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New Policy Elites and the Affordable Care Act: The Making of *Long-Term Insiders*

Abstract: This paper examines the career trajectories of new health policy elites in the American federal government, identifying areas of expertise, partisan alignments, relationships to interest groups, and institutional constraints. We demonstrate that, in both the American and French cases, policy elites who have risen through prestigious educational institutions and undertaken extensive professionalization in government, have in fact developed comparable characteristics that blend broad knowledge of social, institutional, and partisan issues with technical skills. We argue that, benefiting from extensive experience in the back offices of power, deeply entrenched in the health policy sector, and promoting a programmatic reform agenda that reaffirms the regulatory powers of government, the new American health policy elites worked behind the scenes to draft and implement the final ACA legislation. Their ambitious, far-reaching reform effort succeeded where many advocates of comprehensive reform had failed, anchoring the political and institutional framework of the U.S. health care system.

Keywords: Affordable Care Act (ACA), U.S. health care policy, policy elites, Department of Health and Human Services, Clinton Plan, HHS Strategic Plan

Ten years after its passage, the details of the Affordable Care Act (ACA) have been the object of considerable study.[1] In the present article, we seek to expand the scope of analysis in two important ways. Building on a base of primary data and an innovative methodology, we explore the links between this reform and larger transformations in the structure of elite decision making at the federal level. In addition, we place this analysis in the broader comparative context of

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research using for this study methods employed in France and other European cases.[2]

The U.S. governmental elites on whom our attention is focused in this study occupy senior positions in the federal government where expertise, partisan alignments, special interests, and institutional constraints meet. In fact, their role goes far beyond that of expert policy advisors, as they are "in charge" of efforts to formulate government policies. Their professional uniqueness derives from extensive experience in the back offices of power, deep roots in a particular policy sector, and a strong identification with programmatic reform agendas that reaffirm the regulatory capacity of government.[3] They have collectively succeeded in "taming" the financial constraints, adopting a new vision of the role of the state in the governance of health insurance policies, and asserting their sectoral autonomy. In this case study, we have established the substantive link between the emergence of a new elite in health policy and the change in the dominant programmatic orientation of the sector.

Following Hugh Heclo, (1) we initially treat the Washingtonian bureaucracy's dual structure (political appointees and senior civil servants) as more or less corresponding to the one in which European state elites operate,[4] and then (2) we postulate that "politics as an intramural Washington activity" is shared between Congress and the executive.[5] People who have penetrated and persisted in this perimeter of power and its sphere of political action over the long term can form, in certain policy areas, professional elite groups that are likely to have (as in the context of the strong French state) influence in the development of public policy. In the health sector, these governmental elites must combine deep professional knowledge of the substance of health policy issues *and* practical mastery of technocratic policy development and implementation.[6]

In the American context, we will characterize the new health policy elites—which we label "long-term insiders"[7]—through the combination of the following resources: (a) deep expert knowledge of the substance of health care policy, (b) extensive experience and *savoir faire* in the political and practical workings of health care policy making, (c) a shared vision of policies that are both desirable and feasible, and (d) the resolve and capacity to work collectively to promote that vision, as was the case at the time of the ACA. These resources have enabled them to establish a new health policy elite in the sector since the 1990s. This article highlights the elements that have contributed to the formation of this new elite, the constitution of which reveals the existence of groups in a position to influence federal health insurance polcies

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in a decisive manner and over the long term. The existence of these "long-term insiders" in the health sector leads us to call into question at least some aspects of Hugh Heclo's assertion that the central actors in the U.S. Federal Government are exclusively "birds of passage."[8]

DATA AND METHOD: "OPERATIONALIZING PROGRAMMATIC ELITES RESEARCH IN AMERICA"

In this context it is important to consider the recomposition of the apex of the American government since the 1990s by establishing a correlation between the transformation of the professional structure of the governmental elite and the (re)orientation of federal public policies in the health sector. The two major recent U.S. federal health insurance reform efforts, the Clinton Plan (1993–94) and the one that led to the ACA (2008–10), provide insights into the intersecting changes in the structure of Washington's health policy elite with the transformation of the programmatic reform project.[9] After having outlined in broad strokes the socioprofessional characteristics of these elites for the period studied (1988–2010), building from sociobiographical data and over 200 interviews,[10] we analyze the links between, on one hand, their specialized professional training in public policy and their professional trajectories and, on the other hand, their identification with the role of "custodians" of health policy.

From the OPERA database, we carried out a sociographic analysis of a population of 151 people who held positions of power for more than six years as congressional or white House staffers, or senior officials in the Department of Health and Human Services (DHHS). The positions selected in the study were chosen because of their potential links to the health care reform decision-making process. This study of the population of health policy elites in the two branches of government highlights the specificity of their training; the universities they attended; their professional trajectories to the highest levels of government; the average length of their careers; their transfers, secondments, and promotions; and the types of institutional careers that emerged from their career paths. This research focuses on the "long-term insiders," individuals who have occupied (at least six years), one or more public sector positions likely to influence policy making to oversee health coverage and related areas. This sociological inquiry seeks to validate the hypothesis of the formation of a new elite, one professionalized in the government health policy sphere since the 1990s. Their professional *savoir-faire* is simultaneously built upon the

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mastery of health policy issues and command of the power mechanisms specific to political decision making and/or the legislative process.

Longitudinal analysis of the professional trajectories of health policy elites who held positions of power between the failure of the Clinton Plan and the success of the ACA shows the ways in which some of them first specialized in the intricacies of public policies and then collectively developed the objective of achieving far-reaching health reform. These new health policy elites supplanted in their historic role the "reformers" of the Social Security Administration (SSA).[11] Drawing on their experience of the Clinton failure, these new Democratic-leaning elites developed specific professional trajectories in the health sector. In many cases, this included time spent in related health sector roles in the Washington DC periphery, before returning to government to hold key positions in Congress and the executive branch during the Obama years. These distinctive careers had an effect on the definition of the content of programmatic reforms that took place. This manifested itself in a "consensual" vision of the extension of health coverage around a reform project capable of combining three objectives: the need to maintain the elements of the existing system in the new one, integration of market-oriented reforms, and cost control.[12]

Do new policies create new governmental elites?

