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CONTESTED CUSTODY: SOCIAL INSURANCE IN US HEALTHCARE POLICY

Larry Brown & William Genieys

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No observer of the rising politics of populism across Western nations in 2016-17 is likely to doubt the central importance of "elites." Whether and how far groups that achieve insulation from the "proper" scope of popular control manage to shape and steer public policies are questions that have long preoccupied political theory. Elites have been portrayed as, for example, lords of the political system (C.Wright Mills's "power elite"), as the indispensible vehicles of political competition (Schumpeter), as the inevitable bureaucratic precipitates of socialist political parties (Michels), and as largely benign power centers constrained by the checks and balance of political pluralism (Dahl). These disparate images, moreover, readily extrapolate from the shaping of electoral behavior and outcomes to the forging of public policies, in which domain elites have been variously depicted as "special interests" intent on "regulatory capture," as "iron triangles" at odds with larger public interests, as corporatist players that aid the search for agreement among contesting social sectors, and as bureaucrats whose expertise and institutional memories are essential to making government work.

Whatever one's preferred picture, elites are not mere "elements" in the making of policy, the presence, absence, or involvement of which may be adjusted in the manner of seasoning in a recipe; rather they intrinsic to and inseparable from policymaking processes. In Western nations, the 20th century saw (and the 21st century continues to see) a steady growth in statutory and regulative interventions of government in the economy and society—interventions that come equipped with actors, both inside and outside government, who combine political and substantive expertise in service of a commitment to preserve, protect, perpetuate, and promulgate "their" programs. Such actors differ from "entrepreneurs," "advocates," and other promoters of policy, who come and go with bright ideas; their distinctive feature is persistence and longevity in policy roles that may find them in or out of government, but recurrently involved in shaping policies in their chosen arenas.

William Genieys and his colleagues have called these actors "custodians of state policy" and have examined their characteristics and comportment in France, in other European nations, and—perhaps surprisingly—in the United States. The nature of the US political system and of the policies it produces— comparatively small and few public programs of social protection; a heavy reliance on means-tested programs run by the 50 states; limited trust in the good intentions and competence of government, including its experts; more aggressive penetration of political appointees into public bureaucracies; a "revolving door" conveying public officials in and out of a government of "strangers" (Heclo)—might suggest a system that precludes or forestalls a priori the types of custodianship found in other Western nations. Yet Genieys and his colleagues have identified a sizable corps of actors who, over the course of often lengthy careers, combine political and substantive expertise, in a reasonably cohesive and concerted fashion, to protect and advance specific public policies in the defense and health care sectors, thus displaying patterns with some substantial family resemblance to those seen in Europe. This paper extends this line of inquiry further within US healthcare policy.

A question arises at the outset, namely, what IS the "healthcare policy" over which custodianship might be asserted? After all, no major health care policies emerged from the US federal government until after the end of World War II, and while other nations were building and implementing the systems of national health insurance (NHI) that remain the centerpieces of their healthcare systems, the United States, deadlocked on this front, set about developing the supply side, not the demand side, of its system by means of the National Institutes of Health (which promoted biomedical research) and the Hill-Burton Act (which authorized federal grants to the states for the planning and construction of new hospitals). (The custodial dynamics of these supply-side programs lie beyond the scope of this paper, but well deserve a study of their own.)

Unable to make NHI a pillar of the (limited) programs of social protection it adopted, and thrown into disarray by the fragmentation that besets both its public and private health care systems, the United States would seem to offer highly inhospitable terrain for would-be custodians of health care policy. A political-historical examination of the evolution of the theory and practice of social insurance as an approach to the financing of health care in the United States, discloses that, and how, policy custodians became a prominent presence in the US healthcare system. As well, the inquiry throws light on dynamics—sometimes competitive, sometimes cooperative, sometimes accommodative—that shape custodianship in the nation's distinctive political structures.

