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Understanding the Failure of Universal Healthcare Proposals in the U.S. and Paths Forward

An Honors College Project Presented to

the Faculty of the Undergraduate

College of Arts and Letters

James Madison University

by Nicholas James Telesco

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Accepted by the faculty of the Department of Political Science, James Madison University, in partial fulfillment of the requirements for the Honors College.

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# Acknowledgements

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# Abstract

Unlike most developed countries, the U.S. does not have a form of universal healthcare, where the government provides insurance for all citizens, despite attempts dating back to 1915. The Patient Protection and Affordable Care Act (ACA), passed in 2010 by President Obama, was a significant expansion of government power in healthcare policy, yet did not guarantee universal insurance. In recent years, universal healthcare proposals have gained traction as the U.S. healthcare system faces issues of low access, high cost, and mediocre quality. In this thesis, I intended to discover the factors that influenced the passage of past U.S. healthcare reforms and potential paths forward.

I applied Kingdon's multiple streams approach, which addresses the factors in the policymaking process that influences a bill's passage, to the ACA and the Health Security Act, which was a universal healthcare proposal by President Clinton. The ACA was able to achieve passage because of its incremental approach and Obama's presidential strategy, which included delegating the creation of the legislation to Congress, negotiating with organized forces, and maximizing his political capital. Kingdon's multiple streams approach highlights the difficulty Medicare for All advocates will have in gaining passage, especially due to insufficient support among the policy community and political actors. In the short-term, advocates should pursue other policies, such as a public option or Continuous Autoenrollment with Retroactive Enforcement (CARE), that can contain costs and expand coverage.

# Introduction

Debates regarding universal healthcare in the U.S., a policy that would guarantee health insurance for all individuals, have occurred since the early twentieth century. The American Association of Labor Legislation (AALL) sponsored a bill in 1915 that would not establish universal healthcare, but would provide insurance for working class families and those with salaries less than $1200 a year and would be the first national compulsory health plan in the U.S. The bill was modeled off of similar programs that had been implemented in European countries since 1883. The proposal, however, faced strong opposition from the American Federation of Labor, state medical societies, and the private insurance industry. The American Federation of Labor opposed compulsory health insurance and believed public insurance programs would weaken unions by undermining their ability to provide benefits to members, while state medical societies opposed the bill because of disagreements over payments to physicians. Private insurance in the early twentieth century existed to provide benefits upon death, such as by covering funeral expenses. Since the bill provided death benefits, the private insurance industry opposed the bill as it would have negatively impacted their multi-million-dollar industry. Their opposition convinced the American Medical Association, which had formed a committee to work with the AALL on a compulsory health insurance program, to oppose the bill and even deny they had ever supported it. Once the U.S. entered World War I, it was attacked as "German socialist insurance." Universal healthcare was not seriously debated again until the 1930s due to the widespread opposition from significant stakeholders and interest groups (Physicians for a National Health Program).

Universal healthcare has entered, left, and reentered the health policy debate every few decades since its first defeat. Currently, the U.S. healthcare system is fragmented and divided

with both public and private forms of insurance. In 2018, 67.3% of Americans received coverage through a private insurer, with 55.1% of all Americans receiving coverage through their employer. Roughly a third of all Americans, 34.4%, receive coverage through a public plan, such as Medicare or Medicaid. This, however, leaves 8.5% of the population uninsured as they do not have enough money to purchase insurance but they make too much money to qualify for government health programs (Berchick, Barnett, and Upton 2019). Medicare and Medicaid are the two largest public insurance programs in the U.S. as they provide insurance to Americans older than 65 and low-income individuals, respectively. The two programs were passed in 1965 by President Johnson as part of his War on Poverty program, which highlights the relationship between economic status and health insurance (Kaiser Family Foundation).

While universal healthcare continued to be debated following the passage of Medicare and Medicaid, significant healthcare reform would not be achieved until the Patient Protection and Affordable Care Act (ACA) was enacted during President Obama's first term in 2010. The ACA was intended to create "shared responsibility" between the government, employers, and individuals to provide access to health insurance (The Commonwealth Fund). The ACA attempted to achieve this through several policies that aimed to expand access, increase consumer protections, and contain costs (King 2011). The ACA expanded access to insurance through both private insurance and public programs. Since a majority of Americans receive insurance through their employer, the ACA required businesses with over fifty individuals to provide insurance and offered tax incentives to small businesses who provided insurance. The ACA not only mandated businesses to provide insurance but required individuals to purchase insurance or pay a fine. Individuals were also given the opportunity to purchase insurance through the American Health Benefit Exchanges and Small Business Health Options Program

(SHOP). These were created to help individuals and small businesses purchase health insurance and gave states the option to either operate the exchange themselves or allow the federal government to operate it (The Kaiser Family Foundation 2013). Individuals who enrolled in the exchanges were given subsidies according to their income levels to reduce the costs of premiums, or the monthly costs of insurance (King 2011). One of the most significant ways in which the ACA increased access to healthcare is by expanding Medicaid. Medicaid was expanded to cover children, pregnant women, parents, and childless adults with incomes up to 138% of the federal poverty level (FPL). The federal government would finance the entire cost of the Medicaid expansion until 2020 when costs would slowly be shifted back to the states. However, the mandatory Medicaid expansion was ruled unconstitutional because if states did not expand Medicaid, they would lose all federal funds for their Medicaid program and the Supreme Court ruled this amounted to coercion by the federal government, resulting in the expansion becoming optional (Rosenbaum and Westmoreland 2012). As of April 2020, thirty-seven states, including DC, have expanded Medicaid, while fourteen states have not (The Kaiser Family Foundation 2020).

The ACA also included major provisions to protect consumers, particularly those with pre-existing conditions, in terms of cost and access. One of the most important protections the ACA added was prohibiting insurance companies from refusing to cover or increasing premiums because of someone's health status. This provision allowed individuals with pre-existing conditions to receive the same insurance as everyone else (King 2011). Likewise, the ACA prohibited insurance companies from placing lifetime and annual monetary caps, typically ranging from $1 to $2 million on individuals. Insurance companies that placed a $2 million lifetime cap would not pay for any additional medical care after they paid $2 million over an

individual's life. Prohibiting this has helped many Americans with pre-existing conditions, such as premature births, afford necessary treatment (Kliff 2017). Insurance companies both inside and outside the exchanges established by the ACA had to offer an essential benefits package, which is a comprehensive set of services that must be covered. This helped ensure that all individuals with insurance have access to the same set of essential medical care (Kaiser Family Foundation 2013).

It is imperative to understand the ACA because it utilized the fragmented public-private hybrid insurance system the U.S. has and expanded it. Current healthcare reform proposals have again called for an overhaul of the public-private system to expand public insurance. While Democrats have continued to debate whether incremental or more progressive approaches to expand healthcare are the best policy option, healthcare expansion did take center stage during the 2020 Democratic presidential primaries. Sen. Bernie Sanders (I-VT), who was a leading contender for the 2020 Democratic presidential nomination, introduced the Medicare for All Act of 2019, which would enroll all Americans into a health insurance plan administered by the government (S.1129). Another bill, introduced by Rep. Jayapal (D-WA-7) in the House, is nearly identical to the bill introduced by Sanders in the Senate (The Kaiser Family Foundation 2019). While there are other advocates of universal healthcare, Sen. Sanders has emerged as one of the leaders due to the legislative lead he has taken and his role in the 2016 and 2020 Democratic presidential primaries.

Considering that Medicare for All has emerged as a policy option, it is of vital importance to ask the following question, "What factors influence the passage of past healthcare reform in the U.S. and how will these factors impact the passage of future reform?" Scholars have conducted a significant amount of research in regard to various facets of the U.S. healthcare

system. Previous literature has detailed the problems of the U.S. healthcare system, comparisons between the U.S. and other wealthy countries, and historical attempts to enact universal health insurance. By analyzing others' research on all three of the aforementioned topics and conducting my own qualitative research, I plan on discovering the potential paths policy actors could use to enact the preferable form of universal health insurance. I begin this paper by reviewing the major problems associated with the issues of cost, access, and quality in U.S. healthcare along with examining international forms of health insurance as a comparison to the U.S. model and conducting a literature review on failed universal healthcare policies. I then examine previous failed attempts at universal health insurance in the U.S. by utilizing Kingdon's multiple streams approach framework. This approach is ideal because it addresses the policymaking process and the factors that can aid or impede the passage of a policy. I will apply his framework to President Clinton's failed Health Security Act and the Affordable Care Act in order to demonstrate the applicability of the streams approach to health policy. Lastly, I will apply this framework to the Medicare for All Act, which will highlight a potential path forward for its passage and examine its impacts.

# Chapter 1: Overview of U.S. Healthcare System and Literature Review

This literature review seeks to examine and define the problems in the U.S. healthcare system. By defining these problems, I will then be able to examine why the U.S. needs to move towards adopting a system of universal health insurance, followed by a discussion of existing literature regarding the political and theoretical explanations for universal healthcare failure.

## Issues with Cost, Access, and Quality

An extensive amount of academic and government research has focused on the most fundamental measures of a country's healthcare system-- cost, access, and quality. One of the most significant barriers in America's healthcare system is its cost. The U.S. spent $3.6 trillion in health-related expenditures in 2018, with per capita spending exceeding $11,100; overall spending accounted for 17.7% of America's gross domestic product (GDP). This represented an increase of 4.6% from 2017, as seen in the figure below (Centers for Medicare and Medicaid Services 2019).

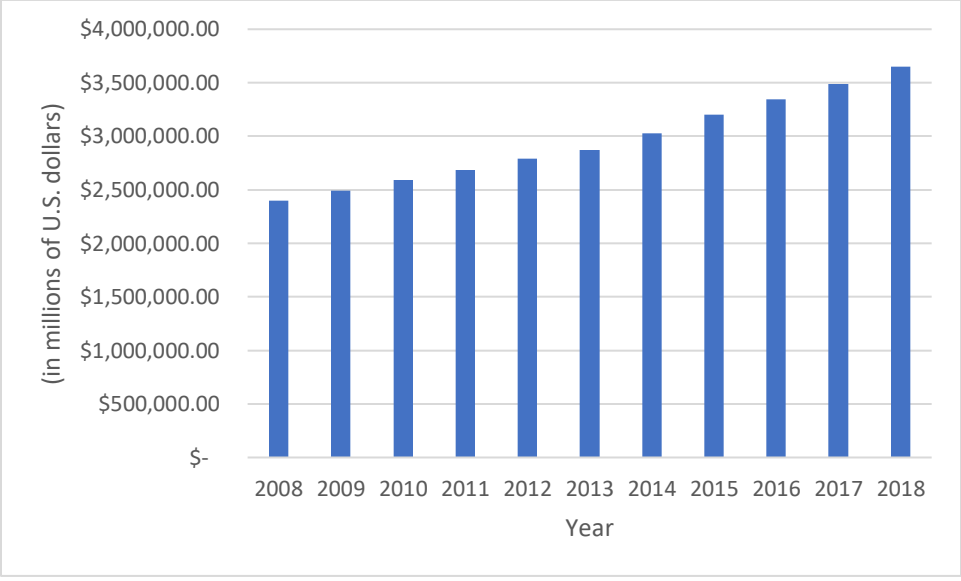


***Figure 1*** *This figure details the growth of national health expenditures, in millions, over the past decade (OECD 2017).*

Spending on hospital care and physician and clinical services, which accounted for 53% of all expenditures, continued to grow in 2018. The federal government and households were the largest spenders as they were each responsible for 28% of all healthcare spending. Private businesses accounted for an additional 20% of all expenditures, followed by state and local governments at 17% and other private sources at 7% (Centers for Medicare and Medicaid Services 2019). These costs are troubling when examining the long-term trend as healthcare expenditures increased every year from 1980, when annual expenditures were $235.7 billion, to 2014, when they were over $3 trillion (Manchikanti, Helm II, Benyamin, and Hirsch 2017). The staggering costs of U.S. healthcare become even more apparent when compared to other industrialized Western countries. The U.S. spent nearly two-and-a-half times more than the average spending for the next 35 OECD countries. Further, the U.S. spent roughly 80% more than Germany and nearly twice as much per capita as Canada, France, and Japan (OECD 2017).

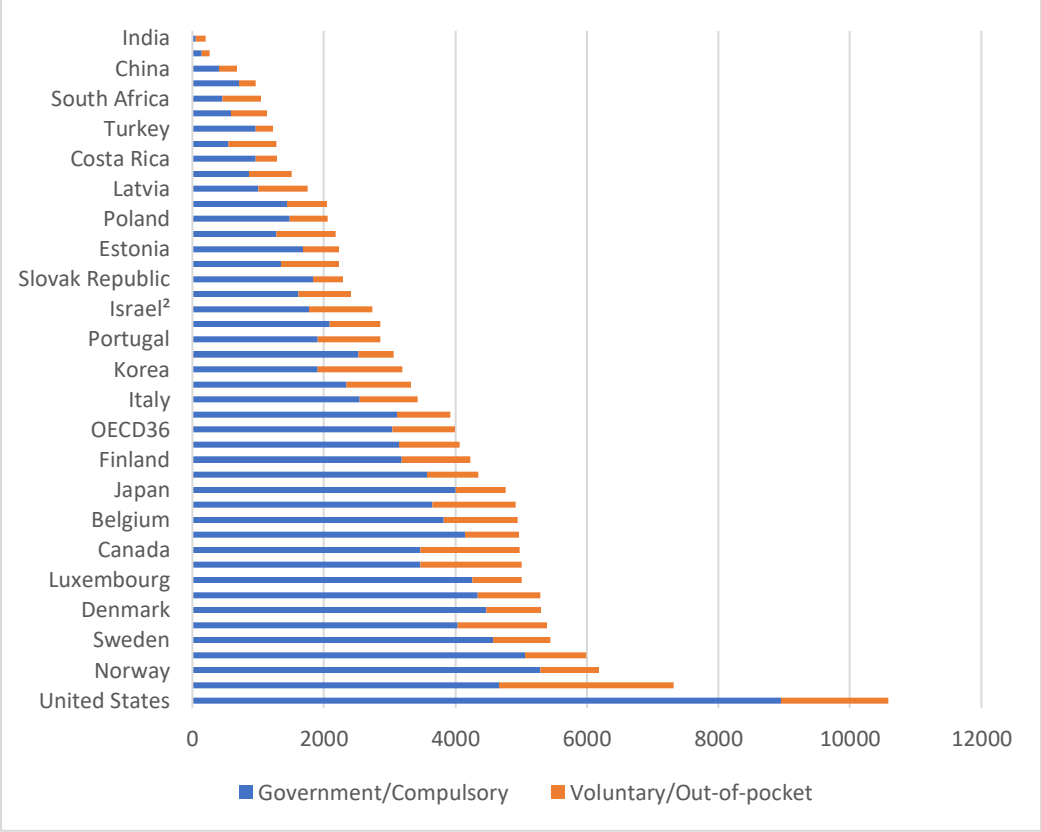

***Figure 2*** *U.S. per capita spending in 2016 was more than double the OECD average (OECD 2017).*

Further, America's healthcare spending accounts for a considerably larger share of its GDP than the OECD average, which is only 9% (OECD 2017). These issues of cost are exacerbated because 5% of the population is responsible for 50% of health expenditures. Collectively, the top 50% of Americans account for 97% of expenditures, compared to the bottom 50% that account for 3% of spending (Sawyer and Claxton 2019). The distribution of expenditures across the population is of importance because it highlights how the elderly and those with chronic conditions face unique health challenges that require increased care.

Issues of exorbitant cost are directly tied to access to healthcare. In 2010, as the ACA took effect, nearly 46.5 million Americans were uninsured, representing 17.8% of the population. By 2016 that had declined to 26.7 million Americans, which increased to 27.9 million in 2018, or 10.9% of the population, with 45% reporting they lacked insurance because the cost was too high (Tolbert, Orgera, Singer, and Damico 2019). While the passage of the Affordable Care Act (ACA) helped reduce the uninsured population, it has since increased.

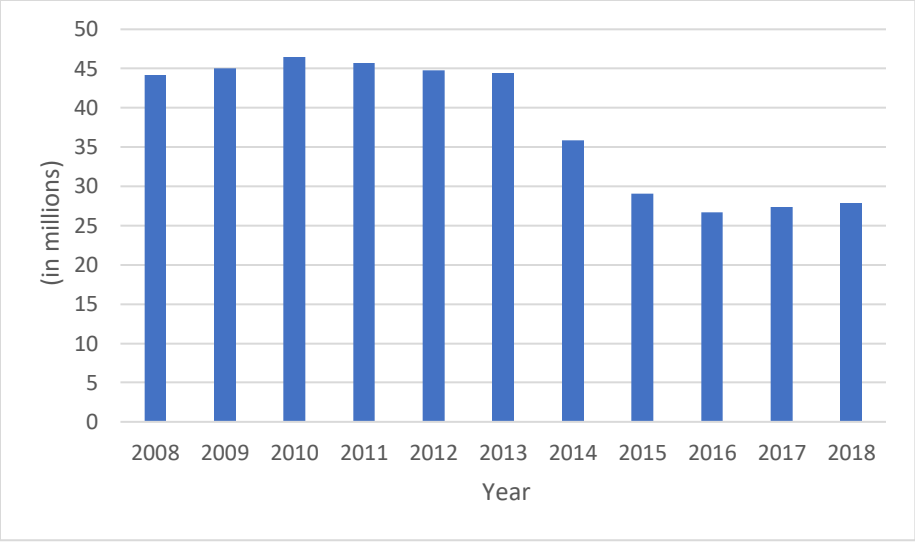


***Figure 3*** *The uninsured population decreased after the ACA took effect but has increased following changes by the Trump administration (Tolbert, Orgera, Singer and Damico 2019).*

Between 2013 and 2016, nonelderly adult Hispanics, African Americans, and Asians experienced at least an 8% drop in the uninsured rate, while those with an income below 200% of the FPL saw a 21% decline. While the uninsured rate has dropped among African Americans and Hispanics, to 11% and 19% respectively, it is consistently higher than white Americans, and rates for all three grew slightly in 2018 (Garfield, Orgera and Damico 2019; Tolbert, Orgera, Singer, and Damico 2019). The ACA played a key role in reducing the uninsured rate, but with over 27 million Americans still uninsured, there is significant room for improvement as nearly 45% of the uninsured are ineligible for financial assistance. The factors of race and income are highly interconnected because most uninsured individuals were low-income and more likely to be non-white (Garfield, Orgera, and Damico 2019). Access to healthcare in the U.S. becomes even worse when compared to other countries.