In the late 1970s, the power of technocrats was challenged on several fronts in Western democracies, particularly by "technician-politicians,"[13] with the exception of the French case where the same technocrats continued to assert their role as state elites.[14] Unwilling to rely on declining Keynesian policies that had fallen into disfavor, a part of the political class converted to neoliberal ideas that held state elites responsible for the economic crisis and, more generally, deplored the bureaucratization of Western societies.[15] This movement originated in the 1960s under the Kennedy and Johnson administrations, especially in the context of the "war on poverty" in which the role of this type of expert was affirmed in the urban and social policy areas.[16] In the following decade, the promotion of New Public Management by conservative governments brought bureaucratic power in governing policy development into question.[17] The health sector, both because of its centrality in domestic policy and the increase in public expenditure it generated, provides good ground for assessing the recompositions at work in elite structures.[18] By the end of the 1970s, political appointees at the head of Federal departments and agencies

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made up a "government of strangers" challenging the power of senior career civil servants in numerous policy sectors.[19]

We already know that the change of the management logic in the Medicaid and Medicare programs, initiated in the 1980s due to the incessant increase of their budgetary cost, but also due to neoliberal opposition, progressively called into question the dominant profile of the bureaucratic and technocratic elites managing these programs.[20] Building on the work of Larry Brown[21] with respect to the articulation between "new policies and new politics," we will demonstrate the ways in which new policies have professionally shaped new health policy elites. The development of new policy instruments, such as the Health Maintenance Organization (HMO), also contributed to fueling the conflict between traditional sectoral elites attached to a corporatist and bureaucratic approach in Medicare and Medicaid (program-oriented elites) and new elites influenced by market-oriented policy analysis.[22] For Larry Brown,[23] administrative reforms and the introduction of new policy instruments pave the way for a "technocratic corporatism," implicating a new policy expertise and new ways of involving interest groups like the American Medical Association and American Hospital Association in shaping policy. Beyond a change in the orientation of health policies under the influence of policy entrepreneurs promoting market ideas, the creation of new political institutions favored the making of new health policy elites.

New institutions shape the careers of the new elites

Under the Carter presidency, in 1977 the creation of a new integrated financial administration at the heart of the Department of Health Education and Workforce (HEW)—the Health Care Financing Administration (HCFA)—oversaw the financial management of the Medicare and Medicaid programs, favoring the emergence of health policy elites who advocated a firmer emphasis on cost control. The main architect of the creation of the HCFA, Secretary of Health and Human Services Joseph Califano, explained the break with the traditional vision of social policy in the Democratic Party in these words: "*I wanted to prove that the Great Society programs could be managed. That was number one. Number two, I wanted to get across to the liberals that you had to have competence and efficiency as well as compassion. There was no sense of efficiency among the liberal establishment, no sense of what that meant. […] I think [the HCFA] achieved some management improvement, some savings. I think more importantly it helped to focus the department on costs, on efficiency, on driving home these things*."[24]

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This development reinforced the role of the Office of the Assistant Secretary for Planning and Evaluation in the microeconomic and prospective analysis of the health system. The Office of the Assistant Secretary for Planning and Evaluation (ASPE) was established in 1966 in the Office of the Secretary of Health, Education, and Welfare (HEW). (Department of Health and Human Services since 1979.) It is composed of about twenty analysts developing forward-looking econometric research to measure the fiscal impact of policy options. Stuart Altman, who held a PhD in economics from UCLA and served as ASPE in the Department of Health and Human Services in the Nixon administration, played an important role in transmitting ideas at the time when HMOs were being established. He distinguished himself from figures such as Elwood and Enthoven by putting himself forward as a pragmatic health economist for whom the market was one instrument among others for combining the extension of health insurance coverage with cost control.[25]

Since the beginning of the 1990s, this agency, with its large budget and growing staff (notably under the Clinton administration), has been at the forefront of the HHS Strategic Plan and has served as an internal think tank for health system reform. On the strength of this cross-cutting approach and its control over the new instruments of budgetary control, a new elite can be said to have emerged, attempting to evaluate systems performance on the basis of "cost effectiveness and quality of care." The social structure of this health policy elite changed over time (Table 1). In place of the bureaucratic or technocratic profiles typical of the SSA, the new elite was characterized by expertise in both economics and policy analysis. A significant number of those who were involved in the choice of programmatic orientations in health policies occupied the functions of the Assistant or Deputy Assistant Secretary for Planning and Evaluation.[26]

One of the persons interviewed for this project, Diane Rowland, now vice-president of the Kaiser Family Foundation, indicated that her time in the financial directorate of the Health Department allowed her to impose herself as a "Medicaid policy person" able to promote both extension of health insurance coverage and cost control while successfully resisting the Treasury's strategy on budgetary questions.[27] Because cost control became an unavoidable objective for all from the 1980s onward, it no longer constitutes a distinctive element of legitimization in a reform effort. What the new elites learn during their careers is how to find the most efficient, plausible, and acceptable instruments to achieve this objective.

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Table 1. Comparison of the *Social Background* of the "Old" and "New" Health Elites

Social Background	Social Security Administration Elites *(1970 to 1990)*	Health Long-Term Insiders *(1990 to 2010)*
Educational institution Graduate diploma	*Ivy League (Yale, Harvard, Columbia)*	*University of Washington D.C. Area and State Universities*
Field of study	*Economics or Law PhD*	*School of Pub. Pol., MPP, MPA, MP Health Ph.D. & JD*
Type of education	*Political Economics and comparative social law*	*Policy analysis and health policy*
Career type and average length in appointment	*Long sectoral career = average duration: 6 and 20 years*	*Long-term insiders = average duration: 6 years and 20 years*
Revolving doors effect on the careers	*Weak effect of "back and forth" system + specialization in governmental agencies*	Weak with "*back and forth system"* in the sector with weak mobility to private sector (NPO, Think tanks, Foundations)
Professional trajectories inside the power branches	*Low circulation between the two branches of power Remain on Committee on Economic Security and within the Social Security Administration*	*Strong circulation between Government and Congress + passage in institutions exercising financial control (OMB & HCFA (CMS) + CBO, Com. Finance, Budget, Ways and Means)*
Dominant professional skill	*Technocratic and bureaucratic*	*Specialized on policy issues and Cost containment instruments*
Values and goals	*Defense of ethics of ultimate ends*	*Promotion of ethics of responsibility*
Policy style	*Interventionist and bureaucratic*	*Market regulation and policy accommodation*

