Reversing Course on Obamacare: Why Not Another Medicare Catastrophic?

Mark A. Peterson
University of California, Los Angeles

Abstract Nearly three decades before the Affordable Care Act (ACA) was put on the precipice of repeal by the 2016 election of a unified Republican government, the Medicare Catastrophic Coverage Act (MCCA) was enacted with fanfare by one Congress and dismantled by the next. As the one social program terminated by Congress—also involving health care coverage expansions for millions of beneficiaries and imposing costs on identifiable constituencies—the MCCA experience could provide insights into the politics that define the fate of the ACA. This article compares and contrasts the two episodes, focusing on the political-institutional contexts of each case, the processes that produced the shifting coalitions from enactment to repeal, and the policy attributes that posed risks or provided protection to each program. The political-institutional contexts and the processes of coalition change could hardly have been more different for MCCA and ACA. However, they had some shared vulnerabilities stemming from program design. The ACA survived the political weakness inherent in its policy attributes due to its particular balance and timing of benefits and costs and by being shielded long enough by election results and the constitutional separation of powers to have its benefits take root.

Keywords Affordable Care Act, Medicare, Medicare Catastrophic

"Remember Catastrophic!" I heard versions of that cry numerous times after I became a Senate legislative assistant for health policy in 1990. It was invoked at a Finance Committee hearing in the Dirksen Senate Office Building as I sat behind my new boss, Senator Tom Daschle (D-SD), and enlivened other legislative forums and meetings on health care during the congressional session. It reminded me of the yell "Remember the Maine!"

Journal of Health Politics, Policy and Law, Vol. 43, No. 4, August 2018
DOI 10.1215/03616878-6527959

that arose in 1898 after an explosion sank the American naval vessel USS *Maine* in the harbor of Havana, Cuba, which helped trigger the Spanish-American War. Although "Remember Catastrophic!" had a similar focusing effect, it was not a battle cry—quite the contrary. It was instead a cautionary plea repeated in the Senate. Just a year before, that chamber and the House of Representatives had dramatically reversed course, repealing the Medicare Catastrophic Coverage Act (MCCA) that they had enacted with much fanfare and nearly by consensus in the previous session of Congress. Never before had Congress terminated a major social program, and so abruptly. It was a searing and ugly experience that no elected official wished to repeat. Whenever the contours of legislation under discussion started to take on the slightest resemblance to the MCCA, the reminder was summoned. All knew its meaning.

The architects of the 2010 Affordable Care Act (ACA, also known by the informal tagline "Obamacare")—both the elected members of Congress and their committee and personal staffs—knew the MCCA story well. They were not blind to the challenges of crafting a major piece of health care reform legislation, rife with the unavoidable and confusing brew of benefits, costs, and regulations, of winners and losers, and the associated political complexities. Many worried that the law as enacted through the Democratic leaders' legislative legerdemain of March 2010—sidestepping a conference committee and subsequent floor votes by having the House accept the Senate version under the risky agreement that both chambers would then adopt a limited cleanup with a reconciliation bill, made politically necessary by the unexpected loss of a filibuster-proof Senate majority following the death of Senator Ted Kennedy—possessed worrisome characteristics leaving it vulnerable to its own "catastrophic" experience (Skocpol 2010). Sure enough, after regaining their House majority in the 2010 midterm elections, Republicans set out immediately to eviscerate the statute. Loudly. They voted on over sixty occasions—January 2011 on through 2016—to terminate, cripple, or partially dismember the ACA (Cowan and Cornwell 2017). At least five occasions entailed full repeal (O'Keefe 2014). Once the GOP returned to the majority in the Senate following the 2014 midterm elections, Republicans gave another shot at full repeal in 2015, which President Obama successfully vetoed (Harris 2016). But it was the 2016 elections, which maintained Republic control of the House and Senate while installing a Republican in the White House, that set the stage for the anticipated final slaying of the ACA. It would be the "dismantling [of] a vast government entitlement program, something that has never been accomplished in the modern era" (Peters 2017). Not even the MCCA met that bar.

We are left, however, with a paradox. The MCCA crumpled quickly, even though based on surface appearances it seemed to embody a number of requisites for durability. The benefits filled serious and long-recognized gaps in Medicare coverage—not all of them, to be sure, but nontrivial ones—and should have been well received by the Medicare population. They included removing the limit on coverage of acute hospital care (thus providing "catastrophic coverage"), providing prescription drug coverage for the first time and of increasing importance, enhancing access to some skilled-nursing facility care, affording support for home health care, and ensuring spousal financial protection, among other provisions (CQ Almanac 1988; Himelfarb 1995). Overwhelming bipartisan majorities had voted for passage in both the House and Senate. The beneficiaries—the tens of millions of senior citizens covered by the Medicare program—as well as preretirement adults had given the law overwhelming support in opinion surveys commissioned by AARP, which then still used its full name, the American Association of Retired Persons. That organization, the largest voluntary membership association in the United States after the Catholic Church and the dominant voice for seniors in American politics, was viewed as a highly credible source of information to policy makers on this issue (Himelfarb 1995: 54). The sixty-five and over constituency is also one of the most highly mobilized and influential politically, prized by elected officials who can draw its endorsement (Campbell 2003).

The ACA, in contrast, seemed to sit on a decidedly rickety political stool, even after it twice narrowly survived the judicial scrutiny of the US Supreme Court. Despite efforts of the ACA's drafters to avoid the perceived political mistakes of the Clinton administration in how it drafted its failed Health Security Act in the early 1990s, which thwarted its enactment, and despite opening an explicit invitation to Republicans by building on more conservative ideas of personal responsibility and competing private plans, the ACA could draw only slender, entirely partisan majorities in Congress (Brill 2015; Peterson 2011). After its enactment the public remained at best split down the middle on its worth; if anything, for most of the years following enactment the public tilted toward opposition even after the act's full implementation in 2014 (Kirzinger, Sugarman, and Brodie 2016: fig. 3). The law's daunting complexity and mix of public and private entities almost assured that few among the public would understand its impact or even recognize themselves as beneficiaries. Opposing interests and partisans could readily frame the ACA almost to their choosing (Ha 2012). The bungled rollout of the federal and many of the state online insurance exchanges only further fed the impression of a failed policy (Goldstein

2016; Jones 2017). And yet the ACA's adversaries have found it remarkably difficult to kill the beast (so far).

This article uses the experience of the passage and subsequent repeal of the MCCA to better understand both the political vulnerability and resiliency of the ACA. I am not looking to draw general conclusions about what underlies the resiliency of policy reforms in general (see Patashnik 2008) but, rather, seek to see if this one dramatic health policy story of the late 1980s—germane to over thirty million beneficiaries—offers leverage in sorting through the politics of the ACA's own vulnerability. I start with establishing why the MCCA is an appropriate lens, among other alternatives, through which to examine the politics of the ACA. I then set up the analytical foundations of the analysis by identifying the specific dimensions along which the two laws can be both compared and contrasted. The rest of the essay explores in empirical detail these similarities and differences, highlighting the distinctive features of the ACA narrative that has given it more secure anchors in American social policy than the MCCA.

The MCCA as an Analytical Lens on the Politics of ACA Repeal

To explain legislative actions, one typically begins with the features of the political-institutional setting that shape the prospects for policy change. Congressional decision making, for example, is largely the product of factors present at the time of legislative deliberations, such as which party holds majorities in each chamber, the degree of ideological conflict between and within the parties, the structure of authority in each chamber, the distribution of legislatively relevant resources, the policy position and sway of the president, and the influence of organized interests. The path-dependency literature, however, reminds us that legislating to end or substantially alter existing programs is likely to have a different character than what is associated with program enactment because of what those programs generate in the way of stakes among constituencies, administrative arrangements, and public expectations (Hacker 2002; Pierson 2000). With that in mind, one could turn in theory to many past instances of policy enactment and subsequent significant policy change to reveal insights into the political dynamics of the ACA. Building on the data set of major laws first assembled by Mayhew (2005), for example, Maltzman and Shipan (2008: 257–58) seek to explain the differences in the "stability" of 262 "landmark laws" added to the federal

statute books from 1954 to 2002. Noting the wide acknowledgment that "new public laws are not immutable," they find that a majority were "significantly amended" (253, 258). In the health realm, one need only consider the enormous changes that have been wrought in the Medicare and Medicaid programs—some expansions, some cutbacks—since their inception in 1965 (Oberlander 2003; Smith and Moore 2008; Cohen et al. 2015). But outright repeal is a different matter entirely, at least in terms of frequency. Relatively few laws, and especially social programs of broad scope, end up in the policy cemetery. Even controversial new reaches of government engagement that provoked intense and concerted campaigns by opponents to defeat them before they were enacted, such as Social Security and Medicare, triggered subsequent loud antagonism but without serious efforts at or success in full reversal or even significant curtailment (Derthick 1979: chap. 6). Indeed, one can look far and wide before identifying the death of a program that conferred substantive benefits to large numbers of beneficiaries.

That is not to say that Congress has not on occasion withdrawn what it has previously sown (Berry, Burden, and Howell 2010; Daniels 1997). In 1982 the legislature enacted and President Reagan signed the Tax Equity and Fiscal Responsibility Act, which included a provision requiring financial institutions to withhold 10 percent of an individual's interest or dividend earnings in anticipation of tax filings for the year. The following year, in response to vigorous lobbying by banks and their stimulation of expressed outrage by millions of account holders, Congress overturned this provision (Hrebenar and Scott 1997: 158–59; CQ Almanac 1983). Another instance involved a free-standing title of the ACA called the Community Living Assistance Services and Supports (CLASS) Act. Advocated by Senator Ted Kennedy (D-MA), it was to establish a voluntary program, funded by private premiums, from which participants would be eligible—after at least five years—for cash benefits to obtain nonmedical services should they become unable to perform at least two activities of daily living or demonstrate comparable cognitive impairment. Because of problematic programmatic design issues, the Obama administration deemed it unworkable and chose not to implement the CLASS Act, and Congress formally terminated it in December 2012 legislation (KFF 2010; Wiener 2013). Neither of these programmatic repeals, however, offers insights into the politics of axing the ACA. The tax withholding law encompassed only an extremely narrow and simple issue and provided no benefits to anyone, other than streamlining tax enforcement for the Internal Revenue Service.

While the CLASS Act not only addressed a kind of health insurance coverage—in this instance, for long-term care—and was even enacted as part of the overall ACA, it does not provide a lens on the politics of potential ACA repeal. The formal administrative implementation process was never initiated, there were no participants in the program, and its repeal happened five years before any benefits would be nominally available.

Unless the ACA itself is ultimately "repealed and replaced," the MCCA remains the *only* past case at the federal level in the United States of a major operational social policy initiative erased from the national statute books (only some minor features were retained) (Himelfarb 1995). It was not as grand in ambitions and reach as the ACA, to be sure, but as I show below, the statutorily defined benefits were substantively meaningful, the beneficiary population was large, and the programmatic costs were politically challenging. The objective of this article is thus to explore whether this sole previous experience, when offered in comparison and contrast to the ACA, affords helpful insights into the risks and resiliencies associated with the ACA.

I delve into three dimensions of the policy experience for each law. First, the *political-institutional context* in which enactment and repeal consideration took place: did the legislative decision making associated respectively with the MCCA and the ACA—both at enactment and in the repeal cauldron—take place in similar or divergent settings, and to what effect? I show that the machinations over MCCA passage and repeal played out in a legislative arena and interest group domain almost identical to one another but significantly divergent from the one in which the ACA has been challenged. Second, to what extent was the *process* by which repeal gained legislative footing due to shifting legislative coalitions—the mechanism by which the majorities flipped from program passage to termination? Did these efforts in each case ride on reversals in votes cast by the same legislators or on replacement of the previously supportive legislators, and to what effect? Along this dimension the contrast could not be starker. MCCA's repeal is a story of a massive switch in votes by the very same people who had originally backed it. Supplanting the ACA has hinged on having sufficiently large-scale replacement of legislators across the partisan divide to build majorities for repeal. Third, regarding the *policy attributes* embedded in the laws themselves and how they are perceived by the public, are there substantive features of the two laws that made one or the other, or both, especially susceptible to or, instead, resistant to reversal? Here there were inklings of

hazardous parallels of the ACA with the MCCA. In this sense, "remember Catastrophic!" had resonance. Although there were reasonable fears among reform advocates that these aspects of the ACA would resemble the vulnerable profile of the MCCA, the ACA profited from two forms of inoculation: (a) by design it included more counterbalancing programmatic features than had the MCCA, and (b), likely the most important factor of all, it benefited from having sufficient time to gain a real foothold with the public. Electoral outcomes and the constitutional divisions of power kept the new antagonistic legislative majorities at bay.

