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**Explaining the Outcomes of the Affordable Care Act through Lowi and
Salamon's Policy Evaluation Models**

by

Anna Moravec

Departmental Honors Thesis

The University of Tennessee at Chattanooga

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ABSTRACT

This paper illustrates how tools-based theoretical models, like Lester Salamon's, can be used to predict the outcome of policy tools. Theodore Lowi and Lester Salamon's theoretical models were applied to select provisions of the Affordable Care Act (ACA) to generate predictions regarding their outcomes. The validity of these predictions was assessed by comparing them to current empirical data and trends. Ultimately, this paper sought to demonstrate how tools-based models can be used to predict policy tool outcomes relatively accurately. Our evaluation used Lowi's original model detailed in his *Four systems of policy, politics, and choice* (1972) paper and Salamon's model detailed in his book, *The tools of government: A guide to new governance* (2002). Lowi's model was applied to the ACA to illustrate why theoretical models need to allow for the multidimensional nature of public policy. The limited classification system Lowi's model employs ultimately prevented it from generating any useful predictions for the selected provisions of the ACA. Because Salamon's model allowed for the multidimensional nature of public policy and policy tools, it was able to generate relatively accurate predictions. However, Salamon's model and other tools-based approaches still require much improvement to be useful to policymakers today. A universal, less subjective classification system is needed to classify policy tools. Additionally, the predicted outcomes of policy tools need to be more clearly defined and qualitatively defined. If these improvements are made, the predictions generated by tools-based models will be replicable and thus of greater utility to policymakers.

INTRODUCTION

In 1964, the famous political scholar, Theodore Lowi, posed the question, “...how much farther along the road of political theory are we?” (Lowi, 1964a). Since asking this question, Lowi developed a theoretical model to predict the political outcomes of public policies. Throughout his studies, Lowi proved the utility of his model, but as some critics, like Lester Salamon, pointed out his model did possess several limitations. In part a response to Lowi, Salamon created his own theoretical model intended to predict the outcomes not of public policies but of the policy tools their programs implemented. Since Salamon’s model, several other models have been created to predict the outcome of policy tool implementation. Together, these models have been known as “the tool-based approach.” Although tools-based models allow for the multidimensional nature of public policy, no consensus has been reached regarding how to classify policy tools. Because of this, several analysts, such as Charles Lindblom, have questioned their utility (Salamon, 2002; Lindblom, 1990). This paper seeks to illustrate the advantages of using tool-based models to predict policy tool outcomes. First, we will apply Lowi’s model to one of the most prominent policies of the 21st century, the Affordable Care Act (ACA), to demonstrate why theoretical models need to allow for the multidimensional nature of public policy. Then, we will apply Salamon’s model to the ACA and compare Lowi and Salamon’s predictions for select provisions of the ACA to current empirical data and trends. Ultimately, we hope to illustrate how tools-based models, such as Salamon’s, can be

used to predict the outcomes of policy tools. We also will address how tools-based models can be improved to make them useful to policymakers today.

This paper is organized into five major sections. To begin, we will discuss the conditions that spurred the ACA's creation; its major provisions; its origins; and the outcomes seen today. In the second section, we will discuss Lowi's model and generate predictions for selected provisions of the ACA. The third section discusses Salamon's model and also uses it to generate predictions for the ACA. In the fourth section, we will compare Lowi and Salamon's predictions for the ACA to current empirical data and trends, assessing their models' relative accuracy and utility in predicting policy or policy tool outcomes. Finally, in the fifth section, we state our general conclusions.

I. THE AFFORDABLE CARE ACT

A. HEALTHCARE PRIOR TO THE ACA: WHAT SPURRED THE CREATION OF THE ACA?

Although many of the major healthcare policies implemented in the US prior to the ACA, such as Medicare, Medicaid, and CHIP, extended coverage to millions of Americans, in 2010 alone, 49.9 million Americans were uninsured, accounting for 16.3% of the population (DeNavas-Walt, Proctor, and Smith, 2011). Since 1987, the number of uninsured individuals in the US had steadily increased, rising from nearly 31 million in 1987 to the 49.9 million uninsured in 2010 (DeNavas-Walt, Proctor, and Smith, 2011). Thus, since 1987, 18.9 million additional US citizens have remained uninsured, meaning approximately 8,200,000 individuals have become or remained

uninsured per year from 1987-2010. Despite the consistently increasing number of uninsured individuals, the percentage of the US population without insurance has increased very little since 1987, rising from approximately 14.0% to 16.3% in 2010, which means since 1987 the percentage of uninsured Americans has increased by a factor of a little over 1 (1.16%). These statistics indicate that while the number of uninsured Americans has continued to significantly increase, the percentage of the American population attributed to this increase has grown relatively little since the late 1980s. This indicates approximately the same percentage of the population (a little larger percent since 1987) has remained uninsured for nearly 30 years, implying policies employed thus far have been ineffective at expanding coverage or targeting appropriate subgroups of the population. Thus, although enrollment numbers may have increased, this increase has been offset by the simultaneous increase in uninsured individuals. Indeed, between 2009 and 2010, both the numbers of uninsured and insured increased. These trends are depicted below in Figure 1.

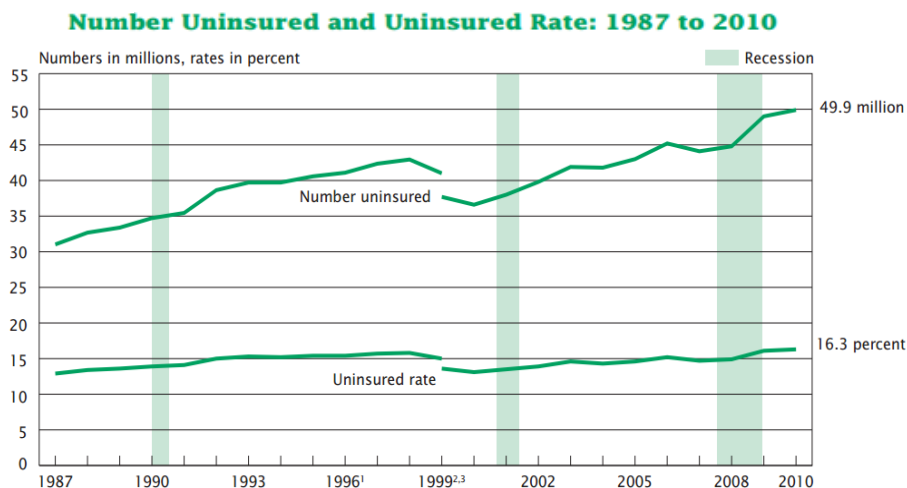


Figure 1: Number Uninsured & Uninsured Rate in the US from 1987-2010
(DeNavas-Walt, Proctor, & Smith, 2011)

Despite cost control mechanisms and a transition to the managed care delivery system, costs have also continued to increase with rising numbers of uninsured. In 2010, national healthcare expenditures comprised 17.1% of GDP (The World Bank Group, 2016). Since as early as 1960, US healthcare expenditures have been rapidly increasing despite cost control efforts and were projected to continue increasing, as shown on the next page in Figure 2 (Peter G. Peterson Foundation, 2016).

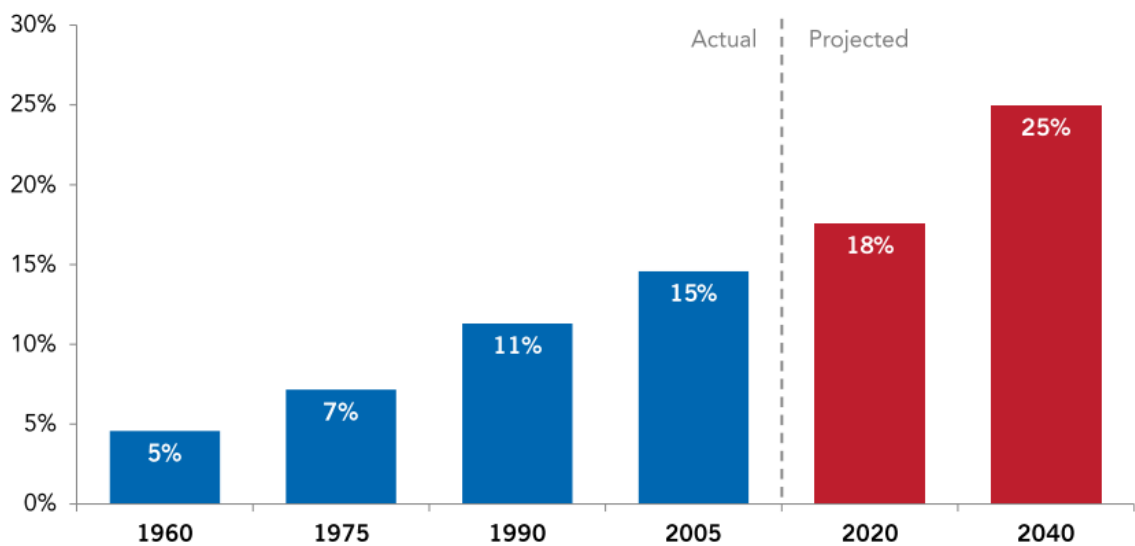


Figure 2: Prior and Predicted National Healthcare Spending (% of GDP)

Source: Peter G. Peterson Foundation, 2016

Affordability has also continued to be an issue despite Medicare, Medicaid, and CHIP's subsidization of healthcare for various vulnerable population subgroups. According to studies conducted by the Commonwealth Fund (2013), affordability has significantly impacted Americans' ability to gain insurance coverage. In fact, in a survey conducted by the Henry J. Kaiser Family Foundation in 2013, 61% of adult respondents said the main reason they are without insurance coverage is because the

cost of insurance is too high or they lost their job and subsequently could not afford to purchase private health insurance coverage (The Henry J. Kaiser Family Foundation, 2013). These findings suggested cost-related access barriers were the primary reason many adults in the US have remained and continue to remain uninsured (The Henry J. Kaiser Family Foundation, 2013; Commonwealth Fund, 2013).

B. INTRODUCTION TO THE ACA AND ITS MAJOR PROVISIONS

In response to these issues, in 2010, President Barack Obama signed into legislation the Patient Protection and Affordable Care Act, which became commonly referred to as the Affordable Care Act (ACA). The ACA's key features focused on increasing affordability, expanding coverage, and protecting consumers (U.S. Department of Health & Human Services, 2015a). Although it did contain some provisions for cost containment, these provisions were sparse and thus in some ways suggest that the ACA's primary focus is not to control costs but rather expand coverage and increase affordability. Cost containment provisions found within the ACA include standardized billing, mandated electronic exchange of PHI, and limited tax exclusions on employer-based plans (U.S. Department of Health & Human Services, 2015a). The following paragraphs discuss some of the ACA's provisions for increasing affordability, expanding coverage, and protecting consumers. The ACA has numerous provisions so only a few, select major provisions are discussed.

The ACA's creation of federal-state health insurance markets serve as its primary provision to increase healthcare affordability (U.S. Department of Health &

Human Services, 2015a). State health insurance markets offer standardized healthcare plans regulated by the federal governments. Each state can customize their standard benefits package but must offer the 10 essential benefits mandated by the federal government, which include: ambulatory or outpatient care, hospital treatments, maternity services, laboratory tests, emergency room care, pediatric care, mental health services, preventative care, prescription drug coverage, and rehabilitative care and necessary equipment. Qualifying individuals choosing to purchase health insurance through federal-state health insurance markets are eligible for federal subsidies. These subsidies are offered to individuals earning between 100-400% of the poverty line who are unable to obtain health insurance through their employer. By offering consumers alternatives to private providers, the ACA aimed to increase competition within the private market, driving down market equilibrium prices within the private sector and thus increasing the affordability of health insurance to consumers. Additionally, under the ACA, small businesses began receiving tax credits to ease the financial burden of providing health insurance for employees. The ACA also expanded services covered under Medicare, offering certain preventative services to Medicare recipients at no cost, while also giving Medicare Part D enrollees up to 50% off on certain name-brand prescription medications. Finally, the ACA also mandated insurance providers replace their 5:1 age-rating band with a 3:1 age-rating band, meaning insurers can now only charge older individuals up to three times as much as younger individuals for the same policy while before the ACA they could charge older individuals up to five times as much.

