Health Care Reform at the State and National Level

Implementing the Affordable Care Act: The Promise and Limits of Health Care Reform

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Abstract The Obama administration has confronted a formidable array of obstacles in implementing the Affordable Care Act (ACA). The ACA has overcome those obstacles to substantially expand access to health insurance, though significant problems with its approach have emerged. What does the ACA's performance to date tell us about the possibilities and limits of health care reform in the United States? I identify key challenges in ACA implementation—the inherently disruptive nature of reform, partisan polarization, the limits of "near universal" coverage, complexity, and divided public opinion—and analyze how these issues have shaped its evolution. The article concludes by exploring the political and policy challenges that lie ahead for the ACA.

Keywords Affordable Care Act, Obamacare, health reform implementation

Passage of the 2010 Patient Protection and Affordable Care Act (ACA) was a remarkable political feat. The Obama administration and congressional Democrats beat the odds, reversing a long record of disappointment and failure in health reform. They surmounted multiple hurdles that easily could have tripped up reformers once again, the most treacherous being the loss of a filibuster-proof Senate supermajority following Ted Kennedy's death and Scott Brown's subsequent election (Brown 2011; Cohn 2010; Jacobs and Skocpol 2010; McDonough 2011).

Yet if the ACA's enactment proved that substantial health reform was indeed possible to legislate in the United States, the past six years have demonstrated how difficult it is to implement such reform. The Obama administration and its allies have faced a formidable array of implementation

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challenges: establishing myriad new institutions, promulgating and enforcing numerous regulations, getting a complicated insurance enrollment system up and running across the country, educating tens of millions of potential enrollees about the law's benefits, and initiating a plethora of experiments in payment and delivery system reform. Moreover, implementation also has (or in some cases, should have) entailed efforts to build a political constituency for the ACA, reassure a confused and anxious public about Obamacare's impact, and persuade reluctant and sometimes hostile state policy makers to participate in the reform project.

How has the Obama administration fared in meeting these challenges? What does the ACA's performance to date tell us about the promise and limits of health care reform? And how might the ACA's trajectory change in coming years? David Mechanic (1994: 44) noted long ago that "it is far too easy to construct a utopian health care system that has no possibility of implementation." The ACA offers a window into the real world of implementation. Because the law aims to do many things—expand access to health coverage, control health care spending, transform medical care payment and delivery, and more—it is impossible to cover all of those policy domains in this space. I focus here on the challenges associated with the ACA's efforts to increase access to health insurance and on the political dynamics that have shaped its implementation.

Transformative Incrementalism

The ACA reflected a political theory of health reform that illuminates much about its postenactment achievements and tribulations. Democrats' autopsy on the Clinton administration's disastrous 1993–94 health reform campaign concluded that it died in part due to an excessively ambitious plan. It alienated already insured, middle-class Americans who worried that reform would worsen their access to medical care and health system stakeholders who feared that the plan would hurt them financially. Public support for the Clinton plan plummeted, and it attracted only tepid backing from congressional Democrats while drawing intense Republican opposition (Hacker 1996; Johnson and Broder 1997; Skocpol 1996).

The Clinton plan's demise seared a number of lessons in Democrats and reformers' collective consciousness that the Obama administration and Congress would apply during 2009–10 (Hacker 2011; Oberlander 2010). Among them was the prime directive of health reform: do not disturb the existing insurance system and the already insured. Most Americans were insured, liked their current arrangements, and presumably wanted to keep their plans. Moreover, various formidable interests—insurers, employers,

the medical care industry, and states—were invested in the prevailing order. The further a reform plan departed from the status quo, according to this perspective, the more it risked losing support from the public and stakeholders. It mattered not that this (non)system was inefficient, inequitable, and irrational, comprising a patchwork of insurance plans that determined eligibility on the basis of age, occupation, and, as Medicare's universal coverage of end-stage kidney disease embodied, even the health of particular organs. Politics dictated building on the status quo and reassuring the insured. Massachusetts's 2006 health care law, which passed with strong bipartisan support, appeared to offer confirmatory evidence for this approach (McDonough 2011).

Obamacare thus began with the proposition that substantial reform legislation could become law only if it left as much of existing arrangements in place as possible. The ACA retained the three long-standing major foundations of insurance in the United States—employer-sponsored coverage, Medicare, and Medicaid (Hacker 2011; Jost 2014a; Starr 2011; Tuohy 2011). Most Americans were expected to keep their health plans after the ACA's onset. The uninsured were to be covered through expansions of familiar institutions, Medicaid and private insurance, though the establishment of health insurance exchanges did represent a key innovation.

The ACA is an ambitious law. The regulation of private insurance, establishment of subsides for the uninsured to buy coverage through new purchasing pools, expansion of Medicaid, requirements on employers to offer and individuals to obtain insurance, introduction of delivery and payment system changes, and much more mark the ACA as transformative public policy. But the way that the ACA seeks to expand insurance coverage is incremental. The ACA does not create a new health insurance model so much as it patches the existing patchwork system (Marmor and Oberlander 2011; Tuohy 2011).