Political-Institutional Context

There are myriad ways to define and measure the political-institutional context of health policy making at any given time and to chart variations over time (Peterson 2017). I will keep it simple for the MCCA and ACA cases. Here I focus on two essential attributes of the political-institutional setting that are open to reasonable variation across time: features of the partisan contours of legislative politics and the structure of the activated interest group community. The issue to consider is twofold. First, as one moves from the period of MCCA enactment in 1988 to its abolishment in 1989, was there a dramatic transformation of the setting that would help account for the profoundly changed politics surrounding the policy? Second, is the debate over dismantling the ACA transpiring in a context similar to what existed at the time of the MCCA repeal?

Partisan Unity and Ideological Polarization

Because the political party affiliation of members of Congress is one of their primary defining characteristics, a good place to begin the assessment is with basic partisanship, more specifically, the extent to which levels of party unity within Democratic and Republican ranks is associated with repeal. Party unity is a standard metric that shows the average percentage of times members of each party vote with their party's majority position when there is a recorded roll call vote pitting a majority of one party against a majority of the other party. As shown in shown table 1, using the scores calculated by Congressional Quarterly, Inc., between the passage and death of MCCA there was no change in the levels of party unity for either Democrats or Republicans. Increased or decreased partisanship does not explain the political earthquake that brought down the MCCA.

Table 1 CQ Party Unity Percentages: Medicare Catastrophic Coverage Act (MCCA) Period and Affordable Care Act (ACA) Period

Chamber	Congress overall	House	Senate
1988 (MCCA enactment) / 1989 (MCCA repeal)			
Democrats	79% / 81%	80% / 81%	78% / 78%
Republicans	73% / 73%	74% / 72%	68% / 78%
2010 (ACA enactment) / 2017 (American Health Care Act of 2017)			
Democrats	89% / 91%	89% / 93%	91% / 92%
Republicans	88% / 88%	88% / 92%	89% / 97%

Sources: Carney 2015, 42; *CQ Magazine* 2018

The figures in table 1 do show, however, that between the late 1980s and the recent years involving the continued challenges to ACA, unity within each party—and with it separation between the two parties—grew substantially, especially in the GOP. At the times of both the MCCA passage and its reversal, within each party's congressional membership there was latitude to facilitate bipartisan coalitions. Those coalitions could also encompass the divided party control between Congress and the White House, with Republican President Reagan willing to sign a law that went considerably further than he had originally endorsed. His same-party successor, President Bush, was equally willing as a "silent" bystander to sign the bipartisan repeal (Blumenthal and Morone 2009: 314–15, 330–31).

Because of the supercharged partisanship evident in the elevated levels of party unity, the setting for the ACA was starkly different. On more votes, such as on the ACA's enactment and the later Republican plans for repeal and replace, the two parties were in heated battle against each other. Partisanship was so intense in 2017 that new heights in unity were reached among House Democrats—93 percent—and Senate Republicans—an astonishing 97 percent (CQ Magazine 2018). To be sure, an extensive literature has captured and explained this rise in partisanship (a good overview is provided by Thurber and Yoshinaka 2015). What is significant for the purposes of this study is that the MCCA proved to be remarkably fragile when, relative to the Obama and Trump presidencies, there was far less intense partisan separation and limited ideological struggle at the time over either Medicare itself or the enacted changes in policy (Oberlander 2003). The standard line of argument is that legislated programs, particularly those of considerable scope, become more widely accepted by the public, are less prone to trigger ongoing opposition, avoid being electoral targets, and prove more enduring when they have drawn the endorsement

of sufficient numbers of legislators in both parties.[1] Lower partisanship did not save the MCCA, however, and partisanship's dramatic rise has not automatically spelled disaster for the ACA, at least as a stand-alone independent variable.

The fact that the members of the two legislative parties stick together more in votes where the parties are in opposition to one another, however, does not necessarily mean that the substantive disagreements dividing Democrats and Republicans are wide and unbridgeable. To get a better sense of what the amplified partisanship really represents, I turn now to ideology. Political scientists Keith Poole and Howard Rosenthal long ago assembled all of the publicly recorded roll call votes by representatives and senators from 1789 to the present, updating the data with each Congress and year. Subjecting these data to sophisticated quantitative analysis, they are able to identify an underlying "factor" or dimension of voting patterns that captures and arrays members along a liberal-conservative scale that is generally comparable over time. Almost all members who have served in Congress have scores that fall within the range of −1.0 (the most liberal position) and +1.0 (the most conservative position).[2]

Figure 1 shows the mean ideological position in the House of Representatives of Democrats and Republicans from 1933 to 2015. The Senate data, not presented here, are very similar. I have added to the figure markers for when MCCA and ACA repeal efforts were under way and show the difference in Democratic and Republican mean scores at each of those periods. To start, as one would expect, little changed in the ideological composition of the two parties in the short period between the rise and fall of the MCCA. With respect to the ideological distance between the two parties, however, the time of MCCA's demise and the era of challenges to ACA could hardly be more different. There has been an almost doubling

1. This claim is based on what I heard during the time I worked in the Senate and recalling years of punditry about the risks of either party pursuing its agenda priorities without enticing any support from members of the other party. If one goes down the list of major new social policies enacted in the United States, however divisive the debates, all enjoyed some degree of bipartisan endorsement in the final House and Senate votes (e.g., Social Security, Medicare and Medicaid, food stamps, the first Elementary and Secondary Education Act, and the Earned Income Tax Credit). Maltzman and Shipan (2008: 255–56) offer the alternative argument that bipartisanship, at least when activated during divided government, can lead to substantively problematic legislative compromises that weaken the law and make it more vulnerable to later amendment (although not necessarily repeal). See Patashnik 2008 for a general analysis of the sources of endurance and instability in "general-interest reform," including ones that "distribute benefits to some broad constituency" (Patashnik 2008: 2).

2. They labeled this dimension DW-NOMINATE, for dynamic weighted nominal three-step estimation. Poole and Rosenthal expanded their team to include a number of other political scientists; the project is now directed by Jeffrey Lewis at UCLA. These data are publicly available through Voteview.com.

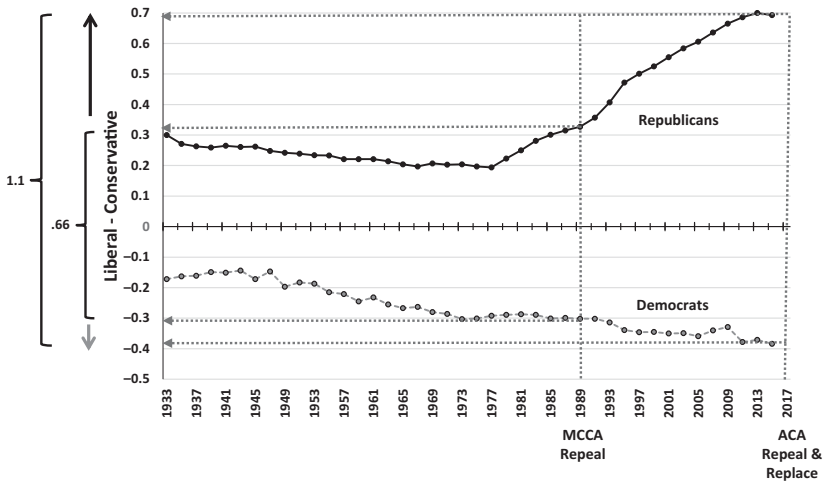

Figure 1 Increasing Partisan Ideological Polarization in the House of Representatives, 1933–2015

Source: Data from Voteview.com 2016. The data for this figure come from what is now the legacy website for Voteview.com: legacy.voteview.com.

Note: Vertical dotted lines indicate when MCCA and ACA repeal efforts were under way; differences in Democratic and Republican mean scores at each of those periods are shown by the y-axis.

of the ideological distance between the average Democrat and average Republican. Moreover, most of that gap results from the striking movement of the Republican conference to the right.

The shift of Republicans in the House to the conservative extreme becomes even more visually pronounced in figure 2. Using the same data as in figure 1, this chart shows from 1933 to 2015 the percentage of Democrats, Republicans, and representatives overall who have ideology scores that place them in their respective party's extreme, defined here as less than –0.5 in the liberal direction and more than +0.5 toward the conservative end. Since the 1960s, Democrats have generally had a fairly consistent distribution of members in the most liberal part of the scale, somewhat over 10 percent of the caucus. There was little difference between the MCCA period and 2015. Since the days of MCCA, though, a swelling proportion of the Republican Party has resided in the rightmost part of the ideology scale. Figure 2 shows that about eight in ten Republicans have scored above +0.5 during the last decade. Speaker Paul Ryan himself lands at about +0.85, well to the right of the center of his conservative party. The resulting grand philosophical divide between the parties, which energizes the significance of the partisan polarization, certainly helps explain the

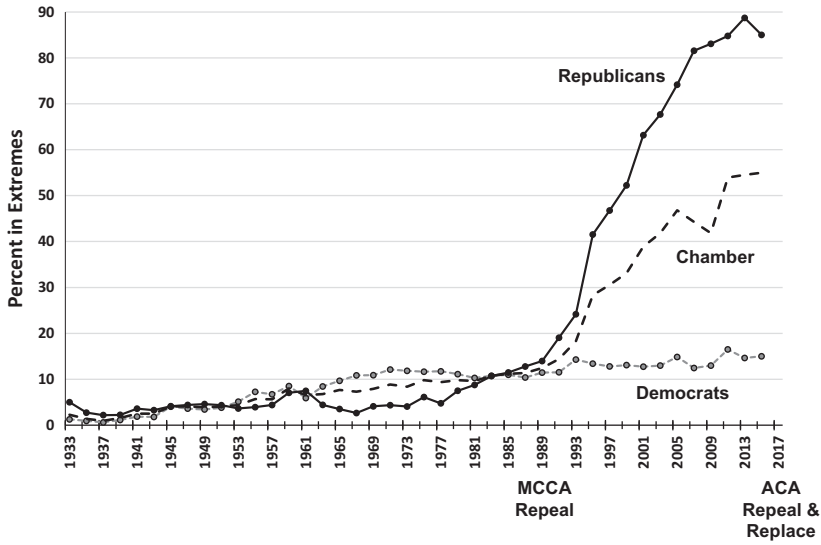

Figure 2 Increasing Republican Ideological Extremism in the House Representatives

Source: Data from Voteview.com 2016. The data for this figure come from what is now the legacy website for Voteview.com: legacy.voteview.com.

Note: Data are percentages of representatives within each party with DW-NOMINATE scores of <–0.5 for Democrats or >+0.5 for Republicans.

intensity of the political warfare over the ACA. Indeed, the issue of health care reform itself has made this political combat nuclear, with enormous states. When President Bill Clinton was pushing his proposed Health Security Act in 1993–94,

> had *any* part of the Clinton plan passed that Congress in *any* form, [Newt] Gingrich and his closest conservative allies believed, their dreams for forging a militantly conservative future would "have been cooked," as a key Gingrich strategist later explained. It would have . . . creat[ed] greater public dependency on government and a government-run plan, and a stronger allegiance of voters to majority Democrats, who provided them their benefits. . . . All [Republican] aims were threatened by the Clinton plan. (Johnson and Broder 1996: 11–12)

The enactment of the ACA a decade and a half later represented the realization of those fears. And it triggered remarkable rhetorical flourish among Republicans. Ben Carson called it "the worst thing that has happened in this nation since slavery" (Sullivan 2013). According to Representative Michelle Bachman (R-MN), "It literally kills women, kills

children, kills senior citizens" (Blake 2013). Paul Broun, a medical doctor and member of Congress from Georgia, exclaimed that "America is going to be destroyed by Obamacare" (Costa 2013). For President Trump, it is simply "the disaster known as Obamacare" (Eilperin and Phillip 2017). Thus far, though, the ideological fervor has not led to the ACA's certain death.

