking departure, both the American Medical Association and the Health Insurance Association of America endorsed a requirement (or "mandate") for employers to provide coverage. Under these circumstances, national health-care reform didn't only seem possible; it had an air of "inevitability," the editor of the AMA's *Journal* wrote in 1991.

But despite these auspicious signs, even Democrats had no positive consensus about what to do. The left wing of the party favored a Canadian-style, single-payer plan, while conservative Democrats favored market-oriented reforms without any commitment to universal coverage or caps on spending. Between these two groups were more centrist liberals, including key Democrats in Congress, who favored an approach called "pay or play" (which would give employers a choice of providing health coverage or paying a tax into a public program). As of early 1992, managed competition within a budget was just beginning to get serious attention. Sen. Bob Kerrey of Nebraska was the first major public figure to introduce a hybrid plan for national health insurance with a unified system of finance and consumer choice among private health plans.

During the 1992 campaign, Clinton had not given health-care reform top billing—his primary issue was the economy, and he probably talked more about welfare reform than about health care. But higher deficit forecasts that fall led him to change his priorities soon after the election. Abandoning his promise of a middle-class tax cut and retrenching on other measures, Clinton opted for deficit reduction in the hope that it would lead to lower interest rates and higher economic growth. The deficit forecasts also highlighted how critical it was to control the cost of health care. If health costs kept gobbling up revenue, they would make long-term deficit reduction impossible and sharply circumscribe what the new administration could accomplish in other areas. Comprehensive health-care reform therefore held more than one attraction. If reform contained health costs, it would contribute to the success of Clinton's economic program. And at a time when he was downgrading other progressive commitments, a high-profile commitment to universal health insurance would bolster his popular support, particularly among Democrats. At one of the Roosevelt Room meetings on the health plan, Clinton remarked that in 1936 the Depression had not ended, but Franklin D. Roosevelt had won reelection because he had passed Social Security and other measures. Perhaps health security could do the same for Clinton in 1996 even if his economic program did not bring results by then. Both health-care reform and the economic programs were gambles, he suggested, but he was comfortable with the odds on both of them, and he could win if either one paid off.

Part of the appeal of the approach to reform that Clinton had adopted in September 1992 was its doubly reinforced method of cost containment. The new framework would create stronger incentives for consumers and health plans to make cost- and quality-conscious choices, but it also had a fail-safe regulatory mechanism.

The basic idea was not complicated. Consumers, not employers, would choose health plans. Firms would pay into a regional health insurance purchasing cooperative (later called an "alliance" in the Clinton plan), which would offer private plans of varying types to all residents under age 65 in an area (Medicare would remain separate). The alliances would be required to offer traditional, fee-for-service insurance as well as health maintenance organizations and preferred provider plans. Benefits, copays, and other features would be standardized so as to make it easier for consumers to compare prices and get the best value for money. Health plans would have to offer coverage to everyone without exclusions of preexisting conditions, and they would be paid according to the characteristics of the population they enrolled. If a plan enrolled a relatively older and sicker population, the money it received from the alliance would be adjusted upward; if it enrolled younger and healthier members, it would get less. Many people misinterpreted "managed competition" to mean "competition among managed care plans." But "managed" as a modifier of "competition" referred to a variety of measures—open enrollment, standardized benefit packages, risk-adjusted payments to plans, independent assessment of the quality of care—intended to stop insurers from trying to cherry-pick healthy subscribers and to get them to focus instead on providing higher-quality service at lower cost.

Sales Pitcher: Talking it up in Deerfield Beach, Fla., as interested party listens.

DENNIS COOK / AP IMAGES

The early versions of the model keyed employer contributions to a percentage of the low-cost plan, with individuals paying the additional amount for all other plans. The Clinton plan eventually called for employer contributions to cover 80 percent of the *average* premium in an alliance (though small employers would have had their obligations capped as a percentage of payroll, with the remainder made up by public subsidies). In other words, no matter what your employer paid, 80 percent of the average premium would be covered, and you'd have to pay out of pocket, dollar for dollar, any additional premium above that level.

Advocates of "pure" managed competition were confident that incentives of this kind would be sufficient to generate price competition among plans and thereby contain costs. But because the evidence on that question was ambiguous (and

many areas of the country were unlikely to have competing integrated delivery systems), the Clinton model also called for back-up regulatory controls limiting the rate of growth of the average premium in an alliance.