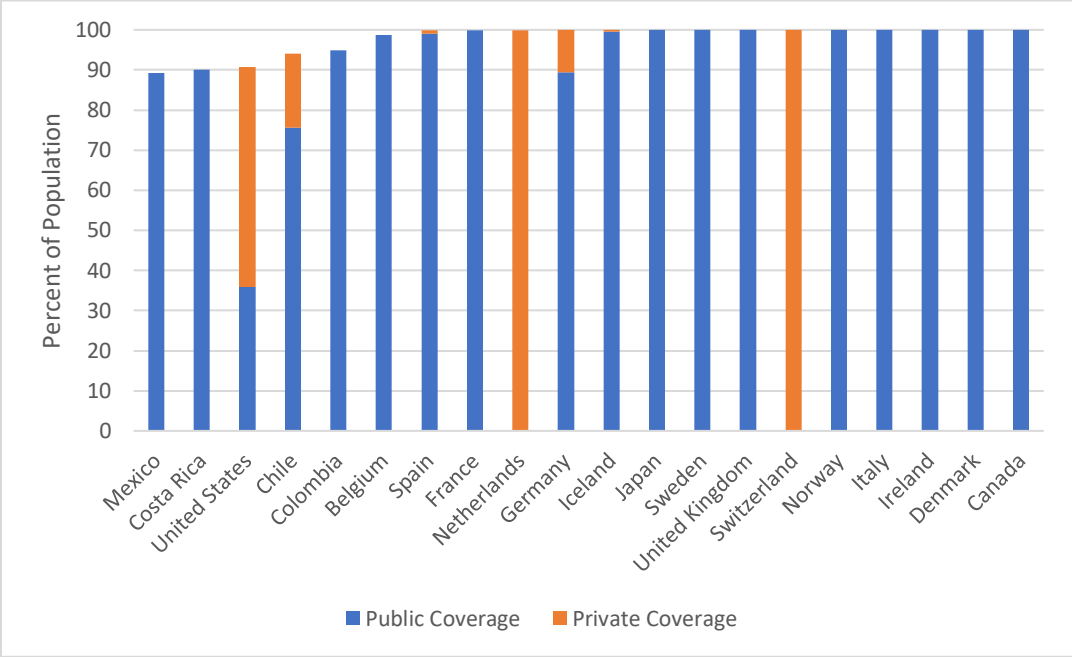


***Figure 4*** *The U.S. has the third lowest insurance rate and is the only country where a majority of individuals received private insurance yet not everyone had access to insurance (OECD 2017).*

The Commonwealth Fund elaborates on the connection between cost and access as they discovered 33% of Americans experienced cost-related problems to access. Even though most

Americans were able to receive the healthcare they need, "a substantial portion of the population-- about one in every ten adults (9%) said they either delayed or did not receive medical care due to cost in 2017" (Claxton, Sawyer, and Cox 2019). These two issues, insurance affordability and access to health care services, are "closely intertwined issues" (Manchikanti, Helm II, Benyamin, and Hirsch 2017, 112). Considering the burden healthcare payments rests on individuals, the leading cause of bankruptcy in the U.S. is catastrophic healthcare costs. Any family or individual that struggles with expensive out-of-pocket payments is increasingly more likely to accumulate debt or face bankruptcy (Jacobs and Skocpol 2010). Increasing out-of-pocket costs further complicate issues of access. The average annual premium for family coverage in 2018 was $19,616, a 20% increase from five years ago. Deductibles, the annual amount an individual must pay out-of-pocket before insurance pays for services, doubled between 2007 and 2018 (Claxton, Rae, Long, Damico, and Whitmore 2018).

Access to healthcare includes more than simply insurance as nearly 16 million insured Americans were technically underinsured or lacked coverage for catastrophic medical expenses in 2010 (Jacobs and Skocpol 2010). Individuals who are underinsured have high deductibles or out-of-pocket expenses compared to their incomes, which makes them more likely to be unable to pay medical bills and skip care because of cost. In 2018, 29% of individuals who had insurance were classified as underinsured, a 6% increase from 2014 (Collins, Bhupal, and Doty 2019). Access also includes unmet medical needs. According to the OECD (2017), 22.3% of Americans purposefully missed a consultation due to the financial cost. Unmet medical needs were particularly excessive among low-income Americans, with 43% reported experiencing an unmet medical need (OECD 2017). This subgroup maintains increasingly high rates of unmet medical needs because "inequalities in employee access to health insurance have become

steadily worse-- and the situation for low-paid workers is scandalously bad" (Jacobs and Skocpol 2010, 20). A distinct trend between earnings and access to employer-provided insurance exists as 37.4% of workers in the bottom fifth of the wage distribution lack insurance, compared to 12.4% of workers in the middle fifth. While both represent high uninsured rates, and are noticeably higher from rates in the 1980s, low-income Americans are at a significant disadvantage (Jacobs and Skocpol 2010). Before the ACA took effect, nearly half of poor Americans were ineligible for coverage under Medicaid and a total of 30% of the poor or near poor under 65 lacked any form of insurance (Rice et al. 2018). One of the most significant provisions of the ACA was the Medicaid expansion, which extended eligibility to individuals within 138% of the FPL. However, not all states have expanded Medicaid, with fourteen states opting not to, excluding 4.4 million Americans from the Medicaid program (The Kaiser Family Foundation 2020). Achieving access is one of the most fundamental aspects of any country's healthcare system as it "provides a critical entry into the healthcare system through access to primary care, preventive services, and referrals to specialists" (Rice et al. 2013, 326). For those who lack insurance, it becomes increasingly challenging to enter the healthcare system as 42% of uninsured Americans were unable to obtain preventive care. The Commonwealth Fund ranked the U.S. eleventh out of the eleven healthcare systems they evaluated because of extremely inadequate access (Schneider et al 2017).

In regard to healthcare quality and outcomes, the U.S. did perform noticeably better. Schneider at al. (2017) ranked the U.S. as fifth out of the eleven healthcare systems examined. America performed well in domains including the doctor-patient relationship, chronic disease management, and shared decision-making with primary care and specialist providers. The U.S. also had lower cancer mortality rates than any other comparable countries. However, the U.S. did

not perform as well in areas involving life expectancy and infant mortality rates, two of the most important indicators of the quality of a country's healthcare system, despite outspending other countries. Outcomes in both measures for the U.S. were lower than the OECD average. One of the most significant measures in which the U.S. underperformed was hospital admissions for preventable diseases (Schneider et al. 2017). The U.S. had higher rates of hospital admissions for congestive heart failure, asthma, and diabetes. This is notable as higher rates of hospital admission are a sign that "prevention services are either not being adhered to or delivered" (Sawyer and McDermott 2019). This is connected to the issues of cost and access as uninsured individuals are "more likely to skip preventative services and report that they do not have a regular source of care" (Garfield, Orgera, and Damico 2019). Nearly 16% of adults utilized the ER for non-emergent care for conditions a physician could have treated. American adults do this roughly twice as much as other countries. The U.S. additionally has a higher amenable mortality rate, which is the measure of preventable deaths if individuals received timely and effective care. The barriers of cost and access are affecting the quality of care individuals receive as 50% of uninsured individuals lack a regular source of care, which means when they do need care, they are forced into utilizing inpatient facilities like a hospital (Schneider et al. 2017). Thus, access to care matters not just for financial or equality reasons, but, more importantly, for health reasons.

Patients in the U.S. were also more likely to experience a medical, medication, or laboratory error compared to other countries (Sawyer and McDermott 2019). These negative outcomes further worsen the economic costs of the U.S. healthcare system. Frenk and Ferranti (2012) note this results in "diminished productivity, higher costs in the future, and disrupted families and communities" (863). U.S. healthcare quality has continued improving, but not at a fast-enough rate. Even Americans who can even afford health insurance are continuing to pay

more for worse healthcare, meaning "we cannot justify our broken-down patchwork system by saying it delivers better health results" (Jacobs and Skocpol 2010, 23).

## Universal Health Insurance Around the World

While every healthcare system has its own policy issues, the U.S. suffers from more severe and deeply embedded issues than other countries. The U.S. performs extremely poorly across all measures compared to countries that provide universal healthcare. Beland, Rocco, and Waddan (2016) argue there is widespread agreement that the U.S. healthcare system needs reform, but disagreements exist on how to best accomplish it. I argue universal healthcare is the best approach because it "provides financial protection against the cost of illness and promotes access to care for the whole population" (OECD 2017, 18). As a result of America's reliance on a hybrid private-public healthcare system, millions lack access to insurance, which is striking when "all other industrial nations provide their entire populations with health coverage." (Jacobs and Skocpol 2010, 22) Universal coverage would not only expand access but can decrease the augmenting healthcare costs the United States has experienced since the 1980s. Over the past few decades, countries that have implemented universal health coverage experience lower overall healthcare costs. These cost savings, according to Frenk and Ferranti (2012), result in greater financial security for families, which in turn reduces the chances of an individual's economic ruin.

Current literature recognizes the variety of universal healthcare systems that exist throughout the world but has been able to classify these systems into one of three types. Health Systems in Transition, an analysis of healthcare systems conducted by The European Observatory on Health Systems and Policies, has contributed an extensive amount of knowledge to health policy literature. The European Observatory on Health Systems and Policies is a

collaborative approach undertaken by the World Health Organization, national and regional European governments, health system organizations, and academia to "support and promote evidence-based policy-making through the comprehensive and rigorous analysis of European health systems, the production of timely and reliable evidence in response to real policy needs, and the communication of evidence in ways that are useful to and usable by policymakers" (European Observatory on Health Systems and Policies). Their research has not only focused on the overall structure of over fifty countries' healthcare system but a country's resources, services, recent reforms, and assessment. Considering the significant amount of information they have gathered, it serves as an ideal frame of reference for when discussing types of universal healthcare and features.

## Socialized Health Insurance (SHI) in Germany

The German model of healthcare originated from Otto von Bismarck upon German unification in 1883 and was gradually expanded. In Germany, all citizens are provided with statutory health insurance (SHI), which is funded through a compulsory contribution split by employees and employers and supplemented by some general tax revenue. Under SHI insurance, employees and employers equally split the 14.6% of wages that must be contributed, while unemployed individuals pay a portion of their entitlement. Although the German government ensures all citizens receive health insurance, they do not actually administer the insurance system. Instead, non-profit non-governmental firms called sickness funds act as the insurers. These sickness funds contract with associations of healthcare providers, such as primary physicians or certain hospitals. Sickness funds function in a similar capacity to health insurance companies in America, albeit less profit-driven since they are non-profit by design and must

provide care to all citizens. Competition is still a strong element among sickness funds as over 124 funds exist in Germany (Busse and Blumel 2014).

Nearly 85% of Germans receive coverage through the SHI system, with 11% of the population electing to utilize Germany's private health insurance (PHI). Germany's PHI system is available to citizens with an income above €56,250, or $71,564, who can elect to enroll in PHI instead, although only 25% choose to do so (Busse and Blumel 2014; Blumel and Busse). PHI also utilizes sickness funds, who contract with the same healthcare associations as SHI sickness funds. People may elect PHI because payments are based on an individual's risk at the point of entry, making it particularly attractive for younger citizens as premiums will not increase with age. PHI enrollees also have a greater choice in terms of premium, coverage, and deductible options. PHI can provide higher savings to some Germans because their premium will not increase due to their age and may serve as a cheaper alternative than losing a fixed percentage of their income (Esmail 2014). Thus, the government plays an indirect role in the financing of healthcare as they mandate and control the contribution rate under SHI but allow for competition among sickness funds under both SHI and PHI.

In terms of regulation, power is shared between regional governments, the federal government, and associations of healthcare professionals, which are mandated to join. The shared decision-making power between the federal government and healthcare associations is highlighted through the Federal Joint Committee (Blumel and Busse; Busse and Blumel 2014). The Federal Joint Committee oversees the German healthcare industry and consists of the four national healthcare professional groups—the National Associations of Statutory Health Insurance Physicians and Dentists, the German Hospital Federation, and the Central Federal Association of Health Insurance Funds. The Federal Joint Committee, however, is under the

supervision of the Federal Ministry of Health. The German healthcare system is a unique combination of public and private players as the government sets broad regulations but allows the healthcare professionals to self-regulate under their oversight (Gemeinsamer Bundesausschuss).

## National Health Insurance (NHI) in Canada

National Health Insurance (NHI) is best exemplified through Canada's healthcare system. An NHI system is primarily funded publicly, with 70% of Canada's expenditures funded through general tax revenues. Canada's NHI structure is heavily decentralized as provinces and territories are primarily responsible for administering, funding, and delivering care to their citizens. The Canadian federal government, however, does assist in financing programs through the Canada Health Act of 1985, which requires all programs to comply with federal standards. Each province establishes a Regional Health Authority, which oversees hospital and physician care by either directly providing care or contracting out to other providers. Often times, RHAs serve simultaneously as the buyer and provider of hospital and long-term care (Marchildon 2013). Due to the considerable degree of decentralization, hospital ownership varies greatly as most of the hospitals in one province may be publicly owned, while in another they may largely be private nonprofit ones. If Canadian individuals want additional coverage, such as vision and dental care, and prescription drugs, they have to purchase private insurance. However, unions, employers, and other organizations paid for 94% of premiums for private insurance plans. Canadians do not have to pay out-of-pocket for services from physicians or hospitals (Allin and Rudoler). In addition to Canada, other nations that have adopted an NHI-type system are Taiwan and South Korea (Reid 2008).

## National Health System (NHS) in the U.K.

National Health System (NHS), the last form of universal health insurance is similar to an NHI system as they are both funded largely through general tax revenue. Similarly, the NHS system in the U.K., established in 1948, is largely decentralized as Scotland, Wales, and Northern Island receive block grants and can largely determine their own health policy. While it is largely decentralized in these areas, NHS in England is different as "The United Kingdom Treasury determines the budget for health and other social services in England", meaning while the other three areas can allocate funds where they see appropriate, England cannot (Cylus et al 2015, 17). There is limited out-of-pocket spending in the U.K. with medical goods, such as prescription drugs, and long-term care accounting for 80% of out-of-pocket spending. Individuals are able to receive free care for a number of services, such as hospitals, because providers are paid through allocations in the English government's budget. The government also retains greater control of providers as most hospitals are publicly owned, with a limited amount of publicly paid physicians (Thorlby and Arora).

This section was designed to highlight the different approaches countries have taken towards providing universal healthcare. The German system is very different from both the NHI and NHS system. Both rely heavily on general tax revenue, while Germany's SHI is funded primarily through the compulsory employer-employee contributions. Germany and England have a similar proportion of citizens who elect to receive private health insurance, while in Canada, over two-thirds hold private insurance. Canada has a high proportion of individuals selecting supplemental insurance as it covers many benefits that public insurance does not, including vision and dental care as well as prescription drugs (Allin and Rudoler). All three countries, according to the Commonwealth Fund, have relatively similar out-of-pocket spending for its citizens, as they range from the high $500s per capita to the mid $600s. Under the NHS system

in England, the Secretary of State for Health oversees the delivery of healthcare services and is responsible for contracting with healthcare providers (Cylus et al 2015). This makes NHS in England very different from Canadian healthcare, which relies on Regional Health Authorities to take the lead in regulation and delivery of care. Germany differs substantially from both as the professional organizations that constitute the Federal Joint Committee self-regulate the industry and delivery of care is primarily private. This discussion emphasizes how countries can guarantee universal healthcare for all of their citizens yet are able to utilize public and private institutions very differently in terms of financing, delivery, and regulation.

## Health Policy Literature Review

While all of these Western democracies have adopted universal health insurance, the U.S. has not. A significant amount of literature has worked to examine the political factors that have impeded legislation to adopt universal healthcare. Before discussing the existing literature on the failures of past attempts to enact universal healthcare, a brief overview of these attempts must be discussed.

### A History of Healthcare Reform in the U.S.

Following the policy discussed in the Introduction, initial attempts to enact universal coverage date back to 1912 when Theodore Roosevelt and the Progressive Party endorsed social insurance as a component of their platform. However, these plans failed to come to fruition, and it was not until President Truman in post-World War II America that universal health coverage was seriously attempted again (The Kaiser Family Foundation 2009). *California and Western Medicine* provides a transcript of Truman's speech in which he proposed the United States adopt an NHI style system. In his address, Truman outlined the problems U.S. healthcare faced in 1945, which are similar to the ones today. Healthcare was characterized by significant urban and

rural disparities and high costs of care that "is true for a large proportion of normally self-supporting people" (Truman 1945, 272). The Wagner-Murray-Dingell (WMD) Bill) supported by Truman was introduced multiple times throughout his presidency, but never gained traction. By the 1960s, according to Berkowitz (2017), national health insurance had morphed not into universal healthcare, but health programs for the elderly and poor.

