

The Affordable Care Act and the Politics of Universal Coverage

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Abstract

In the United States, Universal coverage has long been a key objective of liberal reformers. Yet, despite the enactment of the Patient Protection and Affordable Care Act (PPACA) in 2010, the United States is not set to provide health care coverage to all, even if and when that reform is fully implemented. This article explores this issue by asking the following question: why was a clear commitment to universal coverage, the norm in other industrialized countries, excluded as a core objective of the PPACA and how has post-enactment politics at both the federal and the state level further shaped coverage issues? The analysis traces the issue of universal coverage prior to the debate over the PPACA, during the 2008 presidential race, and during consideration of the bill. The article then looks at the post-enactment politics of coverage, with a particular focus on how states have responded to the planned use of the Medicaid programme to expand access to care. The article concludes by discussing how an explanation of the limits of the PPACA, in terms of both its commitment to universal coverage and, more importantly, the failure to provide comprehensive health insurance to all, requires an understanding of complex institutional and policy dynamics.

Keywords

Patient Protection and Affordable Care Act; Obamacare; health insurance; universal coverage; politics; United States

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The unique nature of the United States' health care system in the industrialized world is well-known, with the country relying much more heavily on the private sector, especially in terms of funding access to care, than elsewhere. This includes liberal welfare regimes such as Australia, Canada, and the United Kingdom (Street 2008), which all have forms of government supported universal access to health care. In the United States, the hybrid public-private health care system has long faced severe problems making the issue of health care reform a recurring feature on the political agenda with a series of presidentially-driven efforts to bring about comprehensive change, which concern both cost control and insurance coverage (Blumenthal et al. 2009). But agreement that there is something wrong has not translated easily into consensus on how to put things right. There have been some important policy innovations, most notably the establishment in the mid-1960s of the Medicare and Medicaid programs (Marmor 2000), but reformers advocating publicly-guaranteed universal health coverage have been continually thwarted. So, in the spring of 2010 when President Obama signed the Patient Protection and Affordable Care Act (PPACA), a major piece of health care reform, into law it was, as Vice President Biden expressed it, a 'big deal'. Yet, although the PPACA is by far the most ambitious health care reform enacted in the United States since Medicare and Medicaid, this reform stops short of guaranteeing universal health coverage. Indeed, the limits of the original legislation were tightened by the June 2012 Supreme Court decision that undermined the expansion of Medicaid so central to the coverage side of the PPACA (Waddan 2013).

The initial estimates of the PPACA's impact never claimed that the law, even if faithfully implemented, would lead to universal coverage. At the time of passage, the

Congressional Budget Office (CBO) predicted that over 30 million Americans would gain insurance coverage one way or another, but this would still have left about 23 million people uninsured in 2019. Overall, the CBO (2010) projected that 92 percent of the non-elderly population would be insured, or 95 percent, if undocumented immigrants were excluded from the calculation. Hence, while the PPACA did set out to reshape the American health care system to give greater access to health coverage to many lower-income households, it was nevertheless clear that the US would still have more people without guaranteed health coverage than in any other industrialized nation. Furthermore, as it became evident that many state governments were refusing to co-operate with the implementation of the law, the CBO increased its estimate of the likely number of uninsured in 2019 from 23 to 29 million (CBO 2013).

This paper explores the politics of coverage surrounding the PPACA before, during, and after its enactment in the spring of 2010. We ask the following question: why was a clear commitment to universal coverage, the norm in other industrialized countries, excluded as a core objective of the PPACA and how has post-enactment politics at both the federal and the state level further shaped coverage issues? To begin, we briefly characterize the absence of universal coverage within the ACA and several potential explanations for this outcome. Next, we specify the data and methods we used in our analysis. We present our results, tracing the issue of universal coverage prior to the debate over the PPACA, during the 2008 presidential contest, and during consideration of the bill. We then look at the post-enactment politics of coverage, with a particular focus on how states have responded to the planned use of the Medicaid programme to expand access to care. The paper then discusses how an explanation of the limits of the PPACA, in terms of both its commitment to universal coverage and, more

importantly, the failure to provide comprehensive health insurance to all, requires an understanding of complex institutional and policy dynamics.

How Universal is Coverage Under the ACA?

In their early assessment of the likely implications of the PPACA, Jacobs and Skocpol (2010: 120) reflect that the law ranked as ‘one of the most important pieces of social legislation since Social Security, Civil Rights, and Medicare. It promised to put the United States on a new path—toward affordable health care for all Americans’. Furthermore, the re-election of President Obama in 2012 meant that the law would not be repealed. Yet, however momentous the passage of the law, there are several key indicators, which were inherent to the methods used to expand insurance coverage, which suggest the limits of its coverage. By universal coverage, we mean a system that covers all citizens, as is the case in countries with welfare states as different as Canada, Denmark, Sweden, and the United Kingdom (Béland et al., 2014; Marchildon, 2014). For us, universal health coverage must include *everyone*, which means it is not a matter of degree. In other words, coverage is universal, or not. Beyond the fact that all citizens should be covered, a certain level of uniformity is necessary for a system to qualify as universal, even if this level of uniformity varies from country to country (Béland et al., 2014).

In the case of the United States, there are several important considerations we must keep in mind. First, eligibility for benefits under the PPACA remains highly segmented (Figure 1). The law does not radically change the manner in which most Americans accessed health care as it assumes that most working-aged Americans employed by mid-size and large employers continue to receive their insurance as a benefit of employment, despite the evidence of the declining efficacy of that insurance model (Gottschalk 2007; Morris 2006).