Implementing Disruption

Judged by the outcome of the 2009–10 health care debate, the political theory of transformative incrementalism was a resounding success. Less was indeed more, as the Obama administration avoided fighting a multifront war against the health care industry and enough Democrats in the House and Senate held together to pass landmark legislation (notably, though, the administration did not win the public opinion battle despite reformers' concerted efforts to assuage the insured). However, the ACA's implementation has underscored the limits of building on the status quo.

Health care reform is inherently disruptive (Feder 2014). Real reform measures make changes and alter current arrangements; that, after all, is the point of reform. If the status quo ante worked well, it wouldn't require change.

The Obama administration tried to minimize disruption by leaving most Americans in place, as reflected in President Barack Obama's promise that "if you like your plan, you can keep it" (Feder 2014). The president's line echoed the message emphasized by pro-reform pollsters that such an assurance would give Americans "peace of mind" (Lake Research Partners and the Herndon Alliance 2009). The problem is that minimal disruption is not the same as no disruption. The ACA actually did not promise to preserve plans on the nongroup market that were altered or purchased after 2010. Yet the fate of persons who already had coverage on the individual insurance market did not garner much attention during the 2009–10 health care debate, perhaps because that market encompassed only about 5 percent of Americans. Many health policy analysts viewed the nongroup market as highly dysfunctional, administratively expensive, unfair to persons with preexisting conditions, replete with inadequate "bare bones" plans, and unstable, with most persons who purchased such policies no longer in them after two years (Sommers 2014). Because of those problems, the ACA always intended to radically overhaul the individual market. Indeed, a central rationale for reform was the inability of the uninsured to obtain affordable coverage through this market.

However, a component of the insurance system that encompasses only 5 percent of the US population still amounts to about 15 million persons. Some of those persons had individually purchased policies that offered comprehensive benefits at reasonable costs, and they liked their plans. Others had limited coverage full of benefit holes but did not understand well those limits. Consequently, when insurers announced in the fall of 2013 that they were canceling several million individual policies in response to the ACA's new benefit and rating requirements, it created a political firestorm (Clemans-Cope and Anderson 2015; Jost 2014a). The president's promise that Americans could keep their health plans was broken.

In a political system that rewarded honesty, Obama could have explained during 2009–10 that no health reform can guarantee that literally all Americans keep their current plans. The pre-ACA status quo in fact guaranteed that many persons would be forced to change plans or lose coverage altogether. He could have further noted that the real test of reform is not whether everyone stays in their plan or all Americans pay less, have

better coverage, and believe they are better off—tests any reform proposal would inevitably fail—but how many Americans would be better off under reform relative to those who have to pay more or involuntarily switch plans. He could have emphasized that the vast majority of persons would remain in their plans after the ACA's implementation. Our electoral system, though, does not reward nuance or forthrightness. Policy makers trying to secure the passage of controversial legislation have strong political incentives to downplay the costs and redistributive implications of their reform, while talking up its benefits (Oberlander and Weaver 2015).

The firestorm over insurance cancellations—seized on and amplified by ACA critics—eventually forced the Obama administration to backtrack as states were given the authority to decide whether to permit such plans to continue until 2014 (a transitional reprieve later extended to 2017). By the fall of 2014, forty states had adopted measures to enable renewal of noncompliant plans on the individual and small group markets (Luca, Corlette, and Williams 2014). Cancellations in 2014 were far less numerous than in 2013 (Clemans-Cope and Anderson 2015). But the political damage had already been done. The episode highlighted how difficult it is to reorder even the smallest slice of the US insurance system. It also demonstrated why politicians have an incentive to oversell health reform's adherence to the status quo—and the political risks of doing so.

Partisan Divide

The ACA passed on partisan lines, with no Republicans voting for the final bill. Still, Democrats had reason to believe that the ACA could broaden its political base over time. Medicare, too, had been controversial and partisan before the program's enactment, after which the GOP quickly accommodated to its popularity among beneficiaries and the wider public. Notwithstanding the rhetoric about a "government takeover" of the health care system, the ACA contained many elements that were in theory palatable to the Republicans and had in fact been part of prior GOP health plans: reliance on private insurance, an individual mandate, consumer choice and competition, health insurance purchasing pools, and a major role for states (Quadagno 2014). Those elements failed to attract any Republican congressional support for the ACA during 2009–10. ACA supporters were nonetheless hopeful that as the law's benefits took hold and the heated rhetoric subsided, the GOP would accept that Obamacare was here to stay. Moreover, Republican-led states whose governors and legislatures were enamored with the prospect of federal dollars might take a more pragmatic view and rediscover the law's conservative virtues.

Yet six years after the ACA's enactment, the partisan fight over health reform raged on, in Congress, state legislatures, and the courts. From the beginning, the ACA's path to potential postenactment bipartisanship got off to a rocky start as twenty-six states joined a lawsuit challenging its constitutionality. The law's reliance on states for implementation backfired as Republicans and conservative groups who had not been able to stop the ACA's passage through Congress now had the opportunity to open up additional fronts of resistance across the country (Starr 2011).

