Health Reform and the Future of American Politics

Lawrence R. Jacobs

The Affordable Care Act of 2010 (ACA) is a landmark in American social policy that is disrupting America's "liberal tradition." It is successfully expanding access and compelling insurers to change their business models to serve more socially-useful purposes; cost control enjoyed initial success but confronts barriers rooted in America's resilient political economy. The ACA is disrupting long-standing patterns of American politics, introducing new developmental paths that unsettle or, in certain respects, offset the familiar patterns of selectivity, deference to private markets, and "drift" that tend to produce government inaction as economic insecurity increases. New policy arrangements for financing and delivering medical care is ushering in a new politics of US health care that are resetting the terms of future debate; the ACA is also challenging familiar approaches to studying politics including analyses of framing, policy effects and political development, and American political thought.

The Affordable Care Act of 2010 (ACA) is a landmark in American social policy that is disrupting America's "liberal tradition." Generations of scholars of US politics and political thought have been preoccupied with the idea that American politics is characterized by a deep-seated aversion to government in the abstract, the institutionalized dispersion of authority, and its skillful manipulation by organized interests to their advantage.[1] The ACA does not, of course, eliminate America's liberal tradition; but it introduces new developmental paths that unsettle or, in certain respects, offset the familiar patterns of selectivity, deference to private markets, and "drift" that tend to produce government inaction as economic insecurity increases.[2] The new politics ushered in by the ACA invites a renewal in the study of American politics to span disciplinary cubbyholes; to situate substantive policy into the over-time struggle for political power and institutional position; and to return to the enduring themes of political economy—the elaboration of social rights that interrupt the dependence of citizens on private markets, the insertion of "the public" into previously privatized discourses and decisions, and the fostering of encompassing forms of political representation.

Lawrence R. Jacobs is the Walter F. and Joan Mondale Chair for Political Studies and Governance in the Hubert H. Humphrey School and the Department of Political Science at the University of Minnesota (ljacobs@umn.edu). *He is grateful to Timothy Jost for closely reviewing his discussion of the Affordable Care Act regulations and policies and Peter Evans for engaging questions and conversation.*

doi:10.1017/S1537592714001625

For generations, failed health reform in the face of enormous and widely accepted problems was Exhibit A for America's history of anti-statism, legislative deadlock, and policy drift. The United States spends nearly 18 percent of its gross domestic product on total health expenditures; Japan, Canada, and Western Europe spend at least one-third less while providing universal access to comprehensive medical care.[3] America's larger expenditures result, in part, from higher prices for most components of medical care—from medications and medical devices to medical procedures (normal obstetric delivery or an appendectomy in the US cost up to double the charges in Canada and Western European countries). Unfortunately, more spending has failed to deliver better health. America's health system stands out internationally for its medical errors—only heart disease and cancer cause more deaths.[4] America also lags most of its allies on a host of measures for the health of the country's population, including infant mortality.[5] Some epidemiologists use the disquieting term "excess mortality" to describe the preventable deaths in the United States and the large racial and economic disparities in sickness and death.[6]

America's liberal tradition is a prime suspect in the demise of comprehensive national reforms to address the country's negative consensus about the health care system. The trail of failure started with Teddy Roosevelt in 1912 and continued through Franklin Delano Roosevelt's defensive decision in 1934 to drop health reform from his legislative initiative to establish Social Security and Harry Truman's series of futile campaigns for national health insurance after becoming president in 1945. In the modern era, national health reform intrigued Richard Nixon in the early 1970s, to no avail, and nearly sank Bill Clinton's presidency in 1993–1994.

An extraordinary confluence in 2008 undercut the liberal tradition that had stymied health reform for a century: the Great Recession shook confidence in the governing philosophy of market deference, the election anointed a unified Democratic government committed to comprehensive national health reform, and the achievements of Massachusetts' insurance exchange generated support for an emerging policy framework. Democratic control—including the 60 votes necessary to defeat Senate filibusters—equipped reformers to weather the trench warfare that repeatedly defeated past reform, but not without delays that stretched the process over more than a year, unseemly but often necessary deals to win votes, and ongoing jousts with America's federal system and the philosophical conservatism that was evoked by warnings about "death panels." Tracing the formulation and passage of the ACA from Obama's inauguration in January 2009 through his signing of the ACA into law in March 2010 requires much more extensive discussion;[7] I focus here on the ACA's implementation since 2010, as steps to widen access and reduce costs have collided with America's entrenched political economy.

The ACA's passage capitalized on the liberal tradition's vulnerability in 2008; its implementation after 2010 both exerted quick impacts on health policy and initiated developmental paths with the significant potential to transform US social policy and politics over time. The ACA is generating the beginnings of new relationships, commitments, and patterns of operation, as anticipated by research on policy feedbacks.[8] Of course, questions, uncertainties, and inadequacies in access and cost controls will remain; they are the product of conflicting values, interests, and partisan motivations—not to mention administrative complexities and real-world hurdles.

In what follows I outline the evidence of the ACA's lock-in as a landmark feature of US social policy and then draw on research about policy feedbacks and political economy to analyze the new emerging patterns of political and institutional development. I conclude with some reflections on the ways that these emerging patterns open new vistas for the study of U.S. politics.

What Health Reform Has Done—Already

The steady political and press carping about the ACA's implementation—along with the dozens of US House votes to repeal it—have created the mistaken impression that health reform is fragile, structurally flawed, and failing. In historical terms, the first four years of the ACA's implementation compares favorably with the Social Security's roll out at a similar point after its enactment in 1935. The initial design of Social Security's financing proved disastrous, putting a drag on already depressed consumer demand and helping to push the country into a recession in 1937. By 1939, FDR was compelled to concede that his signature law needed to be "improved and strengthened" and he signed substantial changes.[9] FDR acknowledged a second fundamental flaw—the benefits were inadequate and poorly targeted—and agreed to expanding benefits for dependents and assistance for poor children.[10]

By comparison, the ACA is successfully expanding access and compelling insurers to help; cost control enjoyed initial success and is now confronting barriers rooted in America's resilient political economy.