Social Insurance on the Federal Policy Agenda

Social insurance (the financing of benefits by means of sums accrued in public trust funds, from contributions by workers and their employers at specific rates over the course of a worker's employment) has been a prominent force in US health care politics since the early 1900s. Aspiring reformers in the Progressive Era inspected innovations in Europe that

extended social protections—notably pensions and health care coverage—to all or part of the citizenry by means of social insurance programs, and sketched how the United States might follow suit. (Rogers, Atlantic Crossings) Such momentum as this movement acquired was dissipated by World War I (which put the United States into conflict with Germany, the pioneer of social insurance in Europe) and by the Russian Revolution of 1917 (which threw suspicion on anything vaguely "socialist"). The Great Depression of 1929 and the election of Franklin D. Roosevelt to the presidency in 1932 brought social insurance to the forefront of policy once again. As governor of New York, Roosevelt had helped to make that state "the cockpit " of battles over social insurance in the United States. (Rogers, p. 438) Now, at the national level, amid what Rogers calls "the intellectual economy of catastrophe," a "quiet, structural, behind-the scenes institutionalization of European-acquired social insurance knowledge in the key university economics departments and policy centers" (Rogers p. 438) supplied the expertise policymakers demanded.

The Social Security program, which used contributory mechanisms to fund pensions for most Americans over age 65, was enacted in 1935, and that legislative success spurred proponents of social insurance, who were numerous and articulate within the councils of the New Deal, to urge a similar approach to national health insurance, which they viewed as the most important major missing pillar in the New Deal's portfolio of social protections (Social Security, Unemployment Compensation, Aid to Dependent Children) that the administration and its Democratic majorities in the Congress had seen through to enactment. Roosevelt, uncertain how much political capital would be required to defeat the opposition of the American Medical Association, demurred and consigned NHI to be studied—and then studied again—by a series of commissions and task forces (Blumenthal/Morone, Heart of Power; Starr, Social Transformation….). Roosevelt's death in 1945 left NHI in limbo, but much on the minds of a cohesive set of social insurance custodians—most notably, IS Falk and Edgar Sydenstricker (the principal authors of the abortive NHI initiative) and Wilbur Cohen (an assistant of Edwin Witte, head of the staff of Roosevelt's Committee on Economic Security and a protégé of John Commons of the University of Wisconsin)-- who diligently defended their principal progeny, Social Security, and awaited a political opening that would permit them to extend that approach to health coverage. (Rogers, pp.442-443).

The accession to the presidency of Harry Truman, an unapologetic proponent of social insurance- based NHI, seemed to offer that opening. Truman's efforts to move the measure through Congress (where social insurance was embodied in the Wagner-Murray-Dingell bill, a proposal that enjoyed substantial but far from majoritarian support) made little headway against the concerted opposing forces of organized medicine, big business, and the lobby of insurance entities (both non- and for-profit) that had filled the vacuum left by federal inaction on public coverage in the 1930s. When Dwight Eisenhower, a moderate Republican with little taste for bigger government, won the presidency in 1952 NHI looked dead, at least for the next four, and perhaps for next eight, years.

From NHI to Medicare

Republicans control of the White House for the first time in 20 years saw the immediate departure from the federal government of some SI custodians (Oscar Ewing left in 1952, for example), the eventual exit of others (Falk exited for good in 1954 and Cohen in 1956, returning under John F. Kennedy in 1961), and also one very prominent retention (Robert Ball, who having held various positions in the Social Security Administration since 1939, left in 1945, returned in 1949 and served as commissioner of that agency from 1962 to 1973). Whether in or out, however, they retained both their commitment to NHI and to finding a political path by which it might be realized. That path, they concluded, must needs be incremental—enact a program for a subgroup of the population, show that this approach worked, and then push to extend it to other subgroups. (Marmor, Politics of Medicare, Oberlander, Political Life of Medicare) The group with which to start, they concurred, was the aged, who had left the work force (hence could seldom be covered by private employer-based insurance), faced higher than average health care needs and costs, and were already familiar with and grateful for the benefits of Social Security, which constituted a real-world model for how the new health coverage would be funded. Indeed, the outlines of such an approach had been unveiled in the last days of the Truman administration by Oscar Ewing, head of the Federal Security Administration, whose plan, crafted by Cohen and Falk, proposed federal hospital insurance for beneficiaries of Social Security. (Oberlander p.23).

