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Daniel Beland
University of Saskatchewan

Philip B. Rocco
Marquette University, philip.rocco@marquette.edu

Alex Waddan
University of Leicester

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Policy Feedback and the Politics of the Affordable Care Act

Daniel Béland
Johnson Shoyama Graduate School of Public Policy, University of Saskatchewan
Philip Rocco
Department of Political Science, Marquette University, Milwaukee, WI
Alex Waddan
University of Leicester

Abstract

There is a large body of literature devoted to how "policies create politics" and how feedback effects from existing policy legacies shape potential reforms in a particular area. Although much of this literature focuses on self-reinforcing feedback effects that increase support for existing policies over time, Kent Weaver and his colleagues have

recently drawn our attention to self-undermining effects that can gradually weaken support for such policies. The following contribution explores both self-reinforcing and self-undermining policy feedback in relationship to the Affordable Care Act, the most important health-care reform enacted in the United States since the mid-1960s. More specifically, the paper draws on the concept of policy feedback to reflect on the political fate of the ACA since its adoption in 2010. We argue that, due in part to its sheer complexity and fragmentation, the ACA generates both self-reinforcing and self-undermining feedback effects that, depending of the aspect of the legislation at hand, can either facilitate or impede conservative retrenchment and restructuring. Simultaneously, through a discussion of partisan effects that shape Republican behavior in Congress, we acknowledge the limits of policy feedback in the explanation of policy stability and change.

Introduction

Much has been written about how "policies create politics" and how feedback effects from existing policy legacies shape the likelihood and character of future reforms. In the United States, a classic example of how "policies create politics" is Social Security, a popular program that has created large constituencies and fiscal imperatives that have made it much harder for conservative politicians to dismantle or restructure (Béland, **2010**; A. Campbell, **2003**; Pierson, **1994**). Yet, some scholars argue that feedback effects from existing policies are not always self-reinforcing (Patashnik & Zelizer, **2013**; Soss & Schram, **2007**) and that they can even undermine specific government programs over time (Jacobs & Weaver, **2015**; Oberlander & Weaver, **2015**; Weaver, **2010**). Overall, there is evidence that a policy's very characteristics are likely to impact its political fate over time, though not necessarily in accord with the expectations of the actors responsible for its development.

Although it is straightforward enough to assess the feedback effects of decades-old programs such as Social Security, the causal analysis of policy legacies created more recently is a challenging task. Take the Affordable Care Act (ACA), for example. Enacted in 2010, this complex reform is being implemented over a nine-year period and involves dozens of actors, including the 50 states. Under attack from the outset, the November 2016 elections presented a direct threat to the very survival of the ACA because the president-elect and Republican leaders in Congress vowed to repeal it. In this context, the politics of the ACA is an ongoing "natural experiment" regarding the potential impact of the policy legacies of programs that are not yet fully implemented.

According to the policy feedback literature, "immature" programs are more vulnerable to retrenchment and outright dismantling than programs that have been around for a long period of time, at least when these more established programs produce positive, self-reinforcing feedback effects. Eric Patashnik and Julian Zelizer (**2013**) highlight a number of reasons why programs in the early stages of post-enactment development, such as the ACA during the Obama presidency, might not produce the expected self-reinforcing effects associated with more established social programs such as Social Security. In addition, Jonathan Oberlander and R. Kent Weaver (**2015**) have shown how key components of the ACA produced self-undermining feedback effects resulting in net negative feedback in the short term.[1] Yet these perspectives contrast with academic accounts that emphasize support for the ACA among intermediary constituencies, such as insurers, governors, and state Medicaid directors (Jacobs & Skocpol, **2010**; Kelly, **2017**) as well as recent evidence showing increases in public approval of

the ACA during congressional Republicans' attempts to repeal and replace the law (Kirzinger, DiJulio, Hamel, Wu, & Brodie, **2017**).

In this article, we draw on the historical institutionalist literature to analyze how policy feedback has shaped the political fate of the ACA following its enactment. We argue that, due in part to its sheer complexity and fragmentation, the ACA generates *both* self-reinforcing and self-undermining feedback effects that, depending of the aspect of the legislation at hand, can either facilitate or impede conservative retrenchment and restructuring. In other words, breaking down the ACA into some of its different policy components is an appropriate way to assess the political weight of its policy legacies on current reform initiatives. Our claim that the ACA has produced powerful self-reinforcing effects offers a corrective to the scholarship that stresses the weakness of self-reinforcing effects in relation to this legislation (Patashnik & Zelizer, **2013**) or even the prevalence of self-undermining effects (Oberlander & Weaver, **2015**). At the same time, our analysis recognizes "the limits of policy feedback" (Patashnik & Zelizer, **2013**) as they relate to partisan effects (Chattopadhyay, **2017**; Jacobs & Mettler, **2018**). In short, our evidence suggests that feedback processes, as they interact over time with other factors such as partisanship, can make policies vulnerable to future contestation, even if they are not retrenched.

This paper proceeds as follows. First, we explore the literature on policy feedback while explaining why it is relevant for the study of the ACA. Next, we assess nature and content of the ACA and its sources for self-undermining and self-reinforcing policy feedback. Drawing on an analysis of Senate votes, we assess the extent to which self-reinforcing effects complicated the task of Republicans in Congress during the first eight months of the Trump administration as they pushed to "repeal and replace" the ACA. Finally, the Discussion section draws three main lessons for the broader literature on policy feedback from this study of the ACA case: first, that policies can indeed generate both self-reinforcing and self-undermining feedback effects; second, that in the context of complex policy legacies, it might be hard to replace unpopular provisions without also undermining popular ones; and, finally, that scholars using the concept of policy feedback should be aware that other factors such as partisan effects can also help explain policy stability and change.

Self-Reinforcing and Self-Undermining Policy Feedback

The claim at the core of the contemporary concept of policy feedback that existing policies can shape politics and future policy developments is hardly new (Lowi, **1964**) and the last quarter century has witnessed a rapid expansion in the scholarship on policy feedback (e.g., Béland, **2010**; A. Campbell, **2003**; Jacobs & Weaver, **2015**; Mettler & SoRelle, **2014**; Oberlander & Weaver, **2015**; Pierson, **1993**). Typically embedded in an historical institutionalist tradition that stresses the impact of historically constructed political and policy institutions on the politics of public policy (e.g., A. Campbell, **2003**; Parsons, **2007**; Pierson, **1994**; Skocpol, **1992**; Thelen, **1999**; Weir, Orloff, & Skocpol, **1988**), the concept of policy feedback broadly refers to how policies impact politics and policy change over time (Béland, **2010**).

There are two main types of policy feedback: self-reinforcing and self-undermining (Jacobs & Weaver, **2015**; Oberlander & Weaver, **2015**; Weaver, **2010**). In his review of the policy feedback literature, Daniel Béland (**2010**) identifies six perspectives on policy feedback found in the historical institutionalist scholarship (for a systematic, up-to-date review see Béland & Schlager, **forthcoming2**). These six perspectives on policy feedback focus primarily on self-reinforcing effects, illustrating how policies create the conditions for their own stability over time, through shaping the material resources and cognition of mass publics, organizations, and government officials. Yet, over the last 15 years, a new wave of historical institutionalist scholarship, associated with the work of researchers such as Jacob Hacker (**2004**) and Kathleen Thelen (**2004**; Mahoney & Thelen, **2009**; Streeck & Thelen, **2005**), has stressed that researchers should focus not only on stability and path dependence, but should spend more energy exploring how path-departing change can emerge over time beyond the logic of punctuated equilibrium. The logic of punctuated equilibrium dictates that self-reinforcing feedback effects that stretch over long periods of relative institutional stability are the dominant policy pattern, but that this is sometimes interrupted by rare episodes of radical change that create a new political equilibrium (Baumgartner & Jones, **1993**).

