Introduction: Health Reform after the 2016 Election

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When Donald Trump was elected president in 2016, along with Republican majorities in both the House and the Senate, the future of US health policy was immediately thrown into doubt. Trump had campaigned against the Affordable Care Act (ACA), promising to replace it with "something terrific" (Sanger-Katz 2017). Trump had also pledged that "I'm not going to cut Social Security like every other Republican and I'm not going to cut Medicare or Medicaid" (Brewster 2017). It was impossible to predict on election night what health reform proposals Trump would actually support once he was faced with the unfamiliar reality of having to govern. Would he embrace the welfare state retrenchment proposals of conservatives like House Speaker Paul Ryan (R-WI)? Or would he seek to carve out a bipartisan middle ground?

During his first year in office, it became clear that Trump would govern from the right on domestic policy and that he would almost certainly sign any health reform bill that landed on his desk. The question then became whether the GOP's seven-year drive to repeal the ACA—the boldest effort to dismantle a major social program in modern US history—would finally succeed. It very nearly did. The House passed a sweeping ACA repeal bill (which also contained a massive cut to Medicaid), but similar legislation fell two votes short in the Senate when Republicans John McCain, Lisa Murkowski, and Susan Collins joined all Democrats to vote against the measure. Still, the battle over health care reform continued. The individual mandate at the heart of the bill was eliminated as part of tax reform, and the Trump administration used its executive authority to undermine the law's implementation.

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The articles in this special issue assess the state of play as of January 2018. What makes the essays of enduring significance is that they use the battle over the GOP's effort to repeal the ACA as an analytical lens to explore big questions about American politics and public policy, including whether the received wisdom about the difficulty of retrenching social programs remains true in the Trump era, whether policy feedback continues to insulate policies from attack, and whether and how populism and white nationalism are reconfiguring not only health policy but also the fundamental definition of America and Americans. Taken together, the essays point to many promising new avenues of research.

In our lead article, Jacob S. Hacker and Paul Pierson examine "the dog that almost barked"—the near passage of legislation to repeal the ACA. A large body of scholarship argues that it is extremely risky for reelection-minded politicians to dismantle social programs. Indeed, it is generally an exercise in "blame avoidance" rather than "credit claiming." The GOP's repeal proposal polled terribly—just 17 percent of Americans said they supported the bill. Why did Republicans nonetheless press forward? To answer this question, Hacker and Pierson emphasize the radicalization of the GOP, a process they call "asymmetric polarization." Lawmakers from overwhelmingly Republican districts believed their greatest electoral threat was a primary challenge. This increased the power and organizational cohesion of conservatives and reduced the influence of moderates. The authors also stress that the ACA was less firmly entrenched than many of its supporters hoped, in part due to conservative resistance to the Medicaid expansion. Hacker and Pierson conclude that, while the old barriers to retrenchment have not vanished, the new political environment has changed the prospects for radical legislative drives. Once unthinkable policy moves such as the repeal of the ACA now have some prospect of success.

The Republicans' proposals to repeal the ACA did not merely seek to undo the new health care benefits created under President Obama in 2010. They also sought to unravel Medicaid, a bedrock social welfare program that finances health care for some 80 million Americans. In our second article, Sara Rosenbaum examines the "existential" threat that Medicaid faced under three distinct waves of attack during the first year of the Trump administration. She explains the goals of each wave, as well as the political and policy reasons why each failed. Rosenbaum argues that, while Medicaid's entitlement structure and funding base are still intact, it remains highly vulnerable to attack from Congress, the presidency, and the judiciary in the current political environment.

Although an exceptionally salient and consequential case, the ACA is by no means the first social program to encounter stress and opposition after its

enactment. In our third article, Mark A. Peterson compares and contrasts the failed ACA repeal drive to a successful effort to terminate a major social program: the repeal of the Medicare Catastrophic Coverage Act. Passed by overwhelming bipartisan majorities and signed into law by President Ronald Reagan in 1988, the act was supposed to protect Americans against bankruptcy from medical bills, but Congress soured on it just a year later when senior citizens (the law's intended beneficiaries) protested against the measure's premiums and failure to provide long-term care coverage. Peterson explores in detail both the similarities and differences between the two cases, focusing on three dimensions of the policy experience for each law: the political-institutional context in which enactment and repeal consideration took place, the process by which repeal gained legislative footing, and the policy attributes embedded in the laws themselves.

Conservatives have never been entirely enthusiastic about the welfare state, but in the past they often contested the enactment of new social programs but supported, or at least resigned themselves to, the policies once they won adoption. Why have conservatives remained unremittingly hostile to the ACA despite the law's relatively moderate design? To address this question, Eric M. Patashnik and Jonathan Oberlander place the post-enactment battle over the ACA in a broad historical-institutional perspective by juxtaposing the strategic choices that conservatives have made to limit the role of the federal government in the core social welfare areas of pensions and health since the New Deal. The authors' central argument is that conservatives' varying strategies of postenactment opposition, resistance, and accommodation to Social Security, Medicare, Medicaid, and the ACA have been shaped by shifts in conservative ideology, changes in control of institutional resources, and the nature of policy feedback. Patashnik and Oberlander argue that attention to these contextual factors helps explain why ACA opponents viewed the law as a grave threat, why opposition did not subside after the law's enactment, and how conservatives managed to keep the conflict going across multiple election cycles.

The subsequent article, authored by James A. Morone, also examines the ACA repeal drive in historical perspective by contrasting the approach to health policy taken by President Trump during his first months in office with the legacies of other modern Republican administrations. While Republican presidents Dwight Eisenhower, Richard Nixon, Ronald Regan, and George W. Bush each sought to limit big government influence on health care policy, they also looked for ways to be constructive and expand coverage, even when it meant pushing more expansive health policy over the objections of an antigovernment minority within the party. Morone argues that Trump broke

with this pattern and links the repeal and replace effort to a major political development: the resurgence of white nationalism among the Republicans' whiter, older, anti-international, rural-leaning coalition. Morone argues that white nationalism and nativism not only challenge the basic idea of a right to health care and erode the social capital that fosters social welfare policies but also amplify questions of American national identity.

In the final essay, Paul Starr turns to the future of American health policy. Starr argues that "counterreform" has been an important dynamic in the struggle over US health policy from the Progressive Era up to the present. When expansive progressive ideas are defeated or watered down, chastened reformers have typically adopted rebound strategies that adjust ideas, proposals, and tactics in light of the institutional and political forces created or set in motion by previous policies. That happened following the defeat of the 1993 Clinton plan, and Starr predicts that it will happen again in the wake of the liberal setbacks of the Trump era. In addition to analyzing counterreform as an ingrained pattern, Starr proposes his own rebound idea to take account of both recent developments and the ACA's vulnerabilities: a "Midlife Medicare" program to expand protection to people fifty-to sixty-four years of age. While Starr's proposal will likely not be the only counterreform idea to receive attention in the years ahead, it merits careful analysis and broad discussion.

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