Partisanship in the politics of ACA implementation emerged unexpectedly in the major policies designed to expand coverage to the uninsured: health insurance exchanges and Medicaid expansion. Initially, all states took federal grants to establish exchanges, which enjoyed strong public support and had been featured in Republican health plans (Jones, Bradley, and Oberlander 2014). However, resistance to taking federal funds for Obamacare grew among Republicans after the 2010 elections, which produced sizable GOP gains in both states and Congress, and the rise of the Tea Party (Jost 2014a). Exchanges became so politically fraught—back in 2010 few had anticipated this level of state resistance—that the Obama administration renamed them "marketplaces," which failed to quell controversy. In the end, only seventeen states and the District of Columbia established their own health insurance exchanges prior to the ACA's inaugural 2013 enrollment period, leaving the federal government to operate the exchanges across most of the country. Exchange politics were largely though not exclusively partisan. In the thirty states with Republican governors, only four created exchanges (Jones, Bradley, and Oberlander 2014).

Undermining the ACA by refusing to set up exchanges appeared to be a futile strategy: it gave liberals what they had wanted in the first place, federal control over insurance marketplaces, without seriously damaging Obamacare. The strategy seemed prescient, though, when the Obama administration oversaw an abysmal rollout of HealthCare.gov—the online enrollment platform to obtain coverage in states without their own exchanges. The juxtaposition of HealthCare.gov's troubled start that prevented Americans who wanted insurance from obtaining it with individual insurance policy cancellations that caused some persons who wanted to keep their coverage to lose it was an extraordinarily bad (albeit short-lived) moment for the Obama administration. States' refusal to cooperate with Washington ended up magnifying the consequences of an implementation fiasco that enhanced Washington's reputation for incompetence, raised serious questions about the federal government's administrative capacity, damaged public perception of the law, and temporarily stunted ACA

enrollment in many states. Furthermore, the subsequent emergence of a serious legal challenge to the availability of health insurance subsidies in states with federally facilitated marketplaces unexpectedly offered opponents the prospect of dealing a more grievous blow to exchange enrollment and the ACA's insurance expansion.

As states resisted creating health insurance marketplaces, Medicaid became another focus of opposition. The 2012 Supreme Court ruling upholding the constitutionality of the individual mandate also effectively made Medicaid expansion optional for states. Still, Medicaid already operated in all fifty states, meaning that unlike with exchanges, no accommodation with a new institution was required. The lure of substantial federal money (with Washington initially paying 100 percent of the costs for new Medicaid eligibles, before phasing down to 90 percent in perpetuity), as well as political pressure from a hospital industry with a strong financial stake in reducing uncompensated care was widely expected to persuade state policy makers to accede to its expansion.

There has in fact been more bipartisanship on Medicaid than on insurance marketplaces, perhaps because states stand to gain (and lose) much more money from expanding Medicaid than from establishing exchanges. It is one thing to mount symbolic opposition to Obamacare; it is something else to oppose it in a way that deprives a state of considerable resources. As of February 2016, thirty-one states and the District of Columbia had expanded Medicaid, including ten states led by GOP governors (KFF 2016a; Rose 2015). But of the nineteen states that have so far declined to expand, eighteen have Republican governors and the other has a GOP-majority legislature. The prospect of losing federal funds, hurting hospital finances, inhibiting the economy, and depriving low-income residents of insurance coverage has not been enough to convince those resisting states to relent. Even the Obama administration's flexibility on Medicaid expansion models—allowing states to use the funds to instead expand private coverage through the insurance exchanges (Arkansas) or impose cost sharing on Medicaid enrollees (Iowa and Pennsylvania)—has persuaded only a handful of additional states to go along.

State resistance to insurance exchanges and Medicaid expansion has created a variable implementation reality. Some Americans live in states that have embraced the ACA and promoted enrollment in Medicaid and the health insurance marketplaces (though some states have struggled to operate their own marketplaces). Others live in states that are double rejecters and have done nothing to encourage enrollment, complicating the Obama administration's and reformers' efforts to reach the uninsured. Such

conditions have given rise to nongovernmental actors like Enroll America that seek to fill that outreach void.

Meanwhile, at the federal level the ACA has not followed Medicare's inviting script of postenactment political gains. Congressional Republicans have hardly come to accept Obamacare, voting repeatedly for its repeal. The GOP additionally has refused to participate in nominating members to the Independent Payment Advisory Board (IPAB) that was to help restrain Medicare spending, effectively blocking its launch (the Obama administration has not moved to implement IPAB, but one major reason for that inaction is Republican resistance). The GOP also has supported multiple efforts to unravel the law through the courts. The constitutional challenge to the individual mandate (*National Federation of Independent Business v. Sebelius*) was nearly fatal to the ACA, and the Supreme Court's accompanying Medicaid expansion decision blew a sizable hole in the law's coverage strategy. The challenge to the legality of the federal government providing tax credits to the uninsured in states that did not set up their own health insurance exchange (*King v. Burwell*) went further than most observers expected, imperiling coverage gains in nearly three dozen states before the Supreme Court sided with the Obama administration in upholding the subsidies (Bagley 2015). House Republicans additionally filed suit against the president (*House v. Burwell*) for exceeding his executive authority in delaying the ACA's employer mandate provisions and providing funds to insurance companies to pay for cost-sharing reductions for lower-income persons enrolled in exchange plans (Jost 2016). If the courts rule Congress did not authorize such payments, then insurers "either will have to cease covering marketplace enrollees or dramatically increase premiums across the individual market" (Jost 2016: 7). Even after the administration's victory in *King v. Burwell* had evidently ended the legal threats to Obamacare, court battles continued. The ACA has proved more vulnerable to legal challenges than its supporters anticipated as the courts effectively became another front in partisan struggles over health reform.