Pushing our understanding of change patterns beyond path dependence and punctuated equilibrium Alan Jacobs and Kent Weaver (**2015**, p. 442) have articulated a coherent framework for the analysis of self-undermining policy feedback that points to "a set of *endogenous* forces—processes deriving from policy itself—that frequently generate strong pressures, and expand the political opportunities, for policy change." In their seminal article, Jacobs and Weaver (**2015**, p. 442) focus on three types of self-undermining policy feedback: "the emergence of *unanticipated policy losses* for mobilized social interests, *cognitive* processes arising from interactions between strategic elites and loss-averse voters, and expansions in the *menu of available policy alternatives*." To a certain extent, each of these three types overlap with one of the six perspectives on policy feedback discussed above since they focus on interest groups, mass political participation, and the availability of policy alternatives, respectively.

Jacobs and Weaver (**2015**) offer original insight by demonstrating how potential self-undermining processes come into play. First, they show how economic and demographic changes can gradually weaken interest group support for policies that those groups might have supported in the past. Here the focus of their analysis is on "*unanticipated* losses—adverse consequences that were not predicted or taken into account by political actors at the moment of policy enactment" (Jacobs & Weaver, **2015**, p. 445). For instance, employers might turn against pension programs they had previously supported because, in the context of demographic aging, the costs of these programs had increased such that employers came to view them as detrimental to their economic interests (on the demographic side of self-undermining policy feedback, see Weaver, **2010**).

Second, Jacobs and Weaver (**2015**, p. 447) explore "mechanisms through which policies can undermine their own support base in the mass public by creating conditions under which voters can be persuaded of the need for or acceptability of major policy change." Although the framing processes political actors use shape public perceptions about the policy status quo, the nature of existing policy legacies and the

losses they might impose on particular constituencies are crucial factors that might become a source of self-undermining policy feedback. This is because "Change-seeking elites will be better positioned to frame the status quo as a loss imposing arrangement …when losses are cross-sectionally or temporally concentrated, making them vivid and visible to the average citizen" (Jacobs & Weaver, **2015**, p. 448).

Finally, in contrast to the lock-in effects that reduce the list of available policy options over time (Pierson, **2000**), Jacobs and Weaver (**2015**) show that, when policies create growing problems over time, the number of credible alternatives to such policies is likely to expand: "Where status quo policy is perceived to generate adverse social outcomes, politicians, bureaucrats, and policy experts become more likely to undertake a search for new alternatives to address those problems" (Jacobs & Weaver, **2015**, p. 449). In other words, policies can generate the opposite of lock-in effects when their negative consequences push experts and politicians to look for credible alternatives to the status quo associated with these existing policies. Importantly, however, change does not automatically result even when these self-undermining effects exist. To bring about change, policy entrepreneurs opposing the status quo must exploit ephemeral "policy windows" (Kingdon, **1984**) created by factors, such as electoral realignments, which are themselves shaped by the broader institutional context (Jacobs & Weaver, **2015**).

Interestingly, Jacobs and Weaver (**2015**) use the example of U.S. health-care arrangements prior to the ACA to illustrate their claims about self-undermining policy feedback. They first argue that the evolution of the U.S. health-care system over time increasingly exacerbated dissatisfaction among key interest groups such as large employers, who faced growing health-care costs. Second, the apparent flaws of that system offered new framing opportunities to reformers seeking to convince a loss-adverse public of the need for change. Finally, growing costs and other problems pushed experts and politicians to look for alternatives to the status quo. In the end, these three forms of self-undermining policy feedback facilitated the successful push for comprehensive reform that led to the enactment of the ACA. This became possible in part because of the political window the 2008 financial crisis opened, which helped the Democrats win the White House and large majorities in Congress in November 2008 (Jacobs & Weaver, **2015**). This combination of ever more evident self-undermining feedback effects and a shift in the partisan balance of power created the conditions for a major overhaul of policy in a domain previously characterized as path dependent (Hacker, **2002**). This is a compelling example of the potential consequences of self-undermining policy feedback and how it can facilitate comprehensive policy change in the context of a particular political window that policy entrepreneurs find a way to exploit.

With these theoretical insights in mind, what can we say about the feedback effects the ACA has generated since its enactment? Writing after the passage of the ACA, but before all its major provisions were rolled out, Eric Patashnik and Julian Zelizer (**2013**) suggested that the law might illustrate what they call the "limits of policy feedback," a concept they understand only in terms of self-reinforcing effects. For them, these self-perpetuating effects might not materialize as the ACA's framers expected due to some of the characteristics of both the ACA and the prevailing political environment.

Oberlander and Weaver (**2015**) argue that the ACA's fragmented structure and submerged benefits made it difficult to generate strong political support for the legislation. Yet, complicating the picture further, just when the political window seemed to open for the ACA's opponents to repeal the law, it became apparent that the 2010 law had in fact generated self-reinforcing mechanisms limiting the capacity of Republicans in Congress and the White House to dismantle or at least profoundly reshape it. This leaves the question of whether to view the evolution of the ACA through the lens of self-reinforcing feedback, self-undermining feedback, or a combination of both, while taking into account how these feedback effects interact with partisan effects and the policy preferences of Republicans pursuing conservative-directed policy change in the aftermath of the 2016 elections.

To answer these questions, we look at the development of the ACA since its enactment in 2010. More specifically, we look at the legislation as a whole and then at some of its key components to identify potential sources of both self-reinforcing and self-undermining feedback effects. Drawing on the work of Jacobs and Weaver (**2015**), we focus on three potential aspects of policy feedback: interest group mobilization; public opinion as related to framing processes; and the decrease in, or the multiplication of, credible alternatives to the 2010 legislation, or at least to some of its core components.

Before continuing, it is important to recall the central limitation of this empirical analysis: the ACA is relatively recent, with its implementation unfolding from 2010 to 2019. Hence, the ACA remains an "immature" policy in the sense that it is a work in progress. More importantly, if the ACA survives in whole or in part, some of its long-term effects will likely only become apparent many years from now. This is why the study below remains exploratory in nature and is grounded in a clear acknowledgment of its limits, in terms of the relatively short time frame used (on the methodological importance of time frame issues, see J. Campbell, **2004**). Future studies will have the advantage of greater hindsight than ours.

The ACA and Policy Feedback

When the ACA was enacted, a *New York* Times (**2010**) editorial drew a parallel with the enactment of Social Security and that program's subsequent development: "Just as Social Security grew from a modest start in 1935 to become a bedrock of the nation's retirement system, this is a start on health care reform, not the end." The implementation of the law, however, would depend on political will, bureaucratic capacity, and popular opinion. Shortly after the ACA was passed, political scientists Lawrence Jacobs and Theda Skocpol (**2010**, p. 177) also drew a parallel with Social Security: "Americans always turn out to value and support major social programs that help individuals and families gain basic security with dignity." Their sketch of how the ACA might attain popular support and prosper as its various parts took effect was a potential model of self-reinforcing policy feedback. They pointed to how both top-down and bottom-up self-reinforcing feedback effects might come into play. First, interest groups would become vested in maintaining key parts of the reform, even if they had not been enthusiastic backers of the ACA. For example, insurance companies would defend new government subsidies for lower income households to buy insurance. Second, the "winners" from the reform, "younger, minority men and women and the less affluent of all backgrounds," might be mobilized to

higher levels of political activity to "defend" the ACA in "future elections and public debates" (Jacobs & Skocpol, **2010**, p. 178). The authors, however, also recognized an alternate path, pointing to how the law might be undermined by challenges in the courts, efforts to weaken implementation at the state level, and a continuing political drive to elect lawmakers at all levels of government opposed to the ACA.