The general idea here was to create a workable compromise between market and regulatory approaches that could attract support from conservatives and liberals and thereby overcome the divisions that stood in the way of change. The plan would preserve a private system and expand consumer choice (under existing arrangements, even most insured employees have no choice at all about the plan their employer gives them), and it would provide broad coverage to all Americans, with strong measures to keep the costs affordable.

But the synthesis was also doubly heretical. Any reliance on private health insurance was heresy to many on the left and some in the Democratic health-policy establishment. And any regulation of health insurance rates was heresy to advocates of managed competition. In addition, Robert Rubin and other economic advisors to the president, though not wholly opposed to reform, were skeptical that any program with a broad benefit package could control costs. Even before selling his plan to Congress and the public, therefore, Clinton had to get the rest of his own government behind it.

Hillary's appointment underscored the president's personal commitment. Although she made no claim to being a health-policy expert, she had successfully led a similar effort to develop educational policy in Arkansas, and her gifts complemented Magaziner's. Besides her quick intelligence, she had the personal tact and ease in communicating with the public that would make her an ideal ambassador for the initiative, while he had organizational skills, command of detail, and imaginative boldness necessary for mastering an ambitious and complex reform.

Hillary had not been present at key meetings during the 1992 campaign when Bill had discussed health policy with his advisors.

The overall direction of policy was not Hillary's choice. She had not been present at the key meetings during the campaign when Clinton had discussed health policy with his advisors, and in the first days in the White House, she was just familiarizing herself with the approach to reform that her husband had adopted. In a meeting with me in her office during the administration's second week, she spoke of "my husband's plan" and thanked me for an article of mine, which she said was helpful in explaining the approach. Whether she fully agreed with that approach, I wasn't sure. But if she had her reservations, she put them aside and, believing strongly in the aims of reform, worked hard to achieve them. The model for reform, after all, only defined its broad outlines; literally hundreds of important questions about the policy still had to be resolved in turning it into legislation.

But the troubles of the President's Task Force began immediately. Before making the announcement, the White House had not thought to check with legal counsel about the implications of formally designating a "task force," and soon it was facing lawsuits challenging the first lady's role and demanding that the meetings be public. Under the task force, Magaziner organized some 30 "working groups" concerned with such issues as the design of the purchasing alliances and with the analysis of the plan from different angles, including costs and ethics. (I helped set up these groups and was responsible for running a "cluster" of three of them.) The membership of the working groups quickly rose to more than 500—mostly federal employees, many of them added at the request of their departments, as well as some independent experts, congressional staff (Democrats only), and state health-care officials (Republican as well as Democrat). Their meetings were intense but short-lived—they dispersed early in the spring, before the plan was written. We also conducted hundreds of meetings with representatives of different organizations that wanted to communicate their views to the White House.

This was the "secretive" process that critics of Hillary have in mind when they attack her. Compared to policy development in other administrations, it was exceptionally open and inclusive, but those very efforts to bring people in excited objections that the White House wasn't open and inclusive enough. In setting up the working groups (which were only supposed to develop preliminary options and information, not to conduct negotiations), the White House left out representatives of interest groups. It also did not invite the press to sit in on the discussions, again because they were preliminary. The interest groups and the media then created the storm of indignation that the process was secret. The real mistake was creating the task force and working groups in the first place and putting them in the vortex of publicity that Hillary's appointment guaranteed. Normally, presidents consult advisors in private without incurring any criticism. No one would have complained about secrecy if the White House had simply done business the usual way—entirely behind closed doors, without any formal external participation.

Not that what anyone wrote or said remained confidential. Some members of the working groups were only too happy to give the media copies of internal memos that they had written or received, leading to stories that typically began, "The White House is considering a proposal to ..."—when, in fact, the proposal was not receiving any serious attention, which may be why its authors leaked it.

The most damaging leaks came from high in the administration. On May 3, 1993, *The New York Times* ran a front-page story headlined "Health-Care Costs May Be Increased $100 Billion a Year." Magaziner had given a few senior administration officials a series of three charts with cost estimates. The first showed the *gross* costs of three different options, with the highest costing $100 billion; the second showed the *savings*

under each of the three options; and the third showed the *net* cost. Only the first chart was leaked—and with words blanked out that would have clearly shown that the numbers were gross costs before savings.