Continued

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Table 1. *Continued.*

Social Background	Social Security Administration Elites *(1970 to 1990)*	Health Long-Term Insiders *(1990 to 2010)*
Social policy learning	*Medicare program development*	*Health Care Security Act failure (Clinton Plan)*
Approach to programmatic change	*From NHI to* MEDICARE *&* MEDICAID *program*	*From Massachusetts Plan to Affordable Care Act*

Source: Genieys, *Gouverner à l'abri des regards. La réussite de l'Obamacare* (2020), 73.

EARLY AND ONGOING TRAINING IN HEALTH POLICY ANALYSIS

The analysis of the trajectory of governmental elites who took up their positions in the 1990s—economists such as Stuart Altman, Gail Wilensky, and Joe Newhouse or political scientists such as Bruce Vladeck and Judy Feder[28]—confirms that they have a high level of training and that women are increasingly prominent within their ranks.[29]

The analysis of their academic backgrounds also reveals a new phenomenon: their specialization within Schools of Public Policy or Public Health, mostly in Washington DC[30] area universities—a change that began with the creation of the 'Schools of Public Policy" through a Ford Foundation program launched in September 1975.[31] Twelve master's programs, inspired by a "policy science" approach that focuses on training in public policy formation and evaluation, were initially set up.[32] These institutions offer interdisciplinary training that enables their students to grasp the issues in public policy formulation and evaluation and endows them with specific university degrees (MPA, MPP, MPH, or even PhD) expected to be useful for future sectoral specialization within Congress and/or the executive branch[33] (Table 1).

The establishment of the Schools of Public Policy had as its objectife objective the training of a new generation of experts and technicians dedicated to less bureaucratic—and more effective—public management. The informal motto of this new generation was "to dream up ways to make the world a better place." Education incorporating a cost-effectiveness perspective on public policy making while taking into account quality of life and social equity issues contributed to the emergence of a new type of policy maker. Since the 1980s, these have progressively taken up key health policy positions in the powerful

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back offices of the federal government. The analysis of elite professional trajectories confirms that the mastery of knowledge in health policy has emerged as a major resource for the pursuit of sustainable careers at the heights of power in the sector[34] especially vis-à-vis expert nongovernmental players (AMA, etc.). On the basis of a different educational trajectory (law and economics versus health economics and health policy), these new health policy elites brought to the back offices of power in Washington a vision that combined regulation and markets. To this end, they sought to distance themselves from the bureaucratic incrementalism of the "SSA reformers" while putting forward an alternative reform project.

Accumulation and transmission of health policy know-how

Health policy elites generally build their professional careers by alternating appointments in the government's back offices of power and periods in the private (often nonprofit) sector. The long-term analysis of the successive stages of their professional trajectories in Washington DC indicates that these public and private sector roles remain within the health sphere. This enables these governmental elites to accumulate know-how that can be invested, when the time comes, in the development of public policies. This is a characteristic that the bureaucratic health policy elites of previous generations mostly lacked.

The earlier elites partook in a bureaucratic culture grounded only in the implementation and management of the Medicare and Medicaid programs.[35] For the generation of health policy elites entering the back offices of power in the 1990s, the passage through new academic fields was a requirement for access to a first staff position with members of congressional committees in charge of health issues (Table 1). The analysis of their professional trajectories also highlights the importance of this passage in the development of sustained careers at the heights of power in the health sector.[36]

Training and experience in policy analysis are important elements in the making of Democratic health policy elites, but thanks to the revolving door system, or when a change of political majority occurs, they can often secure an academic position in public health or policy. Thus, many staffers and the vast majority of political appointees have shared their practical knowledge of government in one or more of the Washington DC area's many public health or policy schools such as the Georgetown Public Policy Institute (since 2013, the McCourt School of Public Policy) and the Johns Hopkins University

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Department of Health Policy and Management, as well as the School of Public Health at George Washington University or at American University. These institutions have become privileged places of professional evolution for predominantly Democratic health policy elites. Their academic departments are particularly interested in professional experience and expertise that can be drawn upon for training in Master of Public Health (MPH) programs.

An analysis of the professional trajectories of Washington's health policy elite reveals that most individuals with advanced health policy degrees (up to and including PhD) have held academic positions (Table 2). Among the Democrats, both Clinton veterans and newcomers had stints at the Johns Hopkins School of Public Health in Baltimore (Diane Rowland, Tom Morford, Cibele Bjorklund, Liz Fowler), at the Center for Health Policy Studies at the Georgetown University School of Medicine (Judy Feder, Brian Biles, Wendell Primus, Karen Pollitz, Jeanne Lambrew), and the George Washington University School of Public Health and Health Services (Andy Schneider Ruth Katz, Carolyn Clancy). This porous professional barrier between the political sphere of government and the academic milieu is a factor that differentiates the professional trajectories of the Democratic elites from those of their Republican health policy counterparts (Table 2).

The latter are more closely tied to the economic world and prone to offer their expertise in the powerful lobbies of the sector (such as the Health Insurance Association of America [now called America's Health Insurance Plans] or the American Hospital Association). We can here evoke the cases of David Abernethy, who has long circulated between the executive and legislative branches of government, who joined the Health Insurance Plan administrators as vice president, and of Charles "Chip" Khan who became president of the Federation of American Hospitals. In this group, Joe Antos, former Visiting Professor at the Gillings School of Global Public Health, University of North Carolina at Chapel Hill, and later as Wilson H. Taylor Scholar in Health Care at the American Enterprise Institute, is an exception that proves the rule on the Republican side.

