Social Policy & Society (2012) 11:3, 319–330
© Cambridge University Press 2012 doi:10.1017/S1474746412000048

The Obama Presidency and Health Insurance Reform: Assessing Continuity and Change

Daniel Béland* and Alex Waddan**

*Johnson-Shoyama Graduate School of Public Policy, University of Saskatchewan
E-mail: daniel.beland@usask.ca

**Department of Politics and International Relations, University of Leicester
E-mail: aw148@leicester.ac.uk

During the 2008 federal campaign, Democratic presidential candidate Barack Obama placed comprehensive health care reform at the centre of his platform. In the light of the growing problems facing the US health care system, the time seemed ripe for another attempt to control health costs while expanding insurance coverage. Elected in the context of the deepest recession since World War II, President Obama nonetheless decided to reform the US health care system at the beginning of his presidency. Drawing on the historical institutionalist perspective, which stresses the effects of existing institutions and policy legacies on social policy development, this article analyzes health politics during the first fifteen months of the Obama administration before assessing the impact of the legislation enacted in March 2010. Although it does not radically break from the past, this legislation should bring about crucial changes to the US health care system.

Keywords: Health insurance, coverage, reform, Obama, United States.

Introduction

Across the industrialised world, governments have adopted health care arrangements that try to reconcile the potentially conflicting goals of providing people with access to health care and containing overall spending on that care. Different nations have adopted alternative systems, but the United States has stood as an outlier with a relatively unique set of arrangements. In that country, health care is provided in the context of a public–private system where private insurance covers most working-age people and their families while government provides basic health coverage to vulnerable populations, such as poor people, as well as people with disabilities and older people, through social assistance (Medicaid) and social insurance (Medicare), respectively. This complex and loosely regulated public–private system has created concerns about both cost control and accessibility (Street, 2008). First, the United States is the OECD country that spends the most on health care as a proportion of GDP. In 2008, the US spent 16 per cent of GDP on health care, compared with 8.7 per cent in the UK (OECD, 2010). Second, at any given time, more than 45 million people live without any health insurance coverage. In the United States, access to care for the uninsured is limited and, simultaneously, health bills are 'the leading cause of personal bankruptcy' (Hunt and Knickman, 2008: 71). Partly

https://doi.org/10.1017/S1474746412000048 Published online by Cambridge University Press

because many uninsured use emergency rooms as a 'last resort' option, the fate of the uninsured negatively affects the health care system as a whole (e.g., Abelson, 2008).

Considering these important social and economic problems, it is not surprising that federal politicians have long attempted to reform the US health care system. Before the election of Barack Obama to the presidency, the last important attempt to restructure this complex system took place at the beginning of the Clinton presidency (1993–2001). Like other Democratic presidents before him, Clinton wanted to bring about universal coverage in the United States. Facing deeply entrenched vested interests in the private health sector, the president pushed for a complex regulatory system centred on the idea of 'managed competition' (Hacker, 1997). Yet, in the end, these vested interests mobilised against the President's Health Security plan and helped turn public opinion and a growing number of members of Congress, including Clinton's Democrat colleagues, against it. The crushing defeat of President Clinton's health insurance initiative favoured a backlash against the federal government leading to a Republican landslide at the 1994 mid-term election (Skocpol, 1996).

Nearly fifteen years after the spectacular defeat of Clinton's Health Security initiative, during the 2008 federal campaign, Democratic presidential candidate Barak Obama placed comprehensive health care reform at the centre of his platform. Given the growing problems facing the US health care system, the time seemed ripe for another attempt to control health costs while expanding insurance coverage. Elected in the context of the deepest recession since World War II, President Obama nonetheless decided to reform the US health care system at the beginning of his presidency.

