Diminishing Democracy in Health Policy: Partisanship, the Courts, and the End of Health Politics as We Knew It

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Abstract Despite unprecedented partisanship, the Affordable Care Act (ACA) traced a familiar political arc: a loud debate full of dramatic symbols, a messy legislative process, clashes over implementation, a slow rise in popularity, entrenchment as part of the health care system, and growing support that blocked Congress from repealing. The politics of the ACA looked, from one angle, like a louder version of health politics as usual. But something new was stirring. Opponents pushed the debate outside the elected branches of government and into the courts—a move that reflects past eras of highly racialized conflict. A federal court marked the ACA's tenth anniversary by doing what Congress could not: it struck down the law, although the litigation continues to wend its way through the court system. The ongoing challenge to the ACA rests on a fundamental critique of the entire New Deal dispensation in jurisprudence. The consequence could be a new era in health care politics.

Keywords Affordable Care Act (ACA), partisanship, politics, race and immigration, courts, political change, entrenchment, politics as usual, dramatic change

The partisan war over the Affordable Care Act (ACA) goes on and on. In December 2019, exactly nine years after Congress passed the ACA, a federal district court in Texas invalidated the law—lock, stock, and barrel. The court stayed its ruling (it did not go into effect) and an appeals court sent it back to the lower court for further consideration. But there is no precedent in post–New Deal US politics for a popular benefit program to face so much opposition—even the prospect of complete repeal—after ten years.

The explanation begins with political partisanship. The differences between the parties has reached a level last seen in the 1890s (McCarthy,

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Poole, and Rosenthal 2016: 10; Morone 2020). However, partisanship—the intense difference between political parties—only sets the parameters for the ACA's embattled history. After all, in many ways the ACA traced the standard political arc: a loud debate full of dramatic symbols, a messy legislative process, clashes over implementation, a slow increase in popularity, entrenchment as part of the health care system, and growing support that stopped Congress from repealing the program. In many ways, the politics of the ACA was simply a louder version of health politics as usual. But this time, something new was stirring.

The crucial break with the past lies in *where* the clash takes place—the *arena* of conflict and its operating rules. Since the New Deal, Congress has been the key decision maker, defining the major choices. Political scientists sometimes called it "the graveyard of health reform" (Peterson 2005). But it was axiomatic that getting a program through Congress, however difficult, was the path to reform.

Something different happened to the ACA. After they lost in Congress, the program's opponents successfully moved the debate into the courts. The courts, in turn, have begun to use the ACA to challenge the permissive jurisprudence that emerged during the New Deal. In effect, opponents have managed to continue the conflict by moving the battle out of the more popular branches of government and into the least responsive.

Right from the start the Supreme Court unexpectedly restarted the ACA debate in all 50 states by ruling that the states could decide for themselves about the Medicaid expansion (*National Federation of Independent Business* [*NFIB*] *v. Sebelius*, 567 U.S. 519 [2012]). In *Sebelius*, four conservative justices would have struck the entire law, using logic that the federal courts would return to in 2019. At the ACA's 10-year anniversary, a single justice, John Roberts, may very well hold the fate of the entire program in his hands.

The bias of the elected branches is well known: it is terrifically difficult to get redistributive social policies through (that graveyard), but once a program is implemented and takes root, it is almost as difficult to repeal. The first year of the Trump administration vividly demonstrated that old wisdom. After months of trying, a Republican-controlled Congress could not even muster 50 Senate votes for a partial repeal (which, to the right's chagrin, still would have left many features of the program intact). The elected branches are unlikely to strip health insurance from 22 million people. The courts, however, may be able to get that job done. The lurch away from democracy has a long, troubled history for, in the past, it has been the reflex against looming majority minorities—whether African Americans in the south, Irish in Boston, or Chinese in San Francisco (Morone 2020).

Consider, first, how the ACA is familiar, then to how it breaks new ground.

Politics as Usual

The Barack Obama administration came to Washington acutely aware of the lessons from past reform efforts (Oberlander 2010). The administration drew four important lessons from history.

