Delegated Governance in the Affordable Care Act

Delegated Governance in the Affordable Care Act of 2010

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One of the many claims made about the Patient Protection and Affordable Care Act (ACA) of 2010 was that it represented a massive "takeover" of the health care sector by the federal government (Boehner 2010). To the contrary: the ACA pursues many of its goals with only a limited increase in federal governing authority. Building upon the existing system of employer-sponsored insurance, the law subsidizes coverage for the uninsured through either private insurers or state Medicaid programs, many of which already contract with private managed care companies to provide insurance. States bear the main responsibility for setting up temporary high-risk pools and health plan exchanges for individuals and small businesses, and they will be responsible for enforcing new federal standards for insurer policies (Nichols 2010). However, direct federal government involvement is truncated. Federal agencies have to write a mountain of regulations[1], oversee the actions of state governments, serve as a fallback if states fail or refuse to perform their assigned tasks, and of course pay much of the bill, but this is a far cry from national health insurance, Medicare for all, or even a national public option for the uninsured.

The ACA is hence the latest example of delegated governance – a pervasive and longstanding feature of the American welfare state in which responsibilities for administering and delivering social programs are shifted away from the federal government to private agents or lower levels of government. Delegation has taken different forms over time. Initially, federal policy-makers turned to non-profit organizations, state or local governments, and professionals such as physicians, to administer social programs or provide publicly-subsidized services. In

[1] See Jacobson in this issue for more details on the importance of regulatory policy under PPACA.

more recent decades, the delegation has been to profit-making firms or individuals, the latter receiving vouchers they can use to choose from marketplaces of social welfare services (such as Medicare Part D drug plans). Although the exact form of delegated governance has varied, the result has been the same: the creation of a Rube Goldberg welfare state that blurs the boundaries between public and private and between levels of government (Clemens 2006).

The motivation for delegated governance has rarely been technical feasibility or efficiency, even when those are the publicly stated justifications, but rather political factors: a combination of public ambivalence toward the federal government; interest group mobilization against centralized governmental authority over their livelihoods; and the fragmented and porous institutional set-up that enables these voices to weigh heavily in the policymaking process. All of these forces were at work in the development of the ACA.

First, Americans hold ambivalent and contradictory opinions about governmental authority in that they both desire social programs and regard the federal government with suspicion (Free and Cantril 1967; Page and Jacobs 2009).[2] One way to square the circle has been to mask the true role of government. Having private insurers administer Medicare, for instance, helped dampen cries that the law represented socialized medicine (Jacobs 1993). Similarly the ACA subsidizes private insurance and allows the uninsured to buy coverage on exchanges run by state governments or non-profit organizations. Otherwise, the ACA leaves the employer-sponsored insurance system intact but imposes new regulations on insurers, enabling reform advocates to argue they were engaged merely in "health insurance reform" and not a wholesale reengineering of the health care system. This was important given that many Americans were already satisfied with their coverage, lacked trust in government (consider the traction that the false rumor of "death panels" got; Shapiro and Jacobs 2010), and feared that large-scale reform

[2] See also Schlesinger in this issue for more details on public opinion regarding PPACA.

would increase insurance costs and erode the quality of the care they received (Brodie et al. 2010).

A second force behind delegated governance is the mobilization of lobbying groups against expansions of governmental control over their livelihoods. [3] In the past, pharmaceutical companies, insurers, physicians, and other providers opposed public health insurance of almost any kind, but they subsequently learned that subsidized insurance can be attractive as long as the federal government does not gain preeminent price-setting power. Responding to these views, the health care reform promised tens of millions of new "lives" to the insurance industry and better-subsidized users of medical care and pharmaceutical products to providers and drug-makers, but left the fragmented payment system in place. Such a reform design succeeded in muffling interest group opposition. Insurers were the fiercest opponents of the law but lacked other medical industry allies to help them block the reform. Other groups worked behind the scenes to fight or weaken objectionable proposals (such as the Independent Payment Advisory Board, charged with recommending Medicare cuts) but remained publicly supportive and ultimately endorsed the final bill. Particularly once the public option was jettisoned, medical interest groups could be assured of greater resources flowing through the health care system without the accompanying heavy hand of government price controls.

Finally delegating the governance of social programs to lower levels of government and/or private actors has been a way to overcome the many institutional barriers to major reforms. [4] Particularly important is the central role of Congress in crafting and passing legislation. With its subcommittees, committees, two chambers, and supermajority requirement for much legislation in the Senate, there are ample opportunities for opposing voices to be heard.

