Race, Policy Feedbacks, and Political Resilience

The ACA a Decade In: Resilience, Impact, and Vulnerabilities

Mark A. Peterson
University of California Los Angeles

Abstract A decade after its enactment, the Affordable Care Act remains both politically viable and consequential, despite Republican efforts to end it. The law's impact on insurance coverage is substantial but remains distant from universal coverage, while its contributions to cost control are at best limited. National public opinion data collected by the author in 2018 reveal both strengths and vulnerabilities in the act.

Keywords Affordable Care Act, public opinion, insurance coverage, cost containment

Those familiar with the film *Apollo 13* will recall the scene. Having suffered a nearly disastrous explosion en route to the moon, and after a slingshot around it to return to Earth, the crew of the hobbled spacecraft had to execute a near perfect manual burn to set a viable course for Earth reentry. If they hit the atmosphere with too steep a trajectory, the capsule and crew would incinerate. Too shallow, they would bounce off the atmosphere and disappear into the oblivion of space. Given the fortunate ending, we know that they successfully navigated into what *Apollo 13* Commander Jim Lovell described as that "very narrow pie-shaped wedge."

Were Lovell a health policy historian, he could have been recounting the passage of the Affordable Care Act (ACA) in 2010. Numerous past health care reform initiatives had bounced off the governing system's unresponsive firmament, ignored, lost without a trace in the political ether. Other proposals, like Bill Clinton's Health Security Act, had slammed into an unforgiving political atmosphere, burning up and leaving damaging debris in their wakes. The ACA, however, found the path to enactment, the very

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first reform legislation to secure floor votes in the House and Senate. Even in the best overall political-institutional context for enacting health care reform in US history, the pie-shaped wedge was truly narrow (Peterson 2019: chap. 11). Passage came in the Senate by overcoming a filibuster with no votes to spare. Final approval in the House rested on just a three-vote margin.

Legislative enactment is but a necessary, not sufficient, outcome. Achieve policy goals is the point. Not even designed to orbit the earth, Alan Shepard's first US manned space flight in 1961 may have seemed intended to do nothing more than thrust a live American into weightlessness and return him alive and unharmed to the ground, but even that mission was part of an orchestrated plan to fulfill national objectives framed by the Cold War competition with the Soviet Union and eventual advances in science. The ACA's political success, however thrilling given its uniqueness, would have meaning only if it had a demonstrable positive impact on the health care system. As with all health care reform initiatives, its two most prominent objectives were to expand substantially insurance coverage and to do something meaningful to rein in rising health care costs, joined by features aimed to promote higher-quality care, invigorate the health professions, and advance population health (Kaiser Family Foundation 2010). At the 10–year mark since its passage, assessment of the ACA confronts three core questions. First, did the law really survive intact its fiery plunge through the intensely partisan and resistant political atmosphere of contemporary America? Second, how well has it fulfilled the promise to enlarge markedly the ranks of the insured population and set a course for universal coverage? Third, how effectively has it put in place mechanisms to contain growing health care expenditures—overall, for government budgets and taxpayers, and out-of-pocket for individuals and families.

The answers in all three respects are mixed. In part that reflects positive returns. The ACA has revealed perhaps surprising resilience, put insurance cards into the hands of millions previously outside the system, and even contributed to some degree of reduced financial burdens. At the same time, all of these gains have been incomplete, remain vulnerable, and are threatened by underlying forces in the political economy. The path to a more secure future for either the ACA or a more ambitious successor is far from clear.

Political Resilience

In the history of American social benefit programs, the ACA has proven to be one of the most susceptible to disruption and outright repeal, risking

joining the Medicare Catastrophic Coverage Act of 1989 on the ash heap of domestic policy (Peterson 2018b). A social policy program that cannot manage to stay in the statute books is not one of consequence. The enactment of the ACA on those meager entirely party-line margins arguably did much to fuel the Tea Party mobilization on the right. That in turn helped enable the 2010 midterm electoral wave that allowed Republicans not only to recapture the majority in the House of Representatives but also to assume a commanding position in the states—state legislatures flipped from 54% Democratic control to 52% in Republican hands, governorships went from 52% blue to 58% red, and the GOP gained the trifecta of unified government in 40% of the states.[1] While the new Republican House majority immediately launched repeated efforts to repeal or eviscerate Obamacare, their fellow partisans in the states initiated collective lawsuits against it and blocked the Medicaid expansions that had been made voluntary by the US Supreme Court's ruling in *NFIB v. Sebelius* (567 U.S. 519 [2012]).