As things turned out, the law did not generate a level of popular backing and interest group buy-in to provide a layer of immunity against continuing partisan challenges. The Kaiser Family Foundation (**2017e**) monthly tracking poll suggests a relatively constant division between people viewing the law favorably and unfavorably from the time of its enactment through to the close of the Obama presidency. There are peaks and troughs, but the unfavorable numbers are generally higher than the favorable ones. In May 2010, the unfavorable number was 44 to 41 percent favorable, while in October 2016 the numbers were tied at 45 percent. Importantly, reflecting how views on the ACA were mediated by partisanship (Oberlander & Weaver, **2015**), clear majorities of Democrats and Republicans viewed the law favorably and unfavorably, respectively. A plurality of Independents consistently regarded the law in an unfavorable light. Again, there are fluctuations, but a relatively consistent picture emerges when looking at data from May 2010 (72 percent of Democrats favorable and 85 percent of Republicans and 49 percent of Independents unfavorable) to October 2016 (76 percent of Democrats favorable and 83 percent of Republicans and 52 percent of Independents unfavorable).

In this context, as Oberlander and Weaver (**2015**, p. 38) reflect, "the fundamental political puzzle surrounding Obamacare" is to resolve why the anticipated build-up of support for the law failed to materialize, at least during the presidency of the person the law came to be named after. In response, Oberlander and Weaver (**2015**) highlight that feedback effects can go in both self-reinforcing and self-undermining directions simultaneously and the balance of the impact of those effects in the political arena—the net feedback effect—can change over time. Republicans gladly campaigned against the law in a series of election cycles, but, by early 2017, it became clear that turning the rhetoric of "repealing and replacing Obamacare" into reality was complicated by the way in which the ACA had laid down roots, such as the requirement that insurers offer affordable insurance to individuals with preexisting conditions, which could not be easily or painlessly ripped out. For some months at least, Republicans looked a little like the proverbial dog wondering what to do next after having finally caught up with the car.

To provide a framework for enquiry, we break our analysis of self-undermining feedback down into three areas: first, the circumstances of the ACA's enactment and how an initially unavoidable period of what might be described as policy immaturity became extended over a number of years; second, the consequences of the institutional fragmentation of much of the authority for implementation for key aspects of the law; and, third, the opaque distribution of its benefits, or, put differently, the disconnect between the "resource" and "interpretive" effects of the law (Pierson, **1993**). Together, these elements emphasize the importance of the policy design of the ACA. Policy design is so important not just because it structures how policy is implemented, crucial though that is, but also because it helps shape

how program beneficiaries perceive, and allocate political credit for, their benefits (A. Campbell, **2011**, **2012**; on the relationship between policy design and policy feedback see also Jordan & Matt, **2014**). We then also point to ways in which the ACA did generate self-reinforcing feedback effects, which at least complicated the task of undoing the law.

Self-Undermining Feedback

Policy (Im)maturity and Ongoing Implementation

New policy initiatives are always at some risk early in their lives, particularly if they are enacted on a partisan basis with opponents determined to reverse course (Patashnik & Zelizer, **2013**). Bipartisan votes are no guarantee of self-reinforcing feedback and program longevity as illustrated by the case of the No Child Left Behind (NCLB) law, which was heralded as an example of bipartisan cooperation in Washington, DC, but failed to build up a constituency of support in the educational establishment or among the state-level political actors charged with enforcing its regulations. It was effectively overridden, though not explicitly repealed, in 2015 by the Every Student Succeeds Act (Tooley, **2015**).**3** The NCLB was at least extended an initial period of good will, but a law enacted in a divisive and highly partisan fashion is likely to face some resistance, at least in the short term. Moreover, if the new policy stumbles as it takes its first steps, then opponents can vociferously denounce the irresponsible single party parent. In this context, the passage of the ACA was almost as partisan and divisive as can be imagined: no Republican voted in favor of the final form of the ACA in either chamber of Congress.

Significantly, ACA opponents stayed highly mobilized even after the passage of the law. On the night the bill was passed, a Tea Party gathering in Massachusetts was energetic rather than exuding a sense of defeat (Skocpol & Williamson, **2012**, p. 3). This energy did not dissipate as time passed, meaning that the ACA did not just begin life against a background of protest but moved into the implementation stage with a continuing drumbeat of noise, including legal challenges denying its very legitimacy. President Obama's re-election meant that the ACA was safe from repeal through to 2016, but after the GOP captured the House in 2010, a series of votes were held in that chamber that demanded the repeal of all or part of the law. By the end of 2016, the House had voted on such measures over 60 times (Cowan & Cornwell, **2017**). At the time, these votes were symbolic rather than legislatively effective, but symbolism has a purpose and the actions of Congressional Republicans helped maintain the impression that the ACA was not fixed in place and could still be reversed; if the ACA was not perceived as settled law, then the process through which policy would re-make politics to the advantage of ACA advocates had less chance to gain momentum.

The ACA's implementation schedule also contributed to self-undermining feedback. In short, the major benefits distributed through the ACA were somewhat delayed. Some popular aspects, such as rules compelling insurers to allow children to stay on their parents' insurance until age 26, were quickly implemented. But the two major planks designed to provide insurance to many millions of the uninsured, subsidies to low-income households to purchase insurance through newly established health insurance marketplaces (through which people with incomes between 100 and 400 percent of

the poverty line would receive subsidies to buy insurance in the individual market), and the expansion of the Medicaid program were not scheduled to come into effect until January 2014 (although people began enrolling in the marketplaces in October 2013). This was not a period of inactivity with regard to implementation; for example, the ACA provided grants to states to help plan setting up exchanges and, as it became clear that there was state-level resistance to creating these new administrative organs, HHS showed flexibility and negotiated means by which states could establish alternative models for their exchange (Béland, Rocco, & Waddan, **2016**, pp. 62–67). Yet these monies and negotiations did not immediately provide people with health insurance. Thus, many of those described by Jacobs and Skocpol as the "winners" from the reform did not experience the winning feeling for nearly four years after the reform was passed, undermining the prospect of these groups coalescing into a powerful lobby supportive of the ACA that might have provided a counternarrative to opponents' attacks. It had also been the case that the full benefits of Social Security did not appear for a significant period, a situation that initially threatened to derail the program which, bereft of beneficiaries in the years after enactment, began life as a "frail political entity" (Béland, **2005**, p. 98). Although Social Security has lived long and prospered, its early vulnerability, partially due to its delayed implementation and then limited application, should not be neglected when discussing how quickly feedback mechanisms do or do not reinforce social policy programs.

It is important to recall that the ACA emerged from a torturous legislative process fraught by interest group demands, partisan polarization, and numerous veto points. If its design was intentional, the goal was swift enactment rather than smooth implementation. In hindsight, however, Democrats may wish that they had followed the example of Medicare, at least in terms of distributing the ACA's benefits more speedily. The delay in putting major parts of the ACA in place, and thus creating self-reinforcing feedback from grateful beneficiaries, contrasts with the quick operationalization of this other major health care reform in the mid-1960s. Over time, while Medicare developed self-undermining feedback, especially with regard to the program's costs, it also developed a protective shield making proposals for retrenchment highly politically risky.

