

Walter Dawson

Green Templeton College

University of Oxford

D.Phil Social Policy

**The CLASS Act and Long-Term Care Policy: The Politics of Long-Term
Care Financing Reform in the United States**

5th October 2012

Dissertation completed by Walter Dawson in completion of the requirements for the D.Phil in Social Policy. Submission Date: Friday 5th October 2012. Word Count: 69,858

Abstract

The CLASS Act and Long-Term Care Policy: The Politics of Long-Term Care Financing Reform in the United States

This thesis seeks to contribute to the knowledge base about social policy in the United States, using long-term care (LTC) financing policy reform as an illustrative example. Specifically, this thesis explores LTC financing reform efforts during three U.S. Presidential administrations: Bill Clinton (1993-2001), George W. Bush (2001-2009), and Barack Obama (2009-2010). Within this historical framework, the LTC provisions of the Health Security Act of 1993, the development of the Community Living Assistant Services and Supports or 'CLASS' Act during the Bush Administration, and the legislative success of the CLASS Act as a part of the Patient Protection and Affordable Care Act of 2010 provide comparable cases to compare the drivers of social policy.

Drawing on the explanatory frameworks of the welfare state such as ideology, historical institutionalism, and an actor-centered approach to policy analysis, this thesis argues that successful path-departing legislation is difficult to achieve due, in part, to the presumed high costs of social programs and the complex institutional framework of the American political system. Policy outcomes result from the interaction between the complex processes and dynamics of the political system through which policy change (or the failure to change) actually occurs. The fact that the CLASS Act was politically successful, yet administratively inoperable as designed, reinforces the argument that social policy outcomes in the United States are reflective of a complex, enduring struggle of competing ideologies.¹ This continual struggle, coupled with a heightened concern over cost control and fiscal austerity, helps to ensure that policies which are legislatively successful within the institutional architecture of the American political system are unlikely to produce major expansions of the welfare state. Social change is therefore highly difficult to achieve, even in the face of significant unmet social needs. Comprehensive reform of U.S. LTC financing arrangements will remain an elusive goal for the foreseeable future. Instead, incremental, highly pro-market solutions are likely to be the types of policies promoted in the years of ahead.

¹ Although legislatively successful in 2010, the CLASS Act was deemed administratively inoperable by the Obama Administration in October of 2011. However, the actual repeal of CLASS did not occur until the "fiscal cliff" agreement on January 1, 2013 as part of the American Taxpayer Relief Act of 2012 (Public Law 112-240). In place of the CLASS Act, a commission was established to make recommendations on how to improve the LTC financing system in the United States.

Table of Contents

Abstract	2
Table of Contents	3
Figures.....	4
Acknowledgements	5
Chapter One: Long-Term Care Policymaking and Policy Change	8
Chapter Two: Literature Review and Analytical Frameworks	27
Chapter Three: Research Design and Methods.....	66
Chapter Four: Long-Term Care Financing Reform During the Clinton Presidency	93
Chapter Five: The Bush Presidency and Long-Term Care Reform.....	132
Chapter Six: The Obama Administration and the Successful Enactment of Long-Term Care Financing Reform.....	179
Chapter Seven: The Demise of CLASS and the Future of LTC Financing in the United States	227
References	252
Appendix A: Sample Letter of Introduction	281
Appendix B: Interview Participant Participation Form	282
Appendix C: Topic Guide	284

Figures

1.1	Population Change by Decade.....	17
1.2	Total U.S. Spending on Long-Term Care in 2010.....	19
4.1	Partisan Control of the United States Congress: 1993-2011.....	109

Acknowledgements

As unusual as it may sound, long-term services and supports (LTSS) policy has been a passion of mine since I was a child. Perhaps it is unsurprising that I would choose to write a doctoral dissertation on LTSS policy—an issue area that is often overlooked by academics as well as the public at-large in discussions of American health care policy. No matter the depth of a person’s passion for a particular topic, the task of completing a doctoral dissertation is a difficult process, and a task that cannot be accomplished without the support of several other individuals. Indeed, there are a number of people I would like to thank for their generous assistance, guidance, and support while I carried out my research and wrote my dissertation. Without the support of these individuals, the task would never have been completed.

My academic supervisors at the University of Oxford, Rebecca Surender of the Department of Social Policy and Intervention and Adam Saunders of the Department of Politics and International Relations, both offered strategic guidance throughout the process. As my academic supervisor when I first arrived at Oxford in 2007, Rebecca was well aware of my deep interest in American health policy. Adam joined the project in 2011 and was tremendously helpful for his knowledge of American politics and social policy development as well as for the energy he brought to his work. Adam and Rebecca read countless drafts of the dissertation and faithfully offered comments, which ultimately led to a much richer thesis. I cannot thank them enough for their support and guidance.

The Salem Hospital Foundation (Salem, Oregon) provided funding early on during my studies at Oxford, which enabled the completion of my initial research proposal. Without the Foundation’s financial support, the research would never have begun. I am

also tremendously indebted to Pamela Larson and Lee Goldberg of the National Academy of Social Science (NASI) in Washington, DC. My initial involvement with NASI came as a Somers Aging and Long-Term Care Policy Research Intern in the summer 2009, although I later joined NASI as a Visiting Scholar in 2011. Each year, NASI brings together a group of students and young professionals to work in organizations around Washington, DC. My placement through NASI took me to the United States Senate Special Committee on Aging, where I spent the summer of 2009 as Congress debated the prospect of national health reform.

Debra Whitman, who served as the Staff Director of the United States Senate Special Committee on Aging, first suggested the idea of researching the Community Living Assistance Services and Supports (CLASS) Act. I am immensely grateful for Debra's suggestion to look at the CLASS legislation as well as for Anne Montgomery's assistance in connecting me with several people closely involved with the development of the CLASS Act. Through my work at the Committee, I enhanced my understanding of the policymaking process in a way that my academic training could offer.

My time at the United States Senate came to an end just before I began the data collection stage of the research process. The focus of my research necessitated that I remain in Washington, DC for several more months. Steve McConnell asked me to work for him at the Atlantic Philanthropies, USA, where I worked from the fall of 2009 through early 2011. At the time, Steve served as the Interim Director of Atlantic's Ageing Programme and was awash in projects focused on supporting vulnerable, older adults with chronic health conditions. The opportunity to work with Steve allowed me to carry out the data collection stage of my research in Washington, DC. I am honored to have worked

with such a dynamic organization as the Atlantic Philanthropies, whose focus on improving the lives of the most vulnerable, older adults – both in the United States and around the World – provided an experience that has been unmatched in the possibilities to create impact on a global scale.

I also want to thank Kelsey Walter for all of her assistance in proofreading each draft of my dissertation as well as her companionship throughout the process. I simply would not have completed the dissertation without her support. For Kelsey's unwavering support, I will always be grateful.

Last, but not least, I want to thank my mother, Clara Jean Dawson, for her continuous support – not just while I wrote the dissertation, but throughout my life. She has been my greatest champion all along. My mother supported me in pursuing graduate studies – first at the London School of Economics and then at Oxford – and continued to remind me of how proud my father, Cecil Dawson, would have been of my accomplishments.

Perhaps it is only fitting to dedicate this dissertation to the memory of my father for his unrelenting passion for knowledge, his hope that I would one day attend the University of Oxford, and his need for long-term services and supports in the twilight of his life. Despite the immense tragedy that surrounded his need for care, it was, without a doubt, the inspiration for my research and interest in long-term care financing policy. I only hope that my research may – at least in some small way – contribute to a system that better provides long-term services and supports to people like my father.

Chapter One: Long-Term Care Policymaking and Policy Change

Introduction

This thesis seeks to advance the understanding of social policy in the United States, using long-term care (LTC) financing policy reform as an illustrative example. Long-term care is defined as the services and supports needed when the ability to care for oneself has been reduced by chronic illness, disability, or old-age (Miller et al. 2007). Specifically, this thesis explores LTC financing reform efforts during three U.S. Presidential administrations: Bill Clinton (1993-2001), George W. Bush (2001-2009), and Barack Obama (2009-2010). These three discrete historical periods provide comparable cases from which to explore the reasons why path-departing financing reform legislation was not enacted during the years of either the Clinton or Bush Presidencies, but only after President Obama took office in 2009. Drawing on the well-regarded explanatory frameworks of the welfare state of ideology, historical institutionalism, and an actor-centered approach to policy analysis, this thesis argues that path-departing social policy reform is difficult to achieve in the United States due, in part, to the presumed high costs of social programs and the complex institutional framework of the American political system. Policy outcomes result from the interaction between the complex processes and dynamics of the political system through which policy change (or the failure to change) actually occurs.

The Health Security Act of 1993 advanced by President Bill Clinton during the 109th Congress included a proposal for LTC financing reform that, if enacted, would have constituted a significant departure from existing financing arrangements. The main components of the LTC proposal included: a new, tax-financed program to pay for the

individual costs of home and community based services (HCBS), loosening the minimum requirements for government assistance for institutional care through Medicaid, and significant tax incentives for the purchasing of private LTC insurance. Together, these policy changes would have increased the government's role in providing protection against the individual financial risks associated with the need for LTC. Although legislatively unsuccessful, the Clinton proposal represented the first time that LTC financing reform was specifically addressed as a part of a comprehensive health reform effort. In the years following the demise of the Clinton health reform effort, incremental reforms to the LTC financing arrangements were successfully implemented, which largely relied on pro-market initiatives such as tax credits to purchase private insurance.

An examination of the years of the Bush Administration provided an opportunity to view the development of LTC financing reform under very different political and institutional conditions than the years of the Clinton or Obama Administrations. Although LTC reform was not high on the Bush Administration's domestic agenda, the CLASS Act was developed into a legislative proposal. However, it was only after the 2008 election and President Obama's landslide victory that a proposal to establish a new state-centered financing mechanism for LTC was able to pass into law as a part of the wider health reform efforts.

The Community Living Assistant Services and Supports (CLASS) Act passed into law as part of the wider health reform package, the Patient Protection and Affordable Care Act of 2010 (P. L. 111-148), which constituted a major shift in the existing policy dynamic and an even more significant development given the economic downturn. The legislation sought to transform the American LTC financing system by establishing a government

administered, yet self-funded, voluntary insurance program for the purchasing of long-term services and supports (LTSS). The program would be open to all actively working adults, regardless of pre-existing physical or mental impairments. Participants in need of assistance with their activities of daily living (ADLS)² would receive a cash benefit of no less than \$50 a day to pay for those supportive services in a home or community setting. In addition, there would be no lifetime limit on the years or amount of benefits that participants could collect. This new financing mechanism was designed to relieve future individual financial burdens associated with LTC, while reducing the U.S. federal government's direct expenditures on LTC through the Medicaid program. The legislative success of the CLASS Act constituted the largest single change to LTC financing policy since the creation of the Medicare and Medicaid programs in 1965. The CLASS Act, therefore, represents a significant break with past policy arrangements after a long period of relative stability. As such a groundbreaking piece of legislation in the field of LTC financing, it provides a useful case to examine the policymaking process in the United States. The CLASS Act's success as part of the larger health reform efforts of President Obama provides a particularly strong comparative case from which to view the failure of President Clinton's efforts.

Despite the unprecedented legislative success in 2010 of establishing a new state-led financing program for the provision of long-term services and supports (LTSS) in the United States, the Obama Administration announced in October of 2011 its intent to abandon efforts to implement the fledgling CLASS program. The Administration cited an

² Activities of Daily Living (ADLS) are defined as basic personal activities such as eating, bathing, dressing, mobility, transferring, and toileting, which are used to determine how dependent an individual may be on requiring assistance in carrying out any of these activities. Instrumental Activities of Daily Living (IADLS) refer to household tasks such as using the telephone, medicating, managing money, housework, cooking, laundry, and shopping for groceries (U.S. Department of Health and Human Services, 2012).

inability to make the program operational under the stipulations of the legislation without significant amendments, which would require legislative action (U.S. Department of Health and Human Services, 2011). However, at this point in time the legislative process was no longer a viable option for making fixes to the Act, as the 2010 mid-term elections shifted the balance of power in Congress decisively away from President Obama's political party—the Democrats. Although designed in such a way as to be politically palatable, the CLASS Act became a casualty of the continuing political battle that engulfed the wider health reform package passed under President Obama and ultimately was not operational in practice. In order to better understand the issues surrounding the LTC financing reform, this chapter will now explore the major challenges that confront health and LTC financing in the United States.

Background: The American Health Care System

The United States is an outlier amongst Organization for Economic Co-operation and Development (OECD) nations in terms of its health care arrangements. With the exception of the United States, every industrialized democracy has made health care universally accessible to its entire population (Waddan and Jaenicke, 2006, p. 242). Meanwhile, the United States spends more on health care than any other OECD nation—nearly \$2.6 trillion, which is 17.6 percent of its total GDP or \$8,233 per capita in 2010 (Organization for Economic Co-operation and Development, 2012). Other high spending nations, by comparison, spent far less on health care, including the Netherlands, which spent 12 percent of its GDP on health care, while France and Germany each spent 11.6 percent of GDP (Ibid). While Western European nations are able to provide universal

access to health care at a lower cost than the United States, the specific arrangements of social protection vary across Europe as social insurance and tax-financing are both used as financing mechanisms (Saltman, 2004). In addition to the large amount of resources annually spent by the U.S. on health, the rate of growth in spending is a major source of consternation. While spending increased by 3.8 percent in 2009 and 3.9 percent in 2010—the two smallest increases in over fifty years and a phenomenon that is largely attributed to the continuing economic recession—total spending on health care is projected to increase by an average annual rate of 5.8 percent over the next ten years (Keehan et al. 2011). Total annual health care spending is projected to reach a remarkable \$4.64 trillion, or nearly 20 percent of total GDP, in the year 2020. Yet, despite the high level of spending, the U.S. only receives average—and sometimes below average—scores on health outcomes when compared to other OECD nations (Organization for Economic Co-operation and Development, 2012).

The disparate financing arrangements of the American health care system also make it unique. The majority of Americans—approximately 83.7 percent of the U.S. population—have some form of health coverage. However, the other 16.3 percent of the population (50 million people) do not have any form of medical coverage at all and are deemed ‘uninsured’ (DeNavas-Walt et al. 2012). Many Americans who do have health coverage are often uninsured for some portion of the calendar year due to job loss, while others who ostensibly have medical coverage are underinsured against the risks of illness (Waddan and Jaenicke, 2006, p. 242). However, with the passage of the Patient Protection and Affordable Care Act in 2010, the number of uninsured Americans is projected to

decrease substantially (Congressional Budget Office, 2012) as the different portions of the legislation become fully operational.

Private insurance is widely used in the United States and is the main source of funding for all health care expenditures accounting for \$822.3 billion in 2010 (Centers for Medicare and Medicaid Services, 2012). While employer-sponsored private health insurance provides approximately 55.3 percent of the U.S. population with health coverage, it accounts for only 34.6 percent of all health care spending (Lyke, 2009, p. 9). The majority of private insurance plans are provided through employment as part of a compensation package. The rest of the population receive their health care through the publicly financed programs of Medicare (14.5 percent), Medicaid (15.9 percent), the U.S. military, and the Veterans Administration (4.2 percent) (DeNavas-Walt et al., 2012). An additional 9.8 percent of the U.S. population relies on other forms of private coverage, such as health insurance purchased independently from employment or paying for medical services entirely out-of-pocket. The heavy reliance on private health insurance to finance health care, the high costs of medical care, and the large number of Americans without medical coverage place the U.S. in a unique position compared to the rest of the world.

The joint role of the federal and state governments in health care adds an additional layer of complexity to the American health system. Medicare is a federal social insurance program which finances acute medical care for adults aged 65 and older, adults with disabilities, and individuals with end stage renal disease. The program has four main parts referred to as parts A, B, C, and D. Initially enacted in 1965, Medicare Parts A and B, cover hospital and physician services, respectively, through a single payer financing mechanism. Medicare Advantage, known as Medicare Part C, offers private health plans

that are financed through the federal government, which individuals can purchase at a subsidized rate to supplement the single-payer program of Part A and B. Medicare Part D, added to the program in 2003, pays for the individual costs of prescription drugs. In 2010, Medicare expenditures were \$524.6 billion (Centers for Medicare and Medicaid Services, 2012), the federal government's single largest expenditure on health care.

The other main governmental health program, Medicaid, is a means-tested, entitlement program and acts as the primary financing mechanism for the health care of many low-income Americans, primarily women and children (Stone, 2009, p. 5). However, older and disabled adults with little or no assets also receive assistance with the costs associated with institutional long-term care through Medicaid, although waivers allow individual states to provide home and community based services (HCBS) in place of institutional services (Thompson and Burke, 2009). While Medicare is an entirely federal program, states and the federal government share joint authority over the Medicaid program. State governments partially fund their own Medicaid programs, but also receive matching funding from the federal government. Overall, approximately 43 percent of Medicaid funding comes from state governments (Kaiser Family Foundation, 2009, p. 19). Total Medicaid spending was \$401.4 billion in 2010 (Centers for Medicare and Medicaid Services, 2012). In 2007, states and local governments financed \$281.4 billion worth of all U.S. health care expenditures (Lyke, 2009, p. 10). States also serve as the main regulators of the private health insurance market, particularly the individual and small group markets, and have jurisdiction over the regulation of business practices associated with the private insurance that employers provide for their employees (Ibid, p. 10).

The Accumulated Challenges of Long-Term Care

Long-term care (LTC) is a growing policy issue for all advanced industrialized democracies as evolving gender roles, changes in family structure (Esping-Andersen, 2009; Armingeon and Bonoli, 2006) and an aging population due to lower birth rates and increased life expectancy, (Coleman, 2006; Griger, 2010) pressure governments to better plan and care for their elderly populations. While the care of the oldest and most vulnerable members of society has traditionally been provided by families, the move to formal care arrangements firmly placed LTC in the policy arena (Österle and Rothgang, 2010). The challenges associated with LTC are ones of the so-called ‘new social risks’ that confront all advanced welfare states due to systemic social and economic changes associated with a transition to a post-industrial society (Hacker, 2004; Taylor-Gooby, 2004; Bonoli, 2005; Esping-Andersen, 1999). This shifting dynamic highlights several financial and organizational concerns in the provision of LTC—which are not country specific—such as the affordability of care, who will pay for care, and how care will be provided.

In the United States the policy challenges associated with an increasing need for LTC assume particular intensity (Gonyea, 2010) amidst the worst economic downturn since the Great Depression and a highly charged political environment focused on government spending and the appropriate role of the state in mitigating social risks. The highly fragmented LTC financing arrangements, which rely extensively on individuals and families to provide and finance care, produce exceedingly high costs for individuals. The high costs of financing LTC continue to grow, officially estimated at \$233.4 billion in 2007 (Stone, 2010, p. 3), adding further strain to the already heavily burdened budget of

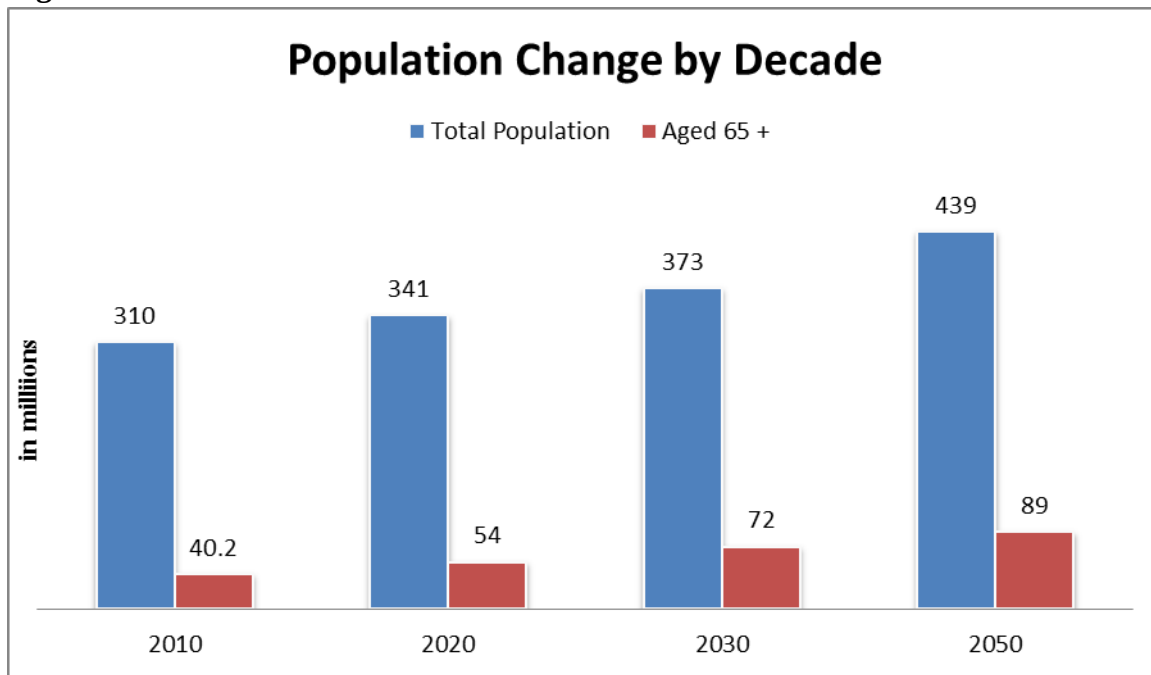
the federal government and of individual states. Estimates of informal, unpaid care and the lost wages associated with the provision of that care, are projected as high as \$450 billion annually (Feinberg et al. 2011). Public assistance—primarily the Medicaid program—is highly residual, paying for care only if an individual is at or below the federal poverty level.³ The arrangements are particularly challenging for vulnerable populations such as low-income older and disabled Americans, who rely extensively on unpaid, informal care that is disproportionately provided by women and minority populations (Scharlach and Lehning, 2012).

Long-term care is defined as the services and supports needed when the ability to care for oneself has been reduced by chronic illness, disability, or aging (Miller et al. 2007). These services include assistance with basic activities of daily living (ADLs) such as feeding, bathing, and dressing as well as instrumental activities of daily living (IADLs) like cleaning and cooking, which are difficult or impossible to carry out due to illness, age, or disability (Stone, 2006). Approximately 15 percent of Americans over the age of 65 and over 25 percent of those over age 85 currently require LTC and the costs associated with the provision of these services and supports are exceedingly high, especially in the context of institutionalized care. Current estimates show that approximately 12 million Americans require LTC (Kaye et al. 2010). Sixty-nine percent of Americans over the age of 65 will need some form of LTC prior to the end of their lives and one-third of the entire U.S. population will spend some time in a nursing home during their lifetime (Wiener, 2009). Of course, not all people who rely on these services and supports to help carry out their daily life functions are elderly. Older Americans account for approximately 58 percent of

³ The federal poverty level for an individual is an annual income of \$11,170 or less in 2012 (U.S. Department of Health and Human Services, 2012).

those in need of LTC, while those under 65 make up the other 42 percent (Feder et al. 2007). Nevertheless, the need for LTC becomes more likely as a person ages, this need transcends age to include people born with disabilities or who become disabled at any age due to accident or illness. Long-term care is thus a particularly relevant policy topic to address given the aging of the baby boom generation. In 2010, it was estimated there were 40.2 million Americans over the age of 65 (Vincent and Velkoff, 2010). The U.S. Census Bureau projects that by the year 2030, nearly one in every five Americans will be 65 or older. This age group is projected to increase to nearly 89 million people by 2050 (Ibid) (See figure 1.1). The demographic changes ahead will add further strain to an already overburdened system, particularly on the ability to finance LTC.

Figure 1.1



Source: U.S. Census data (Vincent and Velkoff, 2010).

Although in the American policy arena LTC is generally subsumed within health policy, it differs with regard to the provision and nature of services including the types of services needed by patients (e.g. help with daily life functions such as eating and bathing rather than intensive treatment of acute illness or disease). Moreover, while elderly Americans are the only major group of U.S. citizens whose access to health care is provided as a legal entitlement through the Medicare program (Feder et al. 2000), those who require LTC are assured considerably less protection.⁴ This gap in coverage stems in part from the highly fractured and inequitable system of LTC financing in the United States. Long-term care is financed through a patchwork system that includes the governmental programs of Medicaid and Medicare,⁵ but also substantial out-of-pocket expenditures and the use of private insurance. Approximately 43 percent of all LTC spending takes place through the Medicaid program, while Medicare accounts for about 24 percent of all spending (Kaiser Family Foundation, 2012). Out-of-pocket expenditures make up another 19 percent, while seven percent comes from private insurance and seven percent from miscellaneous other sources such as the U.S. Veterans Administration, programs within the Older Americans Act, and private charities (See Figure 1.2).

⁴ An entitlement is a program, either means-tested (Medicaid) or universal (Medicare and Social Security), where the U.S. government has a legal obligation to provide benefits to those who meet the program's eligibility requirements. Entitlements differ from other programs as their budgets are governed by permanent laws and therefore are not part of the annual appropriations process in Congress (Chapin, 2010, p. 260).

⁵ Medicare is the acute medical care financing program for adults aged 65 and older and individuals with disabilities. Medicaid is the primary health care financing mechanism for the poor, providing acute medical insurance coverage on a means-tested basis.

Figure 1.2

The chart originally presented here cannot be made freely available via ORA because of copyright reasons. The diagram was sourced at:

Kaiser Family Foundation (2012) *Medicaid and Long-Term Care Services and Supports*, Washington, DC: Kaiser Commission on Medicaid and the Uninsured. <http://www.kff.org/medicaid/upload/2186-09.pdf>

Source: (Kaiser Family Foundation, 2012)

The individual costs associated with LTC are exceedingly high, with most forms of institutional care experiencing between a four and six percent annual growth rate over the past five years (Genworth Financial, 2012). The median annual cost of a private room in a nursing home in 2011 was \$81,030 or \$222 a day, while a room in an assisted living facility cost \$3,300 a month or \$39,600 annually, and the average hourly cost of in-home care provided by a licensed home health aide averaged \$19 an hour or \$43,472 annually (based on 44 hours per week) (Genworth Financial, 2012). Combined public and private expenditures on LTC officially accounted for \$233.4 billion, or just over 10 percent, of all U.S. health care spending in 2007 (Stone, 2010, p. 3). The real costs of LTC, however, are difficult to estimate precisely as many services are provided informally, and unpaid, by family members or friends (Pavalko, 2011). Estimates of the annual cost of informal, unpaid care vary but range as high as \$450 billion (Feinberg et al. 2011). The cost of

providing LTC for the elderly is projected to more than double over the next 30 years as the population ages (Stevenson, 2008, p. 1986).

Meanwhile, the American public appears to be largely unaware of the potential risks of needing LTC in their lifetime, and they are unclear about who will pay for LTC if and when they need it (Scharlach and Lehning, 2012). A 2006 study commissioned for AARP found that 59 percent of Americans erroneously believe that a social insurance program, such as Medicare, will pay for all of their LTC needs in old-age (GfK NOP Roper Public Affairs and Media, 2006, p. 33). In fact, Medicare only pays for an individual's LTC if they were first admitted to a hospital for the same condition that requires LTC and only for a maximum duration of 100 days (Gonyea, 2010).⁶ Other forms of public financial assistance for LTC are also limited or highly restrictive. In order to qualify for LTC assistance through the Medicaid program, an individual must have little or no assets (less than \$2,000 for an individual, \$3,000 for a married couple) to meet the program's means-tested requirements.⁷ Many Americans 'spend down' their assets in order to qualify for assistance through Medicaid, which has become the default payer for most costs not paid out-of-pocket that are associated with LTC. Approximately three million individuals, or just fewer than 30 percent of all LTSS recipients, receive care that is financed through Medicaid (Kaiser Family Foundation, 2011). However, this statistic obscures the actual significance of Medicaid as only two-thirds of all older Americans have sufficient resources to cover one year of institutional LTSS, and ultimately 65 percent

⁶ These services are highly expensive compared to services like cooking, bathing, and household chores, which Medicare does not cover. Thus, although coverage is short term and limited, Medicare still accounts for approximately 22 percent of all LTC expenditures.

⁷ As part of the joint federal-state administration of Medicaid, individual state governments have some flexibility in determining eligibility for LTSS beyond this threshold. Consequently, there is wide variation in actual eligibility for Medicaid across the states (Frank, 2012).

of all LTSS recipients turn to Medicaid for financial support once they exhaust their own assets (Engquist et al. 2010). The need for LTC is therefore one of the most significant risk factors contributing to poverty in old-age.

Since the personal assets of the vast majority of middle-class Americans make them ineligible for Medicaid at the outset of their care needs, private insurance is often touted as a financing option for those whose income and assets make them initially ineligible. However, estimates show that approximately seven million Americans own a private LTC insurance plan (Frank, 2012), and only 10 percent of older adults have the requisite resources to purchase a plan that costs less than five percent of their total income (Gonyea, 2010, p. 200; Zedlewski and McBride, 1992). Furthermore, private insurance is often term-limited to either three or five years of care, which a significant percentage of individuals exhaust over the course of their lifetime (Frank, 2012). Private insurance is particularly challenging for younger disabled adults, who may require decades of services. The highly fragmented financing arrangements leave the majority of people to pay for LTC out-of-pocket, until they exhaust their financial resources and qualify for public assistance from Medicaid. Yet, despite the obvious need for a comprehensive LTC policy that more adequately meets the needs of elderly and disabled Americans, substantial financing reform remained elusive until the passage of the CLASS Act in 2010.

Financing Options: Social vs. Private Insurance

Social insurance is the primary financing mechanism used by a number of social protection programs in the United States, namely Social Security and Medicare (Moss, 2002).⁸ The popularity of these two programs has been historically very high with the American public,⁹ due largely to the ability of these programs to provide health and income security and to reduce the likelihood of poverty in old-age. An expansion of an existing program like Medicare, or the creation of a new social insurance program, has been the preferred financing mechanism of LTC reform advocates. Within the American context, social insurance describes governmental programs typically exemplified by mandatory participation, redistribution from high to low-income earners, and the use of tax-revenue to bolster the financial viability of the program (Graetz and Mashaw, 1999). American social insurance also reflects an emphasis on adequacy (e.g. the minimum level needed to be sufficient) rather than equity in terms of program benefits. It should be noted that historical differences exist between the concept of social insurance in the United States and Western Europe.

The well-documented challenges that confront private insurance (Arrow, 1963; Barr, 2001) are particularly acute with regard to LTC insurance as demonstrated by the LTC insurance market in the United States. Several barriers to the wider utilization of the private LTC insurance market exist, stemming in part from moral hazard, adverse selection, and inadequate risk pooling (Barr, 2010; Wiener et al. 1994).¹⁰ It is widely

⁸ State-based unemployment insurance is the other main social insurance program in the U.S., which is funded primarily through employer contributions as well as intermittent general revenue from the federal government.

⁹ The historical popularity of Medicare and Social Security is thoroughly covered in Page and Jacobs (2009).

¹⁰ Risk pooling is an insurance term that means the medical costs of a large group of individuals are combined together in order to calculate premiums (Barr, 2003). Adverse selection occurs when asymmetrical information exists between two parties. For instance, an individual with a higher risk for illness will buy

argued that LTC insurance is not extensively utilized in the U.S. because of the “widespread denial and misperception of risk” that surrounds LTC (Campbell and Morgan, 2005, p. 892). Illness and disability are unpleasant topics, which many people choose to ignore, especially given the long time frame before the need for care arises (Friedmann et al. 2004; Frank, 2012, p. 341). The denial and misperception of risk ensures that people are unlikely to think about LTC until they reach an age when insuring their risks are prohibitively costly or their care needs make them “uninsurable” through private insurance (Campbell and Morgan, 2005, p. 892). However, undoubtedly the greatest obstacle to the wider use of private LTC insurance in the United States is the high cost of purchasing a private plan (Gonyea, 2010; Wiener, 2009). The high cost of private insurance is particularly challenging for older adults on fixed incomes as the annual cost of a private plan can exceed \$5,000 (Ibid, p. 8). Unlike acute private health insurance, few U.S. employers offer their employees LTC insurance as part of a compensation package. Private LTC insurance plans are therefore more likely to be purchased by high-income, high net-worth individuals rather than middle or working-class Americans (Kassner, 2007, p. 1).

more medical insurance if they are aware of their need for coverage. Thus, the insurer is less informed than the potential buyer about the applicant’s level of risk (Barr, 2010). Moral hazard occurs when an individual who has insurance can influence the insurer’s expected loss without the insurer’s knowledge (Ibid). For instance, individuals who have insurance may take greater risks than they would without insurance because they know they are protected against financial loss.

Plan of Thesis

Chapter Two examines the theoretical frameworks that are routinely used to explain social policy development in the United States, specifically ideological arguments, historical institutionalism, and theories of stakeholder interaction within the policy process. The gaps in the literature on American Social policy are highlighted, with a particular focus on the lack of attention to LTC. While these theoretical frameworks each have their individual limitations, this review of the literature demonstrates that together they can contribute to a better understanding of the design and legislative success of LTC financing reform.

Chapter Three describes the qualitative research design and methods used in relation to the objectives of the study. In addition, this chapter discusses the strategies employed during the data collection and analysis stage, as well as the main issues encountered during these processes. This chapter will also address some of the possible limitations of the selected research design and the steps taken to mitigate those limitations. Proper attention to any potential ethical considerations as well as the reliability and validity of the data are also discussed within this chapter.

The analysis in Chapter Four explores LTC policymaking during the years of the Clinton Administration with particular focus on the failure of comprehensive LTC reform as a part of the Health Security Act of 1993. Several important issues will be addressed within this chapter, including why LTC reform failed to take place in 1993-1994. This chapter will also examine whether the failure to enact comprehensive LTC reform was exclusively a function of the collapse of the broader health reform efforts promoted by President Bill Clinton. The chapter will additionally explore the possible impact that this

failed attempt at LTC financing reform had on future LTC reform efforts, including the CLASS Act in the 2000s.

Chapter Five goes on to address several important questions that will help unpack the complex process through which policy is developed in the United States and how that relates specifically to LTC financing reform. First, it examines how the ideological orientation of the Bush years might have affected the proposed design of LTC financing reform as well as the strategies used to bring about that particular proposal. This question and others will help to demonstrate the complex American policymaking process and how the frameworks of ideology, institutions, and political actors interact within that process to influence policy change.

Chapter Six examines the legislative success of the CLASS Act as a part of the health reform efforts that took place following the election of President Obama. Specifically, this analysis will look at the particular strategies of both the proponents and opponents of CLASS during the Obama health reform efforts, and whether they were significant to the success of CLASS. Given the apparent momentum for change, and the new political environment heralded under President Obama, the chapter will also attempt to explain why a much bolder program was not driven forward by proponents of reform. On the other hand, given the significant evidence that the values of self-sufficiency, individualism, and choice were alive and well in the United States, it also attempts to explain how and why a large new governmental program was created to address LTC financing.

Chapter Seven attempts to draw together the findings presented in each of the three empirical chapters, which focus on LTC financing reform during the three different

Presidential administrations. The chapter additionally attempts to explain why the different explanatory frameworks examined within this thesis are important for gaining a better understanding of LTC policymaking in the U.S. This concluding chapter will also suggest an agenda for future research on LTC policymaking and policy change. Lastly, it will offer some reflections on the future of U.S. LTC financing and the prospects of any future reform effort.

Chapter Two: Literature Review and Analytical Frameworks

Introduction

A general consensus exists amongst scholars that the political institutions and ideological orientation of the United States has produced a welfare state laggard. The institutions and ideological orientations of the political environment of the United States are particularly relevant for the analysis of long-term care (LTC) financing reform. It is now well acknowledged that the United States is distinct when compared to other advanced democracies in terms of the strength and breadth of its welfare state (Wilensky, 1975; Esping-Andersen, 1990; Weir et al. 1988; Skocpol, 1992). A lack of national health provision is regularly cited as evidence for America's status as a welfare state laggard (Béland and Hacker, 2004). However, the situation is more complex and contradictory than at first glance. Medicare, a robust social insurance program, provides health benefits to older and disabled adults, while Social Security is a key source of income for American workers in retirement. Theories about a strong anti-welfare culture within the U.S. also fail to provide a definitive explanation for the unique American welfare state, as opinion polls habitually demonstrate conflicting beliefs over the extent to which the government should play a role in mitigating social and economic risks. While highly supportive of programs like Medicare and Social Security (Page and Jacobs, 2009), the American public's support for additional taxes to maintain existing benefits or to expand coverage appears much less popular. For instance, survey data collected in July 2011 shows that only forty-one percent of the American public supported higher payroll taxes in order to maintain current Medicare benefits (Blendon and Benson, 2011). At once there are high levels of support

for publicly provided social protection and deep skepticism towards government (Morgan and Campbell, 2011). Adding further complexity to any straightforward classification of America's social policy arrangements is the amount of social protection indirectly provided through the federal tax code (Howard, 1997) and through the extensive use of private benefits, such as employer-sponsored health insurance and retirement pensions (Jacoby, 1998; Hacker, 2002; Stevens, 1988). This complex system makes an attempt to explain U.S. social policy development particularly difficult.

Indeed, the United States appears to stand apart when compared to other nations in terms of the level of public social protection afforded to its citizens and the approaches through which such protection is provided (Hall and Soskice, 2001; Esping-Andersen, 1990; Lipset, 1996). In *The Three Worlds of Welfare Capitalism*, Esping-Andersen (1990) classifies three typologies of welfare states: Liberal, Conservative, and Social Democratic. The Liberal model, of which the United States is the archetype, has modest levels of income transfers and lower usage of social insurance, with a focus on individuals and the private market providing most social welfare needs, and anemic, means-tested benefits for low-income populations. Germany is the archetype of the Conservative (or Corporatist) model, which has more robust state involvement in social provision than Liberal nations through benefits that are tied to occupational status. The Social Democratic model, which includes the Scandinavian nations with Sweden as the archetype, is characterized by universal benefits based on social rights and citizenship rather than need or occupational status. Consequently, Social Democratic states tend to have high levels of redistribution across all socio-economic groups. Comparing across models, several scholars have examined national public expenditure on social protection (Huber and Stephens, 2001;

Gilbert, 2010). For instance, total public spending in 2007 on social protection in the United States ranked it well-behind most European nations (Gilbert, 2010, p. 137). A more complex picture emerges, however, when private measures of social protection are taken into account. Hacker (2002) explores the extensive use of private health insurance, pensions, and other forms of social welfare benefits in the United States that, while privately provided, often receive significant financial support from the government. This hybrid system of public and private forms of social protection suggests that social welfare is conceptualized differently in the United States than in European nations in terms of the type of policies pursued, in the way that benefits are provided, and who is eligible to receive those benefits.

A multitude of theories have been posited for the distinct development of American social policy. Historical institutionalism has featured prominently in the analysis of American social policy development given its attention to institutional veto points, path dependency and policy feedback (Amenta, 1998; Thelen and Steinmo, 1992; Mahoney and Thelen, 2010). This framework is based on an assumption that a historically constructed set of institutionalized constraints, as well as policy legacies and feedback, structure the behavior of current and all subsequent policy actors during the policymaking process (Skocpol, 1995; Hall and Taylor, 1996). The role that institutions play in shaping social policy outcomes is particularly well-documented in the case of the American welfare state, since fragmented political institutions provide interest groups and stakeholders with unparalleled access to the policy process (Quadagno, 1988; Pierson, 1995; Campbell, 2003). There is particularly abundant evidence of the role that institutions played in helping to thwart attempts to reform the U.S. health care system prior to the recent

legislative success of the Obama Administration (Immergut, 1992; Steinmo and Watts, 1995; Hacker, 1998; 2002). Yet, the specific impact of institutions on U.S. LTC policymaking has been analysed far less given LTC's emerging role as a 'new social risk' (Taylor-Gooby, 2004; Bonoli, 2005).

A major thread within new institutionalism attempts to explain how institutional change takes place without an explanation based on exogenous shocks. Institutional accounts have been highly valuable in expanding the analytical toolkit for welfare state analysis, particularly for explaining why it is so difficult for those seeking retrenchment to successfully roll back existing policies and programs (Pierson, 1994; 2004; Campbell, 2003). Scholars have attempted to provide a more encompassing explanation for institutional change by examining gradual change within social policy (Hacker, 2004; 2005; Streeck and Thelen, 2010; Thelen, 2003; 2004). This approach has been highly useful for highlighting how policy change can take place through drift, layering, conversion or complete replacement (Thelen, 2003; Mahoney and Thelen, 2010).¹¹ Yet, a lack of empirical evidence on the complex relationships that exist between institutional change and wider political, economic, and ideological factors (Béland, 2007, p. 21) suggests a focus on policy change through the concepts of drift and layering may help to further elucidate the policymaking process, particularly in the LTC financing arena.

Also key among the explanatory frameworks of U.S. welfare state analysis is the role of ideology, which focuses on highly individualistic values and norms, a pro-market outlook, and the pervasiveness of an anti-statist sentiment within the U.S. political environment. According to Williams (1997), ideology provides the lens through which

¹¹ For the application of the concept of layering, please see the analysis within the findings presented on pages 54 and 234.

people relate to political life as well as the conceptual framework through which people understand the political world they inhabit (Williams, 1997, p. 15). In addition, ideology provides a set of values that help individuals construct a better vision for society (Ibid, p. 15). In other words, ideology serves as a framework for what, if anything, people should do to bring their society more in line with their vision of the ideal society (ibid). In the context of policy, ideas are defined as “claims about descriptions of the world, causal relationships or the ideological legitimacy of certain actors” (Parsons, 2002, p. 48; Béland, 2010, p. 622; Béland and Waddan, 2012). Indeed, ideology impacts social policy, and the way that ideology specifically influences LTC policymaking requires analysis.

Theories which emphasize ideology argue that the United States is exceptional and that social policy is viewed differently than in other advanced industrialized nations. The concept of 'American exceptionalism' posits that the United States is different or unique from other nations, particularly those in Europe due to its revolutionary roots, and a national identity based on ideology rather than a shared ethnicity or history (Lipset, 1996). Although it permeates issues as diverse as foreign affairs, attitudes toward immigration, and the absence of a robust socialist political party in the United States, it is also central to explaining social policy outcomes, and the ‘laggard’ American welfare state (Lockhart, 1991; Lipset, 1996; Lipset and Marks, 2001). This theoretical framework contends that America’s reticence toward state sponsored social protection is a product of an anti-statist political culture where private property and individual rights are paramount, distrust of state authority is pervasive, and social problems are best addressed through private or market solutions (Lipset, 1996). Underpinning this framework is the concept of liberalism, an ideology emphasizing individual liberty, a limited role for government, and the primacy

of the free market. This ideological thesis and its implications for policy outcomes in the U.S. is well argued in the literature, including Hartz (1955), Rimlinger (1971), Huntington (1981), Levine (1988), Marmor et al. (1990), Lockhart (1991), Lipset (1991; 1996), Morone (1998), and Marks and Lipset (2001). On the other hand, there is significant evidence that Americans believe the state should play some role in providing a social safety net given the existence of government programs like Medicare and Social Security and their historical popularity with the American public (Page and Jacobs, 2009). Policymakers are, however, hesitant as to what extent that role should be given a persistent neo-liberal, individualistic outlook within the United States. Policy outcomes must often find balance between these two competing currents in order to achieve success within the American political system.

The Case for American Exceptionalism

According to Daniel Levine (1988), differences between welfare states are relative, shaped by the underlying cultural values within each specific nation (p. 11). Originally published in 1835, De Tocqueville's *Democracy in America* was one of the first attempts to document America's unique historical development. De Tocqueville (1998) argued that America was shaped by the social and material conditions that existed at its founding. Waves of immigrants arrived in America seeking to pursue their personal economic interests—an impossibility in Europe as hereditary estates controlled the majority of land (Smith, 1993, p. 551). Additionally, the ideals of Protestant and mainly English settlers, who escaping the rigid and autocratic European state espoused liberty and individual rights, formed the core of a new American culture (Huntington, 1981, p. 19). This was

reinforced by a lack of a sense of superiority of one individual over another as the landowning nobility remained in Europe and wealthy American landowners were not granted the same aristocratic privileges of their European counterparts (Smith, 1993, p. 551). The historical underpinnings of American ideology are also emphasised by Fredrick Jackson Turner (1921), who asserts that American individualism is a product of the frontier and the abundant free land that it offered. Fiercely independent and living in a country which provided abundant, uninhabited land, early Americans developed a nation that viewed society much differently from their European counterparts. However, the strength of the frontier thesis does not appear to hold up when other New World frontier cultures are considered, such as Canada, Australia, and South Africa, whose ideology and social policies deviate greatly from the United States.

Similarly, Louis Hartz (1955) focuses on the historical uniqueness of the United States when accounting for its distinct political culture. In particular, Hartz argues that the absence of feudal institutions and social class ensured that Americans would engage with civic life differently than European polities (Hartz, 1955). The argument that the liberal ideal is pervasive in America is important to Hartz's account of the development of American society. Hartz concludes that the primary assumption of American culture is that the power of the state must be limited (Hartz, 1955, p. 62). Anthony King (1973) echoes the argument that an anti-statist sentiment dominates American political culture. He contends Americans are more individualistic than other polities, more resistant to state intervention in society and more reticent to allow the government to impede the private market (King 1973, p. 418). In sum, the state plays a more limited role in the United States than in other countries simply because Americans appear to want it to have a limited role

(Steinmo, 1993, p. 107). Theorists focused on causal explanations based on ideology contend that anti-statism is central to the American ethos because the nation was founded by immigrants seeking to escape oppressive monarchs (Ibid, p. 106). Samuel Huntington (1981) concludes that while no “American ideology” exists *per se*, the liberal tradition is pervasive in the United States. Instead of a coherent, singular ideology, a distinctive “American Creed” permeates American society (p.16). Huntington similarly argues that the distinctive feature of the American Creed is its anti-government sentiment and that the central themes of American political thought are an opposition to power and a suspicion of government (Ibid, p. 33). Immigrants may have institutionalized their distrust of state power into the nation’s culture, but it also permeates the structure of their government’s political arrangements—demonstrated by the diffusion of power between multiple branches of government and between states and the federal government (Lipset, 1991, p. 8-9). A confluence of forces helped to institutionalize a cultural distrust of government within the United States, which became a persistent fixture of the American polity.

The extent to which ideology can help to explain the welfare state and social policy outcomes in the United States has received considerable attention (Lipset, 1996; Marmor et al. 1990; Shapiro and Young, 1989). The concept of “American exceptionalism” is more thoroughly elucidated by Martin Lipset, who argues that several specific terms define America’s unique ideology: liberty, individualism, populism, and laissez-faire (Lipset, 1996, p. 31). Each of these characteristics of American culture has influenced the policymaking process—particularly the development of the welfare state. Within the American ethos, the liberalist values of individualism and a deeply anti-statist doctrine, which emphasizes a laissez-faire approach to government, dominate (Ibid, p. 36). In terms

of policy outcomes, Lipset highlights the saliency of extreme individualism and the mistrust of central authority, which are often reflected in Americans' tendency to value public policies that emphasize equality of opportunity rather than equality of outcome (Ibid, p. 72). The high value placed on equal opportunity rather than equal outcomes contrasts with the advanced democracies of Europe. Lipset also suggests that Americans are generally content with the distributive role of the private market (Ibid, p. 73), which also contrasts with their European counterparts who were much more concerned with ensuring a strong social safety net to remedy the negative effects of the market. Lipset argues that a belief in the private market as the chief source of redistributive outcomes, held by the majority of Americans, directly translates into the practice of policymaking. In sum, Lipset contends that American social policy reflects a national insistence on a large measure of individual, rather than governmental responsibility (Ibid, p. 75). Individual, or private, approaches to social protection rather than a state-centered approach appear to play a much larger role in the U.S. than in European countries.

Public opinion data appears to support the argument that Americans are less supportive of the concept of government sponsored social protection than their counterparts in other nations (Lipset, 1996; Blekesaune and Quadagno, 2003; Shapiro and Young, 1989; Feldman and Zaller, 1992). For example, survey data shows that only 40 percent of Americans were supportive of government provided health care compared to 80 percent of British and 88 percent of Italians (Lipset, 1996, p. 75). Similarly, 81 percent of British and 80 percent of Italian respondents supported higher spending on old-age pensions, while only 47 percent of Americans felt similarly (Ibid, p. 75). The survey results appear to demonstrate that other countries had strong public support for robust

social safety nets in comparison to the United States. However, it is also well-argued that while Americans may be less supportive of the idea of social intervention, in practice, they are actually highly supportive. Strong, consistent public support of programs like Social Security and Medicare as well as for public education has led many to suggest that Americans are ideological conservatives, yet operational liberals (Free and Cantril, 1967; Page and Jacobs, 2009; Skocpol and Williams, 2012). In attempting to account for varying levels of national support for state intervention, considerable scholarly attention has focused on cross-national levels of public spending on social protection (Brooks and Manza, 2007; 2006). However, Rhem et al. (2012) argue that levels of public spending are insufficient to explain national differences in support for the welfare state, and that it is the correlation between disadvantage and insecurity (or risk) that provides an explanation for national variance as well as variance between specific policies. Opposition to governmentally provided social protection is highest when risk and disadvantage affect the same populations, while support is higher when the two affect different societal groups, allowing for broad, supportive coalitions to emerge that cut across class lines (p. 403). Similarly, when risk and income levels are highly correlated, public support is lower (Ibid, p. 404). In sum, while Americans do appear less supportive of governmental interventions than other societies, it may be particular policy domains, the specific populations they serve, and the individual risks the policies attempt to mitigate which are of greatest significance in accounting for public attitudes toward programs of the welfare state.

An attempt to reconcile a cultural with a structural explanation for the development of American social policy provides a particularly illuminating account of the Social Security program's complementary attributes to American ideology (Lockhart, 1991;

Derthick, 1979). Lockhart focuses on the design and enduring success of Social Security, despite the liberalist tendencies of the United States. Lockhart notes that Social Security was designed to embody principles acceptable to individualistic cultural biases much more thoroughly than other U.S. social programs such as Aid to Families with Dependent Children (AFDC) (Lockhart 1991, p. 517). Eligibility and benefits are earned through paid labor, which fits within the American conception of distributive justice more squarely than social programs based on need. Secondly, policymakers employed terminology that appeals to the cultural context of American individualism such as “contribution” instead of “compulsory tax.” Most importantly, Lockhart notes the image of a bank account to which an individual makes a contribution is invoked, linking individual contributions to individual benefits (ibid). This contrasts with other U.S. social programs and helped policymakers to make a strong case for Social Security, which mitigated several concerns that other social programs create for individualism and the concept of human dignity. While need-based programs often help Americans overcome social risks such as ill-health or old-age, which are difficult to mitigate solely through personal resources, Lockhart suggests they tend to undermine an individualistic conception of personal dignity by highlighting the inability of an individual to be self-reliant (Ibid, p. 519). In contrast, by emphasizing an earned right to retirement, and the link between individual contributions and benefits, Social Security offered Americans a way to protect themselves against the risk of old-age in a way that embraced individualism (Ibid, p. 519). In other words, the ideological values embodied within Social Security were crucial to the program’s political success within the American political environment.

Additional Perspectives on Ideology

While an ideological perspective can provide some insight into the political environment of the United States, one problem with relying on a nation's historical uniqueness to explain subsequent policy outcomes is that all countries possess a unique history (Bell, 1991, p. 50). In terms of American exceptionalism, Bell contends that uniqueness does not necessarily equate to exceptionalism (Ibid, p. 50). Additionally, while ideological accounts may provide plausible explanations for differences, they often overlook how values are actually integrated into social policy outcomes (Quadagno and Street, 2005, p. 53). In other words, what is the direct link between ideology and social policy outcomes in any country, not only the United States?