The depth and persistence of partisan resistance to the ACA is extraordinary, all the more so given just how conservative and limited Obamacare is in many respects. It is, after all, essentially the same health care model that a Republican governor, Mitt Romney, agreed to in 2006, one that rests on private insurance, competition, and federalism. Massachusetts, where reform enjoyed broad bipartisan support, proved to be a poor predictor of the political controversy that followed that model both in other states and Washington.

That Republican opposition to the ACA continues over six years after its enactment has less to do with the law itself than with broader patterns in American politics. We live in an era of historic and rising levels of partisan polarization between Democrats and Republicans in Congress, polarization that is increasing as well at the state level (McCarty, Poole, and Rosenthal 2006; Shor and McCarty 2011). Such polarization has been driven largely by a rightward ideological turn among Republican lawmakers as well as by intense competition between the two parties in a closely contested electoral context (Lee 2009). The ACA, then, was enacted and is being implemented in a strongly partisan and ideologically divisive atmosphere. It is no wonder that the law has yet to achieve a sure political foothold.

The prolonged partisan fight over the ACA is not just evident in electoral politics, court cases, or efforts by congressional Republicans to defund the law. Partisanship has prevented reformers from remedying the ACA's shortcomings and addressing implementation problems. A less polarized Congress could have agreed to pass legislation clarifying that premium tax credits were indeed available to the uninsured in federally facilitated marketplaces. It could have explicitly authorized funds for the law's cost-sharing subsidies that make medical care affordable for low-income persons. It could have addressed the staggering inequity that, in states that have rejected Medicaid expansion, several million low-income Americans lack any viable insurance option. It could have fixed the "family glitch" that is depriving many Americans of affordable insurance options (more on that later). And it could have possibly agreed on an alternative to the law's unwieldy employer mandate that is increasingly out of favor even among ACA supporters (Blumberg, Holahan, and Buettgens 2014). But none of this has happened. The partisan divide has made ACA politics an all or nothing, existential affair. Consequently, sensible reforms of and significant revisions to the ACA await a more conducive political climate.

Near (or Not So Near) Universal Coverage

Despite partisan resistance and contested implementation, the ACA has already reduced the uninsured population substantially, with additional gains expected in coming years. A range of different surveys all have found a sizable increase in persons having health insurance since full implementation of the ACA's coverage provisions (Blumenthal, Abrams, and Nuzum 2015). The Urban Institute reports that "fifteen million nonelderly adults gained coverage between September 2013 and March 2015 as the uninsurance rate fell from 17.6 percent to 10.1 percent" (Long et al. 2015).

The Centers for Disease Control and Prevention's (CDC) National Health Interview Survey similarly found that between January and March 2015, the uninsured rate for all ages at the time of interview stood at 9.2 percent, down from 14.4 percent in 2013 (Cohen and Martinez 2015). Between 2010 and 2015, the CDC estimates that the number of persons without health insurance declined from 48.6 million to 28.8 million (Martinez, Cohen, and Zammitti 2016). While ACA provisions certainly have played a major role in reducing the uninsured rate, other factors such as the business cycle and improving economy also may have affected coverage (Long et al. 2015).

By February 2016, 12.7 million Americans had signed up for or reenrolled in health plans through the ACA's insurance marketplaces (Levitt et al. 2016). Millions more are purchasing ACA-compliant, "off-exchange" plans directly from insurers. The ACA has had a major impact on government insurance programs, with Medicaid and Children's Health Insurance Program (CHIP) enrollment increasing by over 14 million persons between July 2013 and December 2015 (CMS 2016). Even states that did not expand Medicaid saw a "woodwork" effect, with program enrollment increasing on average by 10 percent (Buettgens, Blumberg, and Holahan 2015; CMS 2016). Additionally, the ACA's provision allowing children up to age twenty-six to stay on their parents' health plans has substantially boosted coverage rates among that group.

These impressive gains are a testament to the demand for coverage among the uninsured and to the strengths of the ACA's multipronged expansion model. Put simply, the ACA's major mechanisms for expanding coverage are working. The results are all the more impressive given that nineteen states have not expanded Medicaid, leaving nearly 3 million low-income adults in a coverage gap (Garfield and Damico 2016). Were it not for the 2012 Supreme Court decision that made Medicaid expansion optional for the states, the decrease in the uninsured population would be even larger. For all the controversy surrounding it, all the initial administrative missteps and technical snafus, all the predictions that it would fail, the ACA's substantial insurance expansion in a relatively short period is a remarkable achievement.