Institutional and Territorial Fragmentation

Institutional fragmentation is another factor with the potential to generate self-undermining feedback by empowering prospective opponents of reform. If the capacity to make decisions about how to execute a new program or adapt new aspects to existing policy structures is spread among a variety of political actors, it is likely to cause friction between those actors over exactly where areas of authority begin and end, even when they are all broadly supportive of the direction of policy. For example, in the United Kingdom, there is widespread agreement on the need to better integrate hospital care with social care for people needing ongoing care after leaving the hospital. However, this agreement has only very haltingly resulted in co-operation between different sectors as central government, the National Health Service (NHS), and local authorities argue about who should pay for what (Vize, **2016**). These tensions are inevitably exacerbated as some decision-making power is passed to actors who are opposed to the goals of the new policy directives they are expected to implement, as was the case with the ACA. The ACA was in fact a law of many parts, some aspects of which were already relatively

integrated and could rely on actors inclined to co-operate to make things work. Yet, as a whole, the law was marked by high levels of institutional fragmentation, meaning that, if it was to have a chance of a smooth roll out, leading to self-reinforcing feedback, it would need not just ongoing congressional co-operation but the collaboration of key state-level actors and bureaucrats.

From the time of the ACA's enactment through to the 2016 election, the most significant resistance to the ACA came from the states (Béland et al., **2016**). Many of the law's provisions were applied nationally, but significant areas required the intense participation of state politicians and bureaucrats. To be sure, many of these actors enthusiastically embraced the ACA and worked to implement the law. Elsewhere, ACA opponents saw an opportunity to engage in the politics of dissent (Béland et al., **2016**, pp. 24–29). The potential effectiveness of this strategy increased significantly after the 2010 mid-term elections. As well as inflicting a "shellacking" on Democrats in Congressional elections (Branigin, **2010**), with evidence that a backlash against the ACA-motivated conservative voters (Saldin, **2010**), Republicans gained six governorships and over 600 seats in state legislatures, giving the party its highest number of state legislators since the Great Depression (Hansen, **2010**).

Dissenters were further empowered by the Supreme Court's decision in summer 2012 to effectively re-write the ACA's policy design with respect to a proposed expansion of the Medicaid program (Landers, **2012**; Waddan, **2013**). The ACA intended to create a new national minimum eligibility standard, establishing a greater degree of federal authority over this previously fragmented federal–state- run program. Through a system of fiscal incentives and sanctions, the ACA planned to give states little choice but to cover everyone with an income up to 138 percent of the poverty line. The Court ruled, however, that the sanctions overstepped the mark, giving states a realistic option of abstaining from the program's expansion.

The battle against Medicaid expansion was heavily influenced by intense policy demanders within the Republican Party. While some state chambers of commerce embraced the expansion as an economic stimulus for the state, integrated networks of think tanks and pressure organizations, most notably the American Legislative Exchange Council (ALEC), the State Policy Network (SPN), and Americans for Prosperity (AFP), played an important role in encouraging Republican governors to reject the Medicaid expansion (Hertel-Fernandez, Skocpol, & Lynch, **2016**). To legitimize this option, a number of Republican governors and their allies have framed Medicaid as "welfare" (rather than as "health insurance"), a narrative stemming in part from the association between a black president, Barack Obama, and the ACA (Fording & Patton, **2017**). This "welfarization" of Medicaid points to the impact of race on the program's politics, a situation related to the fact that only 43 percent of Medicaid beneficiaries are white, compared to 81 percent for Medicare and 83 percent for Social Security (Michener, **2017**). As Grogan and Park (**2017**) note, consistent with theories of racial policy backlash, states with large black populations were significantly less likely to adopt the Medicaid expansion, especially when white support for Medicaid expansion was low. On the other hand, illustrating the importance of partisan control, Louisiana did proceed with the Medicaid expansion when John Bel

Edwards, a Democrat, won the state's gubernatorial context and took office in January 2016, with the state's bureaucrats then committing to signing up eligible individuals (Cohn, **2016**)

The powerful combination of interest-group influence and racial priming meant that, by the end of 2016, a total of 19 states had not joined the expansion (KFF, **2017a**). This is a high number of non-implementing states, especially considering the fiscal incentives the federal government provided to encourage states to participate (Béland et al., **2016**). It is worth comparing how states responded to the prospect of joining the expansion with the decisions to engage with the original Medicaid program. Federal funds to states for Medicaid were available from January 1966, which was only six months after the program was established in law, and, even though participation necessitated that states establish a new program and spend their own money, by January 1970 all states barring Alaska and Arizona had done so (Kaiser Commission on Medicaid & the Uninsured, **2012**, p. 2). In addition, in part because of the lack of fiscal incentives such as the ones tied to Medicaid expansion, only 17 states had fully embraced the idea of running their own health insurance marketplace (KFF, **2017b**). In other states, people could still benefit from these subsidies through federally facilitated marketplaces, but again, potential self-reinforcing feedback mechanisms were undermined by this display of often purposeful non-cooperation. The image of the federally run marketplaces was also damaged by a chaotic roll-out of the IT systems in the fall of 2013. Most injurious, however, was the steady drip of negative publicity as stories circulated of insurers withdrawing from the marketplaces, leaving people with few or zero choice of insurance packages and facing higher co-pays and deductibles (for example, see Johnson, **2017**).

Policy Opacity

A third factor that limited the self-reinforcing feedback potential of the ACA was its opaque nature. That is, its complexity made it difficult to comprehend and its benefits were often poorly understood. As Mettler and Soss (, p. 64) emphasize, it is important to distinguish "between the resources delivered by a policy and the mechanisms of their delivery." Again, the comparison with Social Security is instructive. Social Security provides income to the vast majority of American seniors in a clear and relatively transparent manner. The ACA did constitute a significant economic redistribution in favor of poor and lower income households (Leonhardt, **2010**), and it provided important protections for people with ill health worried about being shunned by insurers. Yet, it did not perform these tasks in a way given to a straightforward, and immediately winning, political narrative. This is the case because the distribution of benefits did not immediately foster a grand coalition amongst beneficiaries based on either a shared sense of self-interest or gratitude to the state. As Oberlander (**2012**) explained, the ACA "treats different groups of Americans in different ways at different times, which complicates efforts to explain the law, enroll eligible populations into new benefits, and mobilize public support." That said, the delivery mechanisms for distributing resources to low-income households (through subsidies to buy insurance via a marketplace) and to the poor (through access to Medicaid) were varied enough that there was no reason to assume that an organic alliance between those groups would emerge (Kliff, **2016**) and celebrate a shared positive experience.

Furthermore, while ACA advocates sometimes struggled to demonstrate the law's benefits, the law's opponents were skilled at highlighting its unpopular aspects. In particular, the so-called "individual mandate" was derided as a threat to American values, even after the Supreme Court legitimized it. More generally, Republicans were at least partially successful in framing the ACA as a "loss imposing arrangement" (Jacobs & Weaver, **2015**, p. 448). One poll in January 2017 found that while 27 percent of Americans said the ACA had helped them in their lives, 26 percent said it had harmed them (Science Daily, **2017**). President Trump also orchestrated events where he met with people he described as the "victims of Obamacare" (Kasperowicz, **2017**).

Self-Reinforcing Policy Feedback

Despite these numerous institutional sources of self-undermining feedback, the ACA did not entirely lack an institutional support structure. In fact, as Béland and colleagues (**2016**) show, even amidst significant opposition to the ACA's insurance marketplaces and Medicaid expansion, preexisting institutional legacies, policy designs, and favorable public sentiments enabled the law's important consumer regulations, such as a ban on discrimination for preexisting conditions, to quickly go into effect. Broadly speaking, despite the opacity of the ACA described above, sources of self-reinforcing feedback did include the increasing visibility of its benefits over time, "menu effects" that made it difficult for Republicans to propose a viable alternative, and the mobilization of policy intermediaries. This section briefly details how these factors helped stabilize the ACA against Republican attacks in the first half of 2017.