Steinmo (1993) also challenges the idea that political culture can explain the development of American social policy. While he notes that the power of the cultural argument is its elegance, that the United States is different simply because it always has been (p. 107), there are a number of issues with this framework that Steinmo accurately highlights. Notably, the traditional ideological thesis fails to either explain or account for political or policy change. Second, cultural theorists who focus on ideology have been unable to provide a convincing argument for the existence of conflicting sets of ideas and values in America, and that some dominate at certain times and in certain policy arenas (Ibid, p. 107). Third, despite the arguments of culture proponents, the way political culture works as a causal mechanism in policymaking remains unclear (Ibid, p. 107). Americans may hold differing values than their European counterparts, but that alone is an insufficient explanation for policy outcomes in the United States.

Desmond King (1999) contends the assumption that liberalism can explain American policy preferences is inadequate. The numerous accounts of American political development neglect the way that ‘illiberal’ social policies are intertwined in modern liberal democratic institutions. King contends that illiberal social policies violate liberalism in one of three ways: making judgments about the mental competencies and reasoning powers necessary for citizenship, using collectivist solutions to solve social problems and requiring activities of welfare recipients (King, 1999, p. 10). He argues that the acceptance of illiberal social policies in liberal democracies like the United States can be accounted for by the constant struggle between liberal and illiberal policies. In other words, American political culture is not decidedly liberal; rather, it is a complex mix of inconsistent traditions accompanied by persistent conflicts between those different traditions (King, 1999, p. 26). Put simply, social policy outcomes in the United States are reflective of a complex, continual struggle of competing ideologies.

An alternative account examined by King suggests an intricate entanglement—or symbiosis—of liberal and ‘illiberal’ values rather than a constant conflict between the two sets of values. He argues that American policymakers employ illiberal policies in order to achieve solutions to a particular problem or crisis (Ibid, p. 26). American policymakers may also pursue illiberal policies to win over a particular set of voters. King highlights that liberal democratic governments often undertake illiberal policies while proclaiming their compatibility with liberal values, including illiberal social policies that are advanced in order to achieve liberal ends. An example King offers is the New Deal work camps called the Civilian Conservation Corps (CCC) that were a response to high rates of unemployment during the Great Depression; the necessity of the camps was justified as a

way to preserve the liberal way of life in America by providing temporary work to unemployed young men through a voluntary program, which highlighted the values of volunteerism and hard work rather than a collectivist response to a social problem (King, 1999, p. 194).

Quadagno and Street (2005) challenge the argument that the American welfare state is exceptional due to a pervasive ideology. They suggest that recent policy trends have restructured many American social programs so they are more closely aligned with those of other nations (Quadagno and Street, 2005, p. 53). In particular, they highlight a ‘convergence’ with other ‘liberal’ states like Great Britain and Canada, although they concede that America continues to diverge on health coverage for working-age adults (Ibid, p. 63).¹² Moreover, they argue that public opinion in the United States is seldom reflective of a clear anti-statist consensus, and that policy outcomes regularly conflict with anti-statist values (Ibid, 2005, p. 53). Since the 1950s, state spending and involvement in health care, particularly for the Medicare and Medicaid programs, has increased substantially (Ibid, p. 65). They conclude that anti-statist sentiment regularly appears within the American political debate yet it does not represent an ideological consensus (ibid). More specifically, they find anti-statist sentiment to be a part of the content, but not the outcome of debates on social policy (ibid). The noticeable success of policymakers who employ anti-statist rhetoric to support their policy positions creates a false impression that values are a causal force rather than a tool of the American political arena (Ibid, p. 53). While anti-statism is present in most debates on U.S. social policy, this ideology does not necessarily determine actual policy outcomes.

¹² Further convergence in health between the United States and other advanced industrialized democracies will theoretically occur after the Patient Protections and Affordable Care Act is fully implemented.

The role of race versus that of ideology in relation to support for welfare policies has received extensive analysis (Gilens, 1995; 1999; Sears et al. 2000). Martin Gilens (1995; 1999) confirms the significance of economic self-interest and individualism—both of which are embedded within the liberal tradition in the United States—in shaping public attitudes toward U.S. welfare policy. However, the commonly cited explanations of pervasive individualism and economic self-interest were rejected by Gilens as a comprehensive explanation for attitudes and policy outcomes. Gilens instead argues that racial attitudes are the most important source of opposition to welfare programs amongst white Americans (1995, p. 1010). Americans who believe that most welfare recipients (or the poor) are African-American express more negative views about people who receive welfare and are more likely to blame poverty on a lack of effort rather than circumstances beyond individual control (Gilens, 1999, p. 207). Gilens contends this outlook is a product of traditional prejudice against African-Americans that is still present in a significant portion of the white U.S. population. He concludes from survey data that while white Americans tend to oppose means-tested programs aimed exclusively at the poor, they do support spending on education, health care, and income support for the elderly, as the programs that target these issues are not associated with race. For example, Americans appear to accept the premise that older adults are not expected to work and, therefore, need some form of public support for income and health security (1999, p. 36). The findings suggest a much more nuanced role for ideology in social policy outcomes in the United States that is connected to race and ethnicity.

Move Toward Greater Personal Responsibility

A movement within the American political environment toward a greater reliance on personal responsibility in mitigating individual social and economic risks gained strength in the second half of the twentieth century. In some sense, the personal responsibility movement builds on the normative values of individualism, self-sufficiency, and a faith that pro-market solutions will solve the biggest problems that confront society, all of which are persistent themes within the American political ethos. It is also a response to the growth of the American state that can be traced to the Progressive Movement of the late nineteenth century, the New Deal, and the passage of the Great Society programs in the mid-1960s. This movement, however, is also a function of a consolidated, well-organized campaign by conservatives (Marmor et al. 1990), which began to gain prominence through criticizing the social programs put in place by the New Deal and the Great Society (Mead, 1986; Murray, 1984; Davies, 1996; Critchlow, 2007). Indeed, the movement's main goals are to reduce the role of the federal government and return greater authority to state and local governments, cut taxes and governmental spending, and allow the private market to distribute goods unfettered by government regulation. This viewpoint was institutionalized in the early 1980s with the Reagan Revolution (Waddan, 1997; King and Lieberman, 2009) and further reinforced by successful efforts to redefine existing social programs like Aid to Families with Dependent Children (AFDC) in the 1990s (Weaver, 1998; 2000). The Clinton Administration's failure to achieve substantial reform of the American health system further emboldened this movement, which pushed reform minded policymakers away from the use of bold social policy initiatives to solve the problems of society (Skocpol, 1996).

The years of the Bush Administration advanced this normative agenda further with the 'ownership society' and the enactment of large tax cuts (Hacker and Pierson, 2005; Béland and Waddan, 2007; Pierson and Skocpol, 2007; Hacker and Pierson, 2010a, p. 217). After the 2008 election, it appeared as if the political pendulum had begun to swing the opposite direction as Barack Obama campaigned and won on a platform that called for an expanded role for the state in mitigating individual social and economic risks. Yet, less than a year later, and in the midst of debate over President Obama's signature domestic policy issue, the reform of the U.S. health care system, the Tea Party movement emerged as a powerful political force that invigorated the Republican Party (Skocpol and Williams, 2012). The Tea Party, which supports a strict interpretation of the U.S. Constitution, placing limits on the role of the federal government, and cutting taxes and social spending, paradoxically, is comprised mostly of older Americans who are the primary beneficiaries of public programs like Medicare and Social Security. This apparent contradiction highlights the idea of 'deserving' versus 'undeserving' recipients of social protection, to which Tea Party members believe they have an earned right by paying into these programs, while they oppose benefits for other societal groups, particularly younger adults and ethnic minorities, who they view as undeserving (p. 59-67).

The accumulated effect of this conservative movement, which has manifested itself most recently with the Tea Party, has been to amplify the impact of wider changes within the economic system, which have shifted many economic and social risks once mitigated by the U.S. government onto individual Americans and their families (Sachs, 2011; Hacker, 2008; Hacker, 2012). The shift of risk away from the state and toward individuals and families is particularly stark for America's older adults (Harrington Meyer, 2010). This

appears to suggest that a conservative ethos is alive and well within the United States and that it shapes the types of policies selected by policymakers. Nevertheless, robust social programs endure and many stated goals of the movement toward greater personal responsibility, such as the privatization of Social Security and Medicare, have never come to pass. This view therefore does not dominate the political discourse in the United States; however, it is a significant component of the political ethos, and appears to affect the potential outcomes of American social policy. Indeed, the enduring strength of this conservative movement is particularly relevant for the analysis of LTC financing reform, which as an individual social and economic risk, provides fertile ground for exploring the potential impact of ideology on social policy outcomes.

An Institutional Framework of Social Policy

A revival of scholarly attention to institutions, and the emergence of new institutionalism, has brought the study of institutions back to the forefront of political analysis. This foundational school of thought, which began to formalize through efforts to 'bring the state back in' to the study of politics (Evans et al. 1985), gives institutions theoretical and analytical primacy (Lecours, 2005). Within a policy context, institutions are defined as the structures created by individuals, such as organizations, laws, and rules, which constrain and structure the actions of individuals (Hudson and Lowe, 2004). Institutions can have either formal or informal dimensions and will demonstrate legitimacy and stability over time (Ibid, p. 175). Institutions are important to social policy as they tend to foster stability and mobilize bias against change (Pierson, 1993, Campbell, 2003; Amenta, 2003). Furthermore, institutions define the 'rules of the game,' the formal

structures such as national constitutions or party systems (Hall and Taylor, 1996; Thelen and Steinmo, 1992) or norms and values (March and Olsen, 1989) embedded within the policy process. The institutionalist approach to political analysis pays close attention to path dependence and self-reinforcing policy legacies, emphasizing the impact of previously enacted policies on all current and future policymaking processes, and shapes the strategies of policy actors in advancing policy (Pierson, 2004; Mahoney, 2000). Such an analytic focus ensures that ‘timing’ and ‘sequence’ are key components of political analysis (Pierson, 2000; 2004).

The role that institutions play in shaping social policy outcomes is particularly well-documented in the case of the American welfare state, since fragmented political institutions provide stakeholders and regional interests with unparalleled access to the policy process (Steinmo, 1993; Pierson, 1996, 146; Quadagno, 1988, p. 29; Weaver and Rockman, 1993, p. 26-28). There is particularly abundant evidence of the role that institutions played in helping to thwart attempts at health reform prior to the legislative success of the Obama Administration (Steinmo and Watts, 1995; Hacker, 1998; 2002). Nevertheless, the specific impact of America’s political institutions on long-term care (LTC) policymaking has been far less analysed.¹³ While the need for long-term care has always been a part of the human experience (Österle and Rothgang, 2010), it is a relatively new addition to the policy sphere. Over the twentieth century, advances in medical technology that allowed people to live longer than in previous generations, and evolving gender and family dynamics—namely the entrance of women into the workforce—led to new models of care provision, particularly formal, institutionalized care (Levitsky, 2006;

¹³ A notable exception is Campbell and Morgan (2005), who compared the LTC policy reform processes of Germany (successful) and the United States (unsuccessful) in the early 1990s through the framework of federalism.

2010; Harrington Meyer, 2000). The subsequent emergence of public and private financing mechanisms to pay for the new care dynamic, such as Medicare and Medicaid in 1965 and private LTC insurance in the late 1970s, firmly shifted LTC into the policy realm. Thus, as a ‘new social risk’ that is increasingly a concern for policymakers (Taylor-Gooby, 2004; Bonoli, 2005), the relative ‘newness’ of LTC policy has yet to yield much analysis from within an institutionalist framework.

New Institutionalism

Social scientists have long been interested in the impact of institutions on policy outcomes; however, attention to the role of institutions waned for much of the twentieth century as the behaviorist and structural-functionalist explanatory approaches gained prominence (Thelen and Steinmo, 1992). The behaviorist approach places emphasis on observable behavior, like voting patterns, and tended to take the role of institutions as more or less a constant rather than an important variable within the political process (Dahl, 1961; Truman, 1951). As noted by Skocpol and Amenta (1986), structural-functional approaches, namely industrialization (Wilensky, 1975; Kerr et al. 1960) and neo-Marxism (e.g. O'Connor, 1973; Offe, 1984; Mishra, 1984), downplay the role of politics and emphasize deterministic aspects of welfare state development (p., 136). The explanatory limitations of these approaches motivated a turn to a research agenda that gives institutions theoretical and analytical primacy in explaining action (Lecours, 2005). Indeed, new institutionalism seeks to provide a better understanding of the way policy outcomes are shaped by the institutional settings in which they are debated and passed into law (March and Olson, 1984; Thelen and Steinmo, 1992, p. 2; Hall and Taylor, 1996; Immergut, 1998; Lecours,

2005). While a traditional institutional approach offers a rigid and formulaic analysis of policymaking that tended to play down human action—or agency—and overplays the role of institutions, new institutionalism emphasizes both agency and structure with a particular emphasis on the role institutions play in structuring the interactions between political actors (Hudson and Lowe, 2004, p. 174). In addition, old institutionalism tends to offer overly descriptive and philosophical analysis, while new institutionalism embraces the use of rigorous research questions and empirical evidence as used by behavioralism (Robertson, 1993, p. 3-4). This has produced a highly robust analytical framework that draws on the strengths of the physical sciences as well as history.

Scholars have delineated several different branches of new institutionalism including historical, rational-choice, and sociological (Powell and DiMaggio, 1991; March and Olson, 1989; Hall and Taylor, 1996; Immergut, 1998; Thelen, 1999; Shepsle, 1989). As the name suggests, rational-choice institutionalism draws heavily on the economic theory of rational choice, arguing that the analysis of choices made by rational actors takes place under conditions of interdependence (Immergut, 1998, p. 12). Without institutions the ‘transaction costs’ of decision-making would be too high; institutions allow for the efficient exchange of information and reduce the uncertainty about the behavior of other actors (Hall and Taylor, 1996, p. 945). While policy actors seek to maximize their interests through the institutions in which they operate, the institutions also structure and constrain their behavior and thus policy outcomes (Ibid). The rational choice approach initially emerged as an explanation for the voting behavior of U.S. Members of Congress (Shepsle, 1979). A second branch of new institutionalism is the sociological, or organizational, approach, which has roots in organizational theory (Hall and Taylor, 1996, p. 946).

Proponents of this approach tend to define institutions very broadly: as anything that frames the meanings that guide human action (Ibid). Scholars of sociological institutionalism emphasize the inherent limits on cognition—human, artificial, or organizational—which prevent rational decision-making from taking place (Immergut, 1998, p. 14). Instead, the use of standard operating procedures allows individuals to make decisions (Ibid). Political decisions and policies result from cognitive and organizational procedures that produce decisions despite the inherent uncertainty (ibid).

Historical Institutionalism and Social Policy

Historical intuitionism is based on an assumption that a historically constructed set of institutionalized constraints, as well as policy legacies and feedback, structure the behavior of policy actors and interest groups during the policymaking process (Hall and Taylor, 1996; Béland, 2005a, p. 29). Historical institutionalists define institutions as the formal and informal procedures, norms, and conventions that are embedded within the organizational structure of a national polity (Hall and Taylor, 1996, p. 938; Thelen and Steinmo, 1992, p. 2). In the United States, formal institutions include the different branches of the federal government—the Executive (President), Legislative (both houses of Congress), and Judicial (Supreme Court). An example of an informal convention is the standard operating procedures of a trade union (Hall and Taylor, p. 938). Historical institutionalism also focuses on the way policies are designed and implemented and offers a view of policy development that emphasizes path dependency and unintended consequences. Historical institutionalists often integrate institutional analysis with other explanatory factors for policymaking such as ideas and values (Ibid).

According to Peters et al. (2005) historical institutionalism has emerged as the dominant institutionalist approach to policy analysis (p. 1276). Moreover, Parsons (2007) argues historical institutionalism is the only branch of new institutionalism that truly focuses on institutions since the over-arching concern of other approaches is on cultural (sociological-organizational) and material (rational choice) explanations of politics and policy (Béland 2010, p. 617). As Hudson and Lowe (2004) point out, historical intuitionism is the branch of institutionalism that focuses the most attention on the welfare state (p. 176). Given the significance of historical institutionalism to the study of social policy, much of this analysis will focus on this analytic framework rather than the other branches of institutionalism, particularly examining the role of the institutions of the federal government as potential veto points in the policymaking process.

Since historical institutionalism has been shown to be an important explanatory framework for understanding social policy development, particularly in the United States, it is worth exploring its potential relevance for a more comprehensive analysis of LTC policymaking. This explanatory framework may provide a better understanding of the specific actions of the policy actors and stakeholder groups within the LTC policy arena, who are guided and constrained by the peculiar arrangements of the U.S. political system and existing policy legacies. Additionally, it may help explain why the particular ideological underpinnings of the CLASS Act were successful within the context of the U.S. political system—in other words, which policy ideas were possible and which were not within the system's institutional constraints, particularly within the operation of the U.S. Congress. An institutionalist framework can also help to illuminate why LTC reform succeeded in 2009, in spite of over twenty years of unsuccessful efforts to bring about

reform by policymakers and stakeholder groups. This sudden change of the institutional arrangements of LTC financing within the context of such past relative stability suggests that path dependency and policy feedback are particularly relevant to understanding the legislative success of the CLASS Act. Historical institutionalism will therefore be used as an explanatory framework from which to examine the success of LTC policy reform that took place in the form of the CLASS Act.

Path Dependency, Policy Feedback, and Institutional Veto Points

A fundamental tenet of the historical institutionalist framework is path dependency, which suggests policymakers are bound by existing institutions and structures that guide them along particular policy paths (North, 1990; Mahoney, 2000; Hacker, 2002; Pierson, 1993; 1996; 2000a; 2004). It also argues that the timing, sequence, and self-reinforcing consequences of previous policy decisions matter to the policy process (Pierson, 2000b; Hacker, 2002, p. 25). According to Pierson, once policymakers select a particular policy path, the benefits of travelling further down that path tend to increase, as do the costs of switching to an alternative path (2000b, p. 259). Thus, the probability that additional steps down that same policy path will take place increases with each step (Pierson, 2004, p. 21). This explanation is often used to account for the failure of large-scale social policy initiatives in the United States, such as the inability of twentieth century policymakers to enact national health insurance. The reason, Hacker (1998; 2002) contends, is the emergence of private health insurance plans before the enactment of the government programs of Medicare and Medicaid (2002, p. 190). These private arrangements created supportive constituencies and vested interests, such as powerful insurance companies, that

fought to preserve the private system, while widespread private benefits negated much of the support for national health insurance as labor unions were able to negotiate generous benefits for their members (Ibid, p. 179). Thus, the initial foothold of private insurance as a financing mechanism for health care made it very difficult for U.S. policymakers to subsequently enact national health insurance.

In order for reform to succeed, something more powerful, such as an external—or exogenous—shock, is theoretically required to shift policy in a new direction (Pierson, 2004; 2000; Abbot, 2001). Thus, another significant component of path dependency, paradoxically, is the study of critical junctures that can send policies down new, distinctive paths, such as a major economic crisis or a major partisan shift in the control of government (Collier and Collier, 1991; Hacker, 2002, p. 52). Hacker contends that the common theme amongst all critical junctures is that political forces are realigned enough to overcome the traditional veto points in political institutions as well as the entrenched policy paths created by previous decisions (Ibid, p. 59). An example is the New Deal, which radically transformed U.S. pension policy by establishing the Social Security program that passed during the 1930s when Democrats controlled the Presidency and both houses of Congress by wide margins (Ibid, p. 95).

Capoccia and Kelemen (2007) define critical junctures more specifically as relatively short periods of time during which there is a substantially heightened probability that the choices of actors will affect a particular outcome (p. 348). They caution that not all examples of significant change occur through critical junctures. Substantial change can instead be described as accumulative, where it reaches a tipping point, or threshold, that leads to rapid change, but is not change through a critical juncture (Ibid, p. 351). The

concept of contingency is the essential element of a critical juncture, as contingency is enhanced when the structural constraints imposed upon political actors during path-dependent processes are substantially relaxed. Thus, the key to demonstrating that change has taken place through a critical juncture is counterfactual analysis, where the reconstruction of plausible counterfactual scenarios, based on theoretically informed expectations and narratives of the decision-making process, are supported by empirical evidence (Ibid, p. 368).

The concept of policy feedback is a vital mechanism of path dependency (Weaver, 2010; Pierson, 1993; 2000; 2004; Immergut, 1998; Skocpol, 1992; Skocpol and Amenta, 1986). Policy feedback, either positive or negative, highlights the impact of existing policies on current, as well as future, politics and policy (Skocpol, 1992; Immergut, 1998; Hacker, 1998; Pierson, 2004; 2000; 1993). Policy feedback is concerned with the benefits or costs associated with existing policies and their impact on future policy alternatives (Pierson, 2004). According to Pierson, policy feedback impacts politics and policy via two main mechanisms: ‘resources’ and ‘incentives,’ and ‘interpretive effects’ (1993, p. 626). These mechanisms, in turn, influence the way elites, interest groups or the public reacts to policy. An existing policy may endow a particular interest group with the ‘resources and incentives’ necessary to induce mobilization amongst beneficiaries to support the maintenance or expansion of that policy (Ibid). For example, initial legislative action on a pension system for U.S. Civil War veterans enabled veterans to mobilize as a group to support further benefit increases (Skocpol, 1992, p. 59; Pierson, 1993, p. 599). It is therefore widely argued that positive feedback produces reinforcing loops that perpetuate particular policies and close off possible options for change (Patashnik and Zelizer, 2010,

p. 1). In sum, past choices, and the resulting positive feedback, tend to create stability in public policy and incremental policy change rather than large-scale reform.

Negative feedback is also useful for understanding policymaking, as it helps account for policy change, or path departure, in the absence of an exogenous shock. Weaver (2010) defines negative policy feedback as the “consequences of policy that tend to undermine rather than reinforce the political, fiscal, or social sustainability of that particular set of policies” (p. 137). Negative feedback can result from weak policy design, inadequate institutional support or the poor timing of implementation (Patashnik and Zelizer, 2010, p. 3). When a policy's design fails to provide enough material resources to build a sympathetic constituency of interest groups, that policy is particularly disposed to change (Ibid). The Model Cities program during the Great Depression provides an illustrative example. The program's intended goal was to assess the effectiveness of intensive urban renewal in breaking the cycle of poverty in twelve U.S. cities; however, Members of Congress from districts outside of those cities felt the program was too small and expanded it to include hundreds of cities, providing only meager funding to each one. Without any enthusiastically supportive geographic constituency, and resources spread too thin to be effective, the program soon died (Ibid, p. 10). The dispersion of resources and failure to develop a supportive constituency of interest groups, both products of the policy's design, undermined its survival.

A specific policy design can also produce negative feedback by the way groups targeted by that particular policy perceive their identity and status within society. An example cited by both Weaver (2000; 2010) and Patashnik and Zelizer (2010) is the perceived negative socio-economic outcomes of Aid to Families with Dependent Children

(AFDC), more commonly known as welfare. The program was often characterized as providing the ‘undeserving poor’ benefits that created bad work habits, increased rates of non-marital births, and prolonged separation of low-skilled workers from the labor market. Beneficiaries were stigmatized and the program had low levels of public support (Patashnik and Zelizer 2010, p. 18), which many scholars believe helped to undermine political support for it amongst policymakers (Weaver, 2000; 2010, p. 139). While the program persisted for over fifty years, negative feedback ultimately led U.S. policymakers to enact major welfare reform in the mid-1990s. The concept of negative feedback offers some possibility for a better understanding of policy change; however, the ways that negative feedback applies to policy change are less clear and are unable to solely account for why policy change is able to take place.

An additional focal point of historical institutionalism is the potential institutional veto points or veto players within the policy process (Immergut, 1990; 1992; Tsebelis, 1995; 2002). Immergut (1990; 1992) argues that all democratic political systems contain veto points, which provide opportunities for interest groups to block policy proposals; however, the extent and nature of those veto points varies between nations. These veto points provide ample opportunity for interests in decentralized, federal political systems to block legislation that increases the scope and breadth of the welfare state (Tsebelis, 2002; 1995, p. 310; Huber et al. 1993, p. 721; Swank, 2001; 2002). Indeed, there has been a long-standing consensus amongst comparative scholars that federalism often acts as a major impediment to expansions of social policy (Obinger et al. 2005; Pierson, 1995). Federalism's impact on social policy development is particularly apparent in the United States, as the widespread diffusion of governmental authority limits the ability of

policymakers to accomplish their goals because of the multiplicity of veto points (Weaver and Rockman, 1993, p. 28-30; Steinmo, 1993). Within the federal political system, individual state governments have considerable responsibility for the creation of public policy (Steinmo and Watts, 1995). Moreover, power is fragmented between the different branches of the federal government, making it difficult for any particular branch to pursue large-scale policy initiatives (Weaver and Rockman, 1993; Steinmo and Watts, 1995). A federal political system that disperses power through a system of checks and balances on power can therefore be a significant impediment to policy change.

In the United States, political power is additionally divided within Congress between the House of Representatives and the Senate, as well as the various committees and subcommittees where legislation can be delayed or blocked (Shepsle, 1979; Aldrich and Rohde, 1982; Shepsle and Weingast, 1987; Hall and Grofman, 1990). The filibuster and the use of cloture to end debate within the U.S. Senate are particularly significant veto points, as legislation requires sixty votes in order to move forward (Wawro and Schickler, 2006). Legislation aimed at controversial, often partisan issues like social policy faces great difficulty in obtaining the necessary votes to end debate and avoid the threat of a filibuster. The decentralized American political system also impedes large-scale policy change by increasing the number of veto points such as the courts, the legislative process, and dispersal of power to regional authorities (i.e. the states) where comprehensive reform proposals can easily be thwarted by individual policy actors and interest groups (Quadagno, 1988; 2004). These institutional arrangements foster an environment where vested interest groups wield tremendous power over the policy process, which reinforces the negative effects of institutional fragmentation (Pierson, 1994; Steinmo, 1993; Skocpol,

1995). Congress is highly susceptible to interest group influence as individual members must rely on them for campaign resources (Lipset, 1996; Quadagno, 2004, p. 27). This often results in a lack of support for legislation amongst Members, even when support from the public and party leaders is high. The failure of the Clinton Administration to reform the U.S. health system in 1994 is often explained in terms of veto points and interest groups (Steinmo and Watts, 1995; Quadagno, 2005). The fragmented institutional arrangements of the U.S. government allowed powerful interest groups, most notably the health insurance industry, to thwart the legislation despite initially high levels of public support and backing from the executive branch (Hacker, 1998; 2002; Steinmo and Watts, 1995).

Institutional Stability vs. Change

Institutionalist accounts have been highly valuable in expanding the analytical toolkit of the welfare state, particularly for explaining why it is so difficult for policymakers advocating retrenchment to successfully roll back existing policies and programs (Pierson, 1994; 2001; Campbell, 2003; Amenta, 2003). The durability of existing programs like Medicare, Social Security, and Unemployment Insurance in the United States is a result of the fragmented institutional arrangements of the American political system, and of policy legacies that have created strong, vested interests that mobilize in defense of the benefits provided by these programs if and when they are attacked. Thus, when examining policy, it is argued that high levels of stability will be visible across policies and institutions. Another explanation for stability looks to national economic systems and the way that labor interacts within that framework (Hall and Soskice, 2001;

Iversen and Soskice, 2009). Iversen and Soskice (2009) note that levels of redistribution have remained fairly constant within nations that embraced proportional representation in the nineteenth century, while liberal economies with majoritarian systems like the United States have continued to have lower levels of redistribution (p.461-463). However, as valuable as these accounts are for explaining policy stability, they do not provide a good way to explain change outside of the 'critical juncture.'

In recent years, scholars have attempted to establish a more robust framework for explaining institutional change by examining gradual change to social policies (Hacker, 2004; 2005; Streeck and Thelen, 2005; Béland, 2007; Thelen, 2003; 2004). This approach has been highly useful for highlighting how policy change can take place through drift, layering, conversion or complete replacement (Thelen, 2003; Mahoney and Thelen, 2010). According to Hacker (2004; 2005) and Hacker and Pierson (2010b), the American health care system exemplified a state of policy drift for much of the twentieth century. The term drift describes gradual adaption over time in the absence of significant change. Meanwhile, significant change only takes place when the barriers to policy action are relatively low, such as directly after a major electoral realignment. Hacker and Pierson (2010) suggest that the Patient Protection and Affordable Care Act or 'PPACA,' which passed in 2010 under President Obama, shifted the U.S. health system out of this state of drift.

Policy layering describes a process of change where a new policy is created, but the change that is produced does not entail a complete replacement of the existing system (Streeck and Thelen, 2010; Hacker, 2004; 2005; Thelen, 2003; 2004; Schickler, 2001; Orren and Skowronek, 2004). The concept of policy layering is vividly illustrated within U.S. pension policy arrangements as policymakers sympathetic to privatization layered

new policy structures, such as private 401(k) accounts, on top of the existing public retirement system of Social Security. While conservative policymakers were largely unsuccessful at outright dismantling the Social Security program, they successfully circumvented Social Security's vested interests and the institutional structures of the political system that reinforce the power of those vested interests to thwart unfavorable legislation by layering competing private programs onto the public retirement framework (Hacker, 2005, p. 67-68). Given the lack of empirical evidence on the complex relationships that exist between institutional change and wider political, economic, and ideological factors (Béland, 2007, p. 21) the concepts of drift and layering may help to further elucidate the policymaking process, particularly in the LTC financing arena.

Political Actors and Stakeholders in the Policy Process

Pluralism and Group Theory

A central feature of American institutional arrangements is the significant role afforded to interest groups, or stakeholders, within the policymaking process. David Truman's (1951) seminal study, *The Governmental Process*, broadly defines an 'interest group' as any societal group with shared beliefs amongst its members, which makes claims through any governmental institution on other groups within society (Truman, 1951, p. 33). A slightly narrower definition is offered by Walker (1991), who contends that interest groups are voluntary associations seeking in one way or another to petition the government on behalf of some organized interest or cause (p. 4). Academics and policymakers have debated the role and influence of interest groups throughout American history (Peterson, 1999). Unsurprisingly, there is little consensus on the actual degree of influence that

interest groups have over the policy process (Wright, 2007). For much of the twentieth century, the dominant framework for understanding interest groups was pluralism (Dahl, 1961; 1971; Lindblom, 1959; 1979), which broadly defines ‘democracy’ as the competition, bargaining, and compromises between organized groups within society over decision-making (Dahl, 1961). Power is widely dispersed amongst the differing groups, with no particular group dominating the decision-making process. While a group may be influential in one policy sphere, it is not necessarily influential in other areas of the decision-making process. Policy outcomes are believed to result from the equilibrium reached in the conflict amongst different groups in society (Latham, 1952). The pluralist framework has been debated and expanded for years. While useful for understanding power and conflict amongst groups, pluralism tends to neglect the significant role that institutions play in the policy process.

Sizing Up Actor Preferences

Considerable attention has been paid to the role that business plays in the development of social policy. The stated and unstated preference of different actors within the policymaking process can help to provide some insight into the ability to bring about comprehensive LTC reform in the United States and the success of the CLASS Act. The actual preferences of different actors with regard to policy outcomes are difficult to accurately gauge (Hacker and Pierson, 2002). While business has been traditionally perceived as an antagonist toward expansions of social policy (Esping-Andersen, 1985; Skocpol and Amenta, 1986; Hacker and Pierson, 2002; Korpi, 2006), such a sweeping characterization may not be entirely accurate. Mares (2003a; 2003b) challenges the

premise that business categorically opposes all social insurance, an assumption that has underpinned much comparative research on the welfare state. Mares' (2003a) historical research, which focuses on employers in France and Germany during the development of the welfare state between the 1880s and the 1940s, seeks to identify the preferences of firms, indicating under what conditions they are likely to support expansions of social policies (p. 229). This research suggests there is a strong intersectional conflict within the business community over the support or opposition to social policies. Large firms in high-skilled industries tended to support social insurance policies that afforded a high level of discretion in their administration to business, while small firms were much more narrowly focused on the potential impact on labor costs. Additionally, producers in high-risk industries such as mining and steel supported the expansion of social insurance, while low-risk producers like manufacturers often supported social policies with lower rates of redistribution (Ibid, p. 255). These differences help to explain the variation over time in the support of different industries for social policy expansion. In sum, business cannot be assumed to categorically oppose expansions of social protection.

Additional historical analysis carried out by Swenson (2002) also examines the role of business in the development of social policy in the United States compared to Sweden. Swenson argues that policymakers sensitive to business interests have often sought to account for their preference within reform, which has left business's mark on social policy outcomes. Furthermore, the preferences of employers have at times overlapped with that of labor, which demonstrate cross-class alliances in pushing for policy change (Swenson, 2002). Interestingly, Martin (1995; 2000) found that U.S. employers were supportive of the use of mandates for health insurance. This study conducted during the mid-1990s of firm

preferences for employer mandates showed that support was higher than opposition to this type of policy response (2000, p. 103). This also appears to suggest that employer preferences on social protection are not monolithic and change over time. Further analysis of the role of business in the development of social policy may yield considerable insight into the processes surrounding successful policy change.

Policy Learning and Policy Entrepreneurs

The concept of policy learning has a long history within political science and policymaking (Heclo, 1974; Hall, 1993; Sabatier, 1988; 1999; Sabatier and Jenkins-Smith, 1993). Political learning is a process through which political actors acquire a higher degree of sophistication in the promotion of specific policy ideas and goals (May, 1992), and can be a major determinant of policy innovation and change (Sabatier, 1988; 1999). According to Sabatier, advocacy coalitions, which may include a variety of state and non-state actors, arise out of dissatisfaction with existing institutional arrangements. These coalitions are linked together by a ‘policy-broker,’ someone who is usually a high-ranking government official or senior legislator, whose main concern is keeping the level of political conflict within acceptable limits and reaching some reasonable agreement on the way to address a particular problem (Sabatier, 1988, p. 141). The agent of learning is therefore the policy network and the specific outcomes are the types of policies supported in moving toward the successful achievement of their core policy beliefs (Ibid, p. 151). Since the concept of policy learning suggests a process that takes place over a long period of time, and is also highly linked to past choices and existing policy legacies, policy learning is also directly tied to the concepts of path dependency and policy feedback (Pierson, 1993). This suggests

policy learning may be a particularly useful tool for gaining a better understanding of change within complex policy areas such as LTC financing.

The specific role of a policy entrepreneur is a particularly insightful concept for understanding policy change (Sheingate, 2003; Carpenter, 2001; Walker, 1974; Kingdon, 1995; Polsby, 1984; Dahl, 1961). Policy entrepreneurs define a problem, demonstrate social acuity, and build support within the policy arena for their solution to the problem (Mintrom and Norman, 2009; Baumgartner and Jones, 1993; Mintrom, 2000; Kingdon, 1995, p. 180-81). As Sheingate (2003) notes, institutionalist accounts of the policy process provide considerable space for policy entrepreneurs to operate. Policy entrepreneurs possess deep knowledge of relevant procedures and local norms that serve to define acceptable behavior within the institutions of the policy arena (Mintrom and Norman, 2009). In other words, a political actor inside the policy process is often a source of policy change rather than an outsider. Policy entrepreneurs must, however, be able to understand the workings of a given arena without becoming so acculturated as to lose their motivation to promote policy change (Ibid, 2009; Mintrom, 2000). They must also be able to exploit specific opportunities, or windows, to advance their policy goals (Kingdon 1995, p. 181-82). The concept of a policy entrepreneur may therefore offer a highly insightful approach for understanding the specific role that political actors play in bringing about policy change within the institutional structures in which they are embedded.

U.S. Health and Long-Term Care Policymaking

Health care policy is one of the most heavily analysed social policy issues within the American political arena. The United States is an outlier compared to other advanced industrialized nations in terms of the provision of health care (Organization for Economic Co-operation and Development, 2012). The unique nature of America's health care arrangements is often blamed for a number of enduring problems associated with cost, quality, and access to care, which have in turn encouraged a desire for comprehensive reform of the health care system. Despite these problems, comprehensive health reform remained elusive for nearly a century prior to the signing of the Patient Protection and Affordable Care Act or 'PPACA' (P.L. 111-148) by President Barack Obama on March 23, 2010 (Jacobs and Skocpol, 2010). In fact, six major attempts at health reform took place before the successful legislative efforts of the Obama Administration, since the initial push for reform of the Progressive Movement and the 1912 Presidential campaign of Theodore Roosevelt (Quadagno, 2005; Hacker, 2009; Jacobs and Skocpol, 2010). A key element of the health care literature is the development of private insurance prior to the government programs of Medicare and Medicaid (Hacker, 2002; Hacker, 1998), which provides a particularly illuminating analysis of U.S. health policy. The rise and fall of the comprehensive health reform efforts of President Bill Clinton, the Health Security Act of 1993, has in particular received extensive review by scholars of American social policy (Mann and Ornstein, 1995; Steinmo and Watts, 1995; Skocpol, 1996; Hacker, 1996).

Long-term care is generally considered to be subsumed within health policy as it addresses a number of interrelated issues. While health reform has received considerable scholarly attention over the years, LTC has not received the same level of interest. Indeed,

attempts at reform of long-term care (LTC) financing, however, have been far less numerous, with most change taking place at either the state level or in piecemeal increments federally since the 1980s (Campbell and Morgan, 2005; Scharlach and Lehning, 2012). While comprehensive health reform has been debated extensively in the United States over the past century, the Health Security Act of 1993 was the first comprehensive health reform proposal to also specifically address LTC financing reform (Wiener et al. 2001; Binstock, 1996). However, the Medicare Catastrophic Act (MCA) of 1988 would have added a chronic care benefit to the Medicare program. In effect, this would have covered a significant proportion of the expenses associated with the need for LTC. A specific LTC benefit was also proposed by Representative Claude Pepper (D-Florida) and briefly considered, however, it was never included in the legislation or reached a floor vote in Congress (Himelfarb, 1995; Quadagno, 2005). The MCA was repealed less than a year later under intense criticism from senior advocacy groups due to the imposition of a premium increase and income surtax on Medicare beneficiaries, aimed disproportionately at high income individuals (Street, 1993).

Summary and Conclusions

This chapter has examined several key frameworks within the analytical toolkit for understanding social policy change, with particular regard to the American context. While an ideological thesis is well argued within the literature, the direct link between ideology and social policy outcomes in the United States requires further analysis. Meanwhile, stakeholders and political actors are also a significant component of the policy process; however, the actual preferences of different stakeholders are difficult to assess and often do

not comport to conventional assumptions about their preferences. An institutional analysis provides greater insight into the way that political actors such as individual policymakers and stakeholders are bounded by the institutional frameworks in which they operate, as well as how existing policy legacies may impact policy choices. Taken together, ideology, political institutions, and policy actors can contribute to a better understanding of the development of policy and legislative outcomes within the American policymaking process.

Long-term care (LTC) is one of several ‘new social risks’ that confront individuals in advanced democracies due to systemic social and economic changes associated with the transition to a post-industrial society (Taylor-Gooby, 2004; Bonoli, 2005; Esping-Andersen, 1999). The individual risks associated with LTC, however, pose a new and growing policy challenge for the twenty-first century (Scharlach and Lehning, 2012) as demographic changes and the challenges of financing LTC converge. While already a highly problematic policy area, the provision of LTC will be a major challenge for all rich nations in the years ahead, including the United States (Gonyea, 2010). The frameworks within the analytic toolkit used for understanding social policy change explored in this chapter can facilitate an engagement with the LTC policy process and can help contribute to a better understanding of policymaking in the United States. The following chapter will now delineate the methods and research design used to explore policy change within the LTC financing arrangements of the United States.

Chapter Three: Research Design and Methods

Introduction

This chapter describes the qualitative research design and methods used in relation to the objectives of the study. In addition, this chapter will discuss the strategies employed during data collection and in analysis as well as the main issues encountered during these processes. This chapter will also address some of the possible limitations inherent within the selected research design and the steps taken to mitigate those limitations. Proper attention to any potential ethical considerations as well as the reliability and validity of the data are also discussed within this chapter.

Research Design

Qualitative Approach

A qualitative research approach was employed in this study, using LTC financing reform as an illustrative example, in order to evaluate the drivers of social policy in the United States. Specifically, this research sought to explore the possible impact of several significant themes such as political institutions, ideology, and particular policy actors and stakeholder groups on the design and legislative success of LTC financing reform efforts during three U.S. Presidential Administrations: Bill Clinton (1993-2001), George W. Bush (2001-2009), and Barack Obama (2009-2010). These three discrete historical periods offered a strong analytical framework from which to examine specific legislative initiatives aimed at the reform of the LTC financing arrangements in the United States. The main

pieces of legislation examined include: the LTC focused provisions embedded within President Clinton's Health Security Act of 1993, the development of the Community Living Assistance Services and Supports or 'CLASS' Act during the years of the Bush Administration, and the legislative success of the CLASS Act as a part of health reform efforts advanced by the Obama Administration in 2009-2010.

In recent years, qualitative research has become a particularly well-regarded approach for tracing complex processes (Ritchie 2003, p. 32) such as policymaking. Policy outcomes are the result of complex interactions of interwoven events and interdependent variables. According to Rowlingson (2002) qualitative research allows for “a much richer understanding of processes, motivations, beliefs and attitudes than can be gleaned from a quantitative study,” (p. 632) and is therefore particularly well-suited for an analysis of the policymaking process.

Indeed, the historical framework of this research provides a particularly robust analytical framework from which to compare the drivers of U.S. LTC financing policy reform. While quantitative studies, or statistical analysis, hold a dominate position within the social sciences, a focus on history has gained prominence in recent years (Skocpol and Somers, 1980; Skocpol, 1979; Mahoney and Rueschemeyer, 2003; Evans et al. 1985). The historical approach to political analysis has a long and rich history, particularly in comparative studies of political science (Bendix, 1964; 1978; Moore, 1966; Lipset and Rokkan, 1967; Tilly, 1975). While a quantitative approach is highly appropriate for analysis of single variables across multiple countries, in examining the drivers of change to LTC financing arrangements within the United States, a comparative historical approach is well-suited to draw out the specific connections between actors and interests (Amenta,

1993). This research is, therefore, both comparative and historical (Amenta, 2003) in its design and approach to analysis of LTC financing policy reform in the United States.

Historical focused research often draws upon case studies as the main framework of analysis. Indeed, case studies are a particularly useful research tool for explaining complex processes like policymaking (George, 1979; George and Bennett, 2005; Esckstein, 1975; Mahoney, 2003) as they allow researchers to examine in depth the important variables in relation to the explanatory frameworks. While case studies are often used to gain a deeper understanding of a particular issue, they also provide a way to demonstrate the importance of timing and sequence on particular outcomes (Esckstein, 1975; George, 1979; Pierson, 2004). Case studies are therefore a particularly useful research tool for explaining complex processes like policymaking (George, 1979; George and Bennett, 2005; Esckstein, 1975; Mahoney, 2003) where the sequence of events is highly important to outcomes. Thus, the historically grounded cases of LTC policy reform during the Presidential Administrations of Bill Clinton (1993-2001), George W. Bush (2001-2009), and Barack Obama (2009-2010) were selected to gain a better understanding of social policymaking in the United States. As Goertz and Mahoney (2009) caution, a particularly important component of case selection is the 'scope' of the case under review. Limiting the focus on specific pieces of LTC legislation within these three Administrations was an important component of the research design.

Given the focus of this research on untangling the complex processes that surround U.S. LTC policymaking over several decades and three different Presidential Administrations, process tracing was particularly suitable for the purposes of this research. This method of analysis pays close attention to the causal mechanisms that link cause and

effect (George and Bennett, 2005). Causal mechanisms are the processes and intervening variables through which an explanatory variable exerts a causal effect on an outcome variable (Mahoney 2003, p. 36). Furthermore, causal mechanisms are central to causal explanations and case studies are a method well-suited for examining the operation of causal mechanisms (Tansey, 2007, p. 3-4; George and Bennett, 2005). In such path-dependent policy areas like U.S. LTC financing policy, the use of process tracing and case studies can help reveal the potential impact of actors, existing institutions, and policy legacies on policy change.

Data Collection

The data was primarily collected through semi-structured depth interviews with individuals from specific stakeholder categories within the federal LTC policy arena in the United States. Potential participants were contacted directly either by email or in-person at events in Washington, DC that focused on the CLASS Act or other policies affecting older adults and people with disabilities. Eighty-five potential interviewees were initially targeted for participation; however, sixty-five participants accepted the invitation to be interviewed. The participants, representing different stakeholders within the LTC policy arena, were segmented into categories based on the organization's relevance to the CLASS Act and on whose constituencies would be most influenced by the passage of the legislation. The main categories included consumer advocacy groups for the aging and disability communities (21 participants), Congressional staffers from the United States Senate and House of Representatives (11 participants), LTC provider trade associations (12 participants), the private LTC insurance industry (11 participants), and experts in the

field of LTC policy, such as consultants and academics (10 participants), who were included based on their highly specialized knowledge of LTC financing policy. The official interviews began after the health care reform legislation was passed by Congress, and signed into law by President Obama on March 20, 2010, and were concluded by September 1, 2010.

Depth interviews were necessary for exploring the role and impact of stakeholders on the formation of U.S. LTC policy, as it can be very difficult to demonstrate their impact in other ways. For example, Stake (2010) contends that interviews yield unique information held only by participants and that they provide information that the researcher cannot simply observe on their own (2010, p. 95). Other qualitative research approaches, such as surveys or focus groups, were unlikely to yield the same depth of information about the policymaking process (Gubrium and Holstein, 2002, p. 104). Additionally, interviews can provide much more detailed information than an analysis of any documents produced by the organizations within the LTC policy arena. Depth interviews provide a way for respondents to reveal motives, opinions, and attitudes that would not be revealed in other settings such as group interviews or popular journalism (Punch, 1998). Depth interviews were also appropriate for gaining knowledge about a specific subject like LTC policymaking, where different groups and individuals were likely to have complicated and multiple perspectives on the same subject (Gubrium and Holstein, 2002, p. 105). Furthermore, this method allowed for the creation of a sequential story of what happened during the policymaking process, which is important for understanding the processes surrounding LTC policymaking over several decades.

With regard to developing the potential list of interviewees, it was appropriate to carry out a form of non-probability sampling in order to identify the most appropriate actors within the LTC policy arena. This is a particularly appropriate method in situations where the goal is to obtain information about highly specific events and processes such as in the context of process tracing. Since policy elites were, in some cases, the interviewee, non-probability sampling was helpful in such cases so that participants could refer other potential participants. My background in advocacy on behalf of caregivers and patients who suffered from Alzheimer's disease was an important asset in researching LTC financing reform and the CLASS Act. Through my advocacy for the LTC financing provisions of the Health Security Act in the early 1990s, I made contact with leaders of several highly active organizations in the LTC policymaking arena. A placement through the National Academy of Social Insurance at the U.S. Senate Special Committee on Aging provided additional opportunities to connect with LTC policy experts and Congressional staff. These contacts helped me obtain access to the individuals most significant to the debate on the CLASS Act and provided a subset of potential respondents based on their known relevance to U.S. LTC policymaking (Tansey, 2007). Many of the same people and organizations were still highly involved in the LTC policymaking arena and were therefore familiar with the CLASS Act. This type of recruitment is known as opportunistic sampling (Ritchie, 2003).

Potential participants were contacted directly either by email or in person at events in Washington, DC that focused on the CLASS Act or other policies affecting older adults and people with disabilities. Potential participants were also asked to provide the names of other potential contacts until no new names were provided. Recruiting study participants in

this manner is known as snowball sampling, and is commonly used when researching elites or any group to whom access may be limited (Bernard, 2000, p. 179). Snowball sampling is particularly well-suited for studies in political science and the study of political elites, particularly when the identities of the potentially most influential actors within the policy process are not publically known (Tansey, 2007). Introductions to other potential interview participants were often provided by interview participants, which helped to gain access to certain individuals who might otherwise have been difficult to reach. Snowball sampling also proved important for assessing the level of influence particular political actors might have had within the policy process as an individual whose name was mentioned more often by other participants likely demonstrated their level of influence (Farquharson, 2005).

Ethical Considerations

While interviewing LTC policy elites and other policy stakeholders does not raise the same ethical concerns as research with more vulnerable populations (Patton, 2002; Punch, 1994), due attention was provided to the ethical considerations of the study. At the start of each interview, the purposes of both the interview and of the research project were clearly stated to the participant. Many participants held positions of great responsibility within the U.S. political arena, and often were in the political spotlight. Thus, sensitivity to the use of data was an essential part of the interview process and overall research design. Participants were assured of their anonymity within any written products resulting from this research, unless that participant actively chose to offer a specific, non-anonymous quote.

Sixty-five participants were contacted and accepted the invitation to be interviewed for this study. Several individuals never responded to an invitation to participate in the study, even when contacted a second or third time. It was assumed these individuals simply did not wish to participate in the study. Only one potential interviewee wrote to say they were officially declining to be interviewed. The vast majority of potential study participants from every category of stakeholders were eager to participate in an interview. Yet scheduling an interview with some participants took several months to coordinate due to their numerous professional commitments. Other interviewees agreed to speak and were interviewed within two days of initially being approached to participate in the research.

A letter detailing the structure and intent of the interview as well as the goals of the research project was always provided to a potential participant prior to an interview. Issues of confidentiality and data management were also discussed in the letter including a request to produce a digital recording of the interview to allow for transcription and analysis at a later point. (A copy of the materials provided to each participant can be found in the appendices.) Some debate exists over the necessity of written consent in depth interviews, particularly when interviewing elites, as they are believed to be more aware of the potential threats to their privacy by participating in such a project (Punch, 1998). Written consent from each interviewee was initially deemed necessary on ethical grounds, and early participants were provided a consent form prior to their interview. However after several interviews were carried out, it indeed became clear that most participants viewed written consent as unnecessary, and felt that offering their verbal consent to participate was sufficient. The same guarantees of anonymity and safe data handling were provided to the participants whether their permission to participate was obtained in verbal or written

format. Only two participants asked that their interview not be recorded, although they did not object to the taking of detailed notes.

The collected data, digital recording of interviews, interview transcripts, and notes taken during the actual interviews were all kept secure and anonymous throughout the data collection, analysis, and writing stages of the research project. Interview recordings and transcripts were assigned a number that only the researcher was able to match to the materials, which provided a secure filing system. A key for the numbers assigned to the documents was kept separate from the data materials, but provided the researcher a point of reference if follow up with a specific interviewee was needed. The data materials were kept for the duration of the research, but anything with overtly identifiable information was destroyed in due time.

The Interview Pilot

The depth interviews were organized around an interview schedule that allowed for great flexibility during the course of the interview; however, the schedule also guided the conversation on a path related to the theoretical underpinnings of the research questions. While the same schedule was provided to all participants from within the same stakeholder group, modifications were made for participants who were long-time veterans of the LTC policy versus those who were relatively new to the policy sphere. (For a sample interview schedule for each stakeholder group, please see the appendices.) Participants who had worked in LTC policy for less than ten years were unable to comment on previous LTC reform efforts such as the Clinton Administration's Health Security Act of 1993. All questions concerning the health reform debate of 1993-1994 were therefore skipped for the

interviewees who did not directly participate in that debate. A few participants who had worked on the Clinton health reform legislation stated they had been involved with too many different issues and pieces of legislation since 1994 and could not remember enough detail to answer certain questions from the interview schedule, which suggests these memory lapses potentially limited the usefulness of the information obtained about the Clinton years (Kramer, 1990; Tansey, 2007, p. 767).