At the same time, the ACA's record to date underscores its limits. The Congressional Budget Office (CBO) (2015) had estimated that 21 million enrollees would be in the insurance marketplaces in 2016; while enrollment has been good, it has fallen far short of initial projections. The ACA explicitly aims to attain "near universal coverage," an ambitious, if imprecise, goal. Obamacare is moving the United States closer to that standard,

but for now the universalism or actual near universalism that characterizes other rich democracies remains far away. The CDC estimates that about 29 million US residents lacked insurance in 2015; one out of eleven US residents remain uninsured (Martinez, Cohen, and Zammitti 2016). Not surprisingly, the proportion of Americans without coverage remains much higher in states that have not adopted the ACA's Medicaid expansion than in states that have expanded Medicaid (Long et al. 2015). Even after health insurance exchanges reach their projected maximum enrollment in 2018, the CBO (2015) estimates that there will be 27 million uninsured persons. Despite the ACA's advances, a sizable uninsured population will continue to live in the United States in coming years.

That population comprises diverse social strata, from unauthorized immigrants to low-income adults living in states that have not expanded Medicaid and young adults who choose not to purchase coverage. The limits of Obamacare's scope of insurance coverage reflect, in large part, political compromises made to pass the law. Controversy surrounding unauthorized immigrants ensured that the ACA did not provide any new coverage options for them. The individual mandate is not really a mandate since persons can opt out of it by paying a modest tax penalty and the Internal Revenue Service has only a limited ability to enforce collection of those payments. Preliminary data showed that 7.5 million Americans were subject to the penalty (or, as ACA proponents prefer, the individual shared responsibility provision) in 2014 and paid an average of only $200 (Mazur 2015). The penalty rose substantially thereafter, averaging $969 for households in 2016, though for many persons it still costs much less than the price of purchasing insurance (Rae et al. 2015).

Limited by budgetary considerations that constrained the law's architects, the ACA's subsidies to help the uninsured afford insurance coverage are partial, leaving many persons (particularly those who make above 200 percent of the federal poverty level [FPL], or about $24,000 for an individual) responsible for considerable premium payments. The ACA has struggled to enroll persons who are not very low-income (Blumberg and Holahan 2015). While 76 percent of eligible individuals making between 100 percent and 150 percent FPL are enrolled in the exchanges, only 30 percent of eligible persons earning between 201 percent and 250 percent FPL and 16 percent of those between 301 percent and 400 percent FPL have signed up for exchange plans (Avalere Health 2015a). Moreover, many of the policies available for purchase through the ACA's health insurance marketplaces are high-deductible plans. In the thirty-seven states using Healthcare.gov, the annual average deductible for an individually purchased exchange plan at the silver level—the plan type with the highest

enrollment—was $2,559 in 2015, with average out-of-pocket limits exceeding $5,800 (Claxton and Panchal 2015). Such high deductibles and co-payments impose a significant financial burden on persons with modest incomes and deter their enrollment into ACA plans. Substantial cost-sharing subsidies are available for Americans making up to 200 percent FPL to reduce those costs, but others face very high out-of-pocket costs on top of their premiums. Put another way, the ACA's record to date suggests that the law is underfunded, with insufficient subsidies for many persons it aims to cover (Blumberg and Holahan 2015). The question is not just whether people have insurance but what kind of insurance they have. The ACA's health insurance vision is neither universal in coverage nor comprehensive in its protections against medical care costs (Oberlander 2014a).

Signing up new enrollees for coverage through the insurance marketplaces has been a vast undertaking. There is wide variation across the states in what percentage of eligible persons are obtaining insurance under the ACA (including those who are eligible for tax credits, legal residents who are otherwise uninsured and lack access to employer-sponsored coverage, and individuals who purchase non-group coverage) (KFF 2015b). In Florida, an estimated 59 percent of eligible enrollees have coverage through the ACA marketplace, while that figure stands at only 20 percent in Iowa (KFF 2016b). Overall, through December 2015, ACA exchanges had enrolled only 41 percent of the eligible population nationally (KFF 2016b). Similarly, there is large interstate variation in the proportion of persons eligible for premium subsidies who have signed up for ACA coverage through the marketplaces. Nationally, as of September 2015, 56 percent of persons eligible for financial assistance had enrolled in ACA plans (KFF 2016c).

In other words, millions of Americans who could obtain subsidized insurance are not purchasing it. Focus group and survey data (PerryUndem Research/Communications 2014; RWJF et al. 2015) indicate that many of the remaining uninsured regard ACA coverage as unaffordable. That judgment partly reflects ongoing confusion about the availability of subsidies to help defray premium costs. Over six years after the law's enactment, its benefits are still a mystery to many—35 percent of Americans do not know that the ACA provides financial assistance to low- and moderate-income uninsured persons to help them obtain coverage, and 40 percent do not know that the law gives states the option to expand Medicaid eligibility (KFF 2015a). It also reflects the reality that for many Americans, ACA insurance plans are neither cheap nor comprehensive, even with subsidies. The ACA has, for persons with modest incomes, a serious affordability issue. Caught between inadequate subsidies and a weak penalty, and confronted with a

complex enrollment system, many uninsured Americans have yet to take up coverage. Nor has the ACA erased another long-standing barrier to expanded coverage—that many persons who qualify for government insurance programs do not sign up, even with no or nominal premiums and cost-sharing requirements. As of 2015, 9 million Americans, adults and children, were eligible for but not enrolled in Medicaid and the Children's Health Insurance Program (Garfield et al. 2016). That gap stands as another sobering testament to America's convoluted insurance arrangements.