Benefit Visibility

For all its inadequacies, the ACA did put significant benefits in place that in turn established the law's own policy legacies. This meant that the constant Republican mantra of "repeal Obamacare" was always likely to be a much more complex political task in practice than in rhetorical flourish. Most obviously, the ACA helped reduce the uninsured rate to below 10 percent. Between 2013 and 2015, as the main parts of the ACA came into force, the uninsured rate dropped by 4.3 points (U.S. Census Bureau, **2016**, p. 4). Using a slightly different methodology for its count, the National Center for Health Statistics (**2017**, p. 1) reported an uninsured rate of 8.8 percent in the first nine months of 2016, totaling 28.2 million people, "20.4 million fewer persons than in 2010." Furthermore, surveys found strong support for individual aspects of the ACA. For example, clear majorities supported allowing children to stay on their parents' insurance until age 26 (Science Daily, **2017**) and favored protecting people with preexisting conditions from losing access to affordable insurance (Savransky, **2017**).

Popular backing for these two dimensions of the ACA was in fact well known and opponents consistently promised to keep them in place after repealing the ACA. Other data points, however, suggested that those committed to "repeal and replace" were unlikely to be able to accommodate all popular wishes. By the start of **2017**, 16 states with Republican governors had expanded their Medicaid programs. Twenty-one Republicans also represented these states in the Senate. Quite problematically for these actors, a Kaiser Family Foundation poll (**2017c**) found that 87 percent of people living in those states thought it important that the extra funds the ACA provided continue under any reform. For most

conservatives, however, bringing an end to the Medicaid expansion was a prerequisite of any meaningful repeal of the ACA.

By all accounts, there was a shift in the public opinion as the Republicans took office after the 2016 elections, with polls showing that the ACA gained support. The scale of this shift should not be exaggerated; nevertheless, while a 2017 Kaiser poll (**2017e**) showed that a consistent plurality was unfavorable to the ACA throughout the Obama presidency, this pattern was reversed from January 2017 onwards. The large partisan split in opinion on the law still remained, but self-identified independents had largely warmed to it (KFF, **2017c**). Furthermore, even if support for the ACA remained qualified, public opinion on Republican replacement plans was more decidedly negative. An early poll regarding the first Republican plan introduced in 2017, the American Health Care Act (AHCA), revealed that about half of Americans (48 percent) said the plan would, "result in fewer people having health insurance, compared to one in five (18 percent) who say it would increase the number of people with coverage" (KFF, **2017d**). A similar number of Americans (45 percent) said the plan would result in fewer protections for people with preexisting conditions. Notably, this poll was fielded prior to the Congressional Budget Office's estimate that the first version of the AHCA would result in coverage loss for 24 million Americans (KFF, **2017d**). Later polls in the summer of 2017 asking about the Republican effort in Senate to pass a repeal and replace bill also found that a majority of respondents opposed the GOP's plans (Weixel, **2017**). For the ACA's opponents, citing public skepticism about the law had been helpful when justifying their obstructionism while Obama was in office; by the spring of 2017, however, public opinion did not provide a receptive context for the consideration and passage of legislation to repeal the ACA.

Menu Effects

Another barrier to repeal was that the ACA itself had constrained Republicans' menu of options (Jacobs & Weaver, **2015**). Most importantly, the core architecture of the law was built on a plan the Heritage Foundation, a leading conservative think tank, designed as an alternative to Clinton's health care reform in the 1990s (Quadagno, **2014**). Moreover, its designers explicitly drew on a working model of health reform in Massachusetts, signed into law by a Republican governor (Béland, Medrano, & Rocco, forthcoming). For example, the ACA's use of tax subsidies for private coverage in the insurance marketplace, instead of direct state provision of services, made it difficult to articulate a distinctive conservative alternative to the law.

Moreover, as Rocco and Haeder (**2018**) show, conservative policy demanders within the Republican coalition placed constraints on what congressional leaders could define as repeal by insisting on a "hard" rather than "soft" repeal, making it difficult to co-opt even conservative aspects of the ACA. Indeed, between 2011 and 2015, plans to repeal the ACA tended to involve not minor tweaks but significant retrenchment (McDonough & Fletcher, **2015**). Yet, policy ideas related to actually replacing the ACA tended to come in the form of vague think tank reports rather than comprehensive legislative vehicles.

Thus, when Republicans gained unified control of the federal government in 2017, they lacked a comprehensive vision for repeal. What they *could* commit to was their promise to repeal the most unpopular provision of the ACA, the individual mandate. In fact, all legislative proposals to repeal the ACA that saw action on the chamber floor in 2017 included a provision to repeal the individual mandate. As Table 1 shows, these proposals varied in their appeal to various constituencies within the Republican Party. The first bill House Republicans introduced in 2017, the AHCA, represented not only a dramatic reversal of the ACA's individual market reforms and Medicaid expansion, but also transformed traditional Medicaid from an entitlement program into a system of per capita allotments to states. The same was true for the Senate's Better Care Reconciliation Act (BCRA) and an amendment introduced by Republican Senators Bill Cassidy (LA), Lindsay Graham (SC), Dean Heller (NV), and Ron Johnson (WI) in September of 2017 that came to be known as Cassidy–Graham.

Table 1. Elements of Republican "Repeal and Replace Plans," 2017

Changes in:	American Health Care Act (as passed May 4, 2017)	Better Care Reconciliation Act	Obamacare Repeal Reconciliation Act	Healthcare Freedom Act ("Skinny Repeal")	Cassidy–Graham–Heller Johnson Amendment
Individual mandate	Repealed	Repealed	Repealed	Repealed	Repealed
Premium subsidies	Modified	Modified	Repealed	Not repealed	Repealed, replaced with block grant*
Cost-sharing subsidies	Repealed	Repealed	Repealed	Not repealed	Repealed, replaced with block grant*
Essential health benefits	State waiver	State waiver	No state waiver	No state waiver	No longer applicable under block grant program
Market rules	Age rating modified (5:1 ratio, state option for alternate ratio); state waiver for prohibition on health status rating for market applicants not maintaining continuous coverage	Age rating modified (5:1 ratio, state option for alternate ratio); permits marketplace insurers to sell non-compliant plans outside marketplace; creates new association health plan option	Most rules retained	Most rules retained; modified process for ACA 1332 state innovation waivers to expedite state approval and eliminate "guard rails" on waiver components	Some rules retained (e.g., prohibition on coverage denial for health status; preexisting condition exclusion) but states may permit insurers to vary premiums at issue and renewal based on all factors except sex and genetic information
Medicaid expansion	Repealed	Repealed	Repealed	Not repealed	Repealed

Changes to traditional Medicaid	Converted to capped per capita allotments (CPI-U)	Converted to capped per capita allotments (Medical CPI formula)	None	None	Converted to capped per capita allotments (until 2024, caps are Medical CPI for children and adults; Medical CPI + 1 for elderly and disabled; 2025 and beyond: cap is CPI-U)

Sources: American Health Care Act, H.R. 1628 (as passed May 4, 2017), https://www.congress.gov/115/bills/hr1628/BILLS-115hr1628eh.pdf; Better Care Reconciliation Act, Amendment in the nature of a substitute to H.R. 1628 (as amended July 13, 2017), https://www.budget.senate.gov/imo/media/doc/BetterCareJuly13.2017.pdf; Healthcare Freedom Act, Amendment in the nature of a substitute to H.R. 1628, https://www.budget.senate.gov/imo/media/doc/HealthCareFreedomAct.pdf; Obamacare Repeal Reconciliation Act, Amendment in the nature of a substitute to H.R. 1628, https://www.budget.senate.gov/imo/media/doc/REPEAL7.19.17.pdf; Cassidy–Graham–Heller–Johnson Amendment, Amendment in the nature of a substitute to H.R. 1628, https://www.cassidy.senate.gov/imo/media/doc/LYN17752.pdf
* Cassidy–Graham replaces premium and cost-sharing subsidies as well as the Medicaid expansion with a new block grant program, with an estimated cost of $1.176 trillion over 7 years.