Lessons from the Past, Intimations of the Future

First, the administration had a plan ready to go from the start. The greatest failure of the Clinton Reform effort (1993–94) had been its sluggish start—the plan did not get to Congress till the administration's second year when all eyes were on the looming midterm. The Obama team designing the ACA channeled Lyndon Johnson pushing Medicare: they moved fast (Blumenthal and Morone 2009).

Second, the different pieces of the plan were all familiar. Medicaid's patchwork coverage would be systematized to cover most people under or near the poverty line. The Health Insurance Exchanges, enabling individuals to shop for policies (along with the mandate that required health insurance coverage) were variations of Republican proposals from the 1990s, championed by John Chaffee (R-RI) and cosponsored by Senate Minority Leader Bob Dole (R-KA). The plan borrowed from the bipartisan effort enacted in Massachusetts under Republican Governor Mitt Romney (Quadagno 2011).

Third, the administration negotiated with the major stakeholder groups. In the past, health providers had been ferocious in opposition. This time, health insurers, hospitals, the pharmaceutical industry, and physician groups all came on board—or at least stayed neutral while the reform went through Congress.

Finally, under the banner of expanded access to health care, the ACA made a great many health systems reforms. Hospitals were given incentives to reduce infections, adopt electronic medical records, and reduce readmissions. The plan even included nutrition labeling requirements (Blumenthal, Abrams, and Nuzum 2015).

For everything that the plan did right, the Democrats still confronted at least two familiar burdens of health reform. The unappetizing congressional sausage factory was on full display. The US legislative process is never pretty, and the ACA offered a particularly egregious case of conflict,

bargaining, and logrolling. Conservative Democrats in the House almost derailed the reform over abortion provisions. Negotiations on the Senate Finance Committee went on and on as Democratic chair Max Baucus (D-MT) wooed Chuck Grassley (R-IA), hoping for an anomalous Republican vote or two. Distant Democratic backbenchers demanded concessions—Ben Nelson negotiated for a "Cornhusker kickback" (covering some of the state's Medicaid share, later dropped from the bill), and Joe Liberman (I-CT) blocked a public option from the legislation. All the wheeling, dealing, and grandstanding—sarcastically reported in the press—drained support (which fell, roughly, 15 points as the bill went through the process) (Kirzinger, Munana, and Brodie 2019).

As usual, the enemies of reform came up with vivid images of looming disaster. Obamacare, they said, meant a complete government takeover, socialized medicine, chaos, soaring taxes, and nothing less than bureaucratic death panels coldly meting out life and death on the basis of cost-benefit tabulations. And in the timeless tradition of health reform, stretching back to Harry Truman, proponents responded by diving into the weeds and struggling to refute vibrant memes with long, dull, policy recitations. Even the eloquent President Barack Obama gave professorial lectures about complicated details—I did a BBC interview right after one prime-time address and a crisp Oxford accent intoned over the headphones, "*What* was that man talking about?"

A shrewd observer might have noticed some new straws blowing in the political wind. In the past, the opposition had countered with alternative plans and at least pretended to debate on the merits of the policy. This time, opposition leaders bluntly announced that their goal was to defeat President Obama: "If we are able to stop Obama on this, it will be his Waterloo. It will break him" (Seelye 2009). Only senators who were planning to retire bothered to demur. Far from public view, Republican leaders had all signed the label on a bottle of expensive wine—to be opened when they retook Congress. Even more important, the Tea Party erupted from the grass roots, flooded town hall meetings, and noisily confronted wavering legislators. Chuck Grassley took one look and stunned his Democratic colleagues by repeating the death panel meme (Morone 2016). Still, the Democrats had the shaky votes and pushed the reform through.

Entrenchment

Political scientists had long summed the old pattern: policy makes politics. Once a plan goes into effect, it develops a network of supporters who fight

for their benefits. Moreover, the program becomes part of the infrastructure and grows increasingly difficult to unravel. The ACA quickly extended health insurance to more than 20 million people. In many states, the Medicaid expansion became a vital feature of hospital finance. Insurance companies began to premise their business models on participation in the ACA. The conventional wisdom seemed to apply: To kill programs, strangle them while they're still in the cradle. After that, they grow too entrenched to eliminate (Starr 2019).