The target length of each interview was approximately one hour, although the actual duration of each interview varied slightly. The majority of interviews lasted between 45 minutes and 75 minutes. The shortest interview lasted approximately 20 minutes, while the longest took almost two hours to complete. These differences in length were due to a multitude of factors including the amount of direct influence a person had in the policy process, the participant's role within their organization, the amount of time they had worked in the field of LTC policy, or simply their ability or willingness to sit for an interview on that particular day. The collection of data took nine months to complete.

Several background interviews with individuals familiar with LTC financing were carried out first in order to gain a better sense of the most connected and knowledgeable people in the field. This also provided a preview of the most important events in the story as well as some background on who might be the most relevant organizations or individuals to approach about an interview. This was particularly useful for providing a variety of starting points of referral chains within different categories of interview participants (Lee, 1993, p. 68; Biernacki and Waldorf, 1981) such as the insurance industry or the LTC policy experts, consultants, and academics.

Official interviews did not begin until the health care reform legislation was passed by Congress and signed into law by President Obama on March 20, 2010. Originally, it was anticipated that debate on the legislation would end before December of 2009; however, due to the political controversy surrounding the legislation, the debate lasted through March of 2010, delaying the research process by almost four months. An advantage of beginning interviews sooner might have been a more vivid account of a participant's role in the process as they went about their work on the CLASS Act. However, beginning the interviews while the legislation was still in progress would likely have required follow up interviews after the legislation was complete so that additional relevant information could be captured. The size and complexity of such an undertaking was beyond the scope of this study, which made it most logical to wait until the end of the health reform debate before beginning interviews.

The majority of interviews were carried out with individuals working in the greater Washington, DC metropolitan area, although a few participants were based in other locations such as Boston, Massachusetts and Los Angeles, California. The original research plan included travel to these locations to interview the participants face-to-face. However that plan proved logistically unrealistic due to the high costs and time constraints of travel. These specific interviews were instead carried out over the telephone, an acceptable alternative according to King and Horrocks (2010, p. 81) given time and resource constraints on fieldwork. Another participant changed jobs as their work on health reform concluded, so they were living somewhere in the Midwest at the time of the interview. This participant was therefore also interviewed on the telephone and the conversation was recorded. While telephone interviews tend to be viewed less favorably than interviews

carried out in-person, the data collected by telephone were no less informative or rich in material than those provided by the face-to-face interviews.

Interviewees

In order to provide an accurate basis from which to compare the findings from the depth interviews, the potential participants were segmented into different categories based on the type of organization in which they were employed. The categories were also devised based on the organization's relevance to the CLASS Act and on whose constituencies would be most influenced by the legislation. The main categories included consumer advocacy groups for the aging and disability communities, Congressional staffers from the United States Senate and House of Representatives, LTC provider trade associations, the private LTC insurance industry, and experts in the field of LTC policy, such as consultants and academics, who were included based on their highly specialized knowledge of LTC financing policy.

The participants, representing different stakeholders within the LTC policy arena, had significantly different constituencies and, as such, had different priorities and therefore biases that impacted their outlook on the LTC financing. Similarly, individual participants often had different backgrounds, levels of responsibility in their work, and varying amounts of involvement with the design and passage of CLASS. However, the majority of interview participants had substantial involvement with the legislation, and had been working in the LTC policy arena for several years. A number of interviewees who were less intimately involved with CLASS still had extensive knowledge of the legislation and how it fit into the American LTC policy framework. The number of participants from each

category varied depending on practical issues from how many potential participants agreed to participate in an interview to the importance of that group to the legislation. The diversity of the participant sample strengthened the findings of the research.

In total, it was projected that approximately eighty-five depth interviews across all of the sets of stakeholders would be needed to generate a large enough sample for this research. However, it became clear at sixty-five interviews the interviewees were failing to reveal new, relevant information, which Miles and Huberman (1999, p. 74), refer to as *data saturation*. This was particularly true of certain stakeholder groups such as advocacy groups and LTC providers. As mentioned before, it would have strengthened the research design to have had a government stakeholder segment, but that was not possible under the circumstances. Thus, interviewees ceased at sixty-five participants.

Consumer Advocacy Groups

The subsection originally presented here cannot be made freely available via ORA or within the copy of this thesis deposited to the Bodleian Library. This is to ensure the anonymity of all research participants who were interviewed for this thesis.

The subsection originally presented here cannot be made freely available via ORA or within the copy of this thesis deposited to the Bodleian Library. This is to ensure the anonymity of all research participants who were interviewed for this thesis.

Long-Term Care Provider Trade Associations

The subsection originally presented here cannot be made freely available via ORA or within the copy of this thesis deposited to the Bodleian Library. This is to ensure the anonymity of all research participants who were interviewed for this thesis.

The subsection originally presented here cannot be made freely available via ORA or within the copy of this thesis deposited to the Bodleian Library. This is to ensure the anonymity of all research participants who were interviewed for this thesis.

The subsection originally presented here cannot be made freely available via ORA or within the copy of this thesis deposited to the Bodleian Library. This is to ensure the anonymity of all research participants who were interviewed for this thesis.

Congressional Staff

The subsection originally presented here cannot be made freely available via ORA or within the copy of this thesis deposited to the Bodleian Library. This is to ensure the anonymity of all research participants who were interviewed for this thesis.

The subsection originally presented here cannot be made freely available via ORA or within the copy of this thesis deposited to the Bodleian Library. This is to ensure the anonymity of all research participants who were interviewed for this thesis.

¹⁴ While carrying out interviews with individuals from conservative think tanks might have served as a potential proxy for the Republican position on the CLASS Act, overtly partisan think tanks were avoided from both the liberal and conservative perspectives during the data collection stage. Instead, consultants and experts from non-aligned organizations were sought out for this study.

Long-Term Care Insurance (LTCI) Industry

The subsection originally presented here cannot be made freely available via ORA or within the copy of this thesis deposited to the Bodleian Library. This is to ensure the anonymity of all research participants who were interviewed for this thesis.

The subsection originally presented here cannot be made freely available via ORA or within the copy of this thesis deposited to the Bodleian Library. This is to ensure the anonymity of all research participants who were interviewed for this thesis.

Long-Term Care Policy Experts, Academics, and Journalists

The subsection originally presented here cannot be made freely available via ORA or within the copy of this thesis deposited to the Bodleian Library. This is to ensure the anonymity of all research participants who were interviewed for this thesis.

The subsection originally presented here cannot be made freely available via ORA or within the copy of this thesis deposited to the Bodleian Library. This is to ensure the anonymity of all research participants who were interviewed for this thesis.

Bureaucrats, Administrators and other Government Personnel

The subsection originally presented here cannot be made freely available via ORA or within the copy of this thesis deposited to the Bodleian Library. This is to ensure the anonymity of all research participants who were interviewed for this thesis.

The subsection originally presented here cannot be made freely available via ORA or within the copy of this thesis deposited to the Bodleian Library. This is to ensure the anonymity of all research participants who were interviewed for this thesis.

Policy Documents and Media Sources

In addition to depth interviews, publications about the CLASS Act and the Health Security Act of 1993 were collected, when available, from each participant's organization. The primary purpose of document collection was to provide a second stream of data to help corroborate those obtained through depth interviews. Some organizations produced several documents on the CLASS Act, while others did not produce any—though most organizations had at least one. In total, fifty documents were collected for analysis. The documents ranged from letters in support of the CLASS Act that were written to Members of Congress or President Obama from different stakeholder groups, to policy briefs detailing the benefits the CLASS program would provide to people in need of LTC. The documents were either posted on an organization's website or provided by an individual within a stakeholder organization. Many items were not actually useful for answering the research question, as they merely outlined the proposed design of the legislation and

iterated an organization's support or opposition to the legislation. Still, these documents formed an important part of the overall research process as they served as a check upon the findings from the depth interviews. Documents also proved useful for examining the LTC provisions of the Health Security Act of 1993 since there were fewer individuals who had worked on that piece of legislation readily available. The actual legislation, as well as documents produced by the Congressional Budget Office (CBO), provided highly valuable information. The U.S. Commission on Comprehensive Health Care Reform, known informally as the Pepper Commission, also proved highly insightful for the early 1990s.

Since Republican Congressional staffers declined to participate in the study, it was necessary to turn to published material in the media or the Congressional record in order to demonstrate their views of the CLASS Act. For example, Senator John Thune (R-South Dakota) made several comments about CLASS that were quoted in national newspapers such as the *Washington Post*. Additionally, the opinions of so-called conservative Democrats who opposed the CLASS Act were also included, such as the letter from the seven moderate Senators to Senate Majority Leader Harry Reid stating their opposition to the CLASS Act. These documents were highly valuable for establishing the opinion of those who were not supportive of the CLASS Act but were either unable or unwilling to participate in an interview.

Reliability and Validity

Elite interviews admittedly have several limitations in terms of what information they can provide to a researcher, so proper attention had to be paid to the reliability and validity of the collected data. For instance, an interviewee may withhold certain pieces of

information to protect their career or to be reflected in a positive light. According to Hacker (1997), individuals involved in the policymaking process may not be the best judge of what influence their actions actually have on the process or outcomes (Hacker, 1997, p. 7). Hacker additionally notes that individuals involved in the policy process may attempt to magnify their role, significance and influence (Ibid, p. 7), a phenomenon that was confirmed on occasion during the course of this project. With regard to snowball sampling, a potential limitation is that participants may only suggest other individuals to interview who share the same outlook on the process and skip others who may have different viewpoints (Sheldon and Pappworth, 1983; Lee, 1993). It was therefore necessary to gather a sufficiently large and diverse enough participant pool so not to skew the results in any particular direction (Tansey, 2007).

In order to help ensure the reliability and validity of the data acquired during the interviews, several strategies were employed. Most of the aforementioned limitations were overcome, however, using a careful approach to the collection of data coupled with checking the interview transcripts against other sources of data. These included published accounts of the policy process such as government documents (from Congressional committees and the Congressional Budget Office), and media and historical accounts in the case of the health reform of the early 1990s. Triangulating interview data with other sources such as historical accounts and government publications is a well-established qualitative research technique (Robson, 2002, p. 174) that helps to ensure greater reliability.¹⁵

¹⁵ Triangulation was often used within the analysis, comparing the interview transcripts with documents produced by the interview participant's organization in order to confirm that the data provided in the interview was accurate. For example, if a participant stated their organization's support for the CLASS Act, the official statement of support from their organization was also examined in order to verify their statement.

As previously mentioned, policy reports published by LTC advocacy groups, the private insurance industry, and the trade associations of LTC providers concerning the inclusion of the CLASS Act in health care reform were examined. This helped to demonstrate the key issues and concerns of the various stakeholder groups and to verify the findings of interviews with policy elites. These documents also provided some insight into the aims of their authoring bodies and whether or not their goals were achieved in the version of the CLASS Act that passed into law as a part of the 2009 health care reform debate. This approach did not constitute a systematic review of the documents and publications on the CLASS Act; however, it was a thorough and comprehensive review of the relevant materials. While the primary focus of this research was depth interviews, relying exclusively on a single research method can potentially leave the research overly vulnerable to error (Patton, 2002, p. 248). Document review served as an additional source for verifying the information collected by interviews, as these documents in writing how the CLASS Act developed and progressed through the health reform debate of 2009. The interview data, as well as public documents and media sources, were also compared with documents that participants' organizations produced on CLASS, in order to check for consistency in the findings such as in the timing of particular events, actual vote counts on legislation, and specific content of the legislation.

The use of multiple sources of interview data was another strategy used to ensure the reliability of the findings (Denzin, 1978; Patton, 1990; King and Horrocks, 2010). As previously stated, five distinct groups of stakeholders within the LTC policy arena were interviewed about the design and success of the CLASS Act. In addition to providing a rich source of data, the different perspectives of these stakeholders helped to demonstrate

the accuracy of the themes emerging from the data. If the study had relied on one or two stakeholder groups only, such as Congressional staff or advocacy groups, the findings would lack the validity that multiple perspectives on the policymaking process offers. Comparing participants' responses within and across categories of segmented stakeholder groups provided an additional test of reliability and validity to the data.

Data Analysis

Although analyzing qualitative data is time consuming and can be laborious, when done well, it produces extremely rich results that cannot be obtained through quantitative methods. This is particularly true of data related to the complex processes surrounding policymaking. The interview transcripts were treated as textual data in order to compare and contrast participant responses about the drivers of LTC financing reform and the CLASS Act in relation to the relevant literature on social policy. Analysis began while depth interviews were still in progress, and continued past the point at which all of the interviews were complete.

The interview recordings were transcribed primarily by the researcher in preparation for analysis. As the transcription process continued long past the time initially projected for this stage of the research, ten transcripts were professionally transcribed so that the progression of the research project could be maintained. The transcripts were then formatted so that the data within could be easily read, analyzed, and compared. A thorough reading, or immersion in, the data took place as advised by Wellington and Szczerbinski (2007, p. 101), which allowed for greater familiarity with the content of each text as well as the recurring themes within the data. Although software programs that are specifically

designed for qualitative analysis offer researchers several potential analytic benefits, ranging from a better visual representation of data to an efficient way to manage and analyze large amounts of data (Patton, 2002; Hesse-Biber and Leavy, 2010, p. 320), traditional or conventional analysis (manual) was carried out in this study, which also facilitated the researcher's immersion within the data. Word processing software was used to manage and store the data, which provided satisfactory retrieval capacity (Ibid, p. 319). The use of manual analysis additionally avoided some of the main drawbacks associated with software designed specifically for qualitative research such as a detachment from the data (Fielding and Lee, 2002).

Initial analytic categories were generated using general inductive analysis, yielding several significant themes within the data. These categories were much broader than the initial focus on the role of interest groups in the policy process, although interest groups remained a significant theme. Initial coding began as segments of text were labeled, and then placed into related categories. These labels, or codes, were assigned as the analysis progressed (a posteriori coding) and were recorded in the margins of the transcripts. These thematic categories were deemed important because: 1) they were most directly related to the research question (when they focused on interest groups); 2) they appeared most frequently across the data. Of course due to time constraints, it was not possible to code for every possible theme or category within the data. Thus, decisions were made about the most significant, and most relevant, themes that should be coded.

The tactic of memoing was also employed as themes, ideas, and links between the data segments began to emerge. Links between the initial segments of text were identified and connected to larger, more abstract themes. These abstract themes were then used as the

basis of the sections and sub-sections of the empirical chapters about the development and passage of the CLASS Act. A tree diagram of themes and sub-themes was developed so that a hierarchical relationship within the data could be demonstrated visually, but also “integrative themes,” which cut across several categories, could be easily determined (Creswell, 2007).

Limitations of Research Design

Obtaining access to individuals in highly visible political positions is a challenge that confronts researchers of all areas of sensitive policy analysis. Although a few individuals within the Obama Administration ultimately participated in this study, they generally appeared uncomfortable with the idea of speaking 'on the record' about the health reform process, which included the CLASS Act. Most simply did not respond to an invitation to participate in the study. Perhaps this set of stakeholders would be more amenable to speaking about the process at a point after more time has passed and the political environment is less focused on the health reform legislation.

The potential challenges of collecting useful data from individuals who worked in the LTC policy arena during the early years of the Clinton Administration also became apparent during the data collection process. Although several participants worked in LTC policy during that time period, it was often too far back for many to recall with great clarity the specific details of the health reform process relating to LTC financing. Nevertheless, these participants were highly knowledgeable about policymaking process and LTC financing policy and were therefore extremely valuable to this research.

Chapter Four: Long-Term Care Financing Reform During the Clinton Presidency

“No American should have to become impoverished to qualify for long-term health care. No family should ever have to choose between long-term care for the grandparents or for education for the children” (President Bill Clinton, 1992).

Introduction

Comprehensive health reform has been debated extensively in the United States over the past century; however, the Health Security Act of 1993 was the first comprehensive health reform proposal to also specifically address long-term care (LTC) financing reform.¹⁶ Yet, the Clinton reform proposal ultimately came to naught, and relatively few advances toward mitigating the individual social and economic risks associated with the need for LTC took place in the 1990s. This chapter explores why comprehensive LTC financing reform failed to take place between 1993-1994, and whether this failure to enact comprehensive LTC reform was exclusively a function of the collapse of the broader health reform effort promoted by President Bill Clinton. In addition, this chapter will examine the role that control of the political institutions in the United States, and in particular the shift in the control of Congress after the 1994 election cycle, may have played in obstructing movement on social change like LTC financing reform. The role that policy actors played in moving forward specific issues such as LTC financing reform will also be analyzed. Additionally, the possible impact, or legacy, of the failure to

¹⁶ The Medicare Catastrophic Act (MCA) of 1988 added a chronic care benefit to the Medicare program. In effect, this would have covered a large number of individual LTC expenses for Medicare beneficiaries. A specific LTC benefit was also briefly considered, but never included in the legislation (Himelfarb, 1995). The MCA was repealed less than a year later under intense criticism from senior advocacy groups due to the imposition of a premium increase and an income surtax on Medicare beneficiaries, aimed disproportionately at high income individuals (Street, 1993).

enact LTC financing reform at that particular juncture on future reform efforts, including the Community Living Assistance Services and Supports (CLASS) Act in the 2000s, will also receive some attention.

Bill Clinton was elected President of the United States in 1992 on a platform that included reform of the nation's health care system. Comprehensive health reform had been a long-standing goal of the Democratic Party; however, rising costs and declining coverage through employer-sponsored, private insurance was a growing issue throughout the 1980s (Quadagno, 2005; Hacker, 1996). The economic downturn of the late 1980s and early 1990s, which spiked unemployment, hastened the decline in employer-sponsored private health coverage and brought health reform to the forefront of the political agenda. Clinton's victory was heralded as a moment of great opportunity for social change advanced by a federal government actively engaged in promoting the social welfare of low-income and middle-class Americans (Skocpol, 2000). This seemingly marked an end, or at least a break, from the steady growth in attacks on the federal government as a force for social good, and the notion that individual responsibility and an unfettered private market were the only guarantors of personal economic and social well-being (King and Lieberman, 2009).

Shortly after taking office, President Clinton convened a working group of policy experts to craft a plan to overhaul the health care system. This group, known as the President's Task Force on Health Care Reform, left no aspect of the American health system untouched. The plan that emerged was ambitious in scope, seeking to provide universal coverage for acute medical care through mandating individual participation in regionally-based health maintenance organizations (HMOs) (Hacker, 1996; Skocpol,

1996).¹⁷ However, the plan drew criticism early on from all segments of the political arena. Furthermore, the Task Force deliberated for almost a year, and the plan that was ultimately delivered to Congress by the Clinton Administration firmly ended in defeat in the fall 1994 after a debate that produced few tangible results. In the mid-term elections that year, the Republican Party took control of the House of Representatives for the first in nearly 40 years, which effectively ended the opportunity for debate on expansions of social protection (Peterson, 1998). Instead, existing social programs were put on the defensive, with Congress seeking dramatic cuts in spending on Medicare and Medicaid (Morgan and Campbell, 2011). While these cuts were ultimately unsuccessful, the types of reforms which did occur sought to encourage private approaches to social protection through new incentives for private insurance (Quadagno and Street, 2005) and a reduction in the federal government's direct role in the provision of social protection, most notably in 'welfare reform' (Weaver, 1998; 2000).

From the start of the health reform process, LTC financing reform constituted a significant component of the Clinton Administration's plan, although it was only one portion of an ambitious proposal that addressed all aspects of the U.S. health system. The LTC proposal contained three main provisions: a large, new governmentally-funded program that would provide a home and community based services (HCBS) benefit; a liberalization of Medicaid eligibility for institutional (nursing home) care; and better regulation of the private LTC insurance market, coupled with several clarifications in the federal tax code related to incentives for the purchasing of private LTC insurance (Health

¹⁷ Health maintenance organizations (HMOs) only cover services rendered by providers with a prepaid contract to treat patients under strict guidelines imposed by the HMO. While initially developed during the years of the Nixon Administration in the early 1970s, this approach for expanding coverage was selected by the Clinton Administration for its use of private market forces as well as its purported ability to curb health care costs (Rushefsky and Patel, 2006).

Security Act of 1993). The new HCBS benefit was the most significant component of the Clinton LTC proposal in terms of coverage and cost as well as breaking with existing financing arrangements by moving toward a focus on need rather than means-testing. The recommendations of the LTC work group formally became the LTC financing reform proposal included in the Health Security Act of 1993. By establishing a non-means-tested program for HCBS, the Clinton proposal would have constituted a major departure from the Medicaid-dominated LTC financing system and a comprehensive overhaul of LTC financing in the United States (Wiener et al. 2001, p. 208). However, since the Health Security Act failed to reach a floor vote in Congress, no action was taken on LTC financing reform at that time. In the following years, incremental reforms were implemented that drew largely on pro-market initiatives such as tax credits for the purchasing of private insurance.

Research Findings: Why Did LTC Reform Fail to Pass in the 1990s?

Pepper Commission: Setting the Stage for Reform

In order to better understand the dynamics of the Clinton Administration's proposal, it is necessary to first look at the recommendations made in 1990 by the U.S. Bipartisan Commission on Comprehensive Health Care, known simply as the Pepper Commission, which laid the foundation for the LTC reforms proposed by the Clinton Administration. The Pepper Commission, which was named in honor of the long-time champion of the needs of older adults, Representative Claude Pepper (D-Florida), produced a study on how to reform both the health and LTC financing systems in the U.S. The Commission was a response to the growing challenges of the American health care system, particularly declining coverage and rising care costs, which exerted growing pressures throughout the 1980s (Quadagno, 2005). Notably, the Pepper Commission called for an increased governmental role in providing health care, including LTC, for all Americans. In his remarks as Chair of the Commission, Senator Rockefeller stated:

“Allowing these health and long-term care problems to persist not only deprives millions of Americans of what they ought to be able to have...it diminishes our economy...[and]...the United States of America. I don't think it's possible to say...that we are a civilized nation when so many of our people...do not have long-term care, do not have health insurance” (Senator John D. Rockefeller IV, U.S. Bipartisan Commission on Comprehensive Health Care, 1990).

With regard to LTC reform, the Pepper Commission specifically called for: a new social insurance program to finance home and community based services (HCBS); a

minimum protection level for personal assets (\$30,000 for an individual, \$60,000 for a married couple) for people who rely on Medicaid to finance their nursing home care; the promotion and tighter regulation of the private LTC insurance market; and several measures aimed at improving the quality of care provided in all LTC settings (U.S. Bipartisan Commission on Comprehensive Health Care 1990, p. 16-18). The proceedings of the Pepper Commission demonstrated broad agreement on the need to reform the health and LTC systems; yet, very little consensus existed on how to actually carry out reform or what problems were the most important (Quadagno, 2005, p. 183). Any legislative movement failed to occur following the release of the Commission's report. Nevertheless, a number of the recommendations made by the Pepper Commission would provide a foundation for the LTC reforms proposed by the LTC workgroup of President's Task Force on Health Care Reform, which were ultimately included in President Clinton's Health Security Act just three years later. Though the major recommendations of the Pepper Commission were never enacted, the promotion and tighter regulation of the private LTC insurance market and new regulations on the quality of care provided in institutional settings did become actual policy in the aftermath of the collapse of the reform efforts of 1993-1994 as part of the Health Insurance Portability and Affordability Act (HIPAA).

The Clinton Plan for LTC Financing Reform

The President's Task Force on National Health Care Reform began work in January of 1993. Distinct sub-workgroups concentrated on specific components of the U.S. health system, with one group focused exclusively on long-term care (LTC) financing

issues. The recommendations of the LTC work group became the LTC provisions within the Health Security Act. The Health Security Act was the first time a major LTC financing reform proposal reached the national legislative agenda and, as a part of health reform, was debated by Congress. While the wider focus of health reform sought to provide universal coverage for health care through mandated participation of all Americans in health maintenance organizations (HMOs) (Hacker, 1996; Skocpol, 1996), the LTC focused provisions of the Health Security Act of 1993 were less bold in scope. The LTC provisions did not propose universal coverage for all LTC recipients or of all expenses associated with the need for LTC. Institutional coverage was largely left out of the proposal, although easing the financial requirements for Medicaid eligibility would have modestly increased coverage for institutional expenses. However, the plan did call for an expanded role for the government in the financing of LTC by creating a new government program for HCBS. According to the Policy Director of a consumer advocacy organization that focuses on the needs of older adults:

“The effort to include LTC under Clinton was an effort to get public money for an issue that many people didn't think of as part of health reform. Long-term care was also seen as an issue for the destitute—to be addressed by the Medicaid program. I think a lot of people didn't understand, well if we have Medicaid, isn't that enough? Why do we need something else?” (Aging Advocate, Transcript 27).

A detailed reading of the Health Security Act of 1993 suggests the LTC reform proposal would have shifted greater responsibility from the individual to the state for the provision of benefits within the American LTC financing system. While the LTC plan had four main components, the core of the proposal called for a new, tax-financed, governmentally administered program to pay for home and community based services

(Health Security Act of 1993). This new program was to be administered by the states and would not require the mandatory participation of any individual state government, although it was to be jointly funded by states and the federal government. Given that the majority of states already had some form of a HCBS program in place in the early 1990s, their participation in this new program was assumed highly likely due to an increased stream of funding provided by the Clinton plan (Wiener et al. 2001). Similar to the way the Medicaid program operates, state governments were expected to partially cover the costs of the program; however, they were to receive generous matching funds from the federal government if they elected to participate—at least 28 percent higher than Medicaid funding rates at that time and fund no less than 78 and no more than 95 percent of each state program's total quarterly costs. The plan did not establish a new entitlement for LTC coverage due to the high cost of covering all possible care needs (Wiener et al. 2001); rather it left enrollment and specific benefit design to the discretion of individual states, provided eligibility was based on need (Health Security Act of 1993). In short, the proposal for a HCBS benefit constituted a departure from the existing LTC financing policy arrangements in the United States, combining a needs-based (non-means-tested) benefit with programs administered by individual state governments.

In addition to establishing a new tax-financed program for HCBS, the Health Security Act called for a modest liberalization of Medicaid eligibility for LTC assistance provided in skilled nursing facilities. If passed, the legislation would have made it easier to qualify for public assistance that would cover the costs associated with nursing home care. The asset threshold for eligibility for Medicaid's LTC financing program was to be raised from \$2,000 to \$12,000 (Health Security Act of 1993), which was significantly lower than

the \$30,000 individual income threshold recommended by the Pepper Commission. Nevertheless, while this liberalization of Medicaid eligibility was a modest expansion of coverage, it would have been the largest expansion of Medicaid eligibility for LTC since the program's creation in 1965.

The Clinton proposal additionally offered new tax incentives to individuals for the purchasing of private LTC insurance. The goal was to increase coverage through the nascent private market for LTC insurance, which began to develop in the early 1980s, but experienced slow growth in terms of utilization through the 1980s and early 1990s (Eastaugh, 1992, p. 140). The proposal also sought to provide greater oversight of the LTC insurance industry so that private products would be more accessible and transparent to consumers (Health Security Act of 1993). While these provisions were less costly than other components of the proposal, they were viewed by many stakeholders within the LTC arena as important changes to the LTC financing arrangements with great potential to expand coverage. The provisions focused on tax incentives for purchasing private insurance were also the only components of the LTC proposal to be legislatively successful in the years immediately after the collapse of the Clinton health reform efforts.

If successful, President Clinton's reform proposal would have constituted a major departure from the existing LTC financing arrangements in the United States. The Health Security Act proposed a move away from the means-testing of benefits to benefits based more on level of need. On the one hand, the lack of a legal entitlement to benefits and the state focus of the HCBS system meant this proposal would not have created a social insurance program. The benefits provided in the proposal, while increased from existing levels, were also moderate in scope and did not replace the existing financing arrangements

already in place. Nevertheless, the proposal, and in particular the new tax-financed HCBS program, would have required a large expansion of state capacity in order to mitigate the individual financial risks associated with the potential need for LTC. Furthermore, the plan sought to expand eligibility for Medicaid, an important point to note since such a measure would not be a focus of future LTC reform proposals, although coverage expansion often would take place for acute medical care offered through Medicaid.¹⁸ In any case, the Clinton plan would be the last time a LTC financing reform proposal, which employed a tax-financed mechanism for expanding access to LTC coverage, made it to the top of the policy agenda in the United States.

Cost Concerns

All three components of the Clinton LTC reform proposal were projected to have a negative revenue impact on the federal budget. The Congressional Budget Office (CBO) estimated the cost of LTC financing reform at just over \$60 billion in the first five years after enactment (U.S. Department of Health and Human Services, 1994). However, the new HCBS program and the expansion of Medicaid were to be paid almost entirely through savings in other areas of health reform, primarily significant cuts to Medicare and Medicaid as well as a new tax on the sale of tobacco products (Ibid). Yet the costs of expanding LTC coverage remained somewhat problematic, politically speaking. In a time of concern over the cost of social programs, there was a lack of strong support for LTC

¹⁸ Since 1994, policymakers have significantly expanded the Medicaid program for acute medical care adding coverage for children, and most recently in 2010, coverage for individuals with an income up to 133% of the federal poverty level (Jacobs and Skocpol, 2010). For comparison, the income eligibility threshold for Medicaid's LTC services has only increased once (from \$2000 to \$3000 in assets) since the program began operating in 1965.

coverage amongst policymakers. When asked about the Clinton LTC proposal, an expert in LTC policy with over 30 years of experience working in the field stated:

“...there is a tendency in LTC to try to get attention by emphasizing the growth in the disabled population with a kind of ‘the world will come to an end if we don’t do something’ flavor to it. But many of the proposals that people put forward generally call for spending more money. In the sense of the financial burden, they kind of make it worse. So I think people needed to find a different way to try to get LTC on the agenda” (LTC Policy Expert, Transcript 4).

The appropriate level of public spending on social programs is a particularly thorny issue within the American political environment. Entitlement programs, which redistribute resources to specific populations such as older, disabled, and low-income individuals, became a highly contested political issue in the 1980s and remained controversial into the years of the Clinton Presidency. Since such a large portion of federal spending is for entitlement programs, and a large portion of these programs cover the costs associated with LTC, debates about LTC financing reform cut to the core issues surrounding entitlement reform. Indeed, this statement highlights a perception that public spending on social programs was becoming an increasingly controversial political issue in the 1990s, although most reform advocates and LTC policy experts continued to focus their attention on coverage expansion. The Clinton LTC proposal did enjoy greater support in Congress than health reform overall, but the costs of the LTC proposal contributed to the hefty costs of the wider Clinton health reform proposal and the debate over how those costs would be financed. Thus, to some small degree, the costs of the LTC proposal helped to facilitate the collapse of health reform in 1994 by adding further pressure and complexity to the issue of cost. More importantly, the failure contributed to a growing perception amongst U.S. policymakers and stakeholder groups that LTC reform initiatives needed to cost less than

the plan proposed by the Clinton Administration. This shift in thinking would in turn limit the scope of future LTC reform proposals, which would focus on lower rates of coverage expansion in exchange for a reduction in the budgetary impact of reform.

Institutional Dynamics and Legacies of Existing Policies

Political Parties and Congress

Although the overall number of seats in Congress controlled by Democrats declined with the 1992 election, the party still retained large majorities in both houses of Congress during the 103rd Congress. With the election of President Clinton, the Democrats now controlled the Presidency and both chambers of Congress by wide margins (See Figure 4:1). The partisan control of these political institutions by the Democrats was necessary for health and LTC financing reform to move to the top of the domestic policy agenda. The Democratic Party had a long history of championing health reform as part of their electoral platform and when they held the Presidency. Moreover, public opinion polls from the early 1990s showed that a majority of the American public supported an overhaul of the health care system (Rushefsky and Patel, 1998). Health reform was therefore the main domestic policy issue addressed by President Clinton once in office. While this partisan control of the main political institutions by the Democratic Party was necessary for health reform to be debated, and therefore LTC financing reform, this partisan control was insufficient on its own to allow reform to take place at this particular juncture.

In the aftermath of the collapse of health reform, the Democratic Party lost control of the House of Representatives in the 1994 mid-term elections. This was the first time the

Republican Party had gained control of the House since 1954 (Office of the Clerk, U.S. House of Representatives, 2012), and dramatically changed the tone of the policy debate in Washington, DC.¹⁹ Furthermore, the Democrats' loss of control of Congress and a return to divided government after the collapse of health reform restored a major obstacle to comprehensive LTC financing reform. This impediment would stay in place for some time following 1994. According to the government affairs director of an aging policy focused organization:

“I think that the failure in 1993-1994 plus a Republican Congress from 1995 to 2007—with that brief interlude when the Democrats had control of the Senate—put any comprehensive long-term care—or even health care for that matter—off the table for the rest of the Clinton years and obviously during the Bush years as well” (Aging Policy Advocate, Transcript 18).

With Congress controlled by the opposing political party to that of President Clinton, proponents of LTC reform were unable to move forward any proposal through the legislative framework of the American political system that sought to significantly alter the LTC financing arrangements in the United States. The desire for some type of reform did not, however, simply disappear. Notable incremental developments in LTC financing policy during the later years of the Clinton Administration were the passage of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the establishment of the Federal Long-Term Care Insurance Program in 1999. HIPAA established greater oversight and regulation of the broader private health insurance market, but also added specific incentives to the federal tax code for individuals and employers to purchase private LTC insurance (Quadagno and Street, 2005). The Federal Long-Term Care

¹⁹ While the 1994 mid-term elections were the first time the Republican Party won control of the House of Representatives since 1954 (Office of the Clerk, U.S. House of Representatives, 2012), the Senate and Presidency often switched back and forth between the two political parties during that 40 year period.

Insurance Program established a partnership between the federal government and private LTC insurance industry, allowing all federal employees to purchase private LTC insurance plans with a specified contractor – initially MetLife and later John Hancock. Both reform initiatives focused on encouraging the wider use of private insurance to provide for individual LTC needs and were departures from the approach to reform of the Health Security Act. More importantly, the shift in partisan institutional dominance empowered those seeking to reduce the role of government in mitigating social risks with an opportunity to move their agenda forward. The Republican's 1994 electoral platform, the *Contract with America*, outlined their objectives, which were aimed primarily at reducing the size and scope of the federal government. Significant cuts to Medicare and Medicaid featured prominently in their legislative agenda once in control of Congress (Morgan and Campbell, 2011). While Congressional Republican legislative efforts to curtail the Medicare and Medicaid programs were ultimately unsuccessful, this appears to demonstrate that the partisan control of political institutions was a significant factor in the policymaking process.

The Executive Branch

The Clinton Administration was the primary driver behind health reform including LTC financing reform in the years between 1993 and 1994. Participants believed, however, the way that the Clinton Administration developed and presented their plan for reform created a major impediment to its potential success. While the President often acts as facilitator within the legislative process (Finegold, 2005), the U.S. Congress is where most legislation develops in the U.S. political system. With health reform, however, the Clinton

Administration presented a highly detailed plan to Congress, which was largely developed without significant Congressional input. According to a 30 year veteran of the LTC policy arena, who had worked as a Congressional staffer during President Clinton's attempt at health reform:

“In 1993 it was, ‘We’re the White House. We have a plan. Here it is. Pass it.’ Basically...which is not the way the checks and balances system works; it’s not the way the political protocol system works. Congress produces legislation. The President can propose things that become legislation, but it isn’t done in a way where you bypass the normal processes, which is what happened in 93” (LTC Policy Expert, Transcript 3).

This statement helps to highlight the importance of the legislative process within the institutional arrangements of the U.S. political system. It was widely believed that the way the Clinton Administration handled the legislation contributed to the failure of the Health Security Act. Participants believed that Members of Congress were alienated by the process and were less than willing to move the legislation forward once it was firmly under their control. As a result, LTC reform also failed to pass at that time due to its inclusion within health reform. The fate of LTC reform in the early 1990s was directly linked to that of health care reform more broadly.

Congressional Committees

As a complex policy issue, multiple Congressional committees have jurisdiction over any health care reform package. In 1994, health reform legislation was debated in five separate Congressional committees.²⁰ The only Congressional committee, however, to report out a bill was the Labor and Human Resources Committee chaired by Senator Edward Kennedy.

²⁰ Health reform proposals (all titled “The Health Security Act”) considered during the 103rd Congress, which included LTC provisions: Senate Labor and Human Resources Committee (S. 1757); House Ways and Means Committee (H.B. 3600); Senate Finance Committee (S.1775); The Mitchell Plan (S.2357), which was a merger of the Senate Finance and Labor and Human Resource Committee bills; The Gephardt Plan (also listed as H.B. 3600).

Figure 4:1

Partisan Control of the United States Congress: 1993-2011

Session of Congress	Senate (Out of 100)			House (Out of 435)		
	Democrat	Independent	Republican	Democrat	Independent	Republican
1993-1995	57	0	43	258	1	176
1995-1997	48	0	52	204	1	230
1997-1999	45	0	55	206	1	228
1999-2001	45	0	55	211	1	223
2001-2003*	50	0	50	212	2	221
	50	1	49			
	48	2	50			
2003-2005	48	1	51	205	1	229
2005-2007	44	1	55	202	1	232
2007-2009	49	2	49	233	0	202
2009-2011*	58	2	40	257	0	178
	57	2	41			

* During the 2001-2003 session, three changes in party composition took place in the U.S. Senate. These changes were not the result of elections but from specific Senators switching party affiliation.

* In the first session of the 2009-2011 Congress, the Democrats effectively held a 60 seat majority with 58 Democrats and 2 Independents who caucused with the Democrats. In the special election to fill the seat of former Senator Edward Kennedy (D-Massachusetts), the Republican candidate, Scott Brown won, ending the Democrats' 60 seat majority.

Source: Data from the U.S. Senate and the Office of the Clerk of the U.S. House of Representatives.

House: http://artandhistory.house.gov/house_history/partyDiv.aspx

Senate: http://www.senate.gov/pagelayout/history/one_item_and_tasers/partydiv.htm

Demographics and Medicaid Spending

In 1990, there were 31 million Americans over the age of 65 (U.S. Administration on Aging, 2010). By 2010, the number of older Americans had increased to approximately 40 million. More importantly, by 2020 the number of Americans over the age of 65 will rise to nearly 55 million (Vincent and Velkoff, 2010). Study participants often noted that policymakers were simply not as aware of these projected demographic changes in the early 1990s as their counterparts in the late 2000s. While the Medicaid program was the primary public payer of all individual LTC costs in the United States in the early 1990s, Medicaid's LTC expenditures were, however, modest when compared to program outlays on LTC in the 2000s. For example, in Fiscal Year 1990, total Medicaid spending amounted to \$32 billion (Kaiser Family Foundation, 2009).²¹ Moreover, the major demographic issues that will confront American policymakers in the twenty-first century were still decades away in the early 1990s. The LTC financing reforms proposed by President Clinton would have resulted in a modest expansion of access to Medicaid, therefore, expanding the costs of the program as well. Without a focus on cost control, LTC financing reform was hampered by efforts to expand coverage when the focus on the cost of health reform proved to be a problem.

The level of awareness amongst policymakers of the issues surrounding LTC financing had increased as the accumulated challenges of the system compounded. Among the accumulated challenges of the LTC financing system, the federal government's expenditure on Medicaid was particularly apparent to policymakers. Interviewees who had been involved with the Clinton Administration's health reform proposal noted that in 2009,

²¹ Out of the \$360.9 billion spent on Medicaid in FY 2009, 32%, or \$114.1 billion, went to LTC (Eiken et al. 2010).

Members of Congress had a much better understanding of the problems surrounding a reliance on the Medicaid program to finance LTC than their counterparts in 1994. A journalist, with over twenty years of experience interviewing Members of Congress and their staff on LTC policy issues observed:

“...I think that very much inside the beltway, there is recognition that Medicaid is inappropriate for LTC. I think there was a belief in ‘94 that you could somehow fix Medicaid. And from ‘94 until now there have been....I don’t know how many hundred demonstration projects, all of which were intended to make Medicaid a better program, but with very limited success...I think a lot of people who know this system know there is really not a lot we can do to make Medicaid what we want it to be...” (LTC Policy Expert, Transcript 5).

In place of comprehensive LTC financing reform, and in addition to tax credits to stimulate the use of private LTC insurance, several Medicaid demonstration projects were carried out between 1994 and 2008, which provided waivers from the federal government so that individual states could implement structural reforms to their Medicaid programs (Thompson and Burke, 2009). While many of these demonstration projects showed some progress in making Medicaid more responsive to the needs of beneficiaries and in reducing costs, many simply could not be replicated on a larger level, while most failed to actually curb costs. Thus, between 1994 and 2009 the acute challenges of financing LTC became more apparent to stakeholder groups and even to some policymakers. This growing awareness did not constitute a sudden shift in the need for reform; however, by the late 2000s it would reach a point where those within the federal policy process were aware of the need for substantial reform. This growing awareness may have been beneficial to the passage of the CLASS Act as a part of health reform in 2010, but it did not exist in the early 1990s.

The Proponents of LTC Financing Reform

Congressional Champion

During the health reform efforts of the Clinton Administration, it is significant to note that no distinct champion of LTC financing reform emerged within the U.S. Congress. Representative Claude Pepper (D-Florida), who had long championed the issues of older adults including an expansion of government to cover the individual costs of LTC, died just a few years before President Clinton took office (Henry, 1989). No other Member of Congress emerged as a champion of expanding access to LTC coverage as played by Representative Pepper. During the reform debate, several Members of Congress did call for expanding access to LTC coverage such as Senator David Pryor (D-Arkansas) and Senator John D. Rockefeller (D-West Virginia);²² yet none made LTC reform their primary concern within the reform debate. Furthermore, Senator Edward Kennedy, a long-time champion of expanding access to health care, did not focus the same attention on LTC policy in the early 1990s that he would in later efforts.²³ While the preferences and motivations of individual policymakers are difficult to precisely gauge, expanding access to acute medical coverage was viewed by proponents of health reform as the higher priority from both a policy and ethical vantage point.

In the absence of a strong Congressional champion, efforts to expand LTC coverage through legislative action, much like the wider health reform process, were

²² Senator Pryor proposed that a HCBS benefit program be added to the Senate Finance Committee's health bill, which did not include a significant LTC financing proposal until Pryor's amendment was added the day before the final vote on the committee's health reform bill (Wiener et al 2001).

²³ During the proceedings of the Senate Health and Human Resources Committee, Senator Kennedy did oversee the addition of the Life Care Act (S.1833) to the version of the Health Security Act reported out by that committee. The Life Care Act would have created a voluntary insurance program to pay for nursing home care (Life Care Act of 1993).

therefore driven largely by the Clinton Administration. While campaigning for President in 1992, Bill Clinton often explicitly mentioned LTC reform, stating that any health reform proposal would also include an expansion of LTC coverage (Clinton, 1992). In his proposal for health reform printed in the *New England Journal of Medicine* just prior to the election, Clinton stated:

“No American should have to become impoverished to qualify for long-term health care. No family should ever have to choose between long-term care for the grandparents or for education for the children” (President Bill Clinton, 1992).

The Clinton Administration’s verbal commitment to LTC reform continued once in office and as the health reform process was underway. Future Presidents after Bill Clinton would not put such an emphasis on LTC financing reform in their public statements or in their stated policy objectives. In speaking on behalf of the Clinton Administration during a meeting with stakeholder groups about reform, Vice-President Al Gore stated:

“We are determined that all health issues, including long-term care, will be addressed in health care reform” (Vice-President Al Gore quoted in Connell, 1993).

The public statements in support of LTC reform made by the Clinton Administration—including those of President Clinton and Vice-President Gore—correspond to the findings from participants, who often noted the Clinton Administration’s overarching influence on LTC reform during this timeframe. In fact, the Clinton Administration was the main driver behind LTC reform at this time. On the one hand, this was partially a function that the proposals for health and LTC reform were developed together. However, the Clinton Administration put significant emphasis on the need for LTC reform that future Presidential Administrations would not do. Yet, when President

Clinton abandoned the push for health reform, the Administration also dropped the push for comprehensive LTC financing reform and instead advanced incremental reforms of both health and LTC during the rest of the Clinton years. Without a strong, well-positioned champion within the policymaking process, LTC reform struggled to gain much political traction on its own after the Clinton health reform efforts collapsed in the fall of 1994.

Advocacy and Provider Groups

The aging and disability advocacy communities historically have not always been united in their stance on public policy. This tension is partially a product of populations with similar needs, which are competing for the same scarce public resources. However, any longstanding tensions also stem in part from their differing views toward institutional care and home and community based services (HCBS). Although both communities are now in broad agreement on the need to focus on HCBS, the disability community embraced this concept much earlier than aging (Kane, 2007). This differing viewing stems in part from the care needs of their respective populations, namely older adults who need of LTC often require highly skilled, institutional based care, while younger, disabled adults may not require institutional care at all. As such, the disability community has fought for years to move public financing arrangements, particularly Medicaid, away from an institutional focus. These conflicting views made reaching consensus difficult and therefore complicated LTC reform efforts in the early 1990s.

The advocacy groups, as a whole, were supportive of efforts to reform health care, and generally supportive of the LTC proposal as well. In a 1993 *New York Times* article, AARP's chief lobbyist, John Rother, stated that the Clinton LTC plan would be, "*a real*

breakthrough in covering home and community-based services for people of all ages with mental and physical disabilities—not just older people, but also victims of accidents and children with birth defects” (Pear, 1993). Groups like AARP were, however, not particularly united in their support. The support of the aging and disability groups was explained by one LTC policy expert, who had been involved in drafting the Clinton LTC proposal:

“There was a broad group of elderly and disability groups that were lobbying for various things, but without a whole lot of influence I would say. However, AARP was critical and part of the price of AARP’s support for health reform was there had to be a significant LTC component in the plan. What Clinton had was less than what they wanted. They wanted a full social insurance plan for LTC and they were somewhat grudging in their support for what there was” (LTC Policy Expert Transcript 4).

The advocacy groups supported the addition of a LTC benefit to Medicare, which would have amounted to an expansion of social insurance. However, an expansion of Medicare was not the approach taken by the Administration in designing their proposal for reform. The focus of the Clinton proposal on home and community-based services rather than nursing home care made it highly appealing to disability advocacy groups, but less appealing to the aging advocacy community. The aging policy groups wanted a more robust nursing home benefit, which would have relieved a tremendous financial burden confronting many of their members. While they officially backed the proposal, their support was less than a ringing endorsement.

The subdued support for the Clinton LTC reform proposal was also evident amongst LTC providers. Similar to the aging policy community, a nursing home benefit would have offered LTC providers a more tangible, immediate financial benefit. At least publically, however, providers often stated their support of the Clinton proposal. A benefit

for HCBS would not directly help the business model of LTC provides, who provide services through institutional settings. In a press release demonstrating lukewarm support for the Clinton proposal, the President of the American Association for the Aging (AAHA)²⁴ stated:

“Our members, as part of their historic mission of providing health care, housing and community services to the nation's elderly, have long advocated helping individuals to live as independently as possible for as long as possible. These new benefits are likely to help millions of older Americans and others with disabilities to be cared for in their homes for as long as practicable. AAHA does not feel, however, that this approach to long-term care will cost society less. Nursing home care will continue to be a viable and cost-effective alternative for many persons with serious disabilities for whom care in another setting would be impractical” (Goldberg (1993) quoted in *NewsWire*, September 21, 1993).

The lack of strong, unified support amongst the advocacy groups and LTC providers had several implications for the success of LTC reform at this particular juncture. Firstly, as the above statement suggests, support was not particularly robust from provider groups, an influential stakeholder within the LTC policy arena. Second, the very fact that statements of support were forthcoming only in late September of 1994 suggests that groups were not particularly enthusiastic about the content of the proposal, even when taking into account the time it took the Administration to deliver their plan to Congress. While supportive of Clinton's LTC proposal, AARP never formally endorsed it or the overall Clinton health reform efforts. While it is unlikely that robust support of the LTC proposal would have sustained the viability of the overall health reform efforts by itself, the advocacy groups were not in a unified position to champion LTC reform in the aftermath of the collapse of health reform. Certainly, broader forces served to impede any movement on comprehensive LTC reform in the 1990s; however, a unified advocacy

²⁴ The American Association for the Aging (AAHA) has changed their name twice since 1993 and are now called Leading Age.

coalition could have brought the issue greater attention, particularly in the aftermath of the collapse of the Clinton health reform process.

Political Impediments to LTC Reform

While policymakers made minor changes to LTC policy in the years prior to the passage of the CLASS Act, proposals for comprehensive LTC financing reform failed to gain political traction after the failure of the Clinton Administration's attempt to reform health care in 1993. Several participants stated that many advocates and policymakers believed the Clinton health reform plan failed in part because of the LTC financing component, which "muddied the waters" during the debate. This was largely attributed to the additional costs and complexities of the LTC reform proposal. Despite the cost and complexity of LTC financing reform, several interviewees pointed out that the LTC proposal actually received more formal support during the debate of 1993-1994 than health reform overall. This view is supported by examining the actual committee votes on the LTC proposal within the U.S. Senate.²⁵ The Senate Finance Committee vote on July 3, 1994 was 12 to 8 in favor of the health reform, and 16 to 4 in favor of the LTC financing plan (Wiener et al. 2001). Despite greater support in 1994 for a LTC financing reform plan within the U.S. Senate Finance Committee, the fate of LTC reform at that time was the same as health reform overall; namely, it never made it to a vote on the floor of either the House or the Senate. The CLASS Act would be the only major attempt at LTC financing reform after 1994 besides minor changes to Medicaid, clarification of the federal tax code regarding the purchasing of private LTC insurance, and further regulation of the LTC

²⁵ The House of Representatives Ways and Means Committee also reported out a health reform bill in 1994 that included a LTC financing plan.

insurance market.²⁶ These contrasting perspectives on the Clinton reform efforts suggest that while the Obama Administration may have been wary of including any provision within health reform that might endanger the success of its overall reform efforts, the failure of the Clinton LTC plan did not significantly impact LTC policymaking between 1994 and 2009 as some believed.

The Clinton era health reform efforts were not perceived by participants as the most significant impediment to LTC policy reform in years after the collapse of the Clinton plan. In other words, the failure of LTC in 1994 was viewed largely as a product of the failure of health reform overall and not a problem inherent to LTC. Yet, the failure of health reform in the early 1990s did influence policymakers and how they would approach LTC reform in the following years. Similar to the wider health reform efforts, the main features of the LTC reform proposal called for greater government intervention into the LTC financing arena. Both states and the federal government would assume a bigger role in financing individual LTC costs. Participants believed the extensive role of government in mitigating the risks associated with health was viewed as a part of the reason the Clinton plan failed and why comprehensive LTC reform was also put on hold. According to one LTC policy expert who had worked as a Congressional staffer during the Clinton efforts at health reform:

“One of the outcomes of that [health reform] debate in the 1990s was that everybody ran from the universal coverage concept to something that was employer based because it’s comfortable for people, politically. LTC and the CLASS Act ended up being the same thing...” (LTC Policy Expert, Transcript 20).

²⁶ The Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the Balanced Budget Act (BBA) of 1997 made minor, albeit notable changes to LTC financing arrangements after 1994.