This article analyzes health politics during the first fifteen months of the Obama administration before assessing the impact of the Patient Protection and Affordable Care Act (PPACA) enacted in March 2010. To frame the political component of this analysis, the article draws on historical institutionalism, an analytical framework associated with the work of political scientists like Paul Pierson (1994). For Pierson (1994), formal political institutions and the vested interests stemming from existing social programs create constraints and opportunities for political actors and interest groups involved in social policy reform. In the United States, the weight of formal political institutions is especially significant, as power fragmentation at the federal level, related to 'checks and balances', and the lack of formal party discipline in Congress, offer interest groups direct opportunities to intervene in the law making process to shape the content of legislation. These institutional features of the US polity even led scholars to claim that, without constitutional change, the advent of national health insurance was impossible in the United States (Steinmo and Watts, 1995; for a critique: Hacker, 1997). The weight of vested interests stemming from existing policy arrangements (Pierson, 1994) is particularly heavy in the United States as private health policy actors, tied to existing health institutions, have long influenced the politics of health insurance (Quadagno, 2005). The role of those interests in the Clinton administration's humiliating defeat in health insurance reform illustrates this claim (Skocpol, 1996). But, as the best recent institutional scholarship on policy change suggests, the existence of apparently stable institutional legacies does not prevent significant and, under some circumstances, path-departing change from taking place (Streeck and Thelen, 2005). The following analysis of the 2010 health care reform takes this remark into account while exploring the structuring role of institutional legacies, which are especially crucial in the constraining institutional landscape of US federal health politics.

https://doi.org/10.1017/S1474746412000048 Published online by Cambridge University Press

The Obama presidency and the politics of health insurance reform

During the first months of the Obama presidency, rescuing an economic and financial system on the brink of disaster became the focal point of both the White House and the Democratic-controlled Congress. The President also pushed for health care reform, but Republicans opposed this move, claiming that dealing with the economic crisis constituted the only legitimate priority at the time. Reacting to this type of discourse, President Obama stressed the relationship between health care reform and economic competitiveness as rising health care costs represented a major impediment to the global competitiveness of the US economy (Morris, 2006). Beyond this macro-economic reality, the president pointed to the fact that ordinary citizens increasingly felt the burden of growing health care costs as employers pushed more of the burden of paying for insurance on to their workers. In addition, government run health care programs threatened the fiscal stability of the federal government (CBO, 2010a: 21). Thus, from Obama's perspective, the fight for health care reform and the quest for economic recovery appeared as closely related tasks (e.g., Obama, 2009a). Despite this presidential rhetoric, the bleak economic situation complicated the task of the president, as it increased the size of the federal deficit and forced the administration to focus more than ever on the cost control issue.

In terms of process, one of the most striking aspects of the administration's efforts was the early and generally successful attempt to reduce potential interest group opposition to reform. From the administration's perspective an immediate priority was to prevent a massive and hostile interest group mobilisation similar to the one that had helped defeat President Clinton's Health Security initiative fifteen years earlier. As suggested by historical institutionalist scholars such as Jacob Hacker (2002), the development of private health care institutions since World War II has stimulated the multiplication of powerful market-based actors such as private hospitals, health insurance providers, and pharmaceutical companies in the US. In this institutional context, the Obama administration chose to bargain directly with some of these interest groups to persuade them that the reforms would not have an overly negative impact on their business. For instance, with the support of allies like Democratic Senator Max Baucus (Montana) from the Finance Committee, President Obama secured a 'deal' with the pharmaceutical industry long before the time came for that committee to actually produce a bill. This 'deal' included a commitment on the part of the drug companies to reduce costs, which would help Democrats to produce a less expensive piece of legislation while benefiting from the support of one of the most powerful lobbies in the United States. Not long after, the White House struck a similar deal with the powerful hospital industry. These 'special deals', negotiated behind closed doors, were not always well received by the Democratic Party's base and even by some Democrats in Congress, especially in the House of Representatives. As discussed below, these controversial deals did compromise the final legislation, but they also reduced potential interest group mobilisation against forthcoming reform proposals. Not all interests were reconciled with the reform plans as, for example, the US Chamber of Commerce maintained vociferous opposition, but the Clinton experience of concerted hostility was not repeated (Jacobs and Skocpol, 2010: 66–70). The insurance industry provides an interesting case of a conflicted interest group. Through its engagement with other private sector health players, the White House somewhat isolated the insurance industry. The industry remained unhappy with aspects of the legislation, and channelled

https://doi.org/10.1017/S1474746412000048 Published online by Cambridge University Press

money to help fund the Chamber of Commerce's attacks, but did not itself explicitly reject the idea of reform as it had in 1993 (Hacker, 2010: 865).

Meanwhile, the president tasked Democrats in both chambers of Congress to craft a legislative compromise, with limited White House interference, especially with regard to the House of Representatives. Again, this represented a deliberate shift from the strategy adopted by President Clinton who had imposed a detailed policy blueprint upon Congress (Connolly, 2010: 11–27). This situation increased the role of Democratic leaders in Congress, who worked hard to gather support for comprehensive health care legislation. The situation was particularly delicate in the Senate, where the threat of a Republican filibuster forced Majority Leader Harry Reid to gather sixty votes to ensure the passage of any key legislation. This meant gaining the support of more conservative Democrats in the Senate, whose presence further complicated the legislative task at hand, especially given the strength of Republican opposition. These remarks illustrate how the fragmented nature of federal political institutions – and specifically the increased use of the filibuster as an effective veto point – as well as the absence of formal party discipline in Congress, complicated the reform efforts of President Obama and his allies.