Throughout the the 1950s the custodians (Ball in SSA, Cohen in academia, Reuther in labor, etc.) sought to build support for what came to be called "Medicare," a program, funded by social insurance contributions, to cover the hospital expenses of Americans aged 65 and over. This proposal, like its more comprehensive forebear of the Roosevelt-Truman years, inflamed opposition by the AMA and other conservative interests—opposition that liberal Democrat John F. Kennedy, elected president in 1960, and his legislative allies were unable to surmount. Then events having nothing to do with health policy per se—namely, the assassination of Kennedy in 1963 and the nomination of arch-conservative Senator Barry Goldwater as the Republican opponent to President Lyndon B. Johnson in 1964—triggered an electoral landslide that returned Johnson, an ardent supporter of Medicare, to office and brought a surge of new liberal Democrats into the House and Senate. In 1965 Medicare became law.

To be sure, the SI custodians' agenda had been achieved only in part. Medicare covered solely the aged; its Part A (hospital insurance) was funded by social insurance, but Part B (for physician services) drew instead on the premiums of beneficiaries and the general revenues of the federal government. Moreover, Medicare came accompanied by a sister program for some of the poor—a means-tested, state-run program funded by state and federal general revenues, that encapsulated precisely the features of a "poor people's program" that the SI custodians anathematized. These custodians, however, looked on the bright side: after decades of deadlock, the forces supporting NHI/Medicare had defeated the

AMA and were now well positioned to move along the incrementalist continuum to Medicare for more—and in due course, for all.

The Rise of Custodial Competition: HMOs and Market Forces

The optimism of the SI custodians was soon dashed. Even as events in 1963-64 had created the political conditions in which Medicare became law, so too did domestic turmoil over issues having little to do with health policy – notably the war in Vietnam and the war on poverty—derail the plans of Johnson's Great Society and then usher Republican Richard Nixon into the White House in the elections of 1968. To the new administration Medicare was one of many products of Johnson's relentless overpromising and excessive centralization, and a particularly worrisome one at that because the financial costs of the program were growing all too clear. For the first time the federal budget was responsible for a sizable share of the nation's health care bill, a bill that was rising much faster—an average of 40.2 percent annually in 1968 and 1969-- than its sponsors had predicted. (Oberlander, p. 47). Semantic innovations told the tale: the term "uncontrollable spending" (on programs that could not be trimmed by the annual appropriations process) grew prominent in Washington's budgetary lexicon, and the word "entitlement," lately used with enthusiasm to denote programs that "belonged" to beneficiaries by virtue of the sort of social contract embodied in the contributory principle of social insurance and therefore could never rightfully be "taken away" by government quickly came to connote "run-away" spending (Oberlander, p. 47) on government "giveaways" to grasping beneficiaries of questionable need and desert. These critiques, meanwhile, were finding welcoming homes in proliferating right-wing think tanks—for example, The Heritage Foundation (created in 1973), the Cato Institute (launched in 1974 as the Charles Koch Foundation and renamed in 1976), and the American Enterprise Institute (an organization that dates from 1938 and unveiled its Center for Health Policy Research in 1974). In the short interval between 1965-66 and 1969-70 the SI custodians had been forced to abandon the imminent promise of incremental expansion for defensive maneuvers in a new and disquieting ideological era.

The Nixon team had no illusions about the political fallout certain to accompany any effort to "take away" Medicare's new coverage, but they were both compelled by fiscal angst not merely to sit there but rather to "do something" and at a loss to know what to do. Retrenchment on Medicare invited political retribution; combining tough systemic cost controls with some version of NHI risked handing to the Democratic Congress (and especially to Senator Edward M. Kennedy of Massachusetts, a leading exponent of NHI who was expected to challenge Nixon in the 1972 presidential elections) an opportunity to take control of the legislative action. Slapping regulatory controls on Medicare's prices risked antagonizing medical providers and conservative purists who detested "heavy handed public regulation."