The collapse of the Clinton health reform efforts left policymakers and proponents of social reform in an uncertain position. The failure of health reform was perceived by many policymakers as a repudiation of the approach of the New Deal and Great Society to addressing social protection (Skocpol, 1996). It was regularly noted by interview participants that the LTC provisions added to the overall cost of health reform, which was problematic, but by themselves they did not trigger the failure of the Clinton health reform efforts. However, as a highly complicated policy issue, LTC financing was viewed by many as adding to the overall complexity of health reform, which weighed on the minds of proponents of future health reform efforts, and had an impact on how policymakers and advocates of reform approached social policy more broadly. Social insurance and tax-financed initiatives that would expand coverage for LTC were off the policy agenda for the remainder of the Clinton Presidency.

While the approach to health reform had an impact on the content of all future social reform initiatives in the United States, discussions about health reform did not completely leave the realm of public debate. Long-term care reform, however, largely fell off the public agenda in the years after 1994. Several additional explanations were therefore offered by participants for the failure of policymakers and advocates to bring about major LTC financing reform in the years after the collapse of the Clinton plan. Participants often cited the lack of saliency of LTC as a policy issue amongst most U.S. policymakers as a reason for an absence of major reform. A Congressional staffer, whose portfolio of legislative responsibilities focused on LTC policy, observed:

“LTC is simply not something this country thinks about, or has been educated to think about, as something the government will take care of. And there’s no consensus or agreement about it that I’m aware of. And many individuals are not excited about thinking about the need, their possible need, for LTC. They don’t tend to plan for it...there’s an active aversion to doing so. So I think the combination of those factors is such that it’s just not a political issue that can galvanize its own support” (Congressional Staffer, Transcript 37).

This statement reflects the impact of the perception of policymakers that the American public’s interest in LTC was limited, which in turn made it difficult for LTC reform to gain political traction within the political system. It also highlights the idea that people tend to avoid planning for LTC due to issues surrounding individual decline, disability, and mortality (Frank, 2012). Additionally, it reflects a sentiment that LTC is perceived as a family issue rather than something the government needs to address through public policy (Levitsky 2006; 2010).

State governments served as a source of innovation and reform of LTC policy in the years after the collapse of the Clinton plan. State governments play a substantial role in the financing and administration of the Medicaid program as they hold joint jurisdiction of the program with the federal government. In the absence of major federal action on LTC financing reform, individual states began to carry out their own reform efforts to Medicaid in the late 1990s, although these efforts intensified in the early and mid-2000s (Scharlach and Lehning, 2012). In terms of a policy priority amongst federal lawmakers, a Congressional staffer whose legislative portfolio focused on LTC policy, stated:

“There has been a lot of activity at the state level. States get LTC; they completely understand it and understand that it is the most expensive care there is...that these [people] are the most expensive and frail beneficiaries. They’ve been jumping up and down for years to get the attention of the federal government. But the Congress has been very uninterested in LTC. The executive branch hasn’t been particularly interested in it either” (Congressional Staffer, Transcript 37).

All participants widely believed that the saliency of LTC was lower than other policy issues and was therefore not a high priority of policymakers in the years prior to the passage of the CLASS Act. In place of federal interest in the topic, much of the debate on LTC financing prior to the CLASS Act took place at the state level, which is unsurprising since state governments share responsibility for financing Medicaid with the federal government. LTC did not feature as a more prominent issue at the federal level due to a lack of wider public interest in the topic. It was noted that even while President Obama's health reform efforts were under debate, public attention to the issue of LTC reform remained minimal. The perceived inevitable high cost of addressing LTC was also cited as problematic as a governmental response would be some form of new tax. Thus, while reform of LTC financing was viewed as necessary by many stakeholders within the LTC arena, and even by some policymakers, only minor changes to existing policy arrangements were made prior to the passage of CLASS rather than undertaking comprehensive reform.

Analysis and Discussion: Why did LTC Reform Fail in 1993-1994?

The findings presented in this chapter suggest that comprehensive LTC financing reform failed to take place in the early 1990s due to a number of diverse factors. At the logistical level, the reason was the collapse of the wider health reform process in the early 1990s, the point at which comprehensive health reform was last seriously debated within the American political arena prior to the legislative success of reform in 2010. When health reform collapsed in the fall of 1994, comprehensive LTC financing reform also failed to move forward within the policy process. However, the failure of President Clinton's health reform was not the only factor bringing an end to efforts toward comprehensive LTC reform in the 1990s. Several other factors present within the political environment including, shifting institutional dynamics and the role of political actors, also helped to impede comprehensive LTC reform for the rest of the decade. Although a number of minor policy changes would take place in the latter years of the Clinton Administration, these changes did not significantly transform the LTC financing arrangements.

Why comprehensive health reform collapsed in 1994 despite an aura of seeming inevitability at the onset is a question that has received extensive treatment by scholars of American social policy (Mann and Ornstein, 1995; Steinmo and Watts, 1995; Skocpol, 1996; Hacker, 1996; Marmor and Oberlander, 2003). The findings appear to suggest that the approach of the Clinton Administration toward the entire health reform process was a particularly significant impediment to the success of LTC reform. While the President acts as an agenda-setter within the U.S. policymaking process (Kingdon, 1995; Finegold, 2005), particularly with regard to health reform (Blumenthal and Morone, 2009), the

President is at the same time limited in his or her capabilities to unilaterally push forward policy (Katzenstein, 1978). Congress was particularly unreceptive to the way reform was proposed in 1994. Several factors contributed to the cold reception, including the time it took for the workgroup to devise their plan as well as the secrecy surrounding much of the workgroup's initial work. Instead of an enthusiastic embrace of reform, the Clinton plan ultimately died within the Congressional process. The Administration's approach to health reform, in turn, negatively impacted the success of comprehensive LTC reform given their interlinked fate.

The type of reform pursued by the Clinton Administration had a significant impact on future attempts at LTC policy reform. The failure of the Clinton health reform effort was perceived, at least partially, as a result of the Administration's focus on a large-scale, state-centered approach to reform (Skocpol, 1996). The Clinton health plan was effectively portrayed by conservatives in Congress and their allies who opposed reform, as a dangerous overreach by the federal government (Ibid). This focus on government overstepping its role was then used by Republicans during the 1994 mid-term elections in their successful efforts to win control of Congress. As the LTC proposal focused on a large, new tax-financed program to pay for LTC in HCBS settings, it likely contributed, at least somewhat, to the belief that this reform was a large expansion of government. In the aftermath of collapse, participants noted a subsequent move away from comprehensive approaches to health reform. The Clinton health reform effort marked an end of invoking the New Deal by policymakers—both by Republicans and Democrats—when attempting to address individual social and economic risks. This move away from state-centered, tax-financed policy initiatives to some degree also undermined LTC financing reform,

decreasing the likelihood of a substantial LTC reform proposal reaching a floor vote in Congress.

After exploring what took place in the years between 1993 and 1994, it is also important to address the legacy of what happened and its impact on subsequent LTC financing reform efforts. The specific impact of the failure of the Clinton LTC proposal on subsequent LTC reform efforts was perceived by interviewees as minimal. Participants instead suggested that a lack of interest in LTC policy amongst policymakers, when compared to other health care issues like acute medical insurance, contributed to the relative stability of financing arrangements after 1995. In other words, LTC was a second-tier political issue and, as such, encountered great difficulties getting on the national political agenda. Of course, not all issues addressed by Congress are of high political interest to the American public or even to all Members of Congress, who are often concerned with the broader interests of the nation and particular groups within society when formulating policy (Ripley and Franklin, 1984, p. 48). Indeed, there are a wide variety of goals and incentives that might motivate Members of Congress during the legislative process (Fenno, 1973). Policies that are, however, perceived to help Members of Congress secure re-election often drive the issues that are supported and pushed by legislators. Given the pressures of electoral politics, issues that do not provide policymakers with specific or immediate reward for their resolution may encounter greater difficulty gaining political traction (Wlezien, 2004). In the American political system, Members of Congress are often re-elected based on the benefits their constituents perceive they provide to the district or state. An example is a project that steers federal dollars to a specific local community and therefore creates local jobs. This type of policy is known as

an earmark or pork-barrel legislation (Evans, 2000; Lazarus, 2010). Members of Congress are able to highlight this direct district benefit in their re-election campaigns. LTC financing reform does not provide a specific benefit to a particular district; the benefits are much more diffuse. Thus, lacking wider political interest or providing a specific electoral benefit to a particular congressional district or state, LTC financing reform has had great difficulty gaining momentum within the legislative process.

Furthermore, American policymakers did not view demographic change—specifically population aging—with the same urgency as they would in later years. Moreover, the costs of the Medicaid program were comparatively low in the early 1990s, particularly with regard to LTC expenditures. Medicaid has been the primary payer in LTC financing since 1980 and has played an increasingly central role in LTC financing arrangements since its inception in 1965 (Grogan and Patashnik, 2003). While state governments have been highly concerned about the growth of Medicaid spending, including LTC expenditures (Campbell and Morgan, 2005), controlling the growth of Medicaid LTC expenditures did not provide the same impetus for reform amongst federal policymakers and LTC experts as it did in later LTC reform efforts. In fact, it is notable that President Clinton’s proposal for reform actually called for a liberalization of eligibility for Medicaid coverage of LTC expenses.²⁷ This lack of interest or attention to the demographic changes likely served to impede comprehensive LTC financing reform efforts in the 1990s.

The findings highlight several potential institutional veto points within the U.S. political system that often impede expansions of social protection, like the creation of a

²⁷ While the Health Security Act increased Medicaid spending on LTC, the funds to finance the expansion of all new LTC benefits were funded primarily by cuts to Medicaid (and Medicare) spending on acute care.

generous LTC benefit. The main veto points were the President and the two chambers of Congress, the House of Representatives and Senate (Tsebelis, 2002), which after the 1992 election, placed the institutional levers of power under the control of the same political party and were therefore no longer a direct impediment to carrying out reform. Policy stalemates are less likely to occur in the United States under single party dominance of the political institutional arrangements, as party leaders tend to share similar ideological outlooks (Weaver and Rockman, 1993). While these particular veto points within the political system were absent in the early 1990s due to the partisan control of Congress and the White House, it was insufficient for LTC reform (or health reform for that matter) to take place at that particular juncture. This institutional alignment was, however, a necessary piece of the policy framework for LTC financing reform to be seriously considered. These findings are generally congruent with Immergut (1992) and Steinmo and Watts (1996), who contend institutional veto points frequently impede social policy initiatives in the U.S. as they offer veto players, like interest groups, great influence over the policymaking process. The findings also appear to confirm an argument asserting that the attempt to reform the U.S. health care system in 1994 (Hacker, 1998; Marmor and Oberlander, 2003; Oberlander, 2003) was prevented by groups representing business interests and the insurance industry (Hacker, 2002), who were able to exploit the institutional arrangements of the U.S. political system.

In the short term, the collapse of the Clinton health reform effort also directly contributed to the Republican Party's large victory in the 1994 mid-term elections (Peterson, 1998). When divided government exists, as from 1995 to 2001, a policy stalemate will often occur (Weaver and Rockman, 1993). Due to this institutional

constraint, comprehensive LTC reform was, for all practical purposes, off the federal policy agenda for the remainder of the 1990s as well as the years of the Bush Presidency. This appears to be congruent with an argument which asserts the partisan control of government impacts whether re-distributive policies are implemented in a particular nation (Hibbs, 1987; Huber and Stephens, 2001; Bradley et al. 2003; Rueda, 2008; Bartels, 2008). The use of social insurance to expand coverage for LTC would have constituted such a redistributive policy. The institutional conditions necessary for comprehensive LTC financing reform to be debated would not be present again until after the 2008 election, in which the Democratic Party gained control of the White House and both chambers of Congress.

Another significant theme within the findings was the negative impact of specific policy actors during the health efforts of the early 1990s. Institutionalist accounts of the policymaking process provide considerable space for policy entrepreneurs to operate (Sheingate, 2003; Mintrom and Norman, 2009). Policy entrepreneurs possess deep knowledge of relevant procedures and local norms that serve to define acceptable behavior within the policy arena (ibid). In other words, an individual inside the process is often a source of policy change rather than an outsider. Policy entrepreneurs must be able to understand the workings of a given arena without becoming so acculturated as to lose their motivation to promote policy change (Mintrom and Norman, 2009; Mintrom, 2000; Kingdon, 1995). Participants who had worked in the LTC policy arena during the early 1990s unanimously agreed that the Clinton Administration was by default the primary driver of LTC reform. The LTC reform proposal was developed by a panel of experts who were brought together by the White House as a part of the wider health efforts. When

President Clinton abandoned his push for health reform in the fall of 1994, the Administration also relinquished their role as the main driver of LTC financing reform. As LTC reform lacked a specific legislative champion within Congress, there was no one to push for it once the larger health reform process fell apart. This contrasts with the time period before President Clinton took office, in which Representative Claude Pepper (D-Florida) was a strong champion of LTC financing reform (Stone, 2004; Quadagno, 2005) and the 2000s, when Senator Edward Kennedy and his staff began crafting the CLASS Act. In short, no comparable policy entrepreneur, or champion, existed for LTC reform during the Clinton health reform efforts of the early 1990s.

The advocacy groups most supportive of increased governmental efforts to mitigate the social and economic risks associated with LTC were not particularly successful during the 1993-1994 health reform efforts. While aging and disability advocacy groups were broadly supportive of the Administration's LTC proposal, they failed to form an organized coalition. Moreover, AARP, one of the nation's largest consumer advocacy groups, which could count one in five American voters as a member of their organization in the mid-1990s (Powell, 1995; Beard and Williamson, 2011), never officially endorsed the Clinton plan, although they did make supportive public statements about the proposal. Underlying tensions between the disability and aging policy communities (Kane, 2007) that surfaced over the proposal's focus on HCBS and lack of a nursing home benefit (other than the liberalization of Medicaid eligibility) existed, which may have caused the aging advocacy groups to be less enthusiastic about the plan (Wiener et al. 2001). LTC provider groups meanwhile appeared even more divided than the consumer advocacy groups, with many of the largest trade associations openly opposed to the LTC proposal, while others remained

generally ambivalent. The insurance industry, however, was highly opposed to health reform. Their efforts during the debate were aimed at the overall legislation, but given that LTC was embedded within health reform, their opposition affected LTC reform as well.

The precise impact of business, however, was more complicated than this analysis initially appears to suggest. Interestingly, Martin (1995; 2000) found that employers were supportive of mandates for health insurance as a way to address the problems of the health system. This study of firm preferences for employer mandates demonstrated that support was in fact higher than opposition to this type of policy intervention (2000, p. 103). The actual significance of LTC insurance coverage to business, however, is much less clear than health insurance, as few U.S. employers offer LTCI as a benefit. This is particularly true of the years prior to 1996 and the passage of HIPAA, which, in addition to the regulatory changes to health insurance, established tax credits designed to encourage U.S. employers to offer private LTCI as part of their employee benefit packages. Despite a direct link between LTCI and business interests, the role played by business within the debate over health reform was significant, as exemplified by the opposition of the insurance industry, and a lack of enthusiasm by LTC providers, two highly influential industries within the LTC arena. The lack of robust, unified support from consumer groups and LTC providers failed to mitigate the effects of the united opposition from the insurance industry. More importantly, when the wider health reform efforts collapsed, no individual group or coalition of groups was in a position to push for comprehensive LTC reform.

In the absence of comprehensive LTC financing reform, several minor changes to the financing arrangements of LTC took place during the 1990s, including the

establishment of tax incentives to purchase private LTCI (through HIPAA in 1996) and the Federal Long-Term Care Insurance Program in 1999. Both of these reforms brought about minor expansions in LTC coverage through the wider use of private insurance. Moreover, participants noted that despite the lack of attention to comprehensive LTC financing reform after the collapse of the Clinton health reform efforts, state governments remained highly interested in LTC financing and often pursued their own reform initiatives (Campbell and Morgan, 2005). The success of state and minor federal LTC financing reform during this period appears to be congruent with an argument within the policymaking literature that the United States is generally characterized by incremental change (Dahl, 1963; 1971; Lindblom, 1959; 1979). Incrementalism would appear to describe the form of LTC financing reform that took place during the 1990s. Minor policy change would continue to take place during the years of the Bush Administration in the absence of comprehensive LTC financing reform.

Summary and Conclusions

This chapter has attempted to explain the failure of comprehensive LTC financing reform in the early 1990s and the possibilities for significant reform thereafter. After the collapse of the Clinton plan, comprehensive LTC reform, as well as health care reform, was for all practical purposes, off the policy agenda for the next fifteen years. The departure of LTC from the national policy agenda was not a direct result of the failure of LTC reform in 1994. Rather, it was due in part to the lack of wider political saliency of LTC issues, the subsequent partisan control of the main U.S. political institutions by the Republican Party, and a perceived failure of large governmental interventions, which

require increased spending and major restructuring of social policies, to resonate politically. This broader move away from bold social policy initiatives served to limit the future possibilities of LTC policy development. Long-term care financing reform initiatives instead took place at the state level or through incremental steps federally such as expanding coverage via tax incentives for the private insurance market. Additional changes around the edges of existing programs such as Medicaid took place, but those changes by no means constituted comprehensive reform.

An analysis of the failure of comprehensive LTC financing reform as a part of the Clinton health reform efforts has provided greater insight into the major challenges that have served to impede comprehensive LTC financing reform in the United States. In order to better understand the legislative success of LTC financing reform, which took place in the form of the CLASS Act some 16 years after the collapse of the Clinton reform efforts, several questions must be addressed in the chapters ahead. What impact did the institutional arrangements of the U.S. political system have on the opportunities for LTC financing reform in subsequent years? How might have the ideological outlook of the Bush years affected the design and strategy for LTC financing reform? The following chapter will now explore the LTC financing reform process during the years of the Bush Presidency, focusing particularly on the development of the CLASS Act, in an attempt to answer these important questions regarding the policymaking process in the United States.

Chapter Five: The Bush Presidency and Long-Term Care Reform

“A fair and civilized society is judged on how it treats its most vulnerable citizens. Today in America, millions of senior citizens and persons with disabilities still struggle to obtain the support they need to live fulfilling and productive lives in their communities. Many of them are members of the “Greatest Generation,” and our failure to provide them with a solution for long-term care worthy of their immense contribution to our history is shameful” (Senator Edward Kennedy, 2006).

Introduction

This chapter explores the impact of the particular institutional architecture of the U.S. political system on opportunities for long-term care (LTC) financing reform during the years of the George W. Bush Administration. It also examines the way the ideological orientation of the Bush years may have affected the proposed design of LTC financing reform that emerged in the early 2000s, as well as the strategy to bring about that particular proposal, the CLASS Act. Furthermore, the role of political actors such as policymakers sympathetic to LTC financing reform and stakeholder groups within the LTC arena also receives some treatment as they play an important role in the policymaking process. An examination of these variables within this historical period will help to elucidate the complex American policymaking process and how the frameworks of ideology, institutions, and political actors interact within that process to affect policy change. This chapter will now present the findings to see if the explanatory frameworks of ideology, institutions and political actors can help explain the development of LTC financing reform during the years of the George W. Bush Administration, specifically in the format of the CLASS Act.

President George W. Bush took office in 2001 following a highly divisive election in which Vice President Albert Gore won the popular vote by a razor-thin margin while George W. Bush secured more votes in the Electoral College. The subsequent Supreme Court challenge to the election results led the nation to the brink of constitutional crisis with the Supreme Court ultimately certifying Bush's victory. The domestic policies pursued by the Bush Administration were conservative in their ideological orientation, and focused on mitigating individual social and economic risks through pro-market solutions and a greater reliance on personal responsibility (Jaenicke and Waddan, 2006; Peele, 2006; Pierson and Skocpol, 2007). This contrasts with the early years of the Clinton Administration, in which President Clinton often invoked the legacy of the New Deal (Skocpol, 1996) when speaking about social policy and the appropriate role of government. Moreover, for most of the early years of his Presidency, President Bush presided over a Congress that shared a similar ideological outlook with his Administration (see figure 4.1).

Comprehensive LTC financing reform was not a policy priority of President George W. Bush or Congress, which the Republican Party dominated for much of the 2000s. The relatively minor changes to the existing LTC financing arrangements during this timeframe occurred primarily at the state level, a trend that began in the 1980s, but which became the dominate method of reform after the failure to enact comprehensive health reform during the early years of the Clinton Administration.²⁸ Other areas of social policy were clearly higher on the national policy agenda, most notably Social Security and Medicare reform. Shortly after taking office, President Bush convened a commission to

²⁸ The Deficit Reduction Act of 2005 (P.L. 109-171) contained several provisions relating to LTC policy, particularly with regard to Medicaid. The DRA was the most notable federal legislation addressing LTC financing enacted during the years of the Bush Administration.

study Social Security reform, which called for significant changes to the program that would have instituted greater individual control through the use of personal savings accounts (President's Commission to Strengthen Social Security, 2001). During his campaign for re-election, President Bush continued to appeal for an ownership society and pushed the case for the privatization of Social Security. In his acceptance speech before the 2004 Republican National Convention, President Bush stated:

“Another priority for a new term is to build an ownership society, because ownership brings security, and dignity, and independence...In an ownership society, more people will own their health care plans, and have the confidence of owning a piece of their retirement” (George W. Bush, September 5, 2004).

While the plan for partial privatization of Social Security was a part of the Bush Administration's wider vision for an ‘ownership society,’ which focused on pro-market, private solutions to address individual social and economic risks (Béland, 2005b; Hacker and Pierson, 2005), privatization of Social Security had been priority for conservatives for years and had been advanced unsuccessfully in the early 1980s by President Ronald Reagan (Pierson, 1994; King, 1995). Similarly, the Medicare Modernization Act (MMA) of 2003 instituted a significant degree of privatization into the Medicare program through *Medicare Advantage*, which gave the private insurance industry an expanded role within the program, although this legislation also increased the scope of benefits provided through the program's traditional social insurance elements including coverage of prescription drugs (Hacker, 2004; Béland and Waddan, 2012; Morgan and Campbell, 2011). While the MMA was ultimately legislatively successful, Social Security reform was not. Similar to President Ronald Reagan's privatization efforts of the 1980s (Pierson, 1994; King, 1995), President Bush was also unsuccessful in privatizing Social Security. This failure again

highlights the difficulty in enacting major policy change in the United States due to the political system's complex institutional framework of checks and balances, which provide ample opportunity for vested interests to stymie major changes that may undermine any benefits they receive through the existing policy dynamic (Steinmo and Watts, 1996; Pierson, 2001; Campbell, 2003).

While LTC financing reform may have been largely absent from the policy agenda during the Bush Administration, work on this issue by advocates and sympathetic policymakers did not cease. In fact, it was during this period that the Community Living Assistant Services and Supports or 'CLASS' Act developed into a working piece of legislation within Congress. Much of the shaping of this legislation actually took place during the early years of the Bush Administration. Inspired in part by the legislative success of Ticket to Work and Work Incentives Improvement Act of 1999,²⁹ Senator Edward Kennedy (D-Massachusetts) and his staff began to develop the concept of the CLASS Act in 2003. Furthermore, Senator Kennedy endeavored to bring together a coalition of stakeholders within the LTC policy arena to support the legislation and to mitigate potential opposition. In spite of the efforts of Senator Kennedy, the CLASS Act never advanced through the policy process prior to 2009. Nonetheless, several significant developments took place during the years of the Bush Administration, which helped to ensure the legislative success of the CLASS Act as a part of the wider overhaul of the American health system under President Obama.

²⁹ Legislation sponsored by Senator Kennedy, which established a voluntary program for disabled adults aged 18-64 who receive Social Security Insurance Disability (SSDI) allowing them to work without loss of their SSDI benefits.

LTC Financing Reform and the Development of the CLASS Act in the Bush Years

The Growing Need for LTC Financing Reform

While the findings from the research show that the perceived lack of political saliency of LTC financing reform was a significant theme during the Clinton years, it is striking to note that the initial response from all stakeholder groups was often the same, namely that in the United States, LTC financing arrangements were inadequate. In particular, the Medicaid program, the default public LTC financing mechanism for the majority of individuals with LTC needs, was considered by all participants to be an inadequate way to finance the costs of LTC for the majority of Americans, particularly the middle-class, who spend down their resources in order to meet resource eligibility thresholds to receive benefits (Scharlach and Lehning, 2012). The interviewees highlighted differing motivations for the support of a move away from Medicaid amongst the stakeholder groups. LTC providers for example were concerned with finding a new, more stable source of revenue, rather than continuing to rely on Medicaid as the main source of financing. Aging and disability advocates were likewise interested in creating a new mechanism to pay for the care of their populations. According to the Government Affairs Director of a large aging advocacy organization:

“...we hear constantly that people work their entire life to try to get some sort of savings, plus a pension, and Social Security...but then if necessity came for some sort of LTC, you could lose everything....so I think that was always our impetus for trying to find a mechanism that would take care of meeting that challenge” (Aging Advocate, Transcript 18).

The fact that aging advocacy groups were highly supportive of a new financing mechanism is unsurprising given their traditional support of an expanded role for government in funding care. In addition, disability advocacy groups often highlighted the potentially stigmatizing effect of Medicaid since means-testing forces beneficiaries to remain impoverished for the duration of their LTC needs. This is particularly problematic for young disabled adults who may spend an entire lifetime in poverty in order to receive government financed services. The push to move LTC financing away from Medicaid by disability groups was also expected as they have been vocal about their concerns with Medicaid for years. While Congressional staffers were similarly concerned with the costs of LTC for individuals, as they were highly aware the current financing arrangements were failing to provide adequate coverage, they were also troubled by the federal government's expenditures on Medicaid and argued reform was necessary to reduce this spending.

More interesting perhaps, is that insurance industry representatives also shared the view that Medicaid is an inappropriate default financing mechanism for middle-class Americans as they saw it as a potential obstacle to the wider use of their products amongst this population. While participants from the long-term care insurance (LTCI) industry were generally unsupportive of the format of CLASS, they did often mention the major shortcomings of current financing arrangements and recognized the value of some form of intervention by the federal government. A representative of a large LTCI company, who argued that CLASS was an inappropriate approach to LTC financing reform, stated:

"I do think there is a role for the federal government to play in LTC because not everybody is insurable, so you know, that population has to be cared for and covered. I don't have the answer to how you go about doing that, but I think that that would be where I would direct the federal government or state government's resources" (LTCI Industry Representative Transcript 8).

In addition to an interest in further tax credits or a mandate for LTC insurance, the LTCI was also interested in a way for populations who were deemed risky or uninsurable due to current illness or disability to be covered by a federal program. Medicaid already plays that role to a large extent, but it is interesting that this industry viewed this as an important role of the government within the LTC arena.

Finally, LTC policy experts tended to describe the financing system's problems in great detail and assert that a combination of factors necessitate reform including the same problems with Medicaid mentioned by the other stakeholders. Thus, a desire to move away from Medicaid was held by all stakeholders groups, although their motivations for moving away from that mechanism differed based on their varying constituencies. For example, the concern of the disability policy community over the stigmatizing effects of Medicaid contrasts with those of the insurance industry, which tended to see Medicaid as a potential obstacle to their market growth.

Alternative Reform Options

A variety of possible financing mechanisms were available to U.S. policymakers for addressing LTC reform in the early 2000s. Three distinct mechanisms for LTC financing reform, however, have guided most discussions about reform since the 1980s (Meiners, 1996): private long-term care insurance (LTCI), social insurance, and a hybrid of a public-private system, which is the approach that policymakers ultimately selected with the CLASS Act. How and why the CLASS Act became the preferred mechanism for LTC financing reform is significant given the tendency of existing policy arrangements toward

path dependency, the ideological outlook that underpinned the basic structure of the CLASS Act, and the political actors and stakeholder groups who were involved with LTC financing reform efforts during the early 2000s.

Private Long-Term Care Insurance (LTCI): A Public-Private Partnership

During the latter years of the Clinton Administration, and carrying through to the Bush Presidency, U.S. federal policy was highly supportive of private insurance as a way to finance LTC. Two commonly advocated for ways that government can promote the use of private LTCI are tax credits for individuals or employers, and making the purchase of LTCI mandatory. Such a mandate would be similar to the acute medical insurance mandate that was a key component of the wider health reform legislation ultimately supported by the Obama Administration. Some LTCI respondents suggested that additional investment in LTCI would help achieve broader coverage of LTC, particularly through an individual mandate to purchase LTCI. A representative of a mid-sized insurance company stated:

“As an industry we have looked at ways that we could work with the federal government so that we could have a comprehensive LTC private-public partnership so-to-speak. There is a program called the [LTCI] Partnership that already exists. But we’ve also looked at LTC financing reform....and we’re still looking at what is the best way to use federal dollars to encourage people to buy private coverage” (LTC Insurance Representative, Transcript 43).

The LTCI industry’s support for further government involvement in their marketplace was somewhat unexpected as business interests are traditionally resistant to greater state regulation or involvement in their affairs (Esping-Andersen, 1985; Skocpol and Amenta, 1986). Their support for additional federal revenue to encourage private insurance sales contrasted with the positions of other stakeholder groups on how to best

expand LTC coverage. In fact, several significant problems with a private insurance approach were highlighted by other participants. The high cost of private LTCI was cited as significantly problematic since tax credits would further increase the federal government's expenditure on LTC, albeit indirectly, by directing revenue from the federal budget to subsidize the cost of purchasing private plans.

Social Insurance

Consumer advocates, left-leaning legislators, and several LTC policy experts have for years advocated for social insurance as a way to finance LTC. In 1990, the Pepper Commission called for social insurance to be used as the financing mechanism for home and community based services. However, in spite of the wider popularity of existing social insurance programs like Social Security and Medicare (Page and Jacobs, 2009), most participants believed that a new social insurance program for LTC lacked the political support to succeed legislatively due to the assumed high cost and an aversion to new taxes. This was particularly true in the political environment of the 2000s when the main institutions of the U.S. political system were dominated by Republicans and the Bush Administration's ideologically conservative policy agenda which advanced tax cuts rather than new or increased taxation. According to a LTC policy expert with over 30 years of experience working with the U.S. federal budget, and who provided advice to Congressional staff when designing CLASS:

“While in some sense [Senator] Kennedy's staff thought objectively that a real tax-subsidized, social insurance system that everyone participated in would be the best way of doing it, they realized that just wasn't feasible under the circumstances. There's always a lot of resistance to raising taxes” (LTC Policy Expert, Transcript 45).

All categories of interview participants resisted the idea of raising taxes to fund a social insurance mechanism for LTC financing, including those supportive of the concept, since they believed such a proposal would not be popular with policymakers or with large segments of the American public due to a pervasive aversion to taxation within the American political environment. More importantly, the worsening fiscal state of existing governmental programs like Medicare, made making a political case for a new social program difficult. This suggests that while social insurance may have been a first order preference of many policymakers like Senator Kennedy (Korpi, 2006); a second order preference was pursued with the CLASS Act. They specifically pointed to the widespread criticisms of existing entitlement programs and the failure to successfully enact a LTC reform proposal based on social insurance or increased taxation. While these criticisms were not new to the American political environment as they had been expressed in various forms particularly since the 1970s (Davies, 1996; Critchlow, 2007), their perceived strength had continued to build with time. The years of the Bush Administration, and its focus on tax cuts and self-sufficiency, added further credibility to this assumption.

The Medicare program has often been suggested as a possible vehicle for LTC financing reform. However, similar to the concerns about creating a new social insurance program, participants believed an expansion of Medicare also lacked the necessary political support due to its federal budgetary implications and the need for additional revenue to fund such an approach. Simply put, expanding Medicare to cover the individual costs of LTC would likely require a large increase in taxes. The expansion of Medicare in 2003 to include a prescription drug benefit further decreased the possibility of LTC financing reform taking place through Medicare. While the long-term fiscal outlook of

Medicare has been apparent for some time as rising care costs and an aging population will place tremendous strain on the program in the years ahead, the MMA moved forward the projected date of a fiscal short-fall from 2026 to 2019 (Social Security and Medicare Board of Trustees, 2003). When reflecting on the views of advocacy groups and sympathetic policymakers, an aging advocate stated:

“I think, in an ideal world, most policy people would want LTC to be part of Medicare and provide it for people as part of government health insurance without any questions. And it would be a rich benefit. But that appears to be something that’s not politically achievable in our lifetime given the politics of the country” (Aging advocate, Transcript 24).

Given the lack of success at legislating a social insurance program, and the political environment of the early 2000s, this sentiment from the aging policy community is unsurprising. This comment does not, however, pertain exclusively to the years of the Bush Presidency. It also demonstrates an awareness of the wider political challenges confronting efforts to expand government-sponsored social protection in the United States, which make successful expansions of social policy elusive. While Medicare is a relatively popular government program (Page and Jacobs, 2009), there was a general concern that it being a large, bureaucratic program would make it a target of conservatives if it were used as a vehicle for LTC reform. Furthermore, Medicare was already expanded in 2003 to cover prescription drugs for the elderly, a massive expansion of the program’s coverage as well as its costs, which amplified the program’s long-term fiscal challenges and soaked up any remaining political inertia for further programmatic expansions within Medicare at that time.

Participants from all the stakeholder categories generally agreed this lack of wider political support for an expansion of Medicare had been clear to Senator Kennedy and his

staff as well as the advocacy groups from the first days of developing the CLASS Act. Moreover, Medicare's existing financial issues were highly problematic for LTC reform. A LTC policy analyst for an aging policy organization stated:

"From a political standpoint, trying to expand Medicare at a time when solvency is a big concern....not only to Republicans but also to Democrats....and with the deficit and concern over taxes...those issues made it almost a political impossibility" (Disability Advocate, Transcript 52).

An expansion of social insurance to cover LTC in the United States had proved to be an unattainable goal. The calls to expand coverage through Medicare or through a new social insurance program failed to gain political traction in previous years. Even the Clinton proposal from the early 1990s, which made the most headway within the political system, focused on a HCBS benefit and would have left specific criteria for participation up to individual states, leaving institutional care to be financed through a mix of out-of-pocket expenditures, private insurance, and Medicaid. While supported by several stakeholders and left-leaning policymakers, the political and economic environment of the late 2000s suggests that social insurance was a particularly unlikely approach for LTC reform at that juncture. An expansion of Medicare or a new social insurance program were both "off the table" as potential LTC financing mechanisms. Proponents of social insurance and sympathetic policymakers were therefore seemingly open to a new approach to expanding LTC coverage in order to achieve legislative success on this issue.

The Features of the CLASS Act: Design and Underlying Values

The Eventual Model: Hybrid Public-Private Program (or Quasi Social Insurance)

While the eventual design of the CLASS Act included aspects of traditional social insurance, it also employed several principles of private insurance. The legislation was initially developed during the years of the George W. Bush Administration and a Republican controlled Congress, an era in which the 'ownership society' and pro-market policies were atop the domestic policy agenda (Hacker and Pierson, 2005; Béland and Waddan, 2012). This political landscape significantly influenced the options available to Senator Kennedy and his staff when conceptualizing a new LTC financing mechanism. Yet, a desire to build a public-private hybrid system that shifted financing away from individual, out-of-pocket expenditures, and away from the Medicaid program, was fundamental to CLASS's design. A staff member of a LTC provider trade group, who had for years advocated on behalf of an expansion of Medicare to cover all LTC costs stated:

"I think we all wanted to expand Medicare to provide LTC...and of course the conservatives...what they wanted to do was just rely on private insurance. So I think the CLASS Act was conceived out of perhaps a compromise between those two visions..." (LTC Provider Representative, Transcript 46).

A consensus existed amongst the participants that a new approach to financing LTC was more politically feasible than building on the existing Medicare program due to the program's fiscal outlook and the simmering debate on the future of the program. Although it is the primary financing mechanism for the acute medical care of all adults over the age of 65 and disabled Americans of any age, Medicare does not generally cover

LTC expenses.³⁰ Given the program's focus on older and disabled adults, Medicare has often been touted as a logical way to expand coverage of LTC. Yet, expanding Medicare to cover LTC had proved to be an unattainable goal. Moreover, the program's growing budgetary problems were cited as highly problematic when considering it as a potential vehicle for LTC reform. Thus, the interviewees widely believed the new approach of CLASS circumvented much of the political "baggage" that accompanies existing social insurance programs, while still drawing on certain strengths of social insurance, notably a nationwide, government administered program.

Designing a programmatic structure that would encourage participation in CLASS was a challenging issue for policymakers from both a political and actuarial standpoint. Senator Kennedy and other supportive policymakers initially wanted to make participation in the CLASS program mandatory for all working-age adults. Social Security and Medicare are mandatory for individuals in paid employment,³¹ which ensures these programs have a large enough risk pool to spread costs over a large population. In principal, the spreading of risk is integral to the actuarial solvency of these programs, although the federal debt currently guarantees the actuarial soundness of these programs. However, it was clear early on that mandatory participation in the CLASS Act was not politically possible. As an aging policy advocate, who worked regularly with Senator Kennedy's office and other advocacy groups on the CLASS Act put it:

³⁰ Medicare covers an individual's LTC expenses if they were first admitted to a hospital for the same condition that subsequently requires LTC for a maximum duration of 90 days (Komisar and Thompson, 2007).

³¹ In 2011, approximately 94 percent of American workers were covered by the Social Security program (U.S. Social Security Administration, 2012). U.S. workers who are exempt from participation include: railroad workers covered through the railroad retirement system; federal employees hired prior to 1984; some employees of state and local governments; farm and domestic workers with earnings under minimum requirements as well as self-employed individuals with very low annual earnings (Ibid, p.10).

“A voluntary program is more politically palatable because people aren’t being forced to do something...especially something like deduct money from their paychecks” (Aging Advocate, Transcript 15).

Thus, although supportive of mandatory participation, concerns over the political efficacy of the approach led Senator Kennedy to avoid it with the CLASS Act. The political will necessary to mandate participation in a new program is high compared to a voluntary program, which on principle is much more difficult to oppose. Furthermore, mandatory participation did not comport with the ideologically conservative preferences that dominated during the Bush Administration, which focused on expanding the use of voluntary approaches to the provision of social protection such as health savings accounts and private retirement accounts.

A voluntary approach, while politically more palatable than mandatory participation, raised a number of serious issues related to the levels of participation required for the fiscal sustainability of the program. In order to address these structural issues, Senator Kennedy proposed a semi-voluntary scheme for enrollment in the CLASS program, which employed a voluntary opt-out. Upon an individual’s entry into the workforce that person would have automatically been enrolled in CLASS by their employer. If an individual did not want to participate, they would have to actively remove themselves from the program. This idea was based on 401(k) accounts, which are a type of defined contribution (DC) retirement plans that work similarly, and have higher rates of participation compared to opt-in plans.³² According to a 30 year veteran of the aging policy field who worked on both pension and LTC financing policy:

³² A 401(k) is a type of retirement savings account that has generally replaced defined benefit pension plans in the United States. An individual’s participation in a 401(k) is voluntary, but many organizations use automatic enrollment with a voluntary opt-out. This approach has approximately 40 percent participation

“CLASS really drew on the idea, in some way, of the 401(k)s, you’ve got to plan for your future, be self-sufficient. And the theory is that if you could make it attractive enough to people so that they would participate, it would thereby relieve the government of what was becoming a very heavy financial burden” (Aging Advocate, Transcript 27).

The growth of DC retirement plans, and the success of the 401(k) model as a way to promote enrollment in company sponsored retirement accounts, provided a model for policymakers in designing the CLASS Act. However, the increase in DC plans has taken place in conjunction with rising concerns over social spending on retirees and other populations who receive extensive government sponsored social protection. These plans have also replaced many employer sponsored DB retirement plans, which guarantee a specific income in retirement (Seeleib-Kaiser et al. 2011). Defined contribution plans do not provide the same financial security as DB plans given wide fluctuations in the stock market to which the value of these accounts and benefits they provide are tied, and have served to shift higher levels of risk onto individuals and families in old-age (Hacker, 2008; Harrington Meyer, 2010). Thus, this approach of the CLASS Act blended the perceived strengths of private accounts with an administered government program that would pool funds in government backed bonds rather than the stock market. If successful in boosting enrollment in this new program for LTSS, the approach would also reduce federal spending on Medicaid as well as a dependence on the program—a goal supported by a diverse set of stakeholders within the LTC policy arena. The voluntary opt-out design, a key component of the 401(k) model, was a part of the CLASS Act from very early on in the policy process and remained throughout the years of the Bush Administration, even

rates opposed to opt-in plans that have participation rates around 20 percent (Mulvey and Colello, 2010, p. 11).

though it was eventually dropped in the final days of health reform efforts during the Obama Administration due to a concern over possible reactions to ‘too much government.’

Values: Personal Responsibility, Self-Reliance and Independence

The normative values of personal responsibility, self-reliance, and independence were often cited as key elements in the design of the CLASS Act. These values are often associated with approaches to policy development advocated by conservatives and were a salient feature of the domestic policy agenda during the years of the Bush Administration (Béland and Waddan, 2012). Social policies reflective of these normative values are often pursued in order to cut costs and public spending. The use of health savings accounts to supplement traditional forms of health coverage is an illustrative example. However, an emphasis on cost control and fiscal austerity often has ideological roots (Marmor, 2001; Marmor and Mashaw, 2006), which may help to provide a better understanding of the design of the CLASS Act.

Indeed, several LTC policy experts stated that in addition to cost motivations, the idea to fund CLASS entirely through premiums was intended to give enrollees a sense of ‘ownership’ and that they would see a return from their investment when planning for their potential future care needs. Such an approach would help to counteract the potential political problems associated with increased state involvement in mitigating the personal risks associated with the need for LTC, while also strengthening the voluntary approach of the program. A longtime observer of the LTC policy arena, who either provided analysis of or had been involved with the design of every federal LTC financing proposal for the last twenty years, stated:

“A potential benefit of the approach of CLASS will be ‘psychological’...It will allow people to pay for coverage and in return they will obtain a direct benefit from the money they “invest” in the program. CLASS enrollees will be sold a product which negates the sense of subsidizing care for low-income people” (LTC Policy Expert, Transcript 4).

Paying into CLASS would provide a sense of investment in the program, much as the highly successful Social Security program purportedly operates (Derthick, 1979; Lockhart, 1991). Additionally, CLASS beneficiaries were to have complete discretion over how to spend their benefits. This approach to designing a financing mechanism also draws on the perceived strengths of the Social Security program, which uses similar principles in terms of investment in an individual’s retirement and providing complete discretion over how to use the funds. By embracing aspects of the nation’s most successful social insurance program, the ability of CLASS to pass legislatively was strengthened.

Participants within all the stakeholder categories, and in particular advocacy groups, LTC providers and policy experts, stated that the program reflects a desire to provide people with a way to plan for their future LTC needs, which was a general consensus amongst all the different stakeholder groupings. In other words, the program draws heavily on the normative concepts of self-sufficiency and personal responsibility. According to a staffer of a major LTC provider trade association that pushed for the passage of CLASS:

“...it [CLASS] was all based on the idea of personal responsibility. So there was this feeling that people should be personally responsible for planning their own long-term care and that we all need to think about that” (LTC Provider Representative, Transcript 41).

This focus was at least partially an outgrowth of a trend in recent decades toward greater personal responsibility in areas of personal risks like health care. This statement is

significant as it was made by a member of the stakeholder groups that supported the CLASS Act suggesting they had accepted the merits of such an approach. Advocating greater personal responsibility has become a popular approach within the medical arena to address cost and improve health outcomes; however, it has also gained prominence in other policy areas such as retirement security. Promoting greater personal responsibility in these policy areas were objectives advanced by the Bush Administration.

Indeed, these normative values, particularly personal responsibility, often underpin approaches advocated by conservatives for solving social problems in the United States. During the years of the Bush Administration, conservatives particularly focused their attention on the use of public policy to support private retirement and health savings accounts (Teles and Derthick, 2009; Morgan and Campbell, 2011). Several participants, including those most closely involved with the legislative process, suggested these values were a major component of the design of CLASS due to an attempt to win support from Republican Members of Congress and other traditionally conservative stakeholders. According to a former staffer for a Democratic Member of Congress, who spent much of their time in Congress working on CLASS:

“There’s this whole logic to CLASS that is very Republican...I mean it’s about personal responsibility and people’s own money...there is no government money used” (Former Congressional Staffer, Transcript 48).

In fact, Senator Kennedy, his staff, and advocacy groups for the aging and disability communities spent a great deal of time and energy seeking a Republican co-sponsor for the CLASS Act in the years between 2002 and 2008. Securing a Republican co-sponsor, in theory, would have provided the legislation some credibility with

Republicans, and would have helped move CLASS forward legislatively. Obtaining bipartisan support on legislation is a commonly applied strategy in U.S. politics. A policy advocate with a disability policy organization who had worked on the design of the CLASS legislation stated:

“...early on we had some Republican interest, and it was easier to sell when you are talking about personal responsibility and saving for your own retirement. We had a whole piece that was more kind of on the conservative edge...talking points about how this [CLASS] was structured to support those values” (Disability Advocate, Transcript 2).

The strategy for winning support from conservatives through an emphasis on programmatic characteristics based on personal responsibility does not appear to have been particularly successful. Participants from the advocacy group and LTC policy expert categories noted the success in securing Senator Mike DeWine’s (R-Ohio) support as a co-sponsor in 2005, although Senator DeWine lost re-election the following year. No other Republican Member of Congress signed on to officially support the CLASS Act for the rest of its legislative life. Thus, although the design of the legislation was intended to draw support from conservative Members of Congress, the general lack of their support is notable. More importantly, the conservative values pervasive within the initial design of CLASS remained a fundamental part of the legislation until the passage of the Act in 2010.

Criteria for Participation

The eligibility requirements for participation in the CLASS Act were a highly significant component of the design of the legislation. Thus, asking participants about the way eligibility for CLASS was determined was important for exploring the potential influence of ideology on the scope and generosity of the program. Most participants noted that CLASS would be open to all actively working adults aged 18-65 without a means-testing requirement. This suggests the program's architects were attempting to make CLASS with as few barriers to enrollment as possible, while moving away from the stringent (and unpopular) asset requirements of Medicaid. In addition, participants highlighted the legislation's lack of underwriting based on a program enrollee's age or any existing impairments, an unpopular practice commonly used by the private insurance industry that excludes many currently disabled and older Americans from purchasing private coverage. As a former Congressional staffer and disability policy expert bluntly stated:

“...the private market discriminates against people with disabilities so they can't get private LTC insurance. So there was always a need to do something else and the CLASS Act was that idea” (Former Congressional Staffer, Transcript 48).

However, people who are unable to work due to disability or retirement would be ineligible to participate in CLASS, because in order to become eligible for benefits, a beneficiary must first actively work and pay premiums for at least three years. This provision was cited by interviewees as a way to lower the ratio of non-beneficiaries to beneficiaries without the use of underwriting. This was also cited as a decision based on cost containment, while ensuring as wide as possible participation. Unless steps were taken

to somehow keep the pool of enrollees as healthy as possible, the insurance—or pooled-risk—component of the CLASS program would not work due to the potential risk of adverse selection. Too many enrollees in CLASS in need of benefits would lead to unaffordable monthly premiums.

Given the work requirement, and the three year vesting period before benefit eligibility, many respondents viewed CLASS as a way to prepare for the demographic changes that lay ahead for the United States rather than an immediate policy instrument to cover individual LTC needs. However, this view of the program was not universally held by all stakeholders. Disability advocates initially did not want a vesting period in order to qualify for benefits or strict work requirements, but rather a more immediate benefit for their population. According to an aging policy advocate who worked closely with disability policy advocates and Senator Kennedy's office on the CLASS Act:

“I think the disability groups viewed this [CLASS] as an entitlement for people today with disabilities. I think the aging community views this as a better version of a public-private LTC partnership...meaning it's a program for the future...” (Aging Advocate, Transcript 47).

These differing, yet seemingly reconciled visions for the CLASS Act were cited as important for the advocacy community's unified support of the legislation. In other words, the proponents of CLASS were able to trade off certain priorities in order to make the program financially viable, and therefore more politically acceptable. For example, a monthly work requirement that mirrored eligibility for Social Security was included in the legislation; however, only three years of participation was necessary rather than the ten years of work required to vest with Social Security. This suggests that practical considerations were a major part of the process that drove the design of the legislation.

Benefits and Coverage Provided by CLASS

The size and scope of the benefits provided by a particular program can offer some insight into the normative underpinnings and goals a policy may have played in that program's design. Participants were therefore asked to discuss how the CLASS Act's coverage levels were determined; they stated that CLASS was purposely designed as a partial benefit rather than a comprehensive benefit for LTC. Nearly all the participants, those highly supportive of the legislation as well as those opposed, cited cost control as the primary motivation for a partial benefit. A representative of a LTC provider that supported CLASS explained the reasoning behind a partial benefit:

“Well you’ve got to pay for it. I think it’s one of those things.....this is already a heavy lift for Congress to accept...I think everyone in the room understood that everything is based on [CBO] scoring and finances at the federal level—the fiscal impact! I think that we all recognized that it [CLASS] wouldn’t pass if we made it unrealistic or unaffordable...” (LTC Provider Representative, Transcript 44).

Senator Kennedy's office initially surveyed thousands of college students and young adults on what they believed to be an acceptable daily benefit and monthly premium. Congressional staff noted the survey results helped guide the initial premium and benefit projections. Thus, a \$50 dollar a day benefit was the initial benchmark that Senator Kennedy's staff used when envisioning CLASS. Although actual benefit levels will be determined after the program goes into operation, that \$50 benefit was reflected in the language of the final legislation, which mandated that any actual benefit could never be less than \$50 a day. Originally, Kennedy's office envisioned the program to have a \$30 monthly premium. However, working with actuaries on what the program needed in order to be self-sufficient showed the premiums had to be much higher than what Kennedy's

office and consumer advocates initially wanted, since the original premium to benefit ratio proved unrealistic unless participation in CLASS was mandatory for all working age Americans. As with the daily benefit, the premiums were left to be determined during the implementation process, after approximate levels of participation in CLASS could be projected. According to the same LTC provider representative, these issues contributed to the idea that any reform proposal would be unable to provide a comprehensive benefit:

“The CLASS Act is kind of like Social Security in the sense that it is supposed to be part of your retirement; part of your plan. It’s never going to be enough to pay for absolutely everything” (LTC Provider Representative, Transcript 44).

This sentiment reflected a pervasive view amongst CLASS Act supporters. While Social Security plays a significant role in the retirement plans of millions of Americans, Social Security is often only one source of an individual’s income in retirement as pensions and personal assets are also often used. Many participants projected a similar role for CLASS in an individual’s LTC financing arrangements. In other words, while the CLASS program was intended to provide a new benefit, it was not designed to be a comprehensive financing program for LTC.

Political Actors and the Stakeholder Groups

The concept and design of the CLASS Act originated in the Office of Senator Edward Kennedy. While Senator Kennedy had been a long-time proponent of health reform, and was traditionally highly supportive of an increased role for the government in the financing of health care, it was decided early on that a bolder approach for LTC financing reform, such as a social insurance mechanism, was simply not politically

possible in the political environment of the early 2000s. According to a disability policy advocate who had worked closely with Senator Kennedy's staff on the CLASS Act:

“Senator Kennedy had learned from years of working with Republicans that big government solutions without individual responsibility and private sector involvement are nonstarters for most Republicans and for many conservative and moderate Democrats too. So I think they started this discussion in a place that could appeal to Republicans and they kept it there, and the fact that very few Republicans ever really warmed up to it [CLASS] to me was just a sign that the Republican Party really has no interest in working with Democrats on most issues right now. I don't think it is an indictment of the CLASS concept, it is an indictment of our whole political system” (Disability Advocate, Transcript 50).

