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Unraveling from Within? The Affordable Care Act and Self-Undermining Policy Feedbacks

Abstract: The 2010 Patient Protection and Affordable Care Act (ACA) passed through Congress on partisan lines and with only lukewarm public support. The Obama administration and Congressional Democrats, though, had reason to expect that the ACA's political fortunes would substantially improve as the acrimonious debate over its enactment faded and millions of Americans came to receive significant benefits from health care reform. But 5 years after its passage, the ACA's political foundations remain shaky. We suggest that one reason for the ACA's unsettled fate is the role of policy feedbacks that undermine public support for and opponents' acceptance of the program. The ACA experience highlights how policy feedbacks can vary widely in their political impact, and suggests that some policies are in fact self-undermining. We also emphasize the crucial role of partisan polarization as a mediating factor in shaping policy feedbacks.

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Introduction

The tortuous path to enactment of the 2010 Patient Protection and Affordable Care Act (ACA) has been widely analyzed (Cohn 2010; Daschle and Nather 2010; Kirsch 2011; McDonough 2011; Starr 2011; Jacobs and Skocpol 2012; Brill 2015). Many ACA supporters anticipated that public support for the ACA would grow and partisan conflict would fade over time, with Obamacare gradually winning acceptance among its opponents – even if it was grudging and hostile acceptance in conservative quarters. Presidential advisor David Axelrod, for example, said

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in 2010 that “As the American people become familiar with what this program is and what it isn’t, they’re going to be very, very happy with it” (Baker 2012). As public support for the ACA developed and more Americans obtained benefits through health care reform, Democrats could anticipate that efforts to overturn Obamacare would recede.

In part, this expectation reflected prior experiences with programs that were controversial prior to enactment, but subsequently became much more politically popular and institutionalized – Medicare being the paradigmatic case in health care (Oberlander 2003). But the turn in political support has not occurred for the ACA. Congressional Republicans continue to pursue plans to “repeal and replace” Obamacare through legislative and legal challenges, and many states governed by the GOP have fiercely resisted the ACA’s implementation. Five years after enactment, public support for the ACA has been both quite stable and underwhelming, with more Americans opposed to (47%) than favoring it (40%), as of March 2015, though many of its *individual* provisions are more popular than the overall Act (Brodie et al. 2010; HuffPost Pollster 2015). Partisan differentials in attitudes toward the ACA remain remarkably high, as reflected not just in whether the law is viewed favorably, but also (and less plausibly) in self-reported perceptions of whether the ACA has helped or hurt the survey respondent (Jacobs and Mettler 2011; RAND Corporation 2014; Kaiser Family Foundation 2015a). In short, even as millions of Americans gained insurance coverage and other benefits due to the ACA’s policies – the uninsured population declined by about 9–12 million persons during the first year the law’s major coverage provisions were implemented (Blumenthal and Collins 2014; Long et al. 2014) – its political foundations remain shaky.

Anticipated feedback effects from the ACA played a strong role in the expectation that both support from the public and lawmakers would grow following Obamacare’s enactment. Several ACA provisions that provided concentrated benefits to individuals were “front-loaded,” slated to start shortly after the law’s passage, while some provisions that were likely to be unpopular or controversial were “back-loaded” to several years after the ACA’s major benefits started flowing. Moreover, tens of millions of Americans were expected to gain from the law’s expansion of access to health insurance coverage and new consumer protections. Given the scope of these benefits, and the experience of programs like Medicare that outgrew their controversial origins to attain mass popularity and robust political status, the Obama administration and Congressional Democrats could reasonably expect the ACA’s coalition to strengthen substantially over time. But to date that has not happened – and that is the fundamental political puzzle surrounding Obamacare.

The political logic of entrenching the ACA politically is consistent with a major stream of political science literature on policy feedbacks emanating from the seminal work of Paul Pierson (Pierson 1993, 1994, 2000). In this “historical institutionalist” approach to policy feedbacks, policies become entrenched by offering concentrated benefits to constituencies while many costs are delayed, diffused, or obscured. Because voters develop a sense of entitlement to benefits once they start receiving them, and politicians try to avoid blame for imposing cutbacks (Weaver 1986), benefits are unlikely to be rescinded once they start to flow because politicians fear the electoral consequences of doing so. Opposition fades because politicians, even those who oppose the program, make the political calculation that it is not worth alienating recipients of benefits or supportive publics.