The ACA also possessed several provisions intended to expand coverage. The ACA's individual and employer mandates serve as its primary mechanisms for expanding coverage. The employer mandate required firms with 50 or more employees to provide health insurance for their employees (U.S. Department of Health & Human Services, 2015a). Likewise, the individual mandate required all Americans to purchase health insurance or pay a penalty fine that increases substantially each additional year an individual does not acquire health insurance coverage. Provisions for voluntary Medicaid expansion were also intended to further expand coverage. These provisions would reimburse states electing to expand Medicaid coverage 100% of the initial expansion costs although reimbursement rates would decline and eventually cease with time. The ACA also mandated young adults could remain on their parents' insurance up till age 26 and allows retirees between the ages of 55 and 65 as well as their spouses and dependents to continue receiving coverage through their employer-provided plans.

Provisions intended to protect consumers from the substantial market power of private health insurance providers are also included in the ACA. The ACA prohibits pre-existing conditions clauses, rescinding coverage (using a technical errors to deny coverage of services when sick), and lifetime limits on essential health benefits (U.S. Department of Health & Human Services, 2015a). These provisions were intended to not just protect consumers from self-interested, profit-maximizing private providers but also increase their access to affordable care. Increasing competition within the private sector by creating state and federal health insurance

marketplaces also served to further protect consumers by decreasing the market power of private firms. Thus, by targeting specific barriers to obtaining health insurance while simultaneously expanding coverage of those already insured, the ACA aimed to increase health insurance coverage both directly and indirectly, which it ultimately hoped would significantly reduce the number of uninsured individuals in the US. A summary of the ACA's major provisions that were discussed can be found below in Table 1.

Increase Affordability	<ol style="list-style-type: none"> 1) Federal/state health insurance marketplaces <ul style="list-style-type: none"> ➤ Income-based subsidies 2) Small business tax credits 3) Expanded Medicare services 4) Mandated 3:1 age-rating band
Expand Coverage	<ol style="list-style-type: none"> 1) Employer mandate 2) Individual mandate 3) Voluntary Medicaid expansion 4) Young adults remain on parents' insurance until age 26 5) Retirees 55-65 and their spouses and dependents retain employer-provided plans
Protect Consumers	<ol style="list-style-type: none"> 1) Prohibits: <ul style="list-style-type: none"> ➤ Pre-existing condition clauses ➤ Rescinding coverage ➤ Lifetime limits on essential benefits 2) State/federal health insurance marketplaces: increase competition

C. ORIGINS OF THE ACA

The Affordable Care Act was signed into law on March 23, 2010 (Patient Protection and Affordable Care Act of 2010). There were several bills leading up to the final version of the ACA, which is considered to be H.R. 3590 and H.R.4872 read together (Affordable Health California, 2016; Smith 2012).

The origination of the ACA is quite convoluted. Initially, both the House and Senate drafted their own versions of the bill. The House's version was H.R.3962 or the Affordable Health Care for American Act (Affordable Health Care for American Act of 2009). At this time, the GOP enjoyed a majority in the House, preventing House Democrats from fully fulfilling their desires for the House's version of the bill (Affordable Health California, 2016; Smith, 2012). Essentially, because the Democrats were displeased with the House bill, they decided to draft another version of the bill in the Senate, where they enjoyed a majority and could push more desirable legislation forward (Smith, 2012) Because all revenue bills must originate in the House, the Senate found a qualifying bill that had both originated and passed in the House, H.R.3590, which was originally titled the Service Members Home Ownership Tax Act of 2009 (Affordable Health California, 2016; Coleman et al., 2012; Smith, 2012). The original H.R.3590 had nothing to do with health care (Service Members Home Ownership Tax Act of 2009). This bill merely amended the Internal Revenue Code and essentially served as a military housing bill. To create their version of the ACA, the Senate stripped H.R.3590 of its original language and intent, forming the Patient Protection and Affordable Care Act (Patient Protection and Affordable Care Act of 2010). When the Senate initially created the Patient Protection and Affordable Care Act under H.R.3590, the Democrats enjoyed a majority that allowed them to get just enough votes to pass the bill (Affordable Health California, 2016; Smith, 2012). The amended H.R.3590 was then sent to the Conference Committee. All House bills amended by the Senate are sent to the Conference Committee, where the differences

between the House and amended Senate bill are negotiated and resolved (Coleman et al., 2012). If the bill is further amended in the Conference Committee, both the House and Senate must vote to pass the same version of the resolved bill. Unfortunately for the Democratic Party, after the amended H.R.3590 was passed in the Senate, Democratic Senator Ted Kennedy passed away and was replaced by Republican Senator Scott Brown, making the Democrats lose their majority in the Senate (Affordable Health California, 2016; Smith, 2012). Without this majority, the Democrats would not be able to pass a resolved version of H.R.3590 if the House proposed additional amendments in the Conference Committee. To ensure legislation got passed, Democratic and Republican House and Senate party leaders collaborated to come to an agreement: the House would not amend H.R.3590 any further and allow it to pass, however the Senate must pass a separate bill created by the House that made changes to the version of the ACA proposed under the Senate's amended H.R.3590. The separate bill created by the House was known as the Reconciliation Act of 2010 (H.R.4872) and made a number of financing and revenue changes to H.R.3590 (Health Care and Education Reconciliation Act of 2010). As mentioned, when read together, H.R.4872 and H.R.3590 detail the provisions of the ACA implemented today.

D. OUTCOMES OF THE ACA

i. POLARIZED PARTY POLITICS AND POLITICAL VOLATILITY

As our brief discussion of the evolution of the ACA suggests, the ACA was a highly controversial bill. Throughout the legislation process, the GOP strongly

contested the ACA (Affordable Health California, 2016; Smith 2012; Blodget, 2013; GOP, 2011a; GOP, 2011b). The GOP's primary concern was regarding the economic impacts the ACA may have (Blodget, 2013; GOP, 2011a). Republicans believed the ACA would devastate the American economy by forcing businesses to spend too much on health care, leading to employment cutbacks, preferential hiring of part-time versus full-time workers, and in some cases business failure. The GOP believed the funds demanded by the ACA would significantly increase healthcare costs and ultimately add substantially to the national deficit (GOP, 2011a). Republicans believed the ACA would increase costs for both employers and health insurance providers, causing insurance premiums to rise and potentially forcing Americans happy with their current health insurance plans would lose them (GOP, 2011b). The GOP also found tax increases implemented by the ACA to fund several of its provisions excessive (GOP, 2011a). Ultimately, the GOP believed the ACA would be incredibly detrimental to both the American economy and quality of care provided by the health care system. On the exact opposite end of the political spectrum, the Democratic Party argued the ACA was essential to making health insurance both affordable and available to all Americans (Democrats, 2016). The polarized views of both parties divided both the House and Senate, creating the tumultuous legislative process described earlier.

Since the ACA's passage, the GOP and several states have questioned the constitutionality of both its origins and some of its provisions (Elias, 2013; GOP, 2011a). The GOP argued the ACA was essentially introduced in the Senate, making it

an unconstitutional bill since all bills raising revenue must originate from the House. Some party members also argued the individual mandate violated the Commerce Clause, which mandates that the government cannot force citizens to engage in commerce. Throughout 2011, several states filed joint lawsuits claiming the ACA's individual mandate and originally mandated Medicaid expansion were unconstitutional and violated state sovereignty (Smith, 2012; The Henry J. Kaiser Family Foundation, 2012). Ultimately, political discontent and turmoil did not settle until 2012 when the US Supreme Court issued its final decisions. While this ruling upheld the constitutionality of the ACA's individual mandate, it ruled the original mandated expansion of Medicaid to be unconstitutional, forcing this provision to become voluntary for states.

Despite the Supreme Court's decision, with the upcoming 2016 presidential election, the GOP remains firm in its position against the ACA and has begun taking new measures to repeal it (Benson, 2016; Walsh, 2016; Kim, 2015). With a Republican majority in the Senate, in 2015, the Senate passed a bill that would essentially "gut Obamacare" of the majority of its mandates, taxes, and expenditures (Benson, 2016). However, the Senate also ruled that the bill's provisions to repeal the employer and individual mandate must be removed in order for it to proceed, stating these provisions did not pass the Byrd test (Kim, 2015). Since passing in the Senate, the House has also passed the bill, moving it to President Obama who has since vetoed it (Walsh, 2016). Although President Obama has defeated GOP efforts to repeal the ACA, if a Republican wins the 2016 presidential election, the GOP will

surely renew its efforts and succeed in the years to come, especially since it now has a majority in both the House and Senate.

**ii. STATE & FEDERAL HEALTH INSURANCE MARKETPLACES
ACHIEVED MIXED SUCCESS**

Enrollment in state and federal health insurance exchanges has been steadily increasing since 2014 with enrollment rising from 8.0 million in 2014 to 11.7 million in 2015 (Levitt et al., 2016). At the end of the 2016 enrollment period, 12.7 million US citizens were covered under state and federal exchange plans. Actual enrollment, however, has been somewhat lower than these statistics indicate. Enrollment typically drops throughout the course of each year as individuals do not pay their premiums or have their coverage terminated "...due to inconsistencies on their applications" (Levitt et al., 2016). Attrition further reduces yearly enrollment as some enrollees acquire employer-provided coverage. For example, the number of paid enrollees dropped from 10.2 million at the end of March 2015 to 9.3 million by the end of September. Accounting for these fluctuations, enrollment is projected to be over 10 million by the end of 2016, meeting Department of Health and Human Services (HHS) target for 2016 enrollment (Levitt et al., 2016; U.S. Department of Health and Human Services, 2015b). Although projected 2016 enrollment, meets HHS's target for enrollment, it falls short of earlier projections issued by the Congressional Budget Office (CBO), which have been used as "...an implicit yardstick for judging the law" since its origination (Levitt et al., 2016). Originally, the CBO projected 2016 enrollment to be around 21 million and has since lowered this projection to 13 million (Levitt et al., 2016; CBO, 2016).

There are several reasons why enrollment in state and federal marketplace plans has failed to meet CBO projections (Levitt et al., 2016). Contrary to the GOP's claims, the ACA has not reduced the availability of employer-provided coverage. According to the Kaiser-HRET Employer Health Benefits Survey, the number of firms offering employees coverage did not experience any statistically significant reductions between 2014 and 2015, noting 55% and 57% of firms offered coverage in 2014 and 2015 respectively (Claxton et al., 2015). Thus, it appears "...it may be that incentives for employers to maintain health benefits are more power than expected, at least so far" (Levitt et al., 2016). Most employers with 50 or more full-time employees face more to gain than lose by refusing to offer employees health insurance coverage. Under the ACA, employees receive employer-provided insurance benefits tax-free plus non-compliant employers face significantly penalty fines.

While the ACA's enrollment numbers may seem large, its current 12.7 million paid enrollees are less than 4.00% of the current US population (Levitt et al., 2016). These figures indicate the majority of US citizens continue to obtain coverage outside of state and federal exchanges. Outside coverage includes ACA-compliant plans, grandfathered coverage, and transitional plans. Although no actual data exists regarding the actual number or percentage of plans purchase outside of state and federal exchanges, the Henry J. Kaiser Family Foundation has estimated 57% of individual coverage (i.e. non-group plans) was purchased outside marketplaces by the end of 2014 (Levitt et al., 2016; Levitt et al., 2015).

Although 82% of marketplace enrollees are receiving ACA subsidies, a substantial majority of the American public still cites affordability as an obstacle (Levitt et al., 2016). A poll conducted by the Henry J. Kaiser Family Foundation found that 46% of uninsured, non-elderly adults reported that they did attempt to obtain coverage but were not able to afford it (Levitt et al., 2016; DiJulio et al., 2015a). Individuals with annual income less than 150% of the poverty level qualify for the largest premium subsidies available under the ACA, however these individuals are generally still required "...to pay something towards the premium" (Levitt et al., 2016). For example, to enroll in Silver plan, low-income individuals with incomes at 150% of the poverty level must pay up to around 4% of their income in premiums. Premium subsidies offered to individuals with incomes 300-400% of the poverty level typically run out quickly, leaving these individuals with little incentive (or possibly ability) to retain coverage. The largest drops in health insurance coverage have been among individuals with incomes greater than 400% of the poverty level. Thus, even with these subsidies, low-income Americans may still feel health insurance is unaffordable. However, whether affordability is truly an issue or as much as an issue as these polls indicate remains unclear. Another poll conducted by the Henry J. Kaiser Family Foundation at the beginning of the 2016 enrollment period "...found that 82% of uninsured adults had not been contacted in the previous 6 months about the health law" (Levitt et al., 2016; DiJulio et al., 2015b). These findings indicate a general lack of public awareness about the financial assistance available under the ACA. More extensive outreach efforts to increase public

awareness may reduce the percentage of Americans who still find insurance coverage to be unaffordable.