The Mobilized Interest Groups

Although the initial outlines of the MCCA plan had its origins in the entrepreneurial activities of Dr. Ottis Bowen, secretary of health and human services in the Reagan administration, mobilized interests played decisive roles in both the law's initial success and its ultimate downfall, although in quite different ways. As the act grew larger, more complicated, and substantially more expensive, with a "Christmas tree" of benefits added by proponents in Congress (Himelfarb 1995: 21) and a financing system that for the first time required Medicare beneficiaries to shoulder the full cost of the additional coverage, representatives and senators sought credible assurances that the MCCA would be well received by their constituents, particularly the especially politically responsive older voters. They naturally turned to AARP, given its gargantuan size, established insider links to the Hill, and long history of providing reliable information to Congress (Himelfarb 1995: 54; Rutledge 1992: 42–44). A senate staffer referred to it as the "three-hundred pound gorilla" (Rutledge 1992: 42). The organization was concerned that the legislation did not include long-term care coverage and relied on Medicare enrollees alone for revenue but concluded the total package was nonetheless worthy of support, as did other organizations like the National Council of Senior Citizens (Himelfarb 1995: 37–38). Most important, it commissioned extensive public opinion polling that affirmed widespread support for what Congress was offering (Himelfarb 1995: 38, 44). Soon after the law was enacted, for example, an AARP survey of adults forty-five or more years of age revealed overall support of at least 65 percent for it (and higher still for the specific benefits), including among those sixty-five years old or older and seniors with more than $30,000 a year in income. That latter group reported the highest level of opposition, but that was just 30 percent (AARP 1989: 2–3). Representatives and senators could return to their districts and states confident that they had well served the interests of older Americans.

That assurance, however, proved misplaced. Like the abruptly changing winds that can frustrate even the most skilled sailor, the MCCA interest group story took a turn that altered the political setting. Much younger

(founded in 1983), smaller (claiming five million members), and far less well regarded than the AARP, the National Committee to Preserve Social Security and Medicare, known as the National Committee, had opposed the MCCA during debates over the legislation because of the missing long-term care coverage and the enrollee-only financing, but to limited effect (Himelfarb 1995; Rutledge 1992: 45). A survey of its members showed, for example, eight in ten rejected the argument that "it is only fair" for program enrollees to foot the full cost of the benefits. Moreover, "they prefer long-term care benefits to the current catastrophic benefits by 54% to 23% margin" (Cooper and Secrest 1989: 2). After passage, the National Committee mounted the fourth and most comprehensive of its direct-mail-driven grassroots campaigns that shaped perceptions of MCCA's benefits and costs to enrollees, which stimulated a mountain of mail—2.7 million postcards (Rutledge 1992: 63)—and loud senior outrage at Congress. A committee aide reported a couple of town meetings where members were "beaten up over catastrophic" (Rutledge 1992: 62–63). Virginia Senator John Warner observed, "In my 11 years in the US Senate I have never dealt with an issue which has met with such unrelenting opposition" (Himelfarb 1995: 73). The content of the National Committee's message and why it was effective are an important part of the next section, but here I underscore that this interest group's advocacy against the law reset the political-institutional setting of repeal, armed congressional adversaries of the law, and neutered the cue-giving influence of the traditional policy and party leaders in the House and Senate. Eventually a Coalition for Affordable Health Care formed in opposition, consisting of forty-four organizations encompassing a total of nineteen million members (Himelfarb 1995: 78).

There is no question that interest group politics also shaped the ACA. As occurred in the early 1990s when myriad reform plans animated congressional deliberations both before and during debate on the Clinton Health Security Act, from 2007 to 2010 hundreds of organized interests representing the full political spectrum offered tailored proposals, staked out positions, activated members, marched in the streets, lobbied members of Congress, and made campaign contributions (Peterson 2017: chap. 6; Weissert and Weissert 2012: chap. 3). Until the Obama presidency, health care reform had long been caught on the shoals of opposition by long-standing, well-resourced organizations that had ready access to the committees and members of Congress. This "antireform alliance" included organized medicine, hospitals, the private insurance industry, and both large and small employers (Peterson 2017: chap. 6; Quadagno 2005; Starr 1982). One reason the ACA took the form that it did—strengthened rather

than challenged employer-sponsored coverage and retention of its tax protections, heavy reliance on private insurance in market exchanges along with subsidies for its purchase, and little intervention into the pharmaceutical market—was the political calculation by President Obama and the Democratic congressional leadership that enactment of major coverage expansions depended on negotiating with these industries and securing at least their neutrality, if not their endorsement (Brill 2015: chap. 9; Jacobs and Skocpol 2010: chap. 2; Jones 2017; Peterson 2017: chaps. 6 and 11).

In all of these senses the political story of ACA is even more weighted by interest group dynamics than was MCCA. But that statement misses an essential distinction. Unlike what occurred with the MCCA, organized interests did not define the political-institutional context of 2017 and played almost no role at the national level in the efforts to repeal the ACA under now unified Republican government. As Republicans took up the formal call for "repeal and replace" in the House, with the American Health Care Act (AHCA) repeatedly renegotiated by the leadership in response to legislative intraparty concerns, a remarkable set of organized interests coalesced opposed to the repeal bill. These interests encompassed liberal groups that had supported enactment of the ACA, such as AARP and Families USA. But the lineup also included a panoply of some of the most significant medical provider organizations: the American Medical Association, American College of Physicians, Association of American Physicians and Surgeons, American Academy of Pediatrics, Association of American Medical Colleges, American Nurses Association, American Hospital Association, Federation of American Hospitals, America's Essential Hospitals, Catholic Health Association of the United States, Children's Hospital Association, and American Health Care Association (see, e.g., Goodnough, Pear, and Kaplan 2017; Naylor 2017; Stafford 2017). Perhaps adding injury to insult, even entities on the right expressed opposition—Tea Party organizations, the Club for Growth, the Cato Institute, and the Heritage Foundation—because the bill did not go far enough in dismantling the law, offering instead a version of what they called "Obamacare lite" (Steinhauer 2017). The Senate Republicans' efforts at a repeal bill managed to trigger even greater interest group opposition. The final attempt, the Graham-Cassidy bill (largely handing off the whole issue to the states), which was ultimately not brought to a floor vote, garnered the backing of just five conservative organizations. It sparked the antagonism of at least 114 entities, including all the major provider and hospital organizations, the insurance industry associations, and dozens of patient and specific disease groups, among other types of organizations

(Bajaj and Thompson 2017). This array of groups did not launch a full-throated campaign, but they denied President Trump and Republicans in Congress a supportive external alliance for the governing party (Peterson 1992: 613–16).

When considering the political-institutional context of legislative action, we can draw two conclusions with confidence. First, a decided turn in partisan polarization did not contribute to the repeal of the MCCA. Moreover, bipartisanship did not save it. Perhaps bipartisan support would not have anesthetized ACA either. Moreover, the attacks on the MCCA and the ACA occurred in two completely divergent political-institutional settings. The former was best characterized by still relatively modest levels of partisan and ideology-driven division. The latter is riven with acute ideological partisan polarization that fomented scorched-earth policy debates. Even under conditions of unified Republican government, however, that is not necessarily a formula for the success of ambitions to repeal (or repeal and replace) the ACA. Second, while interest groups populate in some fashion the political narratives of both the MCCA and the ACA, they played an instrumental role in the MCCA story but were swamped by partisanship and ideology when ACA repeal came to a head. The results so far in health care are consistent with the more general contemporary experience. Severe partisan polarization, under conditions of both divided and unified government, has in recent years been associated with policy stalemate rather than action across the full range of policy issues (Binder 2003; Cillizza 2014). But that has occurred primarily subsequent to the MCCA experience, which thus sheds little light on the ACA's prospects in this new kind of political-institutional setting.

Process

In exploring the process by which what had been legislative majorities for passage became majorities for repeal, I look specifically at who constituted each of those legislative coalitions. Shifts in the political-institutional context certainly can influence the nature of emergent coalitions, but they do not determine their composition. Falling between the date that the MCCA was enacted and the moment it was stripped away, for example, were presidential and congressional elections. If one knew nothing about the 1988 elections, one might surmise that a tectonic shift at the hands of American voters must have spelled doom for the MCCA. Not exactly. One would in fact be hard pressed to identify a more stasis election. Vice President George H. W. Bush won the presidency, keeping the White House in Republican hands and symbolically leading the "third term" of the Reagan

Table 2 House and Senate Votes on the 1988 Medicare Catastrophic Coverage Act (MCCA): Enactment and Repeal

Chamber	Overall vote	Democrats	Republicans
Enactment of the MCCA (H.R. 2470), June 1988			
House	328–72	230–9	98–63
Senate	86–11	52–0	32–11
Repeal of the MCCA (H.R. 3299), October 1989			
House	360–66	196–56	164–10
Senate	99–0[a]	54–0	45–0

[a]The Senate was for only partial repeal; it originally rejected full repeal 26–73.
Sources: CQ Almanac 1988, vote 164, 54-H, and vote 170, 29-S; CQ Almanac 1989, 149, 155, and vote 267, 90-H

administration. Democrats gained but two seats in the House and one in the Senate. In short, "the MCCA was *repealed* by Congress under conditions remarkably similar to those in which it had been *adopted*" (Rutledge 1992: 4). That makes the figures in table 2 all the more arresting. In 1988 the MCCA had the votes of overwhelming bipartisan majorities in both the House and Senate. In the House, it drew 82 percent of the vote, including 96 percent of Democrats and 61 percent of Republicans. Support was even higher in the Senate, with nine out of ten senators on board. All of the voting Democrats were joined by three-quarters of the Republicans who cast votes.

With trivial change in the House or Senate memberships, however, the vote distribution for repeal was overwhelming and nearly the same as for passage, but the reverse mirror image! What happened? The vast majority of representatives who voted to terminate MCCA in November 1989—274 out of 360—were exactly the same individuals who in the previous year had favored its enactment.[3] A similar pattern obtained in

3. These figures are based on comparing the membership and votes on the recorded roll call votes for the enactment and repeal of the MCCA, as well as the specific effects of the 1988 election for the House of Representatives. To start, although the partisan distribution of seats was hardly altered at all, there were replacements of some representatives and senators. In the House thirty seats were held by new members, including nine switches in party. That led to twenty-two of the repeal votes, twelve of which came from the new representatives who supported ending the MCCA when the previous seat holder had voted for enactment. The other ten were shifts from members who had not voted to those who cast votes for repeal. Another five seats involved vacancies in one year or the other, yielding at the margin two fewer MCCA supporters and three additions to the repeal group. The rest were individual representatives switching from support at enactment to opposition.

the Senate, although, to be fair, the Senate at first resisted the full repeal movement. Senator McCain (R-AZ) led the effort to push a bill that would do away only with the parts of the bill that had become most problematic politically. Full termination of the program had initially been rejected 26 to 73 until the Senate caved to the House (CQ Almanac 1989). Overall, something in the course of eighteen months had caused a bipartisan majority of the same representatives and senators in Congress to flip 180 degrees. That is a remarkable turnaround given the general desire of members to establish consistent voting records on the same issues (Kingdon 1989).

Turning our lens to the ACA reveals an entirely different dynamic. It was a signature feature of President Obama's agenda, with coalition building the joint enterprise of the White House, House Speaker Nancy Pelosi and the leadership team, and Senator Majority Leader Harry Reid and the party leadership, along with their Democratic compatriot committee chairs (Brill 2015; Jacobs and Skocpol 2010). In March 2010, the votes to enact the law were thoroughly party line, with the exception of a handful of Democrats. As shown in table 3, Democrats voted favorably with supermajorities (85 percent of House Democrats, 95 percent of Senate Democrats). In neither the House nor the Senate did the bill attract a single Republican vote (I report here just the House vote on the Senate version of the act and the Senate vote on the associated reconciliation bill). Once the Republicans retook control of the House with their huge 2010 midterm victories (gaining sixty-three seats), there began the long series of successful votes to either fully repeal or partially dismember the ACA ("successful" only in terms of House passage). When the GOP finally achieved unified government again following the 2016 elections, Speaker Ryan, supported by President Trump, sought to enact the repeal-and-replace plan crafted by the House leadership, the AHCA (Pear and Kaplan 2017). It took two months and three tries to assemble sufficient committed whip-count support from the Republican ranks to risk an actual vote on the House floor (Tumulty and Costa 2017). Once put to a vote on May 3, the AHCA passed by a whisker, 217 to 213. This time there were absolutely no Democratic members against the ACA, while more than nine in ten GOP representatives joined the majority for repeal.[4] Orchestrated by Majority Leader Mitch McConnell, also without any overtures to the

4. I am using the word *repeal* here somewhat loosely. Because these Republican legislative efforts at repeal and replace were being done in the context of reconciliation, the rules required that the provisions of the bill involve either expenditures or revenues and not issues nongermane to them, such as regulatory changes.