The law did in fact contain incentives aimed at getting employers to cover their workforce. Larger firms face penalties if they do not offer insurance while smaller businesses are helped to insure workers through the use of temporary subsidies (Simon 2010: 7-8). In early July 2013, however, the implementation of the so-called employer mandate was abruptly pushed back from 2014 to 2015 (Calmes et al. 2013).

Second, the PPACA relied heavily on means-testing in determining who it would help get coverage. By 2019, according to the CBO's 2010 initial projections, 24 million people would get their health insurance through state or federally run exchanges, which acted as regulated insurance markets (CBO 2010). These began in 2014 and cater to people not covered by their employer or a government programme. The PPACA provides for the federal government to subsidize people to help pay the premiums for qualified health plans, thereby again expanding, if indirectly, its role as a payer for care. These subsidies are available, on a sliding scale, to people with an income of up to 400 per cent of the federal poverty level. Importantly, and extending government intervention in the insurance market, insurers are restricted in how much they can vary premiums in order that the cost is not prohibitive for people with pre-existing medical problems (Marmor et al. 2010). State governments were initially tasked with establishing the exchanges; however, in states that failed to implement the exchanges, the federal government had to step in and do the job. People getting their insurance through exchanges are able to choose from a variety of private insurance plans, but in contrast to some early versions of reform plans, the final PPACA did not provide a public insurance option. If the exchanges functioned as they were designed in the PPACA, they would see the government acting in a manner that significantly reduced the number of

Americans without access to health insurance. Again, however, this government largesse would be distributed on an income-tested basis.

Figure 1 about here

Third, while there were additional measures within the law that explicitly expanded coverage and the role of government as a payer through the Medicaid programme, the nature of those benefits varies significantly across the states. Under the PPACA's Medicaid expansion, everyone with an income of less than 138 per cent of the federal poverty level became eligible for the programme, if their state supported the expansion of the programme. This expansion, which began in 2014, was to be funded by the federal government for the first three years. After that initial period, the federal government would pay 90 per cent of the additional Medicaid costs resulting from the new rules, but this was a still a considerably better deal for the states than the cost sharing arrangements between the federal and state governments that characterised the existing Medicaid programme. In addition to the incentives contained in this package, states were to be 'persuaded' of the virtues of this plan by the threat that they would lose all federal Medicaid funding if they did not sign on to the new rules. According to the Congressional Budget Office (2010), this change would result in coverage for an additional 16 million Americans by 2019.

Clearly, therefore, the Medicaid expansion represented a significant increase in the federal government's commitment to paying for health insurance for millions of Americans. Furthermore, the change was not simply one of scale. In promising to cover *everyone* below the threshold, Medicaid would judge people only according to their income, rather than also testing their deservingness. *Yet* if this latter point edged Medicaid somewhat away from

being a welfare programme that made judgments about why people were poor, it would still be reliant on means testing, and so remained far from being universal in design or principle.

Fourth, the PPACA also introduced new regulations for the insurance industry designed to facilitate access to insurance coverage and to prevent insurers from discriminating against ‘bad risks’. One aspect of the law that was quickly implemented and hailed as a success, children will be allowed to remain covered by their parents’ insurance until age 26 (Langmaid 2011). Also, various means by which insurers might attempt to avoid insuring or limiting their liability for particular individuals were prohibited. For example, insurers can no longer refuse to cover people with pre-existing illnesses and cannot impose annual or lifetime caps on their payments for individuals. These were important measures but reflect the segmented nature of how people received health coverage. Finally the PPACA required that individuals pay for insurance rather than gamble on their medical well-being. Yet this excludes particular groups and centres on fines which, while they increase over time, are still cheaper than the cost of purchasing insurance (Roy 2012). In September 2012, the CBO estimated that 6 million people would pay a penalty under the mandate in 2016 (Baker 2012), simultaneously both undermining the concept of collectivizing risk and meaning that these people themselves would remain uninsured.

Explaining the Absence of Universal Coverage in the ACA

There has been much scholarly attention devoted to the question of why the US developed such an exceptional health care system, with its comparatively limited level of government intervention and an absence of universal coverage. For some, it stems from cultural preferences, national values, and ‘American exceptionalism’ (Ladd 1994; Lipset 1996), or at least is a reflection of how Americans have been sceptical of comprehensive government

interference at critical points in time in the evolution of health policy (Jacobs 1993). Others emphasise the power of vested interests opposed to government activity (Kirkman-Liff 1997), while another school of thought brings the divisive issue of race to the fore (Boychuk 2008). Yet the predominant set of explanations has focused on the distinctive quality of American governing institutions (e.g. Steinmo and Watts 1995). The literature on institutions and health policy suggest three potential explanations for the absence of universal coverage we see in the case of the ACA. These explanations are not mutually exclusive, yet each stands to reveal distinctive relationship between American politics and the lack of universal coverage in the ACA.

Partisan competition: Most significant attempts to expand health insurance coverage in the United States have emerged from highly partisan policy battles (Kriner and Reeves 2014). Especially when electoral competition is intense, parties have incentives to formulate policies and coalitions in a short amount of time (Barrilleaux et al. 2002). By the same token, partisan electoral competition can create additional hurdles for bipartisan policymaking, given that minority parties have little incentive to give the majority a policy victory to celebrate in the next election (Lee 2009). These twin patterns push parties to adopt policy proposals that are essentially incremental in nature. For instance, some accounts of the PPACA note that, among other factors, electoral pressure may have affected the willingness of Democrats to bargain with key stakeholders on the terms of health reform (Jacobs and Skocpol 2010). Partisan competition can also shape post-enactment politics, as turnovers in control of government can lead to policy reversals (Berry et al. 2010).

