The Market Failure Paradox: Political Contention in the U.S. Welfare State

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ABSTRACT

Policies targeting the poor have historically attracted intense partisan conflict in the United States. But this political backlash is not inevitable, and insufficient theoretical attention has focused on why some social policies encounter more controversy than others. This study exploits an unusual case in which two policies that shared the same purpose, period, and national context diverged in political outcomes. Specifically, I leverage the *presence* of political contention within Medicaid—the federal-state health insurance program for the poor—to understand its *absence* in the Community Health Center (CHC) program—an expansive federally funded network of clinics targeting underserved communities. Drawing upon primary documents collected from seven presidential archives (1965-2001) as well as other historical sources, I find that initial policy designs led to the divergence of both discursive opportunity structures and the acquisition of elite support. Specifically, policymakers' articulation of frames aligning with both morals and markets allowed the CHC program to resonate across ideological divides, whereas Medicaid's lack of market alignment and pervasive framing as inequitable inhibited its political support. Developing a concept of the *market failure paradox*, I contend that framing antipoverty policies as correcting for market failures subverts contestations over morality, deservingness, and race that are often at the epicenter of political conflict in the U.S. welfare state.

Keywords: Political Contention; Welfare States; Morals and Markets

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> The right to health care for every citizen is probably the least controversial of any of the rights men have sought through the ages. Controversy does arise, however, over how best to secure the right to every individual. –Edna Tate, Economic Opportunity of Atlanta (1968)[1]

Debate over social policy is perhaps the clearest and most consistent hallmark of partisanship in the contemporary United States. Liberals and conservatives have been sharply divided over the expansion and retrenchment of the welfare state, such that partisan conflict in social policymaking has largely been treated as a foregone conclusion. Indeed, most antipoverty policies do encounter political backlash, leading scholars to conclude that policies targeting the poor are politically vulnerable (Quadagno 1994a; Skocpol 1995; Weir, Orloff, and Skocpol 1988). Yet, political conflict over social policies is *not* inevitable (Howard 2007), and some policies targeting the poor manage to achieve bipartisan support. I argue that this absence of political contention is equally important as its presence (Tilly and Tarrow 2006) if we want to understand the historical evolution and future of the American welfare state.

Despite a wealth of literature on the emergence, variation, and impact of welfare states (Brady and Bostic 2015; Esping-Andersen 1990; Fox 2012; Korpi and Palme 1998; Pierson 2000; Prasad 2006; Skocpol 1992), insufficient attention has been paid to explaining political conflict over social policy beyond traditional cash assistance (for an exception, see Hacker 2002). This is a significant oversight for several reasons. Theoretically, partisan conflict influences all stages of policymaking (Kingdon 1984), but it is particularly important in the initial adoption of policies (Amenta 2003). Political contention is then consequential for program survival, as well as the ability for policies to withstand opposition and adapt to changes in political power. Beyond the

[1] LBJ Library, Papers of Wilbur Cohen, Box 1, "DHEW Medicaid Public Hearing: Atlanta" p. 64 (1968).

policymaking process, political conflict impacts people who rely upon safety net programs; contested policies can engender stigmatization in public program participation and generate antipathy toward the "undeserving" poor (Gilens 1999; Piven and Cloward 1993; Soss et al. 2011). Finally, as political processes generate unequal access to public benefits (Michener 2018; Montez et al. 2020), there are broader implications for how welfare states intervene in or reinforce systems of stratification (Esping-Andersen 1990). Assessing the conditions that generate or suppress political conflict over social policy is, thus, both necessary and timely in the intensely partisan climate of the United States.

To gain purchase on this phenomenon, I leverage an unusual circumstance in which two policies that shared the same purpose, national context, and historical time period diverged from each other in the degree of political contention. Since 1965, the U.S. government has attempted to provide health care to the poor through two major policy interventions: Medicaid, a federal-state health insurance program for low-income families, and the Community Health Center (CHC) program, a federally funded network of clinics targeting medically underserved areas. Unlike Medicaid, which has become a highly contentious policy, the CHC program boasts "almost unprecedented bipartisan favor" (Iglehart 2010). Republicans have wholeheartedly embraced the CHC program as a necessary component of the nation's safety net infrastructure (Mickey 2012). While President George W. Bush was one of the CHC program's foremost proponents, he attempted to slash Medicaid funding. President Obama further expanded the CHC program through the Affordable Care Act—more than doubling the number of delivery sites—yet faced intense opposition from Republicans in expanding Medicaid. Examining how two comparable policies departed so drastically in partisanship provides leverage on broader questions regarding the determinants of political contention in modern American policymaking.

While controversy over Medicaid follows the expectation in the literature that policies targeting the poor are politically vulnerable (Korpi and Palme 1998; Skocpol 1995), bipartisan support for the CHC program is puzzling. There are ample ways in which health centers could have been—or were—politicized. Beginning under President Johnson's War on Poverty, the CHC program was strongly associated with the Democratic party, which could have made it ripe for partisan conflict. The CHC program was also connected with both the Civil Rights Movement and the Black Panther Party (Nelson 2011), such that the earliest clinics almost exclusively targeted urban Black neighborhoods and Hispanic migrant communities (Sardell 1988) and thus could have instigated racial conflict, like other War on Poverty programs (Quadagno 1994). Furthermore, CHCs represented the federal government's direct involvement in the provision of health care, which could have been tarnished by conservatives or the medical establishment as "socialized medicine" or a "government takeover" of health care. To varying degrees, I will show that these conflicts did occur, yet somehow did not induce partisanship. Instead, a groundswell of bipartisan support has led to tremendous growth in the CHC program, such that we now have a nationalized system of clinics serving nearly 30 million Americans in over 12,000 communities nationwide.

With an historically entrenched two-party system, the dearth of empirical research examining the why partisan conflict does or does not emerge in the policymaking process leaves a significant unexplained variable in how safety net institutions have developed in the U.S. To develop a theoretical framework, I draw upon several possible explanations from existing literature of the U.S. welfare state. Policies for the poor can become contentious when they confront debates over deservingness (Cook and Barrett 1992; Katz 1989, 2001; Steensland 2006) and are racialized (Fox 2012; Gilens 1999; Katznelson 2005; Neubeck and Cazanave 2001; Quadagno 1994b; Soss et al. 2011); because the poor lack political power to influence elites (Howard 2007; Nathanson

2010; Piven and Cloward 1993; Weir et al. 1988); depending on how the policies are designed (Prasad 2006; Skocpol 1995; Weir et al. 1988; Wilson 1987); and due to conflicting ideas and philosophies on how the government should address poverty (Campbell 1998, 2002; Jencks 1992; Schön and Rein 1994). While these interrelated explanations provide important components and some of the necessary conditions to understanding the phenomenon, they are insufficient on their own to account for the divergence of political contention.

Rather, I find that frames in alignment with markets and morals were central to the divergence of political contention. Justification of policy intervention in response to the failure of markets—rather than individuals—allowed the CHC program to subvert contestations over morality and avoid political controversy. Building from Somers and Block's scholarship on the ideational embeddedness of market fundamentalism (2005), I develop a concept of the *market failure paradox* to explain these results. First, blaming the market for failing to serve the poor, rather than casting doubt on market principles, instead strengthened its epistemological power over time. Because market failures were perceived as natural or inevitable following principles of competition, employing a market failure logic paradoxically did not challenge the effectiveness of market-oriented policymaking and instead reinforced policymakers' devotion to the market. Second, because the market is understood as failing naturally—through no fault of its own—market failure frames prevent individuals from being blamed for poverty, thereby circumventing debates over morality. Market failure framing counteracted common components underlying political contention over welfare state policies relating to deservingness, personal responsibility, racialization, and stigma. Finally, the blending of market and moral logics allowed for bipartisan political support to coalesce around state interventions in addressing poverty. I therefore contend

the framing of social policies in response to market failures has the potential to suppress political conflict in neoliberal welfare state regimes, like the United States.

Methodologically, this study uses a "parallel case-oriented strategy" (Ragin 1987) by leveraging the presence of political controversy within Medicaid, the positive case, to examine the absence of these features in the CHC program, or the negative case. I draw upon primary documents collected from seven presidential libraries, spanning from both programs' legislative origins in 1965 under President Johnson through President Clinton's administration ending in 2001. The confidential materials from within the executive branch reveal explicit details on political strategizing, rationales for policy decisions, and disagreements among elite actors, providing rich insights into the process of policymaking. Systematically analyzing more than 15,000 pages of archival materials, supplemented with secondary sources and media coverage, I employ techniques of pattern matching and process tracing to assess cross-case associations and identify mechanisms that explain variation in the policy outcomes (Mahoney 2003). The article first reviews possible explanations for the antecedents of political conflict over social policy, defines political contention, details the case selection and methodological approach, and then traces nearly forty years of historical evidence by comparing the policies within each time period.

EXISTING PERSPECTIVES ON THE POLITICS OF ANTIPOVERTY POLICY

Empirical research bridging political contention and the welfare state is limited, due to the widely held conclusion that antipoverty policies are bound to encounter backlash. The foremost program to be studied, Aid to Families with Dependent Children (AFDC), has generated the lion's share of evidence that policies for the poor are stigmatizing and politically vulnerable, and this assumption remains undisputed (for an exception, see Howard 2007). Yet, narrow attention on AFDC has also constrained the field's consideration of antipoverty policies that have avoided political

controversy. As such, we lack a clear understanding of the conditions under which policies do or do not become contentious. To build a theoretical framework, I draw on literature on the politics of social policy, the policymaking processes, political mobilization, and the sociology of ideas, which suggest five interrelated components that influence controversy in the U.S. context.

First, policies for the poor have historically had to navigate contestations over who is deserving of help from the state (Katz 1989). The three issues that have long dominated poverty discourse—how to categorize the poor, the impact of welfare on work and family, and the limits of societal obligation to the poor—all present opportunities for the emergence of contention. Though the boundary-making process continually evolves, individuals are generally determined to be "deserving" if they are perceived as truly in need, due to no fault of their own, have no other resources to meet that need, possess the will to be independent, and use benefits wisely (Cook and Barrett 1992). With evidence that these cultural categories of worthiness shaped the development of the American welfare state (Steensland 2006), this leads to the expectation that debates over deservingness are a central element of political contention in policymaking for the poor. Yet, the case of health care may not follow traditional deservingness boundaries, as the sick are less often blamed for illness nor seen as being able to fulfill the expectation of self-support (Gilens 1999; Taylor 2007). Indeed, Medicaid beneficiaries have been perceived by the public and lawmakers as more "deserving" than welfare recipients for these very reasons (Cook and Barrett 1992). Debates over deservingness may therefore be less consequential to political contention in the domain of health care for the poor than in more controversial cash assistance programs.

Second, race and racial discrimination have been fundamental to the formation of the American welfare state (Fox 2012; Katznelson 2005; Neubeck and Cazanave 2001; Quadagno 1994b; Soss et al. 2011). Social policies in the U.S. have historically discriminated against racial

and ethnic minorities through exclusion from receipt of state assistance while channeling the majority of benefits toward whites (Katznelson 2005). President Johnson's War on Poverty programs attempted to equalize opportunity by centralizing authority within the federal government and targeting aid toward minorities, but this resulted in political backlash and the racialization of both welfare and poverty (Quadagno 1994). Subsequently, the Nixon administration's attempt to redistribute federal aid toward White and Republican constituencies deepened racial divisions in the welfare state and made race the centerpiece of political conflict in social policy (Brown 1999). The "welfare queen" myth, popularized during the Reagan administration, became a potent symbol for the racist idea that welfare recipients lacked work ethic and took advantage of cash assistance (Soss et al. 2011). Often tied explicitly or implicitly with deservingness, the deployment of racial frames has influenced both political opportunities and mobilization around policies (Brown 2013a), and racial stereotypes strongly condition anti-welfare attitudes (Gilens 1999; Soss et al. 2011). Racialized political conflicts also affect the salience of race in social policy debates via interrelated attitudinal, cultural, and political channels, resulting in the passage of stricter, more punitive policies (Brown 2013). As Wilson argues, racially targeted social policies are more apt to incite political conflict than are race neutral policies (Wilson 1987). Thus, the extent to which race, racism, and prevailing cultural stereotypes of racial groups are salient in each policy's development is also expected to shape the degree of political dispute.