Table 3 House and Senate Votes on the 2010 Affordable Care Act (ACA): Enactment and "Repeal and Replace" with the American Health Care Act of 2017

Chamber	Overall vote	Democrats	Republicans
Enactment of the ACA (H.R. 3590), March 2010			
House	219–212	219–34	0–178
Senate	56–43	56–3 (incl. 2 Independents)	0–40
Enactment of GOP repeal plans (H.R. 1628), May and July 2017			
House	217–213	0–193	217–20
Senate	49–51	0–48	49–3

Sources: CQ Almanac 2010, Vote 105, S-23, and Vote 165, H-60; CQ Magazine 2017a, vote 256, and CQ Magazine 2017b, vote 179

minority party, the Senate Republicans then began their own backroom legislative slog in search of an alternative that could garner enough GOP votes (50 out of the 52) to at least let Vice President Pence put them over the top under the rules of a reconciliation bill. Every attempt failed, and McConnell eventually settled on bringing a "skinny repeal" bill to the floor on July 27. With Senator John McCain's literal thumbs down at the clerk's desk, joining two other Republicans in opposition along with every Senate Democrat, the legislation died 49 to 51 (Pear, Kaplan, and Cochrane 2017).

The near success in 2017 to put the ACA to rest, unlike with the MCCA, was almost entirely the result of elections having consequences by changing at the sufficient margin who held seats in Congress. The combined outcomes of the elections since 2008, culminating in the 2016 results, profoundly reoriented the direction of American politics and government in both the House and Senate. That was enough to yield the narrow anti-ACA majority in the House. Passage of health care reform in the Senate on December 23, 2009, which became the ACA, depended on fifty-eight Democrats and two Independents who caucused with the Democrats. By the time of the 2017 vote on the GOP "skinny repeal" bill, death, retirement, or defeat led to the departure of over half of the individual senators who originally voted for the ACA. The elections of 2010, 2012, 2014, and 2016 produced a net of twelve seat changes to the Republicans. It is only because GOP Senators Collins, McCain, and Murkowski—who had previously voted against the ACA but then also voted against the skinny

repeal—that the GOP plans came to a halt in the Senate.[5] Similar opposition to Graham-Cassidy also sealed its fate (Levy 2017).

The process by which the MCCA was repealed in 1989 and the manner in which the House passed and the Senate narrowly missed on advancing replacement of ACA in 2017 have almost nothing in common, a disparity even greater than that which existed for the respective political-institutional settings. The MCCA perished at the hands of precisely the members of Congress—both Democrats and Republicans—who had first voted to give it life, the policy version of filicide. They did so because of an interest group campaign and were prompted in part by legislators outside the usual health policy core and largely against the sentiments of the congressional party leaders and the chairs and a majority of the members of the relevant standing committees and subcommittees (Himelfarb 1995: chap. 6; Rutledge 1992: chap. 4). Between January and September 1989 the cumulative cosponsorship of bills to "reconsider" the MCCA grew from about 50 to over 200 in the House and from close to 0 to 55 in the Senate (Rutledge 1992: 66, figs. 4 and 5). In contrast, the fate of the ACA rested on whether or not its Republican adversaries, following the explicit policy direction and intense lobbying of their legislative party leaders—House Speaker Paul Ryan and Senate Majority Leader Mitch McConnell—were finally able to fire the fatal round by eking out a sufficient number of their own Republican votes, once that party came to hold majorities in both chambers of Congress and had a president eager to sign the enrolled legislation. Perhaps what is most striking about the congressional politics of ACA repeal and replacement early in the Trump presidency is, in turn, the extent to which the Democratic legislative leaders—House Minority Leader Nancy Pelosi, who previously as Speaker led the enactment of the ACA, and Senate Minority Leader Chuck Schumer—were able to keep

5. These figures are based on comparing the membership and votes on the recorded roll call votes on the enactment of the ACA in the House and Senate with the votes on the AHCA in the House and skinny repeal bill in the Senate, as well as the specific effects of the 2010–16 elections for the House of Representatives and Senate. Of the thirty-four House Democrats who had voted against the ACA in 2010, only three were still in office in 2017. All three "switched" to a no vote on the AHCA. Three others were succeeded by Democrats, all of whom also voted against the AHCA. The district of one of the previous Democrats disappeared due to redistricting and the loss of seats in states that lost population. The other twenty-seven Democrats among the thirty-four were supplanted by Republicans (fourteen in the 2010 midterm election alone). All of these "new" Republicans voted in favor of the ACA replacement legislation. The remainder of the additional Republican votes for the AHCA (and thus against the ACA) came from other Democratic seats that switched to Republicans from 2010 onward. The twenty Republicans who voted against their leadership's bill reflected a much more complicated sequence of events. Seven had cast votes against both the ACA *and* the AHCA. Another seven replaced Democrats who had supported the ACA, so their no votes on the Republican plan kept their districts' positions consistent. All of the others entail more individual stories.

their members standing together in unified opposition, despite the enormous turnover in their ranks. That unanimity included those who voted against the original passage of the ACA in the House, the group elected to Congress since the Democrats' drubbing in 2010 in some measure because of the ACA, and the members expected to face serious reelection challenges from Republicans in the 2018 midterm elections (Kilgore 2017; Kim and Schor 2017). Taking into consideration these legislative process issues, here, too, the MCCA fails as a potential explanatory instrument for understanding or foretelling the political future of ACA.

Policy Attributes

The third dimension to consider in search of pertinent lessons from the MCCA for evaluating the prospect of the ACA's demise is the substantive content and structure of the laws themselves. There is now a long policy feedback tradition in political science of considering the reverse direction of causality between politics and policy (Weaver 2010). Just as in the conventional formulation that multiple components of a given political milieu influence the nature of policy outcomes, the attributes of the policies proposed or enacted can be associated with particular kinds and intensities of politics that they generate. As stated most succinctly by Lowi (1972: 299), from this perspective "policies determine politics." Two of the most readily observable features of almost any policy are the distribution of costs and the distribution of benefits. James Q. Wilson (1980) brought to the fore the now well-known simple typology that treats both costs and benefits as being either concentrated or diffuse, and then traced through the implications of the four distinctive combinations for what types of constituencies are likely to mobilize most effectively. A third significant feature is the sequence of benefits and costs during the planned implementation process, the timing of when either benefits or costs start to have their impact (Arnold 1990). Although these three policy attributes can be evaluated in at least roughly objective terms, what matters most politically is how they are perceived by the affected constituencies (Rutledge 1992: 14, 88). Those perceptions, in turn, can be highly dependent on what information is presented in the political arena and how that information is framed. According to R. Douglas Arnold (1990: 25), "Citizens may have an imperfect understanding of cause and effect in the policy world. Nevertheless, their beliefs about cause and effect are important, for beliefs may affect their preferences about policy issues." In this analysis I use the separate incidence of both benefits and costs, the timing of their scheduled

implementation, their level of visibility, and whether any benefits could have been actually experienced at the time of the repeal debates or remained promises for the future.

I start with the allocation of benefits. When the returns of a policy's benefits are concentrated on particular recipients, be they individuals or institutions, those constituencies are most apt to recognize their presence and value the stake they confer to them. That creates general incentives for political mobilization and helps overcome potential barriers to collective action (Olson 1965; Wilson 1980). Threats to take away benefits already in hand warrant serious attention and the development of strategies to resist. The more diffuse the benefits, the less obvious their impact and the lower the stakes perceived by the recipients, actual or projected. The subsequent removal of the benefits may go unrecognized. The distribution of costs has similar bearing on a policy's politics but in mirror image in terms the politics surrounding enactment and potential repeal. Concentrated costs mean that the losers of a policy's enactment and implementation have little difficulty seeing that they are the ones left holding the bag. The costs of a policy are often in the form of taxes to finance the program or regulations to direct choices and behavior. If concentrated, such costs are therefore likely targeted on constituencies with resources, such as the affluent or major industries. Following from Olson (1965), they may well constitute "privileged" groups that are among the easiest to mobilize and especially well armed for political action. As costs become more diffuse, the provocation to organize becomes more muted. There is also an important asymmetry to consider: if a domestic program confers benefits on resource-poor populations, such as low-income individuals and families, and the financing for the benefit is borne by wealthy households or major corporations, the resulting politics is prone to reflect the influence of these social-economic elites rather than the program recipients or the general public (Gilens 2012; Olson 1965).

The sequence of the impact of a policy's benefits and costs also contributes to political perceptions. What features become apparent soon after enactment, and are there any whose effects will emerge only after the passage time? In his *The Logic of Congressional Action* (1990), Arnold notes the favorable legislative politics of recognizable benefits available from the start of a program's implementation ("early-order"), as well as the risks associated with putting the costs up front instead. The incidence and sequence of benefits and costs affect how well recognized they are by various constituencies and the public as a whole, but people both have to know about them and have to consider the nature of their impact. Certainly the media plays a role as the main conduit through which public policy

learning takes place (for media and the MCCA, see Fan and Norem 1992). But how people perceive these policy attributes is also open to manipulation by the messages—the framing of the information—conveyed by politicians and interest groups. As noted by Rutledge (1992: 88), "Citizens' imperfect information offers opposition groups the potential to frame a program differently than it might appear to members of Congress." Making the benefits of a program obvious or finding ways to obscure the concomitant costs helps secure its political footing. Reverse that formulation, putting a spotlight on costs and hiding the benefits, or distorting the size and character of the costs, and that footing can quickly submerge into political quicksand (Beamer 1999). Finally, when an enacted policy is put to the test of proposed repeal, the degree to which benefits are real, concrete, and actually in hand rather than a future, abstract promise can be a bulwark against programmatic adversaries.

This summary of the five ways in which benefits and costs can be characterized naturally yields propositions about what kinds of laws are least and most susceptible to effective political attack, should efforts be made to repeal them. It would be extremely difficult to mount an efficacious campaign against a program with benefits that are concentrated, upfront, widely seen, and fully in hand through completed implementation and costs that are diffuse, in the future, and obscure. At the other extreme, program supporters would have their hands full trying to fend off an attack on a policy burdened by concentrated, immediate, and publicly obvious costs while the benefits are diffuse, scheduled for another time, hidden from public view, and only a promise rather than tangible. It is precisely these types of considerations that bring us back to the cautionary tale behind "remember Catastrophic!" The senators and legislative staffers who emphasized that reminder were talking about the substantive and structural design of the MCCA more than any focus on the immediate political-institutional circumstances. They were underscoring how the politics of repeal were driven by the MCCA's embedded policy attributes, rather than the way the politics of the day exploded into a sudden urge to repeal this general kind of Medicare benefit expansion. The question for the ACA is to ascertain whether it is similarly encumbered (Oberlander and Weaver 2015; Patashnik and Zelizer 2013).