Complexity

Complexity is itself a major challenge for ACA implementation. Rather than creating a new health insurance structure, the ACA builds on the existing fragmented, labyrinthine nonsystem. The ACA addresses holes in that system by layering new policies, regulations, mandates, and institutions on top of the prevailing patchwork. That policy choice did not signify a substantive endorsement of the prevailing (dis)order but instead reflected a political calculation about passing reform. Other simpler, more straightforward plans, from Medicare for All to Senators Ron Wyden and Robert Bennett's Healthy Americans Act, were dismissed by the Obama administration and congressional Democratic leadership. They were seen as overly disruptive of the status quo, rendering them legislatively infeasible.

As noted earlier, the ACA's enactment was a major political triumph for the patchwork approach to health reform. Moreover, the ACA's impressive coverage gains demonstrate that the law's multipronged strategy is not a barrier to making substantial improvements in access to health insurance. Perhaps most importantly, there was no way to pass a major coverage expansion during 2009–10 without building on existing arrangements.

Still, there have been considerable costs to that complexity. The devil is in the details, and some of the ACA's details have weakened efforts to provide meaningful health insurance. One such example is the aforementioned "family glitch." Workers whose employer-sponsored plans cost more than 9.5 percent of income are allowed to go into the health insurance marketplaces and receive subsidized coverage. The Obama administration, much to the consternation of consumer advocates, interpreted the statute to mean that affordability would be measured only in terms of the premium costs of an individual plan, rather than the cost for family coverage. That means that workers whose employers heavily subsidize individual but not family coverage do not qualify for subsidized marketplace insurance, leaving many employees without affordable coverage options for family members (Jost and Pollock 2015).

Elsewhere the ACA's reality has not always lived up to its promise. The law aimed to provide comprehensive coverage for maternity care—before the ACA, a majority of plans on the individual insurance market excluded such benefits. It made maternity services one of the ACA's essential health benefits that health plans on the exchange must cover. However, because pregnancy is not one of the specified qualifying life events that allow people to enroll in subsidized marketplace coverage outside of the annual enrollment period, some pregnant women do not have access to affordable plans with maternity services (Postolowski 2014). Other women are enrolled in employer-sponsored or individually purchased health plans that lack maternity care benefits because they are "grandfathered." Such grandfathered plans operated prior to the ACA and are exempt from many of the law's benefit requirements as long as they do not subsequently make any major changes (Postolowski 2014). Grandfathered plans do not have to provide enrollees with coverage for no-cost preventive services and can maintain annual dollar caps on spending for their enrollees. For many Americans, their access to some ACA benefits is thus restricted, though the proportion of plans with grandfathered status is declining over time. Self-insured plans in the small-group market are similarly exempt from some ACA regulations. Other loopholes in ACA rules have permitted businesses to offer "bare bones" policies that provide little protection to the ostensibly insured. And the law's employer mandate has a host of problems, including convoluted rules, that have led to its delayed implementation and raised concerns over labor market distortions (Blumberg, Holahan, and Buettgens 2014; Jost 2014b).

Meanwhile, over 2 million persons who were enrolled in ACA plans on the insurance exchanges in 2015 and were eligible for cost-sharing reductions did not receive them because they chose a plan that did not qualify for these subsidies (Avalere Health 2015c). And "300,000 low-income taxpayers reported a payment [as part of the individual mandate penalty for not obtaining insurance] when they should have claimed a health care coverage exemption" (Mazur 2015). The law's complex arrangements for premium tax credits requires estimates of enrollees' forthcoming income and then, subsequently, reconciliation of their actual income with the subsidies they received (Jost and Pollock 2015). Over 3 million uninsured persons are eligible for subsidized coverage in the marketplaces that would either require no premium or charge a premium less than the penalty they owe for not having insurance (Rae et al. 2015).

None of this catalog is to take away from the ACA's considerable achievements in expanding access to insurance. It is to say, however, that

some of the law's consumer protections are not as robust or universally applicable as often presumed. Implementing a coverage system as complex as this creates numerous challenges. There are costs to the ACA's approach of layering new rules on top of the preexisting insurance patchwork. While the ACA addresses many gaps in American medical care, it has significant gaps of its own.