For much of 10 years since the statute's enactment, its political health looked precarious. It decidedly lacked the popular acclaim of the sort that arose to undergird programs like Social Security and Medicare. The Kaiser Family Foundation has fielded monthly national tracking polls throughout this period, including fairly regularly taking the temperature of the ACA in the body politic by asking the question: "As you may know, a health reform bill was signed into law in 2010. Given what you know about the health reform law, do you have a generally favorable or generally unfavorable opinion of it?" (Kaiser Family Foundation 2019b). Although health care reform in general and even President Obama's proposed plan had enjoyed net support of 30 percentage points and higher, in the month after formal passage the ACA mustered a positive view from only 46% of the respondents, disfavor from 40%, and a "don't know" opinion from 14%. Late the following year the ACA was held in particularly low regard, with only one-third supportive and just over half now disapproving. Later still, from February 2013 to November 2014 those with a favorable view stayed in the 30% range, including in the low 30% range following the disastrous rollout of HealthCare.gov, the federal website for enrolling in the newly available market exchange plans. For a substantial part of the last decade the law was underwater in public opinion.

Three interrelated events saved the ACA from this unstable purgatory. First, ongoing Democratic control of the Senate until 2015 and President

1. These data were assembled from various election results reported at ballotpedia.org and the National Conference of State Legislatures (ncsl.org).

Barack Obama's reelection to a second term lasting through 2016 meant that Republican efforts at repeal could not succeed until at least 3 years after the full implementation of the ACA's coverage benefits and preexisting condition protections. Consistent with the positive policy-feedback literature and unlike the case with the Medicare Catastrophic Coverage Act, that was sufficient time to anchor the program in the public's expectations and the interests of such stakeholders as insurers, hospitals, and other providers (Peterson 2018b).

Second, the explicit Republican campaign in 2017 to abolish the law—the principal legislative activity of the year, at least until the passage of the Tax Cuts and Jobs Act in December—accorded the public every reason to pay attention to the coverage expansions and protections afforded by the ACA and rise in their defense. Congressional Budget Office (2017) scoring of the Republican plans, which went beyond repeal to curtailing long-standing Medicaid coverage, revealed that 23 million people would lose insurance. More would be uninsured than before the ACA's enactment. Preexisting condition protections would also be largely undone. At the time of the 2016 election, in the Kaiser Family Foundation survey the public's views of the ACA split 43% favorable and 45% unfavorable. Soon after Senator John McCain famously gave the thumbs down to the Senate version of repeal and replace in July 2017, helping defeat it, public support had turned favorable at 52% to 39%. Tracking the same respondents through five waves in a panel study from 2010 to 2018, Jacobs, Mettler, and Zhu (2019: 913) also show a marked increase in support for the law.

In 2018 Darin DeWitt and I designed a health care policy and politics module for that year's Cooperative Congressional Election Study (CCES), a national survey of public attitudes built around common content and the specific investigations of 60 research teams (Ansolabehere, Schaffner, and Luks 2019; Peterson 2018a). Each team's module is administered to a nationally representative sample of about 1,000 respondents. We asked about a large number of specific provisions in health care legislation, without identifying which were associated with the ACA and which derived from the Republican proposals. Of the eight that tracked with actual features of the ACA, despite the ambiguity about the law as a whole, all drew supermajorities of public support, ranging from 60% to 80% (mean, 69.4%). Even the most redistributive and likely to be especially contentious—having Medicaid cover all low-income uninsured adults and providing subsidies to Americans of modest means to buy private insurance—garnered endorsement from over 60% of the respondents.

Third, beyond advocating dismantling the ACA, Republicans weakened their political standing even further by offering replacement approaches that alienated the public and influential interests. When we asked respondents in the 2018 CCES whether they had a generally favorable or unfavorable opinion of the Republican proposals, among the 80% who expressed an opinion, only one-third were supportive and two-thirds opposed. Of the five provisions in our survey associated with the 2017 Republican plans, public support averaged 39.6%. The only one to attract majority support would allow insurers to sell plans that traded lower premiums for higher out-of-pocket costs and uncovered services. At the same time, though, 65.6% of our sample favored a provision that would "require insurers in the individual and small group health insurance markets to cover" the list of 10 "essential benefits" formally included in the ACA, which only 13.1% opposed. With respect to Medicaid, only 35.5% supported denying coverage to able-bodied adults and fewer still (28.1%) agreed with capped federal financial allocations to the states joined with greater state flexibility to determine whom and what to cover. The Republican's legislative efforts also antagonized almost the entire domain of stakeholder interests, many of which had been that party's past allies in health care reform debates. The final GOP initiative of 2017, drafted by Republican Senators Lindsay Graham (SC) and Bill Cassidy (LA), was publicly endorsed by just five conservative groups and opposed by 114 organizations, including most of the provider community and the health insurance industry (Bajaj and Thompson 2017; Zernike, Abelson, and Goodnough 2017).