Institutional fragmentation: While governing institutions in the US are relatively open to new policy ideas, the process for policy enactment and implementation is highly fragmented,

with numerous veto points at which opponents of reform can mobilize against it (Immergut 1992; Steinmo et al. 1995). As a result, policies representing a significant move away from the *status quo* are often difficult to enact. A move towards universal health insurance in a system characterized by a strong reliance on private benefits like the US could thus be seen as politically risky (Hacker 2002). Institutional fragmentation can also shape policies once they are enacted, by giving opponents of major reform the opportunity to scale back initial gains—either by litigating in the courts or blocking implementation in federal agencies or in the states (Béland et al. 2016). In the case of the ACA, the durable legacy of state-level management of key public programmes, notably the Medicaid programme, could have contributed to the absence of universal health coverage (Thompson 2013).

Policy Packages: Reforms like the PPACA are defined by their complexity. A policy idea that gained popularity among health reformers in the US during the years leading up to health reform was that of the “triple aim,” that improvements in cost, access, and quality would need to be undertaken together (Berwick et al. 2008). The heterogeneity in reform ideas has brought together diverse coalitions (Oberlander 2010). At the same time, however, it has meant that ideas that are appealing to a majority coalition may not always be packaged with others that are equally appealing. In fact, the ideas endorsed by a majority coalition at time t may depend on how they were packaged together at time $t-1$ (Weir 1992). During debates over the PPACA, expanding coverage was an important policy idea, but it was hardly the only one (McDonough 2011). Moreover, while universal coverage was appealing to liberal proponents of health reform, it was also hitched to other reform ideas, such as radically reforming service delivery within Medicaid and employer-sponsored health (Lane 2009).

Data

To explore these three explanations for the absence of universal coverage in the PPACA, we drew on analyses of key documents from the period prior to policy enactment (2007-2008); the two years in which health reform was formally considered by Congress (2009-2010); and the five years since enactment (2010-2015). We chose these sources because they allow us to explore specific dimensions of the ACA's design that affect the scope of coverage, including the role of individual subsidies and requirements related to employer-sponsored insurance; the availability of a public insurance plan; and the expansion of Medicaid. For the pre-enactment period, we reviewed policy statements made during the 2008 presidential elections (n=5). During the enactment period, we reviewed key bills considered by Congress (n=8) that express a variety of positions on key dimensions of universal coverage (Cannan 2013). We also review coverage projections for several major proposals (n=7). Finally, during the post-enactment period, we review state decisions on the Medicaid expansion (n=50) and state applications and approvals for waivers of Medicaid provisions under Section 1115 of the Social Security Act (n=5).¹ Detail on the sources used is provided in the Appendix, Table A1.

To structure our analysis of these sources, we considered four empirical implications of the three explanations (see Table 1 for summary). First, each of the explanations implies a different level of Democratic support for universal coverage prior to enactment of the policy. Whereas the institutional fragmentation and partisan competition explanations assume that Democrats are relatively unified in their support of universal coverage pre-enactment, the policy packages explanation suggests that—because universal coverage may be hitched to other policy ideas not preferred by Democrats—it may be incorrect to assume support for

universal coverage *ex ante*.

Table 1 about here

A second implication concerns how universal coverage fits with other key pieces of the legislation. In the policy packages explanation, plans for more extensive coverage are packaged with ideas that are unacceptable to Democratic leaders. By contrast, the other explanations assume that plans with greater coverage are also largely agreeable to Democrats on other dimensions.

Third, there are different expectations for when Democrats should reject proposals for universal coverage. Because the institutional fragmentation explanation assumes that limits to universality will emerge as the result of bargaining, alternatives to universal plans should only emerge after clear veto threats emerge and not beforehand. By contrast, both the partisan competition and policy packages explanations imply that Democratic leaders will adopt more limited forms of coverage, even if veto threats do not emerge. In both cases, this is because leaders are seeking to craft legislation that is appealing to a large majority of the Democratic caucus and will not invoke clear electoral punishments.

Finally, the explanations imply different findings about post-enactment reductions in coverage. Whereas the institutional fragmentation explanation would suggest that significant reductions in coverage could occur through legal challenges to the law and the implementation process, both the partisan competition and policy packages explanations would assume that the universality of coverage is largely shaped earlier in the legislative process.

Results

In this section we consider the four empirical implications of the three explanations described

above. We begin by characterizing Democratic positions on health reform prior to the consideration of the PPACA. Next, we consider the combination of universal coverage with other key features of the reform. We then consider evidence on the timing of Democratic reform proposals. Finally, we address limits to coverage that emerged after policy enactment.

Pre-Enactment Positions on Universal Coverage

Carefully reviewing the state of play on universal coverage prior to the consideration of the PPACA in 2009 and 2010 reveals the absence of a strong commitment to universal coverage among Democrats. Given the history of legislative failure and political disrepute associated with President Clinton's effort at comprehensive health care reform, it was not at all certain that the next Democratic president would attempt to introduce significant change in this issue area and, perhaps, bring about universal coverage. Neither of the Democratic nominees in 2000 or 2004 had featured the issue in their platforms, but Hillary Clinton did push health policy reform to the front of the political agenda in her campaign for the Democratic presidential nomination in 2008. At one point, she declared that her commitment to major reform was the most important difference between her candidacy and Barack Obama's. Obama responded by stressing that he too would make health care affordable for all Americans, though even during the general election campaign he remained cautious about specific aspects of how this would be done (Jacobs et al. 2010: 34-8). This was the case concerning 'the notion of an "individual mandate" that would require all Americans, in due course, to have insurance' (Jacobs et al. 2010: 36). Forcing healthy people who could afford to buy insurance to actually do so was an important way of collectivizing risk as their premiums would help keep down costs for the less healthy. Obama understood this, but worried that this type of compulsion would be hugely unpopular and his campaign even went

as far as to attack Clinton's plans for a mandate in the primary campaign (Brill 2015: 45). In fact, candidate Obama never pledged that, if enacted, health care reform would actually bring about universal health insurance coverage in the United States.

