Making one final pitch for his sweeping health-care plan, the president turned to the issue of cost. Making health insurance affordable, he told the primetime television audience, meant ensuring that “everybody is covered—and this is a very important thing—unless everybody is covered, we will never be able to fully put the brakes on health care inflation.”

In the president’s analysis, achieving universal coverage meant that the federal government had to compel consumers to purchase insurance and force businesses to offer it. “Some call it an employer mandate, but I think it’s the fairest way to achieve responsibility in the health care system,” the president said, defending the controversial proposal. “And it’s the easiest for ordinary Americans to understand, because it builds on what we already have and what already works for so many Americans.”

The president conceded that some people would have to pay more as a result of the costly requirements, while others would get financial relief. “If you’re a small business with fewer than 50 employees, you’ll get a subsidy. If you’re a firm that provides only very limited coverage, you may have to pay more....If you’re a young single person in your twenties and you’re already insured, your rates may go up somewhat because you’re going to go into a big pool with middle-aged people and older people,” the president said. “[A]nd we want to enable people to keep their insurance even when someone in their family gets sick....If you currently get your health insurance through your job, under our plan, you still will. And for the

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first time, everybody will get to choose from among at least three plans,” he promised.

This was the president’s closing address to the American people as he made one final push for passage of his sweeping plan. It was delivered on September 22, 1993. The president was Bill Clinton.

The similarity to more recent presidential health-care reform pitches is not coincidental. The Patient Protection and Affordable Care Act of 2010 borrowed heavily from the Clinton-era plan known as “Hillarycare.” As first lady, Hillary Rodham Clinton played an instrumental role in crafting that 1993 plan, which laid out a sort of blueprint for progressive health-care reform that subsequent proposals have followed—including the plan she proposed as a presidential candidate in 2008.

In fact, Hillary Clinton’s “American Health Choices Plan” for her 2008 presidential campaign serves as an instructive bridge between her 1993 legislation and the achievement of its key provisions in Obamacare. Clinton is the historical author of Obamacare’s principal tenets, and for more than two decades she has served as their most constant champion. In its major elements and its ethos, the passage of Obamacare was a triumph of the legislative effort that Hillary Clinton launched in 1993. And Hillarycare, in turn, can tell us a great deal about where she likely thinks Obamacare should go from here.

THE BLUEPRINT

In 1993, Hillary Clinton was appointed by President Bill Clinton to lead the secretive task force that drafted his administration’s health-care reform proposal. Once it was completed, she was tasked with selling it to Congress. Immediately after President Clinton’s address to a joint session of Congress in September 1993, calling for Congress to pass his bill, Mrs. Clinton pressed for its enactment, appearing for several days of congressional testimony.

The 1993 Health Security Act proposed a comprehensive overhaul of the American health-care system, starting with health insurance. Large employers were required to offer health-care coverage, and every American was required to carry insurance. Employers had to provide at least the federally defined “standard” package of health-care benefits, and businesses had to pay for at least 80% of the cost of covering those benefits. The plan also subsidized companies to help offset some of the cost of the premiums for these mandate-rich policies. After
these premium subsidies, the total cost of the plans to businesses would be capped at 3.5% of their total payroll costs for small firms and up to a maximum of 7.9% of payroll costs for large firms.

Hillarycare, much like Obamacare, didn’t fully exempt self-insured companies from the new rules and mandates. The federal rules that outlined the services that the health plans had to cover, and the amount of cost-sharing permitted, applied to the employer insurance plans. Hillarycare itemized these services, detailing in the proposed statutory text the precise screening tests and vaccinations that insurance policies would have to cover, as well as “family planning services,” which were intended to include abortion coverage. Architects of the plan would later brag that there were almost 100 pages devoted to enumerating the specific tests, treatments, and preventive services that had to be covered. (Obamacare’s authors left many of these specifics for regulators to decide later on; the decisions of those regulators effectively mirrored the Hillarycare lists.)

Hillarycare, like Obamacare, also included a play-or-pay mechanism. Businesses were required to offer health-care coverage. If they didn’t, they had to pay a penalty (or tax). That fee would be used to help offset the cost to the federal government when their employees instead purchased the mandatory coverage in one of the new regional “exchanges.”

In addition to the mandates on individuals and employers, the heart of Hillarycare was the creation of these exchanges, where insurers would be forced to sell their coverage to consumers compelled to purchase it. Clinton’s 1,342-page proposal would have corralled all Americans into what were called “regional health alliances.” These were the precursor to Obamacare’s exchanges. The main difference between the two is the fact that the Clinton exchanges were multi-state and thus fewer in number, whereas under Obamacare, each state is required to set up its own separate, free-standing “marketplace” or employ a federally run one.