This statement demonstrates that Senator Kennedy and his staff were concerned with creating a piece of legislation capable of navigating the complex U.S. legislative process, which suggests that Senator Kennedy was acting as a policy entrepreneur on the issue of LTC financing reform (Kingdon, 1995; Sheingate, 2003; Mintrom and Norman, 2009). Kennedy spent his career in the U.S. Senate working to pass comprehensive health reform legislation, and learned that securing bipartisan support was a highly successful strategy for achieving legislative success on complex social issues. This approach suggests that some degree of policy learning took place about the types of social policy that might be most successful given the legislative mechanics of the U.S. political system without abandoning the goal of increasing access to LTC. Despite this strategic shift by Senator Kennedy to embrace an approach that employed a much more market-oriented, individualistic approach to a financing mechanism, Republican support in Congress for the CLASS Act rarely materialized.

It was often noted by participants that Republican opposition to the CLASS Act could have been much more intense, but as a result of the approach that Kennedy took to

CLASS, much of their opposition was mitigated early on in the development of the legislation. Senator Kennedy attempted to work with Republicans and the insurance industry to shape the legislation so that it could work in tandem with the private market by providing a way to stimulate the growth of LTC insurance. This mechanism was particularly susceptible to the challenges of private insurance, such as adverse selection, moral hazard, and the risk of inadequate risk-pooling due to the uncertainty of need for LTC (Barr, 2010; Wiener et al. 1994). These efforts had the dual effect of establishing a framework that might allow some sort of partnership between the government and the insurance industry to overcome these challenges, while at the same time mitigating the industry's potential opposition to further government intervention into this arena. An executive from an insurance company who had attended meetings with Senator Kennedy's staff to discuss the CLASS Act stated:

“Within our trade association, and independently, we met with people involved [with CLASS]. Person X in particular met with the people involved and encouraged them to think about the best practices of private LTC insurance and how to incorporate that into the CLASS Act. In fact, we had a meeting with a bunch of people to brainstorm—sort of a think tank—on how CLASS could be designed so that it could a) succeed and b) private insurance would want to, and would be able to, supplement it” (LTCI Industry Representative, Transcript 34).

Senator Kennedy's efforts to include the insurance industry in negotiations over the CLASS Act were widely believed to have impacted the industry's response to the legislation. While these efforts did not succeed in winning their formal support of CLASS, participants believed it at least mollified some of their opposition. Their involvement in negotiations meant that the most potentially incompatible components of the program were either removed or never included in CLASS in the first place. Moreover, they were a part

of the negotiation process until Congress began debating health reform in 2009, which prevented them from marshaling a serious challenge to CLASS until relatively late in the policy process. Several participants from the advocacy groups and insurance industry noted that if insurers had mobilized against CLASS at an earlier point, the legislation would have had a much more difficult time making it into health reform legislation considered during the Obama administration.

Two more important stakeholder groups within the LTC arena are service providers and the trade associations that represent them within the policymaking process. The strong support of LTC providers for the CLASS Act is striking. In 1994, there was at best general ambivalence toward the Clinton LTC reform proposal from much of the provider community due in part to its focus on HCBS rather than institutional care as well as their commitment to private insurance. This shift in their preference for financing reform is significant. The reasons underpinning the strong support of providers for CLASS were summed up by a representative of a LTC provider trade association:

“You can look at it two-fold. One, it [CLASS] is good for the people we serve. But it [CLASS] is also good for us as a business because we now offer home and community based services...It made sense for the mission driven side, but it also made sense for the business side” (LTC Provider Representative, Transcript 44).

This statement demonstrates that LTC providers believed the CLASS Act would be of significant benefit to them as well as the individuals they serve. In the 2000s, providers were searching for a more stable and larger revenue stream than the Medicaid program was able to provide. While supportive of the efforts to promote the wider use of private LTC insurance in the early 1990s, private insurance had failed to meet the growing funding gap, which many within the provider community presumed would occur if the private insurance

market was afforded sufficient time and incentives to develop. Furthermore, the move toward the use of HCBS and away from institutional care meant that traditional financing mechanisms that focus on institutional settings, like Medicaid, would likely generate a smaller portion of provider revenue over the long-term. Despite a steady growth in the percentage of the U.S. population who are adults over the age of 65, there has been no comparable growth in nursing home utilization in the United States (Lakdawalla and Philipson, 2002). Simply put, LTC providers were beginning to search for an alternative financing mechanism that would more adequately meet their short and long-term financial needs.

Institutions and the CLASS Act: The Fragmentation of Power

The Fragmentation of Power

While the Bush Administration had very little, if any, direct involvement with the development of the CLASS Act, participants regularly noted that CLASS was conceptualized during the tenure of a Republican President and a Republican controlled Congress, which influenced both the design of the program and the strategy used by proponents in their attempt to build support for this legislation. The political environment of that period suggests that pro-market, family-oriented policies, which promote the individual over the state in addressing unmet social risks, would be the types of policies most likely to succeed politically. A disability policy advocate, who worked to build support for the CLASS Act in Congress throughout the 2000s, offered an analysis of the impact of that political environment:

“Given the outlook of what Congress was looking like when Senator Kennedy and his staff were first considering this [CLASS], an expansion of Medicare was probably not a go; it was not really a possibility” (Disability Advocate, Transcript 53).

Senator Kennedy’s political party, the Democrats, was not in control of Congress or the White House during the early 2000s, and policies that aimed to expand the role of government in social provision were generally off the agenda.³³ Nevertheless, Senator Kennedy and his staff pushed forward in an attempt to address LTC financing for people in need of assistance. Senator Kennedy and his staff, as well as the stakeholder groups supporting the CLASS Act, helped to craft the legislation in such a way so that it might

³³ The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (P.L. 108-173) is a notable exception, which established a benefit for prescription drugs, which had been lacking from Medicare.

appeal to at least a few Republican Members of Congress. By securing some Republican support, the legislation, in theory, would have been more likely to move through the legislative process at that time. Bipartisan support has often been the way that legislation is passed in Congress regardless of which party is in power since it is difficult to obtain the unified support of a single political party in the U.S. legislative system.

As previously noted, an entirely self-financed program, based on individual responsibility and an insurance model, are fundamental aspects of the design of CLASS. Several participants suggested that these programmatic characteristics were, in part, a product of the Republican Party's institutional control of the legislative process for much of the 2000s. In other words, much of the legislation was based on underlying principles that might appeal to conservatives, while solving a social problem many liberal policymakers believed should be addressed through a state intervention. A former Congressional staffer, whose work focused on the CLASS Act throughout their time in Congress, offered their assessment of the political landscape during the years of the Bush Administration:

“I think the CLASS Act was sort of a new way to think about things...and I think you have to remember the environment—the Republicans were in control. And so it was sort of an approach that didn't take government money—that was cost neutral. So I think it had a lot to do with the environment and thinking about the budget situation, which at that point, was not good...” (Former Congressional Staffer, Transcript 48).

The design of the CLASS Act, and the values underpinning its design, suggests the types of social policies which are typically successful within the U.S. political system must blend attributes that appeal to both sides of the ideological spectrum. This points to the belief that an 'entanglement of competing ideological' positions exist (King, 1999), and that

no ideological outlook dominates in the United States (Quadagno and Street, 2005). Indeed, the CLASS Act designers were influenced by the political environment in which the legislation was conceptualized. Even after Democrats regained control of Congress in 2006, the President was still a Republican, therefore, any movement on this legislation remained unlikely. However, participants suggested that the traditionally Republican values, which were embedded in CLASS, did not particularly matter much to the success of the legislation before the 2008 election as it never moved out of the U.S. Senate Health, Education, Labor and Pension (HELP) Committee or the House Energy and Commerce Subcommittee on Health. Nonetheless, the values and norms embedded within CLASS early on remained a part of the design of the legislation after President Obama took office and health reform became a top legislative priority of the new Administration.

Committee Arrangements

Significantly, the CLASS Act did not move out of the HELP Committee for nearly six years between 2003 and 2009. The Act only began to move legislatively once Congress, and specifically the HELP Committee, began to work on the broader health reform legislation pushed by the Obama Administration in 2009. A majority of participants believed that health reform, a related policy issue, provided CLASS the institutional opportunity to move forward. Without the wider interest in the health reform legislation, most participants believed that CLASS would simply have remained in the HELP Committee, perhaps indefinitely. According to a senior Congressional staffer who worked on merging the House and Senate's versions of health reform into the final piece of legislation that passed into law:

“I think the structure of Congress would have helped prevent CLASS on its own. There are so few moving [legislative] vehicles in the Senate. It’s just really hard for smaller bills to go anywhere. This is because there simply isn’t enough time in any given session of Congress to tackle that many bills. So finding a larger vehicle for legislation is important for a bill’s success” (Congressional Staffer, Transcript 35).

Most legislation considered in Congress simply “dies” in the committee to which it is originally assigned. The significance of Senator Kennedy as an advocate of LTC reform, and also as the Chair of the U.S. Senate HELP Committee, was frequently cited as important to the legislative success of the CLASS Act. As the Chair of this influential committee and acting as a policy entrepreneur, participants stated that Senator Kennedy was institutionally well-situated to move the CLASS Act forward when health reform became a legislative prospect in 2009 (Kingdon, 1995; Sheingate, 2003). However, despite his Committee Chairmanship, that alone was insufficient to move the CLASS Act out of this committee prior to the 2008 election. Other factors also play a significant role in determining whether or not legislation can advance within the U.S. Congress (Baumgartner and Jones, 1993). For example, Senator Kennedy’s close relationship with President Obama, and his endorsement early on in the 2008 Democratic primary campaign were also cited as significant to the Obama Administration’s support of the CLASS Act and ultimately its inclusion in the wider health reform legislation. Nevertheless, this draws attention to the multitude of institutional constraints within the U.S. Congress and the American policymaking process (Weaver and Rockman, 1993; Finegold, 2005), which can impede legislation in spite of an institutionally well-positioned sponsor like Senator Kennedy.

Analysis and Discussion: Path Dependency, Policy Feedback and Veto Points

Long-Term Care (LTC) financing arrangements in the United States remained relatively stable during the years of the Bush Administration; no comprehensive plan for LTC financing reform successfully navigated the complex American political process. Instead, only minor reforms took place around the edges of Medicaid such as the LTC provisions included in the Deficit Reduction Act of 2005. When a plan for more expansive reform began to take shape, it did not propose a major realignment of the existing financing system. Instead of a social insurance system to replace the existing financing arrangements, a voluntary insurance program, the CLASS Act, emerged as a potential legislative vehicle for reform. Participants often noted that this new proposal was not designed to displace the existing arrangements; rather the Medicaid program and private insurance were to continue to be significant LTC financing mechanisms along with the CLASS program, although it was hoped that CLASS would improve the way these other financing mechanisms operate.

In spite of its characteristics of private financing, the CLASS Act ultimately proposed a new, large government-managed program to help finance the costs associated with the LTC needs of the U.S. population. The program would pool risk, provide a benefit based on need, and be guaranteed by the government. The interview participants agreed the federal government needed to intervene in the LTC financing system. While never convinced of the merits of the CLASS Act, the insurance industry was supportive of some form of further government intervention into the LTC financing arena. Their support of further involvement in this arena was somewhat unexpected as it might be anticipated that

business interests would view greater state regulation or involvement with skepticism (Esping-Andersen, 1985; Hacker and Pierson, 2002). Their interest appears to demonstrate a much more nuanced relationship between business and social policy than is traditionally assumed (Swenson, 2002; Mares, 2003a; 2003b; Martin, 2000). Mares (2003a) argues that the type of industry, and the potential economic risks confronting that industry, influences the response that industry will have to social policy. Moreover, the form of government involvement matters: if intervention is viewed as helpful to a particular industry, government involvement may be supported by that industry (*ibid*). In the case of LTC, the insurance industry clearly recognized that an expanded role for the federal government in LTC financing could benefit their market. However, the LTCI simply did not appear to believe the CLASS Act was the appropriate form of government intervention. The widespread belief amongst all the stakeholders that the federal government should play a role in LTC financing contrasts with Huntington's (1981) and Lipset's (1996) assertion that the primary assumption of the American political environment is that the power of the state must be limited. If U.S. policymakers were primarily driven by a desire to limit state power, it is unlikely CLASS would have gained traction as a potential piece of legislation.

In designing the CLASS Act policymakers actively avoided the displacement of the private insurance market. Their desire to build a public-private partnership reflected a belief that a social insurance system would not be politically possible due to a lack of support amongst policymakers and the American public. This is, in some ways, puzzling given high levels of public support for Medicare and Social Security, the nation's two largest social insurance programs (Page and Jacobs, 2009). While supportive of these programs, the American public's support for additional taxes to maintain existing benefits

or to expand coverage appears to ebb and flow. Policymakers were apparently aware of these conflicting views, and decided early on that a social insurance model was not a politically viable option for LTC reform at that juncture.

Proponents of CLASS often described the program as ‘quasi-social insurance.’ However, the actual characteristics and economic underpinnings of the program were less clear. Social insurance emphasizes access to publically provided benefits to which workers have an earned right (Quadagno and Street, 2005, p. 65). If participation in CLASS were mandatory, it would have been much closer to a social insurance program. Furthermore, CLASS individualized risk since there was no redistribution of funds from high to low-income enrollees. If CLASS had employed an alternative financing mechanism such as tax-financing or risk pooling through social insurance, participants believed it would not have fit with the ethos of health reform, and therefore would not have been included in the wider legislation. This provides further evidence that a conservative tradition holds great sway within the United States. In particular, evidence for Lipset’s (1991; 1996) argument, as well as evidence for Anthony King’s (1973) argument that Americans are more individualistic than other polities, more resistance to state intervention, and more reticent to allow the government to impede the private market, are clear within the design of the CLASS Act.

The levels of coverage that CLASS would have provided are also important for understanding the role that ideology may have played in the legislative success of the program. The prohibitive cost of a comprehensive program was cited by interview participants as the reason CLASS only provided a partial benefit for LTC needs. Potential program enrollees would have paid monthly premiums in order to receive benefits if and

when they needed them. While the legislation stipulated a minimum benefit of \$50 a day, the actual benefit levels as well as the monthly premiums were left to be determined once the program was implemented. Indeed, cost is a practical concern; however, cost is also an ideological issue. The use of a program that provides a partial benefit assumes that policymakers, and therefore the American people, would not accept a comprehensive LTC financing mechanism. A comprehensive benefit would require mandatory participation and the use of redistribution to ensure financial viability. Both of these options are in direct opposition to the conservative values and norms that scholars such as Hartz (1955), Huntington (1981), King (1973) and Lipset (1996) argue are part of the American ideological ethos.

The idea that people were to pay into CLASS was intended to provide a sense of investment in the program, much as the highly successful Social Security program purportedly provides buy-in and sense of return (Derthick, 1979). In addition, CLASS beneficiaries would have complete discretion over how to spend their benefits as they would be paid in cash, which Medicare and Medicaid do not generally allow. These design characteristics instead draw on the Social Security program, which uses similar principles in terms of investing in an individual's retirement and allowing each individual discretion over the use of benefits. These characteristics of the CLASS program are reflective of Lockhart's (1991) explanation of the political success of Social Security. By embracing the investment concept, which is a part of the nation's most successful social insurance program, the ability of CLASS to pass legislatively was strengthened. Policymakers also hoped this would build lasting political support for the CLASS program, again similar to the experience of Social Security.

The stated and unstated preferences of different political actors within the LTC policymaking process can also help to provide some insight into their involvement in the development of the CLASS Act. The economic risks that confront older adults as well as younger disabled Americans have increased significantly as the costs of LTC services have increased; the number of individuals in need of care has also grown. Furthermore, the effectiveness of existing government programs like Medicaid has decreased as benefits have failed to keep pace with increasing costs and the new demands of an evolving care environment. For many political actors, including Senator Kennedy and many aging and disability advocacy groups, the first preference for addressing the growing risks associated with the need for LTC was a social insurance financing mechanism. Such an approach, however, was deemed politically unfeasible, which helped to spur the development of the CLASS Act. In the case of CLASS, their second order preference (Korpi, 2006) was a program which blended a government solution with the perceived best aspects of the private market. This approach offered the potential to mitigate a significant portion of the major financial risks facing individuals who need long-term services and supports in a more politically palatable way.

While the actual policy preferences of business can be difficult to accurately gauge (Hacker and Pierson, 2002), the policy preferences of business interests within the LTC arena can be traced to the economic risks facing that particular industry (Mares, 2003a). For instance, the risks confronting America's LTC providers evolved considerably since the early years of the Clinton Administration. Although LTC providers had long supported a larger, more stable revenue stream than the Medicaid program was able to provide, private LTC insurance had failed to fill the growing funding gap, which many within the

provider community presumed would occur if the private insurance market was afforded sufficient time and incentives to develop. Furthermore, the move away from institutional care and towards HCBS meant that traditional financing mechanisms, which focus on institutional settings such as Medicaid, would likely generate a smaller portion of their revenue over the long-term. Despite a steady growth in the population of America's older adults, and more importantly, a growth in their percentage of the total U.S. population, there has been relatively no proportional increase in nursing home utilization in the United States (Lakdawalla and Philipson, 2002). In short, LTC providers were left in search of an alternative financing mechanism that would more adequately address both their short and long-term economic risks.

In spite of persistent doubts about the compatibility of the CLASS Act with private insurance, the findings appear to demonstrate that insurers were open to further government intervention into the LTC financing arena as long as intervention did not pose a threat to their market. The risks confronting the LTCI industry had also shifted considerably since the early 1990s with many of the same risks that bedeviled LTC providers and individuals in need of LTC—particularly the growing costs of formal services—increasing those risks. The downturn of the global economy posed several additional challenges to their business model as the insurance industry relies heavily on investments in the stock market to create profit for their shareholders. Moreover, for a variety of reasons, the number of new LTCI policies sold never met initial expectations which further undermined the industry's ability to be dynamic. Fewer new policies were sold than were needed to counteract the financial effects of the growing number of long-time policyholders who were beginning to tap into their policies to finance their care

needs. This suggests some degree of market failure (Barr, 2001; Estévez-Abe et al. 2001) as evidenced by the accumulated effect of these growing risks including the departure of one of the nation's largest LTC insurers, MetLife, from the LTC marketplace in late 2010 (*BusinessWeek*, November 11, 2010). A risk such as the need for LTC is difficult to address through private insurance, which faces much of the same problems as unemployment insurance including moral hazard and adverse selection for which a governmental intervention or collective response is better suited (Barr, 2001). Thus, the LTCI industry was apparently open to some form of governmental intervention that might have helped to mitigate their growing risks. These risks may have served to keep members of the insurance industry at the negotiating table on the CLASS Act for much of the 2000s.

A fundamental principle of an institutional framework analysis of social policy is path dependency, which argues policymakers are bounded by existing institutions and previous policy legacies that direct them along particular policy paths Weir (1992); Hacker (1998, 2002); Pierson (1996; 2000; 2004). As initially demonstrated in Chapter Four, the broader move away from bold social policy initiatives after the collapse of the Clinton health reform efforts comes into clearer focus with the CLASS Act. Since the initial design of CLASS took place during the years of the Bush Administration and a Republican controlled Congress, it would have needed the support of at least a few Republican Members of Congress to have moved legislatively before 2008. Significant attempts to win Republican support for CLASS were made between 2003 and 2008, though with only limited success. Notably, Republican Senator Mike DeWine (R-Ohio) was convinced to become a co-sponsor of the legislation, but lost his re-election bid the following year. No other Republican Member of Congress officially gave their support to the CLASS Act for

the rest of its legislative life. However, the approach that CLASS takes to financing (a voluntary, insurance based model) and the principles (personal responsibility, self-sufficiency) underpinning that approach, were embedded in the program's design well before President Obama took office. It is unlikely that policymakers would have started from scratch to design and build the necessary support for a different LTC financing proposal as potentially transformative as the CLASS Act once Congress began to debate health reform. As CLASS was more or less "ready to go" when the health reform process began in 2009 (Kingdon, 1995; Polsby, 1984), a newly designed major reform proposal would not have received serious consideration. This appears to suggest that policymakers were already relatively locked-in in terms of the shape of LTC reform at this particular juncture (Pierson, 2000), a shape that was solidified many years before President Obama ever took office.

Notably absent from the findings presented in this chapter is a strong role for the federal bureaucracy within the development or legislative processes surrounding the CLASS Act. Historically, the administrative capabilities of the American federal bureaucracy have been comparatively weak (Lowi, 1979; Skocpol, 1985; Jacobs and King, 2011), with major expansions of state capacity occurring in the late nineteenth century (Skowronek, 1984; Skocpol, 1992; Carpenter, 2001; Johnson, 2007), the 1930s (the New Deal) and with the passage of the Great Society in 1965 (Heclo, 1978). These expansions increased the bureaucracy's ability to influence the policymaking process, particularly with regard to certain areas of policy like redistribution (Ripley and Franklin, 1984). Additionally, American civil servants tend to have greater influence over policymaking in 'routine' policy decisions where that particular policy is not embroiled in a high degree of

controversy (Ibid). Nevertheless, the power of the American bureaucracy remains comparatively weak to other advanced industrialized democracies. The bureaucracy in other countries is often a major actor in all forms of policymaking where it plays a much stronger role, such as in France (Weaver and Rockman, 1993). The bureaucracy provides expertise to legislators and is institutionally well-positioned to influence the legislative process. While the French state has undergone significant institutional change in recent decades—notably the dismantling of the *dirigiste*³⁴—state capacity remains highly robust and has merely shifted its focus to labor market policies and the enhancement of social programs (Levy, 2005).

While certain U.S. federal agencies are relatively strong, such as the Department of Defense or the Social Security Administration (SSA), others simply do not hold the same amount of power or influence. The Social Security Administration provides a sharp contrast to the generally weak position of the federal bureaucracy in the United States, which as an agency, has greatly shaped its own organizational development. According to Derthick (1979), the SSA has greatly influenced the outcome of the policymaking process throughout its history. Although that influence has declined in recent years, as other political actors and institutions have assumed a larger role in the Social Security policy process (Derthick, 1979; 2001), the SSA demonstrates that federal agencies, and the administrators within those agencies, can play a strong role in the policymaking process. With regard to LTC, the Centers for Medicare and Medicaid Services (CMS) would be the most comparable agency to the SSA; yet there is very little evidence within the findings presented here to suggest this agency was a driving force behind the design of the CLASS

³⁴ *Dirigiste* refers to the French state's direct intervention into the economy through strategic coordination of capital.

Act.³⁵ Even the Congressional Budget Office (CBO), which had significant impact on the CLASS Act through its budgetary projections, is a part of Congress, and not the federal bureaucracy.

In contrast to the federal bureaucracy's apparent lack of direct involvement with the CLASS Act, specific political actors within Congress had considerably greater impact on the legislation's development. The work of Senator Edward Kennedy and his staff was particularly significant to the development of the legislation during the Bush Administration. Senator Kennedy exemplified several characteristics of a policy entrepreneur by defining a problem, demonstrating social acuity, and building support amongst the LTC policy arena (Mintrom and Norman, 2009; Baumgartner and Jones, 1993; Mintrom, 2000; Kingdon, 1995; Polsby, 1984). According to Derthick and Quirk (1985), Senator Kennedy had previously acted as a policy entrepreneur on the issue of deregulating the airline industry in the early 1980s. Kennedy raised awareness of this issue by holding Senate Committee hearings that helped to provoke deregulation (Derthick and Quirk, 1985, p. 40-43). As mentioned in Chapter Four, no comparable champion for LTC financing reform existed during the Clinton Administration's health reform efforts. First, Senator Kennedy and his staff intentionally designed the legislation so that it might appeal to at least some conservatives as well as the traditional proponents of LTC reform. A more traditional social insurance approach was unlikely to have moved through the political institutions during the 2000s, although it should be noted the CLASS Act also failed move out of committee during these years. In addition, Senator Kennedy and his staff worked to build strong support amongst the main stakeholders within the LTC policy arena. Senator

³⁵ The Office of the Chief Actuary of CMS did provide a cost analysis of the CLASS Act in the final months before it passed as a part of health reform in 2010 (See Foster, 2010).

Kennedy was highly successful at bringing the disability and aging advocacy communities with LTC provider groups in united support of CLASS. Kennedy was, however, less successful at winning support for CLASS from the insurance industry. Nonetheless, participants believed this outreach served to mitigate strident opposition from the insurance industry, who participated for years in negotiations on how to make the CLASS Act complementary to private insurance. While these efforts did not produce a legislative victory on LTC reform during the years of the Bush Administration, they provided the necessary groundwork for later efforts to integrate CLASS into the wider health reforms of the Obama Administration.

The process through which the financing mechanism of the CLASS Act developed as well as the approach to building support for this legislation appears to suggest some degree of policy learning (Heclo, 1974; Sabatier and Jenkins-Smith, 1988, 1993; Sabatier and Weible, 1999; Hall, 1993) within the LTC policy arena. According to Sabatier Jenkins-Smith, advocacy coalitions include a variety of state and non-state actors, which develop from dissatisfaction with existing institutional arrangements. They are linked together by a 'policy-broker,' who is usually a senior legislator like Senator Kennedy in the case of LTC, whose main concern is keeping the level of political conflict within acceptable limits and reaching some reasonable agreement on the way to address the problem (Sabatier and Jenkins-Smith, 1988, p. 141). The agent of learning is the policy network and the specific outcomes are the types of policies supported in moving toward the successful achievement of their core policy beliefs (Ibid, p. 151). Thus, while supportive of social insurance as an approach to financing individual LTC needs, Senator Kennedy and the stakeholder groups working to bring about reform concluded that approach was not politically viable at that

particular juncture. The belief that LTC financing reform was a necessary policy objective was never abandoned (Sabatier and Jenkins-Smith, 1988; 1993); rather the means to bring about change were modified to take a much more market-oriented, individualistic approach in designing a financing mechanism. Senator Kennedy's career in the U.S. Senate was devoted to bringing about comprehensive health reform, though with limited legislative successes. As participants often noted, this shaped Kennedy's approach to advancing LTC financing reform through the CLASS Act. Moreover, after years of unsuccessful attempts by advocacy groups to push for a social insurance benefit, they too appear to have embraced this approach as a way to bring about policy change.

Summary and Conclusions

Several significant themes emerged from the findings presented in this chapter relating to the progress of the work of advocates for LTC financing reform during the years of the Bush Administration, and its subsequent impact on successful reform through the passage of the CLASS Act. To some degree, the major obstacles to enacting comprehensive LTC financing reform in the United States are broad, ongoing challenges, but they were given particular strength by the rightward shift of the political pendulum during the years of the George W. Bush Administration. The domestic policies advanced by the Bush Administration were decisively conservative, focusing on pro-market, private solutions and a greater reliance on personal responsibility to address personal social and economic risks like LTC. This rightward shift within the U.S. political environment contrasts sharply with the early years of the Clinton Presidency, as well as the subsequent

Administration of President Barack Obama, and is reflected in the design of social policies that were developed during this period such as the CLASS Act.

The design of the CLASS Act, which emerged during the 2000s, reflects a middle-of-the-road approach to social policy that is less redistributive than comparable programs in other countries, which tend to provide more generous public support for the mitigation of personal social risks. CLASS ties into an American sense of problem-solving and reflects a tension and subsequent compromise between an expanded role for the state and the primacy of the individual and market forces. The legislation that developed during the years of the Bush Administration is more in line with the concept of individual savings accounts and personal responsibility than shared risk to mitigate the costs of old age and disability. The objectives of the CLASS program are less about equity and more about equality, which is also typical of U.S. social policy. Thus, there is evidence within the findings presented here that a proposal to expand LTC coverage was successful in generating sufficient interest because it tapped into these conservative, anti-statist, pro-market and individualistic values and norms. In short, the emergence of the CLASS Act appears to demonstrate that a conservative ideology remains a prevalent theme of the American political environment. This chapter also clearly demonstrates that the CLASS Act does not purely reflect this conservative ethos, suggesting the policymaking process in the United States is more much complex than monocausal ideological arguments tend to allow. Practical issues, such as cost containment, were a driver of this legislation from early on during the policymaking process. To accept that an ideological framework singularly drives policy outcomes in the United States would provide only a limited explanation for policy development.

The findings also appear to demonstrate that the decisions of different political actors were bounded by the institutional and existing policy frameworks that surround LTC policymaking in the United States, and that the design of the CLASS Act was at least partially due to those existing frameworks. Political actors were bounded by their position within the institutions of the political system, by what policies were possible within those institutional frameworks, and by what strategies for policy change could be successful within those institutional arrangements. The extent to which key stakeholder groups, particularly advocacy groups and LTC providers, voiced concern over existing financing arrangements was also a significant theme in the data. This suggests the presence of negative policy feedback regarding LTC financing arrangements prior to 2009 and provides some explanation for the growing support for reform at that particular juncture. Significantly, participants often mentioned the legislative environment of the Bush years, and its impact on the design of LTC reform that passed into law in the form of the CLASS Act, which may explain why this legislation was never bolder in its ambitions. The circumscribed strategy surrounding the design of CLASS prevented a bolder approach even when the necessary institutional factors for bolder reform were aligned. This is one of the most explicit examples within the findings of path dependency and its potential impact on LTC policymaking in the United States.

The findings presented thus far begin to demonstrate why comprehensive LTC financing reform did not take place during the years of either the Clinton or George W. Bush Presidencies. Nevertheless, the findings in these chapters are only able to account for part of the story surrounding the success of LTC financing reform in the form of the CLASS Act. While helping to elucidate the necessary institutional framework needed for

reform, as well as the influence of ideology and the role of political actors like Senator Kennedy on the development of the CLASS Act, several puzzling questions still remain. What accounts for the particular strategies of both the proponents and opponents of CLASS during the Obama health reform efforts, and were they significant to the success of CLASS? Given the apparent momentum for change and the new political environment heralded under President Obama, why was a much bolder program not driven forward by proponents of reform? On the other hand, given the evidence that the values of self-sufficiency, individualism, and choice were alive and well in the United States, why was such a big government program created to address LTC financing? In order to address these important questions, a wider set of variables must be explored, which may in turn provide a better understanding of the success of LTC financing reform. A deeper understanding of the way ideology interacts with other variables, such as institutions and policy actors, is needed to understand why the CLASS Act passed at that particular juncture in U.S. politics.

Chapter Six: The Obama Administration and the Successful Enactment of Long-Term Care Financing Reform

Introduction

Building on the findings presented in Chapters Four and Five, this chapter will examine the processes surrounding long-term care (LTC) financing reform during the first two years of the Obama Administration. The passage of the CLASS Act represented a significant break with past policy arrangements after a long period of relative stability, making it important to understand how the CLASS Act became law. The legislative success of the CLASS Act also provides an opportunity to examine the way that ideology, institutions, and policy actors interact to influence LTC policymaking in the United States. Moreover, the success of CLASS at this particular juncture provides a highly illustrative contrast to the earlier efforts of the Clinton Administration to bring about LTC financing reform, as well as to the years of the Bush Administration in which the CLASS Act was developed but never successfully navigated the institutional framework of the policy process. An analysis of the legislative success of the CLASS Act can also help contribute to a better understanding of the conditions under which social policy is made in the United States and why significant social policy change is often so difficult to achieve.

The American political landscape shifted dramatically after the 2008 election. The Obama Administration's bold, new ideological policy agenda contrasted sharply with that of President George W. Bush. The financial crisis that began in 2007 and the 'Great Recession' it spawned had a profound impact on the outcome of the 2008 election. This economic crisis influenced the type of policies pursued by the Obama Administration, but it also highlighted the nation's increasing federal deficit, which brought cost and fiscal

restraint to the forefront of the national political discourse. While the economy and the fallout of the ‘Great Recession’ loomed over much of the 2008 presidential campaign, Senator Barack Obama made comprehensive health reform a main theme of his candidacy (Obama, 2008). In his health reform plan, published in the October 2008 edition of the *New England Journal of Medicine*, Senator Obama wrote:

“Now is the time for quality, affordable health care for every American who wants it. This is our moment to turn the page on the failed politics of yesterday’s health care debates and finally bring together business, the medical community, and members of both parties around a comprehensive solution to our health care crisis. The Obama-Biden plan is that solution” (Barack Obama, 2008, p. 1928).

Barack Obama’s election to the U.S. Presidency, coupled with a return of large majorities of the Democratic Party in both houses of Congress, once again helped move comprehensive health reform to the top of the domestic policy agenda (Jacobs and Skocpol, 2010). Congress began drafting health reform legislation soon after President Obama took office in 2009. While the overarching approach to health reform was decided before any debate actually began within Congress, the details of the plan were generally left up to Congressional leaders and the legislative process. The subsequent debate brought several questions to the forefront of national discourse about the extent of the authority of federal government, the state’s appropriate role in providing health care, and the authority of Congress to regulate interstate commerce. After months of acrimonious debate, the Patient Protection and Affordable Care Act or ‘PPACA’ (P.L. 111-148) finally passed into law on March 23, 2010, nearly a year after the health reform process began. This expansive legislation left no aspect of the U.S. health system untouched, including LTC, addressing

the dual goals of expanding access to coverage while instituting cost containment measures.

After years of relative stability within the nation's long-term care (LTC) financing arrangements, this legislation included substantial LTC reform. Several small parts of PPACA targeted the LTC system but the main component, which specifically sought to transform America's LTC financing arrangements, was the Community Living Assistance Services and Supports (CLASS) Act.³⁶ The CLASS Act established a self-funded, governmentally administered, voluntary insurance program for the purchasing of long-term services and supports (LTSS). The new program was intended to build a new public-private partnership within the LTC arena that would expand access to coverage through a financing mechanism other than Medicaid. As part of the Obama Administration's wider health reform efforts, the passage of the CLASS Act constituted the single largest policy change to LTC financing arrangements in the United States since the passage of the Medicare and Medicaid programs in the mid-1960s (Gleckman, 2010).

³⁶ Additional LTC provisions in PPACA include: Money Follows the Person, Community First Choice Option, State Balancing Incentive Program, and the Elder Justice Act (Patient Protection and Affordable Care Act, P.L. 111-148).

Research Findings: How the Passage of LTC Financing Reform Took Place in 2010

The Features of the CLASS Act: Design and Underlying Values

Lack of Redistribution

Despite the wishes of consumer advocacy groups and their allies within the LTC provider trade associations and union groups, the CLASS program would not have subsidized the participation of low-income Americans. The CLASS legislation explicitly stated that neither taxpayer funds nor general revenue could be used to supplement the program; instead it had to be self-sufficient, relying on premiums and interest earned on those premiums once pooled. Additionally, the Gregg Amendment, added during the Health, Education, Labor and Pensions (HELP) Committee's deliberations in May of 2009, mandated the CLASS program's actuarial solvency for 75 years.³⁷ This amendment was a major structural change to the CLASS Act, which significantly limited the options for including any measures of redistribution within the operation of the CLASS program.

Social programs that attempt to limit individual risks to income, such as old-age and disability, are by necessity linked to some method of taxation. For example, Medicaid, the largest governmental funder of LTC in the United States, is a tax-financed program. Levels of taxation therefore impact the amount of redistribution that can be provided by a program (Amenta, 1998). As no federal budgetary dollars could be used to finance CLASS, and the legislation stipulated that the program must be entirely self-funded,

³⁷ The Gregg Amendment helped assuage conservatives' concerns about establishing another entitlement program; however, it had major implications for the implementation of CLASS once passed into law as it placed strict fiscal limitations on the program's operations.

opportunities for redistribution were minimal. Interviewees from advocacy and LTC provider groups that worked closely with Senator Kennedy's office stated that the lack of redistribution became a concern for many advocacy groups during legislative negotiations. According to a policy advocate whose organization promotes social programs that support older adults:

"...my sense is that it's tough in this country to provide assistance for people when they are in dire need. Programs for poor people tend to be poor programs and so frankly, to find the money to really fill the long-term supports and services gap is, in my mind, perhaps the biggest gap in our health care system" (Aging Advocate, Transcript 24).

This advocate's concern reflects an opinion that programs such as Medicaid, which provide benefits to low-income Americans, are both structurally and politically weak. There was a sense of resignation amongst proponents of CLASS because, in order to pass this legislation, tax revenue for low-income subsidies could not be included in the bill. In place of general revenue, CLASS would be entirely self-financed through individual, voluntary contributions in the form of a monthly premium and the interest earned on the pooled funds of all participants. Thus, the CLASS program was designed to operate much like an insurance product, although one offered by the U.S. government rather than a private corporation. The government's primary role was to collect funds, pool resources in government backed bonds, and provide coverage for LTSS in a more efficient manner than private insurance alone could offer. This suggests that CLASS was primarily aimed at people who could afford to participate in the program, namely middle-class Americans. Participants highlighted the importance of the self-financing component of the legislation and agreed that if CLASS had used tax dollars to finance the redistribution of funds to low-income enrollees it would not have been included in the 2010 health reform legislation.

Despite the lack of redistribution from general revenue, low-income Americans and university students were still eligible for five dollar monthly premiums. This low premium was lauded by Congressional staff, advocates, and LTC providers as a way to encourage greater participation in the program while avoiding the use of federal revenue. However, several participants from the insurance industry as well as LTC policy experts questioned the feasibility of this, given CLASS's strict solvency requirements and a clear lack of additional revenue sources. Those opposed to CLASS, who focused much of their attention on the program's financial viability when attacking the program, were particularly mindful of this issue. An actuary, who worked for a large insurance company, explained the industry's concern over the potential cost of the monthly premiums for CLASS:

"The problem is there is a disconnect between how they devised the plan and what the premiums really need to be in order for the plan to be financially viable. And that drove the premium up...it really jeopardized the success of the whole program" (LTCI Representative, Transcript 9).

Thus, while the decision to include a five dollar premium for these populations was intended to generate greater participation in the CLASS program, while averting the use of federal revenue, it also appears right to have generated some uncertainty about the program's financial viability, which provided opponents an opportunity to attack the legislation. Specifically, a five dollar premium for students and low-income individuals would generate less revenue, which in turn would increase the premiums for all other participants and likely lower enrollment amongst younger and healthier individuals. Members of the insurance industry were particularly vocal about this; however, it was a critique from a structural rather than an ideological perspective. In other words, the LTCI were not overtly opposed to the subsidy for college students and low-income participants,

but rather suggested that, as designed, this would undermine the program's financial viability. The balance of subsidizing the participation of low-income populations and students without taxpayer dollars reflects the impact of opposing ideologies in policy outcomes (King 1999; Quadagno and Street, 2005), with no single ideological position dominating.

Values: Personal Responsibility, Self-Reliance and Independence

As discussed within Chapter Five, the values of self-reliance, self-sufficiency and independence were embedded within the design of the CLASS Act during the Bush Administration. In fact, the general structure of the CLASS Act remained largely unchanged from the Bush to the Obama years. Participants from the aging and disability advocacy groups, as well as LTC providers, cited these same values as particularly important to the success of CLASS once it became a part of the health reform debate under the Obama Administration in 2009. One participant suggested that embracing these traditionally conservative values helped to blunt the possibility of attacks based on the appropriate role of the state. One LTC policy expert, in a unique position to gauge Congressional opinions on CLASS because of close links to Members of Congress and their staff, stated:

“...I think some opponents weren't that strong because they didn't think it [CLASS] would pass. And maybe they miscalculated. Maybe they should have been more intensely involved. But you know, I think it was acceptable enough that it didn't warrant vehement opposition” (LTC Policy Expert, Transcript 3).

The design of CLASS reflects several characteristics expected of a conservative approach to mitigating social risk in the United States. These characteristics were largely a

legacy of the program's development during the early 2000s. Consequently, opponents of the CLASS Act did not particularly focus significant attention on the role of government because it had already been minimized in the design of the legislation. The proponents of CLASS on the other hand highlighted the embedded value of self-sufficiency throughout their lobbying efforts. Similar to the position of the policy expert quoted above, some Congressional staffers suggested that while no Republican Member of Congress ultimately voted for CLASS, the traditionally conservative values embedded within the legislation helped to temper serious opposition to the program from many Republicans. This was a widely held belief amongst the LTC policy experts interviewed.

While few participants from the insurance industry stated a belief that CLASS was intentionally designed to undermine their market, most other stakeholders believed the LTCI industry generally saw CLASS as a potential threat to their market. However, the majority of participants believed that the CLASS Act was never intended to supplant the private LTCI market, particularly as CLASS was designed as a partial benefit and aimed primarily at home and community based services (HCBS). Nor was CLASS designed to be a new component of Medicare that specifically addressed LTC, which was the preferred financing mechanism of many LTC reform advocates. According to a Congressional staffer who had been highly involved with drafting the CLASS legislation:

“...this [CLASS] was not about putting anybody out of business...the point was not to make a Medicare Part E, it was to make something that was a public-private partnership but didn't require Medicaid” (Congressional Staffer, Transcript 49).

Participants from advocacy groups and provider trade associations, as well as Congressional staffers, often stated that CLASS could become a platform for private

insurance to “wrap around.” Although this view was held by a majority of these participants, the LTCI industry interviewees did not appear as convinced of the potential benefits of this partnership. They questioned the ability of CLASS to work in conjunction with private insurance, pointing out differences between the two approaches rather than highlighting possible symmetries. Regardless of the insurance industry interviewees’ specific doubts about CLASS, most participants believed a public-private partnership was the best approach to bring about a legislative success on LTC financing reform. The public-private approach draws on the normative values of personal responsibility, self-reliance, and independence, all of which were embedded within the design of the CLASS Act from the earliest days, while employing government to address a social problem.

Voluntary Enrollment

In the final weeks of the health reform debate in 2010, the enrollment provisions within the CLASS Act were shifted from a voluntary opt-out to an opt-in approach. This change occurred due to the great difficulty that Congressional leaders and the Obama Administration encountered in the legislative debate, particularly over the use of mandates for acute medical coverage. By making participation in the CLASS Act entirely voluntary, proponents of the legislation were able to circumvent further conflict on the mandate issue. Yet, enrollment based solely on voluntary was a completely novel approach to government-administered LTC programs in the United States (Gleckman, 2010), and was perhaps the most significant structural change made to the CLASS Act during its legislative development.

Indeed, voluntary enrollment was often cited as a key to the CLASS Act's legislative success as it is much more difficult to oppose the idea of a voluntary program than one that contains mandates. A former Congressional staffer who had worked on CLASS both while in Congress and before they became a Congressional staffer stated:

"I think it's [CLASS] kind of like the American model of a social insurance program in that it's not mandatory. Many of us wanted it to be mandatory, but I think just politically we made the decision that wouldn't be possible" (Former Congressional Staffer, Transcript 48).

On the one hand, this statement reflects the immense political impediments to creating a new mandatory social program in the United States. Moreover, mandates had become a particularly contentious issue during the wider health reform debate. The requirement that all U.S. citizens have some form of acute medical coverage or pay a fine (the individual mandate) was a key component of the strategy used by Congressional leaders and the Obama Administration to expand medical coverage, and was necessary in order to keep the insurance industry from opposing health reform all together. Thus, the mandate to buy acute medical coverage took priority over any other potential mandate, in particular, mandated participation in the CLASS program. The statement also demonstrates a gap between the perceptions of what exists and what is in fact reality in the U.S. The strong perception still resonates that social protection should be provided through private provision and market forces; despite the existence of Social Security, Medicare, and Medicaid, which are all large public programs that provide benefits to millions of Americans. This enduring belief impacts the decisions of U.S. policymakers, who tend to support policies that attempt to mitigate social and economic risks through private, pro-market driven mechanisms.

A Practical Approach to Reform

Despite widespread support for the CLASS Act amongst advocates, LTC providers, and Democratic Congressional staff, interviewees suggested that there was a certain level of disappointment amongst LTC advocates and progressive Members of Congress that a more generous benefit was not pursued. After all, while CLASS would have established a new LTC benefit, the program was not designed to provide a comprehensive LTC financing option. According to a staffer for a Congressional committee that had legislative jurisdiction over the CLASS Act:

“...people were concerned that it wasn’t a robust enough benefit. But you know the whole thing with the CLASS Act is that it’s meant to be like limited supports and services coverage to help people. It’s not meant to be nursing home coverage. It’s an initial step in the right direction” (Congressional Staffer, Transcript 21).

This statement appears to demonstrate a sentiment shared by many participants from aging groups and Congressional staff that the benefits provided through the CLASS Act would ideally have been much greater. However, given the numerous fiscal and political constraints of creating a new financing mechanism, a partial benefit was more politically palatable. After several unsuccessful attempts at expanding coverage for LTC, the stakeholder groups were ready for a success—even if that success did not produce comprehensive coverage. Thus, any disappointment amongst advocates, LTC providers, or Congressional staffers about the benefit levels of CLASS was noticeably tempered by their recognition that CLASS represented a practical approach to achieving a legislative success on LTC reform.

The practical matter of the potential cost of expanding coverage for LTC also permeated the entire legislative life of the CLASS Act. Proponents of the legislation, from

the aging and disability advocacy groups as well as LTC providers, pointed to cost as an explanation for a partial rather than comprehensive benefit. Given the design parameters of CLASS, a comprehensive benefit would not have been possible without the use of mandatory participation or general revenue to bolster the program's resources. According to the government affairs director of a LTC provider trade association that supported CLASS:

"I think everyone in the room understood that everything is based on scoring and finances at the federal level—the fiscal impact! I think we all recognized that it [CLASS] wouldn't pass if we made it unrealistic or unaffordable" (LTC Provider, Transcript 41).

This support again reflects a willingness on the part of proponents to make any necessary concessions to achieve a legislative victory on LTC financing. In fact, several respondents, especially those who had worked on other pieces of legislation over the years, observed that no piece of legislation can ever be perfect, and that a victory, even if less than ideal, was the best possible outcome. However, this also reflects the fiscal environment of the first two years of the Obama Administration (e.g. the 'Great Recession' and the large federal budget deficit), which had a tremendous impact on the accepted cost of any measure contained within the wider health reform legislation. Despite the compromises, most respondents, particularly those from the disability and aging advocacy groups as well as Congressional staffers and LTC provider representatives, stated their great enthusiasm for the CLASS program as it was constructed. In fact, there was a surprising level of consensus on the outcome of the legislation amongst the different categories of participants. Respondents from the insurance industry remained a notable outlier, frequently reaffirming their objections to the structure of the program.

Interestingly, the programmatic details of the CLASS Act, when compared to other pieces of American social legislation, were loosely defined. Several specific provisions of the CLASS program were left to be determined by the Secretary of Health and Human Services during the implementation process. Furthermore, out of the 906 page health reform legislation that passed in 2010, only 19 pages were specifically dedicated to establishing the CLASS program (Patient Protection and Affordable Care Act, P.L. 111-148, 2010). In stark contrast, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173) was 415 pages in length. The format of the CLASS legislation was more similar in structure to legislation produced in other countries such as the United Kingdom, where "enabling legislation" is often used to establish new programs or government agencies.

Passing the CLASS Act: Why 2010 was Different

Issues of Cost and Financial Viability

The financial impact of legislation is typically a highly controversial issue when debating social policy in any country, including the United States. Policies that provide benefits to specific populations require a revenue source, which inevitably results in a debate over the appropriate level of cost. Cost was a major problem for previous attempts to create a new LTC financing system in the United States. The CLASS Act was also subject to intense scrutiny over its projected costs, however it was the first proposal that did not have a negative impact on the federal budget. The projected savings of CLASS contrast sharply with the Congressional Budget Office's (CBO) estimates from 1994 of the projected costs of the Clinton LTC plan.³⁸ The financial impact of reform defined the entire health reform process of 2009-2010. The Obama Administration and Congressional leaders agreed early on that the total fiscal impact of reform could not exceed \$1 trillion dollars. This fiscal threshold defined all possibilities for health reform, including LTC financing reform and the CLASS Act.

The U.S. Congress heavily relies on the CBO's projections for the cost and impact of potential legislation on the federal budget. The budgetary projections of the CBO have, therefore, become highly important to all pieces of federal legislation that may have any financial impact. This is particularly true of policies that expand social protection. Given the cost parameters of health reform, participants unanimously cited the significance of the CLASS Act's CBO score, which projected a surplus ranging from \$58 billion to over \$70

³⁸ For comparison, the LTC provisions of President Clinton's Health Security Act of 1993 were projected to cost \$60.2 billion in the first five years of operation (ASPE, 1994).

billion over the first ten years of the program's operation (Elmendorf, 2009; 2010). According to a LTC provider trade association representative with several years of experience assessing the impact of the cost of legislation that funded LTSS:

"...the whole thing [health reform]...it was driven by CBO and the cost estimates. And no one gave it [CLASS] a second thought when it came with a \$75 billion savings" (LTC Provider Representative, Transcript 17).

This statement demonstrates the significance of the cost savings that CLASS was projected to produce in its first ten years of operation to its own legislative success as well as that of health reform more broadly. The projected surplus provided a pragmatic reason to support CLASS, particularly considering the fiscal environment in which health reform was situated. The projected savings were highly important for reducing the wider budgetary impact of health reform, which both Congressional leaders and the Obama Administration were striving to keep under \$1 trillion. If CLASS had not been included in the package of reforms, Congressional leaders would have been forced to make cuts to other components of the legislation. This would likely have proved highly unpopular given the legislation's already large cuts to Medicare.³⁹

The significance of the projected cost savings of the CLASS Act, however, extended beyond its direct connection to health reform. The vast majority of participants additionally believed that if CLASS had negatively impacted the federal deficit in the short-term, rather than produced a projected savings for the federal government, it would have been removed from the reform package. A representative of a large insurance corporation observed:

³⁹ The majority of cuts were made to payments to Medicare Advantage plans, although Medicare payments for home health and payments to hospitals were also reduced (Elmendorf, 2010).

“...if the CLASS Act had resulted in no revenue or had resulted in negative revenue in the first 10 year period, it’s probably less likely that CLASS Act would have been included in the final [health reform] package. But the fact that it generates...a \$70 billion dollar number, made it too big—particularly for the Senate people putting the bill together—to ignore” (LTCI Insurance Representative, Transcript 1).

Thus, the CLASS Act’s projected surplus was important to policymakers during the health reform process. In the end, CLASS helped to sustain the argument that health reform would reduce the federal deficit by \$138 billion between the years 2010 and 2020 (Elmendorf, 2010). However, the financial solvency of CLASS after the first ten years of operation also produced some controversy during the reform debate. While projecting a large surplus in the first ten years, the CBO projections showed a likely deficit after the year 2029, when program outlays would deplete the funds collected during the initial vesting period. Yet this estimate may have been somewhat flawed given that the CBO is limited to highly specific assumptions in their cost projections and was unable to include the interest earned on the program’s pooled funds in their calculations. Additionally, the CBO’s projections assumed a participation rate of only five percent of the U.S. population, a rate roughly equivalent to the level of private LTC insurance coverage in 2009.

The uncertainty over the long-term financial impact of the CLASS Act provided Members of Congress, who were skeptical of creating a new government program to address the individual economic risks of LTC, ample opportunity to attack the proposed legislation. Several conservative and moderate Democrats expressed specific concern over the financial viability of CLASS and its potential impact on the federal budget. On October 28, 2009, a group of seven self-described ‘moderate’ Senators sent Senate Majority Leader

Harry Reid a letter voicing their opposition to CLASS based on the CBO's long-term cost projections of the program.⁴⁰ The letter from the Senators stated:

"We have grave concerns that the real effect of the provisions would be to create a new federal entitlement program with large, long-term spending increases that far exceed revenues" (Condon, 2009).