While the passage of Medicare and Medicaid were significant steps forward for healthcare advocates, it produced a "fill-in-the-gaps approach" which significantly faltered as early as the late 1970s (Jacobs and Skocpol 2010, 27). Throughout the 1970s, healthcare costs began to increase dramatically faster than both profits and wages. Universal healthcare would not reenter policy conversations until President Nixon attempted to pass a bill in the 1970s. In an address to Congress in 1973, he stated "Comprehensive health insurance is an idea whose time has come. I believe that some kind of plan will be enacted in the year 1974" (Steinmo and Watts 1995, 351). Democratic Senator Edward Kennedy and conservative Democratic Rep. Wilbur Mills, who chaired the influential Ways and Means Committee, crafted a compromise NHI bill with the Nixon administration. However, the bill could not muster enough support as "the left protested because they thought they could get more and the right protested because they believed they could get less" (Steinmo and Watts 1995, 353). President Ford attempted to pass his own NHI bill, but that too failed because it could not garner support within the rest of Congress outside of leadership (Steinmo and Watts 1995). During this time however, the federal government utilized its bargaining power to control Medicare's increasing costs, while businesses and individuals faced the consequences of increased costs. Small businesses began eliminating insurance coverage from employees' benefits packages, while large businesses pushed an increasing amount of premium payments onto workers. Each year "a million

additional working-age people found themselves without health coverage-- even though public programs like Medicaid or the State Children's Insurance Program expanded from time to time" (Jacobs and Skocpol 2010, 27). Creating a for-profit private healthcare system based on voluntary employer insurance led to employers and insurance companies prioritizing profits, with insurance companies aggressively attempting to "weed out individuals or groups of customers who might have unusually expensive healthcare needs" (Skocpol 1997, 22). In the late 1980s, Americans began overwhelmingly supporting universal healthcare, which is unsurprising since between 1987 and 1989 more than one in four Americans lacked insurance (Skocpol 1997).

Healthcare proposals multiplied between 1990 and 1991 amid even higher costs, further reductions in coverage, and successful political campaigns that centered on healthcare (Steinmo and Watts 1995). Bill Clinton emerged in 1992 as one of the frontrunners in the Democratic presidential primary and pledged to pursue healthcare reform. Clinton's failed healthcare reform remains one of the most infamous of the failed attempts with an overwhelming amount of literature focusing on its failure. The Clinton health plan was spearheaded by the Task Force on National Health Care Reform, a significant departure from past attempts as it was previously a combination of presidential and congressional leadership, rather than sole executive efforts, that produced a bill. The Task Force on National Health Care Reform attempted to fulfill the pledge Clinton ran on, which promised a plan that was "competition within a budget" and aimed to produce a bill that created affordable coverage yet contained cost reductions (Skocpol 1995 69). When the plan was released at the end of 1993, support for the 1,342-page bill began to collapse, and soon it was "difficult to find out-and-out supporters" (Clymer, Pear, and Toner 1994). Clinton's efforts to reform the system collapsed and has been described as "spectacular and politically costly to its sponsor" (Jacobs and Skocpol 2010 69).

After the failure of the Clinton health plan, it was "not at all certain that the next Democratic president would attempt to introduce significant change in this issue area and, perhaps, bring about universal coverage" (Beland, Rocco, and Waddan 2016, 435-436). Throughout the 2008 election, in both the primary and the general election, Obama remained very cautious and ambiguous about healthcare reform (Jacobs and Skocpol 2010). The ACA largely reaffirmed America's hybrid public-private insurance system as most Americans would continue to receive coverage through employment and the private insurance market.

## Explanations for the Failure of Universal Healthcare

Arguments explaining why universal health coverage has failed in the past utilizes one of three approaches: an institutional argument, an incrementalism argument, or flaws in presidential strategy.

### *Institutional Theory*

The idea of the institutions themselves preventing healthcare reform is explored by Steinmo and Watts (1995) who argue political culture and the role of interest groups are not the primary reason why healthcare reform has failed. They argue the ability of interest groups to defeat universal coverage stems from the institutions which have enabled economically powerful interest groups to utilize the fragmented structure of American government to sway elected officials. Steinmo and Watts (1995) further argue it is the structure of Congress that prevents a controversial issue, such as universal healthcare, from being enacted. The use of "committee government," in which congressional committees have the most power in determining the legislative agenda, killed Truman's bill as the most senior Democratic lawmakers who led those committees disagreed with the bill and Truman's more liberal civil rights policies (Steinmo and Watts 1995, 343). This connects with explanations espoused by Star (2013) that state it is the

composition of Congress, specifically committees controlled by senior lawmakers and procedural rules in the Senate, that defeats healthcare reform. The focus on the power of congressional committees can be seen in Ford's attempt to enact universal health coverage as it had the backings of congressional leaders, but not the members of the committees. Steinmo, Watts, and Starr all agree the decentralization of Congress and Senate procedural rules are prime examples of the institutional theory as the need for sixty percent of support from the Senate is unparalleled in other democracies and a minority of legislators can block meaningful reform.

### *Incremental Theory*

A closely connected, but differing, approach to explain the failure of universal healthcare attempts is the incremental theory. This approach argues that while institutions play a factor in preventing the passage of universal health coverage, policies in the US need to build off of each other, rather than just radically change the current landscape. Berkowitz (2017) argues Truman failed in his attempt to pass an NHI bill as it would have built off of Social Security, which was deeply unpopular at the time. Social Security's unpopularity could be attributed to its low benefits that were eligible to less than half of the population. Social Security served as an imperfect and unstable foundation for Truman as instead "one should expand Social Security first and only then press for national health insurance" (Berkowitz 2017, 523). This connects with the institutional theory put forth by other scholars as incremental reforms pave the way for subsequent large reforms. By attempting to dramatically expand the role of Social Security without expanding populations covered by Social Security, Truman's failure highlighted how the incremental theory serves as an explanation for why universal health reform has failed. Truman failed because he attempted enacting universal health coverage without initially reforming Social Security. After failing to enact universal health coverage, advocates turned towards incremental

expansions of Social Security. As private health plans began to emerge as the supplier of health insurance for many Americans, older and poorer Americans were having difficulty receiving care. Medicare and Medicaid were able to receive support from lawmakers as they built off the Kerr-Mills Act, which provided insurance to poor elderly Americans. Medicaid built off of this by expanding coverage to include the disabled and low-income children (Berkowitz 2017). Meanwhile, Medicare was able to build off of the newly popular Social Security program, which was appreciated for "the universal and non-means-tested nature of Social Security" (Skocpol 1995 73). During reform attempts in the 1970s, political actors did not learn from previous failed efforts as they attempted to enact a universal healthcare system. Political actors, however, began to learn their lesson as supporters realized "only very low key, incremental efforts had any chance of success" (Skocpol 1997, 21). Heclo's (1995) theory of gestation connects to incrementalism as it explains that successful reform efforts need to have been publicly hashed out and debated. Through the debate between policy actors, the media, and society, "factual claims are tested and countered, the 'problem' is defined and redefined, and alternatives are advanced and attacked" (Heclo 1995, 91). Star (2013) touches on this idea as he argues proponents need to gain enough electoral success over several election cycles to prevent all attempts to block reform.

Beland, Rocco, and Waddan (2016) utilize the incremental approach to explain how Obama was able to secure passage of the ACA. During the 2008 election cycle, Obama learned from the mistakes of past policy actors by not promising universal coverage because it was "seen as impossible due to existing policy legacies (i.e. the weight of private insurance actors and interests within the health system), meaning that reform had to build on the inefficient mix of private and public programs already in place" (Beland, Rocco, and Waddan 2016, 436). After

analyzing three potential causes for universal coverage failures, high partisanship, institutional fragmentation, and the complexity of policy packages, they concluded that no one single factor was the primary reason. They were able to conclude that institutional fragmentation and the complexity of universal health insurance were more useful explanations for multiple failed policy attempts. The ACA was able to achieve successful passage not because it overcame these three barriers, but it never intended to achieve universal coverage (Beland, Rocco, and Waddan 2016). The law succeeded, in terms of enactment, because it "represented an incremental expansion of the existing system for health-care finance, not a revolutionary change" (Berkowitz 2017, 521). As already stated, the ACA was meant to preserve the public-private insurance system, not dismantle it.

### *Presidential Strategy Theory*

Lastly, some have argued that it is the consistent flaws in presidential strategy that have failed to achieve universal health coverage. Schimmel (2016) is an advocate of this approach since he has examined the rhetoric presidents have used when attempting to enact universal health coverage and their response to Republican attacks. He focuses on the social imaginary that presidents have created. The social imaginary is "the ways in which people imagine their co-existence in a national space, and the moral values, relationships, and responsibilities" that relate to the role and purpose of government (Schimmel 2016, 4). His analysis of presidential rhetoric rested on the social imaginary, which is how individuals imagine society to exist, presidential addresses to Congress, and how public discourse either reproduces or challenges the social imaginary. For example, Schimmel (2016) writes how Clinton's social imaginary focused on a slow and steady version of progress that was combined with traditional liberal views of equality. Schimmel (2016), however, does critique Clinton's decision not to reevaluate his social

imaginary after it was clearly failing with public support turning against his plan. In recent healthcare reform debates, primarily in debates over the ACA, political leaders advocating for reform strayed from using a moral lens as Obama "favored practical and administrative arguments about efficiency, economic growth, and economies of scale" (Schimmel 2016, 21). President Obama's ability to enact the ACA was aided in the structuring of his social imaginary, which "champions compromise as a political and moral value itself rather than merely as a concession to pragmatism" (Schimmel 2016, 223).

Schimmel's (2016) application of the social imaginary is just one approach explaining how flaws in presidential strategy doomed universal health coverage. Other approaches have highlighted the partisan political factors as the main obstacle and seek to explain how a widespread, bipartisan reform effort gradually transformed into a conversation where "Republicans were essentially opting out of the process and Democrats were beginning to wonder where it was even headed" (Clymer, Pear and Toner 1994). Skocpol's research across multiple works have focused on the role poor messaging by the Clintons played in his healthcare reform effort and expands on the institutional factors that have impeded reform. Jacobs and Skocpol (2010) also provide a comprehensive account of the numerous political obstacles the ACA had to overcome and how it nearly failed multiple times. Their description helps explain how the ACA was able to succeed compared to many other healthcare reforms that did not. They describe the political obstacles Speaker Pelosi and Senate Majority Leader Reid had to confront in order to secure a sufficient number of votes for passage. They also explain how policy actors actually used institutional designs, namely Senate procedural rules, in their favor, especially after Senate Democrats lost their filibuster-proof majority (Jacobs and Skocpol 2010). One of the key differences in strategy between Clinton and Obama was the ability to hold the Democratic

caucus together. Clinton was unable to build support for his plan amongst his own political party as some congressional Democrats "never did agree with their titular leader, or among themselves, about exactly what kind of reform they wanted" (Skocpol 1997, 99). Even though there were multiple moments of panic among congressional Democrats during debate over the ACA, the turning point came when President Obama took ownership of a plan and was able to utilize Speaker Pelosi and Senate Majority Leader Reid to secure the votes.

My use of Kingdon's multiple streams approach will help inform which of these theories best explains why universal healthcare proposals have failed in the U.S. and paths forward for advocates.

# Chapter 2: The Multiple Streams Approach, the Health Security Act, and the Affordable Care Act

In an attempt to analyze and understand the factors that defeated the Clinton health plan but helped secure passage for the Affordable Care Act, Kingdon's (2011) multiple streams approach will serve as the framework for this comparative case study. The multiple streams approach addresses the policymaking process and the factors that inhibit or enable the enactment of specific policies and how these issues come to be seen as such. In particular, his approach focuses on agenda setting, specification of alternatives, authoritative decisions, and implementation. The multiple streams approach divides the policymaking process into three distinct streams—the problem stream, the policy stream, and the politics stream. In tracking the rise and fall of items on the institutional agenda, Kingdon conducted 247 interviews on transportation and health policy issues between 1976 and 1979 with congressional staff members, executive branch members, and individuals outside of government, such as lobbyists, consultants, and researchers. Kingdon selected these respondents by first identifying important positions, such as congressional staff members and representatives of interest groups, and then utilizing a snowballing technique in which each respondent listed another individual Kingdon should interview. During the interviews, Kingdon asked seven questions that aimed to discover the content of the agenda, seriously considered alternatives, and explanation for the items on the agenda (Kingdon 2011). These three streams can be applied to the failure of the Health Security Act and the enactment of the ACA to discover which factors in each stream caused one to fail and one to succeed. In order to establish this framework as appropriate, the three streams must be discussed and defined.

## The Problem Stream

The problem stream is a critical component of the multiple streams approach as the problem needs to be defined and understood, which can elevate its status on the governmental agenda. First, indicators must be established so elites have a mechanism with which to assess the magnitude of the problem and discover how it will change. For those who pursue policy change, it is crucial they establish indicators and utilize them as a way to build consensus that reform is necessary. Indicators, such as the uninsured rate or healthcare spending as a proportion of GDP, are not enough to warrant action on their own as they can be manipulated by advocates who "grasp for indicators with serious deficiencies" and wrongly interpreted as evidence for a specific problem or solution (Kingdon 2011, 93). Some problems are able to achieve a place on the agenda through a focusing event, which is a crisis or disaster that calls attention to the problem. However, focusing events are less common in terms of health problems due to the already high saliency of health policy. Symbolic acts can also serve as a vehicle to increase the visibility of problems. This occurs when political elites already have an existing problem on their mind and the symbol helps provide focus. Unlike a crisis focusing event, symbols are used not to move a problem onto the agenda, but to "capture in a nutshell some sort of reality that people already sense in a vaguer, more diffuse way" (Kingdon 2011, 98).

An important component of the problem stream is the ability for feedback. Governmental actors rely on feedback of existing programs as it is a primary way in which they gain knowledge of emerging problems. Feedback comes through multiple different forms, such as expenditures, constituent complaints, casework, systematic monitoring, and evaluation studies. Feedback is critical as it can reveal problems that were unintended by legislators, such as implementation that contradicts the intent of the legislation, failure to meet stated goals, higher costs, and unanticipated consequences. Problems can fall off the agenda after legislators believe they have

successfully solved the problem, the consequences have decreased, or because political actors decide to utilize their resources for solving other problems. When it becomes clear that there will be no legislative or authoritative decision, political actors quickly cease attempts to solve that problem in an effort to maintain their scarce resources (Kingdon 2011).

The problem stream also emphasizes the role problem definition plays. Problem definition and its framing is a key factor in this stream as it substantially changes the solutions that will be proposed by political elites. In relation to the stage of problem definition, actors typically place their definition of the problem into a specific category. The category the issue is placed in, such as equal rights or cost containment, will significantly change the proposed solutions. It is difficult for new categories to emerge as they are seen as a "threat to somebody's interests and politicians like to put off that day of reckoning as long as they can" (Kingdon 2011, 112). Eventually however, new categories must be developed as the old categories no longer accurately portray the problem. All of the aforementioned components of the problem stream work together to bring problems to the attention of government officials. The interpretation of indicators assesses the scope and severity of a problem while increasing the attention an issue receives or altering its perception. The usage of indicators can alter how the problem is defined by providing quantitative measures whose interpretation makes individuals believe problems exist on a scale significant enough to warrant public action (Kingdon 2011).

## The Policy Stream

Kingdon (2011) compares the policy stream to a cauldron of soup as ideas are like bubbles, which can become prominent and then fade. The consideration of policies is heavily influenced by the "softening stage," in which ideas are considered, bills are formally introduced, supporters and opponents make speeches, and then proposals are amended, with many ideas

either combining into one or contrasting one another. The soup, much like policies themselves, change not only because of the introduction of new elements, but the "recombination of previously existing elements" (Kingdon 2011, 117). One of the main drivers in the policy stream are policy communities, which consist of specialists inside and outside of government that exchange ideas and research a particular topic. Policy communities are affected by political events, but remain independent from electoral changes and constituent demands, unlike communities in the politics stream. Policy communities are less concerned with the political environment and more concerned with researching and constructing policy alternatives and proposals. While constructing this framework, Kingdon (2011) discovered that the policy communities in health policy are small and intimate with many specialists, deemed policy entrepreneurs, working together to develop proposals regarding the problems with healthcare. Their collaboration reflects the low fragmentation of ideas in the health policy community as the many different policy entrepreneurs are concerned with three issues—cost, access, and quality. This common outlook in the policy community is seen throughout the diverse community, with stakeholders from insurance advocates to biomedical researchers, describing the issue along these three lines. The low fragmentation in the policy community prevents the health agenda from abruptly changing (Kingdon 2011).

While the policy "soup" is an important metaphor, it is not a completely accurate depiction of the policy stream as it places emphasis on the origin of ideas while forgetting that "Wholly new ideas do not suddenly appear. Instead, people recombine familiar elements into a new structure or a new proposal" (Kingdon 2011, 124). A crucial step in the policy stream is policy entrepreneurs "softening up" policy communities and the broader public as it takes time and effort to educate and build inertia for change among communities and the public. The

passage of Medicare, which was briefly discussed in the literature review, is a clear example of how policies build off of each other and need to gather support over a period of time. Policy entrepreneurs typically target the general public, specialized professionals who would be affected, and policy communities themselves to assure that as many specialists as possible are aware of both the problem and policy. Universal healthcare serves as a strong example of the policy stream process as it has been attempted numerous times since the 1940s. The failure highlights the degree to which some policies require extensive "softening up." Further, bills and proposals may be discussed not to secure passage, but for the purpose of "keeping something alive" and gaining attention for the policy until it can be passed (Kingdon 2011, 130).