These Hillarycare “alliances” were charged with implementing the federal rules on benefit design, premiums, and cost sharing. This is how Hillarycare co-opted state regulation of insurance and federalized it—and it is, on these fronts too, the model Obamacare used for its exchanges. Consumers were forced to shop for coverage inside the “alliances” — there was to be no alternative market. If Americans didn’t sign up for one of the plans, they would be automatically enrolled and then penalized; they would have to pay as much as twice the cost of the
premium of the health plan that they ultimately selected. Obamacare includes a similar penalty, which the Supreme Court later ruled to be a tax.

These regional alliances were a state-based system of health-insurance marketplaces that would control access to health plans. They also handled enrollment, collected premiums, and enforced the federal insurance rules. In a report evaluating the Clinton health-care plan, the Congressional Budget Office noted in February 1994 that the alliances “would combine the functions of purchasing agents, contract negotiators, welfare agencies, financial intermediaries, collectors of premiums, developers and managers of information systems and coordinators of the flow of information and money between themselves and other alliances.”

While the similarities between the alliances and the exchanges are revealing, there are some key differences between Hillarycare and Obamacare that are instructive, as they expose some of the lessons learned from the 1993 reform’s failure. First, under Hillarycare, employers were under pressure to move their employees into the exchanges from the outset, although large businesses could opt out of the alliances. Employers with more than 5,000 workers could create their own exchanges, which functioned as separate pools for their own workers.

Obamacare, by contrast, let the individual insurance market co-exist alongside the state-based exchanges, at least in the first year of operation. People could still go out and buy a “grandfathered” health plan directly from an insurance company — if any such policies were still available in their state. Whereas Hillarycare eliminated the individual markets from day one, which would have set off more initial disruptions for people who already had coverage, Obamacare eroded these plans over a period of several years by gradually subjecting them to costly regulation.

It’s clear that Obamacare’s architects expected the health plans sold in the individual market to quickly migrate onto the exchanges — an outcome that is largely unfolding. They also expected the plans sold in the small-group market — mostly fully insured plans available to small businesses — to similarly move onto the exchanges in very short order. It’s a distinction between the two reforms that doesn’t offer much of a practical difference: President Obama knew that individual and small-group plans would be crowded out by the exchanges and quickly wither away. But he learned from the mistakes of 1993 and didn’t abolish these plans at the very outset, which allowed for slower-moving, less direct disruption.
As mentioned above, the 1993 Health Security Act (like Obamacare) sought to mandate a costly package of mostly routine health-care benefits, like regular checkups and reproductive services, that all insurance plans would be required to offer. Shorter shrift was given to catastrophic services; insurers could meet the requirements by offering skinny plans that covered a lot of front-end, primary care but skimped on services when it came time to treat more serious conditions like cancer — again like Obamacare. By requiring a highly prescribed standard set of benefits, the 1993 plan also created both a floor and ceiling on the coverage that health plans would offer.

Hillarycare would have created commodity health plans, with little variation or choice between benefits, drug formularies, or doctor networks. The Hillarycare plans would have largely competed on the price of premiums and cost sharing. This is the same market doctrine that’s taken shape under Obamacare. The insurance plans sold in the Obamacare exchanges are all the same basic, cookie-cutter benefit package, with similar networks of doctors, covered services, and restrictive, closed drug formularies. For the most part, the only thing that varies among a typical insurance company’s choice of differently plated plans — their bronze, silver, gold, and platinum offerings — is the cost-sharing structure. As people pay more money to buy a pricier metal plan, moving from bronze to platinum, they are increasing their premiums to lower their subsequent cost-sharing. In effect, they are buying down their out-of-pocket costs.

These same economic constraints also formed the basis of “competition” in the 1993 alliances, where architects envisioned that competition would similarly turn on premiums, rather than a combination of premiums, cost-sharing, and benefit design. The Hillarycare benefit, like the arrangement under Obamacare, was benchmarked to the arrangements found in lower-end commercial HMOs that were already on the market.