Despite lower enrollment than projected by the CBO, enrollment has continued to grow, suggesting the program will be sustainable (Levitt et al., 2016). Growth is critical to the program's sustainability as it must continue to remain attractive to insurers and keep premiums stable. Because risk is pooled at the state level, "...if enrollment stagnates and skews towards sicker-than-average individuals..." insurers may be forced to increase premiums as costs may exceed revenue, decreasing affordability and creating additional problems. Although current data indicates "...there is considerable room for enrollment growth over the next several years," enrollment would still fall short of CBO projections even if all states had the same enrollment rates as the 10 states with the highest enrollment rates. This suggests CBO projections may have been unrealistic and improper for assessing the relative success of state and federal exchanges. Despite this potential for growth, affordability and outreach issues pose a significant threat. Levitt et al. (2016) has stated, "...absent a substantial boost in outreach or changes to the subsidies to make insurance more affordable, substantial increases in marketplace enrollment are unlikely." Thus, although state and federal exchanges have extended coverage to some Americans and possess potential for significant growth, affordability and outreach issues have and will continue to reduce future growth if not addressed.

Although state and federal health insurance exchanges have been relatively successful, lack of proper government oversight recently caused a dozen exchanges to

fail, costing the federal government over \$1.2 billion (Levin & Goldstein, 2016). The Senate's investigations panel concluded "...federal officials ignored early warnings about the plans' fragility and moved in too late as problems arose" (Levin & Goldstein, 2016). The exchanges' failure left almost three quarters of a million people in 14 different states without coverage. Hospitals and doctors may never get reimbursed for their services. The failure of these CO-OPs has imposed significant social and financial costs. As Senator Rob Portman (R-Ohio) proclaimed, "These failed CO-OPs were a costly experiment gone wrong, and real people got hurt — including the more than 700,000 Americans who lost their health plans" (Levin & Goldstein, 2016). These public and social costs have exacerbated already failing public approval of the ACA's health insurance exchanges, which may give the GOP further leverage in its efforts to repeal the ACA.

iii. PERCENTAGE OF UNINSURED AMERICANS AT HISTORIC LOW

One of the clearest outcomes of the ACA is that the percentage and numbers of uninsured Americans have and continue to decrease (Alonso-Zaldivar, 2016; WHO, 2015). From 2010-2014, the number of uninsured individuals in the US fell from 49.9 million to 33.0 million while the uninsured rate subsequently fell from 16.3% to 10.4%, achieving the most significant change in the uninsured rate throughout the entire history of the United States (WHO, 2015). While some have claimed these gains were due to the economy's spring-back from the 2007-2009 recession, economist Christine Eibner of the RAND Corporation states, "This kind of shift in insurance I don't think can be explained by the economy. The increase (in

coverage) is large enough that it can't be driven by just economic recovery” (Alonso-Zaldivar, 2016). Clearly, coverage has increased because of the ACA.

Which provision stimulated the majority of these gains? There currently exists no data regarding how many or the percentage of the individuals who have acquired health insurance due to the individual mandate. As previously discussed, enrollment in state and federal exchanges encompasses a very small percentage of the population with most individuals purchasing health insurance outside of federal CO-OPs (Levitt et al., 2016). According to the Census Bureau’s American Community Survey, approximately 3 million American gained employer-based coverage between 2010 and 2014, which can be attributed to the ACA’s employer mandate (Alonso-Zaldivar, 2016; Census Bureau, 2014). However, the largest gains have been attributed to states’ elective expansion of Medicaid (Alonso-Zaldivar, 2016; Haislmaier & Gonshorowski, 2014). In the second quarter of 2014 alone, “...71% of that net coverage gain was attributable to the Obamacare expansion of Medicaid to able-bodied, working age adults” (Haislmaier & Gonshorowski, 2014). Despite these gains, several states still refuse to expand their Medicaid programs, arguing it would be too costly to do so. However, a report issued by the Henry J. Kaiser Family Foundation found that the federal government would bear the majority of costs associated with Medicaid expansion with states bearing only modest costs in comparison (Holahan et al., 2012). Moreover, most states who have elected to expand their Medicaid programs have acquired small net budget savings while significantly decreasing their number of uninsured individuals. Ultimately, while it seems all of the

ACA's provisions have worked together to expand coverage, Medicaid expansions have elicited the largest gains.

**iv. INCREASING PROMINANCE OF HIGH DEDUCTIBLE PLANS
MAKES AFFORDABILITY STILL AN ISSUE**

While the ACA has expanded coverage, its efforts to improve affordability may have actually made health insurance even less affordable for a substantial portion of Americans (Evans, 2016; Wharam et al., 2013). As previously mentioned, the ACA's cost-control mechanisms are sparse. Unfortunately, according to Wharam et al. (2013), "Mandating coverage while requiring affordable premiums without enacting other cost-control mechanisms almost inevitably gives rise to increased cost sharing as the simplest mechanism for reducing premiums" (1481). Increased cost sharing essentially means enrollees will be required to pay a greater portion of the costs associated with their medical care. Typically, this takes of the form of high-deductible health plans (HDHPs), which "...require annual out-of-pocket payments of \$1,000 to \$10,000 for many services before more comprehensive coverage begins" (Wharam et al., 2013, 1481; Claxton et al., 2013). HDHPs may be especially attractive to small employers recently forced to provide insurance benefits under the ACA since they are the least expensive option, while larger employers may adopt HDHPs to fulfill ACA-mandated premium levels and avoid significant penalty taxes to be imposed in 2018 (Wharam et al., 2013). The greatest financial burden will be imposed on middle-income Americans who could be forced to pay out-of-pocket payments up to 27% of their annual income.

The ACA's lack of cost-control mechanisms and mandate for affordable coverage has caused HDHP plans to become increasingly predominant, imposing significant financial burdens upon many Americans (Wharam et al., 2013; "U.S. Employees," 2012). If the predominance of these plans continues to grow, many Americans who were sufficiently covered before the ACA may become underinsured (Wharam et al., 2013; Claxton & Levitt, 2012). Moreover, the aggregate health and economic outcomes of previously uninsured individuals may actually improve relatively little under the ACA as HDHPs may effectively transition these individuals from being uninsured to underinsured. According to the Commonwealth Fund Bicentennial Health Survey, in 2014 alone, 31 million US citizens were underinsured (Collins et al., 2015). Between 2003 and 2011, the percent of Americans with HDHPs tripled rose from 3% to 11% (Collins et al., 2015). Much of this growth has been associated with the implementation of the ACA. Among the underinsured, in 2014, over 44% reported not acquiring necessary medical attention due to cost. Additionally, 51% of underinsured adults reported they were currently paying off medical debt or struggling to do so. Shockingly, this is the same rate as adults who remained uninsured during 2014. If this trend continues, acquiring insurance may actually not improve socioeconomic outcomes for many Americans. Some individuals previously covered may also chose to forego coverage if they realize they will essentially face the same financial burden without paying for coverage.

II. LOWI'S MODEL AND ITS PREDICTIONS FOR SELECT PROVISIONS OF THE ACA

A. LOWI'S MODEL: EARLY ORIGINS AND THEORETICAL ASSUMPTIONS

Lowi began constructing his theoretical model to fill the gap between political theory and research, which he felt early theoretical models failed to do (Schulze, 1965; Lowi, 1964a; Lowi, 1964b). The unidimensional flaws of the pluralist and elitist models drove Lowi create a theoretical model that would be general enough to comprehensively explain all political behavior (Schulze, 1965; Lowi, 1964a; Lowi, 1964b). Lowi sought to create a model that would provide a framework for analyzing diverse cases and from these cases produce generalizations that could be supported by theoretical evidence. Ultimately, Lowi desired to create a model that was theory-driven and not self-driven like the pluralist and elitist models.

Lowi's work in New York City politics strongly influenced the fundamental theoretical assumptions guiding his theoretical model (Schulze, 1965; Lowi, 1964b). In his earliest works, Lowi repeatedly emphasized that power was the state's defining characteristic (Lowi, 1972a; Schulze, 1965; Lowi, 1964a; Lowi 1964b). Lowi argued that policy was only created when the state exercised its ability to coerce citizens' behaviors, applying positive or negative sanctions. Therefore, according to Lowi, public policy was "...a rule formulated by some governmental authority expressing an intention to influence the behavior of citizens, individually or collectively, by use of positive and negative sanctions" (Nicholson, 2002; Lowi, 1985, 70). Public policy, then, was not about the issues themselves but rather about how the state utilized its

own power to achieve a given policy goal. Stemming from this idea, Lowi proposed that analyzing how public agencies have exercised their power will reveal variations in the political process across issue areas (Nicholson, 2002; Lowi, 1985; Lowi, 1972a). Thus, Lowi believed an analytic model that focused on the state's application of power may provide significant predictive power regarding the outcomes of a given policy.

Early theoretical models, such as elitism and pluralism, functioned according to predominant premise that politics created policy (Nicholson, 2002; Lowi, 1972a; Lowi, 1971; Schulze, 1965; Lowi, 1964a; Lowi, 1964b). Lowi, however, argued just the opposite, proposing that it was, in fact, policy that created politics. Lowi's model operates under the fundamental assumption that the nature of a public policy is what determines its surrounding political environment. This fundamental assumption distinctly differentiates Lowi's model from early theoretical models, which all predict how politics affects policy.

B. LOWI'S MODEL: LOWI'S POLICY CLASSIFICATION SYSTEM

Lowi decided to develop general categories to classify policies given a series of general assumptions (Lowi, 1964a). First, Lowi assumed that "...the types of relationships to be found among people are determined by their expectations—by what they hope to achieve or get from relating to others" (Lowi, 1964a, 688). Thus, if this was true, "...in politics, expectations are determined by governmental outputs or policies" (Lowi, 1964a, 688). From these assumptions, Lowi concluded:

A political relationship is determined by the type of policy a stake, so that for every type of policy there is likely to be a distinctive type of political relationship. If power is defined as a share in the making of policy, or authoritative allocations, then the political relationship in question is a power relationship or, over time, a power structure (Lowi, 1964a, 688).

Consequently, from his original assumptions regarding political relationships, Lowi concluded that every type of policy would correspond to a characteristic power structure. This power structure would in turn summarize how the state exercised its power to influence its citizens' behavior but also how individuals or groups operated within this power structure. Thus, to develop a model that would cumulatively predict the political environment associated with a given policy, Lowi had to develop a policy classification system first.

A critical component of his theoretical model, Lowi developed a policy classification system, classifying policies as one of four policy types: regulatory, distributive, redistributive, and constituent (Nicholson, 2002; Lowi, 1971). These four types of public policy were then characterized according to two dimensions: specificity and applicability of coercion, which distinguished each corresponding policy type according to its application of public power. Lowi's classification system is shown on the next page in Table 2.

Specificity of coercion	Likelihood of coercion	
	Immediate	Remote
Individual conduct	Regulative	Distributive
Environment of conduct	Redistributive	Constituent

**Table 2: Lowi's Original Policy Classification System
(Nicholson, 2002, 165; Lowi, 1971)**

Lowi attached a few theoretical assumptions to this system, which included:

- 1) Coerciveness is the primary characteristic of power;
- 2) Power is the defining characteristic of the state;
- 3) Power is the ability to impose positive benefits or negative sanctions, which distinguishes it from influence (Nicholson, 2002; Lowi, 1971).

The “specificity of coercion” dimension analyzes what has influenced the state to exert its power (Nicholson, 2002; Lowi, 1971). Under this dimension, “individual conduct” suggests the power exerted by the state is due to a single individual’s actions and is consequently being exerted to alter the behavior of individuals themselves. Speeding tickets are demonstrative of policies with an individual specificity of coercion. Essentially, speeding tickets represent the state enforcing negative sanctions against a specific individual due to their behavior (the

decision to speed). Conversely, policies whose applicability of coercion fall under the “environment of conduct” category are instances where the state is enforcing benefits or sanctions not specifically due to any one individual’s actions but due to the actions of the whole or of a group. Sin taxes are an example of such policies. These taxes are enacted not because one individual chooses to smoke but because multiple individuals are choosing to smoke. Thus, the state enacts these negative sanctions due to the behavior of a group of individuals not just a single individual.