Gaining support among policy communities, however, does not secure passage for a proposal as Kingdon (2011) argues proposals need to fulfill several criteria while in the policy stream. While technical feasibility can be a broad criterion, Kingdon's interviewees defined it as proposals that are well thought out and detailed, with special attention paid to its ability to be carried out and accomplish their purported goals. Value acceptability among the policy community, an important criterion, is heavily influenced by ideology and the principles of equity and efficiency. Ideology refers to the policy community's views on the size and role of government. Kingdon (2011) found that unprompted ideological arguments appeared in 36% of health policy interviews, significantly higher than transportation policy which only saw these arguments in 7% of interviews. However, in some instances it is not personal ideology, but national ideology that shapes value acceptability. National ideology emphasizes the common political values in the US, such as low levels of trust in government, and frames it in a way that goes beyond the individual. Value acceptability also includes equity, which can be driven by the desire to make policies fairer and address power imbalances and can quickly force policies onto

the agenda. Kingdon (2011), however, discovered that equity was not featured predominately in discussions of value acceptability as it only appeared in 13% of interviews. Lastly, efficiency has emerged as a powerful factor in value acceptability as policy makers have begun to consider more heavily the cost of the program compared to the benefits, whether those benefits are justified by the costs, and whether the benefits could be delivered for lower costs. The final criterion that policy communities use within the policy stream is anticipating future constraints. It is important for the policy community to consider future constraints because specialists expect policies to face constraints in the future, so they must consider ways for their policy to overcome and change with those constraints. One such future constraint is a budget constraint as the policy will not be seriously considered if costs are too high. Another type of constraint is public acquiescence, or social acceptability. Public acquiescence can refer to either the general public or a specialized segment of the population that would be heavily affected by the policy. Likewise, receptivity among elites can both be influenced by and influence public acquiescence. Support among elites is crucial as specialists often times withdraw proposals because of a lack of political support. The policy community must consider public acquiescence and elite support when designing policies as negative reactions from either can endanger the passage of the policy (Kingdon 2011).

Following the aforementioned processes, policies that survive enter the short list of ideas within the policy community. Through these processes, the policy community develops consensus in which specialists are aware of the problem and agree on solutions or proposals. Respondents have described emerging consensus as a snowball or having a bandwagon effect. The emerging consensus continues to build until it reaches a tipping point, in which "its diffusion rises rapidly from those few to the point where the idea becomes commonplace" (Kingdon 2011

140). This tipping point, however, usually occurs among specialists within the policy community and is separate from a tipping point that would occur among political actors. However, even when policies fail to reach the tipping point or reach it but still face barriers to enactment, one respondent in Kingdon's survey stated, "Issues fade in and fade out, but they never, ever go away. They always come back—always" (2011, 141).

## The Political Stream

The political stream operates independently of the problem and policy stream and includes events such as public mood, changes in administration, and interest group activity. Kingdon (2011) argues the political stream is a critical component of the policy-making process because it would be misleading to argue the policy-making process only includes the policy community discussed in the policy stream. Kingdon (2011) identifies three elements of the political stream that occur before consensus building—national mood, organized political forces, and governmental phenomena.

The national mood consists of the public holding similar opinions but those opinions can change and shift over time, which has important impacts on policy. The national mood heavily influences the policies governmental actors pursue or choose not to pursue as proposals that have been discussed among elites and policy communities appear once they believe the national mood has shifted. Swings in the national mood, from left to right and back again, can be considered a type of feedback cycle in which "a program is enacted, problems with its implementation emerge, corrections are made, and new problems emerge from the corrections" (Kingdon 2011, 148). For policy actors, the national mood is not just a measure of public opinion, but rather actors assess the values of the country at that moment in time. Politicians gather the national mood through communication with their constituents in addition to "interest groups' leaders both

in Washington and in the hustings; they read newspaper editorials; they give talks and listen to questions and comments at meetings; they see how public events are being covered in both general and specialized media; and they talk to party activists and other politicos who presumably have their ears to the ground" (Kingdon 2011, 149). The sentiments gathered by politicians from all these sources provide an understanding of the national mood, which they then pass onto nonelected officials. Just as the national mood can affect politics, politics can affect the national mood, especially if an election makes people believe a certain mood is dominant. The national mood has a significant impact on policy because it can enable previously dismissed proposals to become viable options (Kingdon 2011).

The second major component of the political stream is organized political forces, which includes interest groups, elites, and political mobilization. The position of interest groups can serve as a powerful catalyst in pushing politicians to either support or oppose a certain policy. When there is agreement among interest groups over a certain policy, politicians side with the interest groups. However, when there is conflict among interest groups, politicians tend to "strike some balance between those for and those against a given proposal" (Kingdon 2011, 150). In regard to health policy, especially when there is conflict among interest groups, hospital groups are powerful because of their reputation as community leaders, making it very difficult for politicians to oppose them. When opposition to a certain policy is great enough, interest groups are not only able to block the policy from being enacted, but from being seriously considered. This can result in advocates abandoning their policy as the cost of attempting to get it passed is often too high. Interest groups are often motivated by the clientele that is created following the creation of a specific program. The clientele aims to block any attempt to decrease funding for the program or change it in a way they deem as unfavorable. While interest groups are powerful

at blocking legislation, they can be overcome depending on swings in the national mood, composition of Congress, and administration (Kingdon 2011).

Lastly, changes in the government, such as elections and battles over jurisdiction, is a major component of the political stream. Agenda change among governmental actors happens through elections or changes in personnel as either can force new items onto the agenda or take others off. Election results and the corresponding changes in the composition of Congress can cause drastic changes in the agenda. A notable example in health policy is the election of 1964, which enabled the Johnson administration to secure enough votes for the passage of Medicare and Medicaid (Kingdon 2011). As parties lose and gain seats in Congress or the White House, issues will rise and fall from the agenda because of the ideological positions of the new policymakers. From his interviews in health policy, Kingdon (2011) concluded that a change in administration can create wide-ranging impacts as it was significantly mentioned in 83% of the interviews. Turnover in regulatory or bureaucratic agencies can have a similar effect on agenda items. Kingdon (2011), however, stresses that change in agendas because of turnover is not because of the loss or gain of the personnel themselves, but the broader shift in mood they signify. Turf battles between agencies and Congress, or between two agencies, impacts the agenda as policy positions are often taken based on jurisdiction and interests of the involved agencies. Universal health coverage is a prime example of a turf battle as multiple congressional committees have a stake and want to claim jurisdiction, while agencies such as the Office of Management and Budget (OMB) wants to select the cheapest possible option. Turf battles can negatively affect a policy, particularly if committees and agencies cannot come to an agreement, or can positively affect it, specifically by motivating committees or agencies into being the first one to support or introduce the policy. The potential popularity of the policy is the primary

reason that affects whether jurisdiction positively or negatively impacts policy consideration (Kingdon 2011).

Whereas consensus building is achieved in the policy stream through persuasion and evaluation of the policy, the political stream reaches consensus through bargaining and exchanging of votes and support. By bargaining, policy actors create coalitions that are needed for bills to be taken into serious consideration. Coalition building ties into the bandwagon effect discussed in the policy stream. As the coalition builds through promises of benefits, others begin to join the coalition because they are fearful they will miss some of the benefits. As bandwagoning increases, opponents of the policy begin to introduce their own proposals as they are afraid some version of the policy will pass. Considering they want to be included in some of the benefits, they propose their own policy in an attempt to gain some of the benefits, in what respondents called "jumping on before it's too late" (Kingdon 2011, 161). Political bargaining increases as the likelihood of passage increases because it causes actors on both sides to move away from the rigid positions in order to compromise.

## The Policy Window

The policy window is the convergence of all three streams that allows for advocates to push their proposal through. The policy window is different from the three streams because it is a critical juncture that occurs after "a problem is recognized, a solution is developed and available in the policy community, a political change makes it the right time for policy change, and political constraints are not severe" (Kingdon 2011, 165). The policy window allows for action to be taken on specific policies, but does not remain open indefinitely, meaning that if proponents are slow to action their policy window will close. Proponents pursuing action during

their policy window, however, does not ensure the passage of their policy. Passage during the policy window depends on the elements that are present (Kingdon 2011).

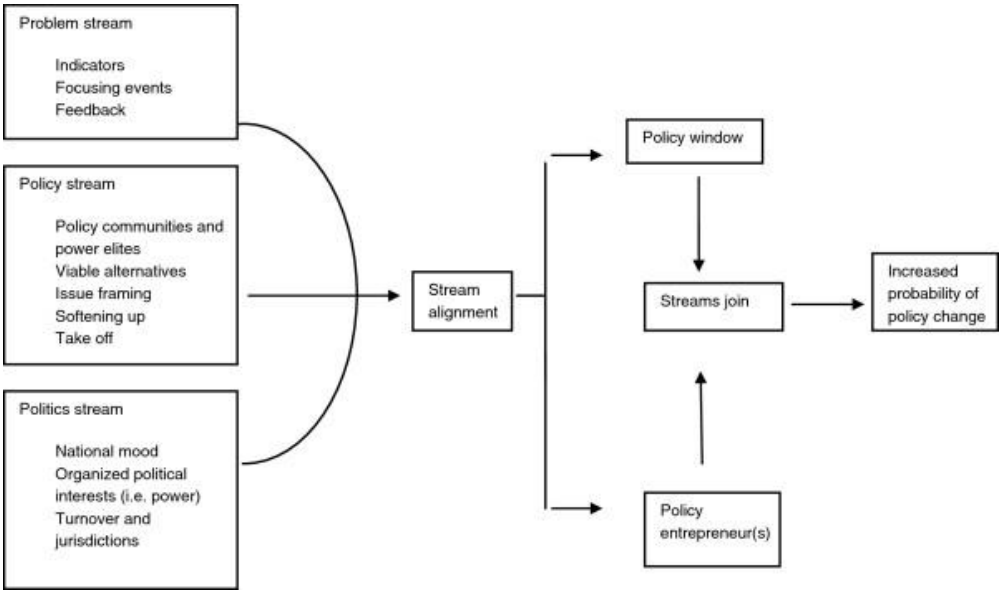


***Figure 5*** *This is a visual representation of the multiple streams approach and how the streams converge into the policy window (Gagnon and Labonte 2013).*

The policy window typically opens because of events in the problem stream, either a new problem emerges, or the political stream, where there is a change of elected officials, administration, or even congressional committee chairs. As the policy window opens, it also closes when participants believe they have addressed the problem in one form or another, when advocates fail to secure action due to an inability to invest resources, the event that caused the window to open ends, a change in personnel closes the window, or there are no available alternatives. One of the most complex features of the policy window is the difficulty participants have of knowing when the policy window is open or closed as they have to rely on their perceptions. A crucial aspect of the multiple streams theory are the policy entrepreneurs who become a central figure in the attempt to pass a certain policy. These policy entrepreneurs must have either expertise, the ability to speak for others, and an authoritative decision-making position, such as the presidency. They must also have political connections or negotiating

prowess and be persistent in pursuing their policy. It is important to understand how policy entrepreneurs and the structural elements affect the policy window as "the window opens because of some factor beyond the realm of the individual entrepreneur, but the individual takes advantage of the opportunity" (Kingdon 2011, 182).

## Applying the Multiple Streams Approach to the Health Security Act and the Affordable Care Act

After discussing the multiple streams approach, it can now be applied to the attempts to pass the Health Security Act and the Affordable Care Act. These two bills proposed significant expansions of the role of government in healthcare and are ideal case studies into understanding the various factors that impede or accelerate the expansion of government run healthcare programs.

### The Problem Stream, the Health Security Act, and the Affordable Care Act

Throughout the 1980s and 1990s, an increasing number of problems emerged in America's healthcare system, with much of the focus on the rising costs of health care. A survey conducted by the Organization for Economic Cooperation and Development (OECD) in 1992 concluded that there was "almost unanimous sentiment that the U.S. health-care financing system is unsatisfactory" (Blankenau 45, 2001). Further, Americans listed cost as their number one concern in a poll conducted by the Kaiser Family Foundation. In the early 1990s, concerns over healthcare costs shifted from being an issue primarily among lower-income Americans to a middle-class issue as employers began to increasingly place more costs on employees (Skocpol 1995). Businesses began to shift costs because owners faced the increased burden of providing insurance, with health care more than doubling as a share of total compensation from 1970 to 1990 (Blankenau 2001). State and federal governments also struggled with rising costs for Medicaid and Medicare. Medicaid was of particular significance as it emerged as the fastest

rising expenditure in state budgets and was a main driver of the federal debt. Hospital patients who used private insurance faced even higher costs as hospitals forced them into paying for uninsured Americans and Medicaid recipients (Plaut and Arons 1994). Concerns over access also emerged as there were roughly over 39.7 million uninsured Americans, a 26% rise over just five years (Budetti 2004). In addition to the millions of Americans who lacked insurance, even more faced limited coverage options. The U.S. underwent an economic recession in 1990-1991, and with health insurance increasingly tied to employment, "lost jobs soon meant no employer health insurance for many of the affected families" (Skocpol 25, 1997).

Healthcare was thrust as one of the major problems facing the U.S. after the surprising electoral victory of Harris Wofford in the Pennsylvania Senate special election in 1991. His opponent, Republican Richard Thornburgh, was a very popular Republican in the state and was expected to have an easy path to victory, with Wofford trailing Thornburgh by 44 points in August of that year. In September, Wofford began to center his campaign around healthcare, airing an advertisement that concluded with "If criminals have the right to a lawyer, I think working Americans should have the right to a doctor" (Skocpol 27, 1997). Before the advertisement aired, many voters saw Thornburgh as having more expertise in healthcare, but one week before election day Wofford led Thornburgh on the issue by 27 points and won the election by ten points. Surveys and focus groups conducted during and after the campaign concluded that Wofford's support for universal healthcare was a major factor in his victory, with one survey concluding that 30% of his supporters voted for him because of his stance on healthcare and another 50% of Pennsylvania voters at the time stated that national health insurance was one of the two issues that decided their vote (Skocpol 1997). Wofford's election is a crucial component of the problem stream as it become the focusing event that highlighted the

issues with American healthcare because policies are not considered for legislative action until "problematic socioeconomic conditions are combined with proposed policy solutions *and* a widespread sense that the 'time is ripe' for political action" (Skocpol 1997, 29). Political pundits declared healthcare as "*the* issue for 1992" and the Kaiser Family Foundation, which conducted one of the aforementioned surveys, argued "national health insurance has arrived as a mainstream political issue" (Skocpol 1997, 30). Wofford's election and emphasis on national health insurance brought national attention to his campaign managers, James Carville and Paul Begala, both of whom served as campaign strategists for Clinton's presidential run in 1992. During the campaign, the Clinton team defined the problem as revolving around high costs and low access for many Americans as he stated in his announcement speech that "in the first year of a Clinton Administration we will present a plan to Congress and the American plan to provide affordable, quality health care for all Americans" (Skocpol 1997, 37). Clinton would use similar rhetoric throughout his campaign. The issues of higher costs, particularly among middle class Americans, worked in conjunction with Wofford's surprise victory to force healthcare reform to be seriously considered once again.

Prior to the passage of the Affordable Care Act in 2010, the same issues of cost and access were prevalent in 2008 and 2009, but as Kingdon argues, "the problems were much worse by the time of the 2008 presidential election" (Kingdon 2011, 233). Once again, one of the major drivers of increased health care costs for states and the federal government were Medicare and Medicaid. The media focused on the widespread rising costs for a majority of Americans as those with employer-based insurance faced higher premiums, deductibles, and copays, while individuals and small businesses were affected by the industry's refusal to cover people with a pre-existing condition (Kingdon 2011). Premiums for individuals with employer-based coverage

increased by 97% between 2000 and 2008, reaching $12,680. Likewise, people who gained insurance through their jobs saw out-of-pocket spending increase 107% from 2000 to 2008 (The Kaiser Family Foundation 2008). Kingdon (2011) outlines two additional components on the problem stream during the 2008 presidential election—the economic recession and globalization. The 2008 economic recession was the worst economic downturn in the U.S. since the Great Depression. The scope and magnitude of the recession, coupled with the major role employment-based insurance played in American healthcare, when one lost their job, their family also lost health insurance. Thus, health insurance could easily be connected to economic fears especially because "the recession had opened the window for many programs that would not have been possible to push without the crisis" (Kingdon 2011, 235). Globalization also played a major role in the problem stream as American companies were forced to compete with international companies who did not have to offer insurance to their employees because the government provided universal health care. Thus, American companies had to push some of the rising costs of healthcare off to consumers of their products. Business management felt pressure from both the rising costs and competition from foreign companies and began to support health care reform in order to reduce the burden on their companies (Kingdon 2011). While these problems existed during Clinton's problem stream, particularly an economic recession, these factors were much more prevalent during Obama's problem stream.

During the 2008 Democratic primaries, Hillary Clinton and John Edwards were pushing more ambitious proposals for universal health care and were seen as having higher expertise than Obama. Obama was hesitant to push for major national reform, which became an issue of contention between himself and Clinton during the primary. She argued in her rallies that Obama's plan "does not, and cannot, cover all Americans. He called his plan universal, then he

called it 'virtually universal' but it is not either" (Jacobs and Skocpol 33, 2010). Obama, however, won the nomination and made a strategic emphasis on health care reform for the general election. He began to focus heavily on a renewed promise for comprehensive health care reform, even as the 2008 economic recession began to worsen. It was a strategic move to utilize the 2008 economic recession as the focusing event for pursuing comprehensive health care reform because between 2007 and 2009 five million adults lost health insurance (Holahan 2011). Obama's economic stimulus packages recognized the connection between the recession and health reform as many included health care provisions, signaling the seriousness of the problem. These provisions included funding for electronic medical records to help modernize the system, research on healthcare treatments, energy-saving initiatives, and a new electronic grid (Kingdon 2011). Kingdon, Skocpol and Jacobs all argue that the recession enabled Obama to more effectively pursue health care reform. All have stated that the recession created a renewed opportunity that Obama could use to push health care reform through.