The conventional wisdom was difficult to see in the first years of the program. Early implementation was a disaster. The websites repeatedly crashed—the administration blamed high volume (California alone saw 1.7 million hits) as people rushed to shop for the insurance. The news media, however, reported that the problem lay in glitches that technicians had long been warning about (NBC Nightly News 2014). Only 13 states managed to put together their own marketplaces (6 more built theirs on a federal platform). The Republican attacks—from both leaders and the grass roots—were withering. And, before the program was in place, the Republicans retook the House and blocked the needed patches and fixes—instead voting to repeal the law, again and again. There were problems, too, in the insurance products. In the first years, the average number of insurers per state fell—from 6 in 2016 to 3.5 in 2018 (Fehr, Kamal, and Cox 2019). And many plans included high premiums and high coinsurance (especially for anxious individuals who did not fully appreciate that they would be receiving refunds). Meanwhile, state take-up of the Medicaid expansion proved both slow and tumultuous.

For all that, the ACA began to sink roots. The number of people without insurance tumbled from 46.5 million (17.8% of the nonelderly population) in 2010 to 26 million (10% of the nonelderly) in 2016 (Garfield, Ortega, and Damico 2019). By 2017, states that expanded Medicaid averaged 8.7% uninsured across the total population, states that did not expand averaged 18.2% (Keith 2018). By 2016, 20 million people had health insurance under the ACA, with the largest rise among poor and near poor; the impact was especially large among Hispanic (a 10.9% drop in uninsured), Asian (8.6%), and black (8.2%) populations (Garfield, Ortega, and Damico 2019).

The Trump administration, elected in 2016, went all out to sink the ACA, both by administrative action and congressional effort. It stopped paying reimbursement to insurers for cost-sharing reductions (for deductibles, and so on); it pressed Congress to cut out the penalty for not buying insurance; it cut back on publicity for the open enrollment periods; and the list of

executive efforts to hobble through goes on. At the program's 10-year anniversary, the surprise to most observers was the hardiness of the insurance exchanges. The number of insurers per state bottomed out and started rising—from an average of 3.5 (in 2018) to 4 (2019) and 4.5 (in 2020). New firms went all in on the exchanges. Some of the lost revenues from the supports to insurers were made up for by premium supports to individuals (it is not clear that the federal government ended up saving the money as cuts in payments to insurers were offset by increased payments to individuals) and, even so, in 2020 the average insurance premium slipped. Of course, it's still early in the war, but the results suggest surprising resilience. As usual.

Public opinion reflected the program's sturdiness. For a long time, proponents had ruefully noted that almost every component of the program polled well (excepting the insurance mandate) even while the program itself did not. However, by the 10-year anniversary the approval rating had reached its all-time high: 52% for vs. 37% against—quite impressive marks in such partisan times (Kirzinger, Munana, and Brodie 2019; KFF 2020).

When President Trump pushed Congress to repeal and replace, they could not get the job done. Amid furious criticism from the Right for leaving too much of the program intact, Republicans in the Senate blocked even a partial repeal, voting down three different approaches. Republicans from states that had expanded Medicaid lobbied intensely for their program. Health providers rallied with support. And, predictably, asking Congress to push 20 million people back into the ranks of the uninsured was simply a political bridge too far to cross.

In short, what we have is a textbook case of the old axiom, policy makes politics. The reform went into place, it provided benefits, developed constituents, organized a public health infrastructure, and grew increasingly popular. Four years after implementation, a very conservative administration enjoyed unified Republican control in Washington. And yet, despite having repealed the program more than 50 times as a symbolic gesture (when President Barack Obama was in the White House to veto the effort), the Republican majority declined to repeal it for real.