The analysis of professional trajectories of long-term insiders further shows that the continuous acquisition of know-how in health policy issues throughout a career is an important marker of identity for the new Washington health policy elites. The back and forth between policy work in the back offices of power and teaching and academic research pushes this unique type of governmental elite to invest in the definition of programmatic orientations in health policy, frequently within powerful Washington think tanks.

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Table 2. Comparison of Trajectories of Long-Term Insiders

Trajectories Subtypes	Institutional Migrants	Technocratic Translators	Policy Bureaucrats
Original occupation	Think tanks (Brookings, Urban Institute), Universities, Foundations (Kaiser Family Foundation)	Lawyer, researcher, or assistant professor	Administrative career, actuary, Inspector General's office
First executive branch or Congressional position	Congressional staffers (legislative assistant), or Adj. dir. HHS, or budgetary advisor (OMB or CBO)	Legislative Branch: staffers subcommittee Executive Branch: Health states administration	Office of the Actuaries and Office of the General Council DHHS; OMB.; Chief tax Counsel Ways & Means
Desired sectoral power position: career objective	Ass. Secretary Planning & Evaluation (ASPE); or budget dir. in HCFA (CMS); OMB or CBO or Chief Health Council or Legislative Director sub. Com. Congress	—**Idem**—+ Health Care Financing Administration (HCFA) in DHHS or Committee staff director or general council in Congress	Senior Executive Service (SES) status; specialization in financial oversight and inspection agencies (Chief Council)
Revolving doors effect (Democrats vs. Republicans)	Democrats ⇒ NPO (Robert Wood Johnson, Kaiser Family Found., Center on Budget and Policy Priorities)	Democrats ⇒ Academic Dpt. of Public Health (Universities) or nonprofit Organization (idem)	Does not apply Typically remain in a single agency
	Republicans ⇒ Interest groups (HIAA, HIP, FAH)	Republicans ⇒ Interest groups	

Continued

Table 2. *Continued.*

Trajectories Subtypes	Institutional Migrants	Technocratic Translators	Policy Bureaucrats
Back to the office at the reform moment	White House ⇐ OM⇔ CBO ⇔ ASPE ⇒ Congress Advisor of Pres.; Prog. Ass. Dir. OMB; Sr. Policy Advisor of Congressional Speaker; Committee staff director.; ASPE	Executive: DHHS ⇒ ASPE or White House (dr. Office for the Health Care Reform or PAD à OMB) Congress: specialization on policy issue ⇒ Chief of staff or General Counsel	Remains in the same position (20–30 years) Possible move to OMB
Socialization loci (I): "Clinton Veterans" (av. 1994)	Pepper commission or/and Clinton Task force or/and bipartisanship organizations	Pepper commission or/and Clinton Task force or/and bipartisanship organizations	Clinton Task force
Socialization loci (II): Clinton Veterans + newcomers (post 1994)	Alliance for Health Reform; Bipartisan Policy Center; Hamilton Project (Dem.); Center on Budget and Policy; Health policy consensus group; or HOPE project (Rep.)	Alliance for Health Reform; Bipartisan Policy Center; Center for American Progress; Hamilton Project (Dem.); Health policy consensus group or HOPE project (Rep.)	Alliance for Health Reform or Bipartisan Policy Center
Exit strategies from government	Universities, think tanks and foundations for the democrats in Washington DC Difference for republicans: more lobby oriented	Universities, think tanks and Foundations for the democrats in Washington DC Difference for republicans: more lobby oriented	Universities, think tanks and Foundations for the democrats in Washington DC Difference for republicans: more lobby oriented

Source: Genieys, *Gouverner à l'abri des regards*, 192.

Long-term professional circulation "inside-the-beltway"

The type and duration of specialization in a specific sector are also distinctive markers of the professional trajectories studied. The average duration of careers in the health sector is greater than twenty years, and these careers tend to be highly mobile.[37] This sectorization of careers is an important element in the shaping of policy. Although it is common to observe frequent circulation between the public and private spheres in the United States, these movements (insofar as they remain circumscribed within the same policy sector) tend to foster the emergence of professional networks that go beyond the formal boundaries of government.[38]

Alongside the Democratic health policy elites who opted for short-term transitions to academia (see above), others temporarily traded "inside-the-Beltway" for the private sector, mainly think tanks (such as Brookings, Urban Institute, Center on Budget and Policy Priorities), foundations (Robert Wood Johnson Foundation, Henry J. Kaiser Family Foundation), and various other not-for-profit organizations (see Table 2). More rarely, they went to business or interest groups. However, whether acquired within or outside the institutional boundaries of government, their policy savoir-faire tends to strengthen the regulatory capacity of the public sector. One of our interviewees, a former congressional staffer, said that working in a "nonprofit group" may be viewed as a criterion for belonging to the "*family of staffers for Representative Henry Waxman.*"[39]

This same individual noted that a defining characteristic of the Waxman "team" was strong interpersonal ties: "*The Waxman staff, no one ever leaves, and when we get fired, we stay friendly with each other. And we call on each other as a network, almost. I mean, we are—it's extraordinarily unusual, so don't form your thesis around this, but we are—and there have been some right-wing political commentators who have said that Henry controls a mafia of liberal policy people. … He is smart, he cares, he is easy to work with, and we are all very devoted to him, so if that's what you mean by elite, we stay there, and year after year, in the books that are written about Congress, people always write about how Mr. Waxman has longstanding staff, the good staff, smart people who know what they are doing and who have been there forever. So, he hires young people, too, because some of us go off to teach law school, some of us go off to represent nonprofit groups.*"

Despite their differences in choice of professional activities in the private sector (for profit versus nonprofit), during the Bush II administration in the 2000s, these Democratic and Republican elites tended to join bipartisan think

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tanks "inside-the-Beltway"[40] to collectively rethink the programmatic nature of health care reform.[41] In addition to traditional think tanks often identified as being on the Democratic side, such as the Urban Institute, Brookings Institution, and the Center on Budget and Policy Priorities (1981), and traditional Republican-leaning ones, such as the American Enterprise Institute and the Heritage Foundation, new bipartisan think tanks emerged—the Center for American Progress (2003), the Bipartisan Policy Center [for Health Reform] (2007), the Hamilton Project (2006), and the Health Policy Consensus Group (2003)—to identify points of convergence (Table 2). The Commonwealth Fund, the Kaiser Family Foundation, and the Robert Wood Johnson Foundation, (re)activated the Alliance for Health Reform as a media forum in which Clinton health reform veterans on the Democratic side and a handful of their former Republican opponents in the debates in the 1990s could develop a consensual and bipartisan vision of health reform, one that integrated market-oriented strategies and sought workable approaches to cost containment.