**The Policy Stream, the Health Security Act, and the Affordable Care Act**

During the 1992 presidential campaign, the policy community began to focus on proposals that emphasized the concept of competitive and inclusive managed competition but included universal coverage and publicly enforced cost controls. Michael Weinstein, a member of the *New York Times* editorial board, wrote over two dozen articles advocating for managed competition as a middle of the road option between proposals from President Bush and congressional Democrats. Many of the principles of managed competition came from Alain Enthoven, who was a member of the "Jackson Hole group," which consisted of like-minded policy entrepreneurs who were also supporters of managed competition. While the group broadly agreed on their vision of managed competition, which would utilize market-competition and

managed care plans to increase efficiency and decrease cost, the group was divided on the role of government as Enthoven supported some governmental regulations and mandated employer contributions to health care (Skocpol 1997).

More liberal reformers, notably John Garamendi, Walter Zelman, and Paul Starr, all advocated for the establishment of "health purchasing alliances", a policy recommended by Enthoven, but wanted to sponsor all plans offered to both employers and citizens. The mandatory alliance would pool the resources of employers and individuals, allowing them to purchase insurance at a lower price. Plans would have to be approved by alliances before being offered to individuals. The government would also provide subsidies for unemployed individuals and small businesses to purchase health coverage, while instituting regulatory mechanisms to hold down costs. Garamendi, Zelman, and Starr were able to advocate for their view of inclusive managed care through memos and personal meetings with the Clinton campaign. They argued it would not expand public insurance programs or require significant tax increases as regulations and competition would force companies to provide good care at low prices. The plan they advocated for was "just what Bill Clinton was looking for" (Skocpol 1997, 44).

In January 1993, Clinton formed the Task Force on Healthcare Reform, which aimed to discover ideas that could be included in a comprehensive health reform plan. The task force, which was headed by then-First Lady Hillary Clinton, had focused on delivering the exact type of healthcare reform championed by Garamendi, Zelman, and Starr in which an employer mandate funded universal coverage along with regulations to keep costs low (Skocpol 1997). However, the policy "soup" Kingdon describes resulted in new proposals bubbling up. Conservative Democrat Jim Cooper introduced a rival bill that would encourage small businesses to purchase insurance and provide some subsidies, but it would not provide universal coverage.

The Cooperites, the policy community that supported Cooper's plan, rejected the employer mandate and government-imposed cost controls. In regard to budget constraints that can affect the acceptability among the policy community, the Congressional Budget Office (CBO), White House budget officials, and the Treasury Department worked to impose tough cost control measures that had "much more influence on the specifics of the Clinton Health Security proposal than did contending conservative, moderate, and liberal political factors" (Skocpol 1997, 67). Value acceptability also played a role within the policy community as President Clinton framed the bill not as providing welfare to the poor, but as providing security to the middle class.

There was potential for the Health Security Act to gain consensus among the policy community, particularly among liberals and budget hawks. They agreed over many important parts of the proposal, such as the health purchasing alliances, government-caps on premiums, the employer mandate, and benefit package (Skocpol 1997). However, the proposal failed to gain diffusion among the policy community as it could not extend support beyond liberals and budget hawks. Kingdon describes the policy community in disarray over the Clinton health plan, with policy entrepreneurs unable to unite over a proposal. The Health Security Act emerged as "complicated, ambitious, and most important of all, unfamiliar and untested" (Kingdon 2011, 236). In addition, the Health Security Act did not fully go through the policy "soup" as described by Kingdon. The plan that emerged contained many of the basic principles that were supported by Garamendi, Zelmann, and Starr. The proposal was not debated, combined, or amended like most policies are at the softening up stage. While there was some movement towards consensus, it failed to reach a tipping point as it was concentrated within liberals and budget hawks.

Whereas consensus among the policy community was very limited in regard to the Health Security Act, policy entrepreneurs agreed on the basic approach in what would become the ACA.

The policy community already had consensus that the major component of the new law would be its individual mandate, while leaving the existing private-public hybrid system in place. Support among the policy community for an individual mandate had already reached a tipping point as it was included in the Health Security Act, Republican alternatives to the Health Security Act, and every bill reported out of committee during the Obama administration made the mandate central to their approach (Kingdon 2011). One of the most important factors in the tipping point of support for the individual mandate was a 2006 Massachusetts law, signed by then-Republican Gov. Mitt Romney, that imposed a mandate and saw almost all of its residents receive health insurance. It was easy for the individual mandate to build a consensus and reach a tipping point because it had been discussed, proposed several times, and previously enacted, allowing policy entrepreneurs to examine its effects. It was easier for the Affordable Care Act to gain consensus among the policy community because it had a clear softening up stage as congressional committees were tasked with "holding many meetings and conferences, producing publications, honing proposals, introducing bills, and trotting out the idea again in more meetings and publications" (Kingdon 2011, 237). This was in stark contrast to the Health Security Act as discussions lead by Hillary Clinton were seen as too secretive and elected officials and interest groups felt alienated. The policy community that existed during the ACA contained no advocates of national health insurance who were outside of it and whose calls were not considered by administration or congressional officials. This connects with two related ideas put forth by scholars, Kingdon's "softening up" stage of the policy community and the incrementalism theory, because national health insurance was still an untested policy that would fundamentally change the structure of U.S. healthcare. A proposal of that magnitude would require a longer "softening up" stage and would need to build off of policies that had already expanded the

government's involvement in healthcare. The policy community during debates on what would become the ACA decided to shift away from national health insurance because of the failure of the Health Security Act, resulting in universal coverage "not being seriously considered" (Beland, Rocco, and Waden 2016, 436). This in stark contrast to the policy community that existed during the Health Security Act as many policy entrepreneurs during that period required plans to obtain universal coverage.

The Affordable Care Act was further able to achieve a greater degree of consensus among the policy community because it fulfilled many of the criteria explained by Kingdon. The Affordable Care Act achieved value acceptability because it worked to reform many of the problems that the policy community widely agreed on, most notably by adding protections for people with pre-existing conditions. The policy community agreed that insurance companies should not be able to ban people from obtaining insurance because of a pre-existing condition but acknowledged that revenue generating policies needed to be enacted to keep spending in check. This shows how value acceptability can connect with budget constraints as the policy community wanted to protect individuals but ensure that the budget was taken into consideration. Thus, they attached the individual mandate so the addition of younger and healthier individuals who require less healthcare would offset the protections given to people with pre-existing conditions. This is further seen through the subsides that were given to people to assist with insurance payments that were offset by the Cadillac tax and increased taxes for the rich. Technical feasibility was reached because the ACA explained its provisions and payment mechanisms in a manner that was easier to understand than the Health Security Act. Because the ACA had fulfilled many of the criteria that exists in the policy stream, many of the proposals that were developed in the policy soup contained the same basic structure of providing subsidies to

low-income individuals, providing a public option to buy Medicare, adding an individual mandate, and keeping the current system largely in place (Kingdon 2011). While these proposals did differ in specific details, such as a public option or eligibility for Medicaid expansion, the number of proposals that included similar provisions shows the degree to which the policy community had established consensus and reached a tipping point (Beland, Rocco, and Wadden 2016).

### The Political Stream, the Health Security Act, and the Affordable Care Act

President Clinton's election itself served as a noticeable shift in the politics stream because of his emphasis on healthcare reform throughout the 1992 election and the promise from all the Democratic candidates to pursue reform if elected (Skocpol 1995). The Task Force on Healthcare Reform completed its work in May 1993; however, Clinton did not fully or publicly address healthcare reform until a presidential address on September 23, 1993. His presidential address captured the national mood at that time by primarily focusing on bipartisanship and remedies for the fears and concerns of the American people. The public was eager for an increase in bipartisan measures and a decrease in Washington gridlock as "many had hoped a new Democratic president might be able to do in dealing with a Democratic-led Congress" (Skocpol 1997, 82). He emphasized how his proposal was bipartisan by combining policy proposals from both Republicans and Democrats and called on legislators from both parties to work together. He declared the work members of both parties did as "a magic moment, and we must seize it" (Clinton 1993). The national mood was characterized by a demand for bipartisanship and Clinton stressed the cooperation between the two parties to help garner increased public support.

Clinton also focused his address on explaining the remedies for concerns and fears over American healthcare, specifically losing insurance and rising costs. Clinton stressed his proposal would allay these problems by establishing security, simplicity, savings, choice, quality, and responsibility. Many Americans were afraid that if they lost their job, they or their whole family would lose health coverage, thus Clinton made security of having health insurance a vital part of his speech. He also argued that the healthcare system should be simplified for all actors involved. Clinton tied in the principle of savings to the idea of inclusive managed competition. Americans felt frustrated and limited in regard to insurance and provider choice, and Clinton capitalized on this by arguing that the choice will be left to consumers, "not the boss and certainly not some government bureaucrat" (Clinton 1993).

National mood, however, is just one part of the political stream as organized political forces, specifically interest group activity, is another significant component. The Task Force on Healthcare Reform made a mistake early on during its meetings with stakeholder groups with financial or occupational roles in healthcare. While members of the task force held hearings and met with leaders from stakeholder groups in order to discover new ideas and gauge the political lay of the land, stakeholder groups believed they were getting implicit commitments from the task force. This was not the intention of the task force, which assumed "that groups would appreciate being heard, even when not heeded" (Skocpol 1997, 58). This became a point of contention between interest groups and the designers of the Clinton health plan as they felt betrayed. Their anger only increased when Clinton's plan was leaked, enabling to see how few of their suggestions were included. Coalitions began to form, not in support of the plan, but in opposition. One of the most influential organized political forces against the Health Security Act was the Health Insurance Association of America (HIAA), which consisted of midsized and

small insurance companies. The HIAA spent between $14 and $15 million opposing the Health Security Act, which was more than any other interest group. The most successful way they targeted the health plan were through their portrayal of a middle-class white couple discussing the limited options imposed by the billion-dollar bureaucracy that was created by the health plan. HIAA also spent millions on grassroots action targeting insurance company employees, small businesses, veteran groups, and older citizens. The combination of the two resulted in "heightened public uneasiness" (Skocpol 1997, 138). HIAA was far from the only organized political force that opposed the Health Security Act as the American Medical Association, American Hospital Association, and Federation of American Health Systems also pursued strategies to decrease support for the plan. These groups were not influential on their own, but rather it was the combination of all of their activities that opposed specific provisions that "worked together to sow anxiety about virtually all the core public regulatory features of the Clinton plan" (Skocpol 1997, 143).

The national mood began to shift because of organized political forces as well as ideological arguments from Republicans. The Republican campaign against the Health Security Act capitalized on the widespread popularity of people's personal medical plans and aimed at convincing "people to forget concerns about the system as a whole by arousing fears that the quality of their personal medical care would be fundamentally undermined should the Clinton plan succeed" (Skocpol 1997, 145). The combination of extreme ideological arguments and interest group activity not only swayed the national mood but created bandwagoning in opposition to it. Opponents of the Health Security Act, particularly interest groups, were able to alter the national mood to their favor as public opinion started to turn against the bill as seen in the figure below.

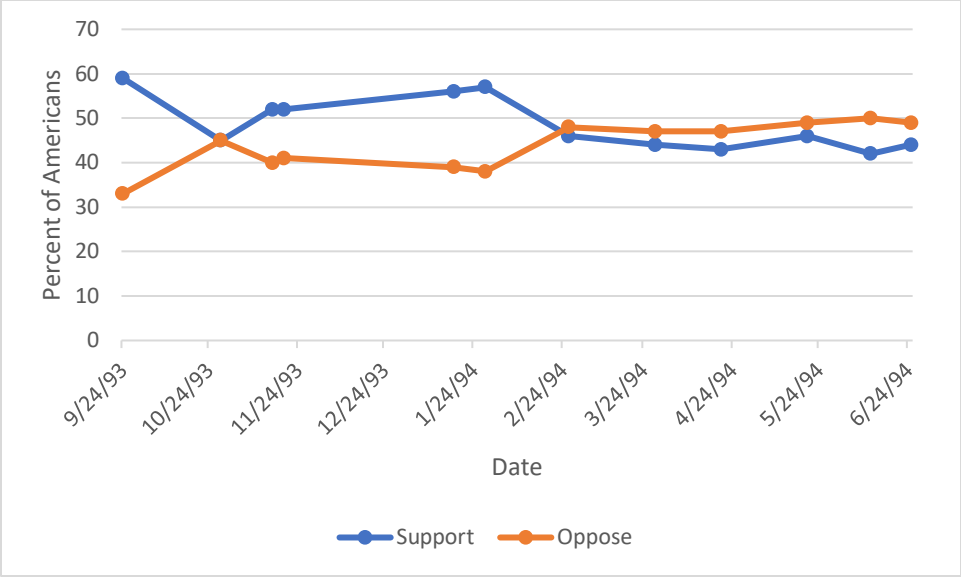


***Figure 6*** *Public support for the Health Security Act was originally strong with 59% of Americans supporting. However, opposition grew in February 1994 and by June 50% opposed the bill (Skocpol 1997).*

A major factor of the Affordable Care Act's political stream was the change in government that occurred with the 2008 election. The election provided Democrats with a majority in the House of Representatives and a filibuster-proof majority in the Senate. While Clinton also saw a majority in both chambers, he did not have a 60-seat majority in the Senate, which was a significant advantage for Obama as it meant the Affordable Care Act could pass with zero Republican votes (Kingdon 2011). However, the 60-seat majority that Democrats held in the Senate served as both a blessing and a curse as Democratic leadership was forced to cater to the needs of each individual Senator as "every single Senator can, in effect, hold up the entire body" (Jacobs and Skocpol 2010, 64). This happened just a few weeks before the entire Senate voted on the Affordable Care Act as Sen. Lieberman, an Independent who caucused with the Democrats, warned on a televised appearance that he could withdraw his support for the bill, which would prevent its passage, prompting a quickly scheduled meeting with White House officials (Jacobs and Skocpol 2010). Other conservative and moderate Democratic senators, such as Levin (MI), Landrieu (LA), and Nelson (NE) were able to extract special provisions for their

constituency in exchange for votes as the ACA needed the support of every Democratic senator (Frates 2009). Another important governmental phenomenon is the battle over jurisdiction between governmental actors. Initially, there was cooperation between congressional Democrats and experts in the CBO, especially since Obama appointed former CBO director Peter Orszag as director of the Office of Management and Budget, which develops fiscally sound proposals. Conflict occurred between Democrats and the CBO when the CBO refused to release preliminary scores for different packages Democrats wanted (Jacobs and Skocpol 2010).

Just as governmental phenomenon provided Democrats with the legislative seats to enact comprehensive healthcare reform, the 2010 special election of Republican Scott Brown endangered passage of the ACA. After his surprise election to the Massachusetts Senate seat, Democrats believed the national mood had turned against them as voters were "worried about a poor economy with vanishing job and sluggish commerce, and irritated that all the DC politicians seemed to be talking about were unsavory deals to complete a huge, expensive, incomprehensible health reform" (Jacobs and Skocpol 2011, 104). Thus, in order for the ACA to pass, the House would either have to pass the exact same bill or the agreed upon adjustments could be passed through the reconciliation process in the Senate, which only required a majority (Jacobs and Skocpol 2010).

Legislators had to remain cognizant of the national mood, especially during the initial stages of designing the new health reform law. During the summer congressional recess in 2009, legislators faced explosive town halls with many angry constituents. These anti-reform protests utilized extreme rhetoric, such as comparing Obama to Nazis and claiming that "death panels" would decide who lived and died and started to turn public support against health reform. Legislators and White House officials began to consider pursuing more moderate healthcare

reform measures, but in a televised speech in September of 2009, Obama once again made the argument for comprehensive health reform which has been credited with improving public opinion and encouraging congressional committees to resume work on health care reform. During his speech, he reframed the debate over the ACA as either "doing something versus accepting a despised and unworkable status quo" (Jacobs and Skocpol 2010, 54). Obama's speech and the several town halls he hosted throughout the country in 2009 allowed for constituents to address their concerns (Jacobs and Skocpol 2010). Holding town halls and listening to citizens' concerns is an essential part of measuring the national mood and shaping it to gain support for policies. President Clinton failed to adequately address the national mood as there was little communication between supporters of the Health Security Act and the general public. The policy and political actors behind the Health Security Act did not directly engage with the public, leading for the public to believe that "the great health care debate of 1994 never took place" (Yankelovich 1995, 10). This highlights how the national mood is fluid and can significantly impact the political stream and can be impacted by it.

The policy actors supporting Affordable Care Act took a different approach by delegating initial responsibility to Congress and bargaining with organized political forces. Clinton and his Task Force on Healthcare Reform took the lead in designing the Health Security Act, essentially sidelining Congress and organized political forces. Obama, however, was not entirely removed from the process as he set broad requirements the new law would need at a White House forum. From then on, Congress had the primary responsibility of developing the law while Obama hosted several town halls around the country on the topic of healthcare reform. Recognizing the failure of the Health Security Act, Obama and the White House made a concerted effort to give Congress the primary leadership role, allowing Congress to "weave its ungainly way toward

actual legislation by building the necessary coalitions to enact it through five committees and the entire House and Senate in less than a year" (Jacobs and Skocpol 2011, 56). While there were trade-offs in regard to Obama's hands-off approach, such as missed congressional deadlines and feelings of abandonment among grassroots allies, it was crucial for Obama to utilize a strategy that was different from Clinton if he wanted to succeed. Legislation crafted by Congress has the highest chance of passage because if "congressional committees draft the bills and then meld the different versions, members of Congress will have a personal stake in the outcome" (Kingdon 2011, 241).