Despite the projected initial ten year surplus of CLASS, this letter demonstrates that concern over the potential costs of the program was high, even amongst Congressional Democrats. This sentiment amongst Democrats was problematic for the CLASS Act, and may help explain the high support amongst Democrats for the Thune Amendment.⁴¹ However, the concern voiced by these Democrats did not create enough resistance to derail or significantly impede the CLASS Act during the health reform efforts.

The increasing concern over the potential long-term costs of the CLASS Act provoked Republican Senator John Thune (R-South Dakota) to offer even more scathing criticism of the legislation. Senator Thune became the leader of conservative efforts to fight against CLASS in the U.S. Senate during the health reform debate. On December 4th, 2009, U.S. Senator John Thune (R-South Dakota) proposed an amendment to remove CLASS from the health reform legislation under debate in the U.S. Senate. Amendments to legislation in debate on the Senate floor require 60 votes to pass under senate rules. The amendment ultimately received 56 votes, including several Democrats, but it failed to reach the 60 vote threshold needed to remove CLASS from the wider health reform bill

⁴⁰ The seven Senators that signed the October 28th letter to Senator Harry Reid were: Kent Conrad (D-North Dakota), Joe Lieberman (I-Connecticut), Blanche Lincoln (D-Arkansas), Mary Landrieu (D-Louisiana), Evan Bayh (D-Indiana), Mark Warner (D-Virginia), and Ben Nelson (D-Nebraska).

⁴¹ Eleven Democratic Senators and one Independent voted in favor of the Thune Amendment.

(Montgomery and Murray, 2009). In a speech delivered on the Senate floor leading up to the vote on the amendment, Senator Thune bluntly stated:

“If we don't take this out of this legislation, if we allow this to become law, we are locking in future generations to deficits and debt as far as the eye can see” (Senator John Thune, 2009).

This type of cost-focused rhetoric was the main form of Congressional opposition to the CLASS Act. Whether or not the cost projections were accurate, the long-term budgetary implications provided skeptics ample opportunity to attack CLASS and to stimulate the cost debate. Not every participant believed that having a negative revenue impact would have led to the removal of CLASS from the wider health reform package. Yet, all the participants unanimously agreed that any short-term cost, no matter how small, would have made the legislation's staying power very low. This was particularly true given the concerns raised by Republicans like Senator Thune and the moderate Democrats about the long-term solvency of CLASS. Interviewees from advocacy organizations were more sanguine about the legislation's chances with a small cost than participants from other stakeholder categories, but even those respondents demonstrated the significance of the budgetary score provided by the CBO.

Anti-Statist Attitudes

The role of the state in the provision of social protection is a contentious issue within the American political environment (Quadagno and Street, 2005), and is widely argued to be viewed with great skepticism (Lipset, 1996). Despite several characteristics of a private financing mechanism, the CLASS Act would have established a large,

government-managed program that would provide a cash benefit to participating individuals if and when they had a need for LTSS. Collected funds would be pooled in government backed bonds rather than the stock market. Proponents of CLASS, from the advocacy groups and LTC providers, often noted this characteristic with enthusiasm. Conversely, those opposed to CLASS, mainly participants from the LTCI, noted their belief that the true intention was a greater government presence in LTC financing. However, these concerns were largely absent from the arguments either for or against the CLASS Act during the actual debate on the legislation. Despite receiving little attention during the debate on health reform, a majority of participants believed that the Act's implications regarding the role of the state would have been highly controversial had CLASS been a standalone piece of legislation.

Indeed, the CLASS Act was never as politicized, at least publically, as the more controversial parts of health reform, such as the Public Option or the individual mandate for acute medical insurance.⁴² As a comparatively small component of the wider legislation, participants believed that CLASS was largely shielded from the ideological attacks on “too much government.” Instead, the main ideological debates within health reform focused on the establishment of a publicly managed insurance corporation for acute care (Public Option) and the government's ability to legally mandate some form of health coverage for everyone. In place of direct ideological questions about the appropriate role of the state in financing LTC, several participants stated that opponents of CLASS made the strategic decision to focus their attention on the program's financial solvency. This decision was attributed to the overarching saliency of cost within the entire health reform

⁴² The Public Option was an unsuccessful proposal within the 2009-2010 health reform process, which would have established a publicly managed insurance corporation for acute medical to compete against private U.S. health insurers.

process. Other participants countered that the focus on financial viability was a strategic miscalculation on the part of opponents. This included participants from the LTCI industry who additionally noted that directing attention to lobbying efforts in Washington, DC, rather than a highly public campaign against the CLASS Act was a miscalculation. A LTCI representative described the insurance industry's role in the debate on CLASS:

“...the insurance companies supported organizations that lobbied and that certainly was important. But they did nothing to play this out in the public domain...in the press...and so, CLASS could have been killed, I believe, just by pointing out that it is the Trojan Horse leading to more public LTC insurance...” (LTCI Representative, Transcript 14).

Thus, whether intentional or not, the opposition to CLASS was largely focused behind the scenes in Washington, DC, and out of the public debate on health reform. Several participants believed that the lack of philosophical attacks on CLASS allowed policymakers to focus on how to make the program pragmatically operational rather than on a philosophical justification for the program. Congressional staffers stated that Republicans and the opposition from within the LTCI industry would have united in their efforts to fight against CLASS if it had been debated independently of health reform. In fact, when significant attention was directed at CLASS, it came under attack. While unsuccessful, the Thune Amendment vote came very close to removing the CLASS Act from health reform. Participants offered this vote, which CLASS just barely survived, as evidence that it would not have been able to survive similar attacks if had been advanced separately from health reform.

Political Institutions, Policy Legacies and the CLASS Act

Stakeholder Groups and Existing Financing Arrangements

While the existing LTC financing arrangements had been in place for a relatively long time prior to the passage of the CLASS Act, the perceived efficiency of the operation of these arrangements was a significant issue throughout the reform process. Indeed, the perceptions of policies often impact the reform debate and what type of reforms are proposed (Béland and Waddan, 2012; Weir, 1993). The perceptions of policymakers also sheds light on the design of the CLASS Act and the possible limits of any future LTC financing reform proposal pursued by U.S. policymakers.

Over the years, advocacy groups that represent the aging and disability communities had fought to expand and improve the Medicaid program. There was a realization amongst all stakeholders that the current financing arrangements were unable to adequately provide for the majority of Americans who require LTC. Thus, the traditionally supportive stakeholders concurrently demonstrated very high levels of dissatisfaction with Medicaid. A predominating concern for these organizations was Medicaid's bias toward financing LTC in institutional rather than home settings.⁴³ The Medicaid program has a legal obligation to fund institutional (nursing home) care for anyone who meets the criteria to be a beneficiary. It does not, however, have the same obligation to fund home and community based services (HCBS). The specific problems Medicaid poses for younger, disabled Americans were summed up by the leader of a major disability advocacy group, which supported the passage of the CLASS Act:

⁴³ Although several states have been granted waivers to use their Medicaid dollars to fund HCBS, certain states are more aggressive at pursuing them such as Minnesota and Washington, which in 2011 spent more on HCBS than institutional care (Reinhard et al. 2011).

“Medicaid wasn’t really designed to meet the needs of people with significant disabilities. Over time it’s become more generous than Medicare, but Medicaid has an institutional bias so to a large extent, depending on what state you live in, if you want the government to help you pay for your LTC needs you’re probably going to have to end up going into a nursing home” (Disability Advocate, Transcript 50).

Despite playing a significant role in funding LTC for disabled Americans, Medicaid’s support amongst this stakeholder group was limited. For years, groups representing the disabled had advocated for decreasing the institutional bias of Medicaid. Despite significant advances toward making HCBS available through Medicaid (Thompson and Burke, 2009), this bias remained a huge concern for the constituents of these groups. The CLASS Act presented an alternative to the Medicaid funding mechanism that perpetuated that unwanted bias.

Furthermore, participants from advocacy groups often noted the stigmatizing effects of means-testing, the criteria used to determine eligibility for Medicaid benefits.⁴⁴ The means-testing requirement of Medicaid necessitates impoverishment, a major concern for disability advocates, whose constituents might spend an entire lifetime in poverty so that they could qualify for adequate care. These unintended effects of Medicaid were recognized as highly problematic by representatives of both the aging and disability policy communities. A staffer for a major aging advocacy organization that actively supported the passage of CLASS observed:

⁴⁴ In order to qualify for Medicaid LTC assistance, an individual must spend down their assets to meet the program’s means-tested requirements. Institutional Medicaid recipients must contribute all of their income towards the costs of their care, except for a \$90 monthly personal allowance and can only retain assets valued at \$2,000 or less, although a house is generally exempt from this requirement if the beneficiary has a spouse (Johnson, 2008, p. 397).

“Medicaid and means-tested programs have a stigma; they are for certain people. You have to spend down [your assets]. You have to be poor. The whole point [of reform] was that you shouldn’t have to spend down and make yourself poor to get the services you need to live in your own home” (Aging Advocate, Transcript 15).

For aging advocates, means-tested benefits were highly problematic as many of their constituents had worked their entire lives, had acquired some savings, and owned a home. Older Americans who require LTC often have to spend down their assets before they can receive any public assistance to pay for their care. In addition to being forced into poverty, the use of Medicaid also ensures they are unable to leave their children an inheritance. Medicaid was therefore seen as an insufficient way to meet the needs of the constituencies of the aging and disability advocacy groups. Thus, there appears to be weak support for Medicaid, the largest existing public LTC financing mechanism in the United States, from the groups that represent the individuals who benefit most from the program.

Long-term care providers and their trade associations also demonstrated limited support for the existing financing arrangements under Medicaid. Participants from LTC provider trade associations often noted the smaller payments made by Medicaid to LTC providers compared to other revenue sources. Unlike aging and disability groups who have supported expanding social insurance for years, LTC providers traditionally advocated for the greater use of private insurance in financing LTC. One provider trade association representative bluntly stated their opinion of Medicaid and its subsequent impact on their residents’ quality of living:

“The [Medicaid] payments are hideous. Half the states don’t even subsidize it. It covers about half the cost of room and board so they [the resident] might have to have a roommate” (LTC Provider Representative, Transcript 33).

This statement demonstrates the general dissatisfaction of LTC providers as a stakeholder group with Medicaid as the primary financing mechanism for LTC. They also highlighted the negative impact of limited and fluctuating benefits on the vulnerable populations they served. The above participant's statement also highlights the instability of Medicaid as a funding mechanism due to the way that individual states and the federal government share joint jurisdiction over the program. Medicaid payment rates are subject to fluctuation based on politics and budgetary cycles at both the state and national levels as both federal and state government have responsibility for funding the program. This creates great uncertainty for LTC providers and fluctuations in who has access to LTC.

The recent economic crisis, and its subsequent impact on state budgets, accentuated the potential problems associated with joint jurisdiction. State governments receive matching funds from the federal government when they spend resources on Medicaid, and therefore have an incentive to spend more on Medicaid services. Medicaid accounted for almost 24 percent of all state spending in 2010 and was the single largest expenditure made by state governments (National Governors Association, 2011). Moreover, state governments do not have the legal authority to run budget deficits.⁴⁵ In times of financial austerity when a short term deficit might allow a state to maintain Medicaid benefit levels, they often turn to cutting services. A representative of a LTC provider that operates care centers across the United States elucidated on the current budgetary cycle's impact on Medicaid funded services:

“As the economy is kind of cranking down and tightening, especially for states, we are effectively already looking at situations where states are slashing services for the young

⁴⁵ Vermont is the only U.S. state without some form of a balanced budget requirement within its state constitution (Dilger, 2012).

disabled and also for seniors, especially those [states] with optional choices [for care settings]” (LTC Provider Representative, Transcript 44).

While Medicaid is the main source of revenue for many LTC providers, their support of the program as a stakeholder group was apparently limited. Medicaid’s benefit levels were problematic for both non-profit and for-profit providers as well as those who offer traditional, institutional care and others who had significant HCBS operations. The disability advocacy group’s desire to move away from Medicaid is striking given its traditional role in financing the care of their population. The aging community was also supportive of moving away from Medicaid, although their opposition appeared more tempered than the disability groups. Taken together, this appears to demonstrate that support for the existing financing arrangements was low amongst all the major stakeholders within the LTC policy arena.

The majority of public spending on LTC in the United States takes place through the Medicaid program. By the time President Obama took office in 2009, the growth of public spending on Medicaid, as well as other social programs, was a central issue within the American policy arena. Many interview participants believed that the feat of financing a substantial portion of LTC costs through Medicaid helped to focus the attention of policymakers on the need for major reform of LTC financing. However, it took several years to reach the point where reform, like the CLASS Act, could occur. Participants often noted that the CLASS Act was not a policy response to a sudden crisis in LTC financing, but rather the product of the slow realization that the financing arrangements were failing and that a new financing mechanism was necessary. Thus, they said that the multitude of challenges confronting the LTC financing system became more apparent to policymakers

with time. The most notable challenge was the increasing life expectancy of the U.S. population that led to more people in need of LTSS each year. According to the director of a research organization focused on policies affecting the health of older adults:

“CLASS is a very important new entry into that new [LTC] sphere and sooner or later something was going to have to happen. I would argue that it didn’t happen out of the blue. There is kind of an important, unmet need that has only become more obvious to policymakers as people live longer. If you think about life expectancy in 1960 compared to the life expectancy now and what the level of functional limitations is in that new last ten years—it is dramatically different”(LTC Policy Expert, Transcript 31).

This statement highlights the gradual shift in the demographics of the United States that began to unfold in the late 2000s. When Medicaid and Medicare were originally created in the mid-1960s, both the aggregate number of older adults and their percentage of the total population were much smaller than in 2009. The need for LTC was therefore much more limited when these programs were originally created. Thus, while participants noted that consumer advocates, LTC policy experts, and many LTC provider organizations had, for years, been keenly aware of the challenges of financing LTC, the magnitude of the accumulated challenges continued to compound over time. Moreover, these same participants stated that the existing financing arrangements, such as the Medicaid program, were making the problems of the system much more apparent.

The Obama Administration and Congress

In addition to the election of President Barack Obama in 2008, his political party, the Democrats, won large majorities in both the U.S. Senate and House of Representatives. This partisan shift moved the idea of health reform, a long standing goal of the Democratic Party, to the top of the domestic policy agenda. According to participants, this rebalancing

of power was significant to the CLASS Act's success at that particular point in time. According to participants, the traditional roadblocks, or impediments, to social policy within the U.S. political system, most notably the dispersion of power between Congress and the President, were absent after the 2008 election because Congress and the White House were both controlled by the same political party, the Democrats. As such, these potential veto points did not impede the passage of health reform and the CLASS Act. When Republicans controlled these same political institutions, or during the periods of divided government such as between 2006 and 2009, social legislation struggled to move forward. Similarly, health reform would only move onto the policy agenda once Democrats controlled both Congress and the Presidency.

Going a step further, interviewees were specifically asked whether the Obama Administration influenced the success of the CLASS Act. Participants from every stakeholder category agreed that the presence of a Democratic President in the White House was necessary for CLASS to move forward within the legislative process, as the President is important for setting the tone of the policy agenda. However, the Obama Administration's level of interest in the CLASS Act, and LTC financing reform more broadly, was unclear. A senior Congressional staffer, who worked closely with Congressional leaders and the Obama Administration when putting together the final version of the health reform legislation, stated:

"I think the Administration supported CLASS and I think that must have been influential. Their support made it likely that CLASS would survive and stay in the overall [health] bill. If the Administration had opposed CLASS, I think it probably wouldn't have stayed in" (Congressional Staffer, Transcript 35).

This statement suggests that the Obama Administration was at least nominally supportive of the CLASS Act. Several participants reflected that while health reform was a top priority of the Obama Administration, the CLASS Act was not a particularly high priority. They suggested that CLASS simply moved forward because the Administration did not oppose the inclusion of CLASS in the larger health reform legislation. This initial ambivalence by the Obama Administration to LTC financing reform provided an opening which allowed the advocacy community and other policy actors, such as Senator Kennedy and Senator Dodd (D-Connecticut) who directed the HELP Committee's hearings on health reform after Kennedy's ill health prevented him from working, to continue to push for the CLASS Act's inclusion in the wider legislation.

It is interesting to note that President Obama never specifically mentioned the CLASS Act in public speeches or interviews about the health reform legislation during the Congressional debate. However, the Administration publicly demonstrated its support in July 2009, when Kathleen Sebelius, Secretary of Health and Human Services, sent a letter to the HELP Committee stating her support for the CLASS Act. The participants, particularly those from advocacy groups and LTC policy experts, believed the letter from Secretary Sebelius was significant to the process. When asked about the specific role of the Obama Administration, one LTC policy expert stated:

“President Obama never said anything [about CLASS] but Secretary Sebelius sent a letter. And I think that letter mattered. In the absence of that letter or if the Administration had opposed this [CLASS] it probably would have died” (LTC Policy Expert, Transcript 5).

In the final weeks of the health reform process, the Administration also signaled its official support of the CLASS Act.⁴⁶ Thus, the general support of a sympathetic President also appears to have been somewhat significant to the legislative success of LTC financing reform through the CLASS Act. While the Obama Administration was not a primary driver of the CLASS Act, the presence of a Democrat in the White House was necessary for the success of this legislation at this particular juncture.

Legislative Arrangements and Processes

In the American political system, all legislation must be officially proposed or sponsored by a Member of Congress for any legislative action to take place. In the case of the CLASS Act, Congress is also where much of the support of policymakers existed, both prior to (2003-2008) and during (2009-2010) the health reform debate, rather than in the Bush or Obama Administrations. The support of Senator Kennedy was significant given his position as a highly respected legislator and well positioned role within the institutional framework of Congress, particularly as the debate on health reform began to unfold in 2009. A LTC policy expert, who held a high ranking staff position in Congress before leaving to work in the private sector, and who continued to work closely with Members of Congress and their staff, summed up the relationship between Congress and the Obama Administration on the CLASS Act:

“Congress was definitely the driving factor...I think Congress gets credit for CLASS being in there...I think he [Obama] really let Congress take the lead on it [CLASS]” (LTC Policy Expert, Transcript 3).

⁴⁶ On February 22, 2010, the White House released the only policy specific proposal throughout the health reform process stating President Obama’s priorities for reform. Notably, the CLASS Act was mentioned in this proposal (Whitehouse.gov).

While this statement reflects the Obama Administration's approach to the CLASS Act, it also reflects the overall approach the Administration took to health reform, which unlike President Clinton, left actual content design of the legislation up to Congress. At key moments President Obama intervened in the reform debate,⁴⁷ but otherwise the Administration remained largely removed—at least publicly—from the legislative process. This approach contrasted sharply with the health reform strategy pursued by the Clinton Administration in 1993, which presented a bill at the start of the process with very little prior input from Congress. Agreeing with a thesis shared by many scholars of health reform, participants cited the more 'hands on' approach of the Clinton White House as a major mistake, one the Obama Administration deftly avoided.

The legislative process in the United States provides abundant opportunities at which legislation can be stymied by opponents. The rules and procedures of the U.S. Senate provide several points where legislation can be easily slowed or blocked. While these rules and procedures are intended to protect the rights of the minority party, they are often used tactically by those opposed to controversial legislation, particularly social policies.⁴⁸ This is still the case if one political party controls both houses of Congress, even by wide margins. In turn, this impacts the types of policies that are actually considered. Policies that are too bold attract the use of procedural tactics, which creates gridlock and, ultimately, often the demise of that particular policy. The rules which govern U.S. Senate procedure for debating and voting on legislation, specifically the threat of a filibuster as an impediment to moving controversial policies forward in the U.S. Senate, were specifically

⁴⁷ A specific example is President Obama's summit with Members of Congress in February 2010 in an attempt to revive the stalled health reform process (Stolberg and Pear, 2010).

⁴⁸ Within the context of the New Deal, Southern Democrats often used the U.S. Senate's procedural rules to impede the passage of social policy legislation (Katznelson et al. 1993; Pierson, 1995).

noted as significant by participants. Since a filibuster is prevented only when sixty or more Senators vote to end debate, which is called cloture, any controversial piece of legislation can be easily thwarted in the Senate. However, it is the mere threat of a filibuster that has become a component of Senate procedures rather than the actual use of the filibuster. Interviewee participants highlighted the “Thune Amendment,” which proposed removing CLASS from health reform. While it received 54 votes, a majority, including those of several Democrats, the amendment failed to cross the 60 vote threshold needed for cloture.

While the majority of debate on CLASS took place in the U.S. Senate, the work of Members of the House of Representatives was also significant to the Act. During the debate on health reform, committees in both the House and Senate were charged with designing the legislation, and multiple committees had jurisdiction over it. In fact, two Senate committees and three House committees were working on health reform during 2009.⁴⁹ The overlap and intersection of Congressional authority over this controversial bill threatened the Act by posing several potential veto points that could have thwarted the further advancement of health reform, and the CLASS Act, in Congress. However, according to several participants, the dispersed authority over health reform actually proved beneficial to the CLASS Act. Firstly, the U.S. Senate HELP Committee’s health reform bill was the first piece of health legislation to pass out of committee during the reform efforts of 2009. This bill contained the CLASS Act, but the overall bill was viewed by many policymakers as liberal Democrat’s ideal version of health reform. According to a LTC policy expert who closely followed the development of the CLASS Act:

⁴⁹ Health reform proposals considered during the 111th Congress: The “Affordable Health Choices Act” (S. 1679) in the Senate HELP Committee; “America’s Healthy Future Act” (no official bill number) in the Senate Finance Committee; the House of Representatives’ “America’s Affordable Health Choices Act (H.B. 3200), a merger of the Education and Labor, Energy and Commerce, and Ways and Means Committee’s work on health reform, which all had jurisdiction over the process.

“The HELP bill comes out and even Democrats are saying this isn’t going to be ‘the bill.’ ...this is kind of what they’d love to see, but this isn’t going to happen. It’s too generous, it’s too expensive...I’m not talking about CLASS...I’m talking about the overall health bill. It’s too generous, it’s too expensive, it’s got this public option...it isn’t going to happen” (LTC Policy Expert, Transcript 5).

In other words, the HELP Committee health bill was the ideal plan of many Democratic Members of Congress from which they could negotiate a bill that could be passed by the entire Senate. Thus, it was significant that CLASS finally moved out of committee in this first Senate health reform bill, but that alone did not guarantee its success. This statement also highlights the multiple points within the legislative process where a piece of legislation, or a specific component of a piece of legislation, can fail. Even if a committee passes out a piece of legislation there are several additional steps through which that bill must pass before it can be voted on by both houses of Congress.

In addition to further steps within a particular legislative chamber—the Senate in the case of CLASS—supporters still must consider how that legislation will navigate the other chamber. This concern was reflected in the responses of several proponents of CLASS, from advocacy groups as well as LTC providers. According to a representative for a highly supportive LTC provider group:

“So we never believed until the very last minute that we [CLASS] were going to stay in...because we all knew that we [CLASS] were very close to being stripped at every critical moment along the way” (LTC Provider Representative, Transcript 6).

In order to increase the chance of success, proponents of the CLASS Act spent a great deal of time attempting to secure sponsors in the U.S. House of Representatives. The two main sponsors of CLASS in the House were Representatives John Dingell (D-Michigan) and Frank Pallone (D-New Jersey), the Chairman of the Energy and Commerce

Committee's sub-committee on health care. Their support was secured long before President Obama was elected and health reform moved onto the legislative agenda. Much like Senator Kennedy, Representative Pallone was institutionally well-positioned to influence the health reform legislation. Thus, several participants emphasized that the significance of including the CLASS Act in the House Energy and Commerce Committee's health reform bill, as it meant that CLASS was in health reform legislation in both the House and Senate. CLASS's inclusion in legislation from both chambers did not guarantee its success, but this helped to strengthen its ability to further navigate the legislative process.

Patient Protection and Affordable Care Act: A Legislative Vehicle

The fact that the CLASS Act was embedded in the wider health reform legislation of 2009 was significant to its success. Participants were asked about the relationship between the CLASS Act's legislative success and its passage as a part of the Patient Protections and Affordable Care Act (PPACA). A majority of participants had several years of experience working with LTC legislation and were well positioned to speak about the legislation's ability to pass through Congress. Overwhelmingly, participants agreed that CLASS would not have passed as an independent piece of legislation, at least not for a very long time.

The inability of the CLASS Act to pass as an independent piece of legislation was often attributed to timing and the way the U.S. Congress operates. As mentioned in the previous section, the sheer amount of legislation that must be addressed in any particular session of Congress means that smaller bills such as the CLASS Act must be packaged

along with a larger piece of legislation in order to be voted on by the full House or Senate. According to a policy consultant who specialized in aging policy, and who had tremendous experience working on several successful as well as unsuccessful pieces of legislation:

“We’ve all learned our lesson about standalone bills: in this environment they’re tough to get passed...the rules, the mechanisms and the politics really prevent a large number of free standing bills to come forward, forcing you to look for the catch-all umbrella vehicle that you can put it as a part of” (LTC Policy Expert, Transcript 3).

Numerous pieces of legislation are introduced in each session of Congress; however, relatively few ever make it through the entire legislative process to become law. This is particularly true of policy issues that are not of high political saliency amongst legislators or the public at large. They need a larger legislative issue—health reform, in the case of CLASS—in order to advance within the policy process. To some degree this is a capacity issue as Congress is simply unable to address all the pending legislation in a particular legislative session. When a policy issue lacks wider political saliency, the institutional structures of the U.S. political system often prove insurmountable without a larger legislative vehicle to help circumvent them.

Several participants from the aging advocacy groups suggested the CLASS Act, or a similar reform proposal might have passed as an independent piece of legislation ten years in the future when changing demographics, and the financial costs of care associated with those changes were too much for the system to bare, forced policymakers to address LTC. But there was unanimous consensus amongst all the stakeholder categories that without a larger, related legislative vehicle like health reform, the CLASS Act would not have passed at that time.

Analysis and Discussion: LTC Reform and Ideology, Political Actors, and Institutions During the Obama Years

Several significant themes have emerged from the findings in this chapter, contributing to an explanation for the eventual passage of the CLASS Act at that particular juncture in American politics. The first of these findings was the importance of the opt-in approach that was included in CLASS in the final weeks of the health reform debate. A voluntary opt-out for enrollment was part of the design of CLASS for most of its legislative life; however, this was dropped for an entirely voluntary, opt-in approach. According to participants, this late change reflected the concern that even an opt-out would be viewed as a mandate for employers, who would have been charged with enrolling their employees in the program. While the actual preferences of particular stakeholders like business are difficult to accurately gauge (Hacker and Pierson, 2002), the stated preference of actors within the policymaking process can help to provide some insight into the ability to bring about comprehensive LTC reform in the United States. Interestingly, Martin (2000) found that U.S. employers are often supportive of mandates for health insurance. This study of firm preferences for employer mandates showed that support is higher than opposition to this type of policy (Ibid, p. 103). The actual significance of LTC coverage to business, however, is much less clear than health insurance as few U.S. employers offer LTCI as a benefit. In any case, the chance of a mandate for the CLASS Act had been lost during health reform's intense struggle over the individual mandate for acute medical insurance. Policymakers opted instead to leave it to the government to persuade employers to enroll their employees in CLASS—with no financial incentive—and to persuade individuals that joining CLASS was in their best interest.

The findings also suggest that the CLASS program reflects deference to the strength of an anti-government sentiment within U.S. political culture (Huntington, 1981). It appears that policymakers crafted a voluntary opt-out approach for participation in CLASS in order to mitigate that concern. Mandatory participation in CLASS would have opened the legislation up to attacks from conservative Members of Congress and their allies who opposed any form of mandate. In the final weeks of negotiations the voluntary opt-out was removed because many policymakers still viewed it as “too much government intervention,” and would put the entire health reform at risk. A completely voluntary approach was selected as the way to manage enrollment in the program. Thus, while the financing arrangements of CLASS diverge from the conservative ethos, the arrangements also appear to demonstrate the strength of the conservative, individualistic, and pro-market ideology within American social policy.

Another factor explaining the legislative success of the CLASS Act was revealed in most participants’ highly pragmatic view of the Act, their overall acceptance that it would be a partial benefit due to the current political environment, and the great difficulties associated with expanding coverage for LTC. Some disappointment did exist amongst LTC advocates and left-leaning Members of Congress that a comprehensive social insurance approach was not pursued during the health reform debate. However, their disappointment was tempered as support for the CLASS Act grew, making it a clear vehicle for achieving a legislative success on LTC reform.

The design of the CLASS Act reflected an inherent tension in American political culture over the role of the state in social policy. On the one hand, as a large government-managed insurance program, CLASS is an example of American policymakers

transcending their distrust of government to expand state authority (Quadagno and Street 2005, p. 56). However, CLASS reflects a commitment in American social policymaking to individual risk and responsibility (Ibid, p. 56). Participation is completely voluntary and the program uses individual contributions rather than tax dollars to fund itself. Additionally, the CLASS Act does not attempt to displace the private insurance market; instead, it is intended to provide a platform from which the private insurance market will be able to expand. These diverging characteristics of the program blend what participants often believed were the best aspects of both a private and a public approach to LTC financing.

The research findings may suggest that the success of CLASS is representative of an entanglement of liberal and ‘illiberal’ social policy as defined by King (1999), who argued that American policymakers can, when necessary, employ ‘illiberal’ policies in order to achieve solutions to a particular problem or crisis (1999, p. 26). King contends that liberal Democratic governments often do this while proclaiming their compatibility with liberal values, including illiberal social policies that are advanced to achieve liberal ends (Ibid, p. 26). In this case, the federal government’s role in LTC financing is clearly increased by the establishment of the CLASS program in order to address a serious policy problem. However, the legislation introduces a large government program to move the current financing system toward a public-private partnership that emphasizes the role of the private market and the individual. The values of personal responsibility, self-sufficiency, and independence were therefore not just key components of CLASS’s design, but a basis for arguments made in support of the program. CLASS proponents did not focus on the need for government intervention, but rather on how to use these traditionally

liberalist values to foster self-sufficiency and lead to a reduction of government spending. These findings, therefore, appear to provide some evidence for King's argument that 'illiberal' social policies are enacted to obtain liberal ends.

The CLASS Act does not squarely align with the anti-statist, pro-market, and highly individualistic ethos of American political culture that many scholars (such as Lipset, 1996; Huntington, 1981; King, 1973; and Hartz, 1955) contend drive policy outcomes. First, CLASS builds on a financing system where the government is already the primary payer of care through the Medicaid and Medicare programs. Second, CLASS is a large government insurance program with the potential to compete against private insurance. Although policymakers intended for CLASS to work in tandem with the private insurance market, many within the LTCI industry viewed CLASS as a potential competitor and therefore a threat. Interestingly, the majority of interviewees from the LTCI industry stated a belief that the federal government and private industry could work together to stimulate greater usage of private LTCI as a way to cover a wider section of the American public's possible LTC needs, which appears to be congruent with Martin's (2000) findings about business support for employer mandates on health insurance. However, the insurance industry was largely unconvinced that the CLASS Act could achieve that aim. This is unsurprising given that many policymakers and advocacy groups initially wanted to create a comprehensive social insurance program to finance LTC. Although they concluded it was not possible at this time, several proponents viewed the CLASS program as a "foot in the door" for social insurance; at a later point, policymakers could decide to make the program mandatory or turn to redistribution to fund participation of low-income

Americans. If laissez-faire market policies drove all policy outcomes in the U.S., the CLASS Act would not have been a likely mechanism for reform of LTC financing.

In stark contrast to the Clinton Administration's LTC reform proposal in the early 1990s, the projected costs of the CLASS Act contributed to its own legislative success as well as that of the wider health reform legislation. All participants unanimously agreed that any cost, no matter how small, would have made the legislation's staying power in health reform very low. All respondents agreed that the cost projection or 'score' provided by the Congressional Budget Office (CBO) was a significant factor for the passage of the Act.

The 'Great Recession' had reduced the federal government's short-term ability to generate tax revenue, while concurrently eliminating jobs, which in turn increased the costs of all social safety net programs (Jacobs and King, 2009, p. 23), including Medicaid, just as more Americans turned to these programs for assistance. Controlling the growth of health care spending was a significant driver of reform irrespective of the recession; however, this wider context of an economic crisis added further fuel to the imperative to reduce health care's impact on federal spending (Hacker, 2010; Jacobs and Skocpol, 2010). A broader fixation on budget deficits, social programs, and fiscal austerity was not a new development and had been percolating for years prior to the recession (Pierson, 2001). The CLASS Act's projected surplus of \$70 billion dollars was simply too much for policymakers to ignore, particularly when they were attempting to find sources of revenue to offset the overall costs of health reform. Every other major LTC financing reform proposal in the last twenty years would have created at least some claims on federal revenue. CLASS generated a budgetary surplus and therefore would reduce the federal deficit in a political environment where that deficit was a high priority.

According to a theory of path dependency, major shifts in policy often occur through exogenous shocks, or critical junctures, to the system in which that policy is situated (Pierson, 2000; 2004). However, an explanation for the success of the CLASS Act based on an exogenous shock does not appear to apply. No imminent crisis, or immediate threat, to the U.S. LTC financing system was cited by participants as the motivation for reform, though participants did cite the changing demographics of the United States—particularly the aging of the baby boom generation—as important for addressing LTC financing reform at that time. The issue of demographic change was not a sudden threat to the LTC financing system. A growing aging populace that continues to require more LTC contributed to a sense of need for reform over time rather than a major shock to the system that required immediate resolution. Nevertheless, it is worth noting that the demographic issues may not have been apparent to policymakers in the early 1990s when major LTC reform was previously proposed as a part of the Clinton health reform proposal. In short, shifting demographics produced an accumulative effect rather than a critical shock to the LTC financing arrangements.

Participants pointed out that LTC financing arrangements prior to the CLASS Act were relatively stable with only minor, or incremental (Dahl, 1963; Lindblom, 1959; 1979), reforms taking place on the edges of Medicaid and through tax incentives to make private insurance more appealing to individuals and employers. When substantial reform occurred, a major realignment of the financing system did not happen. Instead of a social insurance system that replaced existing financing arrangements, a voluntary insurance program, the CLASS Act, emerged as the vehicle for reform. Participants also noted this new program did not displace the existing arrangements; rather, the Medicaid program and

private insurance will continue to be significant LTC financing mechanisms along with the CLASS program. Although, it was hoped that CLASS would improve the way these other mechanisms operate. This allowed proponents of reform to sidestep the vested interests of the LTC policy arena, particularly the LTCI and conservatives in Congress, by adding, or layering (Schickler, 2001; Thelen, 2003; Hacker, 2004; 2005; Streeck and Thelen, 2010; Mahoney and Thelen, 2010) a new program to the existing institutional framework rather than replacing the financing system. This approach is similar to the way conservatives had, at key moments, used 'layering' by implementing policies to compete with existing public programs, such as adding private retirement accounts to supplement Social Security (Hacker, 2004, p. 248). Proponents of CLASS were able to capitalize on the election of President Obama, the Democratic Party control of Congress, and the larger legislative vehicle of health reform to expand LTC coverage. This approach suggests the multitude of possible veto players within the U.S. political system (Tsebelis, 2002), such as the insurance industry and conservatives in Congress, were still able to prevent a social insurance system from replacing the existing financing arrangements. As often noted by participants, if the CLASS program were mandatory or had used taxation as a financing mechanism, opposition would have been intense, and the legislation would likely have been unsuccessful. However, as designed, opponents were also unable to prevent the passage of this new program. In effect, the CLASS Act was added on top of existing LTC financing arrangements. Policymakers intended for this new program to draw people away from Medicaid and ultimately toward a greater use of private insurance, through a public-private partnership between CLASS and private insurance.

The design of CLASS offers some insight into the types of social policies that are typically successful within majoritarian political systems like the United States. These policies contrast with those typically found in proportional representation (PR) systems, which tend to have strong welfare states, such as Sweden or Germany, and use redistribution much more readily than majoritarian systems (Austen-Smith, 2000; Iversen and Soskice, 2006; Cusack et al., 2007). Majoritarian political systems often provide their upper and middle-class voters with a guarantee against too many demands for redistribution from working class voters, even when a left-of-center political party controls the main levers of institutional power (Cusack et al. 2007). Shifting demographics and economic turmoil have further reduced the capacity of all governments—particularly those controlled by left-of-center political parties—to carry out increased redistribution (King and Woods, 1999). Others contend that 'catch-all' parties tend to dominate western democracies like the United States (Kirchheimer, 1966), which seek out voters by eschewing strict ideologies for a centrist approach in their political platforms and policy pursuits. Thus, even though the CLASS Act passed into law under a left-of-center President and Congress, and established a new government-administered financing mechanism for LTC, the program was unlikely to be highly redistributive and is again why CLASS could be characterized as a middle of the road approach to providing social protection.

Participants often noted that the Presidency and both Houses of Congress were controlled by a single party—the Democrats—by the time the CLASS Act became embedded in the overall health reform legislation. Furthermore, the Democratic Party's majority in both the House and Senate was large enough to overcome traditional

institutional barriers to enacting social legislation. Policy stalemates are less likely to occur under single party dominance of the political institutional arrangements, as party leaders share similar ideology, as evidenced by Senator Kennedy's ability to embed the CLASS Act within President Obama's health reform bill, and the subsequent legislative success of both. When a single party controls both branches of government, the minority political party faces great difficulty in moving their policies forward, which appears to be the case for the CLASS Act in the years between 2003 and 2005. Similarly, when divided government exists, as from 2006 to 2009, a policy stalemate will often occur (Weaver and Rockman, 1993). The participants believed that prior to the 2008 election the partisan control of the Presidency and the Congress prevented CLASS from moving forward legislatively, since George W. Bush, a Republican, was President and the House was under Republican control until 2006.

The findings highlighted several potential institutional veto points within the U.S. political system, which could have impeded the legislative success of the CLASS Act. The main veto points were the President and the two chambers of the legislature, the House of Representatives and Senate (Tsebelis, 2002). Congressional committees were also discussed as significant, as were the procedural operations of the U.S. Senate, such as the filibuster and cloture (Wawro and Schickler, 2006). These findings are generally congruent with Immergut (1992) and Steinmo and Watts (1995) who contend institutional veto points often impede social policy initiatives in the U.S. as they offer vested interests tremendous influence over the policymaking process. Scholars argue that this is particularly true of attempts to reform U.S. health care policy (Hacker, 2002; Marmor and Oberlander, 2003; Oberlander, 2003), where interest groups have been particularly adept at exploiting the

institutional arrangements of the U.S. political system. This is also congruent with an assertion that the increasing use of the filibuster is a significant barrier to policy change and can help explain enduring policy arrangements that are widely viewed as inadequate (Hacker and Pierson, 2010). For instance, the CLASS Act barely survived a vote to remove it from the wider health reform bill.

While the Obama Administration may have been sympathetic to the CLASS Act, the success of the legislation was not ideologically driven by the Administration. Participants often noted the amount of attention devoted by the Administration to other aspects of health reform compared to that on the CLASS Act. Although clearly supportive, as evidenced by the letter of support from Health and Human Services Secretary Kathleen Sebelius to the U.S. Senate HELP Committee in June of 2009, the CLASS Act does appear to have been a particularly high legislative priority of the Obama Administration. Nevertheless, the Obama Administration was institutionally highly significant to CLASS as the legislation had to move through this potential institutional veto point in order to move forward in the legislative process. If the Obama Administration had opposed the CLASS Act, the legislation would not have been included in health reform. The President, with literal veto power over legislation, can set the tone of the legislative process and prevent unacceptable legislation from even being considered (Finegold, 2005).

Arguments about the number of institutional veto points within the American political system also highlight the significance of Congressional committees to successful policy outcomes (Shepsle, 1979; Aldrich and Rohde, 1982; Shepsle and Weingast, 1987; Hall and Grofman, 1990). The role played by the Senate's HELP Committee and the House of Representative's Energy and Commerce Committee in designing health reform

highlights the saliency of the political institutional arrangements as argued by Weaver and Rockman (1993); Steinmo and Watts (1995); and Tsebelis (2002). Since Senator Kennedy and Representative Pallone, the main two supporters of the CLASS Act, chaired the Senate HELP Committee and the Energy and Commerce Committee's Sub-Committee on Health, respectively, participants noted CLASS was institutionally well-positioned at the beginning of the health reform process. In other words, having CLASS in both House and Senate proposals for health reform enhanced CLASS's ability to overcome potential institutional veto points. The significance of both legislative bodies was often pointed to by Congressional staffers and the advocacy groups who worked closely with them on CLASS. Since CLASS was in both a Senate and House bill, the likelihood of being included in the final version of the bill that both houses of Congress would vote on was greatly enhanced.

Furthermore, the findings suggest that the CLASS Act likely would not have passed into law as a standalone piece of legislation when it did given the institutional arrangements of the U.S. political system, despite the alignment of several institutional veto points after the paradigm shifting 2008 election. Participants clearly believed that embedding the CLASS Act into the larger health reform legislation, which was pushed by the Obama Administration and Congressional Democrats, was essential for its passage. The health reform efforts afforded the CLASS Act an opportunity or window (Kingdon, 1995) to move forward within the legislative process. America's peculiar institutional arrangements mean that a glut of legislation in any given session of Congress allows only large legislation—or omnibus bills—with significant political support, to pass through the legislative process. Another factor in the need to include the CLASS Act in a larger piece of legislation was the lack of institutional capacity (Schickler, 2001) within the U.S.

Congress to address a second-tier policy issue like LTC financing after addressing a top tier issue such as health reform. In general, smaller pieces of legislation, or issues of lower political salience, need to be tied to larger pieces of legislation, a need that was reflected in participant responses.

Bulky, complex pieces of legislation necessitate large amounts of negotiation and compromise. American policymakers must ultimately be content both practically as well as ideologically with the contents of the legislation. It is often at this stage where considerable ‘watering down’ of legislation occurs. With particular regard to CLASS, it is at this stage that the voluntary opt-out was dropped from the legislation for fear of its wider impact on health reform. However, this stage links back to the earlier discussion of district interests, or ‘pork barrel’ legislation, which often results in specific components of a piece of legislation having no particular connection to the wider interests of the bill other than helping to win support from a particular Congressman or Senator (Collie, 1988; Evans, 2000; Lazarus, 2010). In the case of PPACA, all the provisions were linked to health care; however, certain provisions, such as the infamous ‘Cornhusker Kickback’ in which the federal government agreed to pay the costs of Medicaid expansion for the State of Nebraska in exchange for Senator Ben Nelson’s (D-Nebraska) support of the entire bill, illustrate this dynamic (Lambert, 2010). While this specific provision was ultimately dropped for a plan to cover the Medicaid expansion costs of all fifty states, this demonstrates how specific district or state interests can be added to the legislative process, which is a necessary component of legislative compromise in the United States.

Summary and Conclusions

Together these three chapters, and the frameworks explored within, begin to demonstrate why LTC reform happened when it did and in what particular format. The findings appear to demonstrate that the decisions of stakeholders were bounded by the institutional and existing policy frameworks that surround the LTC policymaking in the United States, and that the success of the CLASS Act at this particular juncture was at least partially due to those existing frameworks. Particular political actors were able to successfully navigate those existing institutional and policy frameworks to get this legislation included in the wider health reform legislation. The findings in this chapter also demonstrate that practical issues such as cost containment were a primary driver of the Act once it was embedded in the health reform legislation. In stark contrast to President Clinton's LTC reform proposal from the early 1990s, the projected cost of the CLASS Act helped to facilitate its own legislative success as well as that of the wider health reform legislation. Thus, the different explanatory frameworks within this chapter add to an understanding of the success of LTC financing reform that an exclusive focus on an ideological, institutionalist or actor-centered theory would be unable to provide.

The concluding chapter will attempt to draw together the findings presented in each of the three empirical chapters. Moreover, it will attempt to answer several important questions which remain unanswered. First, what does the experience of LTC financing reform through the years of the Clinton, Bush and Obama Administrations, which culminated in the passage of the CLASS Act, reveal about the determinants of policymaking in the United States, specifically the links between ideology, institutions and policy actors? Does the CLASS Act represent a radical shift in thinking on U.S. social

policy provision, particularly about the role of the state versus that of the individual? What might the legislative success of the CLASS Act suggest about the future of LTC provision in the United States?

Chapter Seven: The Demise of CLASS and the Future of LTC Financing in the United States

This thesis has explored the notion that long-term care (LTC) can be deemed a 'new social risk' due to the individual risks associated with the emergence of a post-industrial society and as such, is a significant social policy challenge for the twenty-first century (Taylor-Gooby, 2004; Hacker, 2004; Esping-Andersen, 1999). Comparing the development of LTC financing reform in the United States within the historical framework of the Presidential Administrations of Bill Clinton, George W. Bush, and Barack Obama has helped to elucidate why path-departing reform took place when it did and in what format, exploring why the Act did not pass before President Barack Obama took office in 2009. Indeed, the initial legislative success of the Community Living Assistance Services and Supports or 'CLASS' Act as a part of the Obama Administration's wider efforts at reforming the U.S. health care system in 2010 represented a path-breaking departure from existing LTC financing arrangements in the United States. To date, the CLASS Act is the most significant piece of successful legislation aimed at the LTC financing system since the establishment of the Medicaid and Medicare programs in 1965.

Despite this unprecedented legislative success in establishing a state-led financing mechanism for the provision of long-term services and supports (LTSS), it is important to reiterate that, approximately eighteen months after CLASS was signed into law as part of the Patient Protections and Affordable Care Act (PPACA), the Obama Administration announced its intent to abandon efforts to implement the program. This concluding chapter will review the central findings presented in this thesis and attempt to draw some wider conclusions about the LTC policymaking process and social policy more broadly in the

United States. The chapter will also discuss the Obama Administration's decision to abandon the implementation of the CLASS program. In the aftermath of the demise of the CLASS Act, this chapter will also offer some reflections on the future of LTC financing and the prospects of any future reform effort given the relative influence of ideology, institutions, and stakeholders within the American policy process. Several avenues for additional research on LTC policymaking and policy change will also receive some discussion.

Long-term care financing reform was not high on the policy agenda during the years of the Clinton Administration; however, due to the interconnections between LTC and health, LTC financing reform was able to move forward as a part of President Clinton's Health Security Act of 1993. The shape of reform reflected the expansionist position of President Clinton in that the core of the plan proposed a new state-centered, tax-financed program to cover the individual costs associated with home and community based services (HCBS). When the Clinton health reform efforts fell apart in the fall of 1994, so too did the plan for LTC financing reform. The collapse of the Clinton health reform efforts hastened a move away from large-scale social policy initiatives in the United States (Skocpol, 1996), which seek to expand the role of the state and increase public spending to mitigate the effects of individual social and economic risks associated with illness, disability, or unemployment. This shift away from bold policies in the mold of the New Deal had already begun to take hold in the 1980s under the leadership of President Ronald Reagan (King and Lieberman, 2009). Instead, piecemeal reforms such as the passage of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the establishment of the Federal Long-Term Care Insurance Program in 1999, as well

as legislation that shifted responsibility for the provision of social protection away from existing federal programs—like welfare reform in 1996 (Weaver, 1998), were successful within the American political environment. Even though significant health reform would take place under President Obama in 2010, 1994 was the last time an expansion of social protection in the framework of the New Deal was explicitly invoked by an American President as the appropriate policy response to mitigate personal social and economic risks. In the aftermath of the collapse of the Clinton health reform efforts, changes to U.S. LTC financing arrangements were generally incremental, focusing on a strengthened role for private insurance as a financing mechanism or on establishing demonstration projects and individual state waiver programs that might enhance the efficiency of the means-tested Medicaid program.

Although LTC financing reform was off the national policy agenda in any meaningful way during the years of the Bush Administration, Senator Edward Kennedy and several stakeholder groups within the LTC policy arena worked together to lay the foundation for successful reform. However, the design of the proposed financing mechanism that emerged—the CLASS Act—was highly constrained by the political climate in which it was developed: the early years of the Bush Administration. Furthermore, the lessons of the failed attempt at health reform by President Clinton (Skocpol, 1996), which provided further momentum to a shift away from bold social policy initiatives in the mold of the New Deal that began in the 1980s (King and Lieberman, 2009), were evident within the design of the CLASS Act as it moved away from tax financing to pay for a new program to cover LTC expenses. The concept and design of the CLASS Act, which drew heavily on the traditionally conservative values of

self-sufficiency, independence, and self-reliance, much like Social Security (Derthick, 1979; Lockhart, 1991), would remain largely unchanged throughout its legislative life, even when the opportunity for a bolder reform proposal seemed likely after the 2008 election. This suggests policymakers were already relatively locked-in (Pierson, 2000) in terms of the shape of LTC financing reform by 2009, a shape that was solidified many years before President Obama ever took office. This illustrates the power of historical factors on the American policymaking process.

During the early years of the Obama Administration, LTC financing reform was higher on the policy agenda due to the increased saliency of the issue amongst policymakers, particularly due to the high costs associated with the financing of care through the Medicaid program. No imminent crisis or immediate threat to the LTC financing system in the United States existed, though the changing demographics of the United States—particularly the aging of the baby boom generation—appeared to be an important factor for addressing LTC financing reform in 2009. A growing aging population that continues to require more LTC contributed to building a sense of need for reform over time—a cumulative problem—rather than an exogenous shock to the system that required an immediate resolution (Pierson, 2004; Capoccia and Kelemen, 2007). Furthermore, the advocacy coalition that supported the CLASS Act was stronger and more-unified in their support than in previous attempts at LTC financing reform, which was of a modest help in driving the issue forward. The argument for including CLASS in PPACA was built largely on the projected cost savings and budgetary surplus the program would produce in its first ten years of operation. Once the legislation passed into law, and the implementation process began, however, it became clear the CLASS program would

not be financially viable without several legislative changes to allow greater flexibility in the program's administration. These changes were no longer politically possible after the Republican Party regained control of the U.S. House of Representatives in the 2010 elections.

On the one hand, the experience of the CLASS Act demonstrates a victory for advocates of social reform as it represented a major breakthrough on a policy issue that had eluded advocates and sympathetic policymakers for nearly twenty-five years. Furthermore, the CLASS Act was the most significant policy change to the LTC financing arrangements in the United States since the creation of the Medicare and Medicaid programs in 1965. On the other hand, the CLASS Act reflects a compromise between two competing visions for American social protection. The political success of the design as well as the subsequent inability to implement the program demonstrates how difficult it is to successfully enact social policy reform in the United States.

The legislative success of the CLASS Act does not appear to demonstrate the power of political leadership from the top down. While President Obama was necessary for the health reform debate to take place, the leadership of the Obama Administration was not particularly significant to the success of the CLASS Act. The legislative success of CLASS does, however, demonstrate the power of policy entrepreneurs like Senator Kennedy and organized interest groups. Senator Kennedy, who as a highly respected senior legislator, began to assume the role of a policy entrepreneur on the issue of LTC financing (Sheingate, 2003; Kingdon, 1995; Baumgartner and Jones, 1993; Polsby, 1984). The legislation was developed in such a way so it would be acceptable to the majority of stakeholders within the LTC policy arena. Nonetheless, the CLASS Act was likely never

the first order preference of any stakeholder within the LTC arena as many consumer and care provider groups supported a social insurance system and others, notably the insurance industry, wanted the government to further subsidize private insurance. While the design of the CLASS Act may not have been the first order preference for financing reform of any stakeholder (Korpi, 2006), it was at least acceptable to most of the stakeholders in the LTC policy arena. This type of approach to policymaking suggests that some degree of policy learning (Heclo, 1974; Hall, 1993; Sabatier, 1988) took place on the issue of LTC financing reform as Senator Kennedy and the various stakeholders concluded that a social insurance approach was unlikely to succeed within the American political and institutional framework of the 2000s. He forged a path forward on LTC financing reform that avoided the major impediments to expansions of social protection such as the high cost of a new program, concerns over the appropriate role of government, and the possible displacement of the private insurance industry within the LTC arena.