The traditional story ends here. Congress failed to repeal. Democrats seized the health issue and took back the House in 2018. Opponents lost their last real chance back in 2012, when President Obama won reelection just before the ACA went live. All precisely what political science would predict . . . except for one thing. The opponents went to court. And the courts kept the politics of the ACA roiling on both the state and the national level.

The Courts and the Looming Health Politics Dispensation

Modern health care politics begins with President Harry Truman's ambitious 1945 health message to Congress. Truman laid out a vast agenda ranging from national health insurance to hospital construction and from cost control to public health (Blumenthal and Morone 2009). It is only a slight exaggeration to say reformers are still reading Truman's roadmap. The next 75 years offered an immense number of health policies and, for political scientists, a rich sample from which to build generalizations about health politics and policy.

Modern Health Politics: 1945–2012

The 1945 watershed was enabled by a Supreme Court decision eight years earlier. In *National Labor Relations Board v. Jones and Laughlin Steel Corporation*, the court reversed a doctrine that forcefully limited social policies. Known as "the *Lochner* era," the court repeatedly rejected economic and social reforms that interfered with the freedom of contract (the stance is named after *Lochner v. New York*, which in 1905 struck down New York legislation limiting bakery employees to a 60-hour week). In dissenting from *Lochner*, Justice Oliver Wendell Homes charged the court's doctrine with "enact[ing] Mr. Herbert Spencer's social statistics"—the survival of the fittest. The court struck down New Deal programs, one after another, until (under pressure from President Franklin Roosevelt's court packing scheme) the court reversed itself and opened the door to what conservatives would later call "big government." With a new expansive view of the interstate commerce powers, the federal government legislated far and wide. And, even during the Franklin Roosevelt administration, officials began to push hard for adding national health insurance to Social Security—a cause that Truman inherited and pushed with terrific passion (Blumenthal and Morone 2009).

The new era of active government was quietly backed by the most liberal court in US history. Democrats were in power for seven presidential terms, interrupted only by Dwight Eisenhower, who represented the liberal wing of the Republican party and named two of the most progressive judges of all—Earl Warren and Walter Brennan. Health policy specialists, looking back at midcentury politics now take the court's acquiescence for granted. But the court's new and expansive view of the interstate commerce clause—of congressional powers to regulate civil rights and social policy—was a silent policy choice that enabled the New Deal (under Roosevelt), the Fair Deal (Truman), and the Great Society (Lyndon Johnson).

Over time, a rising generation of conservatives, led by the Federalist Society, called for a return to the *Lochner* era. They had watched small-government conservatives struggle in Congress and the executive branch for eighty years—and, as they saw it, there was little to show for the trouble. Slowly, over decades, they proselytized for a radical change in jurisprudence: a return to the *Lochner* era. If they could restore the doctrine that had once blocked the New Deal, they could turn the Constitution itself into a weapon in the battle over public policy.

With terrific efficiency, conservatives stocked the federal bench. The Republicans blocked Democratic appointments (most famously Merrick Garland, whom Obama selected to replace Antonin Scalia). In the first three years of the Trump administration, the Senate confirmed 193 federal judges—a much faster pace than the Obama administration had managed (with 323 judges in eight years). The Republicans aimed to transform the judicial system—from the high court on down.

The scholarly assumptions about health care politics—the familiar lessons from the past—were built on decades of observation during the era of permissive courts. Congress would not withdraw benefits once they grew entrenched and popular. The executive branch would tinker with the rules but not fundamentally rewrite existing programs. The first years of the Trump era seemed, once again, to validate the old wisdom. But all those lessons were drawn during an era when courts permitted active social policies in both Washington and the states. It may be that health reformers in the future will face something they have not seen since the 1930s: The reversion of the courts to the hard Right—where they have been through most of US history.

In any case, the continued conflict over the ACA 10 years after passage is largely a creation of the courts themselves. It's the increasingly conservative courts that enabled the conflict to go on, spread it to the states, and now threaten to strike down the entire ACA.