Interestingly, while interest group resistance to reform was somewhat diminished by the administration's strategy of outreach, the efforts in Congress to build a bipartisan consensus (or perhaps more realistically win over a handful of more moderate Republicans) had little success. As details about health care reform began to emerge, Republicans and their conservative allies launched a campaign against health reform that exploited traditional fears about 'big government' that are ever present in the United States, especially on the right. Claiming that the Obama administration was attempting a 'government takeover' of health care that would lead to a decline in patient freedom and in the quality of care available to those who were already insured, conservative voices tied health care to broader fears concerning the future of personal freedom and the market economy in the United States. A catalyst for the public expression of these conservative fears, the emerging Tea Party movement, strongly opposed the administration. The movement's heated rhetoric helped mobilise the populist right against President Obama and his 'socialistic' health reform. The fact that the White House refused to unveil a detailed legislative proposal in order to give Democratic leaders in Congress more political room to manoeuvre, created an opportunity for conservatives like Sarah Palin, who filled the policy blanks with unsubstantiated allegations about things like the so-called 'death panels' (i.e., the idea the federal government would decide when older people should die in order to save Medicare money), which diverted public attention away from other policy matters. In August 2009, there were dramatic scenes as opponents voiced their rage over the reform plans at various 'town hall meetings' hosted by members of Congress back in their constituencies for the summer recess (see, for example, Jacobs and Skocpol, 2010: 76–8; Urbina and Seelye, 2009). At first, these events shook the Obama administration, which had apparently lost the initiative in the health care debate to conservative Republicans and their allies. Simultaneously, many Democrats frustrated with the president's seemingly passive approach asked him to take a strong stance on health care reform to reverse what seemed like declining public support for reform. Responding to these pressures from his own party, in early September 2009 President Obama gave a major health care speech in front of both chambers of Congress (Obama, 2009b). In this key speech, in addition to stressing the need to control public and private health care costs, the President spoke with passion about the uninsured and of those

https://doi.org/10.1017/S1474746412000048 Published online by Cambridge University Press

who were afraid they might lose their existing coverage. This speech helped fire up the Democratic base and increased pressure on Democrats in Congress (especially on the Senate Finance Committee, which was the last of the relevant congressional committees to report a bill out) to enact legislation amidst conservative attacks and a divided public.

In the fall, reform finally started to take shape in Congress. One central debate was over the virtues of the so-called 'public option'. Supported by the left of the Democratic Party, the 'public option' involved the federal government selling health insurance coverage directly to individuals in order to increase the level of competition within the health insurance market and, as a consequence, forcing private insurance companies to lower their prices, which would result in cost containment from the perspective of the health system as a whole. The House of Representatives included a 'public option' as part of the health care bill, which it passed by a small margin (220 against 215, with all but one of the Republicans opposing the legislation) on 7 November 2009. This legislative 'success' for Speaker Nancy Pelosi was surprisingly difficult to achieve, in large part because of the resistance of anti-abortion Democrats such as Representative Bart Stupak (Michigan) and his allies, who forced the Democratic leadership to strike a deal on abortion supported by Catholic bishops to the frustration of many pro-choice Democrats (Connolly, 2010).

In the Senate, the need for every Democratic vote to break a potential Republican filibuster gave more conservative Democrats and, especially Senator Joseph Lieberman (Connecticut), critical leverage that, in turn, led to the exclusion of the public option from the Senate version of the bill. This decision (which was predictable according to two congressional staffers interviewed for this project in August 2010) exacerbated existing tensions among Democrats in the House and the Senate, as many House Democrats strongly supported the idea of a 'public option'. Discussions over this issue, and over 'special deals' for states aimed at convincing reluctant reformers like Democratic Senator Ben Nelson from Nebraska to support the bill, increasingly monopolised the public debate over health care while exacerbating public discomfort over the reform process itself. Once again, from an institutionalist perspective, this process illustrates how the absence of strict party discipline in Congress complicates attempts at comprehensive reform.