Coverage Has Expanded—More Than Expected

The ACA expanded coverage by pursuing a "progressive federalism" strategy—states were given the option to participate but the federal government retained sticks, carrots, and backup alternatives—as Theda Skocpol and I argue.[11] States had the option to establish health insurance exchanges that showcased private health plans and met basic standards; if they chose not to (as two-thirds did), the federal government created exchanges for their residents. To make the selection affordable, individuals with incomes at 100 percent of the federal poverty line (FPL) up to 400 percent of the FPL (family of four earning up to $95,400 in 2014) were entitled to subsidies in the form of tax credits. About three-quarters of Americans who signed up on the exchanges in 2014 received a subsidy, which averaged $4,410 according to the Congressional Budget Office (CBO).[12]

The second prong of the ACA's progressive federalist strategy was to give states the option of expanding Medicaid to include all individuals (including adults without children) below 138 percent of the FPL ($32,913 for a family of four); if they refused, states risked a substantial portion of their existing Medicaid funding. This was a substantial and significant nationalization of social welfare policy. Before the ACA, many states excluded desperately poor adults who lacked children—their earning had to drop below 25 percent of the FPL in Texas, Louisiana, and Alabama. The Supreme Court's historic decision on the ACA in June 2012 upheld the law's constitutionality but gutted its Medicaid stick; Washington was prohibited from withholding funding. Nonetheless, the ACA wielded powerful enticements—full payment of Medicaid's new coverage for three years and generous support afterward.

Access has been dramatically widened by state and federal insurance exchanges and state expansion of Medicaid in about half of the states—including 12 states with a Republican governor or a conservative Republican legislature. Although precise figures are not final, the ACA has covered between 15 and 24 million people. The workhorses are the insurance exchanges, which attracted 8.1 million to sign up, and Medicaid and its companion program for children (Child Health Insurance Program), which covered an additional 4.8 million.[13] Further gains have come from employer-sponsored health insurance plans (110,000 and possibly 8.2 million more) and the

https://doi.org/10.1017/S1537592714001625 Published online by Cambridge University Press

new coverage for youth up to 26 years of age who are included in their parent's plans (1.60 to 3.1 million).[14]

A growing number of studies using diverse methods are detecting a notable drop off in the rate of uninsurance, as the ACA was implemented. Gallup finds that the percentage of Americans who reported that they lacked coverage quickly fell from 18 percent in late 2013 to 15.9 percent by early 2014—its lowest rating since 2008. This decline is sharpest in states that expanded Medicaid. The Urban Institute reports that the ACA's first open-enrollment period extended coverage to 5.4 million Americans 18 to 64 years of age who were previously uninsured—this represents a 2.7 percent decline in the country's uninsurance rate.[15]

Apocalyptic projections of 5 to 6 million joining the ranks of uninsured as a result of insurance policy cancellations are contradicted by emerging evidence. Some will lose coverage and face higher premiums but early estimates suggest that two-thirds will be eligible for tax credits and will find coverage.[16]

The early pattern of rising enrollment and falling rates of uninsurance is now locking into place. The nonpartisan CBO reports that 34 million will be covered by the exchanges and Medicaid/CHIP as Obama finishes his term, helping to bring coverage to 92 percent of American citizens and reduce the ranks of uninsured by 25 million people.[17]

Of course, hurdles remain. After the first open-enrollment period, 28 percent of those signing up on the federal exchange are "young invincibles" (18 to 34 year olds); the administration's target was 40 percent in order to widen protection and to balance the pool of insured with individuals who were, on average, healthier. This shortfall needs to be tracked but much-ballyhooed claims that it would spike premiums were overstated. The key factor is the mix of healthy people in the exchange insurance pool, not "young invincibles" alone. While premium increases will occur, their magnitude will be moderated by the stabilizing of insurance markets over time and by a series of mechanisms to spread the distribution of less-healthy individuals among insurers.[18] Another ongoing challenge will be enrolling vulnerable populations—often in communities of color.

ACA Strategies to Tame Insurers

Prior to the ACA, American health insurance was a wild west. What made sense for society—covering the costs of being treated for illness—was bad business. The insurance business model was built, in part, to avoid the sick and their higher costs. Meanwhile, millions of Americans lacked insurance; unpaid medical bills became a leading cause of bankruptcies.[19]

One of the ACA's largest impacts is invisible to most Americans—new rules of the road to stop insurers from avoiding the ill or hitting them with exorbitant fees. Insurers are now prohibited from turning away individuals with preexisting medical conditions and charging them (or women) higher premiums. Insurers were also compelled by the "medical loss ratio" rule to invest 85 percent of premiums (80 percent in the market for small groups) to "clinical services" and "activities that improve health care quality," facing penalties for excessive spending on administration, profits, and executive salaries.

The transformation of private insurance markets has been surprisingly smooth. The pricing of premiums has been more moderate than the CBO initially expected and the participation of private health plans has been more extensive than projected—a sign that the new market is working. In addition, policy mechanisms to reap more social benefit from private insurers are also having an impact. The "medical loss ratio" has compelled insurers to pay $1.6 billion to 8.5 million consumers in 2012 and nearly 13 million in 2011. Consumers saved an additional $3.4 billion as insurers cut back on administrative costs that had previously been passed on in premiums, according to the National Conference of State Legislatures.

The Political Economy of Health Care Costs

Health economists label expenditures on medical care as (excessive) "costs;" in fact, they are a register of the program benefits to high-turnout voting blocs and the profits and salaries of well-organized and affluent businesses and professions. Faced with the powerful confluence of private interest and political organization, health reformers in 2009 made a brazen promise to expand coverage to over 30 million Americans while simultaneously "bending the cost curve" downward. Their solutions navigated the shoals of existing political power without directly confronting them.

The rate of growth in health care expenditures would slow, reformers reasoned, in the wake of competition among insurers for customers on the new exchanges, the new "medical loss ratio," and new rules and experiments for paying providers that shifted incentives from rewarding the volume of services to encouraging quality performance by penalizing hospitals for the readmission of patients or bundling payments for one diagnosis (such as a hip replacement) instead of paying for each identifiable service.

Reformers boasted a remarkable accomplishment by the end of 2013: health inflation, which had ranged from 16 percent per year in the 1980s to 9 percent range in the early twenty-first century, fell to 3 to 4 percent after the ACA's passage—the slowest rate in 50 years. By 2014, the cautious CBO and other non-partisan government expert bodies reported that reduced health inflation would decrease the budgetary outlays for the ACA's insurance coverage below previous estimates by $5 billion in 2014 and by $104 billion for the coming decade.[20]

Reformers' victory over health inflation, however, may be short-lived. As the economy strengthened after the

https://doi.org/10.1017/S1537592714001625 Published online by Cambridge University Press

Great Recession and the ACA started to cover millions, both the White House and independent researchers projected increased health spending. The Chairman of Obama's Council of Economic Advisers, Jason Furman, warned in June 2014 of the inflationary pressure of rising demand: "it is likely that the coming quarters will see faster growth in total health care spending as the millions of people who gained health insurance coverage. . . begin to use their new coverage."[21] The White House's warning was echoed by independent analysis that similarly anticipated an acceleration of health care spending because of increased demand both from consumers who had delayed care during the economic downturn and from the newly insured.[22] As demand rises, control over pricing largely remains in the hands of pharmaceutical and medical device producers and hospitals.[23] If health inflation rises, the ACA's tweaks to existing subsidies and cautious deference to stakeholders may pose a challenging choice between anguished benefit cuts and directly challenging powerful private interests.