[3] See Quadagno in this issue for a critical assessment of interest group influence.
[4] See separate essays by Thompson and Sparer for more details on Medicaid reform and the role of the states under PPACA.

Despite winning the presidency with a large popular margin and holding majorities in both chambers, Democrats lacked the supermajority needed in the Senate to overcome a Republican filibuster, and the Democratic camps in both chambers included a considerable sub-group of centrist Democrats who were leery of federal government growth. A reform that preserved much of the existing system of health care finance and delivery and limited the role of the federal government was a way to keep centrist Democrats on board. These centrists especially opposed the public insurance alternative, and they succeeded in keeping this out of the final bill. Moreover, the Scott Brown election ensured that the Senate bill would be the dominant framework, with state-level rather than national insurance exchanges, so that the success of the reform – from patient access to insurance to cost control – hinges on state action (Brennan and Studdert 2010; Jennings and Hayes 2010).

If delegated governmental authority makes passage of reforms possible, it can also complicate their implementation. Legislators rarely warm to the idea of expanding the size of federal agencies, and the ACA was no exception. Relatively little money was budgeted for the ACA's implementation when in fact complex reforms such as these require able administrators, timely rule-making, and effective oversight of the many agents involved (Serafini 2010; Nichols 2010). Moreover, the law depends heavily upon state governments to do the work of overseeing private insurers, when in fact state capacity for insurance regulation is highly variable (not to mention that a number of states – 21 as of July 2010 – sued the federal government to prevent implementation; these suits are unlikely to prevail, but do not bode well for the level of federal-state cooperation needed for reform success [Nichols 2010]). Finally, experience with existing consumer-focused programs (Part D; HSAs) suggests that individuals are not always capable of being the effective consumers that the insurance exchange model assumes (e.g. Abaluck and

Gruber 2009; Dixon, Greene and Hibbard 2008). The ACA will hopefully make insurance coverage a reality for millions of Americans, but its structure exemplifies the problems of administration that plague health care policy and delegated governance more generally.

References

Abaluck, Jason T., and Jonathan Gruber. 2009. "Choice Inconsistencies among the Elderly: Evidence from Plan Choice in the Medicare Part D Program." NBER Working Paper 14759 (February). Available: www.nber.org/papers/w14759.

Boehner, John. 2010. "Why Republicans Will Fight to Repeal Health-Care Takeover." *Des Moines Register*, 24 March.

Brennan, Troyen A., and David M. Studdert. 2010. "How Will Health Insurers Respond to New Rules under Health Reform?" *Health Affairs* 29 (6): 1147-51.

Brodie, Mollyann, Drew Altman, Claudia Deane, Sasha Buscho, and Elizabeth Hamel. 2010. "Liking the Pieces, Not the Package: Contradictions in Public Opinion During Health Reform." *Health Affairs* 29, 6: 1125-30.

Clemens, Elisabeth S. 2006. "Lineages of the Rube Goldberg State: Building and Blurring Public Programs, 1900-1940." Pp. 380-443 in Ian Shapiro, Stephen Skowronek, and Daniel Galvin, eds., *Rethinking Political Institutions: The Art of the State*. New York: New York University Press, 2006.

Dixon, Ana, Jessica Greene, and Judith Hibbard. 2008. "Do Consumer-Driven Health Plans Drive Enrollees' Health Care Behavior?" *Health Affairs* 27 (4): 1120-31.

Free, Lloyd A., and Hadley Cantril. 1967. *The Political Beliefs of Americans.* New Brunswick: Rutgers University Press.

Jacobs, Lawrence R. 1993. *The Health of Nations: Public Opinion and the Making of American and British Health Policy*. Ithaca, NY: Cornell University Press.

Jennings, Christopher C., and Katherine J. Hayes. 2010. "Health Insurance Reform and the Tensions of Federalism." *New England Journal of Medicine* 362 (24): 2244-6.

Nichols, Len. 2010. "Implementing Insurance Market Reforms under the Federal Health Reform Law." *Health Affairs* 29, 6: 1152-7.

Page, Benjamin I., and Lawrence R. Jacobs. 2009. *Class War? What Americans Really Think about Economic Inequality.* Chicago: University of Chicago Press.

Shapiro, Robert Y., and Lawrence Jacobs. 2010. "Simulating Representation: Elite Mobilization and Political Power in Health Care Reform" *The Forum* 8 (1), Article 4. Available at www.bepress.com/forum/vol8/iss1/art4.

Serafini, Marilyn Werber. 2010. "Writing the Rules for the Health Law." *National Journal* (May 1): 6.