The “likelihood of coercion” dimension assesses the likelihood negative sanctions will be imposed upon individuals disregarding the State’s power (i.e. a given policy dictated by the state). If such sanctions are likely, the policy is said to have an immediate likelihood of coercion, while if these sanctions are not likely, it is said to have a remote likelihood of coercion (Nicholson, 2002; Lowi, 1971).

Returning to the concept of speeding tickets, the likelihood of coercion for speeding on a busy interstate or road you know is not frequented by police officers is generally quite remote, meaning the probability of incurring the negative ramifications (speeding tickets) of violating speeding limits is generally low. Conversely, the likelihood of coercion for violating criminal laws, like homicide, is generally immediate, or, in other words, someone is nearly always punished for violating this legislation.

In his later work (1972b), Lowi discovered distinct, systematic differences between distributive, redistributive, and regulative policies through his analysis of 17 case studies of legislation from the 1930s-1950s (Nicholson, 2002). Lowi found the

dominant actors behind distributive legislation were Congressional Committees while the President was virtually absent from the legislative process. Conversely, for redistributive legislation, the President was the dominant actor while the influence of Congressional Committees was minimal. For regulative policies, regardless of whether the President was engaged in the legislative process or not, Congressional Committees, specifically party leaders, were the predominant actors with floor action dominating the policy making process. A summary of the characteristics of each type of policy can be found on the next page in Table 3.

Table 3: A Summary of Lowi's Policy Types		
Policy Dimensions	Specificity of Coercion (Is the Policy Targeting Group or Individual Behavior?)	
Likelihood of Coercion (What is the Likelihood there will be Negative Consequences for those who Disregard the Policy?)	Environment of Conduct (Policy Targeting Group Behavior)	Individual Conduct (Policy Targeting Behavior at Individual Level)
Immediate (Negative Consequences for those who Disregard the Policy Likely)	<u>Redistributive</u> <ul style="list-style-type: none"> • Main actor(s): President • Intended to mandate a given behavior from groups • Essentially, reordering the private equilibrium • Clear benefits to some parties and losses to others (clear “winners” and “losers”) • Ex. ACA: employer mandate 	<u>Regulative</u> <ul style="list-style-type: none"> • Main actor(s): Congressional Committees—party leaders • Intended to mandate a given behavior from individuals • “Stick” of governance • Clear losses to some parties (clear “losers”) • Ex. ACA: individual mandate
Remote (Negative Consequences for those who Disregard the Policy Unlikely)	<u>Constituent</u> <ul style="list-style-type: none"> • Procedural rules for policy making 	<u>Distributive</u> <ul style="list-style-type: none"> • Main actor(s): Congressional Committees • Intended to encourage a given behavior from individuals • “Carrot” of governance • Clear benefits to some parties but no parties loser or are punished if they do not follow policy (clear “winners” but no clear “losers”) • Ex. ACA: Medicaid expansion

C. LOWI'S MODEL: DISCUSSION OF THE ORIGINAL MODEL

Having determined and described the four categories of public policy, Lowi then analyzed the outcomes of representative policies in each category from 1869-1930's (Lowi, 1972a). From these outcomes, he predicted the characteristics of the political environment associated with each policy type, constructing the model shown below in Figure 3. The numbered groups (1, 2, 3, 4) are characteristics typical of the political environment associated with a given policy type. Lowi calls these "marginal characteristics." According to a policy type's applicability and likelihood of coercion, these marginal characteristics will be combined to fully describe the associated political environment. While Lowi did make modifications to this original model, these will not be discussed since the original model will only be used throughout this paper (Nicholson, 2002; Lowi, 2002; Lowi, 1988; Lowi, 1985).

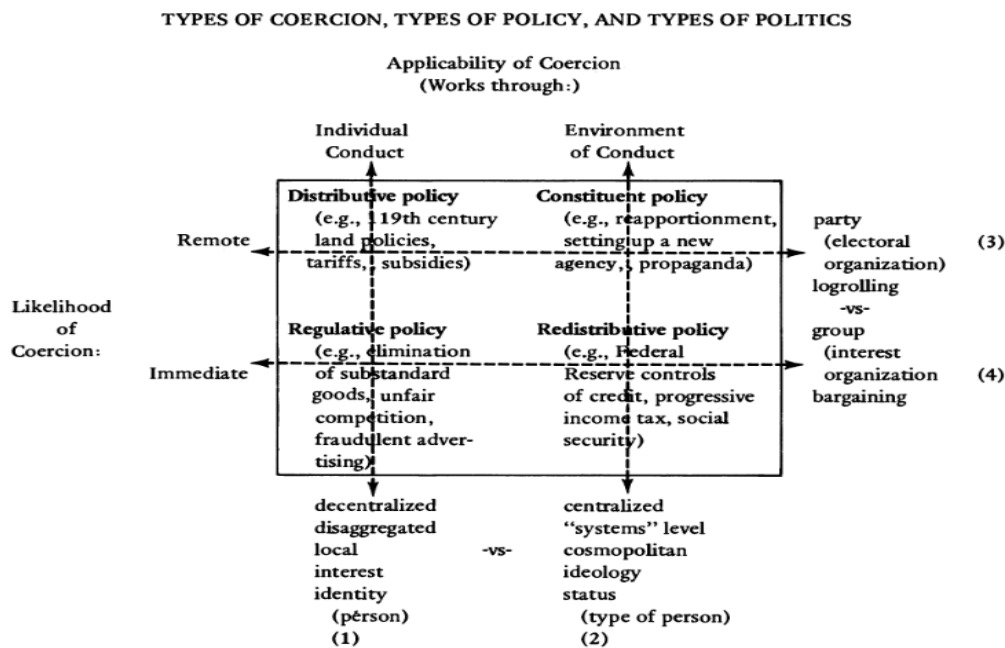


Figure 3: Lowi's Original Theoretical Model (Lowi, 1972a)

As Figure 3 reflects, each policy type corresponds to a characteristic political environment. Because distributive policies have a remote likelihood of coercion, they are associated with a political environment dominated by party logrolling (Lowi, 1972a). In the US, logrolling tends to generate pork-barrel projects, which are spending bills hidden inside other bills to get more money for their constituents. Predominant logrolling behavior allows policymakers to achieve their own interests and goals by ensuring their district policies and pork-barrel projects are passed into legislation. Looking at the characteristics typical of policies with an applicability of coercion that acts at the individual level (individual conduct), the “local” and “interest” characteristics associated with this applicability of coercion describe this ability of policymakers to achieve their own localized interests and goals. Additionally, the “decentralized” and “disaggregated” characteristics associated with this level of applicability of coercion describe the political mechanism of action (i.e. distribution of power) associated with distributive policies. Such policies act to disperse authoritative power amongst several different entities at the state or local level. Thus, the political mechanism of action associated with distributive policies is “decentralized” and “disaggregated” in nature. This can be done with each policy type to predict the characteristics of its corresponding political environment.

D. LOWI'S MODEL: CRITICISMS

As the ACA's provision for the voluntary expansion of Medicaid demonstrated, not all policies are easily classified using Lowi's typology system. Several critics of Lowi's model, including Lester Salamon, argue the model's

ambiguity makes it difficult to classify policies since policies often embody multiple policy types (Nicholson, 2002; Salamon, 2002; Kjellberg, 1977; Hayes, 1978; Wilson 1974). Since Lowi's model does not allow for mixed classifications, critics believed its predictive power may be limited (Nicholson, 2002). Moreover, Hayes (1978) pointed out that some policies may change typology during the policymaking process, further restricting the model's predictive power.

Lowi himself originally noted another flaw of his model: classifying policies "...in terms of their impact of expected impact on society..." produced a limited number of policy types and thus also a limited number of functions government could perform (Nicholson, 2002; Kjellberg, 1977; Wilson, 1974; Lowi, 1964a, 689). In reality, government possesses many more functions than those described by Lowi's model. However, as Lowi mentions, with any model there is some disconnect between the theoretical and empirical realm, and in spite of this disconnect, Lowi argued his model was much more functional than any other theoretical model. Instead of merely describing issue categories, as the pluralist model did, Lowi's model presented functional categories that could be used to classify almost any domestic policy and predict its associated political environment. As Lowi supports in his several publications, unlike other models, his model was supported by, not constructed from, empirical evidence (Nicholson, 2002; Lowi, 1971; Lowi, 1972a).

Another criticism of Lowi's model is that policy classifications do not consider the social or economic consequences of a given policy (Nicholson, 2002; Kjellberg, 1977; Wilson, 1974). However, as Wilson (1974) notes, in order to

determine these implications, the institutional context as well as other contextual variables must be considered. Lowi (1985) essentially refutes these criticisms by claiming that his model is meant to simplify the prediction and classification process. If variables other than the relationship between the state power and citizen were considered, the classification system would be much more complicated. Thus, like any theoretical model, Lowi's model does possess some fundamental flaws that limit its true predictive power.

E. LOWI'S MODEL: METHODS—GENERATING & EVALUATING PREDICTIONS

To generate predictions using Lowi's model, the selected predictions of the ACA will first be classified using Lowi's policy classification system. This system was discussed in Part II, B and will now be applied to the selected provisions of the ACA. After these provisions have been classified, predictions will be generated using Lowi's model (discussed in Part II, C). Finally, Lowi's predictions will be compared to current events to assess their relative accuracy. Since Lowi's model only generates predictions about the political environment associated with implementing a given policy, only current events could be used to assess the relative accuracy of Lowi's predictions. The current events used to assess the relative accuracy of Lowi's predictions were discussed in Part A, D, i (political volatility of the ACA).

Using the policy dimensions previously discussed, Lowi created the four policy types shown in Table 2: distributive, regulative, redistributive, and constituent

policy (Nicholson, 2002; Lowi, 1971). Each policy type has its own unique set of characteristics according to its specificity and likelihood of coercion. Since the ACA is such a large, voluminous policy by nature, specific provisions will be selected and classified using Lowi's policy typology system (see Table 2). The four provisions the ACA is most well-known for are: its individual mandate; employer mandate; voluntary expansion of Medicaid; and, its creation of state and federal health insurance marketplaces. Each policy typology will now be discussed and applied to the four major provisions of the ACA listed above.

As indicated in Table 2, distributive policies are associated with an individual specificity of coercion and remote likelihood of coercion. Distributive policies' individual specificity of coercion suggests these policies are targeting the actions of individuals, but their remote likelihood of coercion indicates parties who disregard these policies will suffer few if any consequences. As Lowi mentions, distributive policies are essentially the "carrot" of governance. These policies are intentionally enacted by the State to encourage a behavior from specific individuals, creating clear winners but no clear losers due to their sparse (or non-existent) consequences. Federal subsidies are examples of distributive policies. These policies are designed to benefit states who electively take them but do not hurt or impose punitive action upon states that do not.

The ACA's creation of state and federal health insurance marketplaces would be considered a distributive policy. This provision is attempting to alter the decisions of individuals, specifically to encourage individuals to purchase health insurance

from a federal insurance marketplace. Thus, it has an individual specificity of coercion. Individuals who chose to not purchase health insurance from a state health insurance marketplace are not penalized, suggesting this provision has a remote likelihood of coercion. As Table 2 reflects, an individual specificity of coercion and remote likelihood of coercion are characteristic of distributive policies. Distributive policies, in general, are intended to encourage a given behavior but impose no negative sanctions upon those electing to not adopt this behavior. According to Lowi's typology system as well as this general definition of a distributive policy, the ACA's creation of state and federal health insurance marketplaces is a distributive provision.

Like distributive policies, regulative policies correspond to an individual specificity of coercion but enact an immediate likelihood of coercion (Nicholson, 2002; Lowi, 1971). The individual specificity of coercion suggests these policies are intended to influence the actions of targeted individuals, while the immediate likelihood of coercion suggests individuals ignoring the state's mandate will suffer negative sanctions. Thus, regulative policies are essentially the "stick" of governance and are enacted to mandate the actions of targeted individuals, creating identifiable losers if ignored. Criminal laws are examples of regulative policies. These policies are designed to mandate the actions of individuals and punish those who ignore this mandate.

The individual mandate of the ACA is a regulative provision. The individual mandate forces all US citizens to acquire health insurance or face a monetary fee that

increases substantially each additional year the individual chooses to not acquire health insurance (immediate likelihood of coercion). Clearly, this policy was enacted due to individual choices to not purchase health insurance and aims to correct this behavior at the individual level (individual specificity of coercion). It also enforces clear sanctions upon noncompliant individuals, fulfilling the immediate likelihood of coercion emulated by regulative policies. By definition, regulative policies are the State's attempt at mandating individuals to adopt a given behavior by imposing negative sanctions upon those who do not. The individual mandate not only possesses Lowi's characteristics of a regulative policy (immediate likelihood of coercion and individual specificity of coercion) but also fulfills this general definition of a regulative policy.