The Politics That Health Reform Is Making

The implementation of health reform both accommodates and disrupts America's political economy. The ACA incorporates private markets but it also generates three developmental paths that unsettle America's traditional deference to market operations and policy frameworks: (1) the establishment of health insurance as a social right financed with resources from the affluent and healthy rather than as a private good based on the ability to pay or on generous terms of employment; (2) the expansion of public scrutiny and authority over medical care and financing in place of what had been privatized decisions by individuals, medical providers, and businesses; and (3) the cultivation of more inclusive representation of broader publics to accompany the familiar American pattern of intense and narrow representation of medical providers, suppliers, and other interest groups. Students familiar with US social welfare history and historical institutionalism would—justifiably—not expect the reconstitution of political economic developments to be quick or linear; some developments may start small and then progress unevenly while others may suffer reversals.[24]

Making Access to Health Insurance a Social Right

One of the enduring comparative features of US social welfare policy is its selectivity and connection to employment in contrast to the tendency in Germany and, especially, North Europe toward universal social rights anchored in citizenship.[25] The ACA departs from the liberal welfare state model by expanding medical coverage and declaring it a social right, loosening the dependence of individuals on private markets for economic security.

The ACA explicitly linked eligibility to the status of being "a citizen or national of the United States." This explicit declaration was partly geared to bar undocumented workers but the structure and language of the ACA legislation is one of "rights." Medical care is no longer distributed to the non-elderly as another commodity traded in private markets but is legally defined as owed to each citizen as a full and equal member of the community.

Tying medical coverage to citizenship (rather than markets and the ability to pay) required a new approach to financing—one that relied on redistribution from relatively affluent individuals, professions, and businesses. The ACA's insurance subsidies, Medicaid expansion, and other benefits are financed by two taxes on individuals whose yearly income exceeds $200,000 or for married couples earning over $250,000—an increase in Medicare's tax on earnings by 0.9 percent and a new 3.8 percent tax on capital gains from investments.[26] These taxes fall on less than 2 percent of tax filers, according to the non-partisan Tax Policy Center.[27] In addition, insurers, and medical device and pharmaceutical manufacturers pay new fees; hospitals face cuts. The CBO and the Joint Committee on Taxation (JCT) projects the ACA will raise $813 billion between 2012 and 2021; the tax bill is picked up by the most affluent 3 percent of households as well as prosperous medical industries and providers.[28] President Obama's efforts at comprehensive tax reform failed but the ACA stealthily enacted the most redistributive changes in decades—changes that were more progressive than the general tax reforms that the Obama administration did consider.

Even as health insurance and medical care were recast as social rights, the selectivity long associated with America's liberal welfare state lingers. Workplace success continues to produce more generous health plans and ability to pay drives individual choice among health plans on the government insurance exchanges.[29] In addition, the decisions (or inactions) of 24 states not to expand Medicaid has left about 5 million Americans in a "coverage gap;" these states denied them coverage because they were childless or earned too much to fall below miserly state eligibility levels but too little to qualify for subsidies to purchase insurance on the government exchanges.[30]

Even as selectivity persists, the ACA pursued subterranean strategies to reduce its effects without alarming its staunchest ideological defenders. With little notice, nearly all states have accepted the ACA's offer to pay 90 percent of the costs associated with modernizing Medicaid's administration and streamlining its enrollment and eligibility infrastructure. Although data are not yet available, this "submerged" strategy is expected to sign up tens of thousands of people who were previously eligible but did not enroll for a number of reasons: they lacked adequate information, were discouraged (often intentionally) by complicated administrative processes, and faced an unresponsive state bureaucracy. Administratively streamlining enrollment largely eluded notice by Tea Party

https://doi.org/10.1017/S1537592714001625 Published online by Cambridge University Press

members and other reform opponents, facilitating its adoption in states (such as Texas and other conservative enclaves) that refused to implement the ACA. Reformers designed the "90/10" program and other low-salient programs that relied on targeted funding and tax subsidies as part of a gap-filling strategy that ducked a futile push for comprehensive universality while building expectations for access and coverage that could be mobilized in the future.[31]

Widening the Boundaries of Public Decision Making

A striking characteristic of American politics is the comparatively restrained boundaries of the public sphere and the more encompassing parameters of the private. Some of the most visible public features of European social welfare—such as family and housing policy—are "silent" or "submerged" in the United States.[32]

The ACA "publicizes" questions, social problems, and economic activities that have long been treated as "private." Before 2010, for instance, communities of color experienced "excess mortality" (black men living in Harlem were less likely to reach the age of 65 than men in Bangladesh) and insurers routinely charged women higher premiums. Meanwhile, it was a private prerogative for commercial health plans to divert up to 30 percent of premium revenues to profits, CEO salaries, and administration.[33]

Deploying government authority to regulate. After the ACA's passage, private businesses (with more than fifty employees) no longer enjoyed the unencumbered prerogative to reach decisions about whether to offer health insurance to their workers and how generous to make policies. Government authority now mandates large employers to offer coverage or pay penalties for each full-time employee who instead turns to the government's exchange and receives tax credits.[34] Employer-provided "Cadillac insurance" (those with annual premiums more than $10,200 for an individual or $27,500 for a family) is also subject to new public scrutiny; beginning in 2018, generous plans are scheduled to be taxed, partially offsetting longstanding exemptions for employer coverage.

In addition, the ACA regulates who health insurers cover, the benefits they offer, and other aspects of coverage. Health insurers are now required to offer—free of charge—a range of preventive health services for women (mammograms, prenatal care, and screenings for cervical cancer), and they can no longer single out women for higher premiums. Moreover, the decisions of commercial insurers to raise premiums are more regularly subject to public review. In addition, the "medical loss ratio" rule is prodding insurers to reduce non-medical expenses and target more resources to health and medical care.[35] In short, these and other ACA regulations are renegotiating longstanding private/public boundaries.