The analysis of professional trajectories of governmental elites shows that most individuals occupying positions in the back offices of power have, during their long careers, accumulated public policy knowledge by alternating between periods of government action and time spent outside the government reflecting on the future of the system. This accumulated Washington-based specialization, which is much more prominent among the Democrats, makes this professional group a breeding ground for health policy elites, a "peri-administration"[42] within which political leaders can seek guidance for their political entourage when there is a change in the political majority in Congress or the arrival of a new administration in the White House.

A lasting commitment to controlling public spending

Strong in the arts of persuasion and argumentation, masters of policy analysis and microeconomics, these governmental elites are endowed with expertise and practical know-how that enables them to calculate the financial impact of policies in order to defend them against attacks from the right. In the health sector operating inside institutions "specialized" in the control of public finance develops their capacities to address the cost of policies, and the analysis of their professional trajectories shows that most of them continue to do so (see Table 2).

Their training path often includes such roles as Program Associate Director within the Office of Management Budget (OMB) at the White House,

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Deputy Assistant Secretary for Planning and Evaluation (ASPE), or a position within the Health Care Financing Administration (HCFA, renamed Center for Medicare and Medicaid Services since 2001). On the Congressional side, in addition to the Congressional Budget Office (CBO), the agency dedicated to the prospective evaluation of expenditures, the career staffers specializing in health policies served within the powerful financial committees (Finance and Budget in the Senate, Ways and Means and Budget in the House of Representatives). Their passage through these institutions is fundamental to understanding the vision upon which the role of custodians of health policy was built during the period analyzed. Thus, Clinton administration veterans—such as Nancy-Ann Deparle and Jeanne Lambrew—who witnessed the major role of the CBO in the failure of the Clinton reform effort, went on to hold important positions within the HCFA or OMB. On the Congressional side, these Clinton veterans were complemented by Democratic newcomers, such as Liz Fowler, Cibele Bjorklund, or Lisa Konwinski, who held key positions in "financial" committees.

However, many interviews carried out as part of the OPERA and ProAcTA studies indicate that the cost-containment argument, which had been honed since the Clinton administration, had been long internalized in the professional trajectories of the aforementioned elites. These governmental elites mobilized collectively within bipartisan reformist think tanks (such as the Bipartisian Policy Center, Center for Budget and Policy Priorities, Hamilton Project) and in policy conferences organized by the Alliance for Health Care Reform to ensure that cost containment remained a central priority in the programmatic reform underway. The Hamilton project, under the direction of economists Peter Orszag and Jason Furman, was launched in 2006 as a group to reflect on the ways to make the reform agenda a reality.[43] Upon appointment to the leadership of the CBO in 2007, Orszag set three primary objectives: enhancing social justice, controlling the trajectory of the health care budget, and reforming the health insurance system.

For his part, Jason Furman served on President Obama's Council of Economic Advisors for eight years.[44] According to a health policy advisor who played an important role at the White House under both Clinton and Obama, "*the policy foundations for a good reform*" must include four "legs": *(1) an insurance reform that broadens access, (2) insurance mandates that bring people into the system, (3) subsidies to ensure affordable access to the insurance market, and (4) cost containment.* On the imperative character of the latter, the source specifies that "*the fourth and last leg of the chair is the reform of the financing system itself. Costs are exploding, so you have to enact some cost*

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control mechanisms, you have to enact value-purchasing, or some financing requirement, to make sure that the health care system is sustainable over time."[45]

In the policy battles waged during the design of the ACA (2008–2010), identification with this cost-control argument was an important element of definition and autonomy for these health policy insiders, distinguishing them from partisans of the public option in the Democratic party, most of whom lacked the day-to-day experience of power.

THE AFFORDABLE CARE ACT: COLLECTIVE CIRCULATION AND PROGRAMMATIC ALIGNMENT

An analysis of the professional trajectories of the long-term insiders reveals the presence of those who circulated in Washington's back offices of power before President Obama's launch of the reform process.[46] Longitudinal study of the trajectories of the elites in the health sector further shows that the boundaries between the two branches of government have often been crossed in the context of their long careers. This circulation reveals their determination to obtain key positions and use them to advance their agenda during the ACA reform. Indeed, the detailed study of the different professional trajectories in the affairs of the government of long-term insiders reveals three distinct paths (Table 3): *institutional migrants* (who serve over time in both the legislative and executive branches), *technocratic translators* (who move in and out of a single branch), and *policy bureaucrats* (experts who enjoy civil servant status within a single branch of government). These trajectories allow us to understand the directions from which these elites converged on the heights of power in the health sector when the Democrats returned to power, first in Congress and then in the executive branch.

Indeed, it was first in Congressional committees that the Clinton veterans and the Democratic newcomers (re)entered the arena of power to prepare the ground for health insurance reform. This work is centered on two democratic political figures with a long history of involvement in health issues: Henry Waxman and Ted Kennedy. The arrival of Waxman in 2009 to the Oversight and Government Reform Committee in the House (until 2011) reunited key players who had never left the House, including Karen Nelson and Philipp Barnett, as well as others like Ruth Katz, Andy Schneider, and Tim Westmoreland, who had joined the faculty in schools of public health. Senator Kennedy's staff showed a stronger integration of newcomers. The latter were recruited, first, by veteran David Nexon and then by his replacement, David Bowen, as

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Table 3. Typology of Long-Term Insiders Trajectoires