Finally, on 24 December the Senate enacted its version of the health care bill, with no 'public option'. At this stage, it seemed that Democrats of both chambers of Congress only needed to agree on a unified legislative text to make reform a reality. By mid-January 2010, despite discontent on the right (opposition to the reform itself) and the left (lament over the likely death of the 'public option'), reform seemed likely. But, on 19 January, the surprising triumph of Republican Scott Brown in a special Senate election to replace Ted Kennedy in Massachusetts altered power relations in Washington as it gave the Republicans 41 votes thus allowing them to sustain a filibuster, an increasingly popular institutional device widely used to block reform in contemporary federal politics (Hacker and Pierson, 2010). Barely a week later, in his first State of the Union address, President Obama reiterated his support for health care while focusing on job creation and economic revival (Obama, 2010), but at that stage the future of health reform seemed highly uncertain.

In the end, however, Obama and his allies decided that it was better for them to enact their controversial reform ahead of the fall mid-term elections rather than face the electorate empty handed. In February and March 2010, intense negotiations between the White House and the Democratic leaders of the House and the Senate took place. Again illustrating the manner in which the formal institutional rules of Congress shape

https://doi.org/10.1017/S1474746412000048 Published online by Cambridge University Press

legislation, the decision was made to pass the Senate version of the bill in the House since it had become impossible to send a new compromise package back to the Senate as the Republicans now had the numbers to filibuster. With the bill passed in the same form in both chambers, Obama could sign that bill into law. This meant, for example, that the public option preferred by the House was dropped. Also problematically, the Senate bill did not have affirmative language restricting the use of public money for abortions, as had been in the House bill. President Obama thus issued an executive order stressing that federal money would not be used for abortions to ensure that Democrats such as Bart Stupak would vote for the Senate bill. The House enacted that version of the bill by a small majority, as Republicans united against it. The House then also adopted a number of 'fixes' to the Senate bill, such as removing the special deal for Nebraska, which were sent to the Senate for approval. Controversially, the administration argued that these limited measures could be enacted via the reconciliation process that does not allow for a filibuster. On 30 March, President Obama signed this second piece of legislation, thus marking the end of a convoluted and highly contentious reform process.

The reform process described above illustrates the critical impact of institutional frameworks and legacies on health insurance reform during the first fifteen months of the Obama presidency. On one hand, considering the fragmentation of federal power and the absence of strict party discipline in Congress, many compromises proved necessary to get any legislation enacted in the first place, including on issues such as abortion, which are not inherently central to health insurance reform. On the other hand, vested interests in the health care sector forced the Obama administration to bargain directly with powerful private health actors, another institutional factor that helped narrow the scope of health insurance reform in the United States.

The 2010 legislation: content and potential impact

In this context, while the final version of the PPACA was inevitably more compromised than many reform advocates would have wished, the bill still introduced significant changes to the organisation of American health care. Most working-aged Americans employed by mid-size and large employers will continue to receive their insurance as a benefit of employment, but some potentially important changes have been made to the nature of the contract between employee and insurer. These include: allowing children to remain covered by a parent's insurance until age 26; prohibiting insurers from refusing to cover people with pre-existing illnesses; and banning insurers from imposing annual or lifetime caps on their payments for individuals. For employers, the PPACA introduced extra incentives to cover their workforce. Larger firms will face penalties if they do not offer insurance, while smaller businesses will be helped to insure workers through the use of temporary subsidies. This will mean, if not explicitly then at least in effect, that employers with over fifty workers will face a mandate to cover some of the costs of insuring their employees (Simon, 2010: 7–8).

The most explicit expansion of public coverage in the PPACA is through the Medicaid program. That program will be extended to cover all those earning less than 133 per cent of the federal poverty level. This will be a new national income standard for determining eligibility and will remove previous discretionary power held by state governments. Importantly, that eligibility will simply depend on income rather than family circumstance, meaning that single adults without children, ineligible under the old rules, will be covered.

https://doi.org/10.1017/S1474746412000048 Published online by Cambridge University Press