A further institutional factor limiting the possible scope of reform concerned the issue of what was to be reformed. The option of a dramatic switch to a single payer system, which would have sent a distinctive message that the purpose of reform was to provide a universal and relatively equitable health system, was never seriously considered. Dismantling the existing health care apparatus was seen as almost impossible due to existing policy legacies (i.e., the weight of private insurance actors and interests within the health system), meaning that reform had to build on the inefficient mix of private and public programmes already in place (Jacobs et al, 2010: 66-75).

The lack of a strong and explicit commitment to universal coverage among Democrats constituted a sharp contrast with the Clinton era, during which universal coverage appeared as a core, explicit objective of President Clinton's Health Security proposal (Skocpol 1997: 60). In his 1994 State of the Union address, Clinton famously declared that he would veto any reform devised by Congress that did not 'guarantee every American private health insurance that can never be taken away' (Ifill 1994). As the next section suggests, disunity among Democrats on universal coverage during the 2008 campaign may have something to do with the way that various dimensions of that coverage were packaged together in pre-existing legislative proposals.

Packaging Universal Coverage: Individual and Employer-Sponsored Coverage

Despite the absence of a single-payer option from the discussion, a significant feature of how the debate over health reform evolved during and after the 2008 campaign is that policy ideas

supporting a more comprehensive level of coverage were scattered between proposals made by both major parties. Under Obama's plan, individuals without employer-sponsored insurance would be eligible for premium subsidies in the form of tax credits—on a progressive sliding-scale—which they could use to buy private or public plans on newly created insurance marketplaces (Commonwealth Fund, 2008).

Yet while new subsidies and exchanges would help to address the problem of those currently uninsured, both Obama's plan and the Democratic platform maintained a highly segmented approach to insurance coverage, insisting that families and individuals “have the option of keeping the coverage they have or choosing from a wide array of health insurance plans, including many private health insurance options and a public plan” (2008 Democratic Party Platform). Increasing employers' responsibility for providing health insurance was based in part on the understanding that the *status quo* for most Americans did not require a remedy. As David Cutler, a Harvard economist and senior advisor to Obama, argued in a *Health Affairs* article,

Most employers that provide coverage are already providing good coverage. They would be unaffected by the Obama plan — although their costs would fall. Those that cannot afford to provide good care would have new options — an insurance exchange with good choices, lower costs, and basic guarantees (Cutler 2008).

In addition to subsidizing the individual purchase of health care for those with inadequate employer coverage, Democrats suggested increasing access to health care by expanding Medicaid (2008 Democratic Party Platform). As a means-tested programme, Medicaid by definition serves the least well off. Yet as of 2008, no two states had the same rules and regulations with regard to the running of their Medicaid programmes. For example, prior to

the PPACA, Minnesota allowed parents of dependent children with incomes up to 215 per cent of the federal poverty line (FPL) access to Medicaid. In contrast, neighbouring South Dakota, which was not the least generous state, had eligibility levels at 50 per cent of the FPL (Kaiser Commission on Medicaid and the Uninsured 2013a). On the other hand, Medicaid incrementally has increased its levels of coverage, even during the 1980s, with Republican presidents in office (Jaenicke and Waddan 2006). In turn, this led some reformers to see Medicaid as a vehicle for expanding health care coverage to the uninsured rather than looking to Medicare as the model to follow (Grogan and Patashnik 2003).

Republicans, on the other hand, did not endorse specific subsidy levels, a public option, or Medicaid expansion. Yet, in contrast to the Democratic plan, Republicans did include a transition away from employer-based insurance. To do so, they borrowed elements of the Healthy Americans Act, a bipartisan bill drafted by Sens. Ron Wyden (D-OR) and Bill Bennett (R-UT) in 2007 and supported by a bipartisan group of six Democrats and six Republicans (Klein 2008). The Wyden-Bennett plan (see Table 2) supported replacing employer-sponsored coverage with an individual mandate and generous tax credits and subsidies to enable individuals to purchase insurance (Wyden and Bennett, 2009). Moreover, Wyden-Bennett replaced Medicaid with free private coverage to individuals living at less than 100 percent of the federal poverty level (FPL). While Republicans did not include the individual mandate, generous subsidies, or the same approach to Medicaid reform, they did support removing employers from the equation, suggesting that ‘the current tax system discriminates against individuals who do not receive health care from their employers, gives more generous health tax benefits to upper income employees, and fails to provide every

American with the ability to purchase an affordable health care plan’ (2008 Republican Party Platform).

Thus, by the time health reform was being debated, one core element of a more inclusive approach to coverage—transitioning away from employer-sponsored insurance—was linked to policy proposals most Democrats found unappetizing, and remained separate from other important elements of coverage expansion, including a public option and Medicaid expansion (Table 2). Early Democratic proposals from the Senate Health, Education, Labor, and Pensions (HELP) Committee and a trio of House committees tended to adopt the Democratic platform approach, blending individual subsidies, a public option, and Medicaid expansion, but maintaining the employer-based system—albeit with new contribution requirements for large employers. By contrast, Republican plans such as those authored by Rep. Paul Ryan (R-WI) and by Sen. Tom Coburn (R-OK) kept the Wyden-Bennett approach to dismantling employer-sponsored insurance—but failed to include the same approach to subsidies or Medicaid reform that would have allowed for major coverage expansions and a near elimination of the employer-sponsored insurance system (see Figure 2).