Institutional Migrant	Technocratic Facilitator	Policy Bureaucrats
"Horizontal" circulation between the two branches Administration ⇔ Congress	Absence of horizontal circulation: career anchored in only one of the two branches	Absence of horizontal circulation: career anchored in only one of the two branches
Vertical circulation including occupation of strategic decision-making positions	Vertical circulation and occupation of strategic decision-making positions always in the same branch of government	Vertical circulation and occupation of strategic decision-making positions always in the same branch of government
Career in executive agencies or congressional committees focused on financial oversight of policies	Career in executive agencies or congressional committees focused on financial oversight of policies	Career in executive agencies or congressional committees focused on actuarial or fiscal issues —advantages of a civil service career
Time spent working for the "inside the beltway" private sector: interest groups (Rep.) or nonprofits (Dem.)	Time spent working for the "inside the beltway" private sector: interest groups (Rep.) or nonprofits (Dem.)	Employment in "inside the beltway" interest groups, but only after the end of a long public sector career
Strong interpersonal network at the heart of both legislative and executive centers of power	Strong interpersonal network + strong expertise and direct role in transforming the programmatic orientations of legislation	Strong technical knowledge of policy (statistical, accounting, legal)

Source: Genieys, *Gouverner à l'abri des regards*, 83.

the chief of staff of the Health, Education, Labor, and Pension Committee. In addition to these two key groups of actors, others who made their mark on the history of the reform include the veteran Wendell Primus—whose remarkable career has led him to serve in the House Ways and Means Committee, the Office of the ASPE as Deputy Director and staff for House Speaker Nancy Pelosi during the G. W. Bush years as Health Advisor—and newcomers Cybele Bjorklund on the House Ways and Means Committee and Liz Fowler on the Senate Finance Committee.

Finally, the "neoregulatory" economist Peter Orszag merits a special mention. A young advisor to President Clinton who found himself in the middle of the subprime loan crisis (2007–2008), Orszag was appointed by Nancy Pelosi to head the CBO before being recruited by Barack Obama to lead the OMB. Clinton-era veteran Alice Rivlin, analyzed his rapid ascension to the highest policy-making levels: "*In the mid-term [2006], he had been the CBO direcor and he realized that health care was going to come back as an issue and his staff in CBO did a lot of analytical work on options and alternatives, and so on, and hired very good people. So the CBO would be ready when the health care reform came. Then Peter Orszag went to OMB, taking with him a lot of analysis and knowledge that had got when he was there.*"[47] It is precisely for this reason that "*Peter Orszag and the OMB played a key role role behind the scenes.*"[48] Orszag made the budgetary question one cornerstone of the ACA reform. His trajectory as an *institutional migrant* shows the importance of building a reform project on the basis of a controlled budget, a vision that he carried as he circulated between the two branches of power.

Beyond the alignment of the stars: The long-term insiders' victory

Unlike the Clinton reform period, experts who were "strangers" to the universe of long-term insiders were marginalized with the goal of smoothing negotiations with Congress so as to make reform possible. For example, when Obama Administration insiders were asked about the influence of Jacob Hacker, a leading promoter of the "public option" one replied, "*he is just an academic. He was consulted by the White House but was never appointed to any position.*"[49] Another of our interview partners noted that "*academics do not have direct influence on our work … we listen to them when we have time.*"[50] To distinguish himself even more sharply from academic experts, one insider affirmed "*true insiders don't write books about their experience. You don't write about what was done confidentially behind closed doors.*"[51]

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Table 4. Clinton Veterans back to the Office under Obama Administration (2008–10)

- Wendell Primus: A.S.P.E./ DHHS ⇒ Sr. Policy advisor to Speaker of the House
- William Corr: Senate ⇒ n°2 position at DHHS
- Karen Pollitz: House of Representatives ⇒ DHHS
- Karen Nelson: O.M.B. ⇒ House of Representatives
- Carolyn Clancy: DHHS ⇒ DHHS
- Michael Hash: House of Representatives ⇒ White House
- Phil Schiliro: House of Representatives ⇒ White House
- Nancy Ann DeParle: O.M.B. ⇒ White House
- Jeanne Lambrew: O.M.B. ⇒ DHHS

Source: Genieys, *Gouverner à l'abri des regards*, chapter 9.

For these long-term insiders, policy governance is an art to be mastered, requiring a deep knowledge of the substance of policy, long experience in the back officies of power, and a common vision of policy. The major feature of the victory of the programmatic orientation that the custodians of health policy championed stemmed from their ability to turn the experience of past failures into a political resource. The search for the consensual reform led to the elimination of divisive alternatives—such as the "public option"—in favor of a mixed solution that integrated private health insurance.[52]

The mission was entrusted to individuals with the trajectory typical of the long-term insider, whose sociological profile was that of the Clinton veterans (Table 4): Nancy-Ann DeParle (Director of the Office of Health Reform); Jeanne Lambrew (close to Senator Tom Daschle); Karen Pollitz; and former aides to Henry Waxman, Mike Hash (health adviser at the White House), and Phil Schiliro (adviser in charge of Congressional relations). These long-term insiders—two technocratic translators and three institutional migrants—owed their appointment to their action in the Clinton reform and to their seniority, but also to ther capacity acquired over time to be "in charge" of policy governance.[53] Alice Rivlin, former director of CBO and OMB—herself a veteran of this type of trajectory—emphasized that "*while many people in the Obama Administration were also part of the Clinton Administration, many of them are not in the same position.*"[54]

The most significant example of this is Nancy-Ann DeParle. Durring the Presidential transition Rahm Emmanuel, Obama's Chief of Staff, insisted that

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this veteran of the Clinton administration be recruited so that she could personally pilot health reform decisions from the White House, perfectly illustrating this political will.[55] For Alice Rivlin, OMB director under Clinton, DeParle's appointment was justified by her long experience: "*She worked for me at the OMB in the Clinton administration. She was in the HHS but during the health care debate (HCFA), she was one of my important people in this 'Task force' thing. She is a very good health analyst and very skilled person, and I think that she learned a lot both from that experience and from when she was administrator of Medicare and Medicaid in the Clinton administration. So she was an important part of the team.*"[56] Len Nichols, another Clinton veteran politically close to the "blue dog" Democrats, confirmed this judgement: "[*she*] *is actualy the only one on the planet who lived through the Clinton political war … [she was] the perfect person for where she was in the White House.*"[57]