A third explanation is that antipoverty policies struggle to gain political support because the poor lack power and influence (Hays 2001). Scholars argue that the poor are a "nonexistent political constituency in an institutional system designed to reflect constituency pressures" (Heclo 1986: 337), and that the lack of political mobilization by the poor renders them unable to exert their policy preferences (Nathanson 2010). Therefore, the narrow targeting of antipoverty efforts

makes these policies unlikely to be passed (Heclo 1986) and, when they are enacted, unlikely to become popular programs as they do not advance the self-interest of the general public or Congress (Cook and Barrett 1992). However, seeing as health care is one of the largest and more profitable industries in the U.S., political support from elite actors and interest groups plays an important role. Medicaid has been widely supported by medical providers and hospitals who want to receive compensation for caring for the poor (Engel 2006; Howard 2007; Olson 2010). Despite an unambiguous absence of political power among the poor to mobilize and advocate for their health care needs, powerful advocacy groups have a vested interest in seeking profits for providing health care to the poor, and politicians also have an incentive to please their constituents. Whether mobilization takes place by the poor or groups who act on behalf of the poor, the achievement of elite support is likely instrumental in determining the degree of political conflict.

A fourth reason why programs for the poor become controversial is due to policy design, especially the longstanding debate over whether policies should be universally available to citizens or target the most disadvantaged. Policies targeting the poor are thought to produce animosity, divide social class groups, and engender stigma through degrading means-tests and difficult application procedures (Brady and Bostic 2015; Skocpol 1995). The two-tiers of the U.S. welfare state are believed to have deleterious consequences on the formation of broad political coalitions and policy outcomes, as this system has politically isolated the poor, especially the Black poor, from the working and middle classes (Prasad 2006; Skocpol 1995; Weir et al. 1988). Not only do racially targeted policies incite conflict, but they are also more likely to benefit the more socially advantaged members of the racial group (Wilson 1987). Monica Prasad (2006) argues that targeted programs in the U.S. created “adversarial policies” that weakened autonomous state structures. For these reasons, scholars conclude that universalism maximizes the range of potential beneficiaries

and is better able to build political consensus around social policies (Weir et al. 1988). Yet, others push back on the notion that the U.S. has a clearly defined two-tier system or that this translates to political popularity, arguing that some policies in the lower tier of the welfare state have more political viability than others (Howard 2007). Through analyzing EITC and Medicaid, Christopher Howard (2007) concludes that policies targeting the poor can gain political support by attempting incremental changes, avoiding the spotlight, and drawing distinctions from traditional welfare.

Beyond the two-tier system, federalist policy design and the role of states is also highly consequential in the U.S. Some contend that federalism protects against the centralization of power by increasing political participation and providing opportunities for innovation at the state level, while others lament the inequities federalism generates across state lines and the cumbersome burden of policy implementation (Nathan 2005). For the case of political contention, though, the consensus is clear: "federalism has been a principal weapon of partisan […] conflict in American history" (Robertson 2014: 345). Federalism has long been used as a tool to achieve political goals—such as the prominent states' rights rhetoric deployed in conflicts over slavery to the block grant revolution under President Reagan—for the simple reason that "fights over federalism are fights about power" (Robertson 2014: 350). In the policymaking process, federalist policy designs increase the number of "veto points." Incorporating multiple levels of government actors introduces more obstacles, whereas centralized policy designs can more easily pass legislation without as many veto points to overcome (Prasad 2006). Therefore, policy design in relation to federalism, centralization, and what entity holds power over policies is an important factor in the emergence of political contention.

Finally, political contention over policies for the poor is affected by conflicting ideological approaches to government and beliefs about the state's responsibility in addressing poverty (Jencks

1992). Political ideologies are formulated in relation to values and principles, and are comprised of both “descriptive” aspects in understanding the social world as well as “prescriptive” features that propose ways to address social problems (Taylor 2007). In general, liberals of the social democratic ideology support more government intervention and aid to the poor than modern-day American conservatives, who largely prefer a laissez-faire approach that relies more upon the private market than the government to address issues related to poverty (ibid). Policies motivated by a particular ideological position are more apt to encounter contention when changes in political power occur like, for example, when the social democratic ideology of President Johnson’s Great Society programs faced the New Federalist conservative ideology of President Nixon.

Ideas about policies are a powerful mode of exchange and influence, with some contending that “all political conflict revolves around ideas” (Stone 1988: 13). At the cognitive level, ideas influence the field of policy actions as well as the range of solutions available (Campbell 1998). At a normative level, policymakers’ taken-for-granted values and beliefs influence decisions on the logic of appropriateness of policies (Campbell 2002; March and Olsen 1989). Contention can emerge when these normative ideas clash among policymakers (Schön and Rein 1994), or among more widespread public sentiments which also shape the actions that elites perceive as being acceptable to the public (Campbell 1998). In contrast, contention can be avoided when normative and cognitive ideas of policymakers align with prevailing public sentiments and are framed in a “culturally resonant,” socially appropriate manner (Campbell 1998; Snow and Benford 1988). The cognitive and normative aspects of ideas shape framing of policies, and thus the presence or absence of culturally resonant frames has the potential to impact political support for policies (Skocpol 1996, 2000). This study leverages a single policy debate—health care for the poor—to

determine how different frames influence support for policies among elite actors and, in turn, political institutions (March and Olsen 1989).

MARKET FUNDAMENTALISM AND THE AMERICAN WELFARE STATE

A well-known trend in the modern American welfare state is the shift away from social democratic policies of the New Deal and Great Society toward market-oriented, neoliberal policymaking in the latter part of the twentieth century (Skocpol 1988). In the 1980s, conservatives united around efforts to delegitimate governmental interventions by accusing the state of interfering with the free market. Devolution, retrenchment, and privatization became common tactics to take authority away from the federal government, with rhetoric criticizing "big government." Instead, conservative policymakers celebrated the efficiency of markets—complemented by the charity of private non-profits or religious organizations—resulting in what some have dubbed the neoliberal paternalist approach to poverty governance (Soss et al. 2011).

This shift toward neoliberalism depicts what is known as market fundamentalism, or the "religious-like certitude of those who believe in the moral superiority of organizing all dimensions of social life according to market principles" (Somers and Block 2005: 260-261). In concert, the emergence of the perversity thesis—or the powerful idea that policies for the poor perversely incentivize dependence on the state—has emboldened market fundamentalism as a solution to enduring issues of poverty. That the perversity thesis and market fundamentalism are impervious to disconfirming evidence (Somers and Block 2005) reveals the socially constructed nature of policy frames. When facts are obscured by normative beliefs in policymaking, this can lead to intractable frame conflict (Schön and Rein 1994). Furthermore, Monica Prasad provides compelling evidence from a cross-national comparison that neoliberal policies arose in the U.S. due to political-economic structures that incited adversarial policies pitting the interests of the poor

against the middle class, which conservatives exploited to garner resentment against welfare policies (2006). With evidence of both the ideational and institutional basis for the rise of market fundamentalism, the historical transition of the U.S. welfare state to align with principles of the free market is consequential for the policies that persisted through this time period.

Because of the dominance of market fundamentalism in policymaking, now prevalent across the ideological spectrum in the U.S., one undertheorized but fruitful component to explaining political contention—or its absence—is through the alignment of social policies with the market. Indeed, Monica Prasad contends that "progressive policies are achieved in concert with, and not in opposition to, business interests," arguing that the European welfare state was able to grow and expand because of its emphasis on market complementarity (2018: 233). Though the majority of welfare state policies of the 1960s did not attempt alignment with the market, I will show that the CHC program did, from its origins, justify its existence based on the natural failure of markets to respond to the underserved. This is what I call the *market failure paradox*. Rather than rejecting the market as a system incapable of caring for the poor, policy elites acknowledged the limitations of the market and sought to remedy its failures by funding clinics that incentivized doctors to practice in low-income areas. Over time, market failure frames paradoxically bolstered devotion to market principles while diminishing debates over morality, and ultimately led to bipartisan support for the CHC program that flourished in the 1990s. Although there were ample opportunities for the Medicaid program to be framed in connection with market failures, this frame was never effectively deployed due to its origins in political compromise and design as a state-run program tied with welfare. With its centralized design that avoided association with welfare, the CHC program's dual logic of morals and market failures proved to be a key factor in evading

controversy, surviving the historical rise of neoliberalism, and achieving its status as a uniquely bipartisan policy for the poor.

POLITICAL CONTENTION AND FRAME CONFLICT

The dynamics of contentious politics have been studied in cross-national comparison of episodes like social movements, revolutions, strikes, nationalization, and democratization (McAdam, Tarrow, and Tilly 2001; Tilly and Tarrow 2006). But what about its continuous, non-episodic occurrence? This study brings to the forefront the long-term undercurrent of political contention that ebbs and flows in the making of policy. While some of this contention takes place in public settings, much of it courses among political elites and out of the purview of the public. As I will show, political contention among policymakers is an ever-evolving, dynamic process, with the potential to change radically given a shift in political climate. I focus here on elite actors, as they hold the power to shape legislation and public opinion (Zaller 1992). This is especially warranted in the domain of health care, as all major health policies in the U.S. have been spearheaded by elite actors—primarily Presidents—rather than grassroots social movements (Hoffman 2003, 2010; Levitsky and Banaszak-Holl 2010).[2] This study draws attention to the internal processes of policymaking by documenting the historical evolution of debates among elites in advancing their policy goals, overcoming opposition, and adapting to changes in power.

Framing is central to policymaking, as frames organize and define issues, construct meanings, and justify or explain the rationale for policy intervention (Benford and Snow 2000; Snow and Benford 1988). "Cultural resonance," or the extent to which a frame aligns with

[2] Of course, mass opinion has a demonstrable impact on policymaking (Brooks and Manza 2007), and indeed I found a plethora of public opinion data in the archives that policymakers relied upon in their decision-making and framing of policies, which I will discuss when relevant. However, public opinion has not played a major role in Medicaid policy (Howard 2007), and this is even more the case for the CHC program.

society's values and principles, is also a key component in determining the effectiveness of frames (Snow and Benford 1988). Cultural resonance brings a natural advantage to frames situated in larger "interpretive packages," which are part of a dynamic process of interaction and contestation over ideas, identities, and ideologies (Ferree 2003; Gamson and Modigliani 1989). Institutions further condition the political acceptability of ideas, or what is known as "discursive opportunity structures" (Ferree 2003), which places bounds on what resonates in the political climate.

A critical component to political contention, then, is conflicts over framing. In their seminal work on frame conflict in policymaking, Schön and Rein argue that "frames determine what counts as a fact and how one makes the normative leap from facts to prescriptions for action" (1994: xviii). Distinguishing between rhetorical frames and action frames, they trace the unfolding of "a policy drama" that can result in controversy when shifts in the situation "trigger conflicts of interest rooted in the actors' divergent frames" (Schön and Rein 1994: xix). Policy controversies emerge when opposing parties hold conflicting frames and can lead to institutionalized political contention when they are "enduring and invulnerable to evidence" (ibid: 4). Building from these insights, this study examines the degree of frame conflict among elite policy actors and how the evolution of interpretive packages in discourse over health care for the poor conditioned the presence or absence of political contention over time.