It will also greatly increase the numbers of low-income parents who qualify for the program. In January 2011, while many states provided coverage to pregnant women and children in households with income above the federal poverty level, eligibility levels for low-income parents were not as generous. In seventeen states, for example, eligibility for this latter group was set at below 50 per cent of the poverty level (Kaiser Commission on Medicaid and the Uninsured, 2011). The PPACA will thus bring significant change to a program that previously did 'not even cover a majority of the federally defined poverty population' (Olson, 2010: 226). The expansion is due to begin in 2014 with the Congressional Budget Office (CBO) projecting that the new rules will result in coverage for 16 million extra Americans by 2019 (CBO, 2010a). Interestingly, for the first three years the federal government will bear the extra costs involved and, after that, will pay 90 per cent of the costs that are additional to Medicaid costs that would be paid for from the current Medicaid pool. States will therefore be protected from the full expense of helping the expanded Medicaid population, but they will incur extra administrative costs and eventually some of the share of covering more people, which may cause problems for cash stricken states with a constitutional obligation to balance their budgets (Newhouse, 2010: 1415). The CBO estimates that the extra cost incurred in the expansion of Medicaid will be $29 billion in 2014, with an aggregate additional cost of $434 billion through 2019 (CBO, 2010b). This is a significant sum of money, comprising 45 per cent of the proposed new spending in PPACA (Jacobs and Skocpol, 2010: 132), but while this provoked agitated discussion amongst state officials, it was not a widely discussed part of the bill in the public arena.

The other way of expanding the insurance umbrella will be through the creation of so-called health insurance exchanges that will become operational in 2014. These will cater for people not covered by their employer or a government program. State authorities will establish the exchanges that will act as regulated insurance markets. People getting their insurance in this way will be able to choose from a variety of private insurance plans (but not, as noted above, a public option). The federal government will provide subsidies to help pay the premiums for these plans. These subsidies will be available, on a sliding scale, to people with incomes up to 400 per cent of the federal poverty level. Furthermore, insurers will be restricted in how much they can vary premiums in order that the cost is not prohibitive for people with pre-existing medical problems. The CBO predicts that, in 2019, 24 million people will get their health insurance through these exchanges (CBO, 2010b). In order to ensure that people, particularly younger and healthier individuals, take insurance rather than gamble on their medical well-being, the PPACA imposes fines that will amount to up to 2.5 per cent of taxable income or $695 in 2016. This so-called 'individual mandate' quickly became a focal point for opposition to the PPACA, with a series of legal challenges launched by to the constitutionality of forcing people to buy insurance. By January 2011, twenty-six states were involved in these challenges (Sack, 2011). The Supreme Court subsequently agreed to make a ruling on these challenges in 2012.

All these changes, however, do not mean that the US will achieve universal insurance. By 2019, it is expected that there will still be 23 million uninsured people equating to 8 per cent of the population excluding seniors (CBO, 2010b), meaning that the US will remain the only industrialised country with significant numbers of people lacking health insurance. Nor will there be any equity of access for the insured population, with insurance packages varying from those offering extensive and generous benefits to those

https://doi.org/10.1017/S1474746412000048 Published online by Cambridge University Press

covering only catastrophic costs with high deductibles for the initial stages of treatment. Many people, even with some health insurance, remain vulnerable to devastating out-of-pocket costs (Thorne and Warren, 2008). Nevertheless, assuming that the PPACA is not significantly diluted by reform, its regulations do mean that insurance will become affordable for many low-income Americans who currently struggle to find the funds for insurance coverage. Moreover, people with health problems will not live in fear of losing that insurance. It is more questionable whether the PPACA will deal effectively with the apparently inexorably rising costs in the US health care system.

Through the legislative process, the CBO's scoring of the fiscal impact of reform proposals was critical. In the end, the CBO predicted that the net impact on the federal budget of all the aspects of the PPACA would be a saving of $143 billion between 2010 and 2019 (CBO, 2010b). That is, the accumulated extra spending involved in expanding Medicaid ($434 billion), setting up the health exchanges and then subsidising premiums for those using them ($358 billion), and other commitments would be more than offset by savings generated in the Medicare and Medicaid programs ($455 billion) and extra revenues such as fees on branded drug manufacturers and insurers ($106 billion) and additional hospital insurance tax ($210 billion) (CBO, 2010c). The savings are mostly to come from changes to Medicare through cuts to the annual updates of Medicare's fee-for-service payments and reductions in monies paid to Medicare Advantage.[1] Furthermore, an Independent Payment Advisory Board is to be established. This will make recommendations to Congress for limiting Medicare spending. Congress will consider these recommendations under special rules that mean it cannot simply ignore the suggested savings.