The cross-cutting analysis of professional trajectories and the programmatic orientation formulated by this new health policy elite shows that their approach achieved consensus on a far-reaching reform while leaving the door open to future improvements.[58] One of them summed up their experience as follows, "*Another lesson I learned during my career was that we are in politics—we are not in an academic environment. So, to enact a reform, you have to make trade-offs, you have to compromise on things you don't like. In the reform, some provisions are ugly, I think also some of them are really stupid, are bad policy… . But at least we did it, and we can reform the reform.*"[59] Veterans of the Clinton administration knew all too well that the search for the perfect reform had led to a resounding failure, leaving millions of Americans without health insurance after what had seemed to be a historic opportunity to acquire it at last.[60]

In managing the weight of the past and the fear of a new failure, these elites had learned to govern policy processes "*from the inside*," guarding their work against the influence of outside policy entrepreneurs and others with different professional characteristics and priorities who were putting forward more divisive projects such as the public option.[61] The work carried out behind the scenes helped to gradually overcome the differences between the two branches and to persevere despite the absence of Republican support for what began as a supposedly bipartisan reform.[62]

Throughout the debate on the reform, these elites worked behind closed doors to create politically acceptable drafts of reform and then to bring the Senate's final version of the legislation to fruition—the only procedural option once a Republican replacement for Senator Kennedy, who died in August 2009, deprived the Democrats of their 60th "filibuster-proof" vote in the upper chamber. Their professional backgrounds well equipped them to reassure the

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CBO and conservative Democrats that their health care reform would broaden access to the insurance system, establishing a system in which mandates would bring people into the insurance market; subsidies would ensure affordable access, and a variety of measures would contain costs.

These long-term insiders thus contributed to the achievement of an ambitious, far-reaching reform of the health care system, averting the pitfalls of a comprehensive systemic reform effort, which they had come to view as impossible, based on their experience. Their long-term accumulation of political and professional know-how in public policy development cast crucial explanatory light on the content, scope, and (at least to date) the durability of the Affordable Care Act.

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NOTES

1. See for example, Jonathan Oberlander, "Learning from Failure in Health Care Reform," *The New England Journal of Medicine* 357, no. 17 (October 2007): 1677–79; "Long-time Coming: Why Health Reform Finally Passed," *Health Affairs* 29, no. 6 (June 2010): 1112–16; Lawrence R. Jacobs and Theda Skocpol, *Health Care Reform and American Politics* (New York: Oxford University Press, 2010); Jacob S. Hacker, "The Road to Somewhere: Why Health Reform Happened," *Perspectives on Politics* 8, no. 3 (August 2010): 861–76; Paul Starr, *Remedy and Reaction: The Peculiar American Struggle over Health Care Reform* (New Haven, CT: Yale University Press, 2013); Eward Berkowitz, "Getting to the Affordable Care Act," *The Journal of Policy History* 29, no. 4 (October 2017): 519–42.

2. William Genieys, *The New Custodians of the State: The Programmatic Elites in French Society* (London: Routledge, 2010); Patrick Hassenteufel, William Genieys, Marc Smyrl, and Javier Moreno, "Programmatic Actors and the Transformation of European Health Care States," *Journal of Health Politics, Policy and Law* 35, no. 4 (August 2010): 517–38; William Genieys and Patrick Hassenteufel, "The Shaping of the New State Elites: Healthcare Policymaking in France since 1981," *Comparative Politics* 47, no. 3 (April 2015): 280–95.

3. Patrick Hassenteufel and William Genieys, "The Programmatic Action Framework: An Empirical Assessment," *European Policy Analysis* 7, no. S1 (February 2021): 28–47, https://doi.org/10.1002/epa2.1088.

4. Hugh Heclo, "In a Search of Role: Amerca's Higher Civil Services," in *Bureaucrats and Policy Making: A Comparative Overview*, ed. Ezra N. Suleiman (New York: Holmes & Meier, 1984), 12–13.

5. Hugh Heclo, "Issues Networks and the Executive Establishment," in *The New American Political System*, ed. Anthony King (Washington DC, 1978), 98.

6. Genieys and Hassenteufel, "The Shaping of the New State Elites"; William Genieys and Jean Joana, "The Custodians of the State Policies Dealing with the Financial Crisis: A

Comparison Between France and the US," International Relations and Diplomacy 5, no. 6 (May 2017): 322–41.

7. William Genieys, *Gouverner à l'abri des regards. La réussite de l'Obamacare* (Paris: Presses de Sciences Po, 2020).

8. Hugh Heclo, *A Government of Strangers. Executive Politics in Washington* (Washington DC: The Brookings Institution, 1977).

9. Genieys, *Gouverner à l'abri des regard.*

10. This article is based on empirical data collected in the OPERA (*Operationalizing Programmatic Elites Research in America*) study, funded by the French *Agence nationale de la recherche* from 2008 to 2012 (ANR-08-BLAN-0032). The project focused on the transformation of the highest levels of U.S. governing structures, particularly in the health sector from 1988 to 2010. The project enabled the creation of a database of 152 detailed biographies and 191 anonymous and semidirective interviews. A second program, *Programmatic Action in Times of Austerity: Elites Competition in the Health Sector Governance in the Health Sector in France, Germany, United Kingdom (England), and the US* (ProAcTA) 2008–2018 (ANR-17-FRAL-0008-01/DGF BA 1912/3-1) is in progress. In this context, we carried out more than a dozen additional interviews (June 2018 to February 2019) in Washington DC with some key actors in the Patient Protection and Affordable Care Act reform to test the hypothesis developed in this article.

11. Johnathan Oberlander, *The Political Life of Medicare* (Chicago: University of Chicago Press, 2003).

12. Genieys, *Gouverner à l'abri des regard.*

13. Robert Putnam, "Elite Transformation in Industrial Advanced Societies: An Empirical Assessment of the Theory of Technocracy," *Comparative Political Studies* 10, no. 3 (October 1977): 383–411.