The inclusion of LTC financing reform within the wider health reform legislation pushed by Congressional leaders and the Obama Administration in 2009 was never a foregone conclusion. On the contrary, while the Patient Protection and Affordable Care (PPACA) Act will likely have profound effects on all aspects of the American health care system, LTC financing reform could easily have been left out of the legislative package due to the complexities of LTC, and the high costs associated with providing coverage for this social risk. Without the strong support of Senator Edward Kennedy, the CLASS Act was unlikely to have been included in the health reform package advocated by the Obama Administration. Senator Kennedy was institutionally well-positioned within the policy process as Chair of the Health, Education, Labor and Pensions or 'HELP' Committee, one

of the two U.S. Senate committees through which any health reform legislation had to pass in 2009. The years Senator Kennedy and his staff spent building support within the LTC stakeholder community meant that the requisite support from many key interest groups existed well-before the health reform debate began to unfold. Hence the impact of a policy entrepreneur and the role of individual advocacy for a particular policy issue are highlighted by the inclusion of the CLASS Act in PPACA.

At first glance, the legislative success of the CLASS program appears to provide some evidence that an expansion of the American welfare state took place. After all, the legislation established a large, federally administered program intended to help mitigate one of the largest personal risks associated with old-age and disability: the need for long-term care. Moreover, the CLASS Act passed under a White House and Congress controlled by the Democrats (Hibbs, 1987; Bartels, 2008), which as a left-of-center political party, is often argued to be associated with higher levels of redistribution (Esping-Andersen, 1985; Rueda, 2008; Bradley et. al 2003). Others contend it is national electoral systems, specifically whether a country has a majoritarian or proportional representation (PR) system, which determine levels of redistribution. Policies supported by policymakers in majoritarian systems like the United States tend not to deviate far from the wishes of the middle—or median—voter (Downs, 1957). These policies contrast with those typically found in PR systems, which often have strong welfare states such as Sweden, and use redistribution more readily than majoritarian systems (Austen-Smith, 2000; Iversen and Soskice, 2006; Cusack et al., 2007). Indeed, on closer inspection it is clear the CLASS Act is not an expansion of the welfare state in the traditional sense. The design of the CLASS Act that emerged during the 2000s reflects a middle of the road approach to social policy

that is less redistributive than other countries that tend to provide more generous public support for the mitigation of individual risks like LTC.

The CLASS Act is deeply embedded within an American sense of problem-solving and reflects a tension and subsequent compromise between an expanded role for the state and the primacy of the individual and free-market forces. The legislation that developed during the years of the Bush Administration is more in line with the concept of individual savings accounts and personal responsibility than shared risk pools to mitigate the costs of old-age and disability. This is most evident because CLASS does not use taxation as a financing mechanism nor does it employ redistribution in the provision of benefits. The program heavily draws on individualistic, pro-market ideals in its concept and design. The objectives of the CLASS program are less about equity and more about equality, which is also typical of U.S. social policy. In short, the emergence of the CLASS Act in the format it took appears to demonstrate that a conservative ideology remains a prevalent theme of the American political environment (Hartz, 1955; King, 1973; Lipset, 1996; Lockhart, 1991). Furthermore, there is evidence within the findings that a proposal to expand LTC coverage was successful in generating sufficient interest because it tapped into these conservative, anti-statist, pro-market, and individualistic values and norms. Thus, the CLASS Act is more closely aligned with the typical forms of social policy that are expected within a majoritarian political system like the United States.

It is highly unlikely that a substantial LTC financing reform proposal would have been legislatively successful at that particular juncture in American politics if its projected costs negatively impacted the federal budget. The projected cost savings of the CLASS Act, estimated as high as \$70 billion by the Congressional Budget Office (CBO), appears

to be a highly significant factor in the proposal remaining a part of the health reform package until the final passage of legislation on March 23, 2010. Policymakers had to design the CLASS Act in a way so that it would be politically successful. However, in order to achieve the projected cost savings, the politically expedient design of the CLASS Act was not properly costed out, which led directly to its eventual demise once the Obama Administration began to implement the program. Nevertheless, the wider focus of the health reform debate on cost control, situated within a framework which stipulated that total reform costs could not surpass one trillion dollars (Hacker, 2010; Jacobs and Skocpol, 2010), provided the CLASS Act an edge that more costly LTC reform proposals would not have enjoyed. Even if an alternative proposal had been crafted in a similar way as CLASS so as to invoke conservative values such as self-sufficiency, and had the enthusiastic support of a senior legislator like Senator Kennedy and most stakeholder groups in the LTC policy arena, if the CBO had scored the proposal as having a negative impact on the federal deficit, its staying power in health reform was likely to be very low. In the end, while ideology, institutions, and stakeholders all mattered significantly to the legislative success of LTC financing reform at this particular juncture, the projected costs of the CLASS program, and more specifically, a large, new revenue source for the U.S. government, was the final piece of the legislative puzzle that propelled the CLASS Act into existence. This contrasts sharply with the experience of LTC financing reform during the Clinton Administration's health reform efforts of the early 1990s, or any other previous reform proposal for that matter, where reform would have actually cost approximately 60 billion dollars over its first five years of operation.

The significance of the CLASS Act's projected cost savings to the passage of this legislation brings into sharper focus the wider budgetary concerns that underpin the current perceptions of all entitlement programs in the United States and the continued economic uncertainty stemming from the financial crisis and recession of the late 2000s. Fiscal anxieties about social programs are not a new phenomenon, however, and have been growing in strength since the logic of the New Deal, and the welfare state more broadly, were first seriously challenged in the 1970s. The decreased economic output of the United States along with lower levels of tax revenue has provided ample space for those opposed to government spending to build a case for fiscal restraint and welfare state retrenchment, while making it increasingly difficult for policymakers to expand levels of social protection (King and Woods, 1999). This has been accompanied by sustained calls for greater personal responsibility in mitigating individual social and economic risks. Yet some of what are labeled as fiscal concerns can be attributed to ideological motivations and vice-versa (Marmor, 2001; Marmor and Mashaw, 2006), suggesting that traditional expansions of social protection remain difficult in the face of what Paul Pierson (2001) refers to as a state of 'permanent austerity,' which more or less confronts all advanced democracies like the United States. This state of fiscal austerity and welfare state skepticism make it difficult to separate out whether fiscal concerns or ideology matter more for policymaking.

The design and passage of the CLASS Act demonstrates the tremendous difficulty in replacing the existing financing arrangements including Medicaid (means-testing) and private insurance with a social insurance system. The private insurance industry remains a powerful stakeholder within the LTC policy arena and has effectively blocked efforts to

create a social insurance program that might undermine their market. The power of this industry has been bolstered by a perception amongst policymakers that expansions of social insurance are simply not politically viable. Moreover, while the Democrat Party may have controlled the institutional levers of power after 2009, that control did not offer them—or any political party—complete dominance over the policy process. The ideology and strength of conservatives would have posed an effective barrier to enacting any new social insurance program that could have replaced existing arrangements, despite many favorable circumstances for bold reform after the 2008 paradigm shifting election. The result of these institutional and political barriers was the CLASS Act, a new program layered on top of the existing LTC financing arrangements. Interestingly, layering is a tactic often employed in the United States by those seeking to undermine stable policy regimes like Social Security or Medicare (Hacker, 2004; Béland, 2005c), whereas in the case of the CLASS Act, layering was used primarily to expand the role of the state in the LTC financing arena.

While the insurance industry and conservatives in Congress remained significant barriers to the creation of a social insurance financing program, proponents of LTC reform were, in effect, able to circumvent them by mitigating much of their stringent opposition in pushing a proposal that drew heavily on the values conservatives traditionally support for providing social protection. Years of engagement between Senator Kennedy and the insurance industry discussing how to shape the CLASS Act in such a way that it might create a viable public-partnership between the private insurance industry and the federal government also dampened opposition, which could have been much more intense if a plan

for reform had been bolder in its ambitions. Through the legislative success of the CLASS Act, institutional change finally took place within LTC financing through policy layering.

Yet, with the demise of the CLASS Act less than two years after its passage, U.S. LTC financing arrangements appear to have returned to a state of policy drift. While drift demonstrates the current state of LTC financing in the United States, drift also suggests that policies will continue to adapt in the absence of major policy change (Hacker, 2005). More specifically, in the absence of significant change, the LTC financing arrangements will become increasingly less adequate as the economic risks associated with LTC grow worse for all stakeholders within the LTC policy arena. The current state of LTC financing arrangements appears to confirm the arguments presented by Hacker (2004; 2005) and Hacker and Pierson (2010a; 2010b) about all forms of social policy in the U.S. and therefore provides a window into the current state of the American political system. However, identifying a state of policy drift, and its roots within the institutions the U.S. political system, does not do enough to explain the implications for LTC financing or its future.

As the U.S. population ages, a crisis will confront the already heavily burdened federal and state budgets, which jointly finance a substantial portion of all LTC expenditures. In the absence of significant policy change, the ability of the private insurance market to offer a viable alternative financing option for LTC will likely be undermined, which could result in increased rates of market failure. The departure of several large insurers from the LTCI market in late 2011 and early 2012 including MetLife, Prudential, and Unum suggests this is a legitimate concern (Ludtke, 2012). As of April 2012, only one insurer, Genworth Financial, was writing new LTCI policies in the

United States.⁵⁰ Most importantly, individuals and families will assume even higher rates of personal risk as they seek to obtain, as well as provide, LTSS within this highly fractured financing system. While the financial issues of the LTC policy arena remain a simmering problem at this time, the significant systemic challenges will ultimately precipitate a full-blown crisis in the absence of reform. Paradoxically, it is likely that a crisis in LTC will inevitably lead to some sort of substantial reform. Whether the change brought about by that reform will produce an adequate solution to these risks or merely provides a short-term fix in order to avert total crisis remains uncertain. Will LTC reform address the growing risks of all the major stakeholders within the LTC arena? Or, conversely, will reform merely seek to reduce the federal and state government's role in financing of care by moving toward greater privatization of the system? Neither outcome will be easy to achieve given the institutional and political roadblocks that exist to significant policy change—either complete privatization or a true social insurance approach—within the United States.

Ultimately, the key findings presented within this thesis suggest that the LTC financing policy process in the United States, like any process surrounding social policymaking, is highly complex. Successful path-departing legislation is difficult to achieve due, in part, to the high costs of covering the care needs of older and disabled adults and the complex institutional framework of the American political system. These policy outcomes result from the interaction between the complex processes and dynamics of the political system through which policy change (or the failure to change) actually occurs. Finally, the fact that the CLASS Act was politically successful, yet

⁵⁰ The insurers that have left the LTCI market will continue to honor all existing policies; they merely will not issue any new policies.

administratively inoperable as designed, reinforces the argument that social policy outcomes in the United States are reflective of a complex, enduring struggle of competing ideologies. This continual struggle, coupled with a heightened concern over cost control and fiscal austerity, helps to ensure that policies which are legislatively successful within the institutional architecture of the American political system are unlikely to produce major expansions of the welfare state. Social change is therefore highly difficult to achieve, even in the face of significant unmet social needs such as the need for a LTC financing system that better mitigates the risks of all the stakeholders within the system. This suggests that comprehensive reform of U.S. LTC financing arrangements will remain an elusive goal for the foreseeable future. Instead, incremental, highly pro-market solutions will be the types of policies promoted in the years of ahead.

The Demise of the CLASS Act: An Epilogue

After the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148) passed into law in late March of 2010, the Obama Administration began its efforts to implement the legislation. Most provisions within the legislation had a delayed start date and would not be operational for a few years. The legislation, for example, stipulated the Administration had two years to implement the CLASS program, although there were benchmarks within the year the Administration had to meet. Indeed, the Obama Administration spent nearly two years designing an implementation strategy for this new program with the intended goal of open enrollment beginning in January 2013. In the final months of writing up the findings of this research, and long after the CLASS Act had passed into law as part of PPACA, the Obama Administration announced their intent to

abandon efforts to implement the CLASS program (Sebelius, 2011). Just two weeks prior to this announcement, the Administration had reiterated their commitment to making the CLASS program operational. This seemingly abrupt reversal in their position on CLASS raises several questions about the program's design and the American political environment in the aftermath of the health reform debate. The decision also poses several questions about the role of institutions and political actors. The demise of the CLASS Act requires a brief discussion to further elucidate the implications of the analysis presented in this thesis and the institutional framework in which U.S. policymakers operate.

In a letter to Congress discussing the outcome of the Administration's efforts to implement the CLASS program, Health and Human Services (HHS) Secretary Kathleen Sebelius wrote: “...*despite our best analytical efforts, I do not see a viable path forward for CLASS implementation at this time*” (Sebelius, October 14, 2011). This letter from Secretary Sebelius accompanied a detailed report from the Obama Administration, which cited the inability to make the CLASS program operational under the stipulations of the legislation. The main challenges cited by the report included the difficulty of enrolling participants without a legal mandate and the inability to project the program's ability as designed to provide benefits to enrollees over the course of a 75 year time frame, as was mandated by the legislation (U.S. Department of Health and Human Services, 2011).

Indeed, the decision not to implement the CLASS Act less than two years after its passage as a part of PPACA was largely a consequence of its design. The institutional framework in which U.S. policymakers operate coupled with a highly partisan political environment focused on reducing government spending and the appropriate role of the state in mitigating social risks amidst the worst economic recession since the Great

Depression were also factors. The same characteristics that this thesis demonstrates helped the CLASS Act to successfully navigate the complex political and institutional environment of the American political system, including the Act's voluntary design, lack of tax-funding, and 75 year solvency requirement, ultimately made it impossible to implement. Former Senator Judd Gregg (R-New Hampshire), author of the Gregg Amendment, which added the 75 year solvency requirement to CLASS, commented during an interview with the Washington Post after the program's collapse:

"I expected that, at some time, it would implode because of the amendment. I didn't think it was a desirable program. I'm surprised at how quickly they came to that conclusion" (Judd Gregg quoted in Kliff, 2011).

Whether or not the initial intent of Senator Gregg was to bring down CLASS, the amendment added a highly constraining provision to the legislation that left the Obama Administration with few options when attempting to make the program operational. This was of concern to many interview participants; however, support for the legislation amongst interview participants did not appear to be muted by the addition of this amendment. While the structural challenges imposed by the Gregg Amendment were noted, it was widely believed that other factors (e.g. voluntary participation and the monthly premium rate required to be actuarially sound) were of greater importance to the success of CLASS. Yet, no other governmental program has a 75 year solvency requirement stipulated in its design. Often the Social Security program is examined within a 75 year solvency window, but that projection is not a requirement of the program's existence. In addition, contributions to Social Security are mandatory, which provides a base point to make long-term assumptions based on population and employment

projections. Nevertheless, the solvency of any program would be tremendously difficult to accurately project over such a long time horizon. This is particularly true of a program like CLASS, which attempts to mitigate the economic risks of a population that will undoubtedly require high benefit payouts to address their LTC needs.

Despite a guaranteed 75 year solvency period stipulated within the CLASS Act, the CBO is only required by law to provide a projected cost analysis of the first ten years of operation for any proposed legislation. The CBO projected the CLASS program would be financially viable in its first ten years of operation due to the large surplus built by an initial five year vesting period before any benefits would be paid out to program enrollees. Enrollment assumptions were largely based on existing usage of private long-term care insurance. Once enacted into law, however, the implementation of the CLASS program was restricted by several other guidelines embedded in the legislation, such as that no general revenue could be used to bolster the program and a maximum of three percent of all program costs could be used for administrative purposes. These provisions further limited the program's ability to 'get off the ground' and to function under the 75 year solvency requirement. Moreover, enrolling enough people in the program to make it financially solvent proved highly difficult without some sort of mandate for participation, or at the very least, the inclusion of a voluntary opt-out provision. In short, these design parameters, which helped the legislation succeed politically during the legislative process, made the task of implementation highly difficult, if not impossible, even for the most supportive of public administrators. Yet, the impact of these administrative constraints is unable to provide a complete account for why the abandonment of CLASS took place so quickly after its legislative success. To be sure, these design flaws were a precursor to

abandonment, but partisan politics, and the peculiar operation of America's political institutions, were the factors that precipitated its demise.

The 2010 mid-term elections witnessed a resurgence of the Republican Party that allowed them to recapture the House of Representatives by a large margin, a dramatic shift in the partisan control of that legislative chamber when compared to President Obama's historic victory just two years before. At the top of the emboldened conservative agenda was a desire to repeal the health reform legislation signed into law by President Obama. In a largely symbolic act, one of the first actions of the House of Representatives during the 112th Congress was a vote to repeal PPACA (Viser, 2011). And yet, while the Republican Party successfully wrested control of the House of Representatives in 2010, they failed to win back the Senate, which remained firmly in the hands of Democrats. Thus, in spite of a large vote in favor of repeal in the House, without a compliant Senate, the legislation could go nowhere. Moreover, President Obama holds veto power over any legislation, which renders a repeal effort highly improbable while he remains in office, even if the Senate had been inclined to join their colleagues in the House to support repeal. This dynamic again demonstrates the significance of the institutional arrangements within the U.S. political system (i.e. the fragmentation of power and the institutional checks and balances within the political system) and their impact on the capacity to bring about policy change.

The inability of Congressional Republicans to repeal PPACA did not mean that opponents of health reform relented in their efforts to undermine the legislation. Several legal challenges were filed, which ultimately made their way to the U.S. Supreme Court.⁵¹

⁵¹ The Supreme Court ruled to uphold the law, although the expansion of Medicaid was found to be unconstitutional. The court's decision gave individual states the choice to expand the Medicaid program to 133 percent of the federal poverty level for all adults or leave their program at existing capacity level (Liptak, 2012).

As the 2012 Republican Presidential candidates began their campaign for their party's nomination to challenge President Obama in the 2012 general election, calls to repeal the health reform legislation continued to grow. These political concerns placed continued intense political strain on the health reform legislation and the Obama Administration. The structural complexities of the CLASS program, and the significant challenges to implementing it as prescribed within the legislation, made it a target of Republicans in Congress who, in a vitriolic partisan atmosphere, seized the opportunity to argue that the problems facing CLASS were representative of the entire health reform legislation passed by the Obama Administration. The Republican controlled House of Representatives voted to specifically repeal the CLASS Act in February 2012 (Smith, 2012). Arguably, this suggests the CLASS Act became a distraction and therefore a detractor to the Administration's commitment to the overhaul of the U.S. health system. In short, any political cover that health reform may have afforded the CLASS Act during the debate of 2009-2010 had vanished.

A number of relatively minor changes to CLASS might have offered the fledgling program a better chance at successful implementation. Arguably, the CLASS program would have been better positioned to remain actuarially sound if a voluntary opt-out provision, as originally proposed by Senator Kennedy, had remained a part of the program's design. The voluntary opt-out provision was removed in the final weeks of health reform in order to avoid the perception of imposing another mandate on U.S. employers, who were already required under the wider health legislation to provide acute health insurance to their employees or pay a fine. Without some sort of mandate, or other tool to boost enrollment, convincing a large enough pool of people to participate in CLASS

to adequately spread risk was a highly difficult task. For example, a transfer of general revenue to the CLASS program might have helped to mitigate the potential financial difficulties associated with a small risk pool. However, this approach was almost certainly a political impossibility given the focus on the budget deficit and the fiscal restraints imposed by a Congress hostile toward further government spending on social programs. Lacking the ability to amend the program, and with CLASS turning into a rallying point for opponents of health reform, the Obama Administration was left with little choice but to abandon their implementation efforts on the CLASS program. Less than two years after the CLASS Act passed into law, the same design characteristics that enabled its legislative success brought down the program.

The current status of the CLASS Act places the program in a state of political and administrative limbo. This precarious existence raises several important questions about the future of the program and, more importantly, about the future of LTC financing in the United States. The state in which the Act lingers suggests several possible scenarios for the future of the program. The legislation, without the funding or administrative capabilities to be properly implemented, could simply wither away into the annals of history; this appears to be the Act's fate as of the writing of this thesis. Alternatively, the CLASS Act might be fully repealed if and when a more conservative President and Congress control all the levers of institutional power in the United States. A third, and far less likely scenario if the CLASS program were to remain in its current status of limbo, is the federal courts forcing the Obama Administration to implement the program. Such a move might provide the Administration with some political cover, claiming they were forced by the courts, which

would be cleaner than spending their political capital on implementing the program, which would surely require additional funds to make it operational.

Perhaps the Obama Administration is simply biding their time for a more favorable Congress, which could then make the changes necessary to ensure the program's financial viability. This seems the most likely scenario for any attempt to bring the CLASS Act out of its state of limbo in order to turn it into a functioning federal program. But as the findings presented in this thesis suggest, while sympathetic to the CLASS Act and to the concept of LTC financing reform, this issue did not appear to be a high priority of the Obama Administration. Again, it is much more likely the CLASS program will remain a part of the federal statutes, but stay administratively inoperable.

No matter the specific fate of the CLASS Act, the future of LTC financing in the United States remains highly uncertain. The underlying risks that confront the major stakeholders within the LTC policy arena will continue to grow in severity with each successive year. At the same time, the impediments to large-scale social reform, such as a major expansion of public financing to cover LTC, or conversely, a move toward the complete privatization of the LTC system, are likely to endure. Specifically, the peculiar institutional arrangements of the U.S. political system, competing ideological perspectives on the appropriate role of the state in mitigating personal risks, and the strength of organized vested interests will make significant policy change highly difficult to achieve. Gradual change is the likely outcome in the face of these obstacles much as the recent history of LTC financing reform, including the CLASS Act, appears to demonstrate. Nevertheless, some type of significant financing reform will be necessary in order to provide a LTC financing system that more adequately addresses the risks and needs of all

stakeholders. On the one hand, any future reform effort will face an uphill battle if the focus is on spending larger amounts of public resources to address the increasing need for LTC. This is particularly true within the institutional arrangements and the highly divisive political environment of the United States, not to mention the precarious state of the global economy, or the growing federal deficit and projected budgetary shortfalls. The calls for greater personal responsibility in mitigating the risks associated with old-age, disability and ill-health are also unlikely to disappear from American political discourse. Conversely, the magnitude of the collective challenges of the LTC financing system requires a solution that will, without a doubt, require U.S. policymakers to make several difficult choices about the appropriate role of the state in addressing these risks. Policymakers and advocates of LTC financing reform will be confronted with a stark choice: embrace the trend toward greater personal responsibility or attempt to reaffirm a strong role for the government in addressing individual social and economic risks such as LTC. Only time will tell which approach policymakers are likely to select.

Future Research Agenda

The possible avenues for future research on LTC policymaking in the United States are extensive. While there is a dearth of existing research on the politics of LTC, there is a lack of empirical evidence to adequately explain institutional change. Indeed, the case of LTC policy remains an under-researched topic that would be well-served by further analysis of the politics surrounding the policymaking process. This is particularly true as the need for a financing system that is able to more adequately address the needs of all the system's main stakeholders becomes apparent. Gaining a better understanding of the casual

processes surrounding policymaking will not only advance the academic field of social policy, it will ultimately produce better policy outcomes. The way that LTC policy compares to other related policy issues, such as retirement security, and LTC's role within the health care system more broadly, are also topics to be explored in greater detail by future research efforts. Such a thread of analysis would help to link the individual case of LTC more closely to other areas of social policy, which may in turn help further elucidate why significant policy change is so difficult to achieve in the United States.

Additional research on LTC could potentially benefit from a focus on activities at the state level, analyzing their attempts to change LTC policy over the past two decades. While some state-focused analysis has been carried out in recent years, most state initiatives have yet to be studied in any rigorous manner. In 2005, for example, the State of Washington considered a LTC financing reform proposal similar to the CLASS Act, which would have established a voluntary insurance program for home and community based services (HCBS) within the state. Several differences between the CLASS Act and the State of Washington's legislation exist, yet given the overall similarities, this legislation may provide a particularly informative case study in the politics of American social policy.

A regrettable limitation of this study was the lack of information gathered directly from members of the Obama Administration and the executive branch of government. While gaining access to these individuals proved highly difficult in the midst of the controversial debate over health reform, perhaps the individuals who worked within the Obama Administration, and who have direct knowledge of the CLASS Act, would be willing to participate in a study after the immediate political dust begins to settle. A comparison of recent LTC financing reform efforts in the United States with reform efforts

in other countries like Germany or Japan, both of which have undertaken significant LTC financing reform in the last decade, might yield insightful information about the way different polities and institutional structures influence significant policy change or how, and under what circumstances, individual risks like the need for LTC become public issues and rise up the policy agenda. While the institutional structures of these two countries differ considerably from the United States, this line of research may augment the wider attempt to explain policy change in advanced democracies.

Summary and Conclusions

The American policymaking process is highly complex and large-scale social reform is difficult to achieve even under the most favorable conditions as demonstrated by the experience of the Patient Protections and Affordable Care Act (PPACA) in 2010, which included path-departing LTC financing reform in the form of the CLASS Act. Policy issues like LTC financing reform, which many consider to be a lower tier priority within the spectrum of health policy, confront an even higher threshold when attempting to successfully navigate the legislative process. This high threshold stems in part from the peculiar institutional architecture of the U.S. political system and the way that Congress operates; the pervasiveness of an ideological orientation which views the American state with high levels of skepticism; and long-term structural changes to the U.S. economy which have, to some degree, limited the ability of policymakers to address personal social risks like LTC. The current political environment and continuing recession further enhance these obstacles to significant policy change by strengthening the argument for fiscal austerity. However, when the timing is right (e.g. when the political institutions align under

the same political party, when a powerful champion in Congress or the White House supports the cause, and when the cost of reform fits within the accepted budgetary framework of the day), significant policy change can occur. In order for comprehensive LTC financing reform to be considered independent of a larger legislative package like health reform and to be legislatively successful, LTC reform must first become a higher priority to U.S. policymakers. The most likely way for that to occur is through a crisis, where the fiscal burden of financing LTC simply becomes too large of an issue for policymakers to ignore, making significant reform unavoidable. In the meantime, one may expect to see only incremental changes to the existing LTC policy arrangements in the United States.

References

- Abbot, A. (2001) *Time Matters: On Theory and Method*, Chicago, IL: University of Chicago Press.
- Aldrich, J. and Rohde, D. (1982) "The Limitations of an Equilibrium Analysis," in Ordeshook, P. and Shepsle, K. (eds) *Political Equilibrium*, Hingham, MA: Kluwer Boston, pp. 65-95.
- Amenta, E. (1993) "The State of the Art in Welfare State Research on Social Spending Efforts in Capitalist Democracies since 1960," *The American Journal of Sociology*, Vol. 99 (3): pp. 750-763.
- Amenta, E. (1998) *Bold Relief: Institutional Politics and the Origins of Modern American Social Policy*, Princeton, NJ: Princeton University Press.
- Amenta, E. (2003) "What We Know About the Development of Social Policy: Comparative and Historical Research in Comparative and Historical Perspective," in Mahoney, J. and Rueschemeyer, D. (eds) *Comparative Historical Analysis in the Social Sciences*, Cambridge, UK: Cambridge University Press, pp. 91-130.
- Armingeon, K. and Bonoli, G. (2006) *The Politics of Post-Industrial Welfare States: Adapting Post-War Social Policies to New Social Risks*, New York, NY: Routledge.
- Arrow, K. (1963) "Uncertainty and the Welfare Economics of Medical Care," *The American Economic Review*, Vol. 53 (5): pp. 941-973.
- Austen-Smith, D. (2000) "Redistributing Income under Proportional Representation," *Journal of Political Economy*, Vol. 108 (6): pp. 1235-1269.
- Barr, N. (1993) *The Economics of the Welfare State*, Stanford, CA: Stanford University Press.
- Barr, N. (2001) *The Welfare State as Piggy Bank: Information, Risk, Uncertainty, and the Role of the State*, Oxford, UK: Oxford University Press.
- Barr, N. (2010) "Long-term Care: A Suitable Case for Social Insurance," *Social Policy and Administration*, Vol. 44 (4): pp. 359-374.
- Bartels, L. (2008) *Unequal Democracy: The Political Economy of the New Gilded Age*, Princeton, NJ: Princeton University Press.
- Baumgartner, F. and Jones, B. (1993) *Agendas and Instability in American Politics*, Chicago, IL: University of Chicago Press.

- Beard, R. and Williamson, J. (2010) "Social Policy and the Eternal Dynamics of the Senior Rights Movement," *Journal of Aging Studies*, Vol. 25 (3): pp. 22-33.
- Béland, D. (2005a) "Ideas, Interest and Institutions: Historical Institutionalism Revisited," in Lecours, A. (ed) *New Institutionalism: Theory and Practice*, Toronto, CA: University of Toronto Press, pp. 29-50.
- Béland, D. (2005b) "Ideas and Social Policy: An Institutional Perspective," *Social Policy and Administration*, Vol. 39 (1): pp. 1-18.
- Béland, D. (2005c) *Social Security: History and Politics from the New Deal to the Privatization Debate*, Lawrence, KS: University Press of Kansas.
- Béland, D. (2007) "Ideas and Institutional Change in Social Security: Conversion, Layering, and Policy Drift," *Social Science Quarterly*, Vol. 88 (1): pp. 20-38.
- Béland, D. (2010) "Policy Change and Health Care Research," *Journal of Health Politics, Policy and Law*, Vol. 35 (4): pp. 615-641.
- Béland, D. and Cox, R. (2011) *Ideas and Politics in Social Science Research*, Oxford, UK: Oxford University Press.
- Béland, D. and Hacker, J. (2004) "Ideas, Private Institutions and American Welfare State 'Exceptionalism': the Case of Health and Old-Age Insurance, 1915–1965," *International Journal of Social Welfare*, Vol. 13: (1): pp. 42–54.
- Béland, D. and Waddan, A. (2007) "Conservative Ideas and Social Policy in the United States," *Social Policy and Administration*, Vol. 41 (7): pp. 768-786.
- Béland, D. and Waddan, A. (2012) *The Politics of Policy Change: Welfare, Medicare, and Social Security Reform in the United States*, Washington, DC: Georgetown University Press.
- Bell, D. (1991) "The Hegelian Secret: Civil Society and American Exceptionalism," in Shafer, B. (ed) *Is America Different? A New Look at American Exceptionalism*, Oxford, UK: Clarendon Press, pp. 46-70.
- Bendix, R. (1964) *Nation-Building and Citizenship*. New York, NY: Wiley.
- Bendix, R. (1978) *Kings or People: Power and the Mandate to Rule*. Berkeley, CA: University of California Press.
- Bernard, H. (2000) *Social Research Methods: Qualitative and Quantitative Approaches*, London, UK: Sage Publications.

- Biernacki, P. and Waldorf, D. (1981) "Snowball Sampling: Problems and Techniques of Chain Referral Sampling," *Sociological Methods and Research*, Vol. 10 (2): pp. 141-163.
- Binstock, R. (1996) "The Politics of Enacting Long-Term Care Insurance," in Binstock, R. and Von Mering, O. (eds) *The Future of Long-Term Care: Social and Policy Issues*, Baltimore, MD: Johns Hopkins University Press, pp. 191-214.
- Blekesaune, M. and Quadagno, J. (2003) "Public Attitudes Toward Welfare State Policies: A Comparative Analysis of 24 Nations," *European Sociological Review*, Vol. 19 (5): pp. 415-427.
- Blendon, R. and Benson, J. (2011) "The Public's Views about Medicare and the Budget Deficit," *New England Journal of Medicine*, Vol. 365 (4): pp. e (8)1-4.
- Blumenthal, D. and Morone, J. (2009) *The Heart of Power: Health and Politics in the Oval Office*, Berkeley, CA: University of California Press.
- Bonoli, G. (2005) "The Politics of the New Social Policies: Providing Coverage Against New Social Risks in Mature Welfare States," *Politics and Policy*, Vol. 33 (3): pp. 431-449.
- Bradley, D., Huber, E., Moller, S., Nielsen, F. and Stephens, J. (2003) "Distribution and Redistribution in Postindustrial Democracies," *World Politics*, Vol. 55 (2): pp. 193-228.
- Brooks, C. and Manza, J. (2006) "Why Do Welfare States Persist?" *Journal of Politics*, Vol. 68 (4): pp. 816-827.
- Brooks, C. and Manza, J. (2007) *Why Welfare States Persist: The Importance of Public Opinion in Democracies*, Chicago, IL: University of Chicago Press.
- Bush, G. (2004) "Now We Go forward," Acceptance Speech Before the 2004 Republican National Convention (September 4, 2004), *Vital Speeches of the Day*, Vol. 70 (23): pp. 707-711.
- BusinessWeek (2010) "MetLife to Stop selling Long-Term Care Insurance," *Bloomberg*, November 11, 2010.
<http://www.businessweek.com/ap/financialnews/D9JE15F80.htm>.
- Campbell, A. (2003) *How Policies Make Citizens: Senior Political Activism and the American Welfare State*, Princeton, NJ: Princeton University Press.
- Campbell, A. and Morgan, K. (2005) "Federalism and the Politics of Old-Age Care in Germany and the United States," *Comparative Political Studies*, Vol. 38 (8): pp. 1-28.

- Capoccia, G. and Kelemen, D. (2007) "The Study of Critical Junctures: Theory, Narrative, and Counterfactuals in Historical Institutionalism," *World Politics*, Vol. 59 (3): pp. 341-369.
- Carpenter, D. (2001) *The Forging of Bureaucratic Autonomy: Reputations, Networks, and Policy Innovation in Executive Agencies, 1862-1928*, Princeton, NJ: Princeton University Press.
- Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, (2012) *National Health Expenditure By Type of Service and Source of Funds*, Washington, DC: U.S. Department of Health and Human Services.
<http://www.cms.hhs.gov/NationalHealthExpendData/>
- Chapin, R. (2010) *Social Policy for Effective Practice: A Strengths Approach*, New York, NY: Rutledge.
- Clinton, B. (1992) "The Clinton Health Care Plan," *New England Journal of Medicine*, Vol. 327 (11): pp. 804-807.
- Coleman, D. (2006) "Population Ageing: An Unavoidable Future," in Pierson, C. and Castles, F. (eds) *The Welfare State Reader*, Cambridge, UK: Polity Press.
- Collie, M. (1988) "The Legislature and Distributive Policy Making in Formal Perspective," *Legislative Studies Quarterly*, Vol. 13 (4): pp. 427-458.
- Collier, R. and Collier, D. (1991) *Shaping the Political Arena: Critical Junctures, the Labor Movement, and Regime Dynamics in Latin America*, Princeton, NJ: Princeton University Press.
- Condon, S. (2009) "Moderate Senators Oppose Long Term Health Care Proposal," *CBS News*, October 28, 2009.
- Connell, C. (1993) "First Public Task Force Meeting Gets Underway," *Associated Press*, March 29, 1993.
- Congressional Budget Office (2012) *Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act*, Washington, DC: Congressional Budget Office.
<http://www.cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf>.
- Corbin, J. and Strauss, A. (1998) *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory* (2nd Edition), London, UK: Sage Publications.

- Creswell, J. (2007) *Qualitative Inquiry and Research Design: Choosing Among Five Approaches (Third Edition)*, London, UK: Sage Publications.
- Critchlow, D. (2007) *The Conservative Ascendancy: How the GOP Right Made Political History*, Cambridge, MA: Harvard University Press.
- Cusack, T., Iversen, T. and Soskice, D. (2007) "Economic Interests and the Origins of Electoral Success," *American Political Science Review*, Vol. 101 (3): pp. 373-391.
- Dahl, R. (1961) *Who Governs: Democracy and Power in an American City*, New Haven, CT: Yale University Press.
- Dahl, R. (1963) *Modern Political Analysis*, Englewood Cliffs, NJ: Prentice Hall.
- Dahl, R. (1971) *Polyarchy: Participation and Opposition*, New Haven, CT: Yale University Press.
- Davies, G. (1996) *From Opportunity to Entitlement: The Transformation and Decline of Great Society Liberalism*, Lawrence, KS: University of Kansas Press.
- DeNavas-Walt, C., Proctor, B., and Smith, J., U.S. Census Bureau (2012) *Income, Poverty, and Health Insurance Coverage in the United States: 2011*, Washington, DC: U.S. Government Printing Office.
<https://www.census.gov/prod/2012pubs/p60-243.pdf>
- Denzin, N. (1978) *The Research Act: A Theoretical Introduction to Sociological Methods*, New York, NY: McGraw-Hill.
- Derthick, M. (1979) *Policymaking for Social Security*, Washington, DC: Brookings Institution.
- Derthick, M. (2001) "The Evolving Old Politics of Social Security" in Levin, M., Landy, M. and Shapiro, M. (eds) *Seeking the Center: Politics and Policymaking at the New Century*, Washington, DC: Georgetown University Press: pp. 193-214.
- Derthick, M. and Quirk, P. (1985) *The Politics of Deregulation*, Washington, DC: The Brookings Institute.
- De Tocqueville, A. (1998) *Democracy in America*, London, UK: Wordsworth.
- Dilger, R., (2012) "State Government Fiscal Stress and Federal Assistance," Washington, DC: Congressional Research Service.
- Downs, A. (1957) *An Economic Theory of Democracy*, New York, NY: Harper Collins Publishers.

- Eastaugh, S. (1992) *Health Economics: Efficiency, Quality, and Equity*, Westport, CT: Greenwood Publishing Group.
- Eckstein, H. (1975) "Case Studies and Theory in Political Science," Greenstein, F. and Polsby, N. (eds) *Handbook of Political Science*, Reading, MA: Addison-Wesley, pp. 79-137.
- Eiken, S., Sredl, K., Burwell, B. and Gold, L. (2010) *Medicaid Long-Term Care Expenditures in FY 2009*, Cambridge, MA: Thomson Reuters.
- Elmendorf, D. (2009) *Letter to Senator Edward Kennedy from Douglas Elmendorf, CBO Director*, Washington, DC: Congressional Budget Office, July 2, 2009.
- Elmendorf, D. (2010) *Letter to Senator Harry Reid from Douglas Elmendorf, CBO Director*, Washington, DC: Congressional Budget Office, March 11, 2010.
- Engquist, G., Johnson, C., Lind A. and Palmer Barnette, L. (2010) "Medicaid-Funded Long-Term Care: Toward More Home-and Community-Based Options," Hamilton, NJ: Center for Health Care Strategies.
http://www.chcs.org/usr_doc/LTSS_Policy_Brief_.pdf.
- Esping-Andersen, G. (1985) *Politics Against Markets: The Social Democratic Road to Power*, Princeton, NJ: Princeton University Press.
- Esping-Andersen, G. (1990) *The Three Worlds of Welfare Capitalism*, Cambridge, UK: The Polity Press.
- Esping-Andersen, G. (1999) *Social Foundations of Postindustrial Economies*, Oxford, UK: Oxford University Press.
- Esping-Andersen, G. (2009) *The Incomplete Revolution: Adapting Welfare States to Women's New Roles*, Cambridge, UK: The Polity Press.
- Estévez-Abe, M., Iversen, T. and Soskice, D. (2001) "Social Protection and the Formation of Skills: A Reinterpretation of the Welfare State," in Hall, P. and Soskice, D. (eds) *Varieties of Capitalism: The Institutional Foundations of Comparative Advantage*, Oxford, UK: Oxford University Press, pp. 145-183.
- Evans, D. (2000) "The Distribution of Pork Barrel Projects and Vote Buying in Congress," in Bianco, W. (ed) *Congress on Display, Congress at Work*, Ann Arbor, MI: University of Michigan Press, pp. 243-264.
- Evans, P., Rueschemeyer, D. and Skocpol, T. (1985) *Bringing the State Back In*, Cambridge, UK: Cambridge University Press.

- Farquharson, K. (2005) "A Different Kind of Snowball: Identifying Key Policymakers," *International Journal of Social Research Methodology*, Vol. 8 (4): pp. 345-53.
- Feder, J., Komisar, H. and Niefled, M. (2000) "Long-Term Care in the United States: An Overview," *Health Affairs*, Vol. 19 (3): pp. 40-56.
- Feinberg, L., Reinhard, S., Houser, A., and R. Choula (2011) *Valuing the Invaluable: 2011 Update: The Growing Contributions and Costs of Family Caregiving*, Washington, DC: AARP Public Policy Institute.
- Feldman, S. and Zaller, J. (1992) "The Political Culture of Ambivalence: Ideological Responses to the Welfare State," *American Journal of Political Science*, Vol. 36 (1): pp. 268-307.
- Fenno, R. (1973) *Congressmen in Committees*, Boston, MA: Little, Brown.
- Fielding, N. and Lee, R. (2002) "New Patterns in the Adoption and Use of Qualitative Software," *Field Methods*, Vol. 14 (2): pp. 197-216.
- Finegold, K. (2005) "The United State Federalism and Its Counter Factuals," in Obinger, H., Leibfried, S. and Francis Geoffrey Castles (2005) *Federalism and the Welfare State: New World and European Experiences*, Cambridge, UK: Cambridge University Press, pp. 138-180.
- Foster, R. (2010) *Estimated financial effects of the "Patient Protection and Affordable Care Act," as Amended*, Washington, DC: Centers for Medicare and Medicaid Services, April 22, 2010.
- Frank, R. (2012) "Long-term Care Financing in the United States: Sources and Institutions," *Applied Economic Perspectives and Policy*, Vol. 34 (2): pp. 333-345.
- Free, L. and Cantril, H. (1967) *The Political Beliefs of Americans: A Study of Public Opinion*, New Brunswick, NJ: Rutgers University Press.
- Friedmann, M., Newman, F., Seff, L. and Dunlop, B. (2004) "Planning for Long-Term Care: Concept Definition and Measurement," *The Gerontologist*, Vol. 44 (4): pp. 520-530.
- Genworth Financial (2012) *Cost of Care Survey 2012: Home Care Providers, Adult Day Health Care Facilities, Assisted Living Facilities and Nursing Homes*, Richmond, VA: Genworth Financial, Inc.
https://www.genworth.com/content/etc/medialib/genworth_v2/pdf/ltc_cost_of_care.Par.40001.File.dat/2012%20Cost%20of%20Care%20Survey%20Full%20Report.pdf.

- George, A. (1979) "Case Studies and Theory Development: The Method of Structured, Focused Comparison," in Lauren, P. (ed) *Diplomacy: New Approaches in History, Theory, and Policy*, New York, NY: Free Press, pp 43-68.
- George, A. and Bennett, A. (2005) *Case Studies and Theory Development in Social Science*, London, UK: MIT Press.
- GfK NOP Roper Public Affairs and Media (2006) *The Costs of Long-Term Care: Public Perceptions Versus Reality in 2006*, Washington, DC: AARP.
https://assets.aarp.org/rgcenter/health/ltc_costs_2006.pdf.
- Gilbert, N. (2010) "Comparative Analyses of Stateness and State Action: What Can We Learn From Patterns of Expenditure," in Alber, J. and Gilbert, N. (eds) *United in Diversity Comparing Social Models in Europe and America*, Oxford, UK: Oxford University Press, pp.133-150.
- Gilens, M. (1995) "Racial Attitudes and Opposition to Welfare," *The Journal of Politics*, Vol. 57 (4): pp. 994-1014.
- Gilens, M. (1999) *Why Americans Hate Welfare: Race, Media, and the Politics of Anti-Poverty Policy*, Chicago, IL: University of Chicago Press.
- Gleckman, H. (2010) "Long-Term Care Financing Reform: Lessons from the U.S. and Abroad," New York, NY: The Commonwealth Fund.
- Goertz, G. and Mahoney, J. (2009) "Scope in Case-Study Research," in Byrne, D. and Ragin, C. (eds) *The Sage Handbook of Case-Based Methods*, Thousand Oaks, CA: Sage Publications.
- Goldberg, S. (1994) "Statement of American Association of Homes for the Aging President on President Clinton's Health Care Reform Plan," *Newswire Association*, September 21, 1994.
- Gonyea, J. (2010) "The Oldest Old and a Long-Lived Society: Challenges for U.S. Public Policy," in Hudson, R. (ed) *The New Politics of Old Age Policy*, Baltimore, MD: Johns Hopkins University Press, pp. 183-207.
- Graetz, M. and Mashaw, J. (1999) *True Security: Rethinking American Social Insurance*, New Haven, CT: Yale University Press.
- Griger, N. (2010) *The Risk of Social Policy: The Electoral Consequences of Welfare State Retrenchment and Social Policy Performance in OECD Countries*, New York, NY: Routledge.

- Grogan, C. and Patashnik, E. (2003) "Universalism within Targeting: Nursing Home Care, the Middle Class, and the Politics of the Medicaid Program," *Social Service Review*, Vol. 77 (1): pp. 51-71.
- Gubrium, F. and Holstein, J. (2002) *Handbook of Interview Research: Context & Method*, Thousand Oaks, CA: Sage Publications.
- Hacker, J. (1996) *The Road to Nowhere: The Genesis of President Clinton's Plan for Health Security*, Princeton, NJ: Princeton University Press.
- Hacker, J. (1998) "The Historical Logic of National Health Insurance: Structure and Sequence in the Development of British, Canadian, and U.S. Medical Policy," *Studies in American Political Development*, Vol. 12 (1): pp. 57-130.
- Hacker, J. (2002) *The Divided Welfare State: The Battle Over Public and Private Social Benefits in the United States*, New York, NY: Cambridge University Press.
- Hacker, J. (2004) "Privatizing Risk Without Privatizing the Welfare State: The Hidden Politics of Social Policy Retrenchment in the United States," *American Political Science Review*, Vol. 98 (2): pp. 243-260.
- Hacker, J. (2005) "Policy Drift: The Hidden Politics of US Welfare State Retrenchment," in Streeck, W. and Thelen, K. (eds) *Beyond Continuity: Institutional Change in Advanced Political Economies*, Oxford, UK: Oxford University Press, pp. 40-82.
- Hacker, J. (2008) *The Great Risk Shift: The New Economic Insecurity and the Decline of the American Dream*, Oxford, UK: Oxford University Press.
- Hacker, J. (2009) "Yes We Can? The New Push for American Health Security," *Politics and Society*, Vol. 37 (1): pp. 3-32.
- Hacker, J. (2010) "The Road to Somewhere: Why Health Reform Happened Or Why Political Scientists Who Write about Public Policy Shouldn't Assume They Know How to Shape It," *Perspectives on Politics*, Vol. 8 (3): pp. 861-876.
- Hacker, J. (2012) "Sharing Risk and Responsibility in a New Economic Era," in Hacker, J. and O'Leary, A. (eds) *Shared Responsibility, Shared Risk: Government, Markets and Social Policy in the Twenty-First Century*, Oxford, UK: Oxford University Press, pp. 3-21.
- Hacker, J. and O'Leary, A. (2012) *Shared Responsibility, Shared Risk: Government, Markets and Social Policy in the Twenty-First Century*, New York, NY: Oxford University Press.

- Hacker, J. and Pierson, P. (2002) "Business Power and Social Policy: Employers and the Formation of the American Welfare State," *Politics & Society*, Vol. 30 (2): pp. 277-325.
- Hacker, J. and Pierson, P. (2005) *Off Center: the Republican Revolution and the Erosion of American Democracy*, New Haven, CT: Yale University Press.
- Hacker, J. and Pierson, P. (2010a) *Winner-Take-All Politics: How Washington Made the Rich Richer—and Turned Its Back on the Middle Class*, New York, NY: Simon and Schuster.
- Hacker, J. and Pierson, P. (2010b) "Winner-Take-All Politics: Public Policy, Political Organizations, and the Rise of Top Incomes in the United States," *Politics and Society*, Vol. 38 (2): pp. 152-204.
- Hall, P. (1993) "Policy Paradigms, Social Learning and the State: The Case of Policymaking in Britain," *Comparative Politics*, Vol. 25 (3): pp. 275-296.
- Hall, P. and Soskice, D. (2001) *Varieties of Capitalism: The Institutional Foundations of Comparative Advantage*, Oxford, UK: Oxford University Press
- Hall, P. and Soskice, D. (2001) "An Introduction to Varieties of Capitalism," in Hall, P. and Soskice, D. (eds) *Varieties of Capitalism: The Institutional Foundations of Comparative Advantage*, Oxford, UK: Oxford University Press, pp. 1-56.
- Hall, P. and Taylor, R. (1996) "Political Science and the Three New Institutionalisms," *Political Studies*, Vol. 44 (5): pp. 936-957.
- Hall, R. and Grofman, B. (1990) "The Committee Assignment Process and the Conditional Nature of Committee Bias," *American Political Science Review*, Vol. 81 (4): pp. 1149-1166.
- Harrington, M. (2000) *Care and Equality: Inventing a New Family Politics*, New York, NY: Routledge.
- Harrington Meyer, M. (2000) *Care Work: Gender, Labor, and the Welfare State*, New York, NY: Routledge.
- Harrington Meyer, M. (2010) "Shifting Risks and Responsibility: The State of Inequality in Old Age," in Hudson, R. (ed) *The New Politics of Old Age Policy*, Baltimore, MD: Johns Hopkins University Press, pp. 21-41.
- Hartz, L. (1955) *The Liberal Tradition in America: An Interpretation of American Political Thought Since the Revolution*, New York, NY: Harcourt, Brace and World Company.

- Health Security Act (1993) H.R. 3600, Washington, DC: 103rd Session of Congress.
- Heclo, H. (1974) *Modern Social Politics in Britain and Sweden: From Relief to Income Maintenance*, New Haven, CT: Yale University Press.
- Heclo, H. (1978) "Issue Networks and the Executive Establishment," in King, A. (ed) *The New American Political System*, Washington, DC: American Enterprise Institute, pp. 87-124.
- Henry, T. (1989) "Farewells Paid to Long-time Champion of the Elderly," Washington, DC: The Associated Press, June 1, 1989.
- Hesse-Biber, S. and Leavy, P. (2010) *The Practice of Qualitative Research*, 2nd Edition, London, UK: Sage Publications.
- Hibbs, D. (1987) *The American Political Economy: Macroeconomics and Electoral Politics*, Cambridge, MA: Harvard University Press.
- Himelfarb, R. (1995) *Catastrophic Politics: The Rise and Fall of the Medicare Catastrophic Coverage Act of 1988*, University Park, PA: Pennsylvania State University Press.
- Howard, C. (1997) *The Hidden Welfare State: Tax Expenditures and Social Policy in the United States*, Princeton, NJ: Princeton University Press.
- Huber, E., Ragin, C. and Stephens, J. (1993) "Social-democracy, Christian Democracy Constitutional Structure, and the Welfare-State," *American Journal of Sociology*, Vol. 99 (3): pp. 711-749.
- Huber, E. and Stephens, J. (2001) *Development and Crisis of the Welfare State: Parties and Policies in Global Markets*, Chicago, IL: University of Chicago Press.
- Hudson, J. and Lowe, S. (2003) *Understanding the Policy Process: Analysing Welfare Policy and Practice*, Bristol, UK: The Polity Press.
- Huntington, S. (1981) *American Politics: The Promise of Disharmony*, Cambridge, MA: Harvard University Press.
- Immergut, E. (1990) "Institutions, Veto Points and Policy Results: A Comparative Analysis of Health Care," *Journal of Public Policy*, Vol. 10 (4): pp. 391-416.
- Immergut, E. (1992) "The Rules of the Game: the Logic of Health Policy-Making in France, Switzerland, and Sweden," in Steinmo, S., Thelen, K., and Longstreth, F. (eds) *Structuring Politics: Historical Institutionalism in Comparative Analysis*, Cambridge, UK: Cambridge University Press, pp.57-89.