Around the beginning of 1970 an off-stage policy entrepreneur broke through these barriers. Paul Ellwood, a physician and policy analysis, chanced to meet with a special

assistant to the undersecretary of HEW, and the two brainstormed about the health policy conundrums with which the administration struggled (This account of HMOs follows Brown, Politics and Health Care Organization.) Ellwood pronounced his diagnosis: health care costs in Medicare, as in the system as a whole, ran too high because the system foolishly conjoined fee for service delivery of care with third party payment for it, thus ensuring the predominance of faulty, incorrect incentives—the more providers did the more they got paid, while both consumers and providers blithely passed along the costs to others. He then followed his diagnosis with a prescription: prepaid group practices (PGPs), exemplified by the Kaiser Permanente plans, well known to the numerous Californians on the Nixon administration, embodied correct incentives by combining in one organizational structure both financing and provision of care (doing away with third party payment) and delivering care solely by means of salaried physicians who worked full time for the plan (thus averting fee for service), a strategy that enabled them to provide reasonable access to good quality care at costs well below those of the traditional sector.

To be sure, the Kaiser plans in California were large million-member entities that could hardly be replicated across the United States. But ingenious policymakers could adopt, as it were, the organizational and financial skeleton of PGP; give the new, streamlined creations an appealing name—"health maintenance organizations" (HMOs), which signaled their resolve to "keep people well, not merely treat them once they are sick"--; furnish modest grants and loans to local entrepreneurs who wanted to develop such plans; and contrive to get consumers to join them. The strategy might be (and soon was) implemented throughout the health care system, at large, but the place to start was Medicare, and the first step would be to create within it a new Part C that allowed beneficiaries to enroll in HMOs for their coverage.

This proposal, which launched in 1970 the "managed care" model that has, for better and/or worse, heavily shaped US health care policy to the present day, appealed strongly to the Nixonites. It reduced no benefits, entailed no expensive NHI gambits, and relied very little on new regulations. Quite the contrary: it worked by means of enlightened incentives (consumers would sign on for all their care with an "integrated" plan); gave consumers choices among such plans and between them and their more costly traditional counterparts such as Blue Cross; and trusted that competition between the older and newer forms of coverage would drive costs down. The HMO proposal, in short, inaugurated the fascination of US policymakers with "market forces" as a means of repairing the faults in the system.

The SI custodians, by contrast, viewed market forces as a dangerous and unwelcome intrusion in Medicare. The law explicitly embraced both fee for service and third party payment. Beneficiaries could freely pick (and change) their physicians and hospitals, which would deliver care and send the government—not private insurers—the bill. HMOs not only abridged free choice of provider but also brought private insurers (including for profit ones) into the picture and thus opened the door to fraud and abuse such as was then unfolding among managed care plans in the Medicaid program in California. And how

exactly how would Medicare's retrospective cost-based payment methods be reconciled with the prospective capitation funding to which PGP/HMOs were accustomed? These innovations violated the custodians' conception of what NHI cum Medicare was supposed to mean.

Resolved to move ahead with a legislative initiative for HMOs, the administration dutifully circulated its plans to HEW for comment, whereupon reviewers registered various objections. Arthur Hess, an official in SSA and (later) a founding member of the National Academy of Social Insurance, for example, noted that the plan gave no sense of "how to get from here to there in any reasonable period of time." (Brown, HMOs, p.209. See also Feder, Medicare, pp. 130-133). The Nixon team discounted these comments as the parochial grousing of bureaucratic "holdovers" from previous Democratic regimes, who were wedded to the programmatic arrangements they had forged and refined and who therefore reflexively resisted innovation.

Authorization for support for the creation of HMOs made its way slowly through Congress, which finally assented in December 1973. Medicare enrollment in "Part C," the guiding notion that put the show on the road, ironically made little headway because congressional critics pressed the above-mentioned arguments that the approach was not consistent with the Medicare statute. Nixon officials had long since concluded, however, that HMO-building should advance on a scale far beyond Medicare itself. Managed care and market forces were quickly becoming part of the health care policy furniture, a development that both accentuated the "exceptionalism" of US health care policy and complicated the calculations of the SI custodians, who continued to await opportunities to resume the push for NHI.