CASE SELECTION, DATA, AND METHODS

There are three theoretical reasons supporting the case selection in this study: Medicaid and the CHC program have the same purpose (access to health care for the poor), share the same national context (the United States), and began in the same year (1965). I am therefore able to rule out the possibility that differences in temporal, national, or political contexts caused the variation in outcomes. This allows for an examination of how discursive opportunity structures matter when

holding contextual factors constant. In approaching the comparison, it is important to emphasize the analytic logic: the primary goal is to use the positive case, Medicaid, in order to identify explanations of the absence of contention in the negative case, the CHC program.

There are also two potential limitations to the case selection. The first is the possibility that, given their similar context, one policy may have impacted the development of the other. In the early years of the programs, I found surprisingly infrequent crossover in the policymaking discussions surrounding Medicaid and CHCs. They operated in entirely separate arms of the government, one in the long-standing welfare administration and the other in the Johnson administration's new Office of Economic Opportunity (OEO). Although the idea was for these programs to eventually work in tandem, in reality, this did not happen. As the Office of Management and Budget stated in a memo to President Carter in 1979, Medicaid and the CHC program were "not logically integrated" and "each has developed as if the other did not exist."[3] Two-thirds of state Medicaid programs chose not to fully reimburse for CHC services until the federal government passed a law requiring them to do so in 1989 (Sardell 1988). Therefore, the lack of interdependence in policymaking between Medicaid and CHCs until the 1990s does matter, but not in a way that threatens the interpretation of results.

A second limitation is the difference in the scale of the policies; Medicaid has always surpassed the CHC program both in terms of cost and recipients. One might logically see why a larger, more expensive program would be more contentious than a smaller, less expensive one. Yet, looking to other social policies indicates that CHCs could have been far more controversial even though they were small in size. Take housing policy as an example: even though housing vouchers are both more costly and have far more users than public housing, there has still been an

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[3] Carter Library, Office of the Cabinet Secretary Jack Watson, Box 291, "1979 Budget Spring Presidential Review."

abundance of political controversy surrounding public housing. The same is true for Title X clinics, which have garnered significant controversy despite being smaller than the CHC program in terms of cost and participants. My argument is not that Medicaid should have been less controversial—indeed, most agree that policies targeting the poor are politically unpopular (Korpi and Palme 1998; Skocpol 1995). Rather, I argue that just because the CHC program has always been smaller than Medicaid does not preclude it from become a divisive policy issue.

The analyses draw upon primary documents collected from the archives of Presidents Lyndon Johnson, Richard Nixon, Gerald Ford, Jimmy Carter, Ronald Reagan, George H.W. Bush, and William Clinton (located, respectively, in Austin, TX; Yorba Linda, CA; Ann Arbor, MI; Atlanta, GA; Simi Valley, CA; College Station, TX; and Little Rock, AR).[4] The search process at archives involved requesting collections relating to welfare, poverty, health, health care, and the like, and assistance from archivists allowed me to identify key actors on these topics within each time period. I reviewed all materials within pertinent collections in order to decipher the context of each program within the larger fields of political and policy debate. Documents containing substantive information—either by directly referring to the programs or containing relevant information in the surrounding text—were scanned and later reviewed systematically.[5] In total, I collected more than 15,000 pages of relevant documents from these archives. I used techniques of pattern matching and process tracing to analyze sequencing of events and locate causal mechanisms explaining the divergent outcomes (Mahoney 2003; Ragin 1987).

[4] I visited all archives except for the Clinton library, which has digitized most materials. I also visited the George W. Bush library in Dallas, TX, but too few of the confidential primary documents have been made public to produce comparable analysis to the other time periods.

[5] Specifically, documents related to Medicaid had to discuss coverage of the poor. I did not collect documents on Medicaid that only pertained to nursing home, long-term care, or persons with disabilities. Some of these topics are found in the same documents, but they are not the focus of my analysis.

The majority of the primary documents analyzed are internal memos and reports between the presidential administration, federal agencies, and Congress. These memos and reports were almost entirely confidential, often describing explicit political strategizing, rationales for policy decisions, and disagreements among elites. The detail with which these inside actors privately discussed the policies allows for a rich understanding of the issues and how political factors undergirded policy decisions. Additional materials analyzed included internal deliberation of talking points, drafts of press statements, internal agency reports, proposed legislation, and public opinion polls. I also examined correspondence sent directly to the executive branch from outside actors such as members of the public, state or local politicians, as well as interest groups. Finally, I collected non-confidential materials within the archives, such as legislation, external policy reports, policy proposals, speeches, press statements, and media. To supplement the perspective of the executive branch, I also integrated secondary sources as well as public documents from government agencies, academic journals, and thinktanks. In the following section, I provide a summarized political history of each program, highlighting key theoretical developments. Within each time period, I first discuss Medicaid—the positive case of political contention—and then compare against the CHC program—the negative case—before drawing conclusions on what components can best explain their divergence in political outcomes.

FINDINGS

The Emergence and Early Years of Medicaid, 1965-1969

Debates over state provision of health care to the poor have recurred throughout U.S. history, long before the eventual passage of the 1965 Social Security Act (Engel 2006; Ruggie 1992; Starr 1982; Stevens and Stevens 1974). Title XIX of this act, or what we now know as Medicaid, initially received minimal attention from policymakers, the press, and the public at large (Engel 2006).

Crafted by the powerful Democratic Representative Wilbur Mills, Medicaid was the result of a political compromise between both political parties and with organized medicine. At its passage, Mills and many policymakers believed that Medicaid would be a temporary building block to national health insurance (NHI). Ironically, the inability for policymakers to agree on NHI in the decades following Medicaid's inception would be a key reason for its survival.

Medicaid's main purpose was to incentivize and pay states to provide health insurance for low-income mothers and children who were recipients of Aid to Families with Dependent Children (AFDC), colloquially known as welfare. From its inception, Medicaid was a piecemeal extension (Stevens & Stevens 1974), incrementally building from the existing structure of grants-in-aid to state welfare agencies. It was designed to provide the states with freedom, control, and rights over administering their Medicaid programs, and limited the role of the federal government. As described by the Department of Health, Education, and Welfare (DHEW) officials: "Basically, a State can include anybody in its medical assistance program and can offer any service… a State can do anything it wishes." [6] States were thus given the ultimate authority over which poor residents were provided with what services, while the federal government provided fiscal relief to the states. While the states' rights frame allowed for the ease of passage at the federal-level, the record shows that states were rather involuntarily thrust into the role of delivering health care to welfare recipients (Stevens and Stevens 1974). Most policymakers at the state-level did not want the fiscal or administrative responsibility of establishing their own welfare medicine programs, resulting in immediate state resistance that has persisted throughout the program's history.

Due to its origins in political compromise and federalist design, Medicaid lacked a unifying philosophy. The program's ambiguity, while providing political viability at the time of enactment,

[6] LBJ Library, Administrative History: DHEW, Vol 1, parts XVII & XVIII, Box 9 (1968).

has been consequential: "the lack of clearly stated national goals for Medicaid in 1965 was a major and reverberating deficiency" and "perhaps its most basic weakness" (Stevens & Stevens 1974:350, xvii). Ambiguity in the goals of Medicaid resulted in administrative and implementation issues, which affected both the experiences of its users as well as the politics the program.

The humanitarian ethos of the 1960s, though, shaped the discursive opportunity structure. The rhetoric was largely in support of equal access to health care and bringing the poor into the "mainstream" of medicine, rather than creating a "separate-but-equal" system that segregated care by social class (Stevens and Stevens 1974). The shared cultural belief that the poor were deserving of equitable access to health care translated into bipartisan policy support, as votes for medical bills in both the House and the Senate were "virtually unanimous" in the late 1960s because they were "so politically important."[7] Despite—and perhaps because of—this belief that the poor deserved aid to receive health care, Medicaid was framed by policymakers across the aisle as ill-conceived in social, economic, and pragmatic policy terms. Socially, it was seen as inequitable and stigmatizing; economically, it exercised no controls over demand or supply; and pragmatically, it suffered from inadequate administrative capacity and logistical planning (Stevens and Stevens 1974). As critics, such as a Democratic State Representative of Illinois, pointed out:

> I find [Medicaid's] framework to be not only ill-conceived but dangerous. Medicaid is a welfare program and that is enough to ensure its failure… Health care is of such high priority that no stopgap, hastily concerned program can be acceptable… Any scheme which further entrenches the image or reality of disparate treatment for rich and poor may cure the local infection only to further inflame the disease which surrounds it.[8]

All parties involved—bureaucrats, advocates, and politicians—agreed that Medicaid was flawed, resulting in the deployment of similar normative frames about Medicaid across the ideological spectrum. Yet, there were conflicting proscriptive ideas over the best course of action to remedy

[7] LBJ Library, Administrative History: DHEW, Vol 1, parts I and II, Box 1 (1967).
[8] LBJ Library, Papers of Wilbur Cohen, Boxes 1-3, "DHEW Medicaid Public Hearing: Chicago" p. 152-156 (1968).

its shortcomings (Campbell 2002; Schön and Rein 1994). Born out of the politics of accommodation (Starr 1982), Medicaid had minimal political support from the beginning.

To summarize, Medicaid's origins in political compromise, structure as a state program, lack of a unifying philosophy, and association with welfare would ultimately set it on a path rife in controversy. Critics immediately pointed to Medicaid's inequities across state lines, as well as its arbitrary means-test and assertion that medical care was only an entitlement for those on welfare. Medicaid was plagued by its link with welfare, leading to its entanglement in debates over deservingness and morality. Thus, Medicaid was designed over concern with the rights of *states* and, as an extension of welfare, was framed as correcting for the failures of *individuals*. The combination of these features of Medicaid's policy design led to its pervasive framing as *inequitable* and *immoral* (Table 1).

Table 1. Comparison of Initial Policy Frames

	Concerned with **Rights** of:	Correcting for **Failures** of:		***Frames:***
Medicaid	States	Individuals	→	*Inequitable & immoral*
Community Health Centers	Individuals	Markets	→	*Moral & economic*

The Neighborhood Health Center Movement, 1965-1969

In an entirely separate wing of the government, President Johnson's flagship effort with the War on Poverty was to establish the Office of Economic Opportunity (OEO). The OEO was equipped with considerable power, large sums of money, and the authority to direct funding to local communities that bypassed welfare offices and county officials (Quadagno 1994). Although health care was not originally one of OEO's priorities, it soon became clear that participants of programs

like Job Corps and Head Start had unmet medical needs that would inhibit the success of those programs if left untreated (Sardell 1988). To address these medical needs among the poor, doctors from Tufts University proposed a new model of health care delivery, the Neighborhood Health Center (NHC) program, that would provide free care to entire communities and address social and environmental factors affecting health. Beginning as a research and development project, with one clinic in a Boston public housing project and another in rural Mississippi in 1965 (Geiger 2005), the NHC program launched inconspicuously under the umbrella of OEO.

In contrast to Medicaid (Table 2), the NHC program had clear, concrete goals with a unified identity and cohesive philosophy. The premise was simple: providing free health care in urban and rural areas with high concentrations of poverty and a lack of health services.[9] In line with the broader War on Poverty, the NHC program was presented as a humanitarian effort in sync with the social justice ethos of the 1960s, to be used as a "vehicle for community development and participation" (Sardell 1988:55). NHCs would treat the poor with "dignity" by providing free health care to all residents of a geographically defined area, rather than requiring a means-test for aid.[10] Building from the Civil Rights movement, activist bureaucrats and health professionals alike viewed the NHC model as one that would confer health care as a human right, staking its claim as a moral and altruistic program (Sardell 1988).