The Public Divide

The ACA did not become law because of a strong public mandate. When Obama signed the ACA on March 23, 2010, 50 percent of Americans opposed the law and 42 percent favored it (*Huffington Post*, n.d.). Democrats could expect, though, that its support would climb over time. There was the precedent of Medicare. Furthermore, the Obamacare debate had been clouded by the threat of mythic "death panels" and "pulling the plug on grandma." Once it was law, ACA proponents could reason, those specters would recede as Americans experienced the law's real benefits. The adoption of subsidized coverage for the uninsured, Medicaid expansion, regulation of private insurers, the abolition of lifetime and annual caps on insurance benefits, limits on insurers' administrative expenses and establishment of consumer rebates, enhanced Medicare benefits, new requirements for insurers to cover preventive and maternity services, the option for parents to keep their children on coverage until age twenty-six—all of these measures and more would make Americans' health care more secure and build a broad political constituency for Obamacare (Jacobs and Mettler 2011).

Those benefits all have gone into effect, affecting tens of millions of Americans. Moreover, national health care spending growth—an area beyond this article's scope—has continued to rise at remarkably moderate rates, defying predictions by critics that Obamacare would drive up costs. Initial premium prices for health plans offered through the insurance marketplaces were significantly lower than anticipated and, for the second-lowest-cost silver plan that is the benchmark for subsidies, grew only 2 percent between 2014 and 2015, weighted for enrollment (Sheingold, Nguyen, and Chappel 2015). In 2016, premiums for such plans did rise by 6 percent on average, with widespread state variation, yet most enrollees in the insurance exchanges receive subsidies that shield them from these increases (Gabel et al. 2016). The ACA is now projected to cost much less—$200 billion less during 2015–19 alone—than the CBO (2015) originally projected in 2010 when the law was enacted. Medicare spending

has been, partly due to ACA measures, significantly lower than expected, reducing the cost-sharing burden on program beneficiaries. Initiatives in the ACA to reduce hospital readmissions and hospital-acquired infections have shown promising early results (Blumenthal, Abrams, and Nuzum 2015). And the ACA has not been the "job killer" that some observers warned about. Through 2014, the ACA had "virtually no adverse effect on labor force participation, employment, or usual hours worked per week," though it remains unclear to what extent, if any, the law is increasing part-time work (Garrett and Kaestner 2015: 3; 2014).

For all the ACA's benefits and accomplishments, the decisive turn in public opinion has not come (Oberlander and Weaver 2015). Over six years after its enactment, following endless debate over the ACA's virtues and vices, the rollout of its core benefits, two elections, advertising that promotes and (mainly) attacks Obamacare, multiple court cases challenging its legality, and endless debates in Washington and the states, attitudes about the health reform law have not changed all that much from 2010. In March 2016, 45 percent of Americans opposed the ACA and 39.5 percent supported it (*Huffington Post*, n.d.).

To be sure, those numbers obscure important nuances. Some who show up in surveys as opposing the ACA actually want more comprehensive reform. Americans strongly favor core ACA provisions like the prohibition on insurers excluding coverage of persons with preexisting conditions and Medicaid expansion (KFF 2014). The ACA's component parts have always been more popular than the law itself (Brodie et al. 2010). Only a minority of the public wants the law repealed. And during 2015 there was a downtick in negative perceptions of the ACA, perhaps attributable to the comparatively trouble-free second open enrollment period and ongoing coverage gains.

Still, public support for the ACA has been underwhelming for an extended period. That Obamacare rather than Affordable Care has become the most common name for the law is itself a sign of the administration's problems selling it. It is not clear that the law will ever attain the popularity of Medicare and Social Security. The ACA, after all, is not a single program but a collection of policies, regulations, and subsidies that affects different groups of Americans in different ways at different times. The lack of a coherent programmatic identity makes it hard for the ACA to build the kind of coalition that Medicare and Social Security enjoy. Many Americans are benefiting from the ACA but do not know they are beneficiaries. The Obama administration has not succeeded in persuading many insured persons, including Medicare beneficiaries, that the law's insurance protections and enhanced benefits are improving their health security. In March 2015, only

19 percent of Americans in a Kaiser Family Foundation survey (2015a) said that the ACA helped them or their family directly, while 22 percent said that it hurt them and 57 percent reported no direct impact.

Partisan polarization is evident in public views of health reform, with Democrats supporting the law at much higher levels than Republicans and Republicans more likely to report that the law has hurt them personally (KFF 2014; Oberlander and Weaver 2015). The death panel myth and other misconceptions, relatively immune to the truth and correctives, persist (Nyhan 2010; Nyhan, Reifler, and Ubel 2013). In this polarized environment, the negative (real and imagined) experiences and consequences of the ACA are amplified, with every bad development in health care blamed on Obamacare regardless of whether the law is actually responsible—a political condition that might be termed "Obamacare-itis." For example, the thinning out of private health insurance, a trend that predates the ACA, may be impacting public perceptions: among those who say the law has directly hurt them, the most cited reason is that it has increased their health care or insurance costs (KFF 2015c). Meanwhile, the ACA's myriad benefits and achievements are obscured (though its advocates also tend to overattribute positive developments to the law).