The continued conflict and uncertainty over Obamacare’s fate suggest that an understanding of policy feedbacks as largely self-reinforcing is incomplete. In this article we sketch out a perspective on the political dynamics of policy feedbacks that is more comprehensive in the range of policy feedbacks that it considers. We discuss fiscal and administrative as well as socio-political policy feedback effects, and we discuss variation in the direction of those feedback effects (self-undermining, mixed, and self-reinforcing), in the timing of initial incidence of those effects (short-term, medium-term and long-term) and in their duration (temporary versus permanent). We also argue that the ACA’s political feedback effects are very different from that of entitlement programs like Social Security and Medicare in terms of the visibility and concentration of benefit flows as well as the fragmentation and political resources of beneficiaries. Understanding the broader range of feedback effects, we argue, helps to clarify why conflict over the ACA continues unabated and why its fate remains uncertain. A central argument is that, as the ACA experience illustrates, policies frequently produce feedback effects that undermine themselves as well as feedbacks that reinforce their base of political support. Many of these self-undermining feedbacks are initially unanticipated or underestimated, as politicians focus on “making a deal” that can win enactment in the gridlock-prone US system and on mobilizing public support. Our analysis also makes clear how sensitive policy feedback effects are to the political and policy environments in which those policies are generated, interpreted, and modified.

We begin by outlining existing approaches to the analysis of policy feedback effects. Next, we briefly review the ACA’s enactment and outline its core provisions. We then examine the ACA’s key provisions and the complex feedbacks that they generated. We conclude by discussing the implications of our analysis for understanding the role of policy feedbacks in public policy and for the ACA’s political trajectory.

Understanding Policy Feedback Effects

The dominant view of policy feedback effects associated with the historical institutionalist approach emphasizes long-term, frequently slow-moving, self-reinforcing effects on political support for programs. As constituencies grow up around programs and public support for those programs builds, the menu of alternatives considered is likely to shrink to incremental – and generally expansionary – adjustments to existing benefits, unless there are exogenous shocks to the “policy regime” (the set of policies in a particular sector) that is in place.

A second major literature on policy feedbacks, associated with the work of Frank Baumgartner and Bryan Jones (2002, 2009; Jones and Baumgartner 2005) and their collaborators, emphasizes the dynamics of punctuated equilibria. Because policymakers face more potential areas for action than they can handle, policy sectors are often dominated by “policy monopolies” of influence that derive benefits from the status quo. Such monopolies reinforce their control by developing “formal or informal rules of access [that] discourage the participation of “outsiders,” and...prevalent understandings of the policy [that] are so positive... they evoke only support or indifference by those not involved” (Baumgartner and Jones 2009). Thus policymaking “is very static but reluctantly changes when signals are strong enough” (Jones and Baumgartner 2005, p. 19), usually as the result of exogenous shocks to existing equilibria such as focusing events, which cause increased attention to be devoted to that subsystem by outsiders who are less likely to be concentrated beneficiaries of the status quo. Proponents of the status quo are often able to re-assert their monopoly as the outsiders’ interest in the policy wanes.

Recent research on policy feedback effects attempts to integrate and extend these literatures. Eight broad conclusions emerge from this literature. First, policies are not always self-reinforcing (Campbell 2011; Patashnik and Zelizer 2013). Policy reforms can be eroded or reversed (Patashnik 2008), and policies may even have feedback effects that endogenously undermine those policies over time (Weaver 2010; Jacobs and Weaver forthcoming).

Second, policy feedback mechanisms and effects vary both in terms of type and intensity. In Table 1, we divide policy feedbacks associated into three broad categories: socio-political, fiscal, and administrative with distinctive causal mechanisms (Weaver 2010; Jacobs and Weaver forthcoming; for a similar categorization, see Patashnik and Zelizer 2013). Socio-political policy feedback effects concern whether public and elite support for a policy regime is reinforced or undermined over time. These mechanisms and effects include feedbacks at the level of mass cognition (e.g., is the policy perceived to be successful or disastrous in achieving its objectives and does it lead predominantly to the mobilization of

Table 1: Self – Reinforcing and Self-Undermining Feedback Mechanisms and Effects.