Within a short time, though, elite policy actors also solidified a compelling justification beyond liberal humanitarian ideals: an explicit economic frame that aligned with market principles. This would have a profound influence on both the survival and evolution of the health center movement. In a 1967 meeting between agency leaders and White House aides, agreement was

[9] LBJ Library, Administrative History, OEO, Box 1, "National Health Affairs" (1969).
[10] For a short time from 1967-1968, the NHC program did implement a means-test at the behest of the medical establishment who initially viewed NHCs as a threat (Sardell 1988). Ever since, health centers have used a sliding scale rather than a strict means-test to determine the amount of government subsidy.

reached that in order to "break through political barriers" and "try to sell" the program—both to organized medicine as well as conservatives—NHCs had to explicitly "relate to supply and demand."[11] Their pitch was that NHCs were a "way to get services and supplies into areas where we now don't have them" and for the government to "organize the supply to meet specific problems" in poor areas (ibid). Due to a lack of providers and the complex health problems induced by poverty, Johnson's top aides believed it was the government's role to harmonize supply with demand in economically distressed communities.

Table 2. Comparison of Policy Origins, 1965-1969

	Medicaid	**Neighborhood Health Centers**
Mission	Unclear, ambiguous goals and no cohesive philosophy	Clear, concrete goals and cohesive philosophy
Economic goal	Demand-side	Supply-side (+ create jobs)
Targeting	States	Local communities
Associated with	Welfare	Civil Rights
Political support	Weak, not aligned with ideology of either party	Strong, aligned with ideologies of *both* parties
Policy design	State control with federal oversight (federalist)	Federal program with local community control (unitary state)

By 1969, NHCs were touted by policy elites as a solution to economic problems plaguing the health care system, including "rising costs, manpower shortages, and utilization."[12] NHCs would be a "creator of jobs that will directly benefit concentrated poverty communities" and provide "incentives to physicians to locate in poverty communities" (ibid). From a market standpoint,

[11] LBJ Library, James Gaither Files, box 206, "Health Meeting Notes" (1967).
[12] LBJ Library, James Gaither Files, box 232, "Report of 1969 Task Force on Health" (1968).

NHCs were seen as necessary to solving supply-side problems: “what is needed is a system of incentives that will encourage health manpower, especially physicians, to practice in areas that have severe shortages.”[13] Johnson’s policy elites argued that NHCs would reduce overall spending, stimulate local economies by providing jobs, and—crucially—address market failures because doctors had little incentive to practice in low-income communities. These economic justifications resonated with conservatives who agreed that the government had grounds to intervene where the market was expected to fail.

The NHC program was also boosted by activist bureaucrats (Marcus 1981; Sardell 1988) and policy entrepreneurs (Anderson 2018), who established strong elite support. Senator Edward Kennedy (D-MA) was the most influential political actor for ensuring its early survival. After visiting the first NHC in Boston, Kennedy became an outspoken proponent of the program. He successfully convinced other elites that NHCs should be distinguished from the controversies of other War on Poverty programs, such as Community Action Agencies, by arguing that NHCs were “run by professionals,” “free of corruption,” and a “legitimate,” “charitable” enterprise (Sardell 1988: 67). Thus, the framing of the NHC program was constructed in direct contrast to other antipoverty programs of the times, which were increasingly associated with racial conflict (Quadagno 1994). Differentiating the NHC program from other Great Society efforts allowed for more widespread support among politicians, who agreed that targeting disadvantaged communities was sensible, as its residents could hardly be blamed for local economic conditions. Thus, the NHC program were framed as addressing structural economic issues rather than correcting for individual failings as implied by Medicaid’s connection with welfare.

[13] LBJ Library, Task Force Reports, Box 22, “Interagency Task Force on Health” (1967).

Shortly after its implementation, the NHC program deployed frames that aligned with ideologies across the political spectrum: it resonated with liberals' focus on social justice and ensuring health care as a human right, leading to frames of *morality*, but it also resonated with prominent conservative beliefs that the government had a role to play in addressing failures of the market, resulting in compelling *economic* frames (Table 1). Because of a unified, cohesive philosophy that was applied in both economic and moral terms, health centers developed early political support and, perhaps more importantly, made few enemies. The result was that, when controversies did arise, they were contained as local issues and never rose to the national level as would future Medicaid scandals. Claiming both economic and moral justifications was a necessary condition, absent in Medicaid, for the NHC program to attract political support. Frame alignment with both liberal and conservative ideologies subsequently affected how the NHC program could adapt to changing political environments, survive opposition, and gain bipartisan popularity.

President Nixon: Righting Medicaid's Wrongs and Transforming Health Centers, 1969-1974

During the Nixon administration, the nation was perhaps the closest it had ever been to passing national health insurance (NHI) (Quadagno 2005; Starr 1982). There are two important elements for this study: the Nixon administration planned to replace Medicaid and proposed to transform and expand NHCs as a pillar to the supply side of health reform. Nixon's initial national health plan was not passed by Congress in 1971, and the subsequent 1974 version of his legislation—which had a higher likelihood of being enacted—never made it through Congress due to the Watergate scandal and Nixon's resignation. Although no major legislative changes in health policy resulted, the Nixon era was rich with political debates over health policy.

The Nixon administration was guided by the philosophy that the private market should provide health care for the majority of Americans, but maintained that that it was the federal

government's duty to ensure that "no American family is ever barred from adequate health care because of inability to pay."[14] The Nixon administration subtly recast Democrats' ideas (Starr 1982) by heavily borrowing from egalitarian rhetoric to build a case against Medicaid:

> Federal dollars are being distributed very unevenly and *inequitably* among the low-income population… Moreover, exclusion of the "working poor" increases the *inequities* of the existing welfare system… encourages marital breakup and discourages the male head of a family from working… an *equitable* program of medical assistance for low-income families… must eliminate geographical *inequities*, categorical *inequities*, work disincentives, and ensure adequate protection.[15] (Emphasis added)

As this quote shows, Medicaid was portrayed during this time period not only as highly inequitable for its geographic variation and means-test, but also as *perverse.* Medicaid was alleged to both incentivize beneficiaries to remain on welfare instead of seeking work and also disincentivize marriage, seeing as single mothers were the only adults eligible for welfare and Medicaid at the time. In a press statement, Nixon claimed that Medicaid "provides an incentive for poor families to stay on the welfare rolls" because "coverage is provided when husbands desert their families, but is often eliminated when they come back home and work."[16] Medicaid thus became vulnerable to attacks based on the perversity thesis, or the idea that governmental policy intended to alleviate poverty actually exacerbates dependence on state aid (Somers and Block 2005).

Pointing to its rampant inequities—across state lines and the social classes—Nixon sought to replace Medicaid with a nationalized program using uniform funding and eligibility levels, called the Family Health Insurance Program (FHIP). FHIP would provide insurance for all of the poor—not just those qualifying for welfare—in addition to the working poor, "for reasons of politics and equity."[17] With an entirely federally financed program, Nixon contended that states

[14] Nixon Library, WHCF Health, Box 2, Presidential Statement, "Key Facts on Health" (1972).
[15] Nixon Library, WHCF Health, Box 1, DHEW report, "Towards a Comprehensive Health Policy for the 1970s: A White Paper," (1971).
[16] Nixon Library, John Price, Box 14, "President's Press Statement on Health," 2/18/1971.
[17] Nixon Library, WHCF Health, Box 1, "Meeting with Elliot Richardson, George Shultz, John Ehrlichman, Bob Finch and Ed Morgan (11/11/70)."

would be “relieved of a considerable burden.”[18] And it was not only Nixon who was attempting to repeal Medicaid. All other proposed health reform plans at the time, of which there were many, endeavored to replace or reform Medicaid. Virtually no political actors were in support of this program that was seen as a temporary stopgap on the way to NHI. Medicaid’s association with welfare was at the core of most criticisms, but stories of waste and fraud also drew a preponderance of negative publicity. Controversies brewed over the high cost of Medicaid and the program was blamed for increasing health care inflation. During this period, just five years after its passage, Medicaid’s political support waned. Its founding legislator, the powerful Chairman Wilbur Mills (D-AR), confessed that Medicaid was “the worst mistake I ever made.”[19]

The events pertaining to the NHC program during the Nixon era portray a stark contrast to Medicaid. One would expect that, because NHCs were part of the Great Society, Nixon would try to eliminate the program. Indeed, contemporary observers believed that NHCs had little chance of surviving the conservative administration (Marcus 1981). Some of Nixon’s advisers warned him to steer clear of NHCs because they would forever be associated with the Democrats. Leaders of the Office of Management and Budget (OMB) levelled criticisms at NHCs that mirrored those made against Medicaid: geographic inequities, no long-term strategy, and biased grantmaking.[20] But the Nixon administration did not heed advice to terminate the NHC program and, instead, his administration sought to grow and transform NHCs. The Nixon administration advanced the Health Maintenance Organization (HMO) model of pre-paid group practice and, because NHCs already followed this model, they were regarded as a steppingstone to achieving the HMO vision and were thus a crucial element to his health reform proposal.

[18] Nixon Library, John Price, Box 14, “President’s Press Statement on Health,” 2/18/1971.
[19] Nixon Library, Kenneth Cole, Box 58, “Mills the Innovator” article in the Washington Post, 4/23/1971.
[20] Nixon Library, James Cavanaugh, Box 25, OMB report, “Access to Medical Care for the Poor: A Preliminary Evaluation of Federal Health Center Programs,” (1971). These same critiques would resurface under President Ford.

Why would the Nixon administration try to expand this Democratic program? Internal memos among agency leaders delineated that the growth of NHCs had the potential to represent a "Nixon building program."[21] The rationale to expand NHCs was compared to Eisenhower's highway system and Kennedy's "moon shot," reasoning that "the American people measure accomplishments and the return for their tax dollars in terms of tangible facilities seen" (ibid). The case was made by OEO director Donald Rumsfeld that the "establishment of new, distinct Neighborhood Health Centers, serving not just the poor, but the working man, could be a physical representation of President Nixon's efforts on behalf of the individual's most vital concern—his health" (ibid). Under the Nixon administration, health centers would emphasize not only serving the poor but would aim to become the primary provider for everyone residing in underserved communities. They were a "highly visible and quick pay-off initiative for the President" that would also leave behind a physical manifestation of Nixon's legacy. Despite some skepticism among Nixon's aides about the program, there was agreement over its political appeal: "the development of health centers… is now the most fashionable concept in medical planning circles in that it is contrary to greed, inefficiency, and poor health."[22] Popular with voters and the press, the health center program served a useful political purpose. [23]

There were other reasons, besides optics, for this surprising development: NHCs were flexible in their centralized structure and were perceived as being able to solve "legitimate" supply-side problems. The NHC program had a broad and open-ended legislative mandate within the terrain of the federal government, which allowed administrators to flex their preferences by

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[21] Nixon Library, Martin Anderson Files, Box 15, NHC Folder, "Proposal: Development of up to 800 NHCs over the Next 3-6 Years" (1970).
[22] Nixon Library, Kenneth Cole, Box 37, "OEO Paper on Neighborhood Health Centers" by Presidential staff assistant, Ray Waldmann, to Ed Harper, special assistant to the President (1971)
[23] Nixon Library, Martin Anderson Files, Box 15, NHC Folder, "Family Health Centers: A Proposal to Create a Balanced Health Delivery System" (1/14/71).

manipulating funding. A number of bureaucratic advocates were also determined to defend the NHC program in the face of changing priorities in the administration (Sardell 1988). Further, Nixon's staff acknowledged that health centers would always require federal assistance because poor areas would not be economically viable for the private sector to enter on its own. The market failure frame carried over from the previous administration and proved to be instrumental to justifying the program's continuation.