Table 4 presents the main provisions of both the MCCA and the ACA (to a considerable extent one can view the Republicans' AHCA as simply flipping the ACA's benefits and costs). I have necessarily made judgment calls as to where each provision falls along the ordinal scales of concentrated to diffuse, early order to late order, obvious to obscure, and tangible to future promise. The distinctions that had or have real policy

Table 4 Main Provisions of the 1988 Medicare Catastrophic Coverage Act (MCCA) and the 2010 Affordable Care Act (ACA)

	Benefits		
Program	Concentrated	Medium	Diffuse
MCCA	▪ Eliminate 3-day hospitalization requirement to qualify for limited skilled nursing facility coverage ▪ Eliminate day limit for hospice care ▪ In-home health services ▪ Respite care ▪ States pay Medicare premiums for elderly beneficiaries below federal poverty line ▪ Spousal impoverishment protections re nursing-home care	▪ **After deductible, coverage of prescription drug costs** ▪ Cap on part B out-of-pocket costs ▪ Mammography screening ▪ In-home health services	▪ **After deductible, coverage for all inpatient hospital costs**
ACA	▪ **Dependent coverage up to age 26** ▪ **Medicaid coverage expansion** ▪ **Premium credits in exchanges** ▪ **Cost-sharing subsidies in exchanges**	▪ **Guaranteed issue and renewability** ▪ **Availability of insurance exchanges** ▪ **Essential health benefits** ▪ Limit age premium variation to 3-to-1 ratio	▪ **No cost sharing for preventive services** ▪ Medical loss ratio requirement ▪ Prohibit annual limits ▪ Prohibit lifetime limits ▪ Limit waiting periods for coverage to 90 days

(*continued*)

Table 4 Main Provisions of the 1988 Medicare Catastrophic Coverage Act (MCCA) and the 2010 Affordable Care Act (ACA) (*continued*)

	Benefits		
Program	Concentrated	Medium	Diffuse
	▪ Prohibit preexisting conditions exclusion for children ▪ **Prohibit preexisting conditions exclusion for all** ▪ **Temporary reinsurance program** ▪ Increase medical expense itemized deduction threshold ▪ Temporary national high-risk pool ▪ $250 rebate to Medicare beneficiaries hitting Part D "donut hole" ▪ Fill in Medicare Part D "donut hole"		▪ Plain language insurance plan information
	Costs		
	Concentrated	**Medium**	Diffuse
MCCA	▪ **Add new supplemental premium (wealthier 40% of beneficiaries, with 5% of beneficiaries paying full supplemental premium)**	▪ **Increase Part B premium ("flat premium") for beneficiaries**	▪ No revenues from non-Medicare beneficiaries (a first for the Medicare program)

Table 4 (*continued*)

	Costs		
	Concentrated	**Medium**	Diffuse
ACA	▪ **Individual mandate** ▪ **3.8% tax on investment income (wealthy)** ▪ **Increased Medicare Part A payroll tax (wealthy)** ▪ **"Cadillac" tax (insurers)** ▪ Medical devices tax (industry)	▪ Fees on pharmaceutical manufacturing ▪ Fees on health insurance sector ▪ Indoor tanning service tax (industry)	
	Sequence of Impact		
	Early-Order	Medium-Order	Late-Order
MCCA	▪ **Increase Part B premium ("flat premium")** ▪ **Add new supplemental premium (wealthier 40% of beneficiaries, with 5% of beneficiaries paying full supplemental premium)** ▪ **After deductible, cover all inpatient hospital costs**	▪ Limit on Part B cost sharing ▪ Mammography services ▪ In-home health services ▪ Respite care	▪ **After deductible, coverage of prescription drug costs, phased in**

(*continued*)

Table 4 Main Provisions of the 1988 Medicare Catastrophic Coverage Act (MCCA) and the 2010 Affordable Care Act (ACA) (*continued*)

	Sequence of Impact		
	Early-Order	Medium-Order	Late-Order
	▪ Eliminate 3-day hospitalization requirement to qualify for limited skilled nursing facility coverage ▪ Eliminate day limit for hospice care ▪ States pay Medicare premiums for elderly beneficiaries below federal poverty line (phase in begins) ▪ Spousal impoverishment protections re nursing-home care		
ACA	▪ Indoor tanning service tax (industry) ▪ **Dependent coverage up to age 26** ▪ Prohibit preexisting conditions exclusion for children ▪ $250 rebate to Medicare beneficiaries hitting Part D "donut hole" ▪ Small business tax credits (small) ▪ Temporary reinsurance program ▪ Temporary national high-risk pool	▪ **Start of individual mandate penalties** ▪ **Employer mandate (originally)** ▪ **3.8% tax on investment income (wealthy)** ▪ **Increase Medicare Part A payroll tax (wealthy)** ▪ Fees on pharmaceutical manufacturing ▪ Fees on health insurance sector	▪ **Full implementation of individual mandate penalties** ▪ **Employer mandate (actual)** ▪ **"Cadillac" tax (insurers)** ▪ Fill in Medicare Part D "donut hole"

Table 4 (*continued*)

	Sequence of Impact		
	Early-Order	Medium-Order	Late-Order
	▪ Plain language insurance plan information ▪ Medical loss ratio requirement	▪ Medical devices tax (industry) ▪ **Medicaid coverage expansion** ▪ **Premium subsidies** ▪ **Cost-sharing subsidies** ▪ Small business tax credits (larger) ▪ Increase medical expense itemized deduction threshold ▪ **Availability of insurance exchanges** ▪ **No cost sharing for preventive services** ▪ **Prohibit preexisting conditions exclusion for all** ▪ **Guaranteed issue and renewability** ▪ **Essential health benefits** ▪ Limit age premium variation to 3-to-1 ratio ▪ Prohibit annual limits ▪ Prohibit lifetime limits ▪ Limit waiting periods for coverage to 90 days	

Table 4 Main Provisions of the 1988 Medicare Catastrophic Coverage Act (MCCA) and the 2010 Affordable Care Act (ACA) (*continued*)

	Level of Visibility		
	Obvious	Visible	Obscure
MCCA	▪ **Supplemental premium** ▪ **Beneficiary flat premium**	▪ **After deductible, coverage of prescription drug costs, phased in** ▪ States pay Medicare premiums for elderly beneficiaries below federal poverty line	▪ **After deductible, cover all inpatient hospital costs** ▪ Elimination of 3-day hospitalization requirement to qualify for limited skilled nursing facility coverage ▪ Cap on Part B out-of-pocket costs ▪ Eliminate day limit for hospice care ▪ Respite care
ACA	▪ **Individual mandate** ▪ **Employer mandate** ▪ **"Cadillac" tax** ▪ **3.8% tax on investment income (wealthy)** ▪ **Increased Medicare Part A payroll tax (wealthy)**	▪ **Cost-sharing subsidies** ▪ **Guaranteed issue and renewability** ▪ **Essential health benefits** ▪ **No cost sharing for preventive services** ▪ Limit age premium variation to 3-to-1 ratio	▪ Prohibit preexisting conditions exclusion for children ▪ $250 rebate to Medicare beneficiaries hitting Part D "donut hole" ▪ **Fill in Medicare Part D "donut hole"**

Table 4 (*continued*)

	Level of Visibility		
	Obvious	Visible	Obscure
	▪ Fees on pharmaceutical manufacturing ▪ Fees on health insurance sector ▪ Medical devices tax (industry) ▪ Small business tax credits ▪ **Dependent coverage up to age 26** ▪ **Medicaid coverage expansion** ▪ **Premium subsidies** ▪ **Availability of insurance exchanges** ▪ **Prohibit preexisting conditions exclusion for all**	▪ Fill in Medicare Part D "donut hole"	▪ Plain language insurance plan information ▪ Temporary reinsurance program ▪ Temporary national high-risk pool ▪ Increase medical expense itemized deduction threshold ▪ Limit waiting periods for coverage to 90 days ▪ Medical loss ratio requirement
	Benefits Experienced at Time of Repeal Consideration		
	Tangible		Future Promise
MCCA	▪ **After deductible, cover all inpatient hospital costs** ▪ Eliminate 3-day hospitalization requirement to qualify for limited skilled nursing facility coverage ▪ Eliminate day limit for hospice care ▪ Limit on Part B cost sharing ▪ Mammography services ▪ In-home health services ▪ Respite care		▪ **After deductible, coverage of prescription drug costs, phased in**

(*continued*)

Table 4 Main Provisions of the 1988 Medicare Catastrophic Coverage Act (MCCA) and the 2010 Affordable Care Act (ACA) (*continued*)

	Benefits Experienced at Time of Repeal Consideration	
	Tangible	Future Promise
	▪ States pay Medicare premiums for elderly beneficiaries below federal poverty line (first phase)	
ACA	▪ **Dependent coverage up to age 26** ▪ **Medicaid coverage expansion** ▪ **Premium subsidies** ▪ **Cost-sharing subsidies** ▪ **No cost sharing for preventive services** ▪ **Availability of insurance exchanges** ▪ **Guaranteed issue and renewability** ▪ Limit age premium variation to 3-to-1 ratio ▪ Prohibit annual limits ▪ Prohibit lifetime limits ▪ Limit waiting periods for coverage to 90 days ▪ Fill in Medicare Part D "donut hole" ▪ Increase medical expense itemized deduction threshold ▪ Medical loss ratio requirement	

Note: Most significant features are in bold.
Sources: CQ Almanac 1988; KFF 2013

consequences, however, are typically not ambiguous. The information in table 4 allows one to identify basic similarities and differences between how policy attributes shaped the repeal politics of MCCA and ACA.

At first glance, it appears that the MCCA offered a panoply of benefits concentrated on particular populations of Medicare beneficiaries in need. Many of the beneficiaries and their families who gained these various forms of coverage would be greatly advantaged by their presence. The Congressional Budget Office (CBO) estimated that, when the MCCA was completely implemented, about a fifth of enrollees would experience an increase in benefits each year, and nearly nine out of ten would witness the gains over the first six years (CBO 1988a: 1–2). But table 4 also reveals the problematic politics of the overall benefit structure of the law. The two benefits most central to the promises of the MCCA—drug coverage and assurance that one would not be devastated by the enormous expenses of sustained, catastrophic medical care—were, by definition, concentrated on the Medicare population as a group but more diffuse in concept (the activation of the prescription coverage was also deferred and phased in). One of the characteristics of catastrophic coverage is that few need it and almost no one can know if or when they would have reason to call on it. Although it went into place immediately, it gave all beneficiaries a more nebulous form of psychological protection against the fear of being financially crushed by worst-case scenarios in health circumstances. Specifically, "the program conceivably offered benefits to many citizens, by providing coverage *in case of illness*. It also arguably offered benefits to few citizens, by paying for services of *those actually in need of* them" (Rutledge 1992: 35). According to the CBO (1989a: 4), "enrollees with long hospital stays comprise only 0.5 percent of the Medicare population." In addition, the benefits that were more overtly concentrated tended to apply to the Medicare beneficiaries least likely to have political resources or to use them—the poor, the dying, those who qualified for long-term care, and family members out of the workforce and burdened with persistent caring for the continuously sick or infirm (Himelfarb 1995; Rutledge 1992). As I mentioned previously, the MCCA also did not include a benefit the enrollee population really desired: coverage for extended nonrehabilitative stays in skilled nursing facilities, nursing homes, and at-home support services. The absence of that benefit was a major motivation for the National Committee to challenge the law rather than come to its rescue (Cooper and Secrest 1989; Himelfarb 1995; Moon 2006; Rovner 1995; Rutledge 1992).

The cost structure of the MCCA was at the outset a response to both the budget neutrality demand of President Reagan and his stipulation that the program be financed by the beneficiaries alone, not tax payers in general. Democrats in Congress accepted those parameters (Oberlander 2003; Rovner 1995). Then, given that context, in a fit of responsible policy making and responding to the past experience of social policies costing more than originally projected, the law was designed to frontload revenue collections. For the participants in the Medicare program, costs came well ahead of tangible benefits (Moon 2006). With the straightjacket of budget neutrality and Medicare enrollee-only financing, because of the bells and whistles in the benefit package added by congressional Democrats—who held majorities in the House and Senate—the program costs rose and became too high to be financed by a simple flat premium across all beneficiaries (Himelfarb 1995; Oberlander 2003). That approach would be unaffordable to those with lower incomes.