Custodians in Conflict: Managed Competition in the Clinton Plan

The managed care initiative came to political life in 1970 in a burst of policy entrepreneurship, found high level support within the federal government, and then came to resemble an "advocacy coalition" (Sabatier) led by a motley but increasingly visible group of theoreticians (most notably Ellwood, a physician, who founded and ran InterStudy, a think tank; Clark Havighurst, a professor of law; Walter McClure, a physicist who worked at InterStudy; and Alain Enthoven, an economist). Over the course of the Reagan-Bush years (1980-1992), this collection of market-minded reformers steadily took on the trappings of a custodial cadre: the Reaganites smoothed the way for penetration of Medicare by managed care plans, and Enthoven's rigorous model of managed competition(which enfolded market forces within firm governmental rules) was a bridge too far for these administrations, the proposition that market forces offered (in the subtitle of a book by Enthoven)" the only practical solution to the soaring cost of medical care" found growing support in think tanks, within the executive branch, and among congressional staff.

In 1992 a fully articulated version of market forces—managed competition—came to center stage, and, ironically, under Democratic auspices. In his quest for the Democratic

presidential nomination that year, Bill Clinton made much of his determination to enact health are reform, a commitment that SI custodians, having weathered more than two decades of withered influence, expected to put their brand of NHI (or something closely akin to it) back on track. In an ideal world these denizens of the "Blueberry Donut Group" of the Washington Advisory Group on Health—Bruce Fried, Judith Feder, Marilyn Moon, and Ken Thorpe among others— (Johnson and Broder, The System, p.70) might have pushed hard for a single payer system, or Medicare for all, but as a practical matter they promoted a "pay or play" strategy that would oblige employers to cover their workers or pay a fine, coupled with new regulations on costs and enough new revenues to ensure coverage for all.

To their dismay, however, the custodians of market forces argued for a reform template built upon managed competition. This cadre embraced first generation proponents of managed care, such as Ellwood and Enthoven; other stalwarts of Ellwood's "Jackson Hole" group, including Lynn Etheredge, Richard Kronick, and Thomas Scully; (for a full list of the Jackson Hole members between 1990-92 see Hacker, Road to Nowhere, pp.186-187); Atul Gawande, who became director of health and social policy for the Clinton campaign in 1992; state insurance leaders in California—commissioner John Garamendi and his deputy, Walter Zelman, who were putting a version of managed competition into practice; and Ira Magaziner, who had affronted the SI custodians by estimating that "health insurance coverage for the uninsured could be funded entirely through Medicare and Medicaid cutbacks and the savings realized by making the system more efficient." (Hacker, p.105)

A traditional SI-based approach, the marketists contended, would leave Clinton vulnerable to the attacks that Republicans had launched against Walter Mondale (1984) and Michael Dukakis (1988) as big –taxing,-spending- and- regulating Democrats. (Hacker, p.167). Their objections were more than "merely" political, moreover. Hacker recounts that as the Clinton plan took shape, many political leaders and policy experts urged that the non-elderly be given the option of buying into Medicare via the purchasing cooperatives. The marketists advising Clinton were, however, "extremely hostile" to the idea. One of them, Paul Starr, "launched a strident assault" on the program, contending not only that it was incompatible with managed competition, but also "a lesson in how not to structure a national health program. This dismissal of Medicare because it did not fit into "the carefully balanced framework of incentives that they envisioned," Hacker sagely observes (p.128), "reflected a stubborn absence of attention to the problems of administrative and structural design."

Furthermore, whereas Medicare granted very little authority to the states, Clinton viewed the world through gubernatorial lenses. As governor of Arkansas he had battled with the federal Health Care Finance Administration (HCFA), which ran Medicare and Medicaid, and now hoped to enlist the support of governors in a national program in which they played a central role. (Johnson and Broder, pp. 99,159). In managed competition, Clinton, who had long concluded that Democratic success in electoral contests required a turn to the

center, saw a vehicle for escaping these predicable political assaults and intergovernmental aggravations. A creative synthesis of government and market, regulation and completion, the model would bridge divisions between Left and Right—or so one might hope. On October 15, 1992, Clinton announced that his health reform agenda would indeed follow the template of managed competition—much to the chagrin of the SI enthusiasts in his camp, whose influence was (correctly) perceived to have waned. (Blumenthal and Morone on Feder, et al)