Throughout the reform debate, Medicare proved to be a source of particular controversy. The bill did close the so-called 'doughnut hole' in the prescription drug benefit available to seniors through Medicare. When it was legislated in 2003, the prescription drug benefit incorporated a gap in coverage that left individuals using significant amounts of expensive drugs facing out-of-pocket expenses potentially amounting to $3,610 in 2010. The PPACA decreed that those who fell into the doughnut hole in 2010 were to be eligible for a $250 one-off rebate and beginning in 2011 the gap would gradually be phased out, finally being ended by 2020 (Connolly, 2010: 114−16). Interestingly, this was one reform welcomed by both the pharmaceutical industry and liberal Democrats.

With regard to cost, conservatives have argued that the cost estimates for Medicare and other items in the PPACA are unreliable. Conservatives protested that the CBO scored the plan as saving money because of the rules that bind the way the body conducts its investigations, rather than from any sense of realism (Nix, 2010: 1). Certainly, while various cost-cutting efforts have slowed the momentum of increased Medicare spending (Jacobs and Skocpol, 2010: 169–70), from 1999 to 2008 the program still grew at a rate that was 2.8 per cent per year higher than the annual growth in the rate of GDP. The question is whether it really is politically feasible to stop that growth rate, potentially incurring the wrath of seniors, or to find extra revenues to continue funding that growth (Newhouse, 2010: 1420–1).

In addition to the uncertainty about the long-term impact that the PPACA will have on the federal budget, it is also important to ask whether there is evidence that the PPACA will reduce costs for business and individuals. Speaking on 'Meet the Press', HHS Secretary Kathleen Sebelius maintained: 'Every cost cutting idea that every health

https://doi.org/10.1017/S1474746412000048 Published online by Cambridge University Press

economist has brought to the table is in this bill' (*Politics Daily*, 2010). The governing assumption behind these ideas is that modernisation of medical care delivery, bringing in greater efficiency and increasing competition between insurers, will restrain costs. For example, groups of providers are encouraged to come together to form 'accountable care organizations'. These will bring together primary and secondary care doctors as well as hospitals committed to provide co-ordinated care to a group of at least 5,000 patients in the traditional Medicare fee-for-service program for a period of at least three years. The aim is to improve efficiency by sharing information so that patients get a whole package of care rather than moving from one independent provider to another as their needs change (Guterman *et al*., 2011). In their analysis, Cutler *et al*. of the Center for American Progress, a think tank close to the Obama administration, argue that the measures included in the PPACA will reduce the growth of annual insurance premiums (Cutler *et al.*, 2010: 7).

For all these measures aimed at cost control, and reflecting the compromises made with major interests during the legislative process, the PPACA does not tackle the fundamental problems inherent in what Moran (2000) has described as the 'supply state' – that is, that the hand dealt to producers and providers is stronger than the hand held by consumers (patients) and payers (government and insurance companies). During the 1990s, there was a period when insurance companies managed to control costs but this did not last (White, 2007). And the PPACA leaves the United States vulnerable to further unmanaged rises in health care costs because, unlike many other countries that spend less than the US, it does not introduce caps on health care spending even within government programmes, or impose strenuous regulation of the services that medical experts provide and the rates that they can charge insurers (Marmor and Oberlander, 2010). While the law includes new rules designed to restrict aggregate Medicare spending, the overall enforcement mechanisms to check provider behaviour are limited. This absence of constraining measures on health care providers reflects the compromises made by the Obama administration in order to get some legislation passed. In particular, the decision to attempt to co-opt some of those stakeholders who had opposed previous efforts at comprehensive reform meant that their interests had to be accommodated (Oberlander, 2010). Once again, these remarks point to the above-discussed institutional constraints inherent to contemporary federal politics and, more specifically, health care reform in the United States.

Conclusion

The 2010 health insurance legislation is probably the most controversial social policy initiative in the United States since the enactment of the 1996 welfare reform. Indeed, the congressional voting patterns over the PPACA were marked by higher levels of partisanship than was the case with welfare reform, and opposition and legal challenges to the law continued through 2012. Yet, unlike welfare reform, which abolished a major program and replaced it with an entirely new scheme, the 2010 health insurance reform is not as radical and clear-cut in its effects, in part because it does take an incremental approach to the restructuring of a highly complex and fragmented public–private system. From this perspective, powerful institutional legacies constrained the reform process, which is consistent with the historical institutionalist perspective discussed above.

Overall, if the new law is implemented as it currently stands, then it should ensure better access to care for many of the previously uninsured and it will therefore

https://doi.org/10.1017/S1474746412000048 Published online by Cambridge University Press

reduce the health care inequities amongst Americans. Furthermore, the expansion of Medicaid and the subsidies to people buying insurance through the insurance exchanges means that government will be either directly or indirectly helping to pay for the care of a greater number of people. This should not be overstated since access and treatment levels will be far from equal, but the PPACA was the most significant measure tackling inequality in the US in a generation (Leonhardt, 2010). On the other hand, the measures to control costs look less certain and clearly established.