So Congress developed a scheme that combined a relatively low flat premium with a graduated income-based supplemental premium to be paid by 40 percent of the beneficiaries. The most affluent 5 percent of beneficiaries would pay the maximum supplemental premium of $800 (Oberlander 2003). This approach to the financing concentrated the costs on individuals who not only possessed the most political resources but also were most likely to already have private supplemental plans with perhaps even better protections (CBO 1988b, 1989a; Day 1993; Oberlander 2003). In its scare mailers, the National Committee was also able to frame the supplemental premium as an added cost that would be paid by not just a few but closer to all Medicare recipients (Himelfarb 1995; Rutledge 1992). Finally, for purposes of administrative simplicity and accuracy, the premiums were to be collected each April on the 1040 personal income tax form. That meant the "premium increase could be characterized as a surtax" (Rutledge 1992: 88). The National Committee in its opposition campaign went even further, identifying it as a tax of an especially pernicious sort—a "seniors-only tax" (Moon 2006; Oberlander 2003; Rovner 1989b). One had to pay a tax for the privilege of getting old. Much of this design made good sense from the standpoint of effective public administration and protection of the public fisc. Even with this financing mechanism, all Medicare enrollees would still enjoy subsidized coverage. On average they would pay for just 34–39 percent of the costs of their expected benefits. Even the "least subsidized high-income enrollee" would get an annual subsidy of $800 and pay only 79 percent of the overall coverage cost (CBO 1989b: 5–6). Nonetheless, the final result that MCCA costs were

concentrated, immediate, and obvious, while too many of the benefits were diffuse, delayed, obscure, and not yet in hand when the opposition that began to mobilize proved disastrous. It led to major blowback, grassroots and media campaigns for repeal, orchestrated mass mailings to members of Congress, and even the sight of senior citizen protesters pounding their hands on the car of House Ways and Means Committee Chairman Dan Rostenkowski (Fan and Norem 1992; Himelfarb 1995; Moon 1990; Oberlander 2003). Representative Henry Waxman (D-CA) lamented, "I have constituents who clearly come out ahead very well who think it's a poor deal" (Rovner 1989a: 1860).

Although there is not a direct instrumental relationship between public opinion and policy decision making, elected officials have their fingers on the pulse of the electorate, in particular as significant views circulate within their own constituencies. That is why these distributions of policy benefits and costs along the various dimensions can matter so much to legislative choices on both enactment of proposed laws and later reconsiderations. Figure 3 shows the striking collapse in net approval of the MCCA among the sixty-five and over population as the law's opponents highlighted—even distorted—its costs, when and on whom they were imposed, and in a form that could be branded a "senior tax." Total support dropped from a peak of 91 percent approval among seniors before the law was passed to just 40 percent not long before the House and Senate voted on repeal (Himelfarb 1995: 62). Confronted with this seemingly widespread outrage by the very people they had intended to aid, when given the opportunity to expunge the new addition to the Medicare program, sizable bipartisan majorities in Congress fell into line. The story of the MCCA is the mismatch between the architecture of the law and the imperatives of policy attributes influencing politics, especially in the legislative arena. The experience also revealed the challenges of measuring support and disapproval among the public for a complex proposal with built-in trade-offs. Given that most health care issues unavoidably present constituents with some combination of balancing costs and benefits, after the MCCA fiasco the AARP started commissioning more sophisticated public opinion research on other issues, such as long-term care, using conjoint analysis to ascertain how respondents would react to different combinations of simultaneous benefit packages and financing mechanisms.[6]

6. This description is based on meetings with AARP representatives I attended as a legislative assistant for health policy.

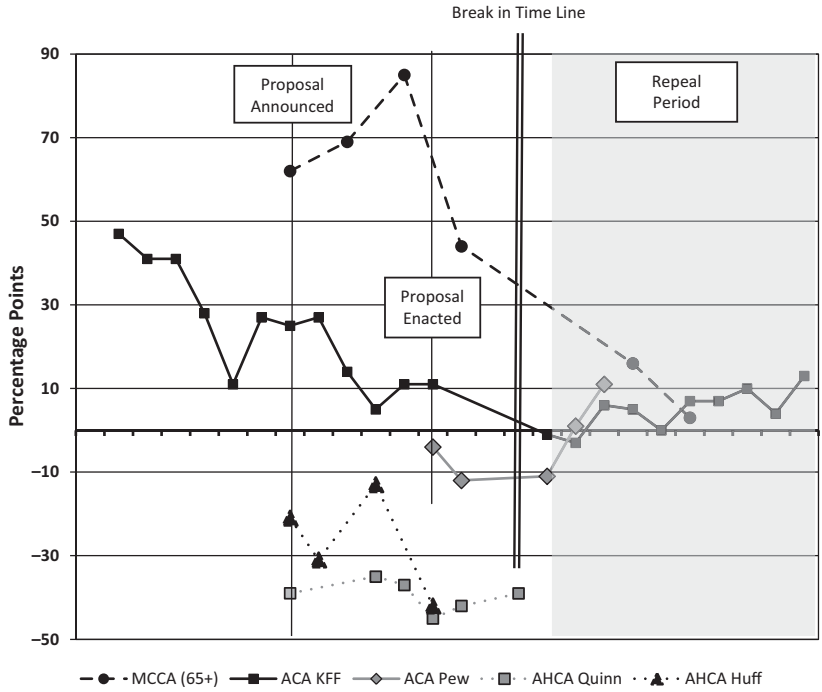

Figure 3 Public Support Minus Opposition for Medicare Catastrophic Coverage Act (MCCA), Affordable Care Act (ACA), and American Health Care Act (AHCA)/GOP Plans, Plotted at Comparable Times of Proposal, Enactment, and Repeal Effort

Source: MCCA (65+), data from Himelfarb 1995; ACA KFF, data from KFF 2017; ACA Pew, data from Fingerhut 2017; AHCA Quinn, data from Quinnipiac University 2017; AHCA Huff, data from Edwards-Levy 2017

Is the ACA structured in a way that mimics the MCCA, and is it likely to replay the politics of the MCCA's demise? Unlike the MCCA, the politics of ACA is rooted in a much larger story of the century-long ideological divide in the United States over the appropriate role of government in overall health care financing and delivery. Relative to the MCCA, this at once makes the program's politics both more intense, because the stakes on both sides are perceived to be so large, and more stable, reflecting the relative durability of the public's respective ideological commitments on this issue. Although the final form is the ultimate question, generally speaking the American public has favored the government taking action to expand insurance coverage and access to medical care (Peterson 2017: chap. 5). In addition, President Obama and the Democrats in Congress, collaboratively deviating substantially from past Democratic reform plans from Harry

Truman's National Health Insurance to Bill Clinton's Health Security Act, chose a policy strategy that avoided the imposition of large-scale "costs" of various sorts entailed in these earlier plans. Quite intentionally, there would be no full-bore redesign either of health care financing, advocated by Truman, or of the health care insurance and delivery system, as required by the Clinton plan. By accepting the bulk of the health care financing system as it existed, including employer-sponsored insurance and Medicare in close to their existing forms, they avoided the institutional disruptions and massive tax transfers to the public sector that would have been required by previous approaches for achieving something approximate to universal coverage (Brill 2015; Peterson 2011, 2017: chap. 11). That minimized but still did not make trivial the call for building new institutions, such as the market exchanges, and the requirement for redistributive, tax-based financing of the expanded insurance coverage through both subsidies to purchase private insurance in the individual market exchanges and the Medicaid expansion. The policy architecture necessarily involved the multiple ways in which benefits and costs would be distributed. Did the end result harbor the same kinds of political landmines that blew up the MCCA? Or does the ACA contain design features that provide some degree of political inoculation?

Aware of the MCCA experience, but also grappling with a policy endeavor of grander scope, the drafters of the ACA tried to embed some early goodies while avoiding the political malpractice of spotlighting major costs at the outset of the law's implementation. As shown in table 4, right from the start parents were able to include their adult children up through age 25 on their insurance plans. Minor children could no longer be subject to preexisting condition restrictions. Rebates for $250 were available to Medicare beneficiaries who entered the donut hole in Part D prescription coverage. That was fairly weak tea compared to the insurance coverage expansions that would come later, but it started the law down the road of reducing the ranks of the uninsured, adding Medicare protections, and launching federal health insurance regulation. Orchestrating the broadening of Medicaid coverage to be inclusive of all people below 138 percent of the federal poverty line (regardless of parental or marital status), building the insurance exchanges from scratch, and operationalizing the income-based premium subsidies for exchange plans were going to be expensive and time-consuming projects. The initial failure of Healthcare .gov, the national insurance exchange, illustrated all too vividly the administrative challenges posed by the law (Goldstein 2016). A senior official in the US Department of Health and Human Services told me in early 2009 of concerns within the department that the timelines in the ACA

were actually unrealistically short, especially when the deadlines did not shift later as the enactment of the law dragged on from 2009 to 2010.

The law also had looming the decidedly concentrated and highly visible taxes levied to pay for the coverage expansions: a new 3.8 percent tax on investment income and an increase in the Medicare Part A payroll tax paid by more affluent individuals—exactly the sorts of people who have considerable political wherewithal (Gilens 2012). The especially well-organized medical device industry, insurers, and pharmaceuticals would be hit by their respective taxes and fees. At least those provisions were not actively generating revenue until around the time the increase in insurance coverage would take off. The "Cadillac" tax on expensive employer-sponsored plans was scripted to start applying years into the life of the act, and it was further delayed after enactment, now until 2020 (Goldstein 2015). The individual mandate, shown in the Kaiser Family Foundation's monthly tracking polls to be the least popular of all of the provisions in ACA—for example, only 35 percent had a favorable view of it, and 43 percent had "very unfavorable" opinion of it, in the November 2011 poll—was also not implemented until the insurance expansions kicked in. Even then it began with a small penalty that would rise over time, and with no real enforcement authority for the Internal Revenue Service written into the statute (KFF 2013). In short, the ACA did not include the immediate trip wires and landmines so detrimental to the MCCA, but structurally it had its own potential ticking time bombs.

Perhaps the most important saving grace for the ACA is something that the MCCA did not enjoy: time (on the effects for the MCCA, see Fan and Norem 1992). Here we must return to the political-institutional context joined by matters specific to each law. President Reagan, long sympathetic to the burdens of high medical costs for patients, favored the introduction of the MCCA following its promotion by his secretary of health and human services, Otis Bowen. But he was surrounded by the rest of the cabinet, budget office officials, and White House staff deeply opposed to the act, which tempered his public enthusiasm and commitment, especially in the elaborated form the proposal took in the Democratic-controlled Congress (Blumenthal and Morone 2009: chap. 8; Himelfarb 1995: chap. 2). When the political tides turned, his successor, President Bush, went along with everyone else (Blumenthal and Morone 2009: 331; Himelfarb 1995). The MCCA disappeared before the most significant benefits could take hold and become part of the full Medicare experience. It had never been a priority of Reagan's administration, beyond Secretary Bowen, who departed with Reagan in January 1989, and thus it lacked an ardent defender when the going got tough.

In the case of the ACA, however, President Obama had campaigned vigorously on the issue and pushed the legislative charge driven by his own dedication to the cause of health care reform. Speaker Nancy Pelosi and others in Congress were equally committed to the reform (Peterson 2011). Colorfully depicted by Vice President Biden as "a big f—ing deal," the ACA "would forever define [Obama's] domestic legacy" (DeBonis 2016). He would not yield readily to shifts in the political sand as long as he remained in office. The continuation of Democratic majorities in the Senate through 2014 kept a bulwark against Republican efforts at repeal. Obama's own reelection in 2012, which secured his command of the veto pen until January 20, 2017, assured that the ACA, unlike the MCCA, would remain law long enough for all of the benefits to kick in, mature, gain media attention, and become expected by tens of millions of individuals. The president was fully aware of those dynamics. That included millions of individuals buying subsidized insurance through national- and state-run exchanges, millions more obtaining coverage through expansion of the Medicaid program in thirty-one states plus the District of Columbia, children on their parents' insurance plans, prohibitions against using pre-existing conditions to deny or price insurance, provision of preventive care without patient cost sharing, and extended women's reproductive services, among many other provisions—most in place for at least three years before President Trump took the oath of office. As I noted earlier, Republicans well understood the consequences of carving another federal benefits program into statutory stone, especially one with any ties to the middle-class electorate, as demonstrated by the popularity of past Democratic successes with Social Security and Medicare (Peterson 1998). Benefits once granted and experienced are decidedly difficult to withdraw. To make matters yet more politically problematic, the GOP plans went even further than ACA repeal and included sharply curtailing the long-standing commitments in the pre-ACA Medicaid program. At their district town halls with constituents following the passage of the AHCA, Republican members of Congress witnessed the public ire that threatened benefits can generate (Jacey and Victor 2017).