As it happened, the ideological and partisan bridge managed competition sought to construct rapidly collapsed, leaving the Clinton plan and its market forces custodians floundering. Some policymakers who sympathized with managed competition nonetheless thought it reckless to hand it "the keys to the treasury," and therefore wanted these market forces backstopped by firm budget constraints, This tampering with the market sent Ellwood and Enthoven to the exits. (Johnson and Broder, p.148). Some viewed Health Insurance Purchasing Cooperatives (HIPCs, retitled Regional Health Alliances by the Clinton team) as crucial to making managed competition work. Others dismissed them as " the domestic equivalent of Star Wars…" (Rostenkowski speech, written by Abernathy, quoted in Johnson and Broder, pp. 399-400). Republican Senator John Chafee sought to couple managed competition with a mandate on individuals, not employers. (Johnson and Broder p.363), but he was isolated within a party that increasingly declined to back any health reform initiative at all. Jim Cooper, a "new" Democrat who was certain that the New Deal, the Great Society, and the rest of his party's programmatic handwork had failed, favored managed competition—but not an employer mandate. (Johnson and Broder, p.311). A long parade of committee chairs and party leaders labored to broker differences within the Democratic party and between it and the Republicans, but in vain.

The rejection of managed competition as a framework for comprehensive reform did not restore the fortunes of the SI custodians. One of them, Democratic Congressman Pete Stark of California, had fought for making Medicare the alternative source of coverage for all who could not obtain it under an employer mandate and a version of his proposal found its way into an 11th hour bill offered by Democratic Senate Majority Leader George Mitchell (Johnson and Broder p. 480), but neither the mandate nor an expanded Medicare gained political traction. Meanwhile Clinton had been convinced from the outset that sizable cuts in the budgets of both Medicare and Medicaid were necessary to reduce the federal deficit. (Johnson and Broder p. 122).

Social insurance in general and Medicare in particular never came close to finding a firm foothold in the great health reform debate of 1993-94. The sad denouement of the episode prompted long second thoughts among the SI custodians, who had since the early 1990s increasingly entertained doubts whether the SI approach, though as desirable as ever, was also feasible as a vehicle of universal coverage. To borrow Weber's famous terms, did the allegiance of SI to the ethic of ultimate ends cede the ethic of responsibility to another vehicle of coverage, namely, Medicaid?

Cooperative Custodians: Ambivalent but Ambidextrous

When 11th-hour deliberations in Congress brought forth Medicaid alongside Medicare in 1965, the SI custodians were ambivalent. On the one (principled) hand, the former program incorporated all the elements of a "poor people's program" they most despised: it was means-tested, linked to eligibility for public assistance ("welfare"), funded by general revenues (a "handout" from "the tax payer" instead of an earned benefit), and subject to extensive discretion by the 50 states. On the other (pragmatic) hand, it was a way to get coverage to populations that neither Medicare nor any other program then on the books or contemplated would reach, and it might (as Wilbur Mills had hoped), secure Medicare and its social insurance base by mitigating pressures to expand that program to new populations. Moreover, supporters of universal coverage could not help but find it unsettling that Medicare, unquestioned social triumph though it was, tilted the nation's public health coverage markedly in favor of the elderly, while doing little for children and the non-aged poor.

By the time Reagan entered the White House it had become clear that this species of "welfare medicine in America" (Stevens and Stevens, Welfare Medicine in America) had burst its bounds as a program for low-income mothers and children on public assistance. Some states availed themselves of federal marching funds (which ran between 50 percent for the richest states to 76 percent for the poorest) to extend coverage to "optional" groups and services. And Medicaid had become the prime source of coverage for a range of lower-income groups—the disabled, the mentally ill, people with AIDS, low-income seniors (also eligible for Medicare), and not least important, formerly middle-class Americans who had "spent down" their assets on long-term care in order to meet the requirements for Medicaid benefits—thereby amassing formidable support among constituencies of beneficiaries and providers of care. (Brown and Sparer, "Poor Program's Progress"). In the Reagan-Bush years, the prospects of extending Medicare to new groups were remote at best, and some within the camp of SI custodians began looking to Medicaid as the next best (obtainable) thing.