Furthermore, the program had virtually no political enemies at this time. There were several local controversies over NHCs that garnered wider regional or national attention, which revolved around racialized conflict and accusations of corruption, like other Great Society programs. Some political disputes centered around health centers targeting migrant communities, tinged by anti-immigrant hostility. One controversy that rose to the national level took place in Zavala county, TX, which Nixon aides described as the "poorest county in Texas" that had become a "hot-bed of political activism by the Chicanos." Local physicians complained that they were not involved in the development of the health center and successfully persuaded the governor of Texas to veto the health center grant. According to OEO documents, the doctors were racially motivated and "wanted to get the spics down" in this county where 85% of the population was Mexican-American. Without Nixon's permission, the OEO director overrode the governor's veto, justifying that "the politics of this are on our side as this is a strong plus with the Chicanos. We can bring their vote around with this project." A similar controversy played out in Othello, WA, where opposition groups stated they were "against anything that will aid the Mexican American segment of our community." With involvement of federal officials, the local opposition was defeated.[24] Except for these instances of localized conflict, the medical establishment generally did not resist

[24] Nixon Library, WHCF Health, Boxes 2 and 14 respectively (1972).

the government's funding of health centers in places where most doctors would not voluntarily practice. Except for a handful of places, NHCs were not seen as competition, and thereby faced little resistance from organized medicine at the national level (Sardell 1988).

As the Nixon administration diminished the non-medical, social-justice elements of the NHC program's original design, retaining only the traditional health services model targeted to poor communities, this spurred the process of institutional homogenization and regression to the status quo (DiMaggio and Powell 1983; Starr 1982). The program was forced to take on a narrower, more medical structure in order to survive the new political environment, which had at least two long-lasting effects. For one, the purely medical model that was aligned with market principles allowed the program to draw more support from the ideologically conservative while also placating the Democrats, who were pleased to see this OEO program continue. Relative to the goal of Democrats, most notably Senator Kennedy, to form a full national health service, NHCs were a compromise.

Second, pressure to defend the NHC program from conservatives during the Nixon era prompted advocates to establish both state and nationwide advocacy networks. Starting with the mobilization of health center advocates in New York and Massachusetts, a nationwide coalition came together in the early 1970s to form what is now known as the National Association of Community Health Centers (NACHC). This grassroots effort flourished with support from bureaucrats, congressmembers, and state and local advocates (Sardell 1988), which eventually laid the multi-level groundwork needed for health centers to successfully mobilize against future attacks (Quadagno 2005). Ultimately, the transition from a social justice to purely medical framework that both political parties could agree upon allowed the health center program to pass

its first test of adaptability and expand its advocacy network, which would be important to its survival in years to come.

Presidents Ford and Carter: Fraud, Federalism, and the Urban to Rural Shift, 1974-1981

Following Nixon's failed attempts at health reform, President Ford advocated for Medicaid to be reformed rather than repealed. His administration proposed removing the inequitable state variation in Medicaid by instating universal eligibility. However, negative news coverage brought Medicaid into the political spotlight in the mid-1970s. During the presidential election against Carter, cases of Medicaid fraud and abuse regularly made headlines. Most of the scandals involved what were referred to as "Medicaid mills," where predatory medical providers would open practices in low-income "ghetto" neighborhoods to profit off of Medicaid recipients.[25] As a presidential candidate, Carter suggested that "Mr. Ford [was] responsible for the 'wasting and stealing of billions of dollars' in the Medicaid program." Carter tarnished Medicaid by saying it "has become a national scandal" and that taxpayers were "being bilked of millions of dollars by charlatans."[26] However, President Ford deflected the blame onto state governments, like Carter's home state of Georgia:

> The facts are, of course, that Medicaid is a program operated and administered by the states, using Federal funds. Where the program is run badly, it is the responsibility of the state administration -- specifically of the Governor… No one has suggested that Jimmy Carter was personally involved in the corruption that existed in the Medicaid program in Georgia under his administration. But he was the man in charge. Through the laxity of his administration, these abuses were permitted to develop.[27]

In this way, Medicaid solidified its status as a political 'hot potato', with the states and the federal government wanting to deflect responsibility for the problems plaguing Medicaid. The state's rights frame was useful for the federal government to avert blame, while also convenient for the

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[25] Ford Library, Spencer Johnson Files, Box 7, "Secretary's Statement on Medicaid Fraud and Abuse" (1976).
[26] Ford Library, President Ford Committee Records, Box H29, Campaign Quotes (1976). First quote is from the New York Times on 9/11/1976 and the second is from the Associated Press on 4/16/1976.
[27] Ford Library, James Reichley files, Box 4, "DHEW Statement on Medicaid for use by Elliot Richardson" (1976).

states to argue that the federal government was encroaching on their authority. Politicized in the presidential election and criticized in the media, Medicaid's federalist design continued to inhibit its political support among different levels of government (Robertson 2014).

Under President Carter, there was a re-emergence of concern over social justice and human rights among policymakers. The political window of opportunity re-opened for NHI, leading Medicaid to once again be on the metaphorical chopping block. As in the Nixon era, "Medicaid would be changed by all of the NHI options under consideration."[28] Critics continued to lament Medicaid's inequities, continuing to portray the program as perverse by contending that Medicaid disincentivized work and family by penalizing recipients who gained employment or those with residential fathers. Fraud and abuse coverage dwindled after regulations were enacted under Carter, but the stigmatized reputation and accusations of corruption clung to Medicaid. Federal budget constraints due to stagflation tied Carter's hands on social policymaking and ultimately precluded his ability to succeed with national health reform, despite many proposals. Carter also faced opposition within his own party from Senator Ted Kennedy, who had support from the progressive wing and interest groups such as organized labor. The dispute split the Democrats, as those further on the left rejected Carter's phased approach to NHI and demanded a more comprehensive plan, leading to political stalemate (Quadagno 2005).

Meanwhile, the health center program faced opposition during the Ford administration. Imitating frames criticizing Medicaid, the health center program was accused of being inequitable. In a memo from the Ford administration to Congress, they argued:

> The individual Federal grant award for health service delivery presents a basic inequity. It singles out for Federal subsidies a few communities for benefits subsidized by the Federal taxpayer from many other communities similarly situated… [and] equally deserving.[29]

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[28] Carter Library, Max Cleland papers, Box 74, "1980 Spring Planning Review: Health Overview."

[29] Ford Library, WHCF FA 6 Public Health Box 16, correspondence from Ford Administration to 26 Democrats in House of Representatives who opposed CHC spending cuts, 1975.

The equity frames temporarily switched under the Ford administration, with Medicaid representing the potential lever for providing equitable health care to the poor. Health centers were also faulted for being expensive and not using "objective" criteria of need in grantmaking decisions. In response, administrators developed specific geographic characteristics determining need, called "medically underserved areas," which represented a more "equitable" approach to funding that minimized rewards for grantsmanship. It was at this time when the nomenclature changed to the Community Health Center (CHC) program, representing a broader programmatic mandate.

Committed to devolving responsibility to states, the Ford administration attempted to block grant the health center program along with 15 other "special programs" providing health care for low-income people. The argument was that these programs were too "narrow," duplicative of one another, uncoordinated, fragmented, and—most importantly—that they were the federal government "singling out a few communities… for preferential treatment."[30] Ford said his block grant proposal was "designed to achieve a more equitable distribution of Federal health dollars among States and to increase State control over health spending."[31] Rhetoric of equity and rights was primarily concerned with states, rather than people. Yet, the political opportunity structure was not in Ford's favor, and the Democratic controlled Congress repeatedly rejected his block grant proposal. Instead, Congress increased funding for CHCs, with the appropriations committee reasoning that there was no evidence that the private market would offer services in impoverished areas so long as they lacked incentives.[32] Ford's multiple vetoes of the legislation—which would have increased spending on CHCs and other health programs—were overridden in Congress by a

[30] Ford Library, WHCF FA 6 Public Health Box 16, Internal memo from Kenneth Cole (aide) to President Ford regarding Enrolled Bill HR 14214 – Health Revenue Sharing and Health Services Act of 1974.
[31] Ford Library, WHCF HE, Boxes 2-3, "Speech to Congress" 2/25/1976.
[32] Ford Library, White House Records Office: Legislation Case Files, Box 57, "Department of Health, Education, and Welfare Appropriations for 1977", House of Representatives (1976).

strong majority, even among his own party. Framing of CHCs as correcting for market failures proved to be key in this political battle. The unsuccessful block-grant attempt stymied by a Democrat controlled Congress further mobilized CHC advocacy groups, foreshadowing future attacks under President Reagan.

Residual accusations of inequities in the CHC program and the threat of state devolution lingered under the Carter administration. Infighting among federal agencies took place, as OMB continued to be critical of DHEW's expansion of the CHC program. OMB argued that the formula-based designation of underserved areas were prone to "gerrymandering," and claimed that it was inappropriate for the government to "steer physicians towards more altruistic behavior" by "forcing" them to serve in "less desirable" locations.[33] DHEW countered that states show "insensitivity to community, urban, minority, and poor person's needs" and that federal grants directly to local organizations "allows support of community participation and recognition of poor and minority needs."[43] Ultimately, the Carter administration sided with DHEW to preserve the structure of the original CHC program with the federal government maintaining control. Because these debates regarding state or federal control of health centers would reemerge, the arguments articulated by DHEW in response to OMB's opposition were important preparation for Reagan's attempt to block grant CHCs.

Ford's principles of federalism and block granting could have dismantled the health center program had it not been for the Democrat majority in Congress. It is clear that, at this time, the CHC program remained favorable among Democrats and, except for a handful of Ford's administrative leaders, were also acceptable among Republicans until some national health reform legislation could be agreed upon. Although CHCs were not yet a fully bipartisan program, they

[33] Carter Library, Office of the Cabinet Secretary Jack Watson, Box 295, "OMB 1980 Budget: Health Programs."

also did not attract partisan conflict. A key factor in this absence of opposition was that, during the Ford-Carter era, the Rural Health Initiative (RHI) was established, which marked a shift in health centers' identity from being a primarily urban program to an emerging rural program. The initiation of rural health centers expanded the political appeal of the program and responded to pressure from interest groups, such as the National Rural Center, which mobilized rural policy advocates. This had also implications for racial politics, shifting the program from focusing on predominantly urban Black communities to one that would also benefit poor rural whites. What was once derogatorily referred to as "ghetto medicine" in the 1960s now expanded to low-income rural populations who were primarily white (Sardell 1988: 117). This transition from urban to rural, at a time when the program was at risk of being devolved to state control, was important for the program's support by Republicans, as its constituency was broadened and became more politically difficult to oppose (O'Connor 1999).

President Reagan: From Retrenchment to Entrenchment, 1981-1989

The Reagan administration ushered in a new era of debate over health policy, as NHI was out of consideration. With a laissez-faire approach that opposed federal intervention in the market and advocated for the authority of states, "philosophically, the Reagan administration believes that the federal government should do less not more in the health care sector… and only bear direct financing responsibility for a 'safety net' of the 'truly needy.'"[34] The Reagan administration heavily relied on frames of liberating states from Washington, with common rhetoric that "states should be freed of all Federal mandates and constraints."[51] Ironically, the Reagan administration

[34] Reagan Library, Robert Carleson files, Box 15, "Health Policy Under the Reagan Administration," National Health Policy Forum (1982).

ultimately strengthened both Medicaid and CHC programs, providing them with more secure footing for the decades to follow.