The battle to control costs. The ACA's renegotiation of public/private boundaries faces a momentous test in its drive to control health care costs; containing costs collides with long established patterns of deference and with the high salaries and bottom lines of well-organized stake holders. At Medicare's inception in the early 1960s, deference to the private decisions of medical providers prompted presidents John Kennedy and Lyndon Johnson to reject the recommendation of civil servants for "direct government control" over provider reimbursement in favor of allowing doctors and hospitals to determine their own charges *after* supplying care. Not surprisingly, Medicare costs rose rapidly.[36]

Torn between controlling rising budget deficits and government activism, President Ronald Reagan deployed national government authority to initiate a prospective payment system that regulated Medicare's reimbursement rates rather than allowing providers to set their own rates retrospectively. In particular, Reagan tied Medicare's hospital reimbursement to a fee schedule for "diagnosis-related groups;" subsequent presidents would expand the prospective system to Medicare's reimbursement of physicians and outpatient care. The result of rate setting for Medicare has, in general, been effective; its spending has risen more slowly per person than private insurers, which pay doctors and hospital 25 percent more. Recently, Medicare cost increases per person (0.5 percent in 2014) have even fallen below the very low general rate of inflation (1 to 2 percent in 2013 and 2014).[37]

The ACA rejected, however, rate regulation (as showcased by Medicare) in favor of uncoordinated efforts and experiments that may prove ineffective, if health inflation accelerates as the Obama White House and independent analysts project.[38] One of the ACA's most significant cost savings was to gradually eliminate the elevated subsidies to private insurers in Medicare Advantage, which were on average 14 percent higher per person than traditional Medicare.[39] Overstated warnings—fanned by insurers—that the subsidy reductions would undercut insurance for seniors in Medicare Advantage provoked widespread congressional protests and a retreat by the Obama administration from the planned payment cuts in 2014 and 2015.[40]

The ACA also took aim at scaling back America's "supply state" of using government payments and subsidies to support private insurers, medical providers, and employer-sponsored insurance (ESI).[41] Reformers delayed and scaled back the proposals by Republicans and moderate Democrats to reduce tax exemptions for ESI during the ACA's journey through Congress in 2009; the legislation signed into law in 2010 is scheduled to impose a new 40 percent excise tax on "Cadillac" insurance plans in 2018. But pressure is building to delay the tax further or to end it altogether—a scenario that appears to be gaining momentum in Washington.

https://doi.org/10.1017/S1537592714001625 Published online by Cambridge University Press

The ACA's reluctance to fundamentally disrupt private insurance and provider markets is epitomized by its revival of a slightly altered managed care model. Managed care organizations blossomed in the 1990s as a means to spur competition among insurers that contract with coordinated provider networks in order to drive down medical costs and improve quality; but they failed as consumer protests against restricted care sparked bipartisan legislation to enact a "patient bill of rights." For its part, the ACA explicitly encouraged Accountable Care Organizations (ACOs), which are groups of providers that are rewarded for improving quality and cost control by coordinating care. ACOs have proliferated in number but doubts persist about its effectiveness—the CBO and independent studies project quite small reductions in annual national health spending, little sustained quality improvements, and new risks to vulnerable populations.[42]

The ACA's rejection of Medicare's model of rate regulation is striking given its effectiveness. Independent research demonstrates that medical providers, especially hospital systems that dominate regions, are quite effective in extracting generous payments from insurers, who pass them along to those paying premiums.[43] Deploying government authority to reduce the prices charged by hospitals, physicians, and other providers has effectively contained costs in Medicare and in Western Europe, Canada, and Japan. Joseph White argues that rate regulation that restrains provider prices "dramatically increases payer power [and] must substantially reduce billing expenses."[44]

In short, the ACA has brought into the arenas of public deliberation and collective choice much of what had been cloistered in privatized decision making among individuals, medical providers, and businesses. Even as public/private boundaries shifted, however, the disruptive impacts on the business of health care have, in the ACA's early years, been tempered.

Socializing the Conflict

Research on "policy effects" suggests that the passage and implementation of the ACA can be expected, over time, to impact political identity and resources.[45] Although seniors did not stand out as a coherent and potent political force before the enactment of Social Security, the program's passage and development led its beneficiaries to consistently define themselves as having a political identity represented by a new political organization (American Association of Retired Persons [AARP]) and to turn out to vote at unusually high rates.[46]

The implementation of certain aspects of the ACA may similarly impact new beneficiaries by changing perception of their stakes, increasing their motivation to participate in politics, and equipping them with the resources to mobilize. Although these changes are unlikely to occur quickly, early signs of politically consequential policy effects may be emerging.

The public's interim general evaluations of the ACA seem contradictory, according to monthly surveys by the Kaiser Family Foundation. On the one hand, a majority or plurality consistently disapproves of the general idea of health reform. On the other hand, specific tangible benefits—such as the insurance exchanges and subsidies to purchase on them—are favored by over 70 percent of Americans, including majorities of Republicans.

Awareness and knowledge of the ACA's benefits appears to be the key to unraveling the mystery of disapproval of health reform in the abstract and support for its specific provisions. Analysis of survey data collected in 2012 found strikingly strong connections between knowledge and support of the ACA: simulating the effects of full knowledge boosted support to 88 percent among Democrats, 74 percent among independents, and 40 percent among Republicans.[47] This dynamic may help to explain initial findings from a panel study that I am conducting with Suzanne Mettler; the ACA's implementation of new benefits between 2010 and 2012 reduced initial worries that reform would raise taxes and, in turn, contributed to support for health reform. Moreover, the advancing and increasingly salient implementation of the ACA's tangible programs also appears to be sapping support for repeal, according to Kaiser surveys. In January 2011, 43 percent favored repealing the entire law (20 percent) or repealing it and replacing it with a Republican alternative (23 percent); by March 2014, the repeal support had declined to 29 percent—with only 11 percent backing full repeal and 18 percent a Republican alternative.