**CONSOLIDATE AND REGULATE**

The standardization of a commodity benefit by each of these plans was no coincidence; it’s a key part of the progressive view of health care. At the root of this strategy is a belief that consumers don’t have enough information or aptitude to responsibly choose among different benefit designs and make informed choices when it comes to their benefits. Since consumers can’t be trusted to decide for themselves, the variables
are largely held constant for them. As a result, in the new markets envisioned by both Obamacare and the 1993 Clinton plan, insurers are left with limited ability to tweak benefits, so they can compete almost exclusively on the price of premiums, which they must do by finding ways to cheapen their networks and drug formularies.

This drastic reform of the market is entirely intentional: Under Hillarycare, and Obamacare after it, the idea was to focus competition away from benefit packages (which were standardized by federal rules) and toward the premium cost of the plans. The only way insurers could really cheapen the underlying benefit and hold down premiums was to get more control over utilization. And when Washington fixes the benefit design, the only way to get more control over utilization is to get leverage over doctors. For health insurers, that means either contracting with only a small number of physicians in very narrow networks or buying out the medical practices so doctors can be controlled outright. In the early 1990s, when it seemed as though something like Hillarycare might be enacted, this bias in favor of the consolidation of health-care providers into large HMOs and health systems was dubbed “managed competition.”

We are witnessing similar consolidation today under Obamacare, as parallel economic principles drive comparable market responses, especially the acquisition of doctors’ practices by hospitals. By 2018 it is predicted that more than 70% of doctors will be employed by hospitals or hospital-based health systems. And this consolidation, in turn, makes it easier for the government both to transfer financial risk onto providers and to regulate doctors.

Another centerpiece of Hillarycare was the creation of the “National Health Board,” a new, presidentially appointed agency. It was, in many regards, a precursor to Obamacare’s Independent Payment Advisory Board, but with more centralized responsibility. The National Health Board, or NHB, also assumed the responsibilities that Obamacare later gave to a new insurance office inside the Centers for Medicare and Medicaid Services and to the United States Preventive Services Task Force.

The NHB was granted oversight over many aspects of health care, including health-insurance premiums, the design of insurance plans, and the approval of new benefits that had to be included in any government-standardized health-care plan sold in Hillarycare’s “alliances.” Like IPAB, the NHB was also empowered to set and enforce spending caps on the growth of the government’s overall health-care budget.
The Clinton plan sought to control costs by outlawing insurance options that would have caused a region to exceed its budget or those that were more than 20% more expensive than the average policy. In this way, the underlying economic value of every plan was standardized. Cost growth would also have been controlled by tying increases in health-plan premiums directly to the consumer price index and bringing cost growth in line with inflation by 1999. Likewise, under Obamacare, the mandate given to IPAB, together with the “Cadillac Tax,” effectively achieves the same standardization and cost-control outcome by capping the value of health-care benefits and tying their growth to measures of consumer inflation. Since both plans tied the rate of growth in benefits to overall inflation, rather than the higher rate of health-care inflation, each plan would gradually erode the real value of the health-care benefit as the increases in medical costs outstrip the index that the benefits are tied to.

The NHB concept also pioneered some of the unusual bureaucratic and legal constructs that were eventually adopted in the creation of the IPAB. For instance, Congress would have to proactively intervene if it wanted to controvert the actions of the NHB. Otherwise, the Board’s proposed health-care spending cuts would automatically take effect. Under Section 5232 of Hillarycare, the NHB’s legislative proposals and its decisions on rates and benefits were formally exempt from legal or administrative review. Similar to Obamacare’s IPAB, the NHB’s policies were also exempted from the review by the Office of Management and Budget that normal regulations must undergo. (The OMB would still have reviewed the NHB’s budget, however.) Once established, both the NHB and the IPAB were specifically designed to operate outside of political control.

For the regulation of doctors’ medical practice, IPAB also borrows from its Clinton-era counterpart. The NHB was meant to stamp out the purported variation in the way that doctors practiced medicine from region to region, which both Hillarycare and Obamacare viewed as a sign of clinical waste and bad decision-making by doctors. This variation in how some medical problems are approached by different doctors was a constant lament among the Obama team, and it was a point of focus in the 1990s as well.

The authors of both plans blamed the same culprit—the fee-for-service reimbursement system, in which doctors are paid separately for each
test or procedure they perform. According to progressive reformers, the variation in medical practice is a function of misinformed doctors and misaligned financial incentives. This public scrutiny of doctor decision-making, and the flawed conclusions that flow from it, form the basis of the public case for how and why progressives seek to regulate the practice of medicine. It is not only necessary to help uninformed, confused consumers by giving them fewer variables to think about; it’s also necessary to protect them from abuse by insurance companies and sometimes even doctors themselves.