In the 1970s and 1980s the growing Medicaid program had generated custodians of its own, including Marian Wright Edelman (head of the Children's' Defense Fund), Sara Rosenbaum and Kay Johnson (CDF staffers with extensive connections with Congress and advocacy groups), and staff at the National Governors' Association, among other sources of influence. (Sardell, Insuring Children's Health, pp.26-30) Beginning in the mid-1980s these custodians seized each chance to expand coverage by the incrementalist strategy that this program (unlike Medicare) invited, namely, lowering the thresholds of eligibility among income groups, clinical conditions, and other "categories." (Smith and Moore, Medicaid) Under Reagan and Bush, Rosenbaum, Johnson, and their allies worked with staff on committees headed by supportive Congressmen (most notably Henry Waxman—dubbed "Mr. Medicaid"-- and George Miller in the House and Lloyd Bentsten in the Senate) (Sardell p.32), who had perfected techniques for including in omnibus reconciliation budget bills

mandates and options that markedly increased the program's enrollment. This expansionary exercise ran near annually from 1984 until 1990, when the NGA rebelled against the rising costs these mandates obliged the states to bear (Sardell,p.31).The ball the governors dropped was, however, was kept in play in other influential quarters—for instance, the Kaiser Family Foundation, which in 1991 the Kaiser Commission (later Program) on Medicaid and the Uninsured.

When reformers (led by the Medicaid custodians) sought to salvage something from the ashes of the failed Clinton plan they turned not to expanding Medicare but rather to crafting in 1997 a Medicaid look alike, the State Children's Health Insurance Program, which (like its model) made federal matching funds available to states offering new coverage to children in families that lacked private health insurance but were not poor enough to qualify for Medicaid itself. (Sardell,p.75, n.16,notes that as early as 1994, when prospects for the Clinton plan looked increasingly dim, staff in the White House, DHSS, OMB, and in the Senate began planning for increased coverage for children, among other incremental reforms.)

Custodial Accommodation: The Affordable Care Act

In the late 1990s and through the years of George W. Bush's presidency, the Medicare program was not static, to be sure. But nothing in the evolution of the program suggested an improving climate for a single payer system (aka Medicare for all). Quite the contrary: while creating SCHIP in 1997, the Clinton administration and Congress, increasingly nervous about the allegedly impending bankruptcy of the Medicare trust fund, legislated sizable cuts in payments to the program's providers. (Oberlander p.177) and sought to accelerate the glacial growth of enrollment in MCOs in Medicare in Part C, now dubbed "Medicare plus Choice" (and shortly thereafter "Medicare Advantage"). (Oberlander pp.180-182) Although these measures struck most SI custodians as steps in the wrong direction, important exceptions suggested that new pragmatic accommodations between SI and not only Medicaid but also market strategies were not out of the question. For instance, Henry Aaron, a highly respected economist and SI stalwart, who in 1977 during his tenure in the Carter administration had supported federal efforts to encourage HMOs (Brown,HMOs, p.360), now, twenty years later, urged that Medicare do more to incorporate private plans lest it be left isolated within a rapidly-changing health care system. (Oberlander p.171).

In 2003 the Bush administration reached agreement with congressional Democrats on a new Part D, which expanded Medicare coverage to outpatient prescription drugs. Democrats had long sought such an enhancement in benefits, but the terms of trade the Republicans demanded for accepting it—the new benefits would be obtained exclusively under competing private health care plans—seemed to the SI custodians a high price indeed. Since the inception of the program few had doubted that keeping Medicare aloof from the private insurance marketplace (the inequities and inefficiencies of which these custodians

generally deplored) was essential to its integrity. "Traditional" Medicare remained a contract between beneficiaries and government but Parts C and D allowed the camel's nose of private insurers not merely under, but deep into, the tent.

Although the Democrats captured the White House and both houses of Congress in the national elections of 2008, the vision of single payer/Medicare for all remained as marginal as it had in the Clinton era, well defended by articulate SI custodians in academia and think tanks, but adjudged impracticable by insiders. The nearest approximation-- a proposed "public option" health care plan, inspired by Medicare and reproducing its stringent payment policies, that exhibit superior efficiencies in competition with private plans (Jacob Hacker, Helen Halpen) – lingered on the periphery of the Democrats' policy agenda, but the heart of action lay elsewhere.