Sebelius: Two Sticks of Legal Dynamite

This judicial history forms the crucial background for the blockbuster 2012 Supreme Court ACA decision. The ruling in *NFIB v. Sebelius* included two different sticks of legal dynamite (Morone 2012).

First, the court blocked the ACA's provision that required states to expand their patchwork Medicaid programs to cover all citizens up to 138% of the federal poverty line. In writing the program, reformers took for granted that Congress had the authority to legislate Medicaid regulations;

states, for their part, could choose whether to participate in the federal program in the first place—Medicaid was a voluntary program. The ACA covered 90% of the costs of the new enrollees—a far more generous formula than traditional Medicaid, which, by statute, paid between 50% and 83%. Nevertheless, in *Sebelius* the court ruled that the Medicaid changes in the ACA were "coercive" toward the states. For the first time, the court blocked congressional authority to spend on health care and limited congressional authority to regulate the federal dollars it sent to the states. Adam Liptak, the *New York Times* law correspondent, called the ruling "the most significant federalism decision since the New Deal" (Liptak 2012) and Medicaid scholars called it an "unprecedented . . . move that shocked almost everyone" (Rosenbaum and Westmoreland, 2012). The decision raised formidable questions: What other health programs or Medicaid provisions might be considered "coercive" toward the states? Didn't the original Medicare and Medicaid programs similarly "coerce" the states? After all, Medicare had required states to desegregate hospitals before being certified for the program.

The decision sent the partisan warfare over the ACA straight to the state capitals as each state debated whether to opt into the Medicaid expansion. It became commonplace to observe how far the fierce health care partisanship extended—from Maine to Florida and from Arizona to Alaska. But it was the bold court decision that enabled—really, required—the debate in the first place. Consider the counterfactual. Most court observers had expected the court to permit the Medicaid expansion. Policy would have made politics: Medicaid would have expanded in every state and the ACA would have quickly grown entrenched in the health policy infrastructure—strongly defended by the health care industry as it grew reliant on the funding. Angry speeches would have rung in the state assemblies as new rules quietly implemented the expansion. The court ruling might have enhanced democracy—permitting each state its own debate. But it upended an assumption of the last 70 years: health care benefits could be legislated by a national majority, regardless of the feelings in a particular state.

Second, the headlines focused on the Supreme Court's decision to save the health care marketplace, but it did so in a way that challenged a major prop of traditional liberal social policy: the interstate commerce clause of the federal Constitution, which had been the workhorse of expanded congressional authority. For example, when Congress passed the Civil Rights Act of 1964, it relied on its interstate commerce powers. Even an Alabama barbecue shack with a local clientele could not discriminate

against African Americans since it served food that came from out of state (Morone 2012). In *Sebelius*, Chief Justice Roberts backed away from the expansive reading of the commerce clause. The Constitution did not permit Congress to rely on interstate commerce and require citizens to purchase health insurance. The ruling appeared to diminish Congressional authority over health care. Again, the decision immediately raised big questions: How far would the conservative court majority go in limiting congressional authority under interstate commerce (and, relatedly, the Constitution's "necessary and proper" clause)? What scope would it permit for social policy? And, most fundamentally, how much further would conservatives manage to get in their desire to get back to the *Lochner* era?

Such questions were obscured by the immediate effect. In an apparent last-minute change of mind, Justice Roberts ruled that, regardless of Democratic rhetoric, the insurance mandate was in reality a tax and, therefore, permissible under the congressional authority to levy taxes. In 2017, as part of its tax cut legislation Congress repealed the insurance mandate—now, the tax argument no longer existed. That might have appeared trivial; after all, the court used the "it's really a tax" argument to uphold the mandate that Congress had now repealed. But 18 state attorneys general trooped back to court arguing that the mandate lay at the heart of the ACA and, with it gone, the entire law should fall. At the center of the case lay the issue of "severability"—whether the mandate could be "severed" from the rest of the ACA. "Of course it can," responded liberal bloggers, Congress had "severed" when it voted to repeal the mandate while it refused to repeal the ACA (Li 2019). Not so fast, responded the Fifth Circuit, in *Texas v. Azar*, and struck down the entire ACA.