Like regulative policies, redistributive policies correspond to an immediate likelihood of coercion but are enacted due to an environment of conduct (Nicholson, 2002; Lowi, 1971). The environmental origins of redistributive policies suggest they are enacted in response to a group's behavior and thus meant to influence or change the behavior of a targeted group. The immediate likelihood of coercion suggests these policies intend to punish groups ignoring the state's mandate. Redistributive policies generally take resources from one group and give them to another. Essentially, redistributive policies are when the state steps in to alter private equilibrium, or the order naturally occurring within society prior to state intervention. To do this, redistributive policies must influence a group's behavior and but also use punitive measures to ensure compliance, creating clear winners and losers.

Applying Lowi's policy typology system, the employer mandate of the ACA is a redistributive provision. The mandate forces employers who were not previously providing their employees with health insurance to do so or pay a penalty fee (immediate likelihood of coercion). Thus, this provision is attempting to influence group behavior, suggesting it has an environmental specificity of coercion. The employer mandate's immediate likelihood of coercion and environmental specificity of coercion indicate it is classified as a redistributive policy according to Lowi's policy classification system (see Table 3). This provision also fits the general definition of a redistributive policy. As mentioned, redistributive policies attempt to alter the private equilibrium. Under the employer mandate, the State is attempting to alter (increase) the private equilibrium of employer-provided health insurance benefits. The employer mandate could also be viewed as the State's attempt at altering the private distribution of wealth, forcing businesses to give up some of their profits and give those profits to employees in the form of nonmonetary compensation (i.e. health insurance). Thus, this provision fulfills the general definition of a redistributive policy and also possesses Lowi's characteristics of a redistributive policy (immediate likelihood of coercion and environmental specificity of coercion).

Finally, constituent policies are created due to the environment of conduct and correspond to a remote likelihood of coercion (Nicholson, 2002; Lowi, 1971). In his early model, Lowi did not develop this policy typology much but proposed constituent policies were essentially the procedural rules for policy making. One example of a constituent policy would be the Senate's Byrd Rule. This rule prohibits

the Senate from passing a given part of a bill if it would be considered “extraneous” according to the criteria set forth under the Byrd Rule. One of the criteria for a portion of a bill being “extraneous” and thus impermissible from being passed by the Senate is if it would increase the national deficit by a certain amount considered to be excessive in nature (Slaughter, 2016). Thus, the Byrd Rule among other rules guides how policy making can be conducted in the Senate and would consequently be considered a constituent policy using Lowi’s classification system.

Using the typology system shown in Table 3, the ACA’s provisions for Medicaid expansion would be considered a constituent provision since states electing to participate in the expansion would receive government subsidies to do so, while states who elect to refrain from expansion do not suffer any negative consequences (remote likelihood of coercion). The State is attempting to encourage states to electively expand their Medicaid programs so that more individuals can be covered under Medicaid, targeting the behavior of the states themselves (environment of conduct). Consequently, according to Lowi’s policy classification system, this provision would be classified as a constituent policy since it possesses a remote likelihood of coercion and environment of conduct specificity of coercion. In general, constituent policies are policies that govern the policymaking process. Although this provision is not governing how policy is made, it does govern how policy is applied. Ultimately, the ACA’s provision for voluntary expansion of Medicaid programs is attempting to alter (specifically loosen) regulations determining Medicaid eligibility, which govern who does and does not qualify for Medicaid coverage. Thus, this

provision loosely fulfills the general definition of a constituent policy in some regards. Although, when considering the basic definition of a distributive policy (to encourage a given behavior but not impose negative sanctions upon those not adopting said behavior), it seems to function more like a distributive policy. Its distributive function and constituent characteristics makes the ACA's Medicaid expansion provision difficult to classify using Lowi's typology system. This provision demonstrates some of the limitations of Lowi's model, which will be discussed in more detail later.

Taken together, Lowi's four types of policy "...define the functions of the state and its parameters of political activity," demonstrating how policy creates politics (Nicholson, 2002; Lowi, 1971). By breaking down policies into a general category, Lowi proposed these categories could then be used to predict the political environment associated with each policy type, predicting which actors would be involved in the policy making process and what degree of influence they would exert over policy outcomes (Tremblay, 2010; Nicholson, 2002; Lowi, 1971). Shown below, Table 4 summarizes the classifications of each ACA provision, which were all assigned using Lowi's classification system (see Tables 2 and 3).

Table 4: Lowi's Classifications of Each Selected ACA Provision	
ACA Provision	Lowi Policy Type
Creation of State and Federal Health Insurance Marketplaces	Distributive
Voluntary Medicaid Expansion	Constituent Characteristics Distributive Function
Individual Mandate	Regulative
Employer Mandate	Redistributive

Lowi's model (see Figure 3 found in Part II, C) will now be used to predict the characteristics of the political environment associated with each selected provision of the ACA. These provisions have already been classified using Lowi's typology system (see Table 4).

The ACA's creation of federal and state health insurance marketplaces was classified as a distributive policy. Using Figure 3 (follow arrow from distributive policy across to 3 and down to 1), Lowi's model predicts the political environment associated with this provision to be dominated by party logrolling. Lowi further predicts the political power associated with the creation of these health insurance marketplaces will be decentralized and disaggregated in nature, meaning the State will give authoritative power (over this policy/provision) to several entities at the state and local level. Finally, Lowi also predicts the politics associated with this provision will allow individual policymakers to pursue and fulfill their own interests at the local or individual level.

The ACA's individual mandate was classified as a regulative provision. According to Figure 3 (go to regulative policy then follow arrow across to 4 and down to 1), the political environment associated with regulative policies is predicted to be characterized by the predominance of group behavior, which is marked by the formation of interest groups and collective bargaining. As for the ACA's provision creating state and federal health insurance marketplaces, Lowi predicts political

power over the implementation and enforcement of the individual mandate will also be decentralized and disaggregated. However, unlike the distributive provision, Lowi predicts the politics associated with this regulative provision of the ACA will allow groups (not individual policymakers) to pursue and fulfill their own interests at a local or individual level.

The employer mandate provision of the ACA was classified as a redistributive policy. Applying Lowi's model (follow arrow across to 4 and down to 2), Lowi predicts the political environment corresponding to this redistributive provision will be dominated by group behavior, specifically the formation of interest groups and predominance of collect bargaining. Unique to this provision, Lowi predicts the political power will be centralized, meaning the State itself will be the primary authority governing this policy provision. Policymaking associated with this provision is predicted to following the systems model. Finally, Lowi also predicts the politics associated with this provision will allow groups to pursue and fulfill their own ideological goals.

The ACA's provision allowing voluntary expansion of state Medicaid programs was not easily classified using Lowi's typology system. As mentioned, although it possesses characteristics of a constituent policy (remote likelihood of coercion and environment specificity of coercion), the provision functions more like a distributive policy by definition. If this provision is classified as a constituent policy, Lowi predicts the political environment associated with this provision to be dominated by party logrolling. Like the ACA's redistributive provision, Lowi predicts

political power will be centralized with policymaking following the systems approach. Again similar to the ACA's redistributive provision, Lowi predicts the politics associated with the ACA's constituent provision for Medicaid expansion will allow groups to pursue and fulfill their own ideological goals. However, if this provision was classified as distributive, Lowi would predict a political environment still dominated by party logrolling but with power decentralized and disaggregated among various authorities at the state and local level. Instead of pursuing ideological goals, if this provision was classified as distributive, Lowi predicts its political environment would allow individual policymakers to pursue and fulfill their own interests at the local or individual level. Since this provision of the ACA is not easily classified using Lowi's typology system, it is difficult to make concrete predictions about its corresponding political environment using Lowi's model. This demonstrates one of the fundamental flaws of Lowi's model noted by many critics. These criticisms will be discussed in detail in the next section. Shown on the next page, Table 5 summarizes the classification of each selected provision of the ACA and well as the predictions made regarding each provision's political environment.

Table 5: A Summary of the Predictions Made about the Political Environment Associated with Each Provision of the ACA when Applying Lowi's Model		
ACA Provision	Policy Type	Corresponding Predictions (Associated Political Environment)
Creation of State and Federal Health Insurance Marketplaces	Distributive	<ol style="list-style-type: none"> 1) Party logrolling predominant 2) Decentralized and disaggregated mechanism of political action <ul style="list-style-type: none"> ➤ Multiple authorities at the state or local level 3) Individual policymakers pursue and fulfill interests at local level 4) Predominant actor(s): Congressional Committees
Individual Mandate	Regulative	<ol style="list-style-type: none"> 1) Group behavior predominant <ul style="list-style-type: none"> ➤ Interest group formation ➤ Collective bargaining 2) Decentralized and disaggregated mechanism of political action <ul style="list-style-type: none"> ➤ Multiple authorities at the state or local level 3) Groups pursue and fulfill interests at local level 4) Predominant actor(s): Congressional Committees—party leaders
Employer Mandate	Redistributive	<ol style="list-style-type: none"> 1) Group behavior predominant <ul style="list-style-type: none"> ➤ Interest group formation ➤ Collective bargaining 2) Centralized political power 3) Policymaking follows systems model 4) Groups pursue and fulfill ideological goals
Voluntary Expansion of Medicaid	Constituent or Distributive	<p>Predictions if classified constituent:</p> <ol style="list-style-type: none"> 1) Party logrolling predominant 2) Centralized political power 3) Policymaking follows systems model 4) Individual policymakers pursue and fulfill ideological goals <p><u>For distributive predictions, see provision for creation of state and federal health insurance exchanges in 1st row</u></p>

Lowi's model was applied to the ACA by classifying the selected provisions using its classification system and then generating predictions using the model. The validity of these predictions was assessed by comparing them to current events discussed in Part I, E, i on page 14. As our discussion of the origins and political outcomes of the ACA in Part I reflect, the politics dominating the passage of the ACA into legislation can essentially be described as polarized party politics with substantial logrolling. Unfortunately, the multidimensional nature of the ACA as well as its sheer volume made it essentially impossible to classify as a whole, single policy using Lowi's classification system. Thus, Lowi's model was used to classify the selected, major provisions of the ACA and generate predictions regarding the political outcome associated with each provision. As mentioned in Part II subpart E, the multidimensional nature of one of the provisions of the ACA, the voluntary expansion of Medicaid, made it difficult to classify using Lowi's classification system. This illustrated one of the primary limitations of the model: it does not allow for the multidimensional nature of public policies as it does not allow for "mixed" categories. Although it was possible to classify specific provisions of the ACA and generate predictions corresponding to each provision, the predictions generated for each provision were diverse and in some circumstances conflicted (ex. predictions for individual mandate and creation of state/federal health insurance marketplaces).

Due to Lowi's limited classification system, the ACA could not be classified as a whole. Only the selected, major provisions of the classification system could be

classified using Lowi's policy classification system, and even then, it was difficult to classify one of the ACA's provisions. Because only the major provisions could be classified, the predicted political environments corresponded only to each provision and not the ACA as a whole. Since the different provisions were all classified as different policy types, their predicted political environments were diverse and in some cases conflicting (refer to example listed in paragraph above). Moreover, the political environment that has been seen throughout the ACA's legislative origins (Part I, D) and its implementation (Part I, Ei) was not merely associated with one provision alone but rather with all the selected provisions together (i.e. with the ACA as a whole, single policy). Consequently, this made comparing predictions for each provision with the political environment that has been seen throughout the ACA's origins and implementation difficult. Ultimately, Lowi's model could not be used to predict the political environment that has been seen throughout the ACA's legislative origins and implementation.

Although our application of Lowi's model is limited only to the ACA, our findings suggest Salamon and other critics' concerns regarding Lowi's limited policy classification system may be quite substantial. In our application of Lowi's model, we were ultimately unable to generate accurate predictions due to our inability to classify the ACA as a single policy, which was in turn the result of Lowi's limited system for classifying policies. These findings may suggest the limitations of Lowi's model makes it of no utility to today's policymakers since, as Salamon alludes to, the policies of today are quite diverse and multidimensional in nature.