Importantly, as the reform will take place over nearly a decade, implementation will be crucial, while that time frame perhaps provides an opportunity for opponents to derail it through administrative and/or legislative decisions (Jacobs and Skocpol, 2010). Immediately after the bill was enacted opponents launched a series of legal challenges, alleging that aspects, notably the 'individual mandate' compelling people to buy insurance, were unconstitutional. For all the uncertainty, however, it is possible to state that this reform is a major step forward in terms of reducing the number of uninsured in American society, which is, in itself, a key policy accomplishment. Yet, partly because of the failure to enact a 'public option', controlling costs is likely to remain an unfinished business in a health care system that is already the most expensive in the world. Hence, while assessing social policy change in the United States is a difficult business (Quadagno and Street, 2006), the 2010 reform is an important yet potentially flawed milestone in American welfare state development.

Note

1 Medicare Advantage (MA) is a scheme whereby private managed care schemes, offering defined benefit packages, compete for business against traditional fee-for-service for Medicare. If people opted for MA, then Medicare pays for that plan. While designed to save money, Medicare ended up paying 'an average of $1,000 more per beneficiary per year than it costs to treat the same beneficiaries through traditional Medicare' (Angeles and Park, 2009: 1).

References

Abelson, R. (2008) 'Uninsured put a strain on hospitals', *New York Times*, 8 December.

Angeles, J. and Park, E. (2009) *Curbing Medicare Advantage Overpayments Could Benefit Millions of Low-Income and Minority Americans*, Washington DC: Center for Budget and Policy Priorities, http://www.cbpp.org/files/2-19-09health.pdf [accessed 06.07.2011].

CBO (2010a) *The Budget and Economic Outlook: Fiscal Years 2010 to 2020*, Washington DC: Congress of the United States, http://www.cbo.gov/ftpdocs/108xx/doc10871/01-26-Outlook.pdf.

CBO (2010b) *H.R. 4872, Reconciliation Act of 2010*, 18 March, http://www.cbo.gov/ftpdocs/113xx/doc11355/hr4872.pdf [accessed 06.07.2011].

CBO (2010c) *H.R. 4872, Reconciliation Act of 2010*, 20 March, http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf [accessed 06.07.2011].

Connolly, C. (2010) 'How we got there', in *Washington Post*, 'Landmark: the inside story of America's new health-care law and what it means for us all', New York: PublicAffairs.

Cutler, D., Davis, K. and Stremikis, K. (2010) *The Impact of Health Reform on Health System Spending*, Washington, DC: The Commonwealth Fund and the Center for American Progress, http://www.americanprogress.org/issues/2010/05/pdf/system_spending.pdf [accessed 06.07.2011].

https://doi.org/10.1017/S1474746412000048 Published online by Cambridge University Press

Guterman, S., Schoenbaum, S. C., Davis, K., Schoen, C., Audet, A.-M. J., Stremikis, K. and Zezza, M. A. (2011) *High Performance Accountable Care: Building on Success and Learning from Experience*, Washington, DC: The Commonwealth Fund, April.

Hacker, J. S. (1997) *The Road to Nowhere: The Genesis of President Clinton's Plan for Health Security*, Princeton, NJ: Princeton University Press.

Hacker, J. S. (2002) *The Divided Welfare State: The Battle Over Public and Private Social Benefits in the United States*, New York: Cambridge University Press.

Hacker, J. S. (2010) 'The road to somewhere: why health reform happened', *Perspectives on Politics*, 8, 3, 861–76.

Hacker, J. S. and Pierson, P. (2010) *Winner-Take-All Politics: How Washington Made the Rich Richer – And Turned Its Back on the Middle Class*, New York: Simon & Schuster.

Hunt, K. A. and Knickman, J. R. (2008) 'Financing health care', in A. R. Kovner and S. Jonas (eds.), *Jonas and Kovner's Health Care Delivery in the United States* (9th edn), New York: Springer, pp. 46–89.

Jacobs, L. R. and Skocpol, T. (2010) *Health Care Reform and American Politics: What Everyone Needs to Know*, New York: Oxford University Press.