Table 2 about here

Despite bipartisan support for moving away from employer-sponsored insurance, and projections that Wyden-Bennett would significantly reduce the number of uninsured compared to other Democratic and Republican proposals (see Figure 2), Wyden-Bennett was eliminated early in the legislative process. In the summer of 2009, liberal interest groups in Wyden’s home state of Oregon complained that he was ‘joining forces with [Republicans] to try to scuttle health care reform’ (Falcone, 2009). The President also criticized the Wyden-

Bennett plan, suggesting that ‘families who are currently relatively satisfied with their insurance but are worried about rising costs ... would get real nervous about a wholesale change’ (Lane, 2009). Indeed, it would appear that—despite the potential for increasing coverage by eliminating employer-sponsored insurance—it failed to attract liberal support due to the other policies in the Wyden-Bennett package.

Figure 2 about here

Timing, the Public Option, and the Individual Mandate

Whereas reforms of employer-sponsored insurance struggled due to policy packaging effects, our analysis of timing suggests that institutional fragmentation helped to demolish the public option, while partisan competition undermined the strength of the individual mandate. The public option was an idea developed by academics and left-leaning think tanks that advocated allowing the federal government to sell health insurance directly to individuals in competition with private insurers. For supporters and critics alike, the public option was a ‘Trojan horse for a single-payer plan’ (Brasfield 2011: 458), and debate about its merits became increasingly contentious during 2009. That summer saw impassioned protests against reform fuelled by the emerging Tea Party movement (Urbina 2009), which emboldened opponents of reform as the administration, and Democrat leaders in Congress, appeared to have lost control of the ideological discourse. Nevertheless, the evidence in Table 2 shows that the public option survived throughout the duration of the fight in the House of Representatives, and was ultimately included in the House-passed legislation.

Given that a majority of House Democrats voted in favour of the public option, the party competition explanation—which suggests that partisan pressure for short-term victories

blocked universal coverage in the PPACA—is incomplete. In fact, examining institutional fragmentation sheds greater light on this provision. In 2009, the Democrats had a 257 to 178 majority in the House, meaning that some House Democrats could stray. As well, and crucially, at the end of 2009, the party had 60 votes in the Senate. This was so vital because heightened partisanship in Congress since the early 1990s meant that any Republican support was always extremely unlikely (Sinclair 2006). It was also key because, the extensive use of the filibuster meant that 60 votes had become the marker for legislative success in the Senate (Wawro and Schickler 2006). Even so, it was vital to retain all 60 Democratic coalition votes in the Senate, in order to prevent potential GOP filibusters. This was always highly problematic for the public option, given the objections of a number of Senate Democrats, and critically of the Independent Joe Lieberman of Connecticut. The Senate’s organization and procedures, in effect, gave a small number of Senators individual veto power. And even though the president expressed support for the principle he was, in the end, willing to let it die to secure passage of the bill in the Senate (Personal interview with Democratic congressional staffer, August 2010).

The public option episode is highly instructive. First, it illustrates in detail the ever-present intricacies of the pivot points in the legislative process with so much depending on the actions of a small number of lawmakers, a situation related to the absence of UK-style party discipline. And second, it shows how even in the 2009 version of the Democratic Party, there were sceptics about how far the government should intervene in the health care marketplace. In the end, therefore, conservative opposition did not stop reform, but the legislative endgame, which necessitated prioritising the measures in the Senate rather than House version of reform, meant that some of the more liberal ideas in the latter’s original

bill, which ‘included a (limited) public option, more generous benefits, more extensive national administration, and higher taxes on the privileged’, were excluded in the final law (Jacobs and Skocpol 2010: 72-3).

By contrast, the scaling back of the individual mandate did not emerge after veto threats. Rather, it emerged after “focus groups and internal polls” conducted by Democrats revealed public fears that health insurance would remain unaffordable and that under both House and Senate bills, those who did not comply with the mandate would face “a year in jail, penalties up to \$1,900 per family, and garnishment of wages” (Chaddock 2009). As a result, Sen. Charles Schumer (D-NY) proposed an amendment to legislation in the Senate Finance Committee, which weakened penalties for uninsured Americans—making numerous exemptions to penalties for those who could not find a plan with a premium less than 8 percent of their adjusted gross income and eliminating criminal penalties on insured people not eligible for a waiver during the first year of the new law (Pear and Calmes 2009). The result of the amendment, which passed on a 21-1 margin, was that 2 million fewer uninsured Americans would not be covered by the reform (CBO 2009). To many in the Obama administration, the weakening of the mandate placed the reform’s coverage expansion in jeopardy (Brill, 2015: 126). Yet, as the Finance’s Committee’s vote on the Schumer amendment shows, Obama was correct to predict that a tough mandate would be politically unpopular.²

Changes in Coverage after Enactment

Five years after the passage of the law it is evident that its various parts led to a significant reduction in the number of uninsured, but that a greater number of Americans would remain

uninsured than had been initially projected in the spring of 2010, meaning that the country's health care system would fall short of providing universal coverage. In September 2015, the Census Bureau reported that 10.4 per cent of people in the US—33 million people—were uninsured at the end of 2014, which was a significant drop on 41.8 million in 2013 (Radnofsky 2015). According to an HHS analysis, between October 2013 and September 2015 'the uninsured rate for African Americans declined by just over 10 percent, for Hispanics it declined 11.5 percent and for whites the rate declined by 6 percent' (Carey 2015). Furthermore, HHS Secretary, Sylvia Burwell promised that, beginning in November 2015, there would be a concerted effort to reach out to eligible individuals not yet participating in the insurance exchanges. Secretary Burwell did, however, also acknowledge that some people would still be hard pressed to afford insurance even taking into account the subsidies available through the exchanges (Carey 2015).