Opponents to the ACA have nonetheless been able to weaken the ACA and perhaps set the stage for its ultimate downfall. The Trump administration has taken a number of executive actions that have lessened its coverage and protections, leading, among other things, to a couple million people joining the uninsured population (Galewitz 2019). The Tax Cuts and Jobs Act of 2017 did not formally terminate the individual mandate to have insurance coverage, but it did zero out the associated penalty administered through the tax collection system (Jost 2017). That, in turn, has provided a foundation for the statutory interpretation claim, in *Texas v. United States* pursued by 20 Republican state attorneys general and accepted by a federal district court judge in Texas, that the rest of the law depends on the mandate and thus must be declared invalid. The case will be decided by the US Supreme Court (Keith 2019).

Considering the public confusion about what the ACA includes and does, the extreme partisan polarization surrounding the law, the dramatic shifts in the nation's electoral winds at both the national and state level, the

myriad court challenges and resistance to full implementation in many of the states, and every effort of President Trump's administration to use executive actions to debilitate one of his predecessor's primary legislative achievements, it may be surprising that the ACA remains viable and functioning 10 years out. When NASA's Houston Control scrambled to save the *Apollo 13* crew, striving through creative adaptation to keep the astronauts alive and give them a shot at a safe return, the motivating dictum was "failure is not an option" (SpaceActs, n.d.). Given what the Congressional Budget Office and other analysts calculated would be the consequence of the ACA's demise, perhaps it applies equally in this case.

The ACA's Impact on Insurance Coverage

The primary mission of the ACA was to make substantial progress toward addressing the outlier status of the United States as the world's sole democracy and developed economy that did not reach anything proximate to universal health care coverage. The estimated consequences of repeal—the millions who would be kicked off the insurance roles—suggest that the progress toward that objective was substantial. A variety of metrics can be used to capture the size of the uninsured population—for example, at the time queried, for some portion of the year, and for longer than a year—and by all of them the implementation of the new health care law had fairly quick and significant effects. The National Health Interview Survey revealed that in 2015, halfway toward this 10–year anniversary, those with an episode of being uninsured during some period in the year fell from 24.4% to 18.1%, and the long-term uninsured dropped from 15.7% to just 9.1% (Cohen, Martinez, and Zammitti 2016). Moreover, the percentage uninsured dropped by a third to a half for every demographic group, from those that had the highest rates when the ACA was enacted (e.g., Hispanics and young adults) to those already at the low end (e.g., children and whites overall) (Garrett and Gangopadhyaya 2016). After 2015 the uninsured percentage continued to fall, reaching the lowest points in 2016–17, with the population-wide figure below 8%. Then came subsequent increases, returning to 8.5% overall, or 27.5 million individuals (Keith 2019). Not only is that a reversal, but even the moment of glory in 2016 was a far cry from the international standard of universal coverage.

The previous singular effort to expand insurance coverage came in 1965 with the enactment of Medicare and Medicaid. I estimate that, with about half the elderly and measurably few of the poor having either private or public benefits of any kind before their enactment, by 1975 the two

programs had brought coverage to about 35 million Americans who would otherwise have been entirely uninsured, roughly 16% of the nation's population (Kaiser Family Foundation 2013; Mikulic 2019; Moon 1996). In 2010, that was the natural limit of what even a truly universal program could accomplish. "Only" 16% of the population—about 49 million people—were still uninsured. The ACA by 2016 cut that percentage roughly in half. That may seem less consequential than Medicare and Medicaid, but it is important to keep two other factors in mind. First, the services covered and financial protections provided by Medicare and Medicaid fell far short of today's typical employer-sponsored plans, inclusive of additional ACA provisions like prohibitions on annual or lifetime caps, free preventive services, or the 10 essential benefits required of ACA exchange plans. Second, Medicare's restriction to one age group and Medicaid's coverage of only certain categories of the poor meant that they, unlike the 2010 law, did not create even a potential pathway to universal coverage, if only for US citizens and lawful permanent residents.

Going forward, however, there are at least three fundamental threats to what the ACA has accomplished in coverage. One reflects the fact that possession of an insurance card does not mean that one is well insured and without barriers to needed health care services. The ACA has done nothing to reduce the aggregate percentage of what the Commonwealth Fund identifies as the "underinsured"—those facing out-of-pocket costs so significant that they lead to foregoing primary or specialist medical care, missing treatments, or not filling prescriptions. The 2018 aggregate figure of 45% for adults 19–64 years old was unchanged from 2010 (Collins, Bhupal, and Doty 2019).