III. SALAMON'S MODEL AND ITS PREDICTIONS FOR SELECTED PROVISIONS OF THE ACA

A. SALAMON'S MODEL: ORIGINS, UNDERLYING THEORY, AND THEORETICAL ASSUMPTIONS

Salamon created his theoretical model in response to what he termed “new governance.” The responsibilities of the federal government have expanded significantly since the post-World War II era, and Salamon and Lund (1989) believed this expansion was due to a fundamental transformation that had “...occurred over the past half century in the underlying structure of the public sector” (Brudney, 1990, 400). According to Salamon and Lund (1989), “This transformation has involved not simply an expansion in the scale and scope of government activity, but more importantly, a significant proliferation in the basic tools the public sector uses to achieve its objectives” (255). Analyzing literature and case studies throughout the 1900s, Salamon (2002) noticed that contemporary policymakers seemed to be under increasing political pressure due to factors such as “...the growing fragmentation of political power, increased complexity of public problems, recent skepticism of government, and the preoccupation with efficiency as the major criterion for public action” (Salamon, 2002, 37). Salamon believed that because of these pressures contemporary policymakers had been forced to “...select those tools of public action that are the most difficult to manage and the hardest to keep focused on their public objectives” (Salamon, 2002, 37). Ultimately, this kept American policymaking caught in a cycle of ineffective policymaking as disappointment with public action influenced policymakers to select suboptimal tools of public action that would most

likely bring further disappointment. In an attempt to break this cycle, Salamon (2002) created his own theoretical model, which he believed presented policymakers with “...a systematic body of knowledge that can help policymakers...take advantage of the special opportunities and cope with the special challenges...” new, modern policy tools bring (19).

Like Lowi, Lester Salamon believed political theorists and policymakers alike needed a set of comprehensive, conceptual tools to “...organize the facts and identify patterns that emerge...” across issue areas (Salamon, 1977). With the rise of “new governance,” Salamon believed constructing such a model was especially essential to helping policymakers sift through the diverse arsenal of modern policy tools and select those best suited to achieve their goals. While Salamon saw the predictive potential in existing theoretical models, like Lowi’s, he also believed these models had significant limitations that restricted their predictive power. Salamon wanted to create a model that would overcome these limitations and better serve the needs of “new governance.” Since modern policymakers had such a diverse plethora of policy tools at their disposal, Salamon felt it was critical to create a model that would provide a diverse, multidimensional classification system, which he and other critics felt Lowi’s model failed to do. In constructing his model, Salamon ushered in a new wave of thought that focused on classifying policy tools versus policies themselves (Fischer et al., 2007).

Unlike Lowi’s model, Salamon’s model did not classify policies but rather policy tools (Salamon, 2002; Salamon, 1989). Salamon (2002) defined a policy tool

as a tool of public action that "...is an identifiable method through which collective action is structured to address a public problem" (19). Essentially, a policy tool is how a given policy achieves its action.¹ Policy tools in the same category all have certain common features, which Salamon terms defining features (Salamon, 2002, 19). While tools in the same category have the same defining features, they also have design features that vary from one tool to another. Thus, policy tools in the same category will have some but not all features in common. According to Salamon (2002), policy tools structure action, meaning they "...define who is involved in the operation of public programs, what their roles are, and how they relate to each other" (19). Specifically, policy tools structure "...'collective action' aimed at responding to 'public programs'" (Salamon, 2002, 20). In other words, policy tools structure government action but also the action of other organizations or groups implementing a public policy. This definition expresses the reality that government is not the only entity involved in policymaking or implementation.

Salamon further divided policy tools into two categories: external and internal. External policy tools are used to affect both society and government, while internal policy tools are intended to only affect government. Salamon (2002) defines internal policy tools as "...the procedures that governments use to handle their own internal operations" (20). Salamon's theoretical model specifically focuses on

¹ Policy tools are not a part of policies themselves but rather they are a part of the programs policies institute. This will be discussed in more detail later in this section.

classifying external policy tools. All policies tools, both internal and external, contain a number of different elements, which include:

- 1) a type of good or activity;
- 2) a delivery vehicle for this good or activity;
- 3) a delivery system, that is, a set of organizations that are engaged in providing the good, service, or activity;
- 4) a set of rules, whether formal or informal, defining the relationships among the entities that comprise the delivery system (Salamon, 2002, 20).

As these elements suggest, the multidimensional nature of policy tools allows them to be classified according to any of their different elements, making no single classification possible. Programs employ policy tools to implement their desired action. Typically, a program will utilize different combinations of policy tools versus a single policy tool to achieve its desired goal. According to Salamon (2002), if policy tools are the tools of collective action utilized by programs to achieve their goals, public policies, then, must be collections of programs operating in a similar field or aimed at some general objective. A table summarizing these definitions can be found on the next page in Table 6.

Table 6: Basic Terminology Forming the Fundamental Theory of Salamon's Model	
Term	Definition
Policy tool	A tool of public action that "...is an identifiable method through which collective action is structured to address a public problem" (Salamon, 2002, 19)
Defining features	The common features all policy tools in the same category share
Design features	The features that vary among policy tools in the same category
External policy tools	Policy tools that are used to affect both society and government <u>Salamon's model specifically classifies external policy tools only.</u>
Internal policy tools	Policy tools that are intended to only affect government. Salamon (2002) defines internal policy tools as "...the procedures that governments use to handle their own internal operations" (20).
Program	Employ policy tools to implement their desired action
Public policy	Collections of programs operating in a similar field or aimed at some general objective

B. SALAMON'S MODEL: HOW THE MODEL CLASSIFIES POLICY TOOLS—CRITERIA FOR ASSESING THE CONSEQUENCES OF POLICY TOOLS AND POLICY TOOL DIMENSIONS

Salamon's model classifies policy tools using a two-step process (Salamon, 2002). First, the consequences of policy tools are assessed using five different criteria: effectiveness, efficiency, equity, manageability, and political legitimacy. Salamon (2002) defines effectiveness as being a measure of "...the extent to which an activity achieves its intended objectives" (23). Effectiveness does not consider the costs involved to produce the results; it merely assesses the extent to which the intended results were accomplished (Salamon, 2002). Efficiency, on the other hand, considers both the results and costs to generate those results. Ultimately, efficiency seeks to determine how much a given result or benefit is worth (cost-wise). Two common measures utilized to quantify efficiency are the cost-benefit ratio and cost-effectiveness ratio. The cost-benefit ratio assigns a dollar value to the benefit or results acquired and then calculates the cost-benefit ratio accordingly (ex. \$10,000 cost and \$40,000 benefit = 1:4 cost benefit ratio). Conversely, the cost-effectiveness ratio does not assign a monetary value to the benefit but rather leaves it in its natural unit of measurement.

Another criterion Salamon's model uses to assess the consequences of policy tools is equity. Salamon (2002) defines equity as being "...basic fairness—the distribution of benefits and costs more or less evenly among all those eligible" (23). However, there are two different types of equity when assessing how benefits and costs are distributed (Salamon, 2002). Horizontal equity involves treating similar

cases similarly, distributing benefits and costs equally amongst beneficiaries. For example, two single person households earning \$30,000 per year will be forced to pay the same amount in taxes under the US tax system. Since these two cases are similar, they incur the same costs and thus horizontal equity is achieved. Conversely, vertical equity involves treating different cases differently, distributing costs and benefits unequally amongst beneficiaries. The US's progressive tax system achieves vertical equity by forcing families of the same size with lower annual incomes to pay less in taxes than those with higher annual incomes. Typically, distributive programs disperse costs and benefits equally among recipients, while redistributive programs tilt the benefits toward and costs away from the disadvantaged.

The fourth criterion Salamon's model uses to assess the outcomes of policy tools is manageability or implementability, which Salamon (2002) defines to be "...the ease or difficulty involved in operating programs" (24). According to Salamon (2002), "...the more complex and convoluted the tool, the more separate actors are involved, and the more difficult it is likely to be to manage" (24). Finally, the last criterion used to assess policy tool outcomes is political feasibility and perceived legitimacy of public action.² Essentially, this criterion assesses whether a given policy tool is likely to receive support and be adopted as legislation. A summary of the criteria Salamon's model uses to assess policy tool outcomes can be found on the next page in Table 7.

² This is one criterion. Salamon has just combined political feasibility and perceived legitimacy into one criterion.

Table 7: Salamon’s Definitions of the Five Different Criteria used to Assess the Consequences of Policy Tools	
Term	Definition
Effectiveness	<p>“...measures the extent to which an activity achieves its intended objectives by focusing exclusively on results” (Salamon, 2002, 23)</p> <p>Does NOT consider the costs involved</p>
Efficiency	<p>“...balances the results against costs” (Salamon, 2002, 23)</p> <p>Ultimately seeks to determine how much a given result or benefit is worth (cost-wise).</p> <p>Common measures: cost-benefit ratio and cost-effectiveness ratio</p>
Equity	<p>“...basic fairness—the distribution of benefits and costs more or less evenly among all those eligible” (Salamon, 2002, 23).</p> <p>Different types</p> <ol style="list-style-type: none"> 1) Horizontal equity: involves treating similar cases similarly, distributing benefits and costs equally amongst beneficiaries 2) Vertical equity: involves treating different cases differently, distributing costs and benefits unequally amongst beneficiaries.
Manageability (Implementability)	<p>“...the ease or difficulty involved in operating programs” (Salamon, 2002, 24).</p>
Legitimacy/Political support (Political feasibility)	<p>whether a given policy tool is likely to receive support and be adopted as legislation.</p>

Considering the criteria discussed above, Salamon (2002) uses four dimensions of policy tools to "...classify tools for analytical purposes..." but also to predict how these dimensions will affect each of the five criteria of policy outcomes. The four dimensions of policy tools Salamon's model uses are: coercion (degree of coercion), directness, automaticity, and visibility.

Salamon (2002) defines coercion as a measure of "...the extent to which a tool restricts individual or group behavior as opposed to merely encouraging or discouraging it" (25). Although, like Lowi, Salamon recognizes nearly all forms of government action involve some degree of coercion, he proposes the extent of coercion used varies significantly amongst different policy tools. Tools that are at the low end of the coerciveness scale "...essentially rely on the voluntary cooperation of individuals and groups for their effects" (Salamon, 2002, 25). Examples of tools with a low degree of coercion include tax expenditures, public information campaigns, and tort liability. Policy tools with a moderate degree of coercion "...are still in some sense voluntary...since the citizen is still permitted to engage in the penalized behavior but has to pay a fine or tax on it" (Salamon, 2002, 25). Tools on the medium end of the coerciveness spectrum are typically those that deliver subsidies. Vouchers, grants-in-aid, loan guarantees, direct loans, contracting, mandatory labeling, and corrective fees and charges are all examples of such programs and are listed in order of increasing coercion. Finally, policy tools that exhibit high levels of coercion are

generally “...social and economic regulations, both of which impose formal limitations on activities considered undesirable” (Salamon, 2002, 26).³

The second dimension of policy tools Salamon’s model uses is directness. Salamon (2002) defines directness as measuring “...the extent to which the entity authorizing, financing, or inaugurating a public activity is involved in carrying it out” (29). Like the coercion dimension, policy tools can have varying degrees of directness (Salamon, 2002). A tool that is authorized, funded, and implemented by the government possesses the greatest degree of directness possible. Such tools are considered to be direct policy tools. On the opposite end of the spectrum, tools that are privately funded and executed are considered to have the least degree of directness. These tools are considered to be indirect policy tools. Tools that are publically funded and privately delivered or privately funded and publically delivered have a moderate degree of directness and are considered to be neither direct nor indirect.

Automaticity is Salamon’s third dimension of policy tools. According to Salamon (2002), automaticity is “...the extent to which a tool utilizes an existing administrative structure to produce its effect rather than having to create its own special administrative apparatus” (32). As with the other policy dimensions discussed so far, tools can also have varying degrees of automaticity (Salamon, 2002). Salamon

³ Government action that sets prices or limitations on firms entering a given market is defined as economic regulation. Minimum wage and anti-trust legislation would both be examples of economic regulation. Social regulation is defined as a series of rules or regulations defining what is impermissible or permissible behavior for citizens, firms, or government agencies. Criminal legislation would be an example of this kind of regulation.

classifies several policy tools according to their degrees of automaticity in a Figure that will be discussed later.

The final dimension of policy tools addressed in Salamon's model is visibility, which is defined as "...the extent to which the resources devoted to a tool show up in the normal government budgeting and policy review processes" (Salamon, 2002, 35). Again, as with the other policies dimensions, tools can have various degrees of visibility. Both the direct and indirect costs of a visible policy (highest degree of visibility) will be evident in the government budget. Shown on the next page, Table 8 summarizes Salamon's policy tool dimensions.