Whereas previous administrations had attempted to replace Medicaid with a broader national health plan, Reagan was the first president to not propose sweeping reform. Therefore, Medicaid was no longer seen as a program that would inevitably be replaced and it was granted more attention. This made Medicaid more vulnerable to scrutiny, and its future looked dim at the beginning of the Reagan administration. Along with AFDC and food stamps, Medicaid was proposed to be block-granted to the states, which would drastically lower the funding to states and reduce coverage of the poor. State governors were opposed to this block grant because it would demand more from their budgets, leading to the idea of a "Medicaid swap" in 1982. Under the swap, if the states took full responsibility for AFDC and food stamps, the federal government would cover all of Medicaid's expenses. White House aides warned Reagan, though, that federalizing Medicaid would be "disastrous", as it would "give complete control of the programs to the Federal government making it easier for a subsequent Administration to effect National Health Insurance"[35] In a shift away from the visions of Nixon and Ford, who advocated for national eligibility and health benefits for the poor as a principle of equity, the Reagan administration now viewed uniformity as a stepping stone to NHI and a potential political victory for their Democratic opponents. Negotiations over the federalization of Medicaid consequently broke down and the swap never transpired.

However, debates over the swap showed that Medicaid was granted favorable status over welfare and food stamps in the Reagan administration. Medicaid was increasingly regarded by policymakers as a legitimate health program worthy of attention and improvement in its own right.

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[35] Reagan Library, Martin Anderson Files, Box 24, "Medicaid Federalism Implementation 2/18/82."

With Reagan targeting welfare, Medicaid became safe from retrenchment and remained relatively unscathed for the rest of his administration. Indeed, during this time, Medicaid eligibility was extended for the first time to cover low-income pregnant women who were not welfare recipients. The Reagan administration began the process of disassociating Medicaid from welfare, which would be finalized the following decade under Clinton's 1996 welfare reform (Smith and Moore 2015). Medicaid was thus strengthened politically during the Reagan era via the initiation of legislative detachment from welfare.

The CHC program was also to become firmly entrenched during the Reagan administration due to another failed block grant attempt. Unlike Ford, Reagan had the advantage of a Republican majority in Congress. CHCs were originally included in the Health Services Block Grant, but after negotiations spearheaded by policy entrepreneurs, like Kennedy, the CHC program was given its own separate Primary Care Block Grant (PCBG) in 1981. Unlike the other health block grants, the PCBG was optional and states would need to apply for it. The PCBG also carried onerous requirements, including that the states needed to fund existing centers at the current level for the first two years, which dissuaded states from participating. Health center advocates argued that states had demonstrated no commitment to providing primary care for the poor and that underserved areas would lose access to basic medical care, especially in rural areas, with the block grant. The nationwide CHC network adopted Reagan's ideological terms, saying that health centers exemplified "highly effective and efficient… locally controlled, private-public partnerships" and argued that health centers had both "strong bipartisan support in Congress and broad public support."[36] This was the first clear pronouncement of bipartisanship.

[36] Reagan Library, HE004, Box 41, Correspondence from National Association of Community Health Centers to President Reagan, 10/16/84.

Legal battles ensued over the PCBG implementation. The Reagan administration repeatedly vetoed attempts by a sympathetic Congress—where CHCs were evermore in good favor, even among conservatives—to have it overturned. In the three years of the PCBG, only West Virginia and Puerto Rico took up the block grant (Sardell 1988). The PCBG was largely seen as a failure. Congress stubbornly held its ground in support of CHCs and, in bipartisan fashion, enacted legislation sponsored by Senator Orrin Hatch (R-UT) in 1986 to eradicate the PCBG. In fact, both the House and Senate voted *unanimously* to allow CHCs to reinstate their previous form.

What explains the initial turn toward bipartisan embrace of the CHC program? Once again, the context of NHI is an important layer to understanding the political climate of the times. Shifting away from consideration of NHI, Republicans now found themselves in the position of needing to compromise on health care and demonstrate some policymaking effort in this arena. As one White House public liaison deputy wrote in a confidential memo:

> I cannot help but be concerned that [health care reform] is another "hot potato" and one that we should approach with tender caution... This "reform" issue is just the type of thing that the Democrats could link to social security and tar Ronald Reagan and the Republicans for another election. Talk about compassion!! This thing could really backfire, if we are not careful … a decent reform in this area will need to be bipartisan, and I do not see that happening in the current environment. If I were a Democrat looking to 1984, this would be a prime target of opportunity for me to blast Republicans as insensitive.[37]

Republicans anticipated being "tarred" by Democrats as "insensitive" if they did nothing and therefore recognized the need to strive for bipartisan agreement in health policy. This sentiment explains some of the surprising coalescence around health centers among Congress members. During the block grant battle, though, many CHCs were defunded, and the scope of continuing centers was substantially narrowed due to funding cuts. However, the block grant attempt also forced the local, state, and nationwide network of advocates to come together in impressive numbers, which further strengthened the CHC program.

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[37] Reagan Library, Elizabeth Dole Files, Box 39, "Medicare/Medicaid 12/13/82" confidential memo from Red Cavaney to Elizabeth Dole.

The Bush Administration: Aligning Markets with Compassion for the Poor, 1989-1993

Though guided by a laissez-faire ideology similar to Reagan, President George H.W. Bush was more focused on the poor than his predecessor. The Bush administration regarded the free market as lacking incentives to address poor people's needs, and viewed the government's role as compensating for this natural market failure. His Health and Human Service (HSS) Secretary stated: "I firmly believe that full access to health care in America will continue to require a public sector that provides a safety-net for those whom the market overlooks."[38] Invoking market failures was a common justification for conservative safety net policymaking and attempts to align Medicaid with the market followed suit. Demand for health reform once again emerged among Congress and the public in the early 1990s, and political pressure built such that the Bush administration was forced to reluctantly propose a plan in anticipation of his re-election bid. One component of Bush's 1992 proposal guaranteed health insurance for all poor and working-class families, not just those eligible for Medicaid, through a government subsidized tax credit, similar to the ACA. In testimony to the House, the CBO stated: "this approach would reduce the current work disincentive Medicaid recipients face."[39] Bush's health reform proposal, which failed to gain traction, sought to both expand Medicaid beyond welfare recipients in order to eliminate its work disincentive, as well as strengthen states' flexibility in structuring their Medicaid programs.

While Reagan sought to stymy the growth of the CHC program through block grants, Bush took a different tactic—partially due to a greater ideological emphasis toward the vulnerable, and partially due to changes in the political climate. With support from Democrats and lack of opposition from most Republicans, expanding CHCs was a politically viable and low-cost option

[38] H.W. Bush Library, Linda Tarplin Collection, OA/ID 08458, "Constraining the Costs of Health Care" (1992).
[39] H.W. Bush Library, Johannes Kuttner Collection, OA/ID 08799, "CBO Testimony Before the Committee on Ways and Means, U.S. House of Representatives" (1992).

to appease calls for health reform. Indeed, CHCs were a centerpiece of Bush's 1992 health reform, mentioned in most press statements, speeches, and talking points. The administration proposed to increase program authorizations by $2.8 billion and more than double the number of patients served from 6 million to 13.5 million over the following five years.[40] In line with his vision for a "kinder, gentler nation," the recurring refrain was that CHCs were committed to the nation's "underserved" in "inner-city and rural areas." Because these places would be otherwise unable to attract doctors without incentive from the government, the program once again evaded any contestation over deservingness and was clearly framed as correcting for the failure of the market "overlook" the underserved.

Beyond the executive branch, health reform proposals across the political spectrum also advocated for growth in the CHC program. House Republicans included CHCs as one of three proposed reform provisions,[41] the Clinton campaign and conservative Democrats proposed expansion, as did various interest groups, including the conservative Heritage Foundation.[42] There was growing consensus around the CHC program for several reasons. It became clear that CHCs would remain a necessary component of the government's efforts to provide health care to the poor, regardless of what kind of health reform was passed, because health insurance would be ineffective without the necessary infrastructure in underserved places. Expanding health centers was also seen across the spectrum as maintaining the integrity of the private sector by targeting government aid only to sparsely populated or economically depressed areas. And finally, for

[40] H.W. Bush Library, Linda Tarplin Collection, OA/ID 08459, "Summary on Health Reform Proposal", internal memo between White House and HHS (1992).
[41] H.W. Bush Library, Stephanie Fossan Collection, OA/ID 06981, "Action Now Health Care Reform Act," Republican House Members press release (1992).
[42] H.W. Bush Library, David Bradford Collection, OA/ID 07931, "Comparison of the Administration, Clinton/Gore, and Conservative Democrats' Health Care Reform Proposals" internal memo between White House aides.

Republicans, the CHC program served as a useful policy alternative to more widespread government involvement in health care.

Although no major health reform was enacted under Bush, two important pieces of legislation were passed in this era that would have a profound impact on the future of the CHC program. Under the 1989 Omnibus Budget Reconciliation Act, the federal government mandated that Medicare and Medicaid must not only reimburse health center services, but also that they would be paid at a higher rate. Recall that only one-third of state Medicaid programs reimbursed CHCs for all of their services at this time (Sardell 1988). Requiring that CHC visits be covered by public insurance vastly improved the financial viability of the program, expected to result in an additional $50 million in annual Medicaid revenue for health centers.[43] In addition, after lengthy negotiations between the Department of Justice and a bipartisan group of Senators, an agreement was reached in 1992 that the federal government would provide malpractice coverage for health center employees. These two legislative changes—mandated and increased Medicare and Medicaid reimbursements, as well as malpractice coverage—spurred the massive growth of the CHC program in the early 2000s. In the future, medical practices that had previously been uninterested in becoming involved with the government's efforts to care for the poor would now see the tangible economic and legal benefits to acquiring federal status as a CHC.[44] Though Bush and the Republican party sought to *limit* government involvement in health care, these two pieces of legislation laid the groundwork for the expansive nationalized primary care delivery system that we have today.

[43] Clinton Library, Health Care Task Force Collection, OA/ID 1229, "Physician Payment Under Medicaid: Options for Reform", report by the Physician Payment Review Commission (1991).
[44] The formal terminology of Federally Qualified Health Center (FQHC) was coined at this time, and is still used to differentiate health centers receiving federal grants, higher public reimbursement rates, and malpractice coverage.

The Clinton Administration: Victory for Republicans and the Market, 1993-2001

In the early 1990s, a major window of opportunity opened for health reform for the first time since the Nixon administration. There was a dizzying array of proposals—more than three dozen at one point in 1993—floated among both parties, along with the Clinton administration's version of universal coverage through managed care.[45] Once again, the majority of these proposals called for the repeal or reform of Medicaid. The same issues that had plagued Medicaid since its origins continued to suppress its political support: stigma, inequity, high cost, and inefficiency. The Clinton administration's proposed Health Security Act (HSA) sought to maintain Medicaid only for AFDC and SSI beneficiaries, while moving all other low-income and working-poor adults to a managed care version of universal coverage. The primary arguments employed were that Medicaid served as a work disincentive for those on welfare and that it stigmatized poor people and providers, as explained in an internal policy brief for Hillary Clinton:

> Medicaid coverage can serve as a *disincentive* to join the workforce… Low reimbursement rates and the *stigma* attached to the program have caused many providers not to accept Medicaid patients… The Health Security Act will remove the stigma attached to obtaining health coverage through Medicaid… promising an end to two-class medicine… Health reform will *free* these welfare recipients to pursue work and economic independence.[46] (Emphasis added)

This refrain of liberating welfare recipients from the stigma of Medicaid was common as the Clinton administration attempted to push for managed care reform. They argued that the HSA would "mean that millions of inner-city welfare recipients who want to work will be […] free to seek jobs, and get off welfare, because they will no longer have to worry about losing medical benefits for themselves and their children."[47] In preparation for subsequent testimony to Congress, Hillary Clinton stated that "for the first time, Medicaid recipients will be just like everyone else"

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[45] Detailed analysis of what transpired in the early 1990s battle for health reform can be found elsewhere (see Starr, Skocpol…)
[46] Clinton Library, First Lady's Office, Pam Cicetti Files, OA/ID 12500, "HRC's Briefing Book for Congressional Testimony Relating to Health Care" (1992).
[47] Clinton Library, First Lady's Office, Press Releases and Health Care, "The Health Security Act of 1993."

and reassured Congress that the administration's plan would do away with discrimination against the poor and avoid "redlining" of health plans.[48] By depicting the inequities and stigma of the existing Medicaid system, the Clintons claimed that their health reform plan would treat everyone equitably and with dignity, and that the poor would be integrated into mainstream health care. Once again, Medicaid was condemned by elite policymakers and framed as part of the problem that the Clinton administration's health plan would solve.