The ACA's implementation varies across states, spotlighting quite distinct political dynamics. The rollout of health reform encouraged liberal states to move in progressive directions and, in a growing number of cases, confronted the conservatism of states (often in the south) that historically depressed program generosity in service of a low wage/low benefit economy. The ACA's progressive federalism opened the door for some states to pursue more liberal health reform than national Democrats were able in 2010; Vermont is working with the Obama administration to receive a waiver to implement the single-payer plan it passed into law in 2011. As the ACA welcomed more liberal reform efforts, it also attempted to disrupt state conservatism and to invite new political forces; the federal government extended coverage to 5.5 million of Americans in states that refused to establish an exchange. The Supreme Court's June 2012 ruling weakened the ACA's stick to push states toward expanding Medicaid; but its carrots—along with pressure from hospitals, patients, and public interest groups—have convinced a growing number of states with Republican control to adopt it.[48] Early research of state decisions on Medicaid suggests that public interest advocacy may be a significant influence (after controlling for political party and other potential factors).[49]

https://doi.org/10.1017/S1537592714001625 Published online by Cambridge University Press

The ACA may, over time, spur the formation of organized support for health reform from a broad coalition of Americans, challenging the one-sided advantages currently enjoyed by long-entrenched conservatives and narrow interest-groups representing insurers, physicians, hospitals, and pharmaceutical companies. Indeed, the widening acceptance of the ACA by stakeholders (including stalwart opponents such as private insurers in 2009 and 2010) reflects an acknowledgement of the changing balance of power.[50]

The synergy of health reform, organizational formation, and political identity is showcased in California, which faced daunting challenges in enrolling people in the ACA—the ranks of its uninsured were one of the nation's largest and were concentrated in diverse, hard-to-reach groups. But the organizational resources of California's community and public-interest groups enabled the state to lead the country in enrollment; it accounted for about one-sixth of the entire country's exchange coverage.[51] In turn, the ACA's resources and programs are supporting newer organizations and feeding back into the efforts of health reformers and other groups to encourage voter registration and broader political mobilization.

Of course, the ACA's political effects remain uncertain and, in certain respects, may fall short of the mobilizing impacts documented by scholars of policy feedbacks. It is quite possible that the ACA's "submerged" elements (such as insurance regulations) may fail to register with Americans as tangible benefits and may face a one-sided assault by the well-organized insurance industry.[52] In addition, the continued poor administration of the ACA's core components—exemplified by the failure of certain states to implement insurance exchanges or to administer them well—may put a drag on the public's assessments.[53]

The New Politics of Health Reform and How Political Science Should Respond

The ACA has introduced new policy arrangements for financing and delivering medical care; it has also ushered in a new politics of US health care with implications for the study of politics more generally.

The ACA is not a magic wand in the face of resilient stakeholders and America's legacy of institutionally enfeebled government authority and administrative capacity. It is no surprise, then, that the Health Insurance Association of America was successful in pressuring the Obama administration and congressional Democrats to scale back the ACA's reductions in payments to private insurers in Medicare Advantage even as Medicare beneficiaries enjoy (and now expect) the ACA's generous new prescription medication coverage, which the reductions were supposed to fund. Pressure from insurers contributed to the administration's decision to weaken the "medical loss ratio" and to take other accommodative steps. Political power and institutional hurdles may slow or perhaps sabotage the ACA's aspiration to reduce health inflation and to redirect some health expenditures from paying insurers and providers toward reducing "excess mortality" in America's communities of color and low income. These are recurrent patterns in American political development that predispose health reform toward uneven implementation and tactics to delay or derail certain components.

The ACA's impact, however, is not adequately judged by its shortcomings as measured against idealized standards but by its immediate and prospective effects—the economic security and peace of mind it has already extended to tens of millions of people and the new developmental paths in American politics that it has initiated. Access to essential care is now a right. Deference to the private prerogatives of insurers and medical providers will ebb and flow, but a new expectation of public scrutiny and collective decision-making has been established. Today's stakeholders enjoy substantial financial and organizational advantages in pressing their interests in health policy debates, but new (or old) organizations may well respond to the opportunities to represent the ACA's new beneficiaries.

In time, unmet gaps in coverage and care and the struggle to contain costs will return to the top of state and national agendas. When they do, the ACA will have reset the terms of debate, introduced a new balance of power, and forged a set of options that were not feasible in 2009.

The changing politics of health care raises a series of challenges for the study of politics. American political thought has long sought to reconcile individualism and the adulation of minimal government with the tangible help of Social Security and other discordant programmatic developments.[54] But the ACA's expansion of social rights, interruption of business prerogatives, and redistribution from affluent individuals, businesses, and professions creates a disruptive juncture. The ACA may well recast the future of philosophical liberalism by elevating encompassing notions of citizenship that justify tangible government responses to illness and economic insecurity, engendering new lines of conflict and fretful searches for new syntheses.

Research on "policy feedbacks" and their orientation toward cross-subfield analysis becomes more relevant as the ACA's (differential) impacts on public opinion, political behavior, and political representation emerge. While political engagement among certain sub-groups may increase in the ACA's wake (as it did after Social Security's enactment), the effects may substantially vary across individuals depending on the visibility and significance of new benefits for their recipients. Adequately investigating individual heterogeneity requires a fuller understanding of the "psychological foundations" of "how policies matter and under what conditions" and the "effects of specific features of policy design."[55] The analysis of political psychology helpfully scrutinizes

https://doi.org/10.1017/S1537592714001625 Published online by Cambridge University Press

individual processing of information but it also miniaturizes this process into temporally discrete instances of "situational framing." A fuller understanding of the ACA's effects requires analysis of "structural framing"—the over-time process of institutionally-based communications of social welfare policies that chronically frame concrete programmatic returns to individuals.[56]

In addition, the ACA's sparking of sustained conflict and ongoing change tests a central theme in American political development—the stasis and durability of self-reinforcing "equilibria" that result from the interplay of social and political action, institutions, and political authority.[57] The ACA is fueling sustained conflicts over social rights, public/private boundaries, and political representation, pitting entrenched interests and ideological commitments against reenergized or newly formed organized interests mobilizing to secure needed medical care. Addressing these points of tension in future US health policy needs a more fulsome scholarly engagement with the study of political economy and its theories of change and crisis in order to capture the iterative processes of policy and political disruption and development.

Historically, health policy and its reform has formed a central arena for broad, discipline-spanning debates within political science about pluralism and its limits,[58] institutions and political development,[59] political representation,[60] American political thought,[61] and comparative analysis.[62] The ACA revitalizes health policy as an arena for research that stretches from the subfields of American and comparative politics to political theory. As in the past, landmark health reform pushes political science from the capillaries of politics and policy into its main arteries.