	Self-Reinforcing Policy Feedback Mechanisms and Effects	Self-Undermining Policy Feedback Mechanisms and Effects	Conditions Exacerbating Self-Undermining Effects
Socio-Political			
Cognitive effects	Perception of widespread benefits increases perceptions of satisfaction in mass public	Perception of concentrated losses increases perceptions of grievance in mass public	<ul style="list-style-type: none"> – High -profile opinion leaders have electoral incentives to frame program as loss-imposing or flawed or constituency as undeserving – Concentrated and organized constituencies were strongly united in support of benefits under <i>status quo ante</i> and have a strong ethical sense of entitlement
Constituency Effects	Flow of concentrated benefits to constituency reinforces sense of entitlement and strengthens organizations capable of defending benefit stream if threatened	Perception of concentrated losses leads to development or strengthening of constituencies seeking policy change, and/or to fragmentation of existing support coalitions	<ul style="list-style-type: none"> – Concentrated policy costs emerge quickly after enactment of policy reform – Beneficiaries of current policy are unorganized and receive diffuse benefits – Key provisions of policy are vulnerable to legal challenge – Multiple sources of policy expertise exist – Incremental policy “patches” have been implemented but fail to address perceived policy problems
Agenda Effects	Constituency and elite satisfaction with program narrows agenda to incremental program fixes	Constituency and elite dissatisfaction with program leads to search for non-incremental program fixes	

(Table 1: Continued)

	Self-Reinforcing Policy Feedback Mechanisms and Effects	Self-Undermining Policy Feedback Mechanisms and Effects	Conditions Exacerbating Self-Undermining Effects
Fiscal	Earmarked revenue stream provides adequate funding for foreseeable future, leading to limited concern and oversight by budget guardians	Large and rapidly growing program demand on general budget and/or ongoing funding crisis when dedicated funding stream becomes inadequate raise strong concerns among budget guardians	<ul style="list-style-type: none"> – Difficult overall fiscal climate – Demographic or cost trends that undermine adequacy of dedicated financing mechanism
Administrative	Administrative agency has clear, achievable mandate that allows it to avoid highly visible failures and develop strong sense of organizational mission and morale, as well as a strong reputation for competence	High-profile programmatic failures blamed on agency performance damage administering agency's (1) external reputation and political support and/or (2) internal morale, sense of organizational mission and ability to recruit qualified staff	<ul style="list-style-type: none"> – Complex and intrinsically difficult organizational mandates – Administrative responsibilities are divided among multiple entities with conflicting organizational mandates and priorities – Administrative failures recur frequently and grow in visibility or appear to get worse

supporters or opponents?). Whether the policy leads to a menu of reform options that is truncated to solely incremental changes or stimulates a search for more dramatic “regime-shifting” reforms (usually in response to a perception of serious and unavoidable policy failings) also influences the odds that a policy remains stable or is subject to revision.

Fiscal effects concern whether a program creates budgetary strains that are likely to raise concerns among powerful actors, notably Treasury or Finance Ministries, weakening the autonomy of groups dominating a policy subsystem. Administrative feedback effects encompass design and operational elements that allow the agencies in charge of implementing a policy to retain or acquire the capacity to implement the program in a manner that is perceived as successful by internal and external constituencies. This in turn will result in the strengthening or weakening of agency morale, external reputation, and external political support. Self-undermining feedback effects of all three types (socio-political, fiscal, and administrative) are likely to involve developments in the program that disrupt relationships between policy “insiders” and “outsiders” in ways that increase attention from and involvement by outsiders because of perceptions by those groups of heightened political salience or costs, budgetary strains, or administrative failures.

Third, few policy feedback effects are “purely” endogenous. Feedback effects are more likely to be self-undermining rather than self-reinforcing under some conditions than others. Indeed, a fourth and related point is that feedback effects can change over time in their direction and intensity: feedback mechanisms that reinforce a program at one point in time may undermine it at another point in time as conditions change. Earmarked revenue sources illustrate both of these points. Earmarking revenue may insulate a program and foster incremental expansion when revenues are flush but spark retrenchment or even a more radical consideration of policy alternatives when revenues run short. And whether revenues in trust funds are flush or lean in turn depends on conditions such as macro-economic growth and demographic shifts that alter the ratio of contributors to beneficiaries. Similarly, public perceptions of costs and risks will be higher when political elites have incentives to highlight those costs or risks. Self-undermining administrative feedbacks will be more prevalent when policy mandates given to administering agencies are intrinsically complex and difficult.