Institutional fragmentation helps to account for the emergence of further limits to universality during the post-enactment period. One unexpected problem for the administration was that over half the states had decided against running their own exchanges, leaving it to an underprepared federal government to organize the exchange in the different states (Kliff 2013). Additionally, all small group and individual insurance packages were to cover a selection of 'essential health benefits' but the law did not define what these were, leaving this for HHS. Furthermore, and illustrative of the complexities of devising uniform standards to cover the wide variety of ways in which insurance is organized, only a year after enactment, authorities had over 1,400 waivers that allowed health plans to provide maximum levels of coverage that fell below the minimum mandated in the PPACA (Pear 2011). Similarly, as a result of pressure from employers during the regulatory review process, the

Obama administration twice delayed implementation of the employer mandate; this increased the number of individuals eligible for premium tax credits, yet it significantly undermined the PPACA's reliance on existing, employer-sponsored insurance as a means of expanding access to coverage (Jost 2013; Jost 2015). While these were important matters in terms of the levels of insurance coverage people receive, there were even more fundamental developments with regard to whether people would actually receive the health coverage apparently promised by the PPACA at all.

By 2015, the federal government was much better equipped to run the exchanges, but states' lack of co-operation extended to other areas. In particular, and with a real impact on individuals' access to health cover, there was widespread resistance to the Medicaid expansion, which had been predicted to cover 16 million people by 2019 (CBO 2010). The framers of the PPACA had not anticipated this resistance. They had assumed that the carrot of federal dollars to pay for the newly eligible Medicaid recipients, coupled with the stick of the threat of withdrawal of existing federal Medicaid money if states did not expand their programmes, would mean that all states would comply. Instead, the Supreme Court's June 2012 ruling in the case of the *National Federation of Independent Business versus Sebelius*, which brought together the different constitutional challenges made against the PPACA, challenged the very idea behind the PPACA's Medicaid expansion. The headline case made against the law concerned the individual mandate, which was ruled constitutional by a 5 to 4 majority. Thus, the immediate interpretation of the ruling was that the administration had triumphed. But the Court's decision also gave considerably greater credibility to challenges to the Medicaid expansion than constitutional experts had predicted. The Court ruled that the PPACA's requirement that states participate in the expansion or lose all their current federal

Medicaid funding was too great an exertion of federal government power (Landers 2012). With this, the Court empowered opponents of the PPACA significantly, giving the states a real choice about whether to participate in Medicaid expansion or not. In James Morone's (2012) pithy phrase, 'Stingy states may choose to stay stingy'. Morone's comment reflects the fact that there was considerable variation in how states, prior to the PPACA, defined Medicaid eligibility. While Medicaid is often described as a programme for the poor, less than half of non-elderly Americans living in households with an income below the federal poverty level were covered prior to the PPACA (Kaiser Commission on Medicaid and the Uninsured 2013b).

When the expansion formally came into effect in January 2014, 24 states did not participate. Although it is important to take factors other than partisanship into account when explaining these states' decision (Béland et al. 2016), the results of the 2010 elections, which significantly increased Republican representation in state legislatures and saw an increase in the number of states with Republican governors, meant that the PPACA was being implemented in a politically hostile environment in many states. By September 2015, the carrot of new federal dollars, along with some flexibility from the federal government in allowing state waivers to deviate from the original rules of the PPACA, meant that the number of states that decided not to participate in the expansion had dropped to 19. That said, the deviations involved in these waivers invited further segmentation of Medicaid benefits and in some cases included significant limitations on benefits as well as requirements for premium contributions and co-payments that did not exist in states that had accepted the Medicaid expansion (see Table 3).

The 19 states not taking the expansion or the waivers included Florida, Texas, and Georgia with over 1.2 million, 1.1 million and 680,000 residents, respectively, who would have been eligible for Medicaid but who were likely to remain uninsured (Families USA 2015). Because lawmakers had expected Medicaid to cover people with incomes below the poverty level, there was no alternative provision in the PPACA to cover poor households who would not come under the Medicaid umbrella. This meant that people with incomes below the poverty level were not eligible for the subsidies to get insurance through an exchange, which were reserved for people with incomes from 100 per cent to 400 per cent of the poverty line. Thus, while millions of people did gain new health coverage under Medicaid expansion, the combination of the Supreme Court decision in 2012 and the resistance of many states to the expansion meant that five years after the law's enactment millions more people remained uninsured than had been anticipated.