However, the Clinton administration's reform proposal suffered a resounding defeat by House Republicans in 1994. No longer possessing the political capital to push for reform, the Clinton administration subsequently pivoted from criticizing Medicaid to embracing it as a tool to advance incremental policy change. The Clinton administration sought Medicaid expansion through state waivers that promoted experimentation and eventually led to the enactment of the Children's Health Insurance Program (S-CHIP) in 1996. In addition, the passage of the 1996 Personal Responsibility and Work Opportunity Act that famously brought an "end to welfare as we know it" formally delinked Medicaid from welfare. These two momentous changes led Medicaid to be framed as both apart from welfare and in relation to children, lessening its stigmatized political perception. Yet, Republicans continued to propose block grants that would drastically reduce Medicaid funding and coverage. These partisan battles over health reform paved the way for even more controversy over Medicaid in the 2000s, primarily concerning the role and authority of the federal government versus the states. Medicaid's federalist design has been—and will continue to be—its clearest and most durable cause of political contention.

Turning to the CHC program, it underwent a surprising transformation from a Democrat- to Republican-leaning program in the early 1990s. The Clinton administration largely ignored the

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[48] Clinton Library, First Lady's Office, Melanne Verveer Files, OA/ID 20035, "Health Reform" (1993).

CHC program while Republican leaders embraced it. Indeed, Republicans proposed more funding for CHCs than did leading Democratic proposals. The most widely supported health reform legislation put forward by the House Republicans, with 106 co-sponsors, boasted of expanding the CHC program on the first page of their press release.[49] It was at this point that CHCs finally became a program that Republicans enthusiastically advocated for, rather than one they simply did not oppose.

Why did the Clinton administration not embrace CHCs in health reform? Clinton's reform was designed to give authority to states, and CHCs decidedly did not align with this vision as they were designed to curtail state policymakers in favor of federal-local partnership. Although CHCs were included as "essential community providers" in Clinton's HSA, the legislation otherwise neglected CHCs and even sought to block grant community-based primary care, along with "enabling services", to fall under state supervision. Health centers thus faced a similar climate in the early Clinton years as they had under Reagan and Ford, compelling advocates to once again fight against devolution.

Like in previous decades, the block-grant attempt mobilized CHC advocates, who were even stronger and more organized after surviving the Reagan era. The national association, NACHC, activated a robust and coordinated campaign to resist Clinton's turn away from health centers by deploying the market failure framing. In order to convince the Clinton administration of their utility, advocates articulated how CHCs were not, in fact, opposed to free market principles but rather in response to market failures and thus complementary to neoliberal policymaking:

> Simply put, underserved Americans are in the health care predicament they are in because they have been *rejected by the private market*. The community and migrant health center programs were enacted by the Federal Government in response to the *failure of market forces* to meet the needs of underserved and vulnerable populations. If market forces work for health care like they have in other sectors of the

[49] Clinton Library, Domestic Policy Council, Chris Jennings Files, Box 46, "[HSA] Congressman Hastert" (1993).

> economy, underserved people and communities run the risk of being red-lined, short-changed and, in the end, getting far less than they need or deserve.[50]

In addition to NACHC, Republicans also explicitly referred to the market failure logic. Senator Chafee (R-RI), a strong supporter of CHCs, explained in one piece of proposed legislation: "pure competition may not work in certain areas of the nation, particularly medically underserved areas, both urban and rural. Additional funds and services need to be provided for these special needs populations."[51] Conservative legislators acknowledged that free market principles were ineffective in poor communities, as did members of Clinton's own administration:

> It is clear that some currently underserved areas may have their needs met through the private market. Other areas have such severe problems that they may never attract providers or investment capital… Because of the scarcity of investment capital in underserved areas, facilities serving existing patients as well as new capacity are essential to attract and maintain providers and to allow existing and new providers to compete in the new system.[52]

The argument was that underserved areas had such "severe problems" that they could not be expected to "attract providers or investment capital." Paradoxically, rather than undermining belief in the market's effectiveness in organizing welfare policy, this argument instead aligned with principles of the market's "natural" failures based on principles of competition. Given the prestige of the medical profession (Starr 1982), it seemed rational that poor communities were unable to attract profit-seeking doctors. Market failure framing averted discussion of deservingness, personal responsibility, and morality that other welfare policies were vulnerable to, and was crucial to winning over Clinton's support. In addition, the Clinton administration became increasingly aware of the popularity of CHCs among Congressmembers. A number of internal memos weighing political strategy made the simple yet powerful claim that CHCs had strong bipartisan ties on

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[50] Clinton Library, White House Health Care Task Force, Richard Veloz Files, OA/ID 3885, "House and Senate Testimony, Jan-Feb 1994."

[51] Clinton Library, Domestic Policy Council, Chris Jennings Files, Box 47, "Misc Chafee Health Reform Proposals" (1992).

[52] Clinton Library, Office of Policy Development, Ira Magaziner, OA/ID 10009, "Access to Care for Underserved and Vulnerable Populations" Presidential Briefing Book (1993).

Capitol Hill. Therefore, despite the Clinton administration's disinterest in CHCs and preference for granting states full jurisdiction, the activation of market failure framing by the robust CHC advocacy network along with bipartisan Congressional allegiance to CHCs rendered the program safe from retrenchment.

Race, Immigration, and The Convergence of Medicaid and Health Centers, 1993-1996

One final development of the 1990s was that CHCs had become more closely associated with racial minorities and immigrants than in any other era since its origins. Health centers were continually discussed as the government's primary means to serving minorities, "inner-city" poor, and Hispanic immigrants, most notably "illegal aliens." However, rather than being negatively framed as research on the racialization of policies would anticipate (CITE), CHCs were instead framed positively as "fixing" problems of racial health disparities. The most significant element of this shift occurred with regard to undocumented immigrants. In the early years of the Clinton administration, CHCs were touted as a solution to the problem of the undocumented lacking access to health care. As of 1993, CHCs and Emergency Medicaid were the only formal ways that undocumented immigrants could receive health care in the U.S., and an estimated 300,000 were served by CHCs that year.[53] Policy elites recognized the problem of undocumented immigrants being highly uninsured, yet the political barriers to including them in the HSA were seen as insurmountable by the Clinton administration. Promoting CHCs became the standard response when the administration was asked what they would do about health care for undocumented immigrants:

> For humane reasons and purposes of protecting the health of the public it is important that a safety net be in place to care for these individuals... Non-emergency care would be provided through the

[53] Clinton Library, Health Care Task Force, General Files, OA/ID 1235, "Working Group Draft" (1993).

> Community and Migrant Health Centers; these centers now serve all persons without regard to citizenship and will continue to do so.[54]

In this way, CHCs were used as justification for why the government need not expand the HSA to cover undocumented immigrants. The CHC program proved its political utility as a tactic to compensate for comprehensive coverage and "solve" contentious policy issues, like immigration.

Debates over the 1996 welfare and immigration reform (PRWORA and IIRAIRA) presented a critical juncture for both CHCs and Medicaid. Initially, conservatives and some officials in the Clinton administration sought to include CHCs on the list of federal programs that immigrants—both undocumented and recently arrived—would be ineligible. The definition of federal public benefits was debated in relation to both PRWORA and IIRAIRA, and it was decided that legal immigrants would now be ineligible for Medicaid during the first five years of residency. In place of Medicaid, newly arrived and undocumented immigrants were expected to receive care at CHCs, get insurance through an employer or independently, or use Emergency Medicaid in critical emergency situations. Like in 1993 when CHCs were used as validation for why the HSA would not include extending coverage to undocumented immigrants, CHCs were again used in 1996 but now to take away Medicaid eligibility from legal, recently arrived immigrants.

The debate over what constituted "federal public programs" explicitly manipulated legal terms in order to allow CHCs to remain available to all immigrants. HHS drafted a definition of federal public benefits that would exclude CHCs because of their focus on places and not people: "since community health centers are structured to serve communities… the centers do not provide federal public benefits to individuals."[55] The emphasis on places rather than people was viewed as grounds to exclude CHCs from the list of programs ineligible to immigrants. This is a long-term

[54] Clinton Library, Health Care Task Force, Richard Veloz, OA/ID 3880, "Hispanic Health Care Q&A" (1993).
[55] Clinton Library, Domestic Policy Council, Elena Kagan, Box 64, "Definition of 'Federal Public Benefit' Under the PRWORA of 1996" paper by Georgetown University Law Center (1998).

consequence of the program's strategic market failure framing, which diverted blame from individuals and counteracted debates over morality, deservingness, personal responsibility, and in this instance, also racialization, that are commonplace in welfare policy.

Furthermore, advocates effectively argued that lack of access to CHCs would pose a public health risk, because "germs do not ask for a green card before they spread."[56] Despite the prevailing policy climate of restricting immigrants' access to government programs, CHC and immigration advocates persevered. HHS coordinated with White House counsel, including future Supreme Court Justice Elena Kagan, to modify the definition of federal public benefits such that CHCs would not be affected, concluding that this was: "major good news for immigrant advocates, who argued that shutting off these centers to illegals would be dangerous to the public health and to citizen children."[57] This victory exemplified a strong mobilization effort by advocates, coordinated with the Congressional Hispanic Caucus, to ensure that undocumented immigrants would have some way of getting health care. Despite the fact that CHCs are, to this day, one of the only federally-funded programs to which undocumented immigrants are not excluded, the covert maneuvers to arrive at this decision kept CHCs out of the spotlight and avoided partisan backlash.

In sum, CHCs first justified the exclusion of undocumented immigrants from Clinton's HSA in 1993, and subsequently justified the restriction of immigrants' Medicaid eligibility in 1996. Only the latter policy was implemented, but it was built on the same arguments and framing as the 1993 debates. The transformation of CHCs into a conservative-supported program in the early 1990s, combined with increasing anti-immigrant sentiment and the severe cutbacks of the nationwide safety net in 1996, served the purpose of inhibiting Medicaid coverage among

[56] Clinton Library, Health Care Task Force, Richard Veloz, OA/ID 3884, "Impact of the Proposed Health Security Act (HR 3600) on Undocumented Immigrants" (1994).
[57] Clinton Library, Automated Records Management System, Emails Received by Elena Kagan, Box 80, emails between Diana Fortuna and Elena Kagan (1998).

immigrants, even among those who were in the country legally. The convergence of the two policies, both relying heavily upon legality frames (Brown 2013a) to determine access to health care, had the ultimate effect of preserving bipartisan support for the CHC program.