Fifth, policy feedback effects are often mixed in direction rather than unidirectional. Pre-2010 health policies in the US, for example, had a number of self-reinforcing feedback effects, notably engendering a sense of entitlement among Medicare recipients and a fear among those with good employer-sponsored health insurance plans that reforms to expand coverage to the uninsured that simultaneously altered their insurance arrangements would make them worse

off. But Medicare policies also engendered concerns about gaps in its benefits and the reliance on employer-sponsored insurance produced anxiety among workers over the potential loss of coverage, particularly during times of economic downturn, and perennial concerns over affordability given rising premiums.

Sixth, policy feedback effects may be either fast or slow-moving. Major focusing events can provoke an immediate policy response. Long-term trends may be more akin to the famous (albeit apocryphal) Al Gore anecdote about a frog being boiled in water that is heated slowly, such as the slow but seemingly inexorable rise in health care's share of the US economy. Slow-moving policy feedbacks are less likely to provoke an intervention by constituencies external to a policy subsystem, but they may also be less likely to experience waning attention by those interests in the latter stages of the issues attention cycle outlined by Anthony Downs (1972).

Seventh, self-undermining feedback effects are rarely a *sufficient* cause of policy change. While suffering concentrated costs may increase concern and an effort to find policy alternatives among affected groups, procedural rules that limit their participation and other factors can create barriers to acting on that disaffection. They may have to wait until sympathetic politicians gain power in order to redress their grievances, and in systems with multiple veto points like the US, even severe self-undermining policy feedbacks can result in the persistence of problems rather than in policy change.

Eighth and finally, when seeking to enact policy reforms, politicians and group leaders may seek to manipulate policy feedback mechanisms and effects to achieve policy and political objectives – for example by front-loading concentrated benefits and back-loading concentrated costs. However, they are likely to encounter a variety of constraints in their efforts to do so. Fiscal rules and constraints that require increased costs and benefits to be balanced within a particular time period, for example, can limit front-loading of concentrated benefits. The need to build political support coalitions for policy change, including actors who reject preferred options of coalition leaders, may require a political compromise that makes some strategies for manipulating feedback mechanisms untenable.

In sum, policy feedbacks are not always self-reinforcing, and such feedbacks can, under certain circumstances, actually undermine a program's political support. These dynamics are visible in the political life of the Affordable Care Act.

The Politics of ACA Enactment

The history of health care reform in the US is largely one of failure (Starr 1982; Blumenthal and Morone 2009; Altman and Shactman 2011; Hoffman 2012). The

Obama administration and Congressional Democrats overcame long odds to win passage of the Affordable Care Act. The extraordinary politics of the ACA's enactment have been discussed extensively elsewhere (Cohn 2010; Daschle and Nather 2010; Oberlander 2010; Brown 2011; Hacker 2011; Kirsch 2011; McDonough 2011; Starr 2011; Jacobs and Skocpol 2012; Brill 2015). Here we focus on the constraints and opportunities that reformers faced during 2009–2010, as well as on the assumptions, decisions, and compromises that shaped the ACA, its implementation, and the resulting socio-political, fiscal, and administrative policy feedbacks.

Reformers presumed that the only viable reform model was one that built on existing health insurance arrangements and left as many insured Americans as possible in their existing plans. The Obama administration and Congressional Democrats believed that the ill-fated Clinton health care plan of 1993–1994 had imploded largely because it was too disruptive to the existing system and alienated the well-insured (Oberlander 2010). In addition, they were strongly influenced by the example of Massachusetts, which in 2006 enacted an ambitious expansion of insurance coverage that leveraged both existing public insurance and private insurance plans – and that drew wide bipartisan support (McDonough 2011). The Massachusetts model combined policies and ideas associated with conservatives (an individual mandate, private plan competition, individual choice of plan) with policies and goals (Medicaid expansion, expanding access to affordable insurance, regulation of private insurers) associated with liberals