These bills attempted to appeal to the hardline conservative faction in Congress best exemplified by the House Freedom Caucus (HFC). Crucially, the HFC withheld its support of the AHCA until House leadership made key concessions regarding retrenching several ACA regulatory provisions (Costa & Winfield Cunningham, **2017**). Nevertheless, House leadership still faced the prospect that, as the Congressional Budget Office (CBO) had projected, the bill would mean that 23 million Americans would lose coverage by 2026 (see Figure **1**). As a result, House leaders whipped votes from moderates by promising that the AHCA would never be enacted into law (Weigel & Winfield Cunningham, **2017**). Even so, the mechanics of the insurance marketplace made it impossible to enact the modest repeal of the individual mandate that many Republicans wanted while *also* fulfilling other electoral promises such as lower premiums and deductibles (Maeda, **2016**).

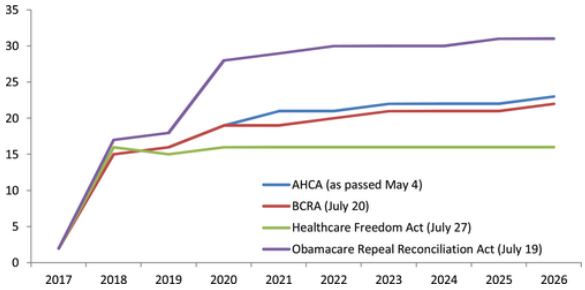

Figure 1 Increases in the Number of Uninsured Relative to Current Law under Various ACA Replacement Plans, 2017–2026 (CBO Projections). *Sources*: Congressional Budget Office, Cost Estimate of H.R. 1628, American Health Care Act of 2017, https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr1628aspassed.pdf; Congressional Budget, Cost Estimate of H.R. 1628, Better Care Reconciliation Act, https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52849-hr1628senate.pdf; Congressional Budget Office, Cost Estimate of H.R. 1628, the Healthcare Freedom Act of

2017, an Amendment in the Nature of a Substitute [S.A. 667], https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/s.a.667.pdf; Congressional Budget Office, Cost Estimate of H.R. 1628, Obamacare Repeal Reconciliation Act of 2017, https://www.cbo.gov/publication/52939.

In addition to the problems associated with getting rid of unpopular aspects of the ACA because of knock-on effects, the commitment to maintaining the popular rule that insurers could not refuse affordable coverage to people with preexisting medical conditions also confused efforts at designing coherent conservative reform. Conservative policy preferences included rolling back what they saw as the burdensome requirements in the ACA about the types of insurance packages that could be sold in insurance marketplaces and also allowing states much greater leeway in determining what types of health benefits needed to be covered. Republicans insisted that incorporating these ideas into their replacement plans did not threaten people with preexisting conditions, but ACA defenders were able to make plausible arguments that the end result would be that those with preexisting conditions would effectively be forced "into segregated markets that will lead them to pay far, far higher costs than everyone else" (Sperling & Shapiro, **2017**).

Arguments about policy detail might seem to be too arcane to have an impact on wider public awareness, yet ironically, by undermining the CBO and lambasting policy experts, Republicans generated backlash from civil society actors. Throughout the repeal debate, talk show host Jimmy Kimmel repeatedly explained the contents of Cassidy–Graham, and other repeal legislation, to an audience of millions. As the bill was under consideration, Kimmel delivered monologues suggesting that its waiver provisions would allow states to opt out of important consumer protections, including offering insurance to people with preexisting conditions. Kimmel urged his viewers to call their senators to register their disappointment with Cassidy for lying about the contents of the bill (Cillizza, **2017**).

Intermediaries as a Support Constituency

Further limiting Republicans' "menu of options" was the opposition of virtually every relevant organizational stakeholder in health-care policy, especially those organizations that served as intermediaries for ACA implementation. In particular, when Speaker Paul Ryan revealed the House's American Health Care Act, several powerful players in the health-care industry, including the American Medical Association (**2017**), the American Hospital Association (**2017**), the American Nursing Association (**2017**), and also the American Association of Retired Persons (Hickey, **2017**), expressed their disapproval. Compared to their objections to the Clintons' 1993 reform plan, industry players' efforts to derail the reform in 2017 were muted (Scott, **2017**), but they did potentially restrict Republicans' room for maneuver. Hospital CEOs and insurance companies repeatedly made public statements highlighting the negative effects of ACA repeal on their bottom lines (Kelly, **2017**). A large number of prominent organizations representing providers, health professionals, patients, and insurers also opposed the Cassidy–Graham legislation when it was introduced in September (Ingraham, **2017**).

Another important source of support for the ACA was the phalanx of state officials responsible for implementing the law. The ACA's Medicaid expansion resulted in significant economic stimulus in states that chose to implement it. Moreover, in many states, Medicaid expansion led to significant decreases in uncompensated care and reduced strain on general revenue funds (Kelly, **2017**). As such, governors played an important role in defending the law. Importantly, this included Republican governors like John Kasich (OH), Rick Snyder (MI), and Brian Sandoval (NV) (Berman, **2017**).

State officials thus placed intense pressure on Republican members of Congress, especially Senators, to take significant cuts to Medicaid off the table. After the House passed the AHCA, Senators from states that expanded Medicaid, including Lisa Murkowski (R-AK) and Shelley Moore Capito (R-WV), informed Senate Majority Leader Mitch McConnell (R-KY) of their opposition to repealing the Medicaid expansion. This, however, further increased opposition from the right flank of the Republican Party. By the end of June, the Senate team drafting BCRA had no plans to take either the reversal of Medicaid expansion or the major cuts affecting the traditional Medicaid population off the table (Rosenbaum, **2017**). Generally speaking, opposition from state officials persisted throughout the Senate's consideration of the Cassidy–Graham bill in September 2017. Directors of all 50 state Medicaid programs also constituted a solid block of opposition to efforts to convert the Medicaid program to capped per capita allotments. In a public statement criticizing the Graham–Cassidy bill, the National Association of Medicaid Directors argued that the bill's Medicaid provisions would "constitute the largest intergovernmental transfer of financial risk from the federal government to the states in our country's history" (quoted in Ramsey, **2017a**).

Feedback and the Politics of "Repeal and Replace"

Perhaps given the complex combination of self-reinforcing and self-undermining components of the ACA, its effects on public opinion were partial and belated. In fact, as Chattopadhyay (**2017**) shows, partisanship has played an important role in conditioning public attitudes about the ACA, especially where its long-term effects are concerned. Given the unevenness of ACA policy implementation at the state level, its effects on voter registration and turnout were asymmetric. States that expanded Medicaid saw significant increases in voter registration in 2014 and 2016 and on voter turnout in 2014 (Clinton & Sances, **2018**).