One of the most significant components of the political stream was the bargaining that took place between Obama, White House officials, and congressional Democrats and organized political forces. White House officials such as Chief of Staff Rahm Emanuel and Senate Finance Committee Chair Max Baucus developed a plan to "keep powerful groups at the table [and]… prevent them from allying against [Obama] as they did against Clinton" (Jacobs and Skocpol 2011, 68). Legislators and government officials worked closely together to alter legislation following feedback from political forces such as healthcare providers, big drug companies, and private insurers. Healthcare provider groups such as the AMA and the AHA agreed to support the ACA as the payoffs they would receive were greater than the cuts. It was especially crucial to get support from the AMA, which opposed comprehensive health reform for the past half century. Interest groups representing drug companies and private insurers engaged in intense bargaining with Democrats, with neither side obtaining all of the measures they desired. White House officials framed the ACA as necessary for healthcare stakeholders as they would receive increased business from the individual mandate, which would help offset the money they were giving up. After the election of Brown in 2010 imperiled the ACA, interest groups concluded

they "wanted something rather than nothing to pass" and worked together to make a concerted final push in support of the law (Jacobs and Skocpol 2011, 111).

Kingdon (2011) concludes that the more favorable attitudes of interest groups, composition of Congress, and the strategic decisions of the Obama administration made passage more likely than during the Clinton administration.

### The Convergence of the Three Streams and the Policy Window

As Kingdon (2011) stated, when the policy window opens, it does not remain open for long. The Health Security Act briefly had a policy window, but Clinton and his advisors did not act fast enough. Following Clinton's presidential address, several media events, and the introduction of the Health Security Act in Congress, the policy window was open as the problem was clearly defined around cost and access, the policy community among liberals and deficit hawks supported the bill, and there was bipartisan willingness to cooperate. However, Clinton and his advisors became distracted by other events, specifically violent conflicts internationally in Somalia, Moscow, and Haiti as well as a concerted focus on the passage of the North American Free Trade Act (NAFTA). Clinton wasted political capital on NAFTA, which was not popular in the Democratic caucus. Instead of pursuing an extensive campaign to build a coalition around the Health Security Act, Clinton waged "an all-out campaign of public persuasion and Congressional arm-twisting just when he should have been devoting his time to explaining his health reform to the American people" (Skocpol 1997, 79). Comprehensive health reform was also pushed aside by budget negotiations that took place over the course of summer 1993. The White House doomed healthcare reform as "from May onward the White House put healthcare reform on hold and-more important- pulled it back into secrecy" (Skocpol 1997, 81). White House officials purposively kept details secret as they feared that opposition would easily mount,

but in keeping the plan secret they deprived people of learning about the plan. Clinton and his allies did not seriously push for passage of the Health Security Act until spring 1994, nearly a year after the task force completed its work. By that point in time, the national mood and organized political forces had turned against reform (Skocpol 1997).

The passage of the ACA shows that Obama and allies were able to take advantage of the policy window that opened. The ACA benefited from more favorable conditions in all three streams as the problems of U.S. healthcare worsened, there was more widespread agreement over the basic structure of reform, greater willingness among organized political forces to bargain, and a more Democratic Congress. Obama and allies were able to capitalize on the opening of the policy window because of smart strategic decisions and increased unity over healthcare reform. Unlike Clinton, Obama did not wait months to try and enact comprehensive healthcare reform like his advisors suggested, and instead included healthcare reform in his first budget. After convening a White House summit on healthcare, he tasked and encouraged congressional committees to assemble bills that followed his broad requisites. There was also unity among Democrats and the policy community among these requisites, which stood in stark contrast with the Clinton plan as only liberals and budget deficits hawks were in support. Further, interest groups were more willing to work to pass comprehensive healthcare reform, especially as they had a formal seat in negotiations and bargaining over specific provisions. With these three streams working together, the policy window opened, however that does not ensure passage. Obama and his allies worked together to achieve passage while the policy window was still open. They recognized it would not stay open forever, and realized they had the greatest chance of success during his first year. By delegating to Congress with drawing up the legislation, it

allowed for Obama to work on other priorities, such as the economic recovery, but still exert presidential leadership and guide the process (Jacobs and Skocpol 2010).

## Paths Forward

After comparing the passage of the ACA with the failure of the Health Security Act through the multiple streams framework, advocates of universal health coverage need to pursue a strategy similar to Obama's. Advocates will need to work closely with organized political forces to compose legislation that can be enacted. Political forces, as exemplified with the Health Security Act, can wage extensive campaigns against universal coverage and failure to actively work with these groups will increase the difficulty in passing universal coverage. In dealing with political forces, specifically interest groups, advocates must actively bargain with these groups and propose enough benefits to outweigh the costs. Obama and his allies learned from the failure of the Clintons by openly bargaining with these stakeholders. Secondly, advocates must realize the best time to propose universal health coverage and have the political acumen to act when needed. Health care, specifically issues with cost and access, have long been salient issues, and as discussed previously these issues have continued to plague U.S. healthcare. The problem stream is already relevant, but advocates must learn from the lessons of the Health Security Act and take action when the time is right. Advocates must prioritize universal healthcare if they want legislation to be enacted. In drafting legislation, advocates need to combine the approaches of Clinton and Obama. Clinton was criticized for too much executive involvement, while Obama was criticized for too little involvement. Further, Obama faced criticism for not providing clear leadership or direction when obstacles occurred, particularly during Brown's special election victory. Advocates must allow the president to set a broad baseline for legislation that Congress will draft and build coalitions within the legislature and provide clear executive leadership that

can guide the legislative process. However, advocates of universal healthcare face the obstacle of incrementalism, which as discussed previously, suggests that universal healthcare proposals continuously fail because reform happens gradually and must build off of existing systems. Advocates must take into account the influence of incrementalism when designing the proposal in the policy stream, otherwise it will most likely suffer the same fate as proposals from Truman, Clinton, and many others.

# Chapter 3: Applying the Multiple Streams Approach to Medicare for All

Considering the issues in the healthcare system that were outlined advocates have made a renewed push for comprehensive health reform, with proposals to establish universal health coverage dominating the conversation among liberal politicians. The most prominent proposal has been Medicare for All, which would mainly eliminate private health insurance and cost sharing in favor of a government funded and administered program. A bill was formally introduced by Vermont Sen. Bernie Sanders (I) during the 116th Congress. Sanders and several other former candidates in the 2020 Democratic presidential primary have expressed support for single-payer healthcare, although there is much variety in their proposed plans (Medicare for All Act of 2019). To better understand the policy context and environment in which Medicare for All is being discussed, I will utilize Kingdon's multiple streams framework. Kingdon's multiple streams framework is relevant for the same reasons as discussed because it addresses the policymaking process and factors that can influence the passage of legislation.

## The Problem Stream

While I have already described the problem in my first chapter, I will expand upon the arguments and information I laid out in that chapter because actions by President Trump and his administration have exacerbated current issues. After Trump's election, which gave Republicans complete control of the federal government, it was widely expected they would attempt to repeal the ACA as they were able to pass a partial repeal in 2015, which Obama vetoed (Haberkorn 2016). The American Health Care Act passed in the House of Representatives on a party-line vote of 217 to 213 and would have phased out funding for Medicaid expansion, removed the individual and employer insurance penalties, allowed insurers to increase costs for sick individuals and set aside $8 billion for states to partially reduce their increased premiums (Jost

2017). Any efforts to partially repeal and replace the ACA were more complicated in the Senate as Republicans did not have the 60 votes to overcome a Democratic filibuster and utilized the reconciliation process so only 51 votes were needed. The Senate considered three different proposals to repeal and replace the ACA. First, there was the Better Care Reconciliation Act, which would have allowed insurers to deny coverage to individuals with pre-existing conditions. BCRA failed with all Democrats and nine Republicans voting against it. The second option, the Obamacare Repeal and Reconciliation Act, would have repealed Medicaid expansion, the individual mandate, and premium subsidies. This, however, also failed with 55 votes against and 45 in favor. The last option was the so-called "skinny repeal", which would only repeal the individual and employer mandates. The skinny repeal had the greatest odds of passage, but also failed with three Republican senators voting against it in addition to the entire Democratic caucus (Park, Parlapiano, and Sanger-Katz 2017). Since these efforts have failed, the Trump administration has shifted strategies by primarily undermining the ACA through executive action. These actions have contributed to worsening the issues of cost and access.

The only major enacted legislation related to the ACA was the Tax Cuts and Jobs Act of 2017 which contained two major provisions regarding the ACA and health policy. First, the bill repealed the individual mandate penalty, which required individuals who did not have insurance to pay a tax penalty. The bill also limited the federal deduction for individuals paying state or local taxes to $10,000, which could cause states that have more generous Medicaid programs to "exert greater tax effort to sustain their current spending on the program" (Thompson, Gusmano, and Shinohara 2018, 402). The CBO and Joint Committee on Taxation (JCT) estimated that repealing the individual mandate would increase the uninsured rate by 13 million by 2027 and increase premiums in the health exchanges by 10% nearly every year for the next decade. The

individual mandate's penalty was the primary reason why many individuals obtained insurance, and with its elimination these people no longer have any incentive to pay for health insurance and makes other provisions difficult to sustain financially (Congressional Budget Office 2017).

Beyond repealing the individual mandate, the Trump administration has implemented several policies through executive action aimed at limiting the potential impact of the ACA. The administration has sought to reduce the number of individuals enrolling in the insurance exchanges by reducing the advertising budget for enrollment, shortening the enrollment and application period from three months to a month and a half, and cutting the funds allocated for enrollment assistance (Thompson, Gusmano, and Shinohara 2018; Center on Budget and Policy Priorities 2020). These policies aimed at decreasing enrollment are likely to have adverse effects on the stability of the exchanges as "the exchanges will require sufficient levels of enrollment, including enrollment from young or otherwise healthy individuals who might be less likely to purchase health insurance" (Government Accountability Office 2018, 1-2). The Trump administration and Centers for Medicare and Medicaid Services (CMS) have issued new rules that allow employers to shift employees to individual health plans, which can create issues due to the complexity of the individual marketplace. Employers with a sicker workforce are more likely to take advantage of this, which would increase premiums for everyone and cost $51 billion over ten years. Further, CMS announced states could alter subsidy structures that help individuals obtain insurance. Currently, subsidies are based on income, but CMS is encouraging states to create a new subsidy based on age, rather than income, and it would be a flat tax credit (Center on Budget and Policy Priorities 2020).

The Trump administration has also jeopardized the insurance markets by approving association health plans (AHPs), which do not have to fulfill the regulations imposed by the

ACA. The ACA created many new regulations for insurance plans that were aimed at protecting people with pre-existing conditions, ensuring plans covered essential benefits, and providing protections against bankruptcy due to illness. The rules previously allowed individuals to enroll in an AHP for three months, but they did not cover all of the benefits that long-term plans must follow according to the ACA. However, the Trump administration has changed this by allowing individuals to stay in an AHP for up to a year with the possibility of renewing the plan. The expansion of AHPs threaten to destabilize the insurance market because they can offer lower premiums than the individual exchange, siphoning off healthy enrollees who will now receive fewer benefits. When these healthy individuals abandon their more comprehensive health insurance for AHPs, they make it costlier to insure individuals with pre-existing conditions who cannot leave their comprehensive plans. The individual market relies on healthy people because without them, costs increase due to the greater number of older and sicker people. Further, these plans offer worse benefits and enrollees could be subject to catastrophic costs when they face coverage gaps (Center on Budget and Policy Priorities 2020).

The Trump administration's decision to end the cost-sharing-reduction (CSR) payments has directly increased costs for many consumers. Under President Obama, the government gave CSR payments to insurers to compensate for insurance reductions given to low and middle-income enrollees in the exchanges. President Trump, however, ceased CSR payments to insurers in October 2017 (Center on Budget and Policy Priorities 2020). Following the elimination of CSR payments, many insurers withdrew from the exchanges, while insurers increased premiums by an average of 20% (Kamal et al. 2017). The CBO reported that in addition to premium hikes for individuals in the exchanges, 1 million people would lose insurance within one year and the federal deficit would increase by $194 billion over ten years (Center on Budget and Policy

Priorities 2020). Eliminating CSR payments increases the federal deficit because insurers are then forced to increase premiums for individuals in the exchanges, requiring the federal government to pay more in tax credits for individuals who receive subsidies (Congressional Budget Office 2018).

While each of these policies implemented by the Trump administration have done damage, the combination of all have worsened the problems of cost and access that were previously discussed. The CBO and JCT report that there were 29 million uninsured Americans below 65 in 2018, which will climb to 35 million by 2028. Federal health coverage subsidies for Americans under 65, which were $685 billion in 2018, are projected to increase at an average rate of 6% every year and cost $1.2 trillion by 2028. The exchanges and nongroup market have stabilized despite the many policies the Trump administration have pursued, but premiums are expected to increase by an average of 7% each year over the next decade. Even though a majority of Americans will still receive coverage through their employer by 2028, nearly 4 million Americans are estimated to lose their employment-based coverage either because of the elimination of the individual mandate or premiums that are rising faster than wages. Medicaid and CHIP are expected to cover 25% of the under 65 population by 2028, although 1/3 of those eligible for Medicaid will not receive it because they do not reside in a state that has expanded Medicaid (Congressional Budget Office 2018). Healthcare is projected to become an even larger share of GDP, increasing from 17.8% in 2019 to 19.4% by 2027, with cumulative health care spending totaling $6.0 trillion. Expenses for both Medicare and Medicaid are expected to grow faster than private insurance between 2020 and 2027 due to an increase of older and sicker enrollees who will need more healthcare services (Centers for Medicare and Medicaid Services 2019).

As expected, advocates of universal healthcare have primarily defined the problems with U.S. healthcare in terms of poor access, high costs, and underperforming quality throughout press conference speeches, press releases, congressional speeches, and congressional hearings. In defining the problem along these issues, they have relied on a combination of indicators, measurements, and personal stories in order to fully capture the scope of the problem (Jayapal 2019; *Original Jurisdiction Hearing: Medicare for All* 2019; "Senator Bernie Sanders Speech" 2019; "Senator Sanders News Conference" 2017). Advocates have also begun to define the problem beyond the scope of cost, access, and quality as they have placed blame on insurance and drug companies, raised concerns over the inefficiencies related to administrative costs and over reliance on emergency medicine, argued the US lags behind other countries, and stated that healthcare is a human right. In speeches and testimony, advocates have decried the immoral insurance and drug companies who have earned billions in profits from the current healthcare system while working Americans are going bankrupt (*Original Jurisdiction Hearing: Medicare for All* 2019). The CEO of UnitedHealth was a recurring example as they had an income of $82 million (Jayapal 2019; "Senator Bernie Sanders Speech" 2019). During a 2017 press conference introducing the bill, Sen. Kirsten Gillibrand (D-NY) stated "Too many insurance companies continue to value profits more than the value of the people they are supposed to be helping. It is time for something better" ("Senator Sanders News Conference" 2017). Advocates have also defined the problem as unique to the U.S. as other countries have forms of universal health coverage and have better access and quality while paying less, with Sen. Sanders tapping into the idea of American leadership as he said "As proud Americans, our job is to lead the world on health care, not to be woefully behind every other major country" ("Senator Sanders News Conference" 2017). Most prominently, advocates have framed health care as a human right that

everyone deserves, not a privilege that can be bought as Sen. Mazie Hirono (D-HI) stated this seven times during her speech ("Senator Sanders News Conference" 2017). This argument has appeared most frequently across speeches in support of Medicare for All with supporters stating that they are fighting for basic human rights. Congressional representatives, medical professionals, and advocates have coupled their statements with measurements and personal stories that provide credibility to their claim that health insurance is currently a privilege (*Original Jurisdiction Hearing: Medicare for All* 2019). By defining the problem as a human rights violation, rather than just focusing on cost and coverage, advocates are able to generate a powerful message about the current structure of healthcare in the US.

## The Policy Stream

Currently in the 116th Congress, there have been two different proposals that would establish universal healthcare by expanding Medicare to all Americans. Both are entitled the Medicare for All Act of 2019, but the two versions do contain some difference. The Senate version (S.1129) was introduced by Sen. Sanders, while Rep. Jayapal introduced the House version (H.R.1384). While several Democratic presidential candidates have put forth their own universal healthcare proposal, with many different variations of Medicare for All, I will focus on the two formal plans that have been introduced as legislation in the 116th Congress in February and April 2019. I will first discuss Sen. Sanders version as he introduced it in 2019 and then discuss some of the differences between the two.

Under Sanders' Medicare for All Act of 2019, the government would become the chief financier of insurance and provide it to all Americans upon birth, who would receive a Universal Medicare card. Medicare for All would establish a Universal Medicare Agency within the Department of Health and Human Services to administer healthcare. While private and employer

insurance is allowed, it can only be used as supplemental insurance to cover benefits not included under Medicare for All. Since Medicare for All would cover all citizens, it would eliminate other government programs, such as Medicaid, CHIP, TRICARE, federal employee health insurance and the exchanges established by the ACA. These programs would be terminated at the start of the fourth year after the bill is enacted. It would, however, keep the Veterans Administration and Indian Health Service separate, at least for ten years. The bill includes a comprehensive list of benefits, including inpatient and outpatient hospital services, ambulatory services, primary and preventive treatment, prescription drugs, mental health services, substance abuse treatment, reproductive care, pediatrics, oral care, vision, audiology, and institutional long-term care. Americans would not pay any type of cost sharing for these benefits, including no deductibles, copayments, or coinsurance. There is an exception, however, to prescription drugs, but the government will negotiate the price of the drugs with pharmaceutical companies. Upon negotiating prescription drug prices, the Secretary would create a formulary, which is a list of all the prescription drugs. The formulary would be used to encourage "best practices" for prescribing them and promote the usage of generics. Under Title III of the bill, providers would have to sign non-discriminatory agreements and would be subject to both national and state standards, which would include quality of facilities, comprehensiveness and continuity of services, and patient satisfaction. The Secretary of the Universal Medicare Agency would develop guidelines, policies and procedures related to eligibility, enrollment, benefits, provider participation, funding levels, and provider payment amounts. The bill also establishes regional offices throughout the country that would work with the Secretary in the implementation and evaluation of universal healthcare. The bill also explicitly mentions the Secretary should collaborate with various stakeholders that form the

health policy community. Existing governmental entities, such as the Center for Clinical Standards and Quality and the Agency of Healthcare Research and Quality, will take the lead in quality assessment of the services provided under the bill. The Center for Clinical Standards and Quality will also be tasked with investigating health disparities along racial, ethnicity, socioeconomic, gender and geographic groups. The Universal Medicare Agency will create an annual budget containing funds needed for all health expenditures, quality assessments, administrative costs, and education. The bill would maintain the current system of Medicare payments, fee schedules, but will allow experimentation to continue with alternative payment structures. Title VII establishes the Universal Medicare Trust Fund, which would contain the budgets of current government-run health programs, such as Medicare and Medicaid (Medicare for All Act of 2019; Health Over Profit 2017; Sanders 2019b).