Leaks of this kind threatened congressional passage of the president's budget and were one of the reasons for delaying final decisions about the health plan in the White House. Critics of "Hillary's task force" say it became so bogged down by its size that it couldn't meet its deadlines, but the delay had other origins. The impetus to move quickly came partly from the hope that the plan could be incorporated into the budget reconciliation bill, which under Senate rules can pass with a bare majority, not the 60 votes otherwise necessary to shut off debate. But when Sen. Robert Byrd, the guardian of Senate rules, said that the health plan couldn't go into the budget bill, there was no choice but to delay submission of health legislation until after the budget passed. And that turned out to take longer than anyone expected. The budget was finally adopted on Aug. 6 without a single Republican vote, passing in the Senate only because of Vice President Al Gore's tie-breaker. The president addressed Congress about the health plan the next month.

The most damaging leaks came from high in the administration and they threatened passage of the president's budget.

Clinton later told journalists David Broder and Haynes Johnson that when Sen. Byrd declared health reform couldn't go into the budget, he should have realized that it would be impossible to pass the full health plan that year. "This is entirely my mistake, no one else's," Clinton said, conceding that he should have scaled back the proposal. "I set the Congress up for failure."

The budget battle prejudiced the outcome on health-care reform in other ways, too. The health legislation would now go to Congress *after* the president had asked members of his party to cast difficult votes for tax increases, budget cuts, gun control, and other measures that many of them knew might doom their reelection chances. Once Democrats voted for one set of tax increases, persuading them to vote for an employer mandate or any other method of financing expanded health coverage was going to be difficult, if not impossible.

So why not compromise? In fact, the Clinton health plan began with a compromise, and the expectation in the White House was that it could be passed only with more compromises. When he made managed competition part of his plan in the fall of 1992, Clinton was moving toward the center right and laying the basis for a future deal with the conservative Democrats and moderate Republicans who also backed managed-competition proposals. Between January and October 1993, however, other political considerations led Clinton to tack left. Rejecting the view of his economic advisors who favored a bare-bones benefit package, he opted for broad coverage, and he also decided to include a new Medicare prescription drug benefit for the elderly, which he had promised during his campaign. The bigger the program, the tighter the cost controls would also have to be.

As I explained in these pages after the health plan failed ["What Happened to Health Care Reform?" Winter, 1995], the argument in the White House for this "bigger, tighter program" rested on two theories. The "enthusiasm theory," as I called it, held that because there would be fierce opponents of reform, we needed equally passionate supporters. We had to give them something worth fighting for, but there would have been no popular support for a bare-bones benefit package. Likewise, we would have lost the elderly if the president defaulted on his promise of prescription drug coverage. The second theory, which I called the "bargaining chip" or "onion" theory (phrases taken from strategy sessions at the White House), held that the administration should go to Congress with a big program intentionally including elements that could be bargained away later: "Some benefits could be cut, the caps relaxed, the alliances scaled back or sacrificed entirely. Layers of the onion could be peeled off, but we would still retain the core of the program." Because only a deal with conservative Democrats and moderate Republicans could provide the votes, it was just a question of when that move back toward the center right would take place. But besides hoping to generate public enthusiasm, the White House also deferred to congressional Democrats who cautioned against making premature concessions and claimed they could best negotiate the final deal themselves.

This strategy did not reflect an unthinking, blind rigidity on the part of the Clintons. It just didn't work—in fact, it failed disastrously. When the debate began, it was reasonable to expect a negotiated deal in Congress; Republicans had introduced their own proposals for health-care reform, and a group around Sen. John Chafee of Rhode Island seemed amenable to compromise. But the whole political climate became toxic; Clinton could not get a single Republican vote for his 1993 budget, and Whitewater broke at the beginning of 1994. All the elements of the conservative coalition, from the anti-taxers to the social conservatives, mobilized against the Clinton health plan and against the Clintons personally, while liberals were ambivalent and Democrats in Congress were divided. Newt Gingrich, Grover Norquist, Bill Kristol, and other figures in the conservative movement saw health reform as an ideological threat because if it succeeded, it might renew New Deal beliefs in the efficacy of government, whereas a defeat of the health plan could set liberalism back for years. Tom DeLay pressed business organizations such as the U.S. Chambers of Commerce, which had been edging toward a deal, to reverse course. Soon Republicans were backpedaling from their own health-reform proposals. The Republican Senate minority leader, Bob Dole, withdrew his first bill and substituted a more limited one and then withdrew that one, too. It was not just the Clinton plan that was stymied; every effort in Congress

to find a compromise failed. While George Mitchell, the Senate majority leader, was drawing up a compromise plan in the summer of 1994, Kristol wrote a memo to Republicans advising, "Sight unseen reject it." Near the end, Sen. Bob Packwood told his Republican colleagues that after killing health-care reform, they had to make sure their fingerprints weren't on the corpse. As I wrote in my postmortem in these pages, "The Republicans enjoyed a double triumph, killing reform and then watching jurors find the president guilty. It was the political equivalent of the perfect crime."