Public attitudes toward the ACA improved most noticeably during the rollout of Republicans' "repeal and replace" plan. In June of 2017, ACA favorability in the Kaiser Family Foundation's tracking poll broke 50 percent for the first time since its creation in 2010 (Kirzinger et al., **2017**). With the exception of the individual mandate, public attitudes about most components of the ACA were largely favorable (Blendon & Benson, **2017**). Democrats uniformly supported the ACA against Republican attacks by pointing to sources of self-reinforcing policy feedback, including growing support for the law among intermediary groups, a growing number of constituents, as well as positive evaluations of the reform (Kelly, **2017**). Yet self-reinforcing feedback was evidently neither quick enough nor strong enough to have an effect on the legislative agenda in the 115th Congress. As Rocco and Haeder (**2018**) show, intense policy demanders within the Republican Party shaped its health policy agenda during ACA

implementation. In particular, their analysis of bills introduced between 2011 and 2016 show that House Republicans receiving higher levels of contributions from business associations were significantly more likely to introduce legislation repealing major provisions of the ACA. The draft version of the AHCA, they suggest, drew on a policy paper published by the Speaker of the House that incorporated ideas from hundreds of these bills. Thus, intense policy demander support shaped GOP legislative initiatives about the ACA before and during the Trump era (Rocco & Haeder, **2018**).

While self-reinforcing feedback mattered, it was not evidently strong enough to keep repeal legislation off the agenda in the Senate. Were this the case, Republican senators from states that had expanded Medicaid might have been more likely to vote against the July 25 motion to proceed with consideration. As the histogram of DW-NOMINATE coordinates in Figure 2 shows, however, a vote on the motion to proceed neatly divided senators along ideological lines.4 Only Sens. Susan Collins (R-ME) and Lisa Murkowski (R-AK) joined Democrats in opposing consideration of the legislation, citing complaints about the rushed legislative process and the absence of committee consideration (Hoey, **2017**; "Murkowski Statement on Motion to Proceed Vote." **2017**). Vice President Mike Pence was thus forced to cast a tie-breaking vote in favor of the legislation (Kaplan, Pear, & Abelson, **2017**).

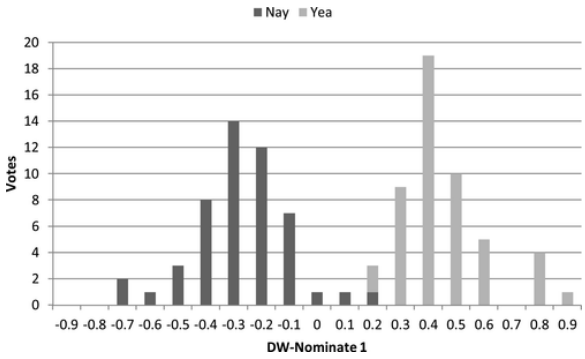

Figure 2 Histogram of Senate Votes on the Motion to Proceed to Consideration of H.R. 1628.

Agenda-setting aside, does policy feedback help us to explain Senate votes on BCRA, partial repeal, and "skinny" repeal? To answer this question, we constructed a simple logistic regression model of Republican votes on each of these proposals.5 Each model contains three variables. First, to capture the potential effect of Medicaid expansion, we include binary variable indicating the Medicaid expansion status of a Senator's home state as of July 15, 2017 (KFF, **2017a**). Second, we tap into the potential effects of policies related to the individual marketplace by measuring the change in marketplace enrollment between 2016 and 2017.6 Third, given the strength of ideological conflict on the ACA, we include each member's first-dimension DW-NOMINATE score. Journalistic accounts also highlighted opposition to BCRA among conservatives on the Senate working group that helped draft the legislation (Kliff, **2017**). In their view, the bill did not go far enough at eliminating market regulations and rolling back taxes under the ACA. Thus, the logit analysis of the vote on BCRA also includes a dummy variable identifying these individuals.

As the first column in Table 2 shows, both Medicaid expansion and marketplace enrollment are negatively associated with support for BCRA, as we might expect if self-reinforcing feedback were

present. That neither of these coefficients is statistically significant does not suggest that self-reinforcing feedback was not important in shaping this vote, however. Rather, the Senate bill was designed specifically to appeal to Senators from select Medicaid expansion states, and included a variety of side payments, financed by some of the "unused" cost savings in BCRA. Senate leaders promised Senators Rob Portman (R-OH) and Moore Capito (R-WV) enhanced Medicaid funding to combat the opioid abuse epidemic in their home states (Haberkorn, Dawsey, & Everett, **2017**). Both Portman and Capito voted in favor of BCRA in the dramatic early morning votes on July 25. Nevertheless, the measure failed.

Table 2. Logit Analysis of Senate Republican Votes to Repeal the ACA

	BCRA (SA 270, 7/25/17)	**"Partial" Repeal (SA 271, 7/26/17)**	**"Skinny" Repeal (SA 667, 7/28/17)**
Medicaid expansion state	−0.21 (.84)	−2.15 (1.28)+	−2.12 (2.35)
Change in marketplace enrollment, 2016–17	−0.91 (4.21)	−3.62 (5.97)	−3.58 (12.71)
First-dimension DW-NOMINATE score	4.03 (3.2)	22.27 (8.92)*	24.16 (10.76)*
Conservative working group member	−3.90 (1.8)*	—	—
Intercept	0.04 (1.53)	−6.01 (3.41)+	−4.6 (3.5)
Proportional reduction in error	0.11	0.14	0.33
N	52	52	52

Note: +$p < 0.10$; *$p < 0.05$. Standard errors appear in parentheses.

Following BCRA's failure, Senate leaders called up the Obamacare Repeal Reconciliation Act, also known as the "Partial Repeal." As noted in Table **1**, this bill accommodated Senate conservatives by repealing all of the ACA's coverage provisions (including the individual mandate, Medicaid expansion, and subsidies). It also attempted to appeal to moderate Republicans by taking cuts to traditional Medicaid off the table and leaving in place insurance market reforms. Perhaps indicative of the self-reinforcing effects of the Medicaid expansion, Republican Senators in states that took the expansion were less likely to vote in favor of partial repeal. The coefficient here is statistically significant ($p < .10$). Even so, first-dimension DW-NOMINATE scores remain a significant predictor of members' votes. Again, the legislation failed to pass by a margin of 10 votes.

Republican leaders called up the so-called "skinny repeal" in a last-ditch effort to repeal only the individual mandate, the ACA's least popular measure, the Medicaid expansion, and other coverage provisions intact. Thus, first-dimension DW-NOMINATE scores remain the only significant predictor of members' votes on the repeal. In fact, a simple spatial model of the vote on skinny repeal (see Figure **3**) results in only one "error," the vote of Sen. John McCain (R-AZ). Back in Washington after surgery and suffering from brain cancer, McCain invited reporters to "watch the show," as he dramatically cast his thumb down when his name was called, eliciting audible gasps in the chamber (Pear & Kaplan, **2017**). While this vote was decisive in killing the skinny repeal, policy feedback does not explain McCain's vote against the plan. Indeed, while McCain voted against partial repeal—which focalized the issue of Medicaid expansion in his home state of Arizona—he had voted in favor of BCRA,

which would have dramatically retrenched the ACA as well as the traditional Medicaid program. His public statements on the vote are vague, but—along with his appearance at a joint press conference with Sens. Lindsey Graham (R-SC) and Ron Johnson (R-WI), both of whom ultimately voted in favor of the bill—hint that McCain's main concerns focused on legislative process, that the legislation was "rammed through" and did not "actually reform" health care. In any case, it seems unlikely that McCain voted against the bill due to expected reprisals from constituents who would lose coverage (Bacon, **2017**; Ramsey, **2017b**).