One of the most significant components of the Medicare for All Act of 2019 is how it will transition the US into a single-payer healthcare system, characterized by public insurance for all with care delivered by private health providers, such as doctors and hospitals. In the first year of enactment, only individuals over the age of 65 will automatically be enrolled in Medicare for All. For individuals under the age of 65, they will have several options, which include keeping their current insurance, whether it is private or public. Individuals in the exchanges, however, will be transitioned into Medicare Transition Plans, which serves as a public option. Only individuals between the ages of 55 and 64 could choose to purchase a Transition Medicare Buy-in plan in the first year, with people between the ages of 45 and 54 eligible for that plan in the second year of enactment. This trend continues in the third year as residents between the ages of 35 and 44 can enroll then. During the first three years, these individuals can keep their current insurance, but upon the fourth year they will be transitioned into Medicare for All (Health Over

Profit 2017; Medicare for All Act of 2019; Sanders 2019b). While the bill does not contain explicit information on funding, Sen. Sanders released a document explaining potential revenue sources. These revenue sources included establishing a 4% income-based premium paid by employees or a 7.5% percent one paid by employers, increasing the progressive tax rate up to 70% for income above $10 million, taxing inheritances valued over $1 billion at a rate of 77%, and proposing taxes on "extreme wealth" (Sanders 2019c).

Rep. Pramila Jayapal's bill is extremely similar to the one described above as it would automatically cover all Americans, eliminate other governmental programs, keep the HIS and VA separate from single-payer care, allow private insurers to cover additional services, prohibits cost-sharing, and establishes a Medicare Trust Fund where funds for government programs would be deposited in the first year. However, there are a few important differences between the two bills. First, Jayapal's bill would utilize a two-year transition to Medicare for All, instead of the four-year transition used in Sanders' version. Individuals who are under the age of 19 or over the age of 55 will be enrolled in Medicare for All in the first year, with all other individuals enrolled in the second year. This bill also contains a more generous list of covered benefits, which includes all long-term care and dietary and nutritional therapies as well as no out-of-pocket costs for prescription drugs. Another important distinction is how the two bills would pay providers as Sanders' bill keeps in place Medicare's fee schedules, while Jayapal's establishes a global budget for payments institutional providers, such as hospitals, skilled nursing facilities, and others. Under this provision, institutional providers would receive one lump sum payment for all covered operating expenses, which includes wages and salaries, prescription drugs, purchase of medical devices and supplies, patient care, education, and administrative costs (Jayapal 2019; Keith 2019; Medicare for All Act of 2019, H.R. 1384; Roamer and Minium

2019). Despite the differences between the two bills, they are extremely similar and both would establish the same form of universal healthcare.

However, Medicare for All is not the only policy to expand healthcare that is being debated in the policy community. Several advocates are pushing for more incremental measures as some believe private insurance should still exist. The two legislative proposals that would expand coverage, yet not at the rate Medicare for All would, are the Medicare for America Act of 2019 (HR 2452) and a federal public option, which has been proposed in several bills. The Medicare for America Act of 2019 would establish a federal health program but allows individuals to opt out in favor of qualified employment-based or private insurance plans (The Kaiser Family Foundation 2019). HR 2452 was introduced by Reps. Rosa DeLauro (D-CT) and Jan Schakowsky (D-IL) and was based on proposals from the Center for American Progress, Yale political scientist Jacob Hacker, and analyst Jon Walker (Cohn 2019). This proposal, and a similar one from former Democratic presidential candidate Pete Buttigieg, have typically been defined as "Medicare for all who want it" (Scott 2019). Under the bill, individuals with Medicare, Medicaid, and CHIP would be enrolled in this plan and would have some amount of cost sharing unless their income is below 200% of the FPL (The Kaiser Family Foundation 2019). The most important distinction between HR 2452 and the proposals advanced by Sanders and Jayapal is that the former maintains a role for private insurance in providing employment-based coverage and Medicare Advantage plans (Statement of Tricia Neuman, *Pathways to Universal Health Coverage* 2019). Another more incremental approach that has received attention is the establishment of a public option, which was discussed during debates over the ACA. Proposals featuring a public option are different from the Medicare for America Act of 2019 because they do not automatically enroll all eligible individuals and keep intact all current

forms of public insurance, like Medicare and Medicaid, as well as private insurance. There are currently four bills in Congress that would establish a public option and it has the backing of two Democratic presidential candidates. The public option would create a Medicare-like program that exchange-eligible individuals could enroll in for better coverage at a lower cost. Proposals differ in the eligibility as some restrict it to exchange-eligible individuals only, while others expand it to large and small employers or to those with private insurance (Oberlander 2019; Statement of Tricia Neuman, *Pathways to Universal Health Coverage* 2019). Medicare for All proposals and these more incremental measures highlight the "policy soup" component of the policy stream Kingdon discussed. These policies are being debated and contested by the policy community and, ultimately, will undergo a period of change and recombination with other policies.

Policy analysis is an important component of Kingdon's multiple streams approach as policies must be discussed and debated within the policy community. By utilizing several evaluative criteria and analyses of Medicare for All, I will conduct my own policy analysis to contribute to the policy community. I have selected criteria from Bardach's eightfold path, which serves as a detailed approach to policy analysis. Bardach identifies three evaluative criteria relevant to health policy—efficiency, equality, and freedom. Political feasibility is a significant criterion and is discussed later in the politics stream section. Efficiency refers to the extent to which the benefit is greater than the cost from a monetary perspective. For this analysis, efficiency is measured as the cost of the proposal and its ability to transition individuals from their current plan to Medicare for All. Two other important evaluative criteria are equality and freedom. Bardach argues equality is best understood through practical examples of seeing how low-income groups or racial minorities may be disadvantaged because of a new policy. For this analysis, equality will refer to the degree that individuals gain access to insurance, as well as the

distribution of the economic costs and effects across disadvantaged groups. Likewise, freedom is a broad concept that includes free markets and economic freedom, free speech, and religious freedom, but will be measured by the amount of choice individuals would have under Medicare for All. Process values refers to the degree to which individuals have the opportunity to provide input on a proposed policy and will be considered as a component of freedom. This can provide not only more legitimacy to the policy but can improve it because of the wide variety of input one would receive (Bardach 2012).

The table below summarizes the cost assessment of several different studies analyzing Medicare for All or other similar single-payer proposals. Blahous (2018) and Pollin et al (2018) used the 2017 version of the Medicare for All Act, while Blumberg et al. (2019) and Liu and Eibner (2018) used a general single-payer system with comprehensive benefits and no cost-sharing.

| Study | Payment Rate | Savings | Projected Utilization | Total Health Expenditures |
|---|---|---|---|---|
| Blahous 2018 | 60% of private insurance | $846 billion from prescription drugs and 7-point reduction in administrative costs | Increases among privately insured, elderly, and uninsured | Between $27.7 and $38.8 trillion over ten years |
| Blumberg et al. 2019 | Either 115% or 140% of Medicare rates | Administrative costs of either 3% or 6% | Capacity either expands to meet demand or decreases | Between $32.5 and $36.9 trillion over ten years |
| Liu and Eibner 2019 | 124% for hospitals and 107% for physicians | Decreased prescription drug spending and administrative costs save $743.3 billion | 50% of new demand is unmet or there is no unmet demand | Between $3.89 and $4.2 trillion per year |
| Pollin et al. 2018 | Current Medicare rates (78% of private insurance) | Savings of 19.2% | Utilization increases among non-elderly, elderly, and uninsured | $2.93 trillion per year |

***Figure 7*** *Estimates for Medicare for All have ranged from $27.7 to $42 trillion over ten years depending on the author's methodology.*

After analyzing some of the potential costs of Medicare for All and single-payer healthcare, the proposals can be evaluated utilizing the evaluative criteria that was discussed earlier. Medicare for All faces several efficiency issues because of its attempt to transition from a hybrid public-private insurance system to an entirely public system. The most challenging part of the transition will be for the 185 million Americans who receive private insurance. The bill remains vague as to how these individuals will be transitioned from their current coverage to Medicare for All in a two-year period under Jayapal's bill or a four-year period under Sanders', which may not be enough time for patients, providers, and regulators to adapt to these changes (Liu and Eibner 2019). Due to the scope of change Medicare for All would impose on American healthcare, a substantial phase-in period is needed (Blumberg et al. 2019). The federal government would need an additional $2.7 trillion in revenue to administer the program just in the year 2020. Over a ten-year period, the federal government will need to raise between $30.6 trillion and $34.9 trillion in additional revenue (Blumberg et al. 2019). The Committee for a Responsible Federal Budget (2019) proposed potential funding sources, which include reducing federal non-health spending by 80% or instituting a 32% payroll tax, while Pollin et al. (2018) argue revenue could be raised through some measures such as an increase in taxes for non-necessary goods and an 0.38% tax on net-worth over $1 million. However, Medicare for All could provide savings and reduce national health expenditures by $458 billion annually. A significant amount of savings would be derived from instituting a unified billing and administrative system. The unified billing and administrative system utilized by Medicare is significantly more efficient than private insurance companies, as administrative costs for Medicare comprise 2.2% of the budget compared to 12.4% for private insurance companies. Utilizing Medicare's administrative system under single-payer coverage could provide savings of

$219 billion. Significant savings could be further gained by negotiating pharmaceutical prices, which would reduce costs by $180 billion (Galvani et al. 2020). While these savings would generate net benefits, there are concerns regarding the costs that Medicare for All would impose. These costs go beyond total health expenditures and include macroeconomic costs. Increasing payroll taxes to finance Medicare for All could have negative economic effects by shrinking the economy (CRFB 2019). While instituting Medicare's fee for service payment rates on hospitals and clinics could provide savings of up to $100 billion per year, it could present net costs (Galvani et al. 2020). If rates are too low, providers may choose not to participate in Medicare for All and instead enter into private contracts, retire sooner, or change career paths (Liu and Eibner 2019). Low payment rates would either make the system more efficient or capacity might not increase to meet demand, resulting in longer wait times and failing to deliver increased access to care (Blumberg et al. 2019; Liu and Eibner 2019).

Medicare for All has a high degree of equality and fairness as it expands coverage to include all Americans. It also removes potentially high out-of-pocket costs for everyone. This is especially important for the uninsured population. Since Medicare for All would insure all Americans and removes out-of-pocket costs that prevent many from seeking necessary care, it achieves a high degree of equality as individuals would be able to receive care regardless of their socioeconomic status. The cost of health insurance remains a primary issue for many families and individuals, but Medicare for All would make sure they are able to receive care. The bill also contains provisions specifically aimed at low income individuals. Since Medicare for All would replace Medicaid, there were some concerns related to how Medicaid recipients would be affected. However, Medicare for All will positively impact Medicaid beneficiaries as well as other low-income individuals because it makes eligibility requirements the same across the

nation, rather than the current system of unequal eligibility requirements. It would also eliminate the variability in benefits packages as all Medicaid recipients would receive the same benefits across the nation and continue to cover essential benefits such as the Early and Periodic Screening, Diagnostic, and Treatment (ESDT) benefit which provides care to low-income children (Tolbert, Rudowitz, and Musumeci 2019). Medicare for All also helps achieve equality as it has the potential to reduce racial disparities in insurance coverage as all Americans would be covered. By removing the financial barriers to health insurance, Medicare for All achieves a high degree of equality as it provides insurance to all socioeconomic levels and racial groups. Medicare for All can also achieve equality as it has the potential to save 68,531 lives per year because it expands access to insurance, with individuals between the ages of 25 and 35 more likely to benefit (Galavni et al. 2020). Freedom under Medicare for All may be limited depending on the degree to which patients can choose their medical provider, which would depend not only on the structure of the program but also provider payment rates and wait times. Freedom could also be potentially limited as it does not let individuals opt out of the insurance system as some could arguing that mandating and automatically enrolling all Americans violates the concept of freedom. Medicare for All, however, does allow for some choice as individuals can buy supplemental private insurance to cover benefits not under Medicare for All.

After there is extensive debate in the policy community, the policy community may or may not reach consensus and a tipping point. In order to understand whether the policy community has reached a consensus, testimony from two hearings held by the House of Representatives will be analyzed. Officials who testified at both hearings provide a strong sample of the health policy community as the individuals have decades of experience in research, advocacy, and delivery of healthcare.

Testimony in front of the House Rules Committee and the House Ways and Means Committee revealed the policy community is divided between Medicare for All and more incremental approaches. Out of the ten policy specialists or advocates who testified in front of either committee and recommended a specific course of action, five expressed direct support for Medicare for All or other forms of single-payer, four acknowledged the benefits of more incremental approaches, and another argued for less government intervention in healthcare. Dean Baker, a Senior Economist at the Center for Economic and Policy Research, testified that the U.S. needs universal healthcare, but first needs to fix Medicare itself and could pursue more transitional approaches before fully expanding the program for all Americans (Statement from Dean Baker, *Original Jurisdiction Hearing on H.R. 1384, Medicare for All Act* 2019). Sara Collins, Vice President of Health Care Coverage and Access for the Commonwealth Fund, likewise testified that Medicare for All could help many Americans, but there are other proposals that can expand access to affordable healthcare that "can be implemented without a major reorganization of the healthcare system" (Statement from Sara Collins, *Original Jurisdiction Hearing on H.R. 1384, Medicare for All Act* 101, 2019). Pam MacEwan, the Chief Executive Officer of Washington's Health Benefit Exchange, and Chiquita Brooks-LaSure, Managing Director at Manatt Health Strategies LLC, also expressed support for policies that would build off of the ACA, such as a public option or Medicare buy-in (*Pathways to Universal Health Coverage* 2019). Policy specialists who testified in support of Medicare for All were steadfast in their belief that healthcare is a human right and the U.S. must establish universal health coverage. Due to this divide, the policy community has not reached consensus and, consequently, has not reached a tipping-point in terms of building support. Medicare for All, however, could slowly garner more support among the policy community if it has a longer

"softening up" stage, but until that takes place, it appears unlikely to receive a major backing from the policy community.

## The Politics Stream

As previously discussed, there are three main components in the politics stream—the national mood, organized political forces, and changes in government. While the national mood has not entirely moved towards supporting Medicare for All, its leftward shift has given politicians the illusion of broad support for single-payer healthcare. The national mood swinging leftwards is natural considering the length it swung towards the right. Even though the ACA is not a conservative policy, it did reflect a rightward shift in the national mood as it built upon, protected, and utilized private insurance to extend coverage (Oberlander 2019). Even the public option, which has now emerged as a popular proposal to expand healthcare coverage, had to be dropped in order to secure passage of the ACA. It was unimaginable for single-payer healthcare to be a central component of the Democratic nominee for president a decade ago and the issue could not even receive a hearing during the debate on healthcare reform that led to the ACA (Oberlander 2019; Wilensky 2019). There are two main reasons why the national mood has moved leftward—the 2016 election and attempted repeal of the ACA (Oberlander 2019). The two events worked together to cause a leftward shift nationally, particularly among Democrats. Proposals to institute a single-payer system have existed for decades, as previously discussed, but Sen. Sanders "put momentum behind it in his 2016 presidential campaign, and is doing so again" (Levitt 16, 2019). The strong performance by Sanders and the challenge he presented to Secretary Clinton during the 2016 primary helped move Medicare for All towards the Democratic mainstream as his success showed a leftward turn in the party (Young 2019). Republican attempts to repeal and replace the ACA prompted backlash from many constituents.

GOP town halls in February 2017 saw crowds yell “Shame!” and “Resist!” and one constituent told a GOP lawmaker that repealing the ACA was akin to “taking away my freedom and justice” (Colliver 2017). Multiple publications describe the town halls that were held by Republican lawmakers from February to August 2017 as raucous, angry, and hostile towards their effort to repeal and replace (Cheney and Bade 2017; Colliver 2017; Fortin and Victor 2017; Weigel 2017). Soon after the GOP’s failure to repeal and replace the ACA, Sanders introduced the Medicare for All Act of 2017, with several influential Democratic senators standing behind him in support. This moment, which featured support from hundreds of healthcare activists, grassroots members, and political allies, helped solidify that the Democratic base believed “that Obamacare hadn’t gone nearly far enough, and the only way to secure its gains was with something more radical” (Cancryn 2019).

The national mood consists of many different components, with public opinion amongst them, and a majority of Americans have supported Medicare for All since June 2017 (Lopes, Hamel, Kearney, and Brodie 2020).