DURING THE BATTLE OVER THE CLINTON PLAN, conservative talk radio hosts and insurance-industry advertising on television conjured up lurid fears that the federal government would control every detail of medical care. But it wasn't only the right-wing noise machine that stirred up panic with outright fabrications. *The New Republic* carried an article that charged the Clinton bill would "prevent you from going outside the system to buy basic health coverage you think is better. The doctor can be paid only by the plan, not by you." In fact, one of the first provisions of the bill stated: "Nothing in this Act shall be construed as prohibiting the following: (1) An individual from purchasing any health care services."

In a January 1995 *Atlantic* article, "A Tide of Misinformation," James Fallows patiently went through the whole catalog of distortions about the Clinton health plan—that it had been "hatched in secret," got bogged down and delivered too late, constituted a government takeover of health care when the problem was "solving itself," and was developed and presented in so politically naive and doctrinaire a way that the administration missed the chance for bipartisan compromise. But, Fallows notwithstanding, the Hillarycare myths live on even in the same magazine. In an article last year, *The Atlantic*'s Joshua Green repeated many of the old canards about the task force and Hillary that Fallows had shown were wrong.

Like Green's article, Carl Bernstein's biography argues that Hillary doomed the health plan because of her secretiveness and rigidity. Bernstein, who can't get the basic facts right, supposes that Hillary was entirely in control. He writes that "by the time Hillary had begun consulting with experts, she already knew where she wanted to go" (as if her husband had not earlier made that decision); that the plan would have replaced Medicare; and that Hillary's "message was unambiguous: she did not want negotiations that would end in compromise" and she "rejected [Bill's] attempts at getting her to compromise." In fact, Bill Clinton made the very decisions about the health plan that Bernstein attributes to Hillary. He chose to submit an ambitious program to Congress rather than a more limited one, hoping to make compromises later. There were repeated approaches to the Republicans, but as Hillary told Fallows, "Every time we moved toward them, they would move away." As time was running out, in September 1994, Hillary did have her reservations when the president gave his approval to Sen. John Breaux of Louisiana to make one concession after another to get Republican support, but it turned out she was right. The Republicans were the ones who for political reasons did not want negotiations to end in compromise. And that gamble paid off for them in the 1994 elections.

THIRTEEN YEARS LATER, THE PROBLEM HAS NOT SOLVED ITSELF. Health-care costs have continued to race upward. From 2000 to 2006, premiums for family health coverage increased 87 percent, four times faster than general inflation and wages. The number of uninsured hit a record high last year, at 47 million Americans. And health-care reform is back in the center of national debate.

Curiously, some liberals now hold the failure of the reform effort in 1993–1994 against Sen. Clinton, arguing that in reaction to that debacle she has become all too flexible—too accommodating to the health-care industry and gun-shy about fighting for universal health care. This year she is giving three speeches about health-care reform, dealing successively with quality of care, cost containment, and universal coverage. (As of press time, she was about to give the last of these; a separate analysis will appear online at www.prospect.org. I haven't spoken with her since she was elected to the Senate and have no involvement in her campaign.) The general tenor of her rhetoric is consensus-oriented—and necessarily so, given the highly polarized public perceptions of her history on the issue. Surely one political lesson from the earlier struggle is to frame a proposal that creates the broadest possible support for reform and splits the opposition.

In health care and other areas of domestic policy, what Hillary Clinton might accomplish as president will depend on whether Democrats can increase their slim majorities in Congress. More than any other candidate, she has to set achievable goals in health care—and, if elected, achieve them. As a practical matter, the scale of the first steps in health-care reform should probably be calibrated to fit into a budget reconciliation bill. But those first steps need not be insignificant. Clinton's 1993 budget quietly included an expanded earned-income tax credit that represented the biggest anti-poverty measure since the 1960s. A 2009 (Hillary) Clinton budget that turned the State Children's Health Insurance Program into the foundation of universal health coverage for children would be a victory of no small measure. And, yes, as Republicans fear, it just might give Americans confidence that their government could guarantee health care for all.

More than any other candidate, Hillary Clinton has to set achievable goals in health care—and, if elected, achieve them.

I'm confident of one thing. The first time around, Hillary took the blame for her husband's plan. As president, she'd be making the decisions herself. **TAP**