The favorable effect of time in securing the ACA's benefits was reflected in the public's attitudes toward the law since it was enacted and now into the period in which repeal has been actively pursued by its opponents. The data in figure 3 show that Congress passed the ACA while the president's initiative retained net positive reviews from the public (in contrast, by the time Congress had pulled the plug on debates over the Truman and Clinton plans, popular support for them had thoroughly collapsed; Peterson 2017: chaps. 5 and 10). But as I reported earlier, the country remained at best split

about the act since 2010. As House and Senate Republicans moved into a position to press for repeal after the 2016 election—a real possibility as opposed to the earlier symbolic votes—the public's impressions of the ACA moved back into positive territory. The debate over the AHCA, and the CBO's projection that it would result in 24 million Americans losing their health insurance coverage, brought home the reality of the benefits the law provides. These were benefits in place, already affecting people, shaping their access to actual health care services and the returns they produce for health status (CBO 2017a). That came into even greater focus when the AHCA as amended and passed by the House put at risk both protections against preexisting condition exclusions and community rating of health plan premiums (Fiedler 2017).

The data in figure 3 further allow us to consider the Republicans' AHCA as a proposal in its own right. After all, it would not just abolish the ACA the way the statute books were stripped clean of the MCCA's core provisions; it would replace the ACA with a new plan for financing health care services and regulating (more often deregulating) the health insurance industry and the states' operations of their respective Medicaid programs. As presented by many advocacy groups and in much of the media coverage, the AHCA and versions of the Senate plans would turn many of the ACA's concentrated and visible costs into benefits for wealthy and influential constituencies. At the same time, concentrated, visible, and tangible benefits of the ACA would, by their removal or reduction, become similar kinds of costs under the House and Senate GOP bills (CBO 2017a). As major reform proposals emerge and gain public attention, they typically start off with fairly high levels of public approval (that was the case with multiple past health care reform plans and the MCCA; Peterson 2017: chap. 5). The campaigns in support of the initiatives frequently push the initial numbers even higher. It is only after the opposition organizes and launches its own countercampaign, sowing confusion and instigating fear, that popular backing of the plan becomes soft or decays. Not so with the AHCA: the first polling revealed that right from the start far more of the public was unfavorable than favorable (a net of −39 percentage points, e.g., in the Quinnipiac University poll of March 2017). In the HuffPost/YouGov survey (Edwards-Levy 2017), there may have been some gains in support from March to May, but it remained on the decidedly negative side of the equation, with 31 percent in favor and 44 percent opposed. Time did not improve the situation. Overall, public attitudes in spring 2017 were far more positive about the existing ACA than its proposed replacements, complicating the Republicans' ambition to do away with President Obama's "signature domestic achievement" (Associated Press 2016).

Conclusion

Revisiting together the histories of the MCCA of 1988 and the ACA of 2010—each of which involved various kinds of health care benefit expansions mixed with the challenges of financing expensive new coverage provisions—revealed that common characteristics associated with the political-institutional context or the process of coalition decay and formation were not the driving forces of program repeal. The MCCA went from the heights of relatively uncontroversial enactment to the depths of stunningly quick reversal by respective Congresses and presidential administrations that had barely changed in composition. Passage and repeal were both by robust bipartisan majorities. The ACA was given birth in the cauldron of acute partisan and ideological policy battle. That overall setting endured through the 2017 failed effort at repeal and replace, despite the dramatic shift in the specific political party that controlled the House and Senate and laid claim to presidential authority.

Nonetheless, the ACA could have been short-lived for the same reasons the MCCA suffered political collapse: the architecture of each program's combination of benefits and costs. Both laws had prominent features that could give opponents—among legislative partisans and in the interest group community—the opportunity to activate popular and group rebellion against them. Those attributes were especially pronounced in the design of the MCCA. They triggered political action before the construction of the program was complete and the policy concrete set. The drafters of the ACA, aware of that history, were able to build in some programmatic protections. But the most significant prophylactic that shielded the ACA from demise was time. Because the origins and future of the health care reform law were fully in the maw of partisan politics and ideological contestation, what mattered most was if, or when, the opposing party would finally capture the instruments of governing. That happened with the 2016 election, but this alignment came years after the benefits of the program were already insinuating themselves into the experiences and needs of Americans as they confronted actualized or feared adverse health care events. Given the unified government window of opportunity the 2016 election presented to Republicans—just the third with an incoming president since the Depression and featuring the largest House and Senate majorities of the three—Republican leaders simply could not keep their policy ambitions in check. As part of repeal of the ACA they also folded in emasculating the coverage guarantees and financing for the Medicaid program as it had existed for many years prior to the Obama presidency.

The scoring done by the CBO showed just how devastating the legislation would be to insurance coverage and various kinds of protections. Moreover, Republicans now in the role of a governing instead of an opposition party could not manage to compromise sufficiently among themselves in order to govern. As Speaker Paul Ryan observed, 64 percent of his fellow Republicans in the House had never previously served during unified Republican government, including with a Republican president (Parkinson and Bruce 2017). Their entire legislative experience had been as a vociferous conservative opposition generally not having to worry about the actual practice of governing and the kinds of conciliations that necessarily entails. The effort to eviscerate the ACA faltered in an ideologically changed institution with majority party members lacking experience in the imperatives of lawmaking.

This is not to say, of course, that the legislative fight over the ACA ended with the failure of full-scale statutory repeal. At the end of 2017 the Republicans managed to gut the individual health coverage mandate—the feature of the ACA that was truly disliked by the public—with a provision in the Tax Cuts and Jobs Act signed by President Trump on December 22. The tax law did not delete what is formally the "shared responsibility payment" provision of the ACA; instead it zeroed-out the financial penalties associated with failure to comply starting with the 2018 tax year (Section 11081, Public Law No. 115-97). Although that change is expected to reduce the ranks of the insured by several million individuals and will potentially disrupt private individual insurance markets (CBO 2017b), it is unlikely to produce an unraveling of the ACA, even in combination with various administrative actions taken by the Trump administration (Molina 2017).

■ ■ ■

Mark A. Peterson is professor of public policy, political science, and law at the UCLA Luskin School of Public Affairs. An elected member of the National Academy of Social Insurance and former editor of *JHPPL*, he worked on health care reform and Medicare policy as a legislative assistant for health policy in the US Senate, chaired the National Advisory Committee for the Robert Wood Johnson Foundation's Changes in Health Care Financing and Organization program, and served on the National Academy of Social Insurance's Study Panel on Medicare and Markets. He is completing a book titled "Hardball Politics, Hobbled Policy: Contexts, Choices, and Consequence in U.S. Health Reform."
markap@ucla.edu

Acknowledgments

I wish to thank Peter (Bo) Rutledge, dean of the School of Law at the University of Georgia, for having provided me twenty-five years ago with the original unpublished documents that he acquired when conducting the research on the Medicare Catastrophic Coverage Act for his 1992 senior thesis in the Department of Government, Harvard University, which I advised.

References

AARP (American Association of Retired Persons). 1989. "Opinions of Americans Age 45 and Over on the Medicare Catastrophic Coverage Act." Report on a survey conducted by Hamilton, Frederick, and Schneider, AARP Research and Data Resources Department, January.

Arnold, R. Douglas. 1990. *The Logic of Congressional Action*. New Haven, CT: Yale University Press.

Associated Press. 2016. "President Obama Vetoes Republican Bill to Abolish Obamacare." *Los Angeles Times*, January 8.

Bajaj, Vikas, and Stuart A. Thompson. 2017. "Republicans Are Remarkably Good at Uniting Opposition against Themselves." *New York Times*, September 25.

Beamer, Glenn. 1999. *Creative Politics: Taxes and Public Goods in a Federal System*. Ann Arbor: University of Michigan Press.

Berry, Christopher R., Barry C. Burden, and William G. Howell. 2010. "After Enactment: The Lives and Deaths of Federal Programs." *American Journal of Political Science* 54, no 1: 1–17.

Binder, Sarah A. 2003. *Stalemate: Causes and Consequences of Legislative Gridlock*. Washington, DC: Brookings Institution.

Blake, Aaron. 2013. "Bachmann: Obamacare 'Literally Kills' People." *Washington Post*, March 21.

Blumenthal, David, and James A. Morone. 2009. *The Heart of Power: Health and Politics in the Oval Office*. Berkeley: University of California Press.

Brill, Steven. 2015. *America's Bitter Pill: Money, Politics, Backroom Deals, and the Fight to Fix Our Broken Healthcare System*. New York: Random House.

Campbell, Andrea Louise. 2003. *How Policies Make Citizens: Senior Political Activism and the American Welfare State*. Princeton, NJ: Princeton University.

Carney, Eliza Newlin. 2015. "Standing Together against Any Action." *CQ Weekly*, March 16, 37–45.

CBO (Congressional Budget Office). 1988a. "Cumulative Counts of Enrollees Affected under the Medicare Catastrophic Coverage Act, Multi-year Effects Simulated for 1980 through 1985." Memorandum to Brian Biles from Sandra Christensen, October 25. Washington, DC: US Congress.

CBO (Congressional Budget Office). 1988b. "Impact of the Medicare Catastrophic Coverage Act on Enrollees with Employment-Based Insurance Coverage." Memo-

randum to Health Staff from Sandra Christensen, December 12. Washington, DC: US Congress.

CBO (Congressional Budget Office). 1989a. "Impact of the Medicare Catastrophic Coverage Act on Enrollees by Selected Demographic Characteristics." Memorandum to Health Staff from Sandra Christensen, January 5. Washington, DC: US Congress.

CBO (Congressional Budget Office). 1989b. "Subsidy Values under Medicare." Staff Memorandum, May 24. Washington, DC: US Congress.

CBO (Congressional Budget Office). 2017a. "Cost Estimate, American Health Care Act." March 13. Washington, DC: US Congress.

CBO (Congressional Budget Office). 2017b. "Repealing the Individual Health Insurance Mandate: An Updated Estimate." November 8. Washington, DC: US Congress.

Cillizza, Chris. 2014. "How Congress Became the Most Polarized and Unproductive It's Ever Been." *Washington Post Blog*, February 3. www.washingtonpost.com/blogs/the-fix/wp/2014/02/03/how-congress-became-the-most-polarized-and-unproductive-its-ever-been/?wpisrc=nl_politics.

Cohen, Alan B., David C. Colby, Keith Wailoo, and Julian E. Zelizer, eds. 2015. *Medicare and Medicaid at Fifty: America's Entitlement Programs in the Age of Affordable Care*. New York: Oxford University Press.

Cooper and Secrest Associates, Inc. 1989. "Member Poll Results: National Committee to Preserve Social Security and Medicare." Memorandum to Interested Parties from Cooper and Secrest Associates, September 5. Alexandria, VA: Cooper and Secrest Associates.

Costa, Robert. 2013. "Conservatives Wary of Deal." *National Review*, October 7. www.nationalreview.com/corner/360598/conservatives-wary-deal-robert-costa.

Cowan, Richard, and Susan Cornwell. 2017. "House Votes to Begin Repealing Obamacare." Reuters, January 13. www.reuters.com/article/us-usa-obamacare/house-votes-to-begin-repealing-obamacare-idUSKBN14X1SK.

CQ Almanac. 1983. "Interest Withholding Requirement Repealed." Washington, DC: Congressional Quarterly.

CQ Almanac. 1988. *CQ Almanac 1988*. Washington, DC: Congressional Quarterly.

CQ Almanac. 1989. *CQ Almanac 1989*. Washington, DC: Congressional Quarterly.

CQ Almanac. 2010. *CQ Almanac 2010*. Washington, DC: Congressional Quarterly.

CQ Magazine. 2017a. "Health Care Market Place Overhaul—Passage." May 4. floorvote115-261777000 or library.cqpress.com/cqweekly/floorvote115-261777000.

CQ Magazine. 2017b. "Health Care Marketplace Overhaul—2010 Health Care Overhaul Repeal." July 28. floorvote115-263975000 or library.cqpress.com/cqweekly/floorvote115-263975000.

CQ Magazine. 2018. "CQ Vote Studies: Party Unity." February 12. weeklyreport115-000005263236 or library.cqpress.com/cqweekly/weeklyreport115-000005263236.

Daniels, Mark R. 1997. *Terminating Public Programs: An American Paradox*. Armonk, NY: M. E. Sharpe.