- Immergut, E. (1998) "The Theoretical Core of New Institutionalism," *Politic and Society*, Vol. 36 (1): pp. 15-34.
- Iversen, T. and Soskice, D (2006) "Electoral Institutions and the Politics of Coalitions: Why Some Democracies Redistribute More Than Others," *American Political Science Review*, Vol. 100 (2): pp. 165-181.
- Iversen, T. and Soskice, D. (2009) "Distribution and Redistribution: The Shadow of the Nineteenth Century," *World Politics*, Vol. 61 (3): pp. 438-486.
- Jacobs, L and King, D. (2009) "The Political Crisis of the American State: The Unsustainable State in a Time of Unraveling," in Jacobs, L. and King, D. (eds) *The Unsustainable American State*, Oxford, UK: Oxford University Press, pp. 3-33.
- Jacobs, L. and Skocpol, T. (2010) *Health Care Reform and American Politics: What Every American Needs to Know*, Oxford, UK: Oxford University Press.
- Jacoby, S. (1998) *Modern Manors: Welfare Capitalism Since the New Deal*, Princeton, NJ: Princeton University Press.
- Jaenicke, D. and Waddan, A. (2006) "President Bush and Social Policy: The Strange Case of the Medicare Prescription Drug Benefit," *Political Science Quarterly*, Vol. 121 (2): pp.217-240.
- Johnson, K. (2007) *Governing the American State: Congress and the New Federalism, 1877-1929*, Princeton, NJ: Princeton University Press.
- Johnson, R. (2008) "The Strains and Drains of Long-Term Care," *American Medical Association Journal of Ethics*, Vol. 10 (6): pp. 397-400.
- Kaiser Family Foundation (2009) *Medicaid and Long-Term Care Services and Supports*, Washington, DC: Kaiser Commission on Medicaid and the Uninsured. http://www.kff.org/medicaid/upload/2186_06.pdf.
- Kaiser Family Foundation (2011) *Medicaid and Long-Term Care Services and Supports*, Washington, DC: Kaiser Commission on Medicaid and the Uninsured. <http://www.kff.org/medicaid/upload/2186-08.pdf>
- Kaiser Family Foundation (2012) *Medicaid and Long-Term Care Services and Supports*, Washington, DC: Kaiser Commission on Medicaid and the Uninsured. <http://www.kff.org/medicaid/upload/2186-09.pdf>
- Kane, R. (2007) "Coalitions Between Aging and Disability Interests: A Potential Vehicle to Promote Community Care for Older Adults," in Putnam, M. (ed) *Aging and Disability: Crossing Network Lines*, New York, NY: Springer Publishing Company, pp. 135-160.

- Kassner, E. (2007) *Long-Term Care Fact Sheet*, Washington, DC: AARP Public Policy Institute.
- Katzenstein, P. (1978) *Between Power and Plenty: Foreign Economic Policies of Advanced Industrial States*, Madison, WI: University of Wisconsin Press.
- Katznelson, I., Geiger, K. and Kryder, D. (1993) "Limiting Liberalism: The Southern Veto in Congress, 1933-1950," *Political Science Quarterly*, Vol. 108 (2): pp. 283-306.
- Kaye, H., Harrington, C. and LaPlante, M. (2010) "Long-Term Care: Who Gets It, Who Provides It, Who pays, and How Much?" *Health Affairs*, Vol. 29 (1): pp. 11-21.
- Keehan, S., Sisko, A., Christopher J., Truffer, C., Poisal, J., Cuckler, G., Madison, A., Lizonitz, J. and Smith, S. (2011) "National Health Spending Projections Through 2020: Economic Recovery and Reform Drive Faster Spending Growth," *Health Affairs*, Vol. 31 (9): pp. 1594-1605.
- Kennedy, E. (2006) "CLASS Act Seeks to Provide Long-Term Care with Dignity," in Shreefter, K. (ed) *Berkshire Senior*, Vol. 21 (6): pp. 1-16.
- Kerr, C., Dunlop, J., Harbison, F. and Myers, C. (1960) *Industrialism and Industrial Man*, Oxford, UK: Oxford University Press.
- King, A. (1973) "Ideas, Institutions and the Policies of Governments," *British Journal of Political Science*, Vol. 3 (3): pp. 291-313.
- King, D. (1995) *Actively Seeking Work?: The Politics of Unemployment and Welfare Policy in Great Britain and the United States*, Chicago, IL: University of Chicago Press.
- King, D. (1999) *In the Name of Liberalism: Illiberal Social Policy in Great Britain and the United States*, Oxford, UK: Oxford University Press.
- King, D. and Lieberman, R. (2009) "American State Building: The Theoretical Challenge," in Jacobs, L. and King, D. (eds) *The Unsustainable American State*, Oxford, UK: Oxford University Press, pp. 299-322.
- King, D. and Wood, S. (1999) "The Political Economy of Neoliberalism: Britain and the United States in the 1980s," in Kitschelt, H., Lange, P., Marks, G., and Stephens, J. (eds) *Continuity and Change in Contemporary Capitalism*, Cambridge, UK: Cambridge University Press, pp. 371-397.
- King, N. and Horrocks, C. (2010) *Interviewing in Qualitative Research*, London, UK: Sage Publications.

- Kingdon, J. (1995) *Agendas, Alternatives, and Public Policies* (2nd Edition), New York, NY: Longman Press.
- Kirchheimer, O. (1966) "The Transformation of Western European Party Systems," in La Palombara, J. and Weiner, M. (eds) *Political Parties and Political Development*, Princeton, NJ: Princeton University Press, pp. 177-199.
- Kliff, S. (2011) "Meet the senator who killed the CLASS Act," *The Washington Post*, October 18, 2011.
- Komisar, H. and Thompson, L. (2007) *National Spending on Long-Term Care*, Washington, DC: Georgetown University Health Policy Institute.
- Korpi, W. (2006) "Power Resources and Employer-Centered Approaches in Explanations of Welfare States and Varieties of Capitalism: Protagonists, Consenters, and Antagonists," *World Politics*, Vol. 58 (2): pp. 167-206.
- Kramer, M. (1990) "Remembering the Cuban Missile Crisis: Should We Swallow Oral History?" *International Security*, Vol. 15 (1): pp. 212-218.
- Lakdawalla, D. and Philipson, T. (2002) "The Rise in Old-Age Longevity and the Market for Long-Term Care," *American Economic Association Review*, Vol. 92 (1): pp. 295-306.
- Lambert, L. (2010) "Obama Plan Kills "Cornhusker Kickback," Boosts Medicaid," *Reuters*, February 22, 2010.
- Latham, E. (1952) "The Group Basis of Politics: Notes for a Theory," *American Political Science Review*, Vol. 46 (2): pp. 376-397.
- Lazarus, J. (2010) "Giving the People What They Want? The Distribution of Earmarks in the US House of Representatives," *American Journal of Political Science*, Vol. 54 (2): pp. 338-352.
- Lecours, A. (2005) "New Institutionalism: Issues and Questions," in Lecours, A. (ed) *New Institutionalism: Theory and Practice*, Toronto, CA: University of Toronto Press, pp. 3-25.
- Lee, R. (1993) *Doing Research on Sensitive Topics*, London, UK: Sage Publications.
- Levine, D. (1988) *Poverty and Society: The Growth of the American Welfare State in International Comparison*, New Brunswick, NJ: Rutgers University Press.
- Levitsky, S. (2006) *Private Dilemmas of Public Provision: The Formation of Political Demand for State Entitlements to Long-Term Care*, Madison, WI: University of Wisconsin-Madison.

- Levitsky, S. (2010) "Caregiving and the Construction of Political Claims for Long-Term Care Policy Reform," in Hudson, R. (ed) *The New Politics of Old Age Policy*, Baltimore, MD: Johns Hopkins University Press, pp. 208-230.
- Levy, J. (2005) "Redeploying the State: Liberalization and Social Policy in France," in Streeck, W. and Thelen, K. (2005) *Beyond Continuity: Institutional Change in Advanced Political Economies*, Oxford, UK: Oxford University Press, pp. 103-126.
- Life Care Act (1994) S. 1833, Washington, DC: 103rd Congress.
- Lindblom, C. (1959) "The Science Of 'Muddling Through,'" *Public Administration Review*, Vol. 19 (2): pp. 79–88.
- Lindblom, C. (1979) "Still Muddling, Not Yet Through," *Public Administration Review*, Vol. 39 (6): pp. 517–526.
- Lipset, M. (1991) "American Exceptionalism Reaffirmed," in Shafer, B. (ed) *Is America Different? A New Look at American Exceptionalism*, Oxford, UK: Clarendon Press, pp. 1-45.
- Lipset, M. (1996) *American Exceptionalism: A Double-Edged Sword*, New York, NY: Norton and Company.
- Lipset, M. and Marks, G (2001) *It Didn't Happen Here: Why Socialism Failed in the United States*, New York, NY: Norton and Company.
- Lipset, M. and Rokkan, S. (1967) *Party System Alignments: Cross-National Perspectives*, New York, NY: Free Press.
- Liptak, A. (2012) "Supreme Court Upholds Health Care Law, 5-4, in Victory for Obama," *New York Times*, June 28, 2012.
https://www.nytimes.com/2012/06/29/us/supreme-court-lets-health-law-largely-stand.html?pagewanted=all&_moc.semityn.www.
- Lockhart, C. (1991) "American Exceptionalism and Social Security: Complementary Cultural and Structural Contributions to Social Program Development," *The Review of Politics*, Vol. 53 (3): pp. 510-529.
- Lowi, T. (1979) *The End of Liberalism: The Second Republic of the United States* (2nd Edition), New York, NY: W.W. Norton.
- Ludtke, A. (2012) "Genworth Bets on Long-Term Care as Insurers Flee Market," *Bloomberg*, March 28, 2012.
<http://www.bloomberg.com/news/2012-03-28/genworth-bets-on-long-term-care-as-insurers-flee-market.html>.

- Lyke, B. (2009) "Health Care Reform: An Introduction," Washington, DC: Congressional Research Service.
- Mahoney, J. (2000) "Path Dependence in Historical Sociology," *Theory and Society*, Vol. 29 (4): pp. 507-548.
- Mahoney, J. (2003) "Strategies of Causal Assessment in Comparative Historical Analysis," in Mahoney, J. and Rueschemeyer, D. (eds) *Comparative Historical Analysis in the Social Sciences*, Cambridge, UK: Cambridge University Press.
- Mahoney, J. and Thelen, K. (2010) "A Gradual Theory of Institutional Change," in Mahoney, J. and Thelen, K. (eds) *Explaining Institutional Change: Ambiguity, Agency, and Power*, Cambridge, UK: Cambridge University Press, pp. 1-37.
- Mahoney, J. and Rueschemeyer (2003) *Comparative Historical Analysis in the Social Sciences*, Cambridge, UK: Cambridge University Press.
- Mann, T. and Ornstein, N. (1995) *Intensive Care: How Congress Shapes Health Policy*, Washington, DC: American Enterprise Institute / The Brookings Institution.
- March, J. and Olsen, J. (1984) "The New Institutionalism: Organizational Factors in Political Life," *American Political Science Review*, Vol. 78 (3): pp. 734-749.
- March, J. and Olsen, J. (1989) *Rediscovering Institutions: The Organizational Basis of Politics*, New York, NY: The Free Press.
- Mares, I. (2003a) "The Sources of Business Interest in Social Insurance: Sectoral Versus National Differences," *World Politics*, Vol. 55 (2): pp. 229-258.
- Mares, I. (2003b) *The Politics of Social Risk: Business and Welfare State Development*, Cambridge, UK: Cambridge University Press.
- Marmor, T. (2001) "How Not to Think About Medicare Reform," *Journal of Health, Politics and Law*, Vol. 26 (1): pp. 107-118.
- Marmor, T. and Mashaw, J. (2006) "Understanding Social Insurance: Fairness, Affordability and the Modernization of Social Security and Medicare," *Health Affairs*, Vol. 25 (3): pp.114-134.
- Marmor, T., Mashaw, J. and Harvey, P. (1990) *America's Misunderstood Welfare State: Persistent Myths, Enduring Realities*, New York, NY: Basic Books.
- Marmor, T. and Oberlander, J. (2003) "Paths to Universal Health Insurance: Progressive Lessons from the Past for the Future," *University of Illinois Law Review*, Vol. 2004 (1): pp. 205-230.

- Martin, C. (1995) "Nature or Nurture? Sources of Firm Preference for National Health Reform," *American Political Science Review*, Vol. 89 (4): pp. 898-913.
- Martin, C. (2000) *Stuck in Neutral: Business and the Politics of Human Capital Investment*, Princeton, NJ: Princeton University Press.
- May, P. (1992) "Policy Learning and Failure," *Journal of Public Policy*, Vol. 12 (4): pp. 331-354.
- Mead, L (1986) *Beyond Entitlement: The Social Obligations of Citizenship*, New York, NY: Free Press.
- Medicare Prescription Drug, Improvement and Modernization Act (2003) P.L. 108-173, 108th Congress, December 8, 2003.
- Meiners, M. (1996) "The Financing and Organization of Long-Term Care," in Binstock, R. and Von Mering, O. (eds) *The Future of Long-Term Care: Social and Policy Issues*, Baltimore, MD: Johns Hopkins University Press, pp. 191-214.
- MetLife (2011) *The MetLife Study of Caregiving Costs to Working Caregivers: Double Jeopardy for Baby Boomers Caring for Their Parents*, Westport, CT: MetLife Mature Market Institute.
- Miles, M. and Huberman, M. (1999) *Qualitative Data Analysis*, London, UK: Sage Publications.
- Miller, B., Ranji, U., Hisey, H., and Salganicoff, A. (2007) *Financing Long-Term Care: Background Brief*, Washington, DC: Kaiser Family Foundation.
- Mintrom, M. (2000) *Policy Entrepreneurs and School Choice*, Washington, DC: Georgetown University Press.
- Mintrom, M. and Norman, P. (2009) "Policy Entrepreneurship and Policy Change," *The Policy Studies Journal*, Vol. 37 (4): pp. 649-667.
- Mishra, R. (1984) *The Welfare State in Crisis: Social Thought and Social Change*, New York, NY: St. Martin's Press.
- Montgomery, L. and Murray, S. (2009) "Senate Pushes Ahead on Long-Term Care Program," *The Washington Post*, December 5, 2009.
- Montgomery, R. (1999) "The Family Role in the Context of Long-Term Care," *Journal of Aging and Health*, Vol. 11 (3): pp. 383-416.

- Moore, B. (1966) *Social Origins of Dictatorship and Democracy: Lord and Peasant in the Making of the Modern World*, Boston, MA: Beacon.
- Morgan, K. and Campbell, A. (2011) *The Delegated Welfare State: Medicare, Markets, and the Governance of Social Policy*, Oxford, UK: Oxford University Press.
- Morone, J. (1998) *The Democratic Wish: Popular Participation and the Limits of American Government*, New Haven, CT: Yale University Press.
- Moss, D. (2002) *When All Else Fails: Government as the Ultimate Risk Manager*, Cambridge, MA: Harvard University Press.
- Mulvey, J. (2009) *Factors Affecting the Demand for Long-Term Care Insurance: Issues for Congress*, Washington, DC: Congressional Research Service.
- Mulvey, J. and Colello, K. (2010) "Community Living Assistance Services and Supports (CLASS) Provisions in the Patient Protection and Affordable Care Act (PPACA)," Washington, DC: Congressional Research Service.
- Murray, C. (1984) *Losing Ground: American Social Policy, 1950-1980*, New York, NY: Basic Books.
- National Governors Association and National Association of State Budget Officers (2011) *The Fiscal Survey of States: Fall 2011*, Washington, DC: National Association of State Budget Officers.
<http://www.nga.org/files/live/sites/NGA/files/pdf/FSS1111.PDF>.
- North, D. (1990) *Institutions, Institutional Change, and Economic Performance*, Cambridge, UK: Cambridge University Press.
- Obama, B. (2008) "Affordable Health Care for All Americans: The Obama-Biden Plan," *Journal of the American Medical Association*, Vol. 300 (16): pp. 1927-1928.
- Oberlander, J. (2003) "The Politics of Health Reform: Why Do Bad Things Happen To Good Plans?" *Health Affairs*, Vol. 22 (4): pp. 391-404.
- Obinger, H., Leibfried, S. and Castles, F. (2005) "Introduction: Federalism and the Welfare State," in Obinger, H., Leibfried, S. and Castles, F. (eds) *Federalism and the Welfare State: New World and European Experiences*, Cambridge, UK: Cambridge University Press, pp. 1-48.
- O'Connor, J. (1973) *The Fiscal Crisis of the State*, New York, NY: St. Martin's Press.
- Offe, C. (1984) *Contradictions of the Welfare State*, London, UK: Hutchinson.

- Office of the Clerk, U.S. House of Representatives (2012) "Party Divisions of the House of Representatives (1789 to Present)," Washington, DC: U.S. Congress.
http://www.house.gov/house_history/partyDiv.aspx.
- Organization for Economic Co-operation and Development (2012) *OECD Health Data 2012: How Does the United States Compare?*
<http://www.oecd.org/unitedstates/BriefingNoteUSA2012.pdf>.
- Orren, K. and Skowronek, S. (2004) *The Search for American Political Development*, Cambridge, UK: Cambridge University Press.
- Österle, A. and Rothgang, H. (2010) "Long-Term Care," in *The Oxford Handbook of the Welfare State*, Castles, F., Leibfried, S., Lewis, J., Obinger, H. and Pierson, C. (eds) Oxford, UK: Oxford University Press, pp. 378-390.
- Page, B. and Jacobs, L. (2009) "No Class Warfare: Economic Inequality and the American Public," in Jacobs, L. and King, D. (eds) *The Unsustainable American State*, Oxford, UK: Oxford University Press, pp.135-166.
- Parsons, C. (2002) "Showing Ideas as Causes: The Origins of the European Union," *International Organization*, Vol. 56 (1): pp. 47–84.
- Parsons, C. (2007) *How to Map Arguments in Political Science*, Oxford, UK: Oxford University Press.
- Patashnik, E. and Zelizer, J. (2010) "When Policy Does Not Remake Politics: The Limits of Policy Feedback," Presented at the Republic of Statutes Conference, Yale Law School, December 10-11, 2010.
- Patient Protection and Affordable Care Act (2010) Public Law 111-148, 111th Congress, March 23, 2010.
- Patton, M. (2002) *Qualitative Research and Evaluation Methods*, Thousand Oaks, CA: Sage Publications.
- Pavalko, E. (2011) "Caregiving and the Life Course: Connecting the Personal and the Public," in Settersten, R. and Angel, J. (eds) *Handbook of Sociology of Aging*, New York, NY: Springer, pp. 603-616.
- Pear, R. (1993) "Clinton Health Proposal Includes New Program for Long-Term Care," *New York Times*, September 08, 1993.
- Peele, G. (2006) "Electoral Politics, Ideology and American Social Policy," *Social Policy and Administration*, Vol. 39 (2): pp. 150-165.

- Peters, G., Pierre, J. and King, D. (2005) "The Politics of Path Dependency: Political Conflict in Historical Institutionalism," *The Journal of Politics*, Vol. 67 (4): pp. 1275-1300.
- Peterson, M. (1998) "The Politics of Health Care Policy: Overreaching in An Age of Polarization," in Weir, M. (ed) *The Social Divide: Political Parties and the Future of Activist Government*, Washington, DC: Brookings Institution Press / New York, NY: Russell Sage Foundation, pp. 181-229.
- Peterson, M. (1999) "Motivation, Mobilization, and Monitoring: The Role of Groups in Health Policy," *Journal of Health Politics, Policy and Law*, Vol. 24 (3): pp. 415-420.
- Pierson, P. (1993) "When Effect Becomes Cause: Policy Feedback and Political Change," *World Politics*, Vol. 45 (4): pp. 595-628.
- Pierson, P. (1994) *Dismantling the Welfare State? Reagan, Thatcher, and the Politics of Retrenchment*, Cambridge, UK: Cambridge University Press.
- Pierson, P. (1995) "Fragmented Welfare States: Federal Institutions and the Development of Social Policy," *Governance*, Vol. 8 (4): pp. 449-478.
- Pierson, P. (1996) "The New Politics of the Welfare State," *World Politics*, Vol. 48 (2): pp.143-179.
- Pierson, P. (2000a) "Increasing Returns, Path Dependence, and the Study of Politics," *American Political Science Review*, Vol. 94 (2): pp. 251-267.
- Pierson, P. (2000b) "Not Just What, but When: Timing and Sequence in Political Processes," *Studies in American Political Development*, Vol. 14 (1): pp. 72-92
- Pierson, P. (2001) "Coping with Permanent Austerity: Welfare State Restructuring in Affluent Democracies," in Pierson, P. (ed) *The New Politics of the Welfare State*, Oxford, UK: Oxford University Press, pp. 410-456.
- Pierson, P. (2004) *Politics in Time: History, Institutions and Social Analysis*, Oxford, UK: Oxford University Press.
- Pierson, P. and Skocpol, T. (2007) *The Transformation of American Politics: Activist Government and the Rise of Conservatism*, Princeton, NJ: Princeton University Press.
- Polsby, N. (1984) *Political Innovation in America: The Politics of Policy Initiation*, New Haven, CT: Yale University Press.

- Powell, L. (1995) "The National Council of Senior Citizens," in Ramsay, C. (ed) *United States Health Interest Groups*, Westport, CT: Greenwood Press.
- Powell, W. and DiMaggio, P. (1991) *The New Institutionalism in Organizational Analysis*, Chicago, IL: University of Chicago Press.
- President's Commission to Strengthen Social Security (2001) *Final Report: Strengthening Social Security and Creating Personal Wealth for All Americans*, Washington, DC, December 21, 2001.
- Punch, K. (1998) *Introduction to Social Research: Quantitative and Qualitative Approaches*, London, UK: Sage Publications.
- Punch, M. (1994) "Politics and Ethics in Qualitative Research," in Denzin, N. and Lincoln, Y. (eds) *The Sage Handbook of Qualitative Research*, Thousand Oaks, CA: Sage Publications.
- Quadagno, J. (1988) *The Transformation of Old Age Security: Class and Politics in the American Welfare State*, Chicago, IL: University of Chicago Press.
- Quadagno, J. (2004) "Why the United States Has No National Health Insurance: Stakeholder Mobilization Against the Welfare State, 1945-1996," *Journal of Social Behavior*, Vol. 45 (Extra Issue): pp. 25-44.
- Quadagno, J. (2005) *One Nation, Uninsured: Why the U.S. Has No National Health Insurance*, Oxford, UK: Oxford University Press.
- Quadagno, J. and Street, D. (2005) "Ideology and Public Policy: Antistatism in American Welfare State Transformation," *Journal of Policy History*, Vol. 17 (1): pp. 57-75.
- Reinhard, S., Kassner, E., Houser, A. and R. Mollica (2011) *Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers*, Washington, DC: AARP Foundation.
- Rhem, P., Hacker, J. and Schlesinger, M. (2012) "Insecure Alliances: Risk, Inequality, and Support for the Welfare State," *American Political Science Review*, Vol. 106 (2): pp. 386-406.
- Rimlinger, G. (1971) *Welfare Policy and Industrialization in Europe, America, and Russia*, New York, NY: Wiley.
- Ripley, R. and Franklin, G. (1984) *Congress, the Bureaucracy, and Public Policy*, Homewood, IL: The Dorsey Press.

- Ritchie, J. (2003) "The Applications of Qualitative to Social Research," in Ritchie, J. and Lewis, J. (eds) *Qualitative Research Practice: A Guide for Social Science Students and Researchers*, London, UK: Sage Publications.
- Robertson, D. (1993) "The Return to History and the New Institutionalism in American Political Science," *Social Science History*, Vol. 17 (1): pp. 1-36.
- Robson, C. (2000) *Real World Research: A Resource for Social Scientists and Practitioners-Researchers*, Oxford, UK: Blackwell Publishing.
- Rowlingson, K. (2002) "Private Pension Planning: The Rhetoric of Responsibility, the Reality of Insecurity," *Journal of Social Policy*, Vol. 31 (4): pp. 623-642.
- Rueda, D. (2008) "Left Government, Policy, and Corporatism: Explaining the Influence of Partisanship on Inequality," *World Politics*, Vol. 60 (3): pp. 349-89.
- Rushefsky, M. and Patel, K. (1998) *Politics, Power and Policymaking: The Case of Health Reform in the 1990s*, New York, NY: M.E. Sharpe.
- Rushefsky, M. and Patel, K. (2006) *Health Care Politics And Policy in America*, New York, NY: M.E. Sharpe.
- Sabatier, P. (1988) "An Advocacy Coalition Framework of Policy Change and the Role of Policy-Oriented Learning Therein," *Policy Sciences*, Vol. 2 (21): pp. 129-168.
- Sabatier, P. (1999) *Theories of the Policy Process*, Boulder, CO: Westview Press.
- Sabatier, P. and Jenkins-Smith, H. (1988) "An Advocacy Coalition Framework of Policy Change and the Role of Policy-Oriented Learning Therein," *Policy Sciences*, Vol. 2 (21): pp. 129-168.
- Sabatier, P. and Jenkins-Smith, H. (1993) *Policy Change and Learning; An Advocacy Coalition Approach*, Boulder, CO: Westview Press.
- Sabatier, P. and Weible, C. (1999) "The Advocacy Coalition Framework," in Sabatier, P. (ed) *Theories of the Policy Process*, Boulder, CO: Westview Press.
- Sachs, J. (2011) *The Price of Civilization: American Values and the Return of Prosperity*, New York, NY: Random House.
- Saltman, R. (2004) "Social Health Insurance in Perspective: The Challenges of Sustaining Stability," in Saltman, R., Busse, R. and Figures, J. (eds) *Social Health Insurance Systems in Western Europe*, Buckingham, UK: Open University Press, pp. 3-20.

- Scharlach, A. and Lehning, A. (2012) "Government's Role in Aging and Long-Term Care," in Hacker, J. and O'Leary, A. (eds) *Shared Responsibility, Shared Risk: Government, Markets and Social Policy in the Twenty-First Century*, Oxford, UK: Oxford University Press, pp. 229-249.
- Schickler, E. (2001) *Disjointed Pluralism: Institutional Innovation and the Development of the U.S. Congress*, Princeton, NJ: Princeton University Press.
- Sears, D., Sidanius, J. and Bobo, L. (2000) *Racialized Politics: The Debate about Racism in America*, Chicago, IL: University of Chicago Press.
- Sebelius, K. (2011) "Letter to Congress about CLASS," October 14, 2011. <http://www.hhs.gov/secretary/letter10142011.html>
- Seeleib-Kaiser, M., Saunders, A., and Naczyk, M. (2012) "Shifting the Public-Private Mix: A New Dualization of Welfare," in *The Age of Dualization: The Changing Face of Inequality in Deindustrializing Societies*, Emmenegger, P., Hausermann, S., Palier, B. and Seeleib-Kaiser, M. (eds) Oxford, UK: Oxford University Press, pp. 151-175.
- Shapiro, R. and Young, J. (1989) "Public Opinion and the Welfare State: The United States in Comparative Perspective," *Political Science Quarterly*, Vol. 104 (1): pp. 59-89.
- Sheingate, A. (2003) "Policy Entrepreneurship, Institutional Change and American Political Development," *Studies in American Political Development*, Vol. 17 (2): pp. 185-203.
- Sheldon, A. and Pappworth, J. (1983) *By Word of Mouth: Elite Oral History*, London, UK: Methuen Publishing.
- Shepsle, K. (1979) "Institutional Arrangements and Equilibrium in Multidimensional Voting Models," *American Journal of Political Science*, Vol. 23 (1): pp. 27-60.
- Shepsle, K. (1989) "Studying Institutions: Some Lessons from the Rational Choice Approach," *Journal of Theoretical Politics*, Vol. 1 (2): pp. 131-47.
- Shepsle, K. and Weingast, B. (1987) "The Institutional Foundations of Committee Power," *The American Political Science Review*, Vol. 81 (1): pp. 85-105.
- Skocpol, T. (1979) *States and Social Revolutions: A Comparative Analysis of France, Russia, and China*, Cambridge, UK: Cambridge University Press.
- Skocpol, T. (1985) "Bringing the State Back in: Strategies of Analysis in Current Research," in Evans, P., Rueschemeyer, D. and Skocpol, T. (eds) *Bringing the State Back In*, Cambridge, UK: Cambridge University Press, pp. 3-43.

- Skocpol, T. (1992) *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States*, Cambridge, MA: Harvard University Press.
- Skocpol, T. (1995) *Social Policy in the United States: Future Possibilities in Historical Perspective*, Princeton, NJ: Princeton University Press.
- Skocpol, T. (1996) *Boomerang: Health Care Reform and the Turn Against Government*, New York, NY: W.W. Norton and Company.
- Skocpol, T. (2000) *The Missing Middle: Working Families and the Future of American Social Policy*, New York, NY: W. W. Norton and Company.
- Skocpol, T. and Amenta, E. (1986) "States and Social Policy," *Annual Review of Sociology*, Vol. 12 (1): pp. 131-157.
- Skocpol, T. and Somers, M. (1980) "The Uses of Comparative History in Macrosocial Inquiry," *Comparative Studies in Society and History*, Vol. 22 (2): pp. 174-197.
- Skocpol, T. and Williams, V. (2012) *The Tea Party and the Remaking of Republican Conservatism*, Oxford, UK: Oxford University Press.
- Skowronek, S. (1982) *Building a New American State: The Expansion of National Administrative Capacities, 1877-1920*, Cambridge, UK: Cambridge University Press.
- Smith, D. (2012) "House Votes to Repeal Part of Healthcare Law," *Reuters*, February 1, 2012.
- Smith, R. (1993) "Beyond Tocqueville, Myrdal, and Hartz: The Multiple Traditions in America," *American Political Science Review*, Vol. 87 (3): pp. 549-566.
- Social Security and Medicare Board of Trustees (2003) *Status of the Social Security and Medicare Programs: A Summary of the 2003 Annual Reports*, Washington, DC: Centers for Medicare and Medicaid Services.
- Stake, R. (2010) *Qualitative Research: Studying How Things Work*, New York, NY: The Guilford Press.
- Steinmo, S. (1993) "American Exceptionalism Reconsidered: Culture or Institutions," in Dodd, L. and Jillson, C. (eds) *The Dynamics of American Politics: Approaches and Interpretations*, Boulder, CO: Westview Press, pp. 106-131.
- Steinmo, S. and Watts, J. (1995) "It's the Institutions Stupid! Why Comprehensive National Health Insurance Fails in America," *Journal of Health Politics, Policy and Law*, Vol. 20 (2): pp. 329-372.

- Stevens, B. (1988) "Blurring the Boundaries: How the Federal Government Has Influenced Welfare State Benefits in the Private Sector," in Weir, M., Orloff, A., and Skocpol, T. (eds) *The Politics of Social Policy in the United States*, Princeton, NJ: Princeton University Press, pp. 123-148.
- Stevenson, D. (2008) "Planning for the Future—Long-Term Care and the 2008 Election," *New England Journal of Medicine*, Vol. 358 (19): pp. 1985-1987.
- Stolberg, S. and Pear, R. (2010) "President Urges Focus on Common Ground," *New York Times*, February 25, 2010.
- Stone, J. (2010) "Long-Term Care (LTC): Financing Overview and Issues for Congress," Washington, DC: Congressional Research Service.
- Stone, R. (2004) "Where Have All the Good Advocates Gone?" *Generations*, Vol. 28 (1): pp. 59-64.
- Stone, R. (2006) "Emerging Issues in Long-Term Care, in Binstock, R. and George, L. (eds) *Handbook of Aging and the Social Sciences*, New York, NY: Academic Press (Elsevier).
- Strauss, A. (1987) *Qualitative Analysis for Social Scientists*, Cambridge, UK: Cambridge University Press.
- Streeck, W. and Thelen, K. (2005) "Introduction: Institutional Change in Advanced Political Economies," in Streeck, W. and Thelen, K. (eds) *Beyond Continuity: Institutional Change in Advanced Political Economies*, Oxford, UK: Oxford University Press, pp. 1-39.
- Streeck, W. and Thelen, K. (2010) "Institutional Change in Advanced Political Economies," in Hancke, B. (ed) *Debating Varieties of Capitalism: A Reader*, Oxford, UK: Oxford University Press, pp. 95-133.
- Street, D. (1993) "Maintaining the Status Quo: The Impact of Old-Age Interest Groups on the Medicare Catastrophic Coverage Act of 1988," *Social Problems*, Vol. 40 (4): pp. 431-444.
- Swank, D. (2001) "Political Institutions and Welfare State Restructuring: the Impact of Institutions on Social Policy Change in Developed Democracies," in Pierson, P. (ed) *The New Politics of the Welfare State*, Oxford, UK: Oxford University Press, pp. 197-237.
- Swank, D. (2002) *Global Capital, Political Institutions, and Policy Change in Developed Welfare States*, Cambridge, UK: Cambridge University Press.

- Swenson, P. (2002) *Capitalists Against Markets: The Making of Labor Markets and Welfare States in the United States and Sweden*, Oxford, UK: Oxford University Press.
- Tansey, O. (2007) "Process Tracing and Elite Interviewing: A Case for Non-probability Sampling," *Political Science and Politics*, Vol. 40 (4): pp. 765-772.
- Taylor-Gooby, P. (2004) "New Social Risks and Social Change," in Taylor-Gooby, P. (ed) *New Risks, New Welfare: The Transformation of the European Welfare State*, Oxford, UK: Oxford University Press, pp. 1-28.
- Teles, S. and Derthick, M. (2009) "Social Security from 1980 to the Present: From Third Rail to Presidential Commitment—and Back?" in Glenn, B. and Teles, S. (eds) *Conservatism and American Political Development*, Oxford, UK: Oxford University Press, pp. 261-290.
- Thelen, K. (1999) "Historical Institutionalism in Comparative Politics," *Annual Review of Political Science*, Vol. 2 (1): pp. 369-404.
- Thelen, K. (2003) "How Institutions Evolve: Insights from Comparative Historical Analysis," In Mahoney, J. and Rueschemeyer, D. (eds) *Comparative Historical Analysis in the Social Sciences*, Cambridge, UK: Cambridge University Press, pp. 208-240.
- Thelen, K. (2004) *How Institutions Evolve: The Political Economy of Skills in Germany, Britain, the United States and Japan*, Cambridge, UK: Cambridge University Press.
- Thelen, K. and Steinmo, S. (1992) *Historical Institutionalism in Comparative Politics*, in Steinmo, S., Thelen, K. and Longstreth, F. (eds) *Structuring Politics: Historical Institutionalism in Comparative Analysis*, Cambridge, UK: Cambridge University Press, pp. 1-33.
- Thompson, F. and Burke, C. (2009) "Federalism by Waiver: Medicaid and the Transformation of Long-term Care," *Publius*, Vol. 39 (1): pp. 22-46.
- Thune, J. (2009) "Service Members Home Ownership Tax Act of 2009," *Congressional Record*, Friday, December 4, 2009, Vol. 15 (179): pp. S12390.
- Tilly, C. (1975) *The Formation of National States in Western Europe*, Princeton University Press.
- Truman, D. (1951) *The Governmental Process: Political Interest and Public Opinion*, New York, NY: Alfred A. Knopf.

- Tsebelis, G. (1995) "Decision Making in Political Systems: Veto Players and Presidentialism, Parliamentarism, Multicameralism, and Multipartism," *British Journal of Political Science*, Vol. 25 (3): pp. 289-325.
- Tsebelis, G. (2002) *Veto Players: How Political Institutions Work*, New York, NY: Russell Sage Foundation / Princeton University Press.
- Tumlinson, A., Agular, C. and O'Malley-Watts, M. (2009) *Closing the Long-Term Care Funding Gap: the Challenge of Private Long-Term Care Insurance*, Washington, DC: Kaiser Commission on Medicaid and the Uninsured.
<http://www.kff.org/insurance/upload/Closing-the-Long-Term-Care-Funding-Gap-The-Challenge-of-Private-Long-Term-Care-Insurance-Report.pdf>.
- Turner, F. (1921) *The Frontier in American History*, New York, NY: Henry Holt and Company.
- U.S. Administration on Aging, United States Department of Health and Human Services (2010) *A Profile of Older Americans: 2010*, Washington, DC: Government Printing Office.
http://www.aoa.gov/aoaroot/aging_statistics/Profile/2010/docs/2010profile.pdf.
- U.S. Bipartisan Commission on Comprehensive Health Care (1990) *A Call to Action, Final Report*, Washington, DC: Government Printing Office.
- U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy (1994) *Cost Estimates for Long-Term Care Provisions under the Health Security Act*, Washington, DC: Government Printing Office.
<http://aspe.hhs.gov/daltcp/reports/hcrctest.pdf>.
- U.S. Department of Health and Human Services (2011) *A Report on the Actuarial, Marketing, and Legal Analyses of the CLASS Program*, Washington, DC: The Offices of CLASS, ASPE, and the General Counsel, October 2011.
<http://aspe.hhs.gov/daltcp/Reports/2011/class/index.shtml>.
- U.S. Department of Health and Human Services (2012) "Annual Update of the HHS Poverty Guidelines," *Federal Register*, Vol. 77 (17): January 26, 2012, pp. 4034-4035.
<http://aspe.hhs.gov/poverty/12fedreg.pdf>.
- U.S. Senate (2012) "Party Division in the Senate, 1789-Present," U.S. Senate website.
http://www.senate.gov/pagelayout/history/one_item_and_tasers/partydiv.htm.

- U.S. Social Security Administration, Office of Retirement and Disability Policy, Office of Research, Evaluation, and Statistics (2012) *Annual Statistical Supplement to the Social Security Bulletin, 2011* (SSA Publication No. 13-11700), Washington, DC: Social Security Administration.
<https://www.socialsecurity.gov/policy/docs/statcomps/supplement/2011/supplement11.pdf>.
- Vincent, G. and Velkoff, V. (2010) *The Next Four Decades: The Older Population in the United States: 2010 to 2050*, Washington, DC: U.S. Census Bureau.
<https://www.census.gov/prod/2010pubs/p25-1138.pdf>.
- Viser, M. (2011) "GOP wins vote against health law," *The Boston Globe*, January 20, 2011.
http://www.boston.com/news/nation/articles/2011/01/20/gop_wins_vote_against_health_law/.
- Waddan, A. (1997) *The Politics of Social Welfare: The Collapse of the Centre and Rise of the Right*, Cheltenham, UK: Edward Elgar Publishing.
- Waddan, A. and Jaenicke, D. (2006) "Recent Incremental Reforms in the US: A Way Forward or False Promise?," *Policy and Politics*, Vol. 34 (2): pp. 241-263.
- Walker, J. (1974) "Performance Gaps, Policy Research, and Political Entrepreneurs: Toward a Theory of Agenda Setting," *Policy Studies Journal*, Vol. 3 (1): pp.112-116.
- Walker, J. (1991) *Mobilizing Interest Groups in America: Patrons, Professions, and Social Movements*, Ann Arbor, MI: University of Michigan Press.
- Wawro, G. and Schickler, E. (2006) *Filibuster: Obstruction and Lawmaking in the U.S. Senate*, Princeton, NJ: Princeton University Press.
- Weaver, K. (1998) "Ending Welfare as We Know It," in Weir, M. (ed) *The Social Divide: Political Parties and the Future of Activist Government*, New York, NY: Russell Sage Foundation / Washington, DC: The Brookings Institution, pp. 361-416.
- Weaver, K. (2000) *Ending Welfare As We Know It*, Washington, DC: Brookings Institute Press.
- Weaver, K. (2010) "Paths and Forks or Chutes and Ladders?: Negative Feedbacks and Policy Regime Change," *Journal of Public Policy*, Vol. 30 (2): pp. 137-162.
- Weaver, K and Rockman, B. (1993) *Do Institutions Matter? Government Capabilities in the United States and Abroad*, Washington, DC: The Brookings Institute.

- Weir, M. (1992) *Politics and Jobs: The Boundaries of Employment Policy in the United States*, Princeton, NJ: Princeton University Press.
- Weir, M., Orloff, A. and Skocpol, T. (1988) *The Politics of Social Policy in the United States*, Princeton, NJ: Princeton University Press.
- Wellington, J. and Szczerbinski, M. (2007) *Research Methods for the Social Sciences*, Trowbridge, Wiltshire: Cromwell Press.
- White House (2010) "The President's Proposal," Washington, DC: The White House, February 22, 2010.
<http://www.whitehouse.gov/sites/default/files/summary-presidents-proposal.pdf>.
- Wiener, J. (2009) *Long-Term Care: Options in an Era of Health Reform*, Washington, DC: RTI International.
- Wiener, J., Illston, L. and Henley, R. (1994) *Sharing the Burden: Strategies for Public and Private Long-Term Care Insurance*, Washington, DC: The Brookings Institution.
- Wiener, J., Estes, C., Goldenson, S. and Goldberg, S. (2001) "What Happened to Long-Term Care in the Health Reform Debate of 1993–1994? Lessons for the Future," *Milbank Quarterly*, Vol. 79 (2): pp. 207-252.
- Wilensky, H. (1975) *The Welfare State and Equality: Structural and Ideological Roots of Expenditures*, Berkley, CA: University of California Press.
- Williams, L. (1997) *American Liberalism and Ideological Change*, DeKalb, IL: Northern Illinois University Press.
- Wlezien, C. (2004) "Patterns of Representation: Dynamics of Public Preferences and Policy," *Journal of Politics*, Vol. 66 (1): pp. 1–24.
- Wright, J. (2007) "The One Thing You Need To Know about Interest Groups," Prepared for Conference in Honor of Richard G. Niemi, University of Rochester, Rochester, NY, November 3, 2007.
- Zedlewski, S. and McBride, T. (1992) "The Changing Profile of the Elderly: Effects on Future Long-Term Care Needs and Financing," *The Milbank Quarterly*, Vol. 70 (2): pp. 247-275.

Appendix A: Sample Letter of Introduction

Dear Sir or Madam,

I am a doctoral student at the University of Oxford, carrying out my research on long-term care policy. Please accept this invitation to partake in a research study. The purpose of my research is to learn about the way interest groups within the long-term care policy arena have influenced the development of the CLASS Act. The goal of the study is to understand what impact interest groups within the long-term care policy arena had in shaping the progression of the CLASS Act legislation both before and during the 111th Congress. The study results will be used as part of a doctoral thesis at the University of Oxford (and possibly in academic articles, public lectures or books).

You have been invited to take part in this research study because of your special knowledge and/or personal involvement with the CLASS Act legislation. Your participation will involve an interview during which you will be asked several questions regarding your work on (or particular knowledge about) the CLASS Act. The amount of time required for your participation in this study should not exceed an hour.

You may choose to withdraw your consent for the study at any time. You may also omit any questions you do not feel comfortable answering after the interview has begun. Your name, your employer (or affiliated organization) and any statements that you make during the interview will remain anonymous in any written materials made public at the end of this study such as a doctoral dissertation, public lectures or academic articles.

Please feel free to contact me at any time with questions about this research. I can be reached at the email address below. The project is being conducted under the supervision of Dr. Rebecca Surender of the University of Oxford's Department of Social Policy and Social Work. If you require any additional information about the study, Dr. Surender can be reached at the department. The Department of Social Policy and Social Work's Departmental Research Ethics Committee (DREC) has reviewed and given ethical clearance to this project.

I greatly appreciate any time that you can offer. Your experience and views will be essential in gaining a better understanding of long-term care policymaking and in turn improving future efforts to reform long-term care policy.

Sincerely,
Walter Dawson
D.Phil Candidate

Appendix B: Interview Participant Participation Form

Information for Research Participants

Invitation to Participate

Please accept this invitation to partake in a research study. Walter Dawson, a doctoral student at the University of Oxford, will carry out the research. The project is being conducted under the supervision of Dr. Rebecca Surender of the University of Oxford's Department of Social Policy and Social Work. The University of Oxford's Central University Research Ethics Committee has reviewed and given ethical clearance to this project.

The goals of this research study will be clarified by the following information. A brief explanation of how the research will be conducted and what your participation would involve if you accept this invitation are also provided. If you have any questions after reading this information, feel free to ask the researcher. You will be given as much time as you need to decide whether or not you would like to participate. You may also choose to withdraw from the study once the interview has already begun.

Research Description

The purpose of this research is to learn about the way interest groups within the long-term care policy arena have influenced the development of the CLASS Act legislation. The goal of the study is to understand why policymakers chose to include the language found in the various forms of the CLASS Act legislation proposed during the 111th Congress, and what impact interest groups within the long-term care policy arena had in shaping the progression of the CLASS Act legislation during the 111th Congress. The study results will be used as part of a doctoral thesis at the University of Oxford.

Participation

You have been invited to take part in this research study because of your special knowledge and/or personal involvement with the CLASS Act legislation. Your participation will involve an interview with Walter Dawson during which you will be asked several questions regarding your work on (or particular knowledge about) the CLASS Act. The amount of time required for your participation in this study will not exceed an hour and a half.

Your participation in this research study is completely voluntary. Questions may be asked before or at any time during the course of the study. You may choose not to participate and you may withdraw your consent at any time. You may also omit any questions you do not feel comfortable answering after the interview has begun.

Data Collection

Written notes will be taken by the researcher during the interview. The researcher will also electronically record the interviews so that they have a better record from which to write the dissertation later on. If at any time you would like to say something confidential or ask a question about the study you are welcome to do so. Anything you say off the record will not be recorded or reported at any time.

Confidentiality and Handling of Data

After your interview is complete, the researcher will immediately type up his written notes. The notes as well as the electronic recording of the interview are the sole property of the researcher, Walter Dawson, and can be used at his discretion. Your name, your employer (or affiliated organization) and any statements that you make during the interview process will remain anonymous in any written materials made public at the end of this study such as a doctoral dissertation, public lectures or academic articles.

Use of Data

The results of the data will be used as part of an Oxford doctoral thesis (and possibly in academic articles, public lectures or books). If you would like a copy of the final doctoral thesis, please notify the researcher after the interview, in person, or by using the contact details listed below.

Contact information

Additional questions about this research can be directed to:

Walter Dawson
Department of Social Policy and Social Work
University of Oxford
Barnett House
32 Wellington Square
Oxford, OX1 2ER
United Kingdom

Questions or comments are welcome at any time. Your participation is greatly appreciated!

Appendix C: Topic Guide

Introductory Questions

1. How long have you worked in the long-term care policy arena?
2. What organization do you currently work for?
3. What is your position at this organization?
 - a. Have you been in this position for the duration of your employment at this organization, or have you held other positions there?
 - b. What position did you hold at the time the CLASS Act was being developed?
 - c. What responsibilities does your position entail?

The CLASS Act (2003-Spring 2009)

4. I am interested in how the CLASS Act originally came about. What do you believe were the most important variables?
5. Was your organization consulted on the development of the CLASS Act?
 - a. If so, how were you involved?
6. What other groups (or individuals) were involved with developing the CLASS Act?
 - a. How were these other groups involved?
7. In your opinion, what were the most influential groups (or individuals) in the developing stages of CLASS Act?

- a. In what ways were these groups important or influential?
 - b. Was CLASS originally a disability initiative or were both aging and disability groups involved from the beginning?
8. In your opinion, what issues were taken into consideration while developing the CLASS Act?
- a. CLASS is a quasi-social insurance program. How was the decision made to make it a social insurance program available to everyone rather than a means tested benefit like Medicaid?
 - b. The bill provides at least \$50 a day for 2 ADLs. How did the consulting parties decide on the extent of coverage to be offered by CLASS?
 - c. What considerations were given to the changing demographics of the US (the aging of the baby boom generation) when developing the CLASS Act?
9. During the early development of CLASS, what compromises were made to reach consensus amongst the various stakeholders that supported it?
- a. Was building consensus between the various stakeholders an easy process?
 - b. What tensions existed?
10. How does the public's perception of the role of government in providing social protection affect what could have been included in legislation like the CLASS Act?

Comprehensive Health Reform (Spring 2009-Present Day)

11. CLASS is a part of the health reform bill that was passed by Congress. In your opinion, why did that happen?
12. In your opinion, why was the CLASS Act merged into the comprehensive health reform legislation in 2009?
13. Why was the CLASS Act used in comprehensive health reform rather than some other approach to LTC financing reform?
14. To what extent did individual political actors influence the decision to include CLASS in comprehensive health reform?
 - a. To what extent did the fact that Senator Kennedy championed this legislation play in the decision to include CLASS in comprehensive health reform?
 - b. What influence did Senator Kennedy's death have on CLASS?
 - c. What role do you believe the Administration / President Obama played?
 - d. What influence did Congressional staff have?
 - e. Advocacy groups?
 - f. The program's projected budgetary surplus (CBO Score)?
15. In your opinion, what other factors might have influenced policymakers to include CLASS as a part of comprehensive health reform?
16. Did any organization push to keep CLASS in comprehensive health reform?
 - a. Which organization(s)?
 - b. If so, what did they do to push for it to remain a part of health reform?

17. In your opinion, why has there been such great consensus amongst advocacy groups concerning the CLASS Act?
18. In your opinion, how is the final legislation viewed by other key stakeholders such as insurance companies and providers?
 - a. Why did they take that position on the CLASS Act?
19. In your opinion, were interest groups influential in the CLASS Act's progression through the legislative process?
 - a. Which groups do you believe were most influential?
 - b. How were these groups influential?
20. Did your organization work to keep the CLASS Act in comprehensive health reform, and if so, how?
21. Does the final version of CLASS reflect all of your organization's priorities?
 - a. Did your organization want provisions that were not included in CLASS?
 - b. If not, which priorities have been omitted from the current version?
 - c. Are there any provisions in the current legislation that you and your organization oppose?
22. In terms of strategy, do you think that it was a good idea to include CLASS in comprehensive health reform?
 - a. What were the tradeoffs in moving CLASS from a standalone piece of legislation to part of comprehensive health reform?

- b. In your opinion, would the CLASS Act be able to pass Congress independently from comprehensive health reform?

- a. Why (or why not)?

23. What possible lessons does the CLASS Act have for future LTC reform?

LTC Reform and the Health Security Act of 1993

24. Major long-term care reform was last considered in the early 1990s as a part of President Clinton's health reform proposal. In your opinion, why did LTC reform fail then but passed now?

- a. What do you see as the key differences between the early 1990s and current reform efforts?
 - a. The content of the legislation?
 - b. The process?
 - c. The political actors involved?

25. Was your organization involved in the debate over the long-term care financing provisions of President Clinton's Health Security Act of 1993?

- a. If so, how was your organization involved?
- b. Were you personally involved with that attempt to reform LTC financing?
 - b. If so, what was your role?

26. How do you think interest groups were involved with the LTC portion of the Clinton plan for health reform?

- a. In your opinion, which interest groups were most influential in the LTC portion of the Clinton plan?
- b. How were they important or influential?

27. What aspects of the Clinton proposal were most popular with interest groups?
- a. What were the least popular components of the plan?
28. To what extent did individual political actors influence the decision to include LTC reform in the Clinton health reform proposal?
- a. Members of Congress
 - b. Congressional Staff
 - c. The Clinton Administration
 - d. Advocacy Groups
29. In your opinion, what impact did the experiences of the Clinton era attempts at LTC reform have on proceeding attempts at LTC reform?
- a. What influence might they have on drafting the CLASS Act?