The package of policies that became the ACA in 2010 was pioneered by Massachusetts in 2006. Both laws assumed that most citizens would continue to get healthcare coverage from private insurers in an employer-based system and set out to repair flaws and fill gaps in that system. To prevent selection of preferred risks, new rules limited the power of insurers to tailor enrollment and prices to the health histories and risks of subscribers. To avert adverse selection in insurance markets they imposed an individual mandate—all citizens (with certain exceptions) were to buy or otherwise secure coverage or face a financial penalty. Medicaid was expanded to cover more low-income citizens. Those who were too well off to qualify for Medicaid but unable to afford private coverage had their costs offset by income-scaled subsidies, which enabled them to buy coverage in new "health exchanges" (aka marketplaces)—organizations that helped consumers to shop among and enroll in health care plans. In short, Medicaid (which now covers more than 70 million Americans) and market forces (now enshrined not only in Parts C and D of Medicare but also in the exchanges and in Medicaid managed care plans) dominated the reform agenda.

Medicare "contributed" to the ACA mainly by means of savings it accrued (and freed up for broader coverage) by cutting its payments to hospitals, a move that reflected the diminished burdens hospitals would bear as they came to serve fewer uninsured patients. Otherwise, the program remained intact, but largely extraneous to the designs of reformers. The SI custodians could properly take pride in their defensive acumen (though the rise of penetration of Medicare Advantage plans within the program to one-third of beneficiaries suggested that the ramparts were crumbling), but their venerable hope that SI would triumph, albeit incrementally, with the achievement of a universal, single-payer/Medicare for all, SI-funded coverage, purged of the defects inherent in the private health insurance sector, remained unrealized.

Conclusion: Comparative Custodianship

In France, under the influence of a social democratic agenda, proponents of SI created after World War II a broad-ranging system of social protections, one "regime" of which consisted of contributory NHI. As the "trente glorieuse" gave way in the 1970s to

sharper concerns about the costs of health care, the architects of and advocates for that system evolved into "custodians," who defended it with analyses and innovations that aimed to protect it against the incursions of powerful critics (especially the finance ministry).

In the United States, SI-based health coverage was proposed but deferred, leaving coverage for most of the population in the hands of health insurance plans (some for-profit, some nonprofit) in the private sector. Checkmated at the midpoint of the 20th century, SI custodians trimmed their designs down to Medicare, celebrated its enactment in 1965, envisioned incremental expansion toward universal coverage, and then, disappointed in this expectation, settled into defensive maneuvers to protect Medicare from a growing corps of critics who relentlessly derided the alleged vices of a "government monopoly" such as Medicare (and of course its extension into a universal single payer program). This shift from an expansionist to a defensive agenda by the SI custodians left the policy terrain open to alternative "visions," two of which—expansion of Medicaid and market forces—came to the fore. As these policy blueprints, inaugurated by entrepreneurs, embroidered by advocates, and gradually embraced by custodians of policy, gained ground, the SI custodians stayed in the game by pragmatically accepting accommodations that were in many ways antithetical to their social philosophy— embracing, for example, the non-universal, means-tested, state-run Medicaid program and the insertion of mini versions of managed competition within Medicare and the ACA.

In France, SI custodians worked to reaffirm and reenergize SI as the best policy means to a consensual end (affordable universal coverage understood as a right). In the United States their counterparts were obliged to revisit both ends (universal coverage versus coverage for more of the disadvantaged) and means (Medicare for all versus Medicaid for more, and a system freed of the dysfunctions of private health insurance versus one that retained that sector but sought to repair its major shortcomings). In France, these custodians labored to ensure that they and their programmatic progeny would remain at the center of policy. Those in the United States stayed in the action both by defending their island of idealism and by acquiescing in discordant models the pragmatic promise of which sustained cadres of custodians that diverged philosophically from but overlapped politically with the SI custodians.

In France, the financial coherence of the health care system and the centralization of political structures encouraged and supported the emergence of a cohesive set of policy custodians that successfully (at least so far) improvised adaptions to the SI model over time. In the United States, the financial fragmentation of health care coverage and the porousness of political structures encouraged the emergence of reforms on three distinct normative and strategic fronts (SI, Medicaid, and market forces), whereupon competition, cooperation, and accommodation among these models and the custodians who embraced them ironically added to the system new complexities in the guise of rationalizing old ones.

Bibliography (forthcoming)