Table 3 about here

Discussion

Based on the above analysis, it is clear that the absence of universal coverage in the ACA cannot be explained by one single factor. This is the case because the lack of universal coverage is the product of a series of policy decisions that each necessitates a distinct explanation. The best way to show this is to systematically return to the three alternative explanations discussed above:

Partisan competition: this provides the strongest compelling explanation of the weakening of the individual mandate. The Senate Finance Committee abandoned a stronger mandate only after receiving information about the potential political consequences of imposing strong punishments on individuals who could not afford insurance. By contrast, partisan

competition does not explain the emergence of other limits to universal coverage. For instance, the fact that House and Senate Democrats supported the public option is not consistent with the claim that partisan pressure blocked universal coverage in the PPACA. In fact, from a partisan standpoint, however, what is perhaps the most striking is the scope of the policy divisions within the Democratic camp, which did not strongly unite around shared reform ideas such as universality. These divisions made threats of Senate filibusters a significant part of the debate over the public option. The strong impact of the 2010 state elections on PPACA implementation suggests does illustrate the importance of partisan control of different levels of government in post-enactment politics, but at the same time, there is strong evidence that post-enactment struggles in the states over Medicaid coverage are not just about partisan competition (Béland and al. 2016).

Institutional fragmentation: this explanation is more useful than partisan competition to account for a number of decisions leading to the lack of universal coverage that characterizes the PPACA. For instance, institutional fragmentation largely explains the death of the public option (in this case the 60 vote requirement in Senate and the lack of a means for the Senate Democratic leadership to enforce discipline on its caucus), which could have helped bring move the health care system in the direction of a single-payer model, over time. Institutional fragmentation related to the politics and the policy legacies of federalism also helps explain the advent of further limits to the extension of coverage during the post-2010 implementation period.

Policy Packages: this explanation about the articulation of reform ideas into discrete policy packages also helps account for absence of universal coverage. For example, plans to shift away from the model of employer-sponsored insurance, which is at the heart of the U.S.'s

uneven and unequal health care system, were packaged along with policy proposals that many Democrats found highly problematic. Hence discussion of reforming this major part of the prevailing health care arrangements remained separate from other crucial matters, such as Medicaid expansion and the public option.

The PPACA is clearly a major piece of legislation that will improve the economic security of millions of Americans by providing them with affordable access to health insurance. Yet, it falls short of bringing about universal coverage. Explaining why this is so, even after such a president was finally able to bring about significant reform, remains a crucial policy issue demanding close attention. As the ongoing politics of implementation of the PPACA remain in flux, on the ground there is reason for scholars to further investigate the continuing relevance of the three explanations offered in the article to explain why millions of Americans are likely to remain uninsured for the foreseeable future, meaning that the U.S. remains the ‘exception’ in this context in the industrialised world.

Endnote

¹ Waivers are a means by which states apply to the federal government, in this case the Department of Health and Human Services, for permission to exercise some discretion in the implementation of policy.

² For detail on the application of the mandate see Kaiser Family Foundation, 2015.

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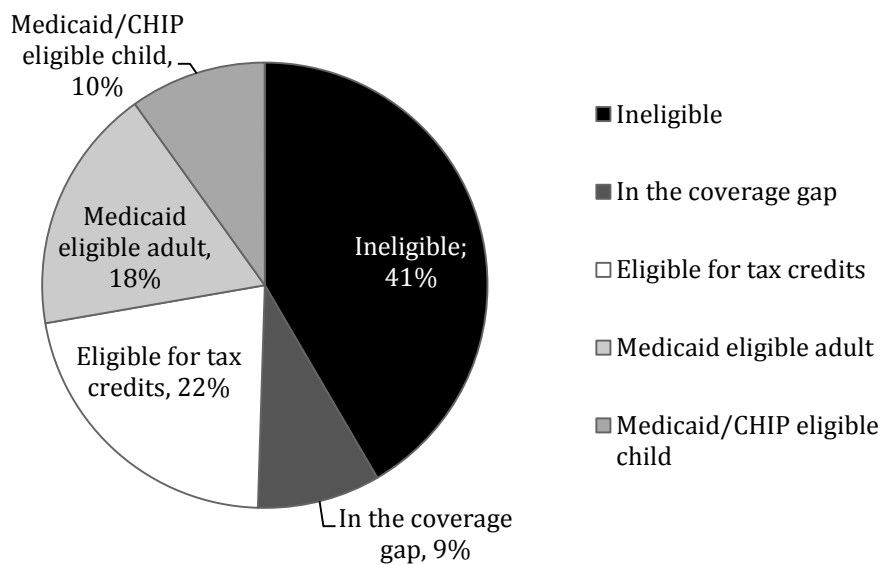
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Source: Kaiser Family Foundation (2016)

Table 1. Empirical Implications

	Partisan competition	Institutional fragmentation	Policy packages
1.) Dems relatively unified on universal coverage pre- enactment?	Yes	Yes	No
2.) Universal coverage proposals include ideas objectionable to Dems?	No	No	Yes
3a.) Dem. leaders reject universal coverage in response to veto threats?	No	Yes	No
3b.) Dem. leaders reject universal coverage in response to electoral risks?	Yes	No	No
4.) Do new limits to coverage emerge during implementation?	No	Yes	No