Consequently, a large gap between the ACA's performance and perception has developed. The law is working well in crucial respects, yet public support remains tepid. Stronger public support for Obamacare would, of course, not solve its implementation challenges. But it could raise the electoral costs of opposing the law, perhaps persuade some politicians to rethink their recidivist stances, and solidify the ACA's standing as beyond repeal. Nonetheless, the barriers to broad public support for the ACA are unlikely to disappear soon and additional challenges await. Congress has delayed onset of a controversial measure, the Cadillac tax on private insurance, beloved by health policy experts but unlikely to win many fans among insured Americans, from 2018 to 2020. If it actually is implemented, the Cadillac tax could reduce public support for the ACA as it exacerbates underinsurance. Employers are already blaming the tax, whose impact will accelerate over time, for decisions to cut back on coverage and shift costs to workers.

Beyond Utopia

The ACA's implementation has been rocky. It has faced substantial state resistance, and partisanship has engulfed health care reform. Legal challenges to the ACA have proved formidable. The 2012 Supreme Court

decision on Medicaid expansion and subsequent state decisions to reject expansion seriously damaged the ACA's platform to cover low-income uninsured adults. The 2013 rollout of HealthCare.gov and the federal health insurance marketplace was disastrous. The cancellation of individual insurance policies contradicted the president's promise that the ACA would allow Americans to keep existing coverage. Public opinion on the ACA remains divided, and confusion about what Obamacare does and does not do persists.

And yet the ACA has overcome those pitfalls. Obamacare has delivered on its promise to make insurance more affordable and accessible. Twenty million Americans have gained insurance coverage. Millions more have better insurance benefits and more secure coverage today because of the ACA's market reforms. Americans with preexisting conditions cannot be denied coverage or charged higher premiums. Insurers can no longer impose benefit limits on persons with serious, expensive medical conditions. Persons with conditions from mental illness to cancer and many more no longer face discrimination by insurance companies. Many of those who have gained insurance coverage through the ACA experience improved financial security as a result. The American health care system in 2016 is more just than it was in 2010.

The ACA has significant shortcomings. But given the constraints of a fragmented political system that defies radical reform, compels compromise, and is currently beset by extraordinary levels of partisan and ideological polarization, and the imperviousness of a fragmented health care system that is resistant to bold departures from the status quo, the ACA is, as an approach to health reform, probably as good as it gets in the United States. Simply put, making reform work in this environment is incredibly hard. The first six years of ACA implementation have shown that it is possible to make meaningful changes in American medical care, including a major expansion of access to health insurance, and also revealed the limits of change. The ACA is not utopia. It is what substantial health care reform looks like in the United States.

The Path Ahead

The question is what health reform will look like in coming years. Two key issues that loom in the ACA's future are the ongoing trajectory of health insurance coverage expansion and a changing political environment.

It is unclear how much further the ACA can reduce the uninsured population absent reforms to strengthen its coverage provisions. Even with an increase in the individual mandate penalty, sign-ups for the ACA

marketplaces rose only from 11.7 million in 2015 to 12.7 million in 2016 (Avalere 2015d; Levitt et al. 2016). Enrollment growth in coming years will require signing up persons with modest incomes, a population that the insurance exchanges have struggled to attract to date because of inadequate subsidies (Avalere Health 2015a). Even as the penalty for not obtaining insurance rises, for many persons in this income range it will remain less expensive than buying the cheapest plan on the exchange (Avalere Health 2015b). And while so far a small percentage of Americans have paid modest penalties for not obtaining health insurance, as those numbers rise so too could the political fallout. The stability (or potential instability) of the health insurance marketplaces, including insurer participation and premium rates, is another crucial issue, especially given that many insurers have reported losses on their ACA business, including United Healthcare, which has announced plans to withdraw from most of the state exchanges in which it had participated. The forthcoming expiration of policies that stabilize ACA marketplace premiums could, unless there is federal intervention to maintain them, inject substantial volatility into the marketplaces (Laszewski 2015).

The ACA's political future is uncertain and highly dependent on the outcome of the 2016 elections. If Democrats win the White House and gain Congressional majorities, they could try to strengthen the ACA by addressing its affordability issues, continuing premium stabilization policies, seeking ways to increase enrollment, and encouraging state efforts to create public plans to compete against private insurers on the marketplaces. However, if a Republican wins the presidency and the GOP holds majorities in the House and Senate, the ACA faces a much more perilous future. The GOP could use budget reconciliation to repeal many of the ACA's core provisions, though not the entire law. Reconciliation would enable Republicans to circumvent the requirements for a Senate supermajority to end a filibuster; they could make changes in Obamacare with a simple majority. But it is unclear what the GOP might advance as a replacement plan for the ACA or whether Republicans want to incur the high political risks—including de-insuring millions of Americans—associated with repeal. Too much has changed in American medical care, too many Americans are benefiting from the ACA, and too little public support for total repeal exists to go back to status quo ante (Oberlander 2014b). Still, even absent repeal, a Republican president committed to its dismantling could do much to undermine the ACA's implementation and stall further progress. The ACA has had a troubled rollout with a president in office who wants the law to work. Imagine the possibilities if it operates under a president who wants it to fail.

In short, six years after its historic enactment, the politics of ACA implementation remain volatile. Health care reform has already achieved much, but there is a long way to go.

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