The other two are inherent in the structure of the ACA itself. To avoid major political roadblocks, the architecture of the law—unlike past comprehensive reform plans from President Truman to President Clinton—is predicated on minimizing disruptions in the existing system (Peterson 2019: chap. 11). It keeps largely intact employer-sponsored insurance, Medicare, and Medicaid and builds on them to expand coverage. Cracks in those underpinnings to the insurance system could undermine the ACA coverage model. The ongoing financial viability of employer-sponsored insurance for both employers and employees, for example, might well be questioned. As of 2018 the mean total annual premium for a single employee in the United States came close to $8,000; for family coverage it was just shy of $20,000. On average, the employee premium contribution and deductible hit 11.5% of median household income (Collins, Radley, and Baumgartner 2019).

The public perceives that there is a broad set of risks to the system. In our 2018 CCES survey, we asked the respondents whether seven changes occurring in the realm of employment and insurance, such as contracting out jobs, would result in "certain failure" of employer-sponsored insurance, pose a "threat" to it, or not be a problem. Individually the "certain failure" responses fell below a third, but in total 60% selected that category for at least one of the seven factors. In the meantime, the current Medicare program and its financial stability remain caught in the maw of the nation's polarized politics, while the eligible population grows dramatically with the aging of the baby boom generation (Aaron and Lambrew 2008).

The ACA has one other feature, compelled by contemporary political forces, that stands in the way of ever achieving universal coverage. It explicitly prohibits the inclusion of undocumented immigrants, which in 2017 the Pew Research Center estimated to be 10.5 million individuals or roughly 4 in 10 of the currently uninsured (Passel 2019). In our 2018 CCES survey, there was strong opposition—58.9% to 22.2%—to "allow[ing] undocumented immigrants to receive financial help from the government to buy health insurance," much less be given access to direct benefit programs like Medicaid.

The ACA's Impact on Health Care Costs

The ACA also had the stated mission of tackling the high cost of health care in the United States. As President Obama himself put it in his September 2009 health care speech to a joint session of Congress,

> There is the problem of rising costs. We spend one-and-a-half times more per person on health care than any other country, but we aren't any healthier for it. . . . Our health care system is placing an unsustainable burden on taxpayers. When health care costs grow at the rate they have, it puts greater pressure on programs like Medicare and Medicaid. . . . Put simply, our health care problem is our deficit problem. Nothing else even comes close.

Pass his health care reform initiative, he pronounced, and "it will slow the growth of health care costs for our families, our businesses, and our government" (Obama 2009). The president's senior advisers and a number of allies in the analytical community often repeated various versions of the refrain that provisions in the law would "bend the cost curve" (e.g., Orszag and Emanuel 2010: 602). Campaigning for the presidency, candidate Obama projected that his health care plan would "cut the cost of a typical

family's premiums by $2,500" (best understood in relation to what premiums would otherwise be) (Kessler 2012).

The problem is that the law was simply devoid of the kind of cost-control mechanisms, from budgets to rate setting, that had proven effective abroad or in some states and were included in some form in previous reform proposals like President Bill Clinton's Health Security Act (Peterson 2019: chaps. 4, 10). Because every dollar of expenditure is a dollar of income for someone in the system, aggressive restraints on spending would seriously pinch influential stakeholders whose political support was needed (Evans 1997). In addition, what most voters worry about is what they pay out of pocket, rather than system totals (Blendon et al. 2006). The drafters of the ACA turned to less empirically proven but conceptually attractive devices to lower costs through the more hidden-hand approach of enhanced efficiency, such as incentives, deterrents, and competition; and a more effective delivery system, such as through coordination of care and investments in innovation (Oberlander 2011; White 2018). Oberlander (2011) aptly captured the experimental and scattershot methods in the ACA as "throwing darts," looking with more optimism than conviction to see which ones might actually land on the target and score (see also Marmor, Oberlander, and White 2009).