President Obama has said that the flawed payment system has meant that treatments might be prescribed to the detriment of patients:

The doctor may look at the reimbursement system and say to himself, “You know what? I make a lot more money if I take this kid’s tonsils out.” Now, that may be the right thing to do, but I’d rather have that doctor making those decisions just based on whether you really need your kid’s tonsils out or whether it might make more sense just to change; maybe they have allergies. Maybe they have something else that would make a difference…. So part of what we want to do is to free doctors, patients, hospitals to make decisions based on what’s best for patient care.

Each plan, therefore, tries to standardize clinical practice around a common set of “evidence-based” practices, which requires more regulation and changes in how doctors are paid. Under both schemes, these efforts began with less obtrusive means—pushing government-financed studies to doctors, with the hope of influencing their decisions. (That was the part meant to address the misinformed doctors.) To these ends, Obamacare established the Patient Centered Outcomes Research Institute as a way to finance government studies comparing popular medical treatments to conceivably cheaper alternatives. It was viewed as a way to discreetly steer doctors to cheaper options. The scheme also set aside money to pay government workers to “detail” doctors with the results of these studies. These efforts resemble Hillarycare’s NHB provisions “by which the [National Health] Board shall collect, report, and regulate the collection and dissemination of the health care information.” From there, efforts to regulate care became considerably more invasive.
Both Hillarycare and Obamacare also empowered their respective boards to impose direct controls on clinical practice. The 1993 Health Security Act stated, “The Board shall submit to Congress, by not later [than] July 1, 1995, detailed recommendations respecting the specific method to be used to eliminate the variation” in health-care spending. “In taking into account health care input prices, the Board shall explain what percentage of variation found should be adjusted and what percentage of the premium should be adjusted.” In short, the Board was charged with estimating what percentage of clinical variation between the high- and low-spending providers was an indication of errant clinical practice. It was then tasked with using regulation to try to stamp out these purportedly bad clinical practices.

The NHB was to be charged with setting national guidelines for determining which treatments could be added to a standard government health-insurance package and which were not “medically necessary.” Similarly, Obamacare’s IPAB has de facto authority over access to new treatments and technologies for seniors, since it can cap the rate of spending growth for Medicare. And just as Obamacare gave the United States Preventive Services Task Force the authority to mandate which preventative services have to be covered by both commercial and government health plans, the Clintonian NHB was also required to stipulate “specific items and services as clinical preventive services” and which ones had to be covered by the standard benefit package that all plans were required to offer.

There were many other key similarities between Obamacare and its precursor. If a state refused to set up or join an “alliance” under Hillarycare, the federal government took on the responsibilities for the “non-participating” state—very similar to how states that refuse to set up their own exchanges default into the federal marketplace under Obamacare. To force states to come along, Obamacare contained some of the coercive methods introduced in Hillarycare. For instance, just as under the 1993 proposal, the federal government was empowered to withhold federal funding for other state health programs if a state chose not to comply.

**BRIDGING THE GAP**

As she outlines her platform for her 2016 presidential campaign, Hillary Clinton will be forced to revisit health-care reform. The challenges that
Obamacare has faced will make it tempting for her to try to distance herself from the unpopular reform. And had the 1993 statute been her only foray into writing health-care policy, perhaps the more than two decades that have passed would have given her enough wiggle room. But her 2008 campaign and its health-care reform proposal concretely bridge the gap. Clinton can’t easily shy away from taking credit (or blame) for the fundamental blueprint of Obamacare.

Like her 1993 plan, the key feature of Clinton’s 2008 proposal was a mandate that all Americans must either buy health insurance or pay a “shared responsibility” payment. For Americans who were not covered by their employers or whose employer-based coverage was deemed inadequate, similar to Obamacare and her 1993 plan, Clinton’s 2008 proposal would have offered consumers a refundable tax credit to offset the cost of buying into one of two federal insurance schemes that she proposed to create. The first was an expanded version of Medicare and the second a single, federal exchange that would pool all Americans together.

Under Clinton’s 2008 proposal, employers would also have been required to offer health-care coverage or pay into a federal fund that would be used to help offset the cost of the alternative, government-sponsored health plan—just like her 1993 proposal. It was never clear which employers would be subject to the employer tax, but comments from her campaign suggested that she had a break point of 25 employees in mind. So, under Clinton’s 2008 health-care plan, all employers with more than 25 employees would have to “play or pay.” Obamacare drew the same line at 50 employees.