Notes

1 Hartz 1955; Burns 1963.
2 Hacker 2004.
3 World Bank 2013a.
4 Koechlin, Lorenzoni, and Schreyer 2010.
5 World Bank 2013b.
6 Nolte and McKee 2012; McCord and Freeman 1990.
7 Jacobs and Skocpol 2012.
8 See, among others, Jacobs and Skocpol 2012; Jacobs and Mettler 2011 and 2014; Pierson 2000.
9 Achenbaum 1986.
10 Mink 1995.
11 Jacobs and Skocpol 2014.
12 CBO 2014b.
13 The actual number of individuals enrolled in health plans will decline a bit during 2014 because 10-15 percent have not paid their premiums.
14 Department of Health and Human Services 2014; Gaba 2014.
15 Long et al. 2014.
16 Sommers 2014; Claxton et al. 2014; Cohn 2014.
17 CBO 2014a and b.
18 Kaiser Family Foundation 2014a.
19 LaMontagne 2014.
20 CBO 2014b
21 Furman 2014.
22 Hancock 2014; PricewaterhouseCoopers 2014.
23 Berenson et al. 2012; White 2013.
24 Pierson 2000; Hacker 2002; Jacobs and King 2010 and 2012.
25 Esping-Anderson 1990.
26 Barthold 2012.
27 Tax Policy Center 2012; Dittmer and McBride 2012.
28 Elmendorf 2011; Tax Policy Center 2010.
29 Employers are increasingly shifting health coverage costs to many of their workers and imposing high deductibles on them; this hits less-well paid employees most significantly, prompting them to delay or forego needed medical care. Galbraith 2012.
30 Kaiser Family Foundation 2014c.
31 Jacobs 2012.
32 Katznelson 1986; Orloff 1993; Mettler 2011.
33 Koechlin, Lorenzoni, and Schreyer 2010; McCord and Freeman 1990; Austin and Hungerford 2009.
34 As part of its adjustments to implement the law, the Obama administration slightly extended the timeline for employers to implement this provision without facing a federal penalty. Specifically, the timeline for employers with 50 to 99 workers has been lengthened from 2014 to 2016; those with more than 100 workers are required to offer coverage to 70 percent in 2015 instead of 95 percent.
35 Cox, Claxton, and Levitt 2013.
36 Jacobs 1993.
37 Medicare Payment Advisory Commission 2009; Horney and Van de Water; Hurley, Strunk, and White 2004; White 2013.
38 Furman 2014; Hancock 2014; PriceWaterhouse-Coopers 2014; White 2013.
39 Medicare Payment Advisory Commission 2009; Jacobs and Skocpol 2012.
40 Millman 2014. The Obama administration reversed its proposals for 2.3 percent *cut* for Medicare Advantage plans in 2014 (as the ACA anticipated) into a 3.3 percent *increase*; its proposed 1.9 percent for 2015 payments were flipped to a 0.4 percent increase.
41 Jacobs 1995.
42 James 2012; Christensen, Flifer, and Vijayaraghavan 2013.
43 Berenson et al. 2012.
44 White 2013.
45 Campbell 2005; Mettler 2005; Mettler and Soss 2004.
46 Campbell 2005.
47 Gross et al. 2013.
48 Jacobs and Skocpol 2014.

49 Callaghan and Jacobs 2014; Jacobs and Callaghan 2013.
50 Jacobs and Ario 2012.
51 Eaton and Weir 2014.
52 Mettler 2011.
53 After the dismal inauguration of the federal insurance exchange in October 2013, it performed well enough to enroll over 8 million, including a surge of 3.8 million during the final rush before the March 31 deadline. Oregon and perhaps other states that failed at starting their own exchange are turning to the federal hub even as work continues to improve its "backroom" operations or to successful state exchanges such as Connecticut's.
54 Morone 2014.
55 Pierson 1993; Mettler and Soss, 2004.
56 Jacobs and Mettler 2011.
57 Pierson 2000.
58 Eckstein 1960; Marmor 1983.
59 Skocpol 1996; Hacker 2004.
60 Jacobs 1993; Jacobs and Shapiro 2000.
61 Morone 1991 and 2014; Disch 1996.
62 Marmor 1983; White 2013.

References

Achenbaum, Andrew. 1986. *Social Security Visions and Revisions*. New York: Cambridge University Press.

Austin, D. Andrew, and Thomas Hungerford. 2009. "The Market Structure of the Health Insurance Industry." Congressional Research Service. September. http://www.fas.org/sgp/crs/misc/R40834.pdf (accessed June 15, 2014).

Barthold, Thomas. 2012. Letter on Partial Re-estimate of Tax Provisions in ACA. June 15. http://waysandmeans.house.gov/uploadedfiles/jct_june_2012_partial_re-estimate_of_tax_provisions_in_aca.pdf (accessed June 15, 2014).

Berenson, Robert, Paul Ginsburg, Jon Christianson, and Tracy Yee. 2012. "The Growing Power of Some Providers to Win Steep Payment Increases from Insurers Suggests Policy Remedies May Be Needed." *Health Affairs* 31(May): 973–81.

Bureau of Economic Analysis. 2014. "Gross Domestic Product: First Quarter 2014 (Advance Estimate)." http://www.bea.gov/newsreleases/national/gdp/2014/pdf/gdp1q14_adv.pdf (accessed June 15, 2014).

Burns, James McGregor. 1963. *The Deadlock of Democracy: Four-Party Politics in America*. Englewood Cliffs, N.J: Prentice-Hall.

Callaghan, Timothy, and Lawrence Jacobs. 2014. "Advocating for Health Reform: Enrollment in the Affordable Care Act." Presented at the American Political Science Association Washington, D.C. August 28–31.

Campbell, Andrea. 2005. *How Policies Make Citizens: Senior Political Activism and the American Welfare State*. Princeton, NJ: Princeton University Press.

Christensen, Clayton, Jeffrey Flier, and Vineeta Vijayaraghavan. 2013. "The Coming Failure of 'Accountable Care'." *Wall Street Journal*, February 18. http://online.wsj.com/news/articles/SB10001424127887324880504578296902005944398 (accessed June 15, 2014).

Claxton, Gary, Larry Levitt, Anthony Damico, and Matthew Rae. 2014. "Data Note: How Many People Have Nongroup Health Insurance?" Kaiser Family Foundation. January 3, 2014. http://kff.org/private-insurance/issue-brief/how-many-people-have-nongroup-health-insurance/ (accessed June 15, 2014).

Cohn, Jonathan. 2014. "Maybe Those Obamacare Plan Cancellations Weren't As Bad As You've Heard." *New Republic*, April 24. http://www.newrepublic.com/article/117497/obamacare-cancelled-policies-study-says-impact-was-actually-small (accessed June 15, 2014).

Congressional Budget Office. 2014a. "Budget and Economic Outlook, 2014–2024." February. Washington, DC. Pub. No. 4869. http://cbo.gov/sites/default/files/cbofiles/attachments/45010-Outlook2014_Feb.pdf (accessed June 15, 2014).