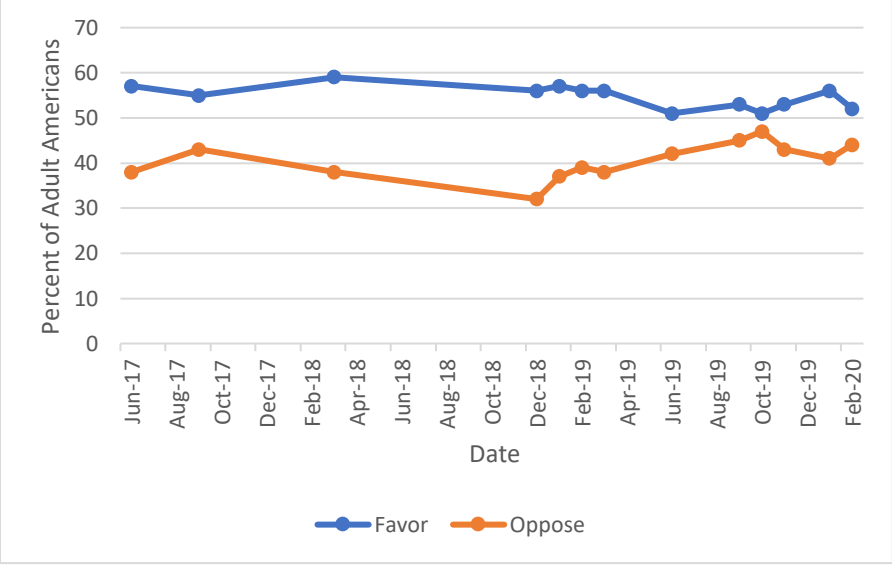


***Figure 8*** Over the past two years, a majority of Americans have supported Medicare for All (The Kaiser Family Foundation 2020).

Democratic candidates for the 2020 election have established single-payer healthcare as the "benchmark" for healthcare reform, however, support fluctuates depending on how the plan is described (Young 2019).

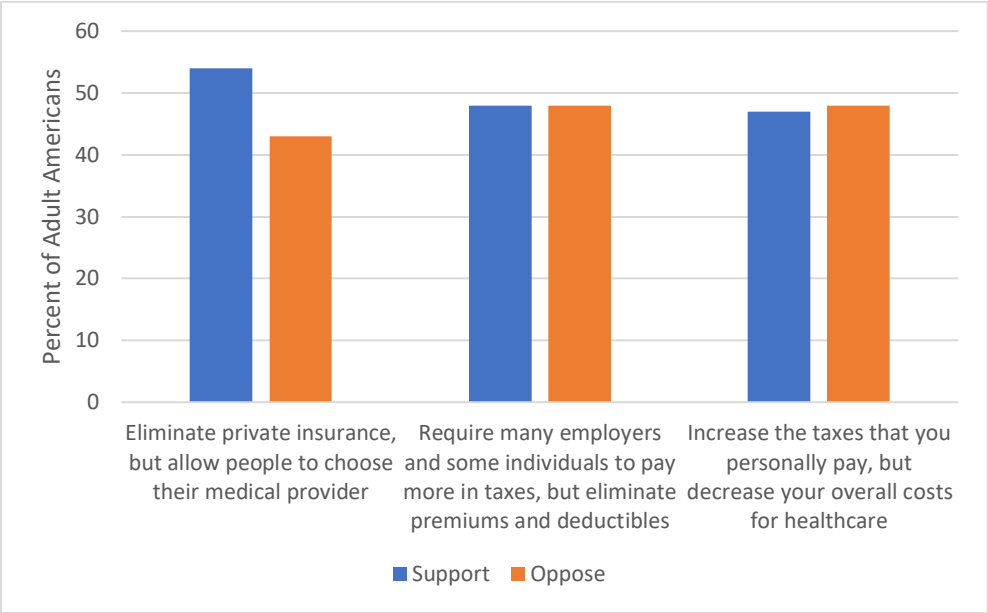


***Figure 9*** *Support for Medicare for All decreases depending on how it is framed (The Kaiser Family Foundation 2020).*

While the surveys from the Kaiser Family Foundation report a majority of Americans support Medicare for All, a majority of respondents also believe that people would be able to keep their current insurance (Lopes, Hamel, Kearney, and Brodie 2020). These findings undermine support for Medicare for All as most Americans are unaware of the actual effects of the bill. A majority of Democrat voters, meanwhile, would rather vote for a candidate who supports building on the ACA rather than replacing it with Medicare for All (The Kaiser Family Foundation 2020). Concerns have already been raised by constituents as freshmen Rep. Elissa Slotkin, who represents a Michigan swing district, stated that people have already become nervous about the prospect of government-run insurance (Armour and Jamerson 2019). The national mood serves as just one obstacle towards Medicare for All in the politics stream.

As the national mood towards Medicare for All continues to evolve, organized political forces have begun to take action. In response to Medicare for All, the Partnership for America's Health Care Future was formed to oppose passage of single-payer healthcare. The Partnership consists of groups from nearly every facet of the health industry. The Partnership received over $5 million in just the first six months of its existence, with the coalition serving as "the most formidable source of focus resistance to 2020 Democrats' health plans outside of the Trump reelection campaign" (Cancryn 2019). Even though the Partnership had not begun lobbying lawmakers in the first quarter of 2019, its member organizations did not wait. From the first quarter of 2018 to the first quarter of 2019, the number of lobbyists working on Medicare for All increased from 29 to 270 as nine of the ten organizations with the most lobbyists oppose Medicare for All (Sandler 2019).

Democratic political elites remain divided over Medicare for All. Rep. Jayapal's bill has received 118 cosponsors, while Sen. Sanders' 2019 version has 14 cosponsors. Two caucuses have formed within the House of Representatives that have endorsed single-payer healthcare. Over 60 House Democrats belong to the Medicare for All Caucus, which was launched in the summer of 2018 (Weixel 2018). Single-payer healthcare has support from a significant number of either current or former 2020 Democratic presidential candidates as four senators cosponsored Sanders' bill, three cosponsored Jayapal's bill, and Mayor Bill de Blasio also said he supports single-payer (Young 2019). However, it is unlikely Speaker Nancy Pelosi (D-CA) will allow a vote on Rep. Jayapal's bill to occur in order to protect moderate freshman representatives. Speaker Pelosi opposes Medicare for All as she supports more incremental approaches that can build off of the ACA (Wilensky 2019). Pelosi and moderate members want to work to stabilize and improve the ACA, lower out-of-pocket costs for prescription drugs, allow individuals in

their 50s to buy into Medicare, and ban short-term insurance plans that do not offer comprehensive benefits. Political elites, who previously considered the idea of a public option as too liberal, now welcome the idea as a moderate and incremental approach to expand coverage (Stolberg and Pear 2019). Opposition to Medicare for All among organized political forces will make it extremely difficult for the bill to gain passage.

The last significant component of the politics stream is change in government. With the 2018 midterm elections, Democrats regained control of the House, ending any attempts to repeal and replace the ACA. As previously discussed, Democratic representatives in the House have moved in opposite directions as some have pushed for Medicare for All, while others have pushed for more incremental measures. Progressive Democrats may feel emboldened to pursue Medicare for All because of their success in the midterm elections as well as the leftward movement of their party. However, Medicare for All was not a successful policy platform for Democratic House candidates in the midterm elections. In the midterm elections, only a slight majority of Democratic House candidates, 51%, supported Medicare for All. Only in districts that were labeled as Safe Democratic, meaning Clinton won by at least 20 points in the 2016 election, did a majority of candidates support Medicare for All. Support for Medicare for All was lowest in districts that Trump won by less than 5% as only 15% of candidates supported single-payer healthcare, signifying that "Democratic candidates were least likely to support Medicare for All in marginally Republican districts where it could reduce their chances of winning" (Abramowitz 2019). An analysis of 2018 election results in competitive House districts where there was either no Republican incumbent or Trump won the district by less than 10 points showed that Democrats who didn't support Medicare for All won more races than those who did support it (72% versus 45%). This is significant as at least thirty-one of the forty seats Democrats

won were in these competitive House districts (Abramowitz 2019). While the midterm elections were a victory for Democrats, it was a noticeable defeat for single-payer proponents and this will make it increasingly difficult to increase support for Medicare for All if politicians in competitive races will lose if they support it.

It is difficult to predict how the 2020 presidential election will affect Medicare for All's passage, but it will be difficult to enact Medicare for All no matter the outcome of the election. Sen. Warren (D-MA), a former leading contender for the Democratic nomination, was forced to alter her proposed timeline of healthcare reform following significant backlash. Under her current plan, she would work to expand public healthcare coverage to all children, Americans who make up to 200% of the FPL, and allow people to buy into it. She would then pursue Medicare for All in her third year of office. In response to this, Sen. Sanders announced he will introduce Medicare for All legislation in the first week he's in office (Goodnough, Kaplan, and Sanger-Katz 2019). Even if Democrats retake control of the White House from Trump, Medicare for All is still far away from passage. If candidates supportive of Medicare for All were more likely to lose in the midterm elections, they may face significant obstacles if the Democratic nominee intends to pursue single-payer healthcare. Democrats do not control the Senate and many 2020 Senate Democratic candidates running to unseat Republican incumbents in Arizona, Colorado, Iowa, and North Carolina and trying to defend their seats in Alabama, New Hampshire, and Michigan are campaigning on incremental measures rather than Medicare for All (Ollstein and Arkin 2019).

Currently, Medicare for All has failed to gain significant support from the national mood, organized political forces, or changes in government. Further, there is no consensus over Medicare for All in the policy community. The policy window only opens when all three streams

converge. As of now, it is extremely unlikely for the policy window to open as the politics and policy stream are not fully supportive of single-payer healthcare.

## Policy Alternatives

Other policy options, such as a public option, are being considered and debated by the policy community. While analyzing Medicare for All, Blumberg et al. (2019) also analyzed several other policy options. The options they analyzed represent some of the proposals that are being debated within the policy community.

The first two options Blumberg et al. (2019) analyzed are described as incremental as both make only small changes to the ACA. Their first reform option would reduce cost-sharing requirements and premiums for individuals up to 400% of the FPL. This option would expand coverage to nearly 4 million Americans and decrease the uninsured rate by 12.5%. Under this reform option, federal spending would increase by $25.7 billion per year, but federal costs for uncompensated care would decrease by $4.8 billion. State and average household spending would also slightly decrease due to less uncompensated care and an increase in insured nonelderly individuals. The second reform option is the same as the first one but would also restore the individual mandate and prohibit short-term limited-duration plans. Even though this option would provide insurance to 6.3 million people, the number of uninsured would equal the first reform option because this one would prohibit short-term limited-duration plans. The federal government would pay slightly less under this plan, $24.5 billion, but state governments, employers, and individuals would all spend roughly the same compared to the first reform option (Blumberg et al. 2019).

The next several reform options analyzed by Blumberg et al. (2019) would go further than the first two options. A third option would give individuals who live in states that have not

expanded Medicaid premium tax credits and cost-sharing reductions if their income is below the FPL. It would also automatically enroll SNAP and TANF participants into either their state's Medicaid program if it was expanded or into a private insurance program with premium subsidy levels at or below non-expansion state's. The federal government would also pay all the costs associated with Medicaid expansion in states that have expanded their program. This option would provide insurance to an additional 10.8 million Americans but would increase federal spending by $81.3 billion per year. Employers, states, and households would have significant savings under this program; however, total national spending would increase by $40 billion. The next reform builds on these provisions by including a public option and would cap provider payment rates in addition to having all of the same components as the third reform option. This option would expand coverage to 11 million additional Americans and increase federal spending by $46.7 billion. The last reform they analyzed creates a public option with Continuous Autoenrollment with Retroactive Enforcement (CARE) which all individuals would be enrolled into if they do not otherwise have insurance, most clearly resembles the Medicare for America Act of 2019. This option would also eliminate the penalties for employers who do not provide health insurance. Through the automatic enrollment into the public option, the uninsured rate would decrease by 80% as 25.6 million Americans would gain insurance. However, 6.6 million would remain uninsured because they are not legal residents. Federal healthcare costs would increase by $122 billion, but employers would save roughly $90 billion in healthcare costs (Blumberg et al. 2019). Since the policy community has yet to reach a consensus on Medicare for All, they are still considering a variety of other policies that may have greater political and technical feasibility in addition to social acceptability.

# Conclusion

Efforts to reform U.S. healthcare to address the issues of cost, access, and quality through universal healthcare have spanned decades. As discussed earlier, the existing literature has espoused several theories explaining its failure over the decades. The institutional theory argues it is institutional factors, such as Senate procedural rules, that prevent universal healthcare from gaining enough support. While the incremental theory appears similar, it is different from the institutional theory because it states that policies must build off of each other and gestate long enough for the public, media, and policy actors to fully debate the proposal. Lastly, flaws in presidential strategy, such as President Clinton drafting his universal healthcare proposal rather than Congress, have also been seen as the primary cause for failed attempts at establishing universal healthcare.

After applying Kingdon's multiple streams theory to Clinton's health plan and the Affordable Care Act, I argue that the incremental and presidential strategy theory are the most applicable for understanding why universal healthcare proposals like Clinton's have failed but a major expansion of the government's role in healthcare through the ACA succeeded. The incremental theory is best examined through the policy stream where it is being debated and modified by the policy community. The incremental theory explains the enactment of the ACA because it directly built on the existing public-private hybrid system and utilized policies that were discussed before the ACA was considered, such as the individual mandate or previous proposals to expand Medicaid. Components of the ACA were even modeled off of Massachusetts's healthcare reform law of 2006. This is in stark contrast to the Health Security Act, which would already face several obstacles since it would represent a major shift in how Americans would receive health insurance. Not only was the Health Security Act proposing a

fundamental change in the insurance industry, but did not include provisions from previous proposals, with Kingdon writing that the bill appeared "unfamiliar and untested" (Kingdon 2011, 236). Since the ACA utilized an incremental approach by building off of, rather than replacing, the current system and included provisions that were previously discussed, it highlights the benefits of gestation. By allowing the policy community and those outside to fully debate and consider the proposals over time, it allows for a stronger degree of consensus to be established. The presidential strategy theory is most clearly seen in the political stream. By allowing Congress to draft the legislation rather than forming a presidential task force to do so, the ACA had a greater likelihood of passage because congressional leaders could design it to maximize their votes. President Obama also integrated and included interest groups in forming the bill better than the Clinton administration. These two significant differences in presidential strategy bolstered the chances for the ACA to be enacted.

Unlike the other two theories, the institutional theory only partially explains the enactment of the ACA and the failure of the Health Security Act. President Obama and senior congressional Democrats leveraged the institutions to help secure passage, such as only needing a majority in the Senate rather than sixty votes to pass the ACA. However, the institutional theory is not entirely applicable to the failure of the Health Security Act. The institutional theory can potentially be seen as a factor depending on the outcome of the 2020 presidential and congressional elections as a candidate who supports Medicare for All could win the presidency but fail to have a majority in Congress. Thus, while the institutional theory should not be completely dismissed, future scholarship and evaluation of healthcare reform proposals should primarily enlist the incremental and presidential strategy theories to explain whether it can be passed.

Applying these two theories to the Medicare for All Act is a useful strategy to further evaluate its odds of passage. While Medicare for All is tied to an existing program, it is a fundamental shift in the purpose of Medicare as instead of covering seniors, it would cover everyone. Further, it would entirely replace the public-private hybrid system and create an entirely new system. According to the incremental theory, it would be extremely difficult to gain sufficient support. While it is too early to assess how the presidential strategy theory would impede or aid the Medicare for All Act, it already faces significant barriers. These barriers include the aforementioned organized political forces and many congressional Democrats. Supporters of Medicare for All, however, may emphasize the support the proposal has among the general public and how elected officials should focus on this rather than opposition from political forces. Advocates should primarily focus on the policy stream to increase support for Medicare for All because if the policy community could reach a consensus, some moderate Democratic lawmakers could be swayed. The policy stream can also change and alter Medicare for All in order to resolve some of its issues, such as the high cost.

Due to these issues, other policies can be considered. The policy that comes closest to establishing universal healthcare, while not placing all Americans on Medicare, is the Continuous Autoenrollment with Retroactive Enforcement (CARE) proposal. The CARE proposal has already gained some traction among the policy community outside the Urban Institute, which conducted the original analysis, as policy entrepreneurs from the Brookings Institute have expressed support for some version of it (Young 2019). This option would serve as a more incremental approach and a potential compromise between the differing factions in the Democratic party.

There are several limitations to the arguments and conclusions that appear throughout this paper. First, this paper is constrained due to time limitations. This is especially evident during the application of the multiple streams approach to the Health Security Act, ACA, and Medicare for All as time limits the amount of research I can conduct because I am unable to discuss every single aspect of the problem, policy, and politics stream for all three bills. Further, I primarily utilized secondary sources that describe and analyze the events surrounding each of the three bills and did not use primary sources. The individual analyses of Medicare for All have their own limitations as well. Each analysis of Medicare for All includes different assumptions as to how the law will be implemented, specifically for provider payment rates, and possible effects, such as supply constraints. The different assumptions each researcher included in their design explains the range of cost estimates. This serves as a limitation on the overall Medicare for All analysis I have conducted as it is impossible to know all of the specifics of Medicare for All that have not been included in the bill as well as the externalities.

Future research should further examine the previously discussed theories in explaining the failure or success of healthcare reform. Scholars should continue to analyze Medicare for All, despite not knowing all of the details. If scholars examine the costs and impacts of different versions of Medicare for All that have different components, such as the generosity of benefits, provider payment levels, or cost-sharing requirements, policy entrepreneurs would be able to make a more informed decision. Researchers and policy entrepreneurs should also analyze other forms of universal health insurance beside Medicare for All. While Medicare for All has emerged as the dominant policy proposal, there are other forms of universal coverage, such as the national health service (NHS) and socialized health insurance (SHI). Research must be conducted to see if either form could provide higher quality care at a lower cost.

This study aimed to explore the current systemic problems in the U.S. healthcare system and possible reform options to achieve universal coverage and the barriers they could face by examining past reform efforts. By conducting this analysis, it contributes an understanding of the factors involved in past healthcare reform attempts and provides a framework suggesting that the best path forward is to attempt more incremental measures to contain costs and extend coverage.

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