Kaiser Commission on Medicaid and the Uninsured (2011) *Where Are States Today? Medicaid and CHIP Eligibility Levels for Children and Non-Disabled Adults*, http://www.kff.org/medicaid/upload/7993-02.pdf [accessed 06.07.2011].

Leonhardt, D. (2010) 'In Health Bill: Obama attacks wealth inequality', *New York Times*, 23 March.

Marmor, T. R. and Oberlander, J. (2010) 'The Health Bill explained at last', *New York Review of Books*, 19 August.

Moran, M. (2000) 'Understanding the welfare state: the case of health care', *British Journal of Politics and International Relations*, 2, 2, 135–69.

Morris, C. (2006) *Apart at the Seams: The Collapse of Private Pension and Health Care Protection*, New York: The Century Foundation Press.

Newhouse, J. (2010) 'Assessing health reform's impact on four key group's of Americans', *Health Affairs*, 29, 9, 1714–24.

Nix, K. (2010) 'Top 10 disasters of Obamacare', Heritage Foundation Web memo, http://thf_media.s3.amazonaws.com/2010/pdf/wm_2848.pdf [accessed 06.07.2011].

Obama, B. (2009a) 'Remarks of President Barack Obama – as prepared for delivery address to joint session of Congress', Office of the Press Secretary, The White House, Washington, DC, 24 February.

Obama, B. (2009b) 'Remarks by the President to a joint session of Congress on health care', Office of the Press Secretary, The White House, Washington, DC, 9 September.

Obama, B. (2010) 'Remarks by the President in State of the Union Address', Office of the Press Secretary, The White House, Washington, DC, 27 January.

Oberlander, J. (2010) 'Long time coming: why health reform finally passed', *Health Affairs*, 29, 6, 1112–16.

OECD (2010) *OECD Health Data for 2010*, Directorate for Employment, Labour and social Affairs, http://www.oecd.org/document/16/0,3343,en_2649_34631_2085200_1_1_1_1,00.html [accessed 06.07.2011].

Olson, L. K. (2010) *The Politics of Medicaid*, New York: Columbia University Press.

Pierson, P. (1994) *Dismantling the Welfare State? Reagan, Thatcher, and the Politics of Retrenchment*, New York: Cambridge University Press.

Politics Daily (2010) 'HHS Secretary Kathleen Sebelius on NBC's Meet the Press', 7 March, http://www.politicsdaily.com/2010/03/07/hhs-secretary-kathleen-sebelius-on-nbcs-meet-the-press/ [accessed 06.07.2011].

Quadagno, J. (2005) *One Nation Uninsured: Why the US Has No National Health Insurance*, New York: Oxford University Press.

Quadagno, J. and Street, D. (2006) 'Recent trends in US social welfare policy: minor retrenchment or major transformation?', *Research on Aging*, 28, 3, 1–14.

Sack, K. (2011) 'Federal Judge rules that health law violates constitution', *New York Times*, 31 January.

https://doi.org/10.1017/S1474746412000048 Published online by Cambridge University Press

Simon, K. (2010) *Implications of Health Care Reform for Employers*, Washington DC: Center for American Progress, http://www.americanprogress.org/issues/2010/05/pdf/health_employers.pdf [accessed 06.07.2011].

Skocpol, T. (1996) *Boomerang: Clinton's Health Security Effort and the Turn against Government in US Politics*, New York: W. W. Norton.

Streeck, W. and Thelen, K. (eds.) (2005) *Beyond Continuity: Institutional Change in Advanced Political Economies*, Oxford: Oxford University Press.

Street, D. (2008) 'Balancing act: the public–private mix in health care systems', in D. Béland and B. Gran (eds.), *Public and Private Social Policy: Health and Pension Policies in a New Era*, Houndmills, UK: Palgrave Macmillan, pp. 15–44.

Steinmo, S. and Watts, J. (1995) 'It's the institutions, stupid! Why the United States can't pass comprehensive national health insurance', *Journal of Health Politics Policy and Law*, 20, 2, 329–72.

Thorne, D. and Warren, E. (2008) 'Get sick, go broke', in J. S. Hacker (ed.), *Health at Risk: America's Ailing Health system and How to Heal It*, New York: Columbia University Press, pp. 66–87.

Urbina, I. and Seelye, K. (2009) 'Senator goes face to face with dissent', *New York Times*, 11 August.

White, J. (2007) 'Markets and medical care: the United States, 1993–2005', *The Milbank Quarterly*, 85, 3, 395–448.

https://doi.org/10.1017/S1474746412000048 Published online by Cambridge University Press