——. 2014b. "Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act." April. Washington, DC. Pub. No. 4930. http://www.cbo.gov/sites/default/files/cbofiles/attachments/45231-ACA_Estimates.pdf (accessed June 15, 2014).

Cox, Cynthia, Gary Claxton, and Larry Levitt. 2013. "Beyond Rebates: How Much Are Consumers Saving from the ACA's Medical Loss Ratio Provision?" Kaiser Family Foundation. http://kff.org/health-reform/perspective/beyond-rebates-how-much-are-consumers-saving-from-the-acas-medical-loss-ratio-provision/ (accessed June 15, 2014).

Department of Health and Human Services. 2014. "Health Insurance Marketplace: Summary Enrollment Report for October 1, 2013 to March 31, 2014." May 1. http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014Apr_enrollment.pdf (accessed June 15, 2014).

Dittmer, Philip, and William McBride. 2012. "Obamacare's New Taxes, and How You May Be Affected." July 5. http://taxfoundation.org/blog/obamacares-new-taxes-and-how-you-may-be-affected (accessed June 15, 2014).

Disch, Lisa. 1996. "Publicity-Stunt Participation and Sound Bite Polemics: The Health Care Debate 1993–94." *Journal of Health Politics, Policy and Law* 21 (Spring): 3–33.

Eaton, Charlie, and Margaret Weir. 2014. "How Powerful Consumer Advocates Help Obamacare Succeed in California." Scholars Strategy Network.

http://www.scholarsstrategynetwork.org/sites/default/files/ssn_basic_facts_eaton_and_weir_on_obamacares_success_in_california.pdf (accessed June 15, 2014).
Eckstein, Harry. 1960. *Pressure Group Politics*. Palo Alto, CA: Stanford University Press.
Elmendorf, David. 2011. "Letter to Speaker John Boehner." February 18. http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/120xx/doc12069/hr2.pdf (accessed June 15, 2014).
Esping-Anderson, Gosta. 1990. *Three Worlds of Welfare Capitalism*. Princeton, NJ: Princeton University Press.
Furman, Jason. 2014. "Third Estimate of GDP for the First Quarter of 2014." (White House blog, Council of Economic Advisers), June 25, 2014. http://www.whitehouse.gov/blog/2014/06/25/third-estimate-gdp-first-quarter-2014 (accessed June 29, 2014).
Galbraith, Alison, Stephen Soumerai, Dennis Ross-Degnan, Meredith Rosenthal, Charlene Gay, and Tracy Lieu. 2012. "Delayed and Forgone Care for Families with Chronic Conditions in High-Deductible Health Plans." *Journal of General Internal Medicine*. 27 (September):1105–1111.
Gallup Polling Organization. 2016. "Uninsured Rate Drops More in States Embracing Health Law." April 16. http://www.gallup.com/poll/168539/uninsured-rates-drop-states-embracing-health-law.aspx (accessed June 15, 2014).
Gross, Wendy, Tobias Stark, Jon Krosnick, Josh Pasek, Gaurav Sood, Trevor Tompson, and Jennifer Agiesta. 2013 "Americans' Attitudes toward the Affordable Care Act: Would Better Public Understanding Increase or Decrease Favorability." Stanford University. https://pprg.stanford.edu/wp-content/uploads/Health-Care-2012-Knowledge-and-Favorability.pdf (accessed June 15, 2014).
Hacker, Jacob. 2002. *The Divided Welfare State: The Battle over Public and Private Social Benefits in the United States*. New York: Cambridge University Press.
———. 2004. "Privatizing Risk without Privatizing the Welfare State." *American Political Science Review* 98(2): 243–60.
Hancock, Jay. 2014. "Employer Health Costs Forecast To Accelerate In 2015." Kaiser Health News. June 24, 2014. http://capsules.kaiserhealthnews.org/index.php/2014/06/employer-health-costs-forecast-to-accelerate-in-2015/ (accessed June 29, 2014).
Hartz, Louis. 1955. *The Liberal Tradition in America*. New York: Harcourt Brace Jovanovich.
Horney, James, and Paul Van de Water. 2009. "House-Passed and Senate-Passed Bills Reduce Deficit, Slow Health Care Costs, and Include Realistic Medicare Savings." Center on Budget and Policy Priorities, Washington D.C. December 4. http://www.cbpp.org/files/12-4-09health.pdf (accessed June 15, 2014).
Hurley, Robert, Bradley Strunk, and Justin White. 2004. "The Puzzling Popularity of the PPO." *Health Affairs* 23(2): 56–68.
Jacobs, Lawrence. 1993. *The Health of Nations: Public Opinion and the Making of Health Policy in the U.S. and Britain*. Ithaca, NY: Cornell University Press.
———. 1995. "The Politics of America's Supply State: Health Reform and Medical Technology." *Health Affairs* 14(2): 143–57.
———. 2012. "Community Clinics: The Hidden Revolution." Scholar Strategy Network Policy Brief. http://www.scholarsstrategynetwork.org/sites/default/files/ssn_basic_facts_jacobs_on_community_health_clinics_1.pdf (June 15, 2014).
Jacobs, Lawrence, and Joel Ario. "The Affordable Care Act Leaves the Intensive Care Unit for Good." *Health Affairs* 31(December): 2603–08.
Jacobs, Lawrence, and Timothy Callaghan. 2013. "Why States Expand Medicaid: Party, Resources, and History." *Journal of Health Politics, Policy and Law* 38 (October): 1023–50.
Jacobs, Lawrence, and Desmond King (eds). 2010. "Varieties of Obamaism: Structure, Agency and the Obama Presidency." *Perspectives on Politics* 8(3): 793–802.
———. 2012. *Obama at the Crossroads: Politics, Markets, and the Battle for America's Future*. New York: Oxford University Press.
Jacobs, Lawrence, and Suzanne Mettler. 2011. "Why Public Opinion Changes: The Implications for Health and Health Policy." *Journal of Health Policy, Politics and Law* 36 (December): 917–933.
———. 2014. "Taming Conservatism: The Policy Effects of the Affordable Care Act on Attitudes Toward Taxation." Presented at the Annual Meeting of the Midwest Political Science Association, Chicago, IL, April 5.
Jacobs, Lawrence, and Robert Y. Shapiro. 2000. *Politicians Don't Pander: Political Manipulation and the Loss of Democratic Responsiveness*. Chicago: Chicago University Press.
Jacobs, Lawrence, and Theda Skocpol. 2012. *Health Care Reform and American Politics*. 2d ed. New York: Oxford University Press.
———. 2014. "Progressive Federalism and the Contested Implementation of Obama's Health Reform." In *The Politics of Major Policy Reform*, ed. Jeffrey Jenkins and Sidney Milkis. Cambridge, UK: Cambridge University Press.
James, Julie. 2012. "Health Policy Brief: Pay for Performance." *Health Affairs* October: 1–6. http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_78.pdf (accessed June 15, 2014).