Day, Christine L. 1993. "Older Americans' Attitudes toward the Medicare Catastrophic Coverage Act of 1988." *Journal of Politics* 55, no. 1: 167–77.

DeBonis, Mike. 2016. "The Political Price of Obamacare." *Washington Post*, August 16.
Derthick, Martha. 1979. *Policymaking for Social Security*. Washington, DC: Brookings Institution.
Edwards-Levy, Ariel. 2017. "Less than a Third of the Public Supports the GOP's New Health Care Bill." *Huffington Post*, May 8.
Eilperin, Juliet, and Abby Phillip. 2017. "White House Touts the ACA's Demise Even as Insurers Seek Help in Stabilizing Its Marketplace." *Washington Post*, June 7.
Fan, David P., and Lois Norem. 1992. "The Media and the Fate of the Medicare Catastrophic Coverage Act." *Journal of Health Politics, Policy and Law* 17, no. 1: 39–70.
Fiedler, Matthew. 2017. "New Amendment to GOP Health Bill Effectively Allows Full Elimination of Community Rating, Exposing Sick to Higher Premiums." *Brookings Institution Blog*, April 27. www.brookings.edu/blog/up-front/2017/04/27/new-amendment-to-gop-health-bill-effectively-allows-full-elimination-of-community-rating-exposing-sick-to-higher-premiums/.
Fingerhut, Hannah. 2017. "Support for the 2010 Health Care Law Reaches New High." February 23. Washington, DC: Pew Research Center. www.pewresearch.org/fact-tank/2017/02/23/support-for-2010-health-care-law-reaches-new-high/.
Gilens, Martin. 2012. *Affluence and Influence: Economic Inequality and Political Power in America*. Princeton, NJ: Princeton University Press.
Goldstein, Amy. 2015. "Congress to Delay ACA's 'Cadillac' Tax on Pricey Health Plans until 2020." *Washington Post*, December 16.
Goldstein, Amy. 2016. "HHS Failed to Heed Many Warnings That HealthCare.gov Was in Trouble." *Washington Post*, February 23.
Goodnough, Abby, Robert Pear, and Thomas Kaplan. 2017. "Health Groups Denounce G.O.P. Bill as Its Backers Scramble." *New York Times*, March 8.
Ha, Jeasik. 2012. "'Health Care Reform' vs. 'Obamacare': Partisan Framing of Fox, MSNBC, NYT, and WSJ." *gnovis*, November 30. www.gnovisjournal.org/2012/11/30/health-care-reform-vs-obamacare-partisan-framing-of-fox-msnbc-nyt-and-wsj/.
Hacker, Jacob S. 2002. *The Divided Welfare State: The Battle over Public and Private Social Benefits in the United States*. New York: Cambridge University Press.
Harris, Gardiner. 2016. "Obama Vetoes Bill to Repeal Health Law and End Planned Parenthood Funding," *New York Times*, January 8.
Himelfarb, Richard. 1995. *Catastrophic Politics: The Rise and Fall of the Medicare Catastrophic Coverage Act of 1988.* University Park: Pennsylvania State University Press.
Hrebenar, Ronald J., and Ruth K. Scott. 1997. *Interest Group Politics in America*, 3rd ed. New York: Routledge.
Jacey, Fortin, and Daniel Victor. 2017. "Critics at Town Halls Confront Republicans over Health Care." *New York Times*, May 9.
Jacobs, Lawrence R., and Theda Skocpol. 2010. *Health Care Reform and American Politics: What Everyone Needs to Know*. New York: Oxford University Press.
Johnson, Haynes, and David S. Broder. 1996. *The System: The American Way of Politics at the Breaking Point*. Boston: Little, Brown.

Jones, David K. 2017. *Exchange Politics: Opposing Obamacare in the Battleground States*. New York: Oxford University Press.

KFF (Kaiser Family Foundation). 2010. "Health Care Reform and the CLASS Act: Summary." Focus on Health Reform Issue Brief, April. kaiserfamilyfoundation .files.wordpress.com/2013/01/8069.pdf.

KFF (Kaiser Family Foundation). 2013. "Summary of the Affordable Care Act." April 25. kff.org/health-reform/fact-sheet/summary-of-the-affordable-care-act/.

KFF (Kaiser Family Foundation). 2017. "Kaiser Health Tracking Poll—November 2017: The Politics of Health Insurance Coverage, ACA Open Enrollment." November 17. www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-november-2017-the-politics-of-health-insurance-coverage-aca-open-enrollment/.

Kilgore, Ed. 2017. "Democrats Remain United against GOP Health Plan Because It's Politically Stupid." *New York Magazine*, June 29. nymag.com/daily/intelligencer/2017/06/democrats-owe-their-unity-to-gops-political-stupidity.html.

Kim, Seung Min, and Elana Schor. 2017. "How Schumer Kept Dems United on Obamacare." *Politico*, June 28. www.politico.com/story/2017/06/28/schumer-democrats-unity-obamacare-240020.

Kingdon, John W. 1989. *Congressmen's Voting Decisions*. 3rd ed. Ann Arbor: University of Michigan Press.

Kirzinger, Ashley, Elise Sugarman, and Mollyann Brodie. 2016. "Kaiser Health Tracking Poll: November 2016," December 1. www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-november-2016/.

Levy, Gabrielle. 2017. "Senate Republicans Admit Defeat on Graham-Cassidy." *USA Today*, September 26.

Lowi, Theodore J. 1972. "Four Systems of Policy, Politics, and Choice." *Public Administration Review* 32, no. 4: 298–310.

Maltzman, Forrest, and Charles R. Shipan. 2008. "Change, Continuity, and the Evolution of the Law." *American Journal of Political Science* 52, no. 2: 252–67.

Mayhew, David R. 2005. *Divided We Govern: Party Control, Lawmaking, and Investigations, 1946–2002*, 2nd ed. New Haven, CT: Yale University Press.

Molina, J. Mario. 2017. "Trump Didn't Kill Obamacare by Repealing the Individual Mandate." *Newsweek*, December 28. www.newsweek.com/trump-kill-obamacare-repealing-individual-mandate-763095.

Moon, Marilyn. 1990. "The Rise and Fall of the Medicare Catastrophic Coverage Act." *National Tax Journal* 43, no. 3: 371–81.

Moon, Marilyn. 2006. *Medicare: A Policy Primer*. Washington, DC: Urban Institute Press.

Naylor, Brian. 2017. "Medical, Hospital Groups Oppose GOP Health Care Plan." NPR, March 9. www.npr.org/2017/03/09/519450642/medical-hospital-groups-oppose-gop-health-care-plan.

Oberlander, Jonathan. 2003. *The Political Life of Medicare*. Chicago: University of Chicago Press.

Oberlander, Jonathan, and R. Kent Weaver. 2015. "Unraveling from Within? The Affordable Care Act and Self-Undermining Policy Feedbacks." *Forum* 13, no. 1: 37–62.

O'Keefe, Ed. 2014. "The House Has Voted Fifty-Four Times in Four Years on Obamacare: Here's the Full List." *Washington Post*, March 21.

Olson, Mancur, Jr. 1965. *The Logic of Collective Action: Public Goods and the Theory of Groups*. Cambridge, MA: Harvard University Press.

Parkinson, John, and Mary Bruce. 2017. "House Speaker Paul Ryan: 'No Doubt' Republican Health Care Plan Will Pass." ABC News, March 8. abcnews.go.com/Politics/house-speaker-paul-ryan-doubt-republican-health-care/story?id=45994737.

Patashnik, Eric M. 2008. *Reforms at Risk: What Happens after Major Policy Changes Are Enacted?* Princeton, NJ: Princeton University Press.

Patashnik, Eric M., and Julian E. Zelizer. 2013. "The Struggle to Remake Politics: Liberal Reform and the Limits of Policy Feedback in the Contemporary American State." *Perspectives on Politics* 11, no. 4: 1071–87.

Pear, Robert, and Thomas Kaplan. 2017. "How Republicans Unveil Plan to Replace Health Law." *New York Times*, March 6.

Pear, Robert, Thomas Kaplan, and Emily Cochrane. 2017. "Health Care Debate: Obamacare Repeal Fails as McCain Casts Decisive No Vote." *New York Times*, July 27.

Peters, Jeremy W. 2017. "A Republican Principle Is Shed in the Fight on Health Care." *New York Times*, May 7.

Peterson, Mark A. 1992. "The Presidency and Organized Interests: White House Patterns of Interest Group Liaison." *American Political Science Review* 86, no. 3: 612–25.

Peterson, Mark A. 1998. "The Politics of Health Care Policy: Overreaching in an Age of Polarization." In *The Social Divide: Political Parties and the Future of Activist Government*, edited by Margaret Weir, 181–229. Washington, DC, and New York: Brookings Institution and Russell Sage Foundation.

Peterson, Mark A. 2011. "It Was a Different Time: Obama and the Unique Opportunity for Health Care Reform." *Journal of Health Politics, Policy and Law* 36, no. 3: 429–36.

Peterson, Mark A. Forthcoming. *Hardball Politics, Hobbled Policy: Contexts, Choices, and Consequences in US Health Reform*.

Pierson, Paul. 2000. "Increasing Returns, Path Dependence, and the Study of Politics." *American Political Science Review* 94, no. 2: 251–67.

Quadagno, Jill. 2005. *One Nation, Uninsured: Why the US Has No National Health Insurance*. New York: Oxford University Press.

Quinnipiac University. 2017. "US Voters Oppose GOP Health Plan 3-1." March 23. poll.qu.edu/images/polling/us/us03232017_Ukqbwg46.pdf/.

Rovner, Julie. 1989a. "Catastrophic-Costs Dilemma Grips Ways and Means." *Congressional Quarterly Weekly Report*, July 22, 1859–61.

Rovner, Julie. 1989b. "Conferees Struggle to Finish Catastrophic-Costs Rewrite." *Congressional Quarterly Weekly Report*, November 11, 3061.

Rovner, Julie. 1995. "Congress's 'Catastrophic' Attempt to Fix Medicare." In *Intensive Care: How Congress Shapes Health Policy*, edited by Thomas E. Mann and Norman Ornstein, 145–78. Washington, DC: American Enterprise Institute and Brookings Institution.

Rutledge, Peter Bowman. 1992. "Prescription for Repeal?" Senior thesis, Department of Government, Harvard University.

Skocpol, Theda. 2010. "The Political Challenges That May Undermine Health Reform." *Health Affairs* 29, no. 7: 1288–92.

Smith, David G., and Judith G. Moore. 2008. *Medicaid Politics and Policy*. New York: Routledge.

Stafford, Dylan. 2017. "American Medical Association Joins Other Major Groups in Opposing Senate Health Bill." CNN Politics, June 26. www.cnn.com/2017/06/26/politics/ama-opposes-senate-health-bill/index.html.

Starr, Paul. 1982. *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry*. New York: Basic Books.

Steinhauer, Jennifer. 2017. "G.O.P. Health Bill Faces Revolt from Conservative Forces." *New York Times*, March 7.

Sullivan, Sean. 2013. "Ben Carson: Obamacare Worst Thing 'since Slavery.'" *Washington Post*, October 11.

Thurber, James A., and Antoine Yoshinaka, eds. 2015. *American Gridlock: The Sources, Character, and Impact of Political Polarization*. New York: Cambridge University Press.

Tumulty, Karen, and Robert Costa. 2017. "How the House Got a Health-Care Bill after Trump and Ryan Stepped Back." *Washington Post*, May 4.

Voteview.com. 2016. "The Polarization of the Congressional Parties." January 30. legacy.voteview.com/political_polarization_2015.htm.

Weaver, R. Kent. 2010. "Paths and Forks or Chutes and Ladders? Negative Feedbacks and Policy Regime Change." *Journal of Public Policy* 30, no. 2: 137–62.

Weissert, William G., and Carol S. Weissert. 2012. *Governing Health: The Politics of Health Policy*. 4th ed. Baltimore: Johns Hopkins University Press.

Wiener, Joshua M. 2013. "After CLASS: The Long-Term Care Commission's Search for a Solution." *Health Affairs* 32, no. 5: 831–34.

Wilson, James Q. 1980. "The Politics of Regulation." In *The Politics of Regulation*, edited by James Q. Wilson, 357–94. New York: Basic Books.