Clinton’s 2008 proposal also established a “comprehensive minimum benefit threshold” similar to Obamacare’s essential benefits, a costly list of mandated services that health plans must cover, which would have disqualified many health savings accounts. When Clinton announced the proposal in September 2007, Neera Tanden, then-policy adviser to the campaign, told the Washington Post that the plan “puts the consumer in the driver’s seat by offering more choices and lowering costs.” She continued: “If you like the plan you have, you keep it.”

Clinton later echoed Tanden’s assurance while speaking at a primary debate, coining a talking point that President Obama would later borrow. “The reason why I have designed a plan that, number one, tells people, if you have health insurance and you are happy with it, nothing changes,” Clinton said, “is because we want to maximize choice for people.”
Under both her 1993 and 2008 plan, those who did not buy coverage would pay a penalty. This became a key point of debate in the 2008 Democratic primary. In April 2008, the Obama campaign ran a commercial that said that Clinton’s health-care plan “forces everyone to buy insurance, even if you can’t afford it. And you pay a penalty if you don’t.” It was true. At the time, Obama’s health-care proposal did not yet rely on a mandate, a difference that he accentuated on the campaign trail.

Obama laid out the problems with the mandate at a Democratic presidential primary debate in Los Angeles, on January 31, 2008. “If, in fact, you are going to mandate the purchase of insurance and it’s not affordable, then there’s going to have to be some enforcement mechanism that the government uses,” then-senator Obama said. “And they may charge people who already don’t have health care fines, or have to take it out of their paychecks. And that, I don’t think, is helping those without health insurance,” he said. The next month, as the primary race in Ohio tightened, the Obama campaign sent out a direct mail piece to Ohio residents, arguing that “Hillary’s health care plan forces everyone to buy insurance, even if you can’t afford it.” The mailer warned that Clinton’s proposal would “have the government force you to buy health insurance, and she said that she’d consider ‘going after your wages’ if you don’t.”

The mandate, however, was always a key part of the progressive blueprint for health-care reform, evidenced by its inclusion in both of Clinton’s plans. And, like other elements of the Clinton blueprint, it would find its way into the final 2010 legislation.

Clinton defended her proposal with language that President Obama would later borrow for statements in defense of his adoption of her key premise. She said:

[W]e cannot get to universal health care, which I believe is both a core Democratic value and imperative for our country, if we don’t do one of three things. Either you can have a single payer system, or — which, I know, a lot of people favor, but for many reasons, is difficult to achieve. Or, you can mandate employers. Well, that’s also very controversial. Or, you can do what I am proposing, which is to have shared responsibility.

President Obama would later use this same rhetoric. He called his “individual mandate” a penalty to purposely avoid labeling it a tax. After
the Supreme Court labeled it a tax, President Obama tried to refashion it as a “shared responsibility payment.”

Obama’s position on some of the essential features of Clinton’s 1993 and 2008 proposals famously changed after he won election. In short order, the president’s own health-care plan would evolve into something much closer to Clinton’s two proposals. As Princeton professor and Democratic adviser Paul Starr writes, it was in large measure because he inherited his health-care advisors from Clinton. According to Starr, President Obama “dropped or marginalized his health policy advisers from the campaign and brought in advisers with old Clinton connections.” Tanden was among those who joined Obama’s policy staff. Starr writes that Tanden later recalled that, when she asked Obama directly about what he thought of a mandate, he replied, “I kind of think Hillary was right.”

Health-care populism

Now that Clinton’s plan has largely come to fruition with Obamacare, she will need to embrace the shared elements between her own plans and President Obama’s while distancing herself from Obamacare’s problems. This will be no easy feat. But here again, her 1993 campaign for Hillarycare and her 2008 campaign for president provide a plan for moving forward—a populist attack on special interests. The message will likely go something like this: Obamacare successfully expanded access but didn’t solve the problem of high costs. This is the fault of the health-care industry’s special interests—insurers and drug makers—who are profiting from the coverage expansion at the expense of “ordinary Americans.”

During the debate over her 1993 plan, Clinton dismissed objections as the “opposition” and “exploitation” of business interests. Clinton pursued a similar line of reasoning a decade later in an article she wrote for the New York Times Magazine, attempting to recast the public’s perception of her role in the 1993 foibles. “I know what you’re thinking,” she wrote, “Hillary Clinton and health care? Been there. Didn’t do that.” She went on to blame most of our problems of rising health-care costs and difficulty accessing medical services on the technological progress that she said costs too much and on drug makers, hospitals, and providers that earn too much. “Medical advances have the potential to overwhelm the health care system top to bottom,” she wrote. “What drives skyrocketing spending?” she asked rhetorically. “The cost
of prescription drugs” and hospital charges, in large measure because “more than one in four health care dollars goes to administration.”