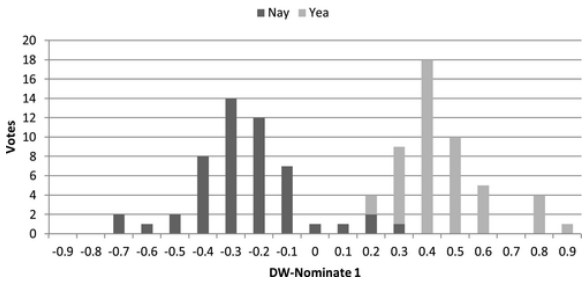

Figure 3 Histogram of Senate Votes on the Senate Amendment 667 ("Skinny" Repeal).

Thus, while Republican leadership longed to take credit for repealing and replacing the ACA, eliminating the individual mandate was the only politically viable item on the menu. Following the defeat of BCRA, Senate leaders were skeptical about bringing other major replacement legislation, such as the Graham–Cassidy bill, to the floor. Yet as with BCRA, Graham–Cassidy's failure likely had more to do with ideological divisions within the Republican Party rather than self-reinforcing from the ACA. Like BCRA, Graham–Cassidy contained large cuts to traditional Medicaid while maintaining a subsidy that conservatives like Rand Paul disdained. With another potentially embarrassing floor vote on the horizon, Senate leadership killed the bill (Haberkorn, Everett, & Kim, **2017**; Ingraham, **2017**). At the same time, however, Republican leaders effectively blocked consideration of a measure sponsored by Sens. Lamar Alexander (R-TN) and Patty Murray (D-WA) that restored cost-sharing reduction payments that had been cut off by the Trump administration (Haberkorn, **2017**; Kaplan & Pear, **2017**).

By the end of 2017, then, the individual mandate remained the most unpopular provision of the law, and hence last best option for Republican leaders seeking to claim credit for repealing Obamacare. Yet despite the unpopularity of the mandate itself, the CBO continued to make dour predictions about the effects of repeal on insurance coverage. Surveys conducted by the Kaiser Family Foundation in the fall of 2017 revealed that whereas only 42 percent of Americans opposed repeal of the individual mandate, that number jumped by 20 percent when respondents learned about the effects of mandate repeal (Altman, **2013**). This may help explain why Republican leaders folded mandate repeal into a $1.5 trillion dollar Tax Cuts and Jobs Act. By zeroing out the penalties imposed by the mandate (rather than repealing the mandate itself), Republicans also generated over $300 billion in savings that could be put toward the proposed tax cuts, which passed along party lines before the end of the year.

Taken together, policy feedback appears to have exerted a partial effect on the legislative politics of "repeal and replace." Self-reinforcing feedback did help to keep Democrats unified in opposition to the ACA repeal and to generate marginal support from some Republicans in Congress (Kelly, **2017**). Yet it

was not sufficient to keep repeal off the legislative agenda in 2017. Additionally, ideological divisions among Senate Republicans appear to account for the failure of BCRA, leadership's initial legislative vehicle for repeal, as well as the refusal of Republican leaders to introduce Graham–Cassidy in September of 2017. By contrast, self-reinforcing feedback from the Medicaid expansion appears to have exerted at least some influence on the failure of Republicans' second-choice "partial repeal" strategy. Additionally, the persistent unpopularity of the individual mandate, especially in contrast to other provisions of the ACA, made it the last, best option on the menu for Republicans seeking to claim credit for repealing at least parts of the ACA.

Discussion

As a case in the policy feedback literature, the ACA resists easy coding or categorization. While initial scholarship (Jacobs & Skocpol, **2010**) predicted that the reform's benefits would generate rapid self-reinforcing feedback, post-implementation assessments of the ACA suggested otherwise (Oberlander & Weaver, **2015**; Patashnik & Zelizer, **2013**). To some extent, the evidence we present here helps confirm that the ACA's institutional design—particularly the opacity of its benefits and its fragmented implementation structures—has contributed to what Jacobs and Weaver (**2015**) refer to as "self-undermining feedback." At the same time, it has been difficult for the law's Republican opponents to fulfill their commitments to "repeal and replace" it. How should we make sense of these contrasting observations?

Our evidence suggests several lessons for the broader literature on policy feedback. First, while much research on policy feedback has identified more or less "pure" cases of self-reinforcing or self-undermining feedback, institutionally complex reforms may be subject to both positive and self-undermining feedback simultaneously. For example, the ACA's regulatory reforms built on prior policy legacies were politically popular and less institutionally fragmented than other parts of the law (Béland et al., **2016**). As a result, these reforms stabilized more rapidly. By 2017, few credible proposals for repeal included threats to specifically undo the ACA's consumer protections. As well, while many Republican states did not expand Medicaid, those that did became vocal critics of repeal, joining a chorus of other policy intermediaries. In contrast, the ACA's individual mandate has remained broadly unpopular, was subject to legal contestation, and engendered symbolic opposition in the form of states' refusal to implement health insurance marketplaces. Future research on policy feedback should pay greater attention to how feedback processes vary within, not only across, policies. A more nuanced understanding of within-policy variation would allow us to evaluate how different combinations of policy elements contribute to "net" policy feedback effects.

Second, policy feedback processes may emerge from what Mettler (**2014**) refers to as "lateral effects" within a given reform. Because major reforms are interdependent webs of regulatory and fiscal authority, unpopular provisions may not be easily replaced without undercutting popular reforms. The unpopularity of the individual mandate itself was essential in helping Republicans keep the repeal of the ACA alive as an electoral issue. Nevertheless, as the analysis of "repeal and replace" efforts suggest, the ACA's design made it difficult to repeal the mandate without dramatic losses in insurance

coverage. An alternative type of "lateral effect" can be seen with Republican commitment to maintain affordable coverage for individuals with preexisting medical conditions. This was a highly popular aspect of the ACA and keeping it seemed a relatively simple promise for GOP lawmakers. Yet this belied the fact that people with preexisting conditions often have the highest medical expenses and, as illustrated by the Senate's efforts at reform, it was difficult to accommodate the insurance needs of these individuals while undoing the ACA's other insurance regulations. Future research should more concretely conceptualize how lateral interactions between policy components affect feedback.

Third, the evidence here suggests that, while policy feedback is one important factor that affects post-reform politics, it is not the only factor that matters. A range of recent scholarship on post-reform politics suggests that policy stability can be damaged by fluctuations in the partisan and interest group environment, as well as by policy design itself (Jenkins & Patashnik, **2012**). Policies can destabilize as the result of shifts in governing coalitions (Maltzman & Shipan, **2008**). In the case of the ACA, intense policy demanders within the Republican Party—whose mobilization was in no way contingent on health reform itself—played an important role in keeping repeal on the legislative agenda (Rocco & Haeder, **2018**). Moreover, as our analysis suggests, policy feedback alone explains neither the content of replacement legislation nor Senate voting patterns. In general, our findings suggest that, conflicting feedback processes, as they interact over time with other factors such as partisanship, can make policies vulnerable to future contestation, even if they are not retrenched. Future studies should be more careful when ascribing the stability or instability of reform to internal institutional dynamics.

The ACA represents the most significant "case" of U.S. social policy reform in a generation. Yet it is different in kind from its predecessors, both in terms of content and in relation to the political context of its passage and implementation. Unlike Social Security, it was primarily constructed out of a set of fundamentally conservative policy tools. Unlike Medicare or Medicaid, the ACA was initially implemented in a context of unprecedented partisanship, which is especially problematic in the context of checks and balances and, more generally, the country's fragmented political institutions. Whatever path this reform takes, and whatever feedback processes it engenders, it seems reasonable to expect that they will differ from prior policies. If nothing else, this represents a moment of opportunity to update our understanding of the concept of policy feedback itself.

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