14. By "state elites" we mean the type of governmental elites who adopted the role of planners after the Second World War, situating their action at the intersection of the executive and legislative branches and the administration, developing policy styles that vary from state to state. Genieys, *Gouverner à l'abri des regard*, 42–46.

15. Paul Pierson, *Dismantling the Welfare State? Reagan, Thacher, and the Politics of Retrenchment* (Cambridge: Cambridge University Press 1994).

16. Martha Derthick, *Policymaking for Social Security* (Washington DC: The Brookings Institution, 1979).

17. Ezra Suleiman, *Dismantling the Democratic States* (Princeton, NJ: Harvard University Press, 2003).

18. Genieys and Hassenteufel, "The Shaping of the New State Elites"; Genieys and Joana, "The Custodians of the State Policies Dealing with the Financial Crisis."

19. Heclo, *A Government of Strangers.*

20. Lawrence Brown, *Politics and Health Care Organization: HMOs as Federal Policy* (Washington DC: The Brookings Institution, 1983).

21. Lawrence Brown, *New Policies, New Politics: Government's Response to Government Growth* (Washington DC: The Brookings Institution, 1983).

22. Brown, *Politics and Health Care Organization*, 17.

23. Lawrence Brown, "Technocratic Corporatism and Administrative Reform in Medicare," *Journal of Health Politics, Policy and Law* 10, no. 3 (Fall 1985): 579–99.

24. Joseph Califano, interview by Edward Berkowitz, August 31, 1995, The Health Care Financing Administration Oral History, https://www.ssa.gov/history/CALIFANO2.html.

25. This centrist and largely bipartisan position allowed Altman to advise five successive presidential administrations. See Stuart Altman and David Shactman, *Power Politics and Universal Health Care* (Amherst, NY: Prometheus Books, 2011), 72.

26. Genieys, *Gouverner à l'abri des regards*, chaps. 2, 4, and 5.

27. OPERA Interview, Washington DC, October 26, 2011.

28. Ulrike Lepont, "Façonner les politiques aux marges de l'Etat: le rôle des experts dans les réformes de la protection maladie aux Etats-Unis (1970-2010)" (PhD diss. University of Montpellier, 2014).

29. Mohammad-Saïd Darviche, William Genieys, Catherine Hoeffler, and Jean Joana, "Des '*long timers*' au sommet de l'État Américain: Les secteurs de la Défense et de la Santé (1988–2010)," *Gouvernement et Action Publique* 2, no. 1 (January 2013), 10–38.

30. For a comprehensive view of the results of the sociographic analysis of the social background of Washington's health policy elites, see Genieys, *Gouverner à l'abri des regards*, chap. 3.

31. Douglas Yates Jr., "The Mission of Public Policy Programs: A Report on Recent Experience," *Policy Sciences* 8, no. 3 (September 1977), 363–73.

32. Graham Allison, "Emergence of Schools of Public Policy: Reflections by a Founding Dean," in *The Oxford Handbook of Public Policy*, ed. Michael Moran, Martin Rein, and Robert G. Goodin (Oxford: Oxford University Press, 2006), 58–79.

33. Darviche et al., "Des '*long timers*' au sommet de l'État Américain," 15–18.

34. Genieys, *Gouverner à l'abri des regards.* At the origin of the program of the Ford Foundation there were eight schools, and today they are about 40 on American territory, which train more than 10,000 graduates per year. See James Pierson and Naomi Schaefer, "The Problem with Public Policy Schools," *The Washington Post*, December 6, 2013.

35. Oberlander, *The Public Life of Medicare.*

36. Genieys, *Gouverner à l'abri des regards*, chaps. 4, 5.

37. Darviche et al., "Des '*long timers*' au sommet de l'État Américain," 22–26.

38. Ulrike Lepont, "Out but In: The Reconfiguration of American Health Policy Expertise and the Advent of a 'Peri-Administration' (1970-2010)," *Governance* 34, no. 2 (March 2021): 435–56, https://doi.org/10.1111/gove.12518.

39. OPERA Interview, Washington DC, May 28, 2010.

40. Ulrike Lepont, "Out but In."

41. Genieys, *Gouverner à l'abri des regards*, chap. 8.

42. Ulrike Lepont, "Out but In."

43. Philip G. Joyce, *The Congressional Budget Office. Honest Numbers, Power and Policymaking* (Washington DC: Georgetown University Press, 2011).

44. Genieys, *Gouverner à l'abri des regards*, chap. 8.

45. OPERA Interview, Washington DC, April 30, 2010.

46. Genieys, *Gouverner à l'abri des regards*, chap. 9.

47. OPERA Interview, Washington DC, April 28, 2010.

48. OPERA Interview, Washington DC, April 2, 2010.

49. ProAcTA Interview, Washington DC, June 21, 2018.

50. ProAcTA Interview, Washington DC, June 20, 2018.

51. ProActTA Interview, Washington DC, June 19, 2018.

52. John McDonough, *Inside National Health Reform* (Oakland: University of California Press, 2012).

53. Genieys, *Gouverner à l'abri des regards*, chap. 9.

54. OPERA Interview, Washington DC, April 28, 2010.

55. Nancy-Ann Min DeParle, interview with Edward Berkowitz, Washington DC, April 2, 2015, 60–61, https://www.nasi.org/research/2016/insights-top-oral-history-medicare-medicaid.

56. OPERA Interview, Washington DC, April 28, 2010, 5.

57. OPERA Interview, Washington DC, May 18, 2010.

58. For a different interpretation, see Kevin P. Donnelly and David A., Rochefort, "The Lesson of 'Lesson Drawing': How the Obama Administration Attempted to Learn from Failure of the Clinton Plan," *The Journal of Policy History* 24, no 2 (March 2012): 184–223.

59. OPERA Interview, Washington DC, April 30, 2010.

60. OPERA Interview, Washington DC, May 24, 2010.

61. John McDonough, *Inside National Health Reform.*

62. Anne-Laure Beaussier, "The Patient Protection and Affordable Care Act: The Victory of Unorthodox Lawmaking," *Journal of Health Politics, Policy and Law* 37, no. 5 (October 2012): 743–78.