Table 8: A Summary of Salamon's Policy Tool Dimensions	
Term	Definition
Coerciveness	"...the extent to which a tool restricts individual or group behavior as opposed to merely encouraging or discouraging it" (Salamon, 2002, 25).
Directness	Measures "...the extent to which the entity authorizing, financing, or inaugurating a public activity is involved in carrying it out" (Salamon, 2002, 29) Direct policy (most direct): publically financed and executed Indirect policy (least direct): privately financed and executed
Automaticity	"...the extent to which a tool utilizes an existing administrative structure to produce its effect rather than having to create its own special administrative apparatus" (Salamon, 2002, 32).
Visibility	"...the extent to which the resources devoted to a tool show up in the normal government budgeting and policy review processes" (Salamon, 2002, 35). Visible policy (most visible): direct and indirect costs in government budget

C. SALAMON'S MODEL: DISCUSSION OF THE MODEL

Salamon's model ultimately combines the five criteria for assessing policy tool outcomes and four policy tool dimensions previously discussed (Salamon, 2002).

Salamon analyzed numerous policy tools of the same dimension (and degree of) to

develop conclusions about how various degrees of the four policy tool dimensions affected the five different criteria for assessing policy outcomes. Generated from this analysis, Salamon's conclusions regarding how the various degrees of each policy tool dimension will affect the five different criteria are shown below in Figures 4A-4D. Representative policies are also provided in these tables.

<i>Degree of Coerciveness</i>	<i>Illustrative Tools</i>	LIKELY IMPACTS				
		<i>Effectiveness</i>	<i>Efficiency</i>	<i>Equity</i>	<i>Manageability</i>	<i>Legitimacy/ Political Support</i>
<i>Low</i>	Tort liability Information Tax expenditures	Low	Moderate	Low	Moderate	High
<i>Medium</i>	Vouchers Insurance Grants-in-aid Government corporations Loan guarantees Direct loans Contracting Labeling requirements Corrective taxes	Moderate	High	Moderate	Moderate	Moderate
<i>High</i>	Economic regulation Social regulation	High	High/Low	High	Low	High/Low

Figure 4A: Salamon's Predictions for Policy Tools Grouped by Various Degrees of Coercion (Salamon, 2002, 26)

<i>Degree of Directness</i>	<i>Illustrative Tools</i>	LIKELY IMPACTS					<i>Legitimacy/ Political Support</i>
		<i>Effectiveness</i>	<i>Efficiency</i>	<i>Equity</i>	<i>Manageability</i>		
<i>Low</i>	Tort liability Grants Loan guarantees Government-sponsored enterprises Vouchers	Low	High	Low	Low		High
<i>Medium</i>	Tax expenditures Contracting Social regulation Labeling requirements Corrective taxes/ charges	Low/Med.	Medium	Low	Low		High
<i>High</i>	Insurance Direct loans Economic regulation Public Information Government corporations Direct government	High	Medium	High	High		Low

Figure 4B: Salamon's Predictions for Policy Tools Grouped by Various Degrees of Directness (Salamon, 2002, 29)

<i>Degree of Automaticity</i>	<i>Illustrative Tools</i>	LIKELY IMPACTS					<i>Political Support</i>
		<i>Effectiveness</i>	<i>Efficiency</i>	<i>Equity</i>	<i>Manageability</i>		
<i>Low</i>	Economic regulation Social regulation Direct government Government corporations Information Direct loans Insurance	High	Low	High	Moderate/Low		High
<i>Medium</i>	Grants Contracting Loan guarantees Labeling requirements	Moderate	High	Moderate	Low		Moderate
<i>High</i>	Vouchers Tax expenditures Corrective taxes/ charges Tort liability	Low	High	Moderate/Low	High/Moderate		Moderate

Figure 4C: Salamon's Predictions for Policy Tools Grouped by Various Degrees of Automaticity (Salamon, 2002, 33)

<i>Degree of Visibility</i>	<i>Illustrative Tools</i>	LIKELY IMPACTS				
		<i>Effectiveness</i>	<i>Efficiency</i>	<i>Equity</i>	<i>Manageability</i>	<i>Legitimacy/ Political Support</i>
<i>Low</i>	Economic regulation Social regulation Labeling requirements Insurance Tort liability	N/A	Low	Low	Low	High
<i>Medium</i>	Contracting Information campaigns Loan guarantees Tax expenditures	N/A	Moderate	Moderate	Moderate	Moderate
<i>High</i>	Direct government Government corporations Grants-in-aid Direct loans Vouchers Corrective taxes/ charges	N/A	High	High	Low	Low

Figure 4D: Salamon's Predictions for Policy Tools Grouped by Various Degrees of Visibility (Salamon, 2002, 36)

Cumulatively, Figures 4A-D are Salamon's predictive model. These figures can be used to predict the likely outcomes of using a policy tool of certain dimensions. For example, in the case of grants-in-aid, according to Figure 4D, these policies tools possess a high degree of visibility, which Salamon predicts will have high efficiency and equity but low manageability and legitimacy. Implied in Figure 4D, Salamon found that visibility did not have any effect on the effectiveness of a given policy tool's outcome (hence N/A). As Figures 4A-D suggest, a given policy tool can be analyzed among multiple dimensions (visibility, coerciveness, etc.). Thus, the predicted outcomes of a given policy tool depend upon which policy dimension is

being assessed, meaning a single policy tool can have multiplied predicted outcomes when using Salamon's model.

D. SALAMON'S MODEL: LIMITATIONS OF TOOLS-BASED MODELS

The diverse, multidimensional nature of policy tools has made it difficult for theorists to come to a clear consensus regarding the numbers and types of policy tools that exist (Salamon, 2002). Throughout the development of the tools approach, several different classification systems have been developed, which all classify policy tools according to different dimensions (Salamon, 2002). For example, Schneider and Ingram classified tools according to the behaviors that the programs utilizing them sought to modify, while Vedung classified policy tools according to the original system developed by F.C.J. van der Doelen that classified tools based on their degree of coercion (Salamon, 2002; Vedung, 1997; Schneider & Ingram, 1990). Considering no consensus has or really can even be reached regarding how to classify policy tools, some analysts question their true predictive power (Salamon, 2002; Lindblom, 1990). As our classification of the ACA's policy tools using Salamon's model revealed, several different predictions can be made for a single policy tool depending upon which policy dimension is being used. However, Salamon (2002) argues the diverse nature of policy tools is actually one of the primary benefits of using a tools-based approach. Salamon (2002) asserts that "...multiple classifications of tools are entirely appropriate since different classifications will highlight different facets" (22). Whether this diversity makes a tools-based approach have stronger or weaker

predictive power remains unclear since no empirical data exists that supports the accuracy or reliability of predictions made using tools-based models.

One limitation of Salamon's model in particular is that it is limited to functions of the federal government (Mauldin, 2005; Salamon, 2002; Salamon, 1989). Consequently, Salamon's model can only be used to predict policy outcomes for policy tools "...operating within this federal system" (Mauldin, 2005, 33). Other tools-based approaches, such as that constructed by Schneider and Ingram (1990), have taken a more general approach than Salamon at classifying policy tools, making these models applicable to all levels of government (Mauldin, 2005).

E. SALAMON'S MODEL: METHODS—GENERATING & EVALUATING PREDICTIONS

To generate predictions using Salamon's model, the selected provisions of the ACA will first be classified using Salamon's policy tool dimensions. This system was discussed in Part III, B. Next, Salamon's model will be used to generate predictions regarding the outcomes of policy tools according to his criteria for assessing the consequences of policy tools. These criteria are discussed in Part III, B and were discussed within the context of the model in Part III, C. To assess the relative accuracy of these predictions, they will be compared to current events and data regarding the outcomes of the ACA discussed in Part A, E, i-iv.

Salamon's model will now be used to predict the outcomes of each selected provision of the ACA. To relate Salamon's predictions to Lowi's, all provisions will

be classified according to their tools' degrees of coercion. In order to make predictions using Salamon's model, the policy tool of each provision must first be determined.

Referring to Figure 4A, the ACA's creation of federal and state health insurance marketplaces would have a medium degree of coercion. This provision is creating a health insurance program through government and thus its policy tool is considered to be the "insurance" illustrative tool listed in the medium degree of coercion category. Considering Salamon's definition of coercion (see Table 9), this provision is a moderately coercive policy by definition since it does allow consumers to choose whether or not they will purchase insurance through the government or another provider. As shown in Figure 4A, Salamon predicts the outcomes of moderately coercive policy tools will have high efficiency but only moderate effectiveness, equity, manageability, and legitimacy.

The policy tool employed by the ACA's individual mandate is considered to be the 'social regulation' illustrative tool in the high degree of coercion category in Figure 4A. The individual mandate stipulates all citizens must purchase health insurance or pay an increasing penalty fine. Thus, this provision is demonstrative of social regulations since the government is dictating a behavior that is not permissible of citizens (i.e. not purchasing health insurance). Shown in Figure 4A, Salamon predicts the outcomes of highly coercive policy tools will achieve high effectiveness and equity but low manageability. If such policy tools achieve trivial public costs but significantly larger social costs, Salamon predicts they will achieve high efficiency

when assessed in terms of public costs but low efficiency when viewed in terms of social costs hence the “High/Low” prediction. The same is true for the predicted legitimacy of highly coercive policies. The employer mandate uses the same policy tool as the individual mandate: social regulation. Consequently, Salamon’s predictions discussed for the individual mandate’s policy tool are the same as those predicted for the employer mandate.

Finally, the ACA’s provision for voluntary state expansion of Medicaid programs employs the ‘grants-in-aid’ policy tool listed in the medium coercive category. Grants-in-aid are grants distributed by the central government to state or local governments for a specific program endorsed by the federal government. The ACA’s voluntary expansion of Medicaid uses grants-in-aid to encourage states to expand their Medicaid programs by providing states participating states with grants to do so. Since grants-in-aid are a moderately coercive policy tool, Salamon predicts the outcome associated with this tool will achieve high efficiency but only moderate effectiveness, equity, manageability, and legitimacy. Salamon’s predictions for each provision’s policy tool can be found on the next page in Table 9.

Table 9: Summary of Salamon's Predictions for the Policy Tools Corresponding to Each ACA Provision			
Provision	Policy Tool	Extent of Coercion	Predictions
Creation of state and federal health insurance exchanges	Insurance	Medium	Effectiveness: Moderate Efficiency: High Equity: Moderate Manageability: Moderate Legitimacy: Moderate
Individual mandate	Social Regulation	High	Effectiveness: High Efficiency: High/Low Equity: High Manageability: Low Legitimacy: High/Low
Employer mandate	Social Regulation	High	Effectiveness: High Efficiency: High/Low Equity: High Manageability: Low Legitimacy: High/Low
Voluntary expansion of Medicaid	Grants-in-aid	Medium	Effectiveness: Moderate Efficiency: High Equity: Moderate Manageability: Moderate Legitimacy: Moderate

As discussed, Salamon's model was applied to the selected provisions of the ACA by first classifying these provisions using Salamon's policy tool dimensions and then applying the model to generate predictions. The relative accuracy of these provisions was assessed by comparing them to current data and trends regarding the ACA discussed in Part I, E. Since Salamon's model classifies policy tools instead of policies themselves, it was much easier to use this model to generate predictions for the various provisions of the ACA. As previously mentioned, although Salamon's

model does allow for the multidimensional nature of public policy (versus Lowi's model which limits policy types), diverse predictions can be made for a given policy tool depending on what policy dimension is being used. Because Lowi's model generated predictions according to policies' levels of coercion, the coerciveness policy tool dimension was used to generate predictions using Salamon's model.