Kaiser Family Foundation. 2011. Kaiser Family Foundation. "Kaiser Health Tracking Poll." December. http://kff.org/tag/tracking-poll/ (accessed June 15, 2014).
———. 2014a. "Explaining Health Care Reform: Risk Adjustment, Reinsurance, and Risk Corridors." January 22. http://kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/.
———. 2014b. "Kaiser Health Tracking Poll." March. http://kff.org/tag/tracking-poll/ (accessed June 15, 2014).
———. 2014c. "The Coverage Gap: Uninsured Poor Adults in States That Do Not Expand Medicaid." Policy Brief. April 2014. http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/ (accessed June 15, 2014).
Katznelson, Ira. 1986. "Rethinking the Silences of Social and Economic Policy." *Political Science Quarterly* 101(2): 307–25.
Koechlin, F., L. Lorenzoni, and P. Schreyer. 2010. *Comparing Price Levels of Hospital Services across Countries: Results of a Pilot Study*. OECD Health Working Paper, No. 53. Paris: OECD Publishing.
LaMontagne, Christina. 2014. "Medical Bankruptcy Accounts for Majority of Personal Bankruptcies." *Nerdwallet*. March 26. http://www.nerdwallet.com/blog/health/2014/03/26/medical-bankruptcy/ (accessed June 15, 2014).
Long, Sharon, Genevieve M. Kenney, Stephen Zuckerman, Douglas Wissoker, Dana Goin, Michael Karpman, and Nathaniel Anderson. 2014. "QuickTake: Number of Uninsured Adults Falls by 5.4 Million since 2013." Urban Institute. April 3. http://hrms.urban.org/quicktakes/changeInUninsurance.html (accessed June 15, 2014).
Marmor, Theodore. 1983. *Political Analysis and American Medical Care*. New York: Cambridge University Press.
McCord, Colin, and Harold P. Freeman. 1990. "Excess Mortality in Harlem." *New England Journal of Medicine* 322(January 18): 173–77.
Medicare Payment Advisory Commission. 2009. "Report to Congress: Medicare Payment Policy." http://www.medpac.gov/documents/mar09_entirereport.pdf (accessed June 15, 2014).
———. 2011. Report to the Congress: Medicare Payment Policy. http://medpac.gov/documents/Mar11_EntireReport.pdf (accessed June 15, 2014).
Mettler, Suzanne. 2005. *Soldiers to Citizens: The G.I. Bill and the Making of the Greatest Generation*. New York: Oxford University Press.
———. 2011. *The Submerged State: The Paradox of American Politics and How We Can Overcome It*. Chicago, IL: University of Chicago Press.
Mettler, Suzanne, and Joe Soss. 2004. "The Consequences of Public Policy for Democratic Citizenship: Bridging Policy Studies and Mass Politics." *Perspectives on Politics* 2(1): 55–73.
Millman, Jason, 2014. "Medicare Reversed Payment Cuts, and Not Many Are Happy about It." *Washington Post Wonkblog*. April 14. http://www.washingtonpost.com/blogs/wonkblog/wp/2014/04/14/medicare-reversed-payment-cuts-and-not-many-are-happy-about-it//?print=1 (accessed May 11, 2014).
Mink, Gwendolyn. 1995. *The Wages of Motherhood*. Ithaca, NY: Cornell University Press.
Morone, James. 1991. *The Democratic Wish: Popular Participation and the Limits of American Government*. New York: Basic Books.
———. 2014. *The Devils We Know: Us and Them in America's Raucous Political Culture*. Lawrence, KS: University Press of Kansas.
National Conference of State Legislatures. 2013. "Medical Loss Ratios for Health Insurance." http://www.ncsl.org/research/health/health-insurance-medical-loss-ratios.aspx (accessed May 10, 2014).
Nolte, Ellen, and C. Martin McKee. 2012. "In Amenable Mortality—Deaths Avoidable through Health Care—Progress in the US Lags That of Three European Countries." *Health Affairs* 31(September): 2114–22.
Orloff, Ann Shola. 1993. "Gender and the Social Rights of Citizenship: The Comparative Analysis of Gender Relations and Welfare States." *American Sociological Review* 58(June): 303–28.
Pierson, Paul. 1993. "When Effect Becomes Cause: Policy Feedback and Political Change." *World Politics* 45(July): 595–628.
———. 2000. "Increasing Returns, Path Dependence, and the Study of Politics." *American Political Science Review* 94(2): 251–67.
PricewaterhouseCoopers. 2014. "Medical cost trend: Behind the numbers 2015." June 2014. http://www.pwc.com/en_US/us/health-industries/behind-the-numbers/assets/hri-behind-the-numbers-2014-chart-pack.pdf (accessed June 29, 2014).
Skocpol, Theda. 1996. *Boomerang: Clinton's Health Security Effort and the Turn against Government in U. S. Politics*. New York: W. W. Norton.
Sommers, Benjamin. 2014. "Insurance Cancellations in Context: Stability of Coverage in the Nongroup Market Prior to Health Reform." *Health Affairs* 33 (April): 700–706.
Tax Policy Center. 2010. "Senate Health Bill and Reconciliation Act of 2010: Medicare Tax; Baseline: Current Law; Distribution by Cash Income Level, 2013." March 19. http://taxpolicycenter.org/numbers/displayatab.cfm?docid=2697&doctypeid=1 (accessed March 27, 2014).

——. 2012. "The Numbers: Tax Units Above and Below the $250,000/$200,000 Threshold." November 26. http://www.taxpolicycenter.org/numbers/displayatab.cfm?Docid=3634&DocTypeID=7 (accessed May 2, 2014).

White, Joseph. 2013. "Cost Control after the ACA." *Public Administration Review* 73(September/October): 24–33.

World Bank. 2013a. "Health Expenditure." http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS (accessed May 13, 2014).

——. 2013b. "Mortality Rate: Infants." http://data.worldbank.org/indicator/SP.DYN.IMRT.IN/countries?display=default (accessed May 10, 2014).

https://doi.org/10.1017/S1537592714001625 Published online by Cambridge University Press