DISCUSSION

This study leverages a comparison of two policies with the same purpose and national-historical context in order to answer the question of why some social policies become more politically contentious than others contention. Despite the prevailing belief that antipoverty policies inevitably attract partisan conflict and engender stigma, I argue this is *not* a foregone conclusion and needs to be better understood. This study first posits a general theoretical framework for assessing the underpinnings of political vulnerability in social policymaking. Pulling together five interrelated explanations from existing literatures—including deservingness, race, elite support, policy design, and the role of ideas—I assess how each factor contributes to understanding political controversy. However, I ultimately conclude that these explanations are insufficient on their own, and that the extent to which each policy was framed in alignment with market principles was instrumental to the divergence of political contention. As social policymaking in the United States shifted away from a social democratic orientation of the New Deal and Great Society and toward the present-day era of neoliberalism, the CHC program was able to attract bipartisan support because it was both framed in moral terms—namely, health care as a human right—and as correcting for the failure of markets to serve the poor. In contrast, Medicaid was primarily concerned with states' rights and framed as correcting for failures of individual welfare recipients, which inhibited its political backing and incited conflict among a variety of actors. After reviewing existing explanations, I then elaborate on how the concept of *market failure paradox* contributes to scholarship on partisanship in the U.S. welfare state.

The cases analyzed in this study complicate predominant explanations of deservingness in the politics of social policy. Counter to the prevailing literature, I found no instances in which policymakers explicitly debated *whether* the poor deserved health care aid from the government. Even during the era in which conservatives had the most political power—the early Reagan administration—a common thread continued in the sentiment that it was unconscionable to deny health care from the poor. Prevailing social norms underscore ethical consensus that the sick deserve help: "no one can be against medical care or health for all American citizens" (Stevens and Stevens 1974: 359). This politically popular rhetoric did not necessarily translate into action, as conservatives did little to improve the situation of the poor, but at the very least health care deservingness was not a central dispute as it has been in other welfare state programs. Instead, one of the primary issues plaguing Medicaid was that it went *against* this norm of health care deservingness by demeaning recipients due to its long-standing linkage with welfare. In the context of health care provision, the perversity thesis lacked the "cultural resonance" needed for an effective frame (Snow and Benford 1988; Somers and Block 2005). Cultural categories of worthiness deployed in welfare discourse, thus, did not resonate in the life-or-death matters inherent to debates over access to health care (Steensland 2006), and in fact were a central instigator of political opposition against Medicaid in both parties, but especially among liberals. In contrast, the CHC program's alignment with human rights and charity provided a straightforward moral frame across ideological perspectives. Liberals admired its relation to social justice and equality. Conservatives saw it as a charitable program to help the poor who could not be blamed for the economic conditions and lack of medical providers in their community. In this way, the failure of the market rendered debates over deservingness obsolete.

Moving to the second explanation, I also found little supporting evidence that race was a key component explaining the divergence of political contention. The racialization of AFDC clung to policymakers' views toward Medicaid and attempts to retrench the program, especially in Southern states. There was surprisingly infrequent explicit discussion of race in the context of Medicaid policy, but this was largely the result of AFDC absorbing racialized political conflict in place of Medicaid. Evidence shows that Medicaid covered whites disproportionately more than racial minorities, and that covert mechanisms suppressed access to Medicaid for minorities (Engel 2006). Therefore, the absence of explicit racial conflict in Medicaid could also be due to the fact that whites were benefiting from the program more so than minorities. In contrast, race was explicitly discussed far more frequently in the CHC program. Like other War on Poverty programs, CHCs initially targeted urban Black communities and were originally referred to as "ghetto medicine." There was a non-trivial amount of localized racial conflict in the opening of clinics, particularly surrounding those serving immigrants. The program then expanded in the mid-1970s to rural areas, with predominantly poor white populations, which was likely an important reason that the CHC program did not incite racial conflict. Yet, even when the CHC program became strongly associated again with Hispanics and undocumented immigrants during the 1990s, political conflict still did not ensue, even though this was a time when immigration was a hotly contested policy issue at the federal level. If race was a central reason the programs differed, the existing literature would lead us to expect that Medicaid was more racialized or experienced more racial conflicts than the CHC program. This was decidedly not the case, as the CHC program was equally if not more racialized than Medicaid, especially in the early years of both programs. Furthermore, both Medicaid and CHCs have historically served roughly the same proportion of racial minorities, with Hispanic and Black populations comprising a slightly larger percentage of CHCs patients

than Medicaid recipients (Kaiser Family Foundation and HRSA Uniform Data System). Though race was undeniably important in the development of both policies, I do not find evidence that it was as salient to the divergence of political contention.

Third, sources of political support proved to be an important though indirect explanation to the divergence in contention. Conflict emerged in Medicaid not because the poor lacked power but instead because of the program's origins in the politics of accommodation (Starr 1982). Neither political party was in support of Medicaid from its enactment, and no efforts were made to coalesce around compelling frames in order to grow its support base. The combination of lacking both moral and market-based frames suppressed political support for Medicaid as debates over NHI prevailed. With one NHI failure after the next, Medicaid reached a state of institutionalized political contention (Schön and Rein 1994) during the 1990s, which continued through the 2000s and the passage of the ACA. In contrast, the early CHC program had strong initial support from policy entrepreneurs and bureaucratic advocates, who crafted the moral and market-based frames that grew its political popularity. Eventually this led to the widespread, grassroots advocacy network at federal, state, and local levels, organizing a formidable force in the face of block grant attempts from Presidents Ford, Reagan, and Clinton. These advocates established strong ties with Congress, the final line of defense when the executive branch sought to devolve the CHC program. The absence of elite support for Medicaid and presence for the CHC program provides evidence for its role in determining political contention, but the underlying cause of the support came through the channels of policy design and market-based framing.

The design of both policies proved to be instrumental in explaining the divergence of political contention. Although aligned with principles of federalism and the liberal welfare state (Ruggie 1992), the state variation in program design, funding, and participation led Medicaid to

generally be viewed as highly inequitable, dampening its support and inciting opposition. Because Medicaid eligibility was initially tied with welfare receipt, it also adopted the long history of stigma affiliated with public assistance and became perpetually entangled in contestations over deservingness (Katz 1989). Thus, Medicaid was fundamentally structured and framed along the lines of the perversity thesis (Somers and Block 2005), to correct for failures of individuals who were dependent on the state. Medicaid's federated policy design and pervasive inequity frames stymied the program's ability to gain political support until it was finally disconnected from welfare in 1996. To this day, conflict between states and the federal government continues to be the primary cause of Medicaid's political contention. In contrast, the CHC program's centralized design in which the federal government exercises complete authority, bypassing involvement from state or local governments, allowed for the CHC program to adapt to changing political environments. Starting with Nixon's elimination of the program's social justice elements, subsequent administrations have been able to manipulate the program to suit their policy preferences. Centralized authority allowed the program to be flexible, though also vulnerable, to the whims of whoever was in power.

Policy design laid the groundwork for the deployment of frames. Ideas about policies were strongly conditioned by the opportunity structures available based on the initial design of the policies. Medicaid was fundamentally constrained in articulating either moral- or market-based frames due to its structure as an extension of welfare and federalist design that both created inequities across state lines and increased "veto points" due to a greater number of political actors involved (Prasad 2018). While the states' rights frame that led from Medicaid's federalist design was an important factor in getting the legislation passed, it has been the centerpiece to its political conflict, continuing through the ACA and Republican governors' opposition of Medicaid

expansion. In contrast, the CHC program had a much wider discursive opportunity structure due to its centralized authority within the federal government that bypassed veto points among state or local political actors. Without the flexibility in its structure, the effectiveness of the CHC programs' dual moral- and market-based frames may have been irrelevant, and its bipartisan support as well as national advocacy network may have never flourished. One theoretical contribution is, therefore, that discursive opportunity structures are not only variable across nation-states (Ferree 2003), but also highly contingent upon policy designs themselves. Because this study is uniquely able to hold contextual factors constant, I find the resounding influence of policy design in establishing discursive constraints over and above cultural, attitudinal, or political forces within a national context.

In addition to these existing explanations, though, market complementarity emerged from the analysis as a meaningful distinction between both policies. Medicaid lacked a clear alignment with the market and, instead, was criticized both for disincentivizing work and family formation, as well as blamed for causing widespread inflation in health costs. There are ample ways in which Medicaid could have been framed in alignment with the market. For one, people cannot work if they are sick, and having an insured workforce should improve market productivity. Likewise, a market failure logic could have been deployed: because private insurance companies had little incentive to cover poor people, as they tend to have worse health and be more costly, the federal government could have framed its role in insuring the poor as correcting for the market failures of the private insurance industry. Some evidence exists that these economic frames were used, but not until the late 1980s when Medicaid was extended to include more pregnant women and infants (Grogan and Gusmano 2007).

In contrast, the CHC program's centralized structure within the federal government enabled its malleability during the rise of neoliberalism. Indeed, the groundwork of its supply-side framing had been laid as early as 1967, despite the emphasis on social democratic policymaking during that era. As market-oriented policymaking took firm hold in the 1980s, CHCs had an effective justification: free market principles of competition simply do not work in poor areas. In fact, that is the reason why they are underserved, as doctors seeking profit would not rationally choose to practice in these places. This is what I refer to as the *market failure paradox*. Policymakers accepted that market forces could not be applied the same way in poor places because of the competitive nature of the free market. Thus, the government's involvement in the CHC program depicted not a rejection of the market, but an acknowledgement of its inherent limitations. Evincing the ability of market fundamentalism to survive disconfirming evidence (Somers and Block 2005), the market failure paradox uses the logic of incentives for profit-seeking enterprises to justify the federal government's intervention in poor places, which counteracted moral contestations over deservingness as the residents could not be blamed for their local economies or the lack of medical providers. The market failure paradox not only allowed the CHC program to survive the historical shift toward neoliberalism, it also set the stage for the proliferation of place-based policies since the 1990s (Kline and Moretti 2014; Tach et al. 2020), which target poor places rather than poor people and largely boast bipartisan support.

CONCLUSION

The founding frames in alignment with morals and markets set the CHC program on a path toward political receptivity, resonating across the ideological spectrum, but its institutional structure laid the foundation for these frames to be effective among political elites, especially Congress.

Ultimately, it was the dual flexibility in both ideology and design that allowed the CHC program to gain political support, overcome controversies it encountered, and achieve bipartisanship. As these features were conspicuously absent in the Medicaid program, one general conclusion is that centralized authority and the articulation of market complementarity are two necessary conditions in the evasion of partisan conflict among policies targeting the poor. Indeed, some of these features can be found in other bipartisan supported social policies, like the Earned Income Tax Credit, which has a centralized structure and is framed in alignment with the market. Likewise, place-based policies such as the Low-Income Housing Tax Credit (LIHTC), Empowerment Zones, and the New Markets Tax Credit (NMTC) also are centrally administered and justify their intervention in relation to market failures. Therefore, the design and degree of market alignment of social policies is consequential for the development of bipartisanship in the American context, and potentially other neoliberal welfare states.

Considering that both Medicaid and the CHC program have survived for more than 55 years, political contention does not necessarily determine the success of a policy. Indeed, both policies have experienced extraordinary growth since the turn of the century, despite intensifying hostility of Republicans toward Medicaid and polarization over safety net policies more generally. Yet, partisan conflict is important because it colors the experience of policies for the public and creates unequal distributions of government aid (Michener 2018; Montez et al. 2020), both of which can have severe effects on enduring social inequalities. A large body of literature has shown the state fragmentation of Medicaid is associated with disparities in a variety of health outcomes, meanwhile evidence has found that the CHC program is associated with lower mortality and reduced health disparities, particularly among racial and ethnic minorities (Bailey and Goodman-Bacon 2015; Buchmueller et al. 2016; Goodman-Bacon 2018; Miller et al. 2019; Shi et al. 2001,

2004). Historical processes underlying the development of political contention are consequential, therefore, not only to the shape of the welfare state but to the people who rely upon it. Although policies targeting the poor tend to be vulnerable to partisan backlash in the modern climate of polarization, this study demonstrates that a concerted effort to position policies in relation to market failures can lead to the evasion of political contention in the U.S. welfare state.

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