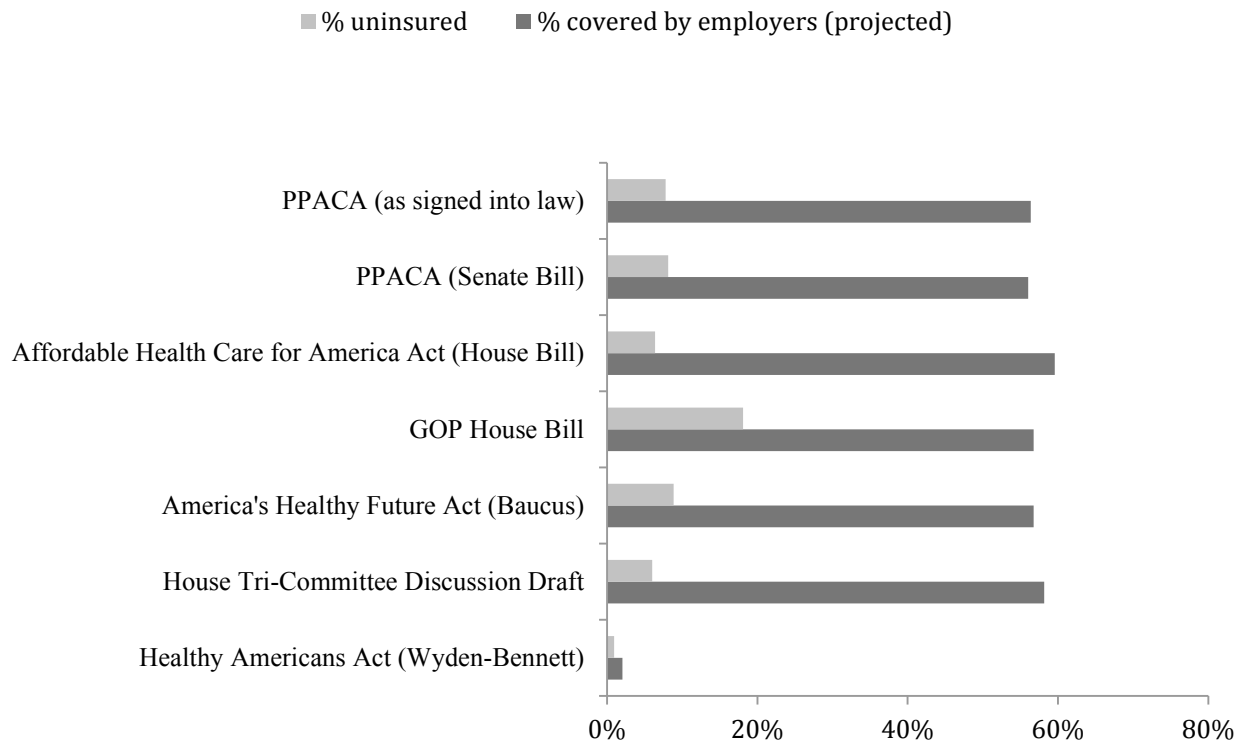
Table 2. Features of various health reform plans, 2009–2010

Plan	Individual Subsidies	Transition to non-employer based system?	Public Option	Medicaid Expansion
Healthy Americans Act, S 391 (Wyden-Bennett bill, 2007 and 2009)	Yes: for people earning up to 400% FPL	Yes: Eliminates tax exclusion, replaces with tax deduction for health insurance; new tax payments from employers to federal government.	No	No: limits Medicaid coverage and fully subsidizes private coverage for households earning <100% FPL
Senate HELP Bill (Unnumbered Draft, 2009)	Yes: for people earning up to 500% FPL	No: employers must contribute to premiums (few details specified)	Yes	Yes: covers households earning <150% FPL
Patients' Choice Act (Ryan-Coburn bill, 2009)	Yes: Tax credits plus subsidies for people earning up to 200% FPL	Yes: Eliminates tax exclusion, replaces with refundable tax credit for health insurance	No	No: limits Medicaid coverage
House Tri-Committee Discussion Draft (2009)	Yes: for people earning up to 400% FPL	No: employers with over \$500,000 in payroll must pay 65 percent of family premiums or a penalty based on payroll	Yes	Yes: covers households earning <133% FPL
America's Healthy Future Act, S 1796 (Baucus bill, 2009)	Yes: for people earning up to 400% FPL	No: Imposes fine on employers with 50+ employees when employees receive subsidy	No	Yes: covers households earning <133% FPL
Common Sense Health Care Reform and Affordability Act, HR 4038 (GOP House Bill)	No: refundable credits to families earning less than \$50,000	No	No	No

Affordable Health Care for America Act, HR 3962	Yes: for people earning up to 400% FPL	No: employers with over \$500,000 in payroll must pay 65 percent of family premiums or a penalty based on payroll	Yes	Yes: covers households earning <150% FPL
Patient Protection and Affordable Care Act, HR 3590 (Engrossed Senate Bill, 2009)	Yes: for people earning up to 400% FPL	No: Imposes fine on employers with 50+ employees when employees receive subsidy	No	Yes: covers households earning <133% FPL
PPACA (signed into law, 2010)	Yes: for people earning up to 400% FPL	Mandatory: employers with 50+ employees must offer 60% of cost of covered services and coverage must be affordable or pay penalty based on number of employees receiving subsidy.	No	Yes: covers households earning <138% FPL

Source: See Appendix Table A1.

Figure 2. Projected coverage in various health reform proposals



Source: See Appendix Table A1.

Table 3. Characteristics of Medicaid section 1115 waivers approved by the federal government

	Arkansas	Iowa	Indiana	Michigan	Pennsylvania
Health insurance coverage					
Coverage provided via exchange	X	X			
Premiums or contributions at >100% FPL	X	X	X	X	X
Copayments	X	X	X	X	X
Health care related accounts	X		X	X	
Coverage limits					
Lock out from coverage		X	X		X
Waiver of retroactive coverage			X	X	X
Limited benefits for non-frail adults	X	X	X	X	X
Waive non-emergency transportation requirement	X	X	X		X
Other waiver provisions					
Healthy behavior incentives		X	X	X	X
Work requirement			*		*

Source: See Appendix Table A1.

Note: *CMS approval permitted Indiana and Pennsylvania to use non-federal funds to develop a program to encourage employment, but not to require employment as an eligibility condition.