Fourteen years after Hillarycare, she defended her 2008 campaign plan, and its similarities to her 1993 proposal, with the same populist swipe at the health-care industry. “Individuals will have to have insurance, but we’re going to make it affordable. The health care industry, the drug industry, are going to have to change the way they conduct business,” she told Chris Wallace during her last presidential campaign. “Business will take responsibility, but within a system that will actually get their costs down.”

Speaking that same month at a campaign stop at the Broadlawns Medical Center, she said that to “put patients… first” means “changing the way [drug and insurance companies] do business…. Because ultimately, the American taxpayer pays for the development of a lot of these drugs through NIH grants and other kinds of research grants; we pay for the clinical trials, and then we pay the highest prices in the world. And we’re going to begin to rein that in.”

These same themes have carried through to her contemporary statements when she has lent her support to Obamacare. This year, on May 17, Clinton took to Twitter to argue that “Repeal of the ACA would let insurers write their own rules again.”

In the coming year, Clinton can be expected to turn back to this well-honed theme and to blame any of the health-care system’s problems, which she has done more than just about anyone to advance over the years, on the greed of assorted special interests, rather than on the failure of the left’s economic assumptions. She will be buoyed in these efforts by sharp increases in the cost of medical care and insurance, which she will blame not on the shortcomings of Obamacare, but on the avarice of doctors, hospitals, and especially the companies that manufacture drugs and medical devices. Health-care costs are likely to be a central theme in the next Presidential election.

The Obama administration has taken credit for health-care costs supposedly being kept in check. But they are not being kept in check. It’s true that the cost of providing insurance coverage at the workplace has been held to modest annual increases. But that’s only because employers are adopting the same cheap, narrow doctor networks and restrictive drug formularies made fashionable by the Obamacare plans. Employers are also shifting more costs to consumers in the form of higher co-pays
and deductibles. But every other measure of health-care cost is rising. It will be common this year for consumers to see increases in their insurance premiums of 10% to 30%.

Underlying medical charges are also increasing, much of it the result of consolidation among providers that is enabling hospitals to raise their prices. Meanwhile, utilization rates remain at low levels as consumers, many of whom are saddled with high deductibles and co-pays, avoid seeking medical care. In short, we are paying more money and getting less medical care. These costs are now becoming more apparent, and they will provide a useful backdrop for Clinton’s demagoguery.

A Vision Fulfilled

In 1994, shortly after Clinton’s health-care bill failed to pass Congress and as the conversation turned to the tactics the White House had used to advance the legislation, the New Yorker wrote that Ira Magaziner—one of Clinton’s closest advisers and a key figure in helping her draft the 1993 bill—implied that Hillarycare was similar to Clinton’s education plan when she was first lady of Arkansas. When it came to health care, “the end point was known from the beginning to those at the very top of the pyramid.”

By embracing Obamacare and scapegoating the health-care industry for its ongoing problems, Hillary Clinton is merely pursuing the fulfillment of her original vision for American health care. She is the author of most of Obamacare’s elements, and many of the pieces of the regulatory apparatus have not yet been fully activated. Obamacare, like its blueprint, Hillarycare, established the tools necessary to exercise the required control on the health-care industry, if it has yet to put all those tools to use.

Clinton’s NHB envisioned a much more robust and direct role for government in managing access to medical technology and procedures and a more active role in price setting than that being realized by Obamacare so far. A President Clinton would be more likely than Obama to finally constitute IPAB and set it loose regulating the whole industry. The elements of even greater control of medicine are all embedded in Obamacare, but these provisions are still waiting for their full exercise. This is the unfinished element of the progressive health-care agenda, the detailed outline of which was first laid down more than 20 years ago.
Obamacare, like Hillarycare, principally asserted government control over the delivery of health care. Clinton’s 2016 platform will no doubt focus on exercising that control as a means to forcibly lower prices to make the coverage itself, in her words, more affordable. Of course, Obamacare’s problems go well beyond high prices. But even on the price issue, Clinton looks likely to offer yet another false premise. Prices aren’t rising because businesses are exploiting Obamacare, as Clinton seems set to profess, even if some might be. Prices are going up mostly because businesses are following the law’s dictates—rationally responding to an irrational framework that was invented largely by Hillary Clinton.