Right from the start many specialists in the health policy field, especially those with eyes on the comparative experience, did not expect this eclectic collection of technical remedies, disincentives, funding streams, and demonstration projects to have much sway on the costs borne by any of the payers in the health care system (Gusmano 2011; Marmor, Oberlander, and White 2009; Oberlander 2011; White 2018). The intervention with likely the farthest-reaching impact—the so-called Cadillac tax that was claimed, with considerable controversy, to discourage excessively generous employer-sponsored insurance plans—was set to begin fully 8 years after enactment of the law (2018), then was delayed by congressional action until 2022, and now is at risk of repeal (in July 2019 the US House of Representatives voted 419–6 to kill it) (Gusmano 2011; Luthi 2019; Oberlander 2011; White 2018). The only other provision that had some real regulatory teeth and might have been consequential for at least its target of Medicare spending, the Independent Payment Advisory Board and its implementation tools, was never allowed to become operational before it was terminated by Public Law No. 115–123, the Bipartisan Budget Act of 2018, (Oberlander and Spivack 2018).

That is not to say that passage of the ACA had demonstrably no bearing on the costs of health care. In the years immediately following enactment,

there appeared to be a slowing down in medical inflation and reduced rates of growth in per capita national health expenditures, private health insurance premiums, and Medicare and Medicaid spending (Hartman et al. 2018; Peterson 2019: chap. 11). By some estimates, "total health care costs were almost $650 billion less than anticipated" in pre-ACA 2010 projections (Glickman, DiMagno, and Emanuel 2019: 1151). It is difficult, however, to disentangle the lingering effects of the Great Recession of 2008–9, the influence of the ACA, and the role of other dynamics in the health care system (Blumenthal, Stremikis, and Cutler 2013; White 2018). Moreover, the system-wide metrics of swelling costs since full implementation of the law in 2013 show some signs of returning to the earlier patterns (Peterson 2019: chap. 11; Sisko et al. 2019). Premiums and deductibles for employer-sponsored coverage have climbed as well as in recent years, well over growth rates in median income, and include shifting burdens to workers' wallets (Collins, Radley, and Baumgartner 2019; Kaiser Family Foundation 2019a). As desired by the Obama administration, health care system features like electronic health records and accountable care organizations have soared. For electronic health records, just under half of physician offices used them in 2010, compared to nearly 9 in 10 in 2017, and accountable care organizations have leapt from 58 in 2011 to 1,011 in 2018, about half involving Medicare and Medicaid (Muhlestein et al. 2018; Office of National Coordinator for Health Information Technology 2017). Over a third of health care payments in that latest year fit with value-based payment models (Lagasse 2018). And yet all of that modernization of the US health care system has come without clear or consistent beneficial financial effects (e.g., Schultze and Fry 2019). One area where one can have some confidence is that the Medicaid expansion feature of the ACA mitigated to some extent financial burdens on the poor and diminished the previous regressivity of American health care financing (Jacobs and Selden 2019; McKenna, Alcala, and Grande 2018).

Conclusion

Passage of the ACA 10 years ago depended on setting a precise political course with little margin for error. The calculations that made that possible instilled the law with greater political resiliency than might have been imagined at the time, but also assured that its mission to drive toward universal coverage and constrain health care expenditures, including at the level of families and individuals, would produce mixed results at best and be weighted toward coverage expansions rather than cost control. The

Republican Party of the twenty-first century, in full display during the repeal efforts of the 115th Congress (2017–18), has abandoned the commitments of some past leaders to expanded insurance and comprehensive access to medical care—themes promoted in the 1970s and 1990s by President Richard Nixon, Senate Republican Leader Robert Dole, and Senators John Chafee and Jim Jeffords—focusing instead on promoting health plans with lower premiums but limited benefits, private market competition, and restricted federal spending (Peterson 2019: chap. 12). With the impossibility of serious Republican partners and the inherent shortcomings of the ACA architecture to address coverage and costs, Democrats entered the 2020 election season—the law's tenth birthday—debating whether the ACA offered a viable foundation for a substantially more expansive next step or whether it was necessary to hearken back to President Truman and the party's original pledge of tax-payer-financed national health insurance under the current rubric of "Medicare for All." If it is the latter, will such an initiative hit the political atmosphere too directly, burning up on entry and thwarting capture of the White House in the next presidential election? Or will it skip off a resistant atmosphere, summarily rejected like most past reform efforts? Or will it pass through, dented, singed, and missing some pieces, but landing functional on the health policy terrain? Those will be the central questions of the next decade in health care reform.

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Mark A. Peterson is professor of public policy, political science, and law and former chair of the Department of Public Policy at the UCLA Luskin School of Public Affairs. A specialist on American national government and the policy process, he is an elected member of the National Academy of Social Insurance, past recipient of a Robert Wood Johnson Foundation Investigator Award in Health Policy Research, and former editor of *JHPPL*. His book manuscript, "American Sisyphus: Health Care and the Challenge of Transformative Policymaking," is a comprehensive study of the nation's century of health care reform politics.
markap@ucla.edu

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