Salamon's predictions achieved a mixed success when comparing his predictions to current data and trends regarding the ACA.⁴ For the creation of federal and state health insurance exchanges, Salamon predicted moderate effectiveness, equity, manageability, and feasibility with high efficiency. In reality, the CO-OPs did achieve a moderate level of effectiveness, equity, manageability, and feasibility. While they did expand coverage for many Americans, this portion was a very small percentage of the population. Although subsidies were provided to qualifying low-income families, they disappeared quickly for some low-income groups and were found to not reduce financial barriers enough for others. Additionally, failed CO-OPs caused many insured under marketplace plans to lose their coverage, forcing them to obtain coverage from outside providers. Thus, while low-income individuals could purchase public insurance in some states, individuals in the same income bracket could not purchase the same insurance in another. Considering these factors, this provision of the ACA could be said to achieve moderate equity. As the current debate over the failed CO-OPs indicate, this provision achieved a moderate level of

⁴ Data and trends regarding the ACA used to assess the relative validity of Salamon's predictions were discussed in Part I: D & E.

feasibility. While some are still of favor in continuing to develop the CO-OPs, proposing recent failure should merely be viewed as “a small business start-up problem,” others, like Senator Portman believe the social and public costs recently experienced are too great to be viewed so lightly (Levin & Goldestein, 2016). The success of some CO-OPs but failure of others suggests this provision of the ACA was moderately manageable. The only prediction that seemed to deviate from current data and trends was Salamon’s prediction of high efficiency. Although the marketplaces currently cover around 12.7 million individuals, the failed marketplaces cost the federal government over \$1.2 billion and caused almost three-quarters of a million Americans to lose their coverage. These results suggest the creation of state and federal insurance marketplaces achieved a moderate degree of efficiency, achieving significant social benefits but also substantial social and public costs.

For the individual mandate, Salamon’s model predicted high effectiveness and equity with low manageability. He also predicted efficiency and legitimacy to be high or low depending on the social and public costs and benefits involved. As mentioned, there is no data regarding how many Americans have acquired insurance due to the individual mandate. Consequently, we cannot assess the relative effectiveness or efficiency of this provision. This provision did achieve high equity as all citizens are forced to acquire insurance or pay some degree of a penalty fine. In terms of manageability, empirical data and trends suggest there have been no significant problems in implementing the individual mandate, further suggesting that this provision achieved a high degree of manageability, which contradicts Salamon’s

predictions. The political volatility and GOP attempts to repeal the individual mandate suggest this provision achieved a low level of legitimacy. Although a few of Salamon's predictions were comparable to data and current trends, most of his predictions for this provision we were unable to compare due to lack of relevant data. We do not believe this was ultimately due to any limitations of Salamon's model but rather was due to the nature of the provision itself. As the rest of our conclusions will reveal, all other predictions had relevant data to compare with Salamon's predictions.

Salamon's model predicted the employer mandate would achieve high effectiveness and equity with low manageability and high/low efficiency and legitimacy. As the data suggests, the employer mandate did increase coverage for millions of Americans, suggesting it was a highly effective provision. In terms of efficiency, we argue it achieved moderate efficiency versus Salamon's high/low prediction. Although the employer mandate did extend coverage to many Americans, it also imposed significant social costs by encouraging employers to switch to HDHPs. This transition has imposed a great financial burden upon a substantial portion of Americans, causing them to become underinsured. In terms of equity, Salamon's prediction of high equity was fulfilled in reality as all employers of 50 or more employees are required to provide health insurance benefits or pay a penalty fine. As for efficiency, we also argue this provision achieved a moderate level of legitimacy instead of Salamon's high/low prediction. The GOP was vehemently against the employer mandate while the Democrats fought just as strongly for it. Finally, there is no empirical data or trends that suggest the employer mandate has

been anything but manageable. Consequently, we believe this provision achieved high manageability, which directly contradicts Salamon's prediction of low manageability.

For the voluntary Medicaid expansions, Salamon predicted moderate effectiveness, equity, manageability, and legitimacy with high efficiency. Empirical data and trends suggest this provision did achieve moderate effectiveness. Although a majority of the gains in insurance coverage under the ACA were attributed to states' voluntary Medicaid expansions, not all states elected to expand their programs. This also suggests this provision did indeed achieve moderate equity as not all US citizens who could qualify for Medicaid under the ACA were able to do so due to states that did not elect to expand their programs. The political turmoil this provision created suggests Salamon's prediction of moderate legitimacy was relatively accurate. Although many states readily expanded their Medicaid programs, several filed joint lawsuits claiming this portion of the ACA was unconstitutional. Findings issued by the Henry J. Kaiser Family Foundation suggest this provision did achieve Salamon's predicted high efficiency as states electing to expand Medicaid coverage have substantially reduced their number of uninsured citizens while also acquiring a small net budget savings (Holahan et al., 2012). Empirical data and trends do not suggest Medicaid expansion has been difficult for states to manage, contradicting Salamon's prediction of moderate manageability. Shown on the next page, Table 10 summarizes Salamon's predictions and their relative accuracy when compared with current data

and trends regarding the ACA. Salamon’s predictions listed in red were those that were considered to be inaccurate upon comparison with current data and trends.

Table 10: Summary of Salamon’s Predictions for the Policy Tools Corresponding to Each ACA Provision & What was Found to Have Actually Occurred in Reality from Our Discussion of Current Data and Trends Regarding the ACA		
Provision	Salamon’s Predictions	Outcome in Reality (Determined by Discussion of Current Data and Trends Regarding the ACA—See Part I: D & E)
Creation of state and federal health insurance exchanges	Effectiveness: Moderate Efficiency: High Equity: Moderate Manageability: Moderate Legitimacy: Moderate	Effectiveness: Moderate Efficiency: Moderate Equity: Moderate Manageability: Moderate Legitimacy: Moderate
Individual mandate	Effectiveness: High Efficiency: High/Low Equity: High Manageability: Low Legitimacy: High/Low	Effectiveness: no data for comparison Efficiency: no data for comparison Equity: High Manageability: High Legitimacy: High/Low
Employer mandate	Effectiveness: High Efficiency: High/Low Equity: High Manageability: Low Legitimacy: High/Low	Effectiveness: High Efficiency: Moderate Equity: High Manageability: High Legitimacy: Moderate
Voluntary expansion of Medicaid	Effectiveness: Moderate Efficiency: High Equity: Moderate Manageability: Moderate Legitimacy: Moderate	Effectiveness: Moderate Efficiency: High Equity: Moderate Manageability: High Legitimacy: Moderate

As Table 10 reflects, Salamon's model was able to accurately predict most of the outcomes associated with the various policy tools implemented by the ACA. Although our application of Salamon's model was restricted only to the ACA's policy tools, our findings suggest it may be of great utility to policymakers since most of its generated predictions were considered to be relatively accurate upon comparison to current data and trends regarding the ACA.

Although Salamon's model was able to accurately predict most of the outcomes associated with the various policy tools implemented by the ACA, the replicability of these results is questionable. Salamon's model does not clearly define its policy tool outcomes. The model does not clarify what a low, moderate, or highly effective, efficient, equitable, manageable, or legitimate policy tool outcome is. Consequently, how we assesses the relative validity of Salamon's predictions was somewhat biased and may not be replicable. To make the model more useful to policymakers, future work should clarify what a low, moderate, or highly effective policy tool outcome is (effective, efficient, etc.). This will create a standardized method for assessing the relative validity of the model's predictions.

IV. COMPARING AND CONTRASTING THE MODELS

As mentioned, both Salamon and Lowi's theoretical models sought to serve the same purpose: to generate predictions. However, the models differ regarding what they intend to predict. Lowi's model is intended to predict the political environment associated with a given policy, while Salamon's model intends to predict the outcome

of implementing certain policy tools.⁵ Thus, the purpose of applying both models to the ACA was to generate a comprehensive prediction, predicting the political environment associated with each provision as well as the outcomes associated with each policy tool implemented by the ACA.⁶ The models were also constructed very differently.

Lowi's model was constructed according to the underlying assumption that policy creates politics. Consequently, Lowi's model attempted to predict the political environment associated with a policy by classifying a given policy to be one of four different policy types (Lowi, 2002; Lowi, 1988; Lowi, 1972a). Lowi's model classified policies according to how the State exercised its power to coerce citizens' behavior, analyzing policies' coercion along two different dimensions: likelihood of coercion and applicability of coercion. Thus, Lowi's series of predictions regarding a policy's corresponding political environment, in turn, depended upon which type of policy a given policy was classified as. As several critics of Lowi's model noted, his typology system provided a limited number of policy types and did not allow for mixed categories, making classification of many policies quite difficult.

Salamon believe the limited policy types offered by Lowi's model significantly restricted its predictive power. In turn, Salamon sought to offer policymakers a theoretical model that would readily allow for the multidimensional

⁵ Outcome being in terms of the five criteria Salamon uses to assess the consequences of policy tools. Policy tools are tools with a specific degree of a given policy tool dimension (e.g. high coerciveness or low automaticity).

⁶ In this paper, each selected provision of the ACA were considered to be policy tools.

nature of public policies. Unlike Lowi's model, Salamon's model was constructed according to the underlying assumption that policy tools create politics (Salamon, 2002). Salamon defined policy tools as essentially the collective action through which a program dictated by a given policy operates to achieve its desired purpose. Salamon classified policy tools according to several policy tool dimensions, which were levels of coercion, directness, automaticity, and visibility. Because any given policy tool could have one or more of these policy tool dimensions, Salamon's model could generate multiple predictions regarding the outcomes associated with a given policy tool. Although this made the model more realistic in the sense that it allowed for the multidimensional nature of policy tools, it also somewhat limited the model's predictive power since any given policy tool can have multiple predictions depending on which policy tool dimension is being assessed.

Both Salamon and Lowi's models were used to generate predictions. Lowi's model generated predictions regarding the political environment associated with select provisions of the Affordable Care Act (ACA), while Salamon's model predicted the outcomes associated with each policy tool implemented by the ACA. As mentioned, in this paper, each selected provision of the ACA was considered to be a policy tool. Since Lowi's model classifies policies solely regarding their extent of coercion, only the coercion policy tool dimension was used when using Salamon's model to generate predictions. This was done to relate the predictions generated by both models. However, as the predictions generated by each model reflect, the types of predictions generated by each model are quite different. The predictions generated

by Lowi's model describe the political environment associated with each ACA provision, while Salamon's qualitatively describe the outcome associated with implement each ACA policy tool. Instead of comparing these predictions to each other, we compared them separately to current data, events, and trends regarding the ACA.

V. CONCLUSIONS

This study sought to illustrate the potential of tool-based theoretical models for accurately predicting the outcomes of policy tools employed by public policies. Lowi's model was applied to the ACA to demonstrate why models must allow for the multidimensional nature of public policy. Salamon's model and other tools-based models allow for this multidimensional nature of policy tools, which ultimately enables these models to generate useful predictions. Thus, while some critics have viewed this characteristic as a flaw, our evaluation illustrates its utility in predicting policy tool outcomes. Finally, Salamon's model was applied to the ACA to demonstrate the utility of tool-based models in predicting policy tool outcomes. As our evaluation suggests, the model generate relatively accurate predictions but does need some improvements to be useful to policymakers. Ultimately, tools-based models, like Salamon's, show significant potential for predicting the outcomes of policy tools, and future work should seek to improve these models so that they can be useful to policymakers.

Our application of Lowi and Salamon's theoretical models to the ACA generated mixed results. Lowi's model did not generate any useful predictions that could be compared with current empirical data and trends. Because Lowi's model does not allow for the multidimensional nature of public policy and presents a very limited number of policy types, we were not able to classify the ACA as a single policy. Instead, we were forced to classify different provisions of the ACA. The predictions generated for these provisions contradicted each other and failed to explain the political events that have ensued throughout the ACA's legislative journey and implementation. Our application of Lowi's model to the ACA illustrates one of the primary points this evaluation sought to demonstrate: theoretical models must allow for the multidimensional nature of public policy to generate relatively accurate and useful predictions. This is what makes Salamon's model and other tools-based approaches much more useful than other theoretical models, like Lowi's.

As expected, Salamon's model was much more useful than Lowi's because it allowed for the multidimensional nature of the policy tools public policies employ. Although different predictions can be generated depending on the policy tool dimension being used, the predictions it did generate when using the coerciveness policy tool dimension overall agreed relatively well with current empirical data and trends. For the individual mandate, no relevant data or trends existed to assess the validity of Salamon's predictions for the effectiveness and efficiency policy criteria. However, as mentioned, we believe this was not due to a flaw or limitation in the model but rather due to the nature of the provision itself.

Over all, this theoretical study indicates Salamon's tools-based approach could be quite useful to policymakers in predicting the outcomes associated with policy tools implemented by programs of public policies. Given the ACA is a very large, diverse public policy, the relative accuracy of Salamon's predictions for its policy tools suggests it can be useful for generating predictions associated with policy tools implemented by programs of even very large, complex public policies. However, in order for it to be useful to policymakers, a standardized method for assessing the relative validity of the model's predictions must be created. Future work should address what a low, moderate, or highly effective, efficient, equitable, manageable, and legitimate policy tool outcome is so that the validity of the policy tool outcomes predicted can be assessed in a replicable manner.

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