Back when the court ruled on *Sebelius*, four conservative justices were adamant that the insurance mandate and the rest of the ACA were not "severable." If the mandate did not stand, the whole thing had to go. The case is now wending its way toward still another rendezvous with the Supreme Court. Four justices on the high bench have expressly supported precisely the logic that led the circuit court to strike down the act. On the 10th anniversary of Obamacare, the entire act, and the health care coverage of more than 20 million Americans, may rest on the judicial reasoning of a single individual, Chief Justice Roberts.

In short, political science logic easily applies to Congress: programs that are entrenched and covering millions are safe from repeal. Sure enough, even conservative Republican majorities refused to repeal despite entreaties and tweet storms from President Trump. The rising new conservative courts

open up a new venue for health care debates—and put both the old wisdom and the ACA on perilous ground.

The Racialized Regime

At every turn the partisan battle over the ACA taps the most powerful currents running through US history—race and immigration (Tesler 2012; Morone 2016). Take Medicaid expansion. There are 14 states that have made no move to expand; 11 were slave states at the start of the Civil War. In those states, centuries of white supremacy politics filter into every social policy debate. More generally, the endless ACA battle reflects the racial conflicts and anxieties (Tesler 2012).

Meanwhile, high passion about immigration led Congressman Joe Wilson to shout, "You lie" at President Obama on national television (and rake in $2 million in campaign contributions the following week). The immigration issue took its contemporary form (and sides) during the 1996 welfare reforms, which left even legal immigrants ineligible for health programs (for 5 years). In 2019, the Trump administration heaped on still another immigrant limitation tied to health care. A new rule would deny immigrants entry if they failed to prove that they could secure health insurance within a month (Cooke and Rosenberg 2019).

Social scientists have demonstrated the rising racial anxiety—pumped up by both President Trump's rhetoric and by fears of a rising majority minority. The tensions are exacerbated because, for the first time in US history, liberals on both immigration and civil rights are in one party, nativists and racially anxious white people in the other. Majority minority sounds, to the anxious, like majority Democratic (or the Republican nightmare—just like California) (Morone 2020).

This is not to suggest a simple relationship between racial anxiety and health policy. Rather, the new partisan divide—again, with African Americans and recent immigrants overwhelmingly in one party, white nativists in the other—gives tribal intensity to policy differences. Debates about programs and policies slip into fears about us and them.

The consequences go deeper than one administration, one congressional session, or any one policy. Rather, they lead people anxious about their racial status to do what local areas that confronted rising facing majority minorities have done throughout US history: Put politics—especially social benefits—beyond the reach of "those dangerous people" by pulling back on democracy itself. That reflex lends force to conservative court doctrines which, in turn, render the ACA still vulnerable—despite its rising popularity—10 years after President Obama signed the ACA into law.

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References

Blumenthal, David, Melinda Abrams, and Rachel Nuzum. 2015. "The Affordable Care Act at Five Years." *New England Journal of Medicine* 372: 2451–58. doi: 10.1056/NEJMhpr1503614.

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

Cooke, Kristin, and Misa Rosenberg, 2019. "Trump Rule on Health Insurance Leaves Immigrants, Companies Scrambling." *Reuters*, October 19. www.reuters.com/article/us-usa-immigration-insurance/trump-rule-on-health-insurance-leaves-immigrants-companies-scrambling-for-answers-idUSKBN1XA1G6.

Fehr, Rachel, Rabah Kamal, and Cynthia Cox. 2019. "Insurer Participation in the ACA Marketplaces." Kaiser Family Foundation, November 21. www.kff.org/private-insurance/issue-brief/insurer-participation-on-aca-marketplaces-2014-2020/.

Garfield, Rachel, Kendal Orgera, and Antony Damico. 2019. "The Uninsured and the ACA: A Primer—Key Facts about Health Insurance and the Uninsured amidst Changes to the Affordable Care Act." Kaiser Family Foundation, January 25. www.kff.org/report-section/the-uninsured-and-the-aca-a-primer-key-facts-about-health-insurance-and-the-uninsured-amidst-changes-to-the-affordable-care-act-how-many-people-are-uninsured/.

Keith, Katie. 2018. "Two New Federal Surveys Show Stable Uninsured Rate." *Health Affairs*, September 3. www.healthaffairs.org/do/10.1377/hblog20180913.896261/full/.

KFF (Kaiser Family Foundation). 2020. "Health Tracking Poll." February 21. www.kff.org/interactive/kff-health-tracking-poll-the-publics-views-on-the-aca/#?response=Favorable—Unfavorable&aRange=twoYear. (accessed February 24, 2020).

Kirzinger, Ashley, Cailey Munana, and Mollyann Brodie. 2019. "Six Charts about Public Opinion on the Affordable Care Act." Kaiser Family Foundation, November 27. www.kff.org/health-reform/poll-finding/6-charts-about-public-opinion-on-the-affordable-care-act/.

Li, Jhou. 2019. "The Latest Legal Challenge to the Affordable Care Act, Explained." *Vox*, July 10. www.vox.com/policy-and-politics/2019/7/9/20686224/affordable-care-act-constitutional-lawsuit-fifth-circuit-court-texas-district-court.

Liptak, Adam. 2012. "Supreme Court Upholds Health Care Law, 5-4, in Victory for Obama." *New York Times*, June 28. www.nytimes.com/2012/06/29/us/supreme-court-lets-health-law-largely-stand.html?_r=2&pagewanted=all.

McCarthy, Nolan, Keith Poole, and Howard Rosenthal. 2016. *Polarized America: The Dance of Ideology and Unequal Riches*. Cambridge, MA: MIT Press.

Morone, James A. 2012. "Seven Consequences of the Health Care Ruling." *New York Times*, June 28. campaignstops.blogs.nytimes.com/2012/06/28/seven-consequences-of-the-health-care-ruling/.

Morone, James A. 2016. "Partisanship, Dysfunction, and Racial Rears: The New Normal in Health Care Policy." *Journal of Health Politics, Policy and Law* 41, no. 4: 827–46.

Morone, James A. 2020. *Republic of Wrath: How American Politics Turned Tribal from Washington to Trump.* New York: Basic Books.

NBC Nightly News. "Obamacare Website Fails as Deadline Arrives." March 31. www.nbcnews.com/storyline/obamacare-deadline/obamacare-website-fails-deadline-arrives-n67666.

Oberlander, Jon. 2010. "Long Time Coming: Why Health Reform Finally Passed." *Health Affairs* 29, no. 6. doi.org/10.1377/hlthaff.2010.0447.

Peterson, Mark A. 2005. "Health Reform and the Congressional Graveyard." In *Healthy, Wealthy, and Fair: Health Care and the Good Society*, edited by James A. Morone and Lawrence R. Jacobs, 205–34. New York: Oxford University Press.

Quadagno, Jill. 2011. "Interest Group Influence on the Patient Protection and Affordability Act of 2010: Winners and Losers in the Health Care Reform Debate." *Journal of Health Politics, Policy and Law* 36, no. 3: 449–54.

Rosenbaum, Sara, and Timothy Westmoreland. 2012. "The Supreme Court's Surprising Decision on the Medicaid Expansion: How Will the Federal Government and the States Proceed?" *Health Affairs* 31, no. 8. www.healthaffairs.org/doi/full/10.1377/hlthaff.2012.0766.

Seelye, Katharine. 2009. "Fighting Health Care Overhaul and Proud of It." *New York Times,* August 30. www.nytimes.com/2009/08/31/us/politics/31demint.html.

Starr, Paul. 2019. *Entrenchment*. New Haven, CT: Yale University Press.

Tesler, Michael. 2012. "The Spillover of Racialization into Health Care: How President Obama Polarized Public Opinion by Racial Attitudes and Race." *American Journal of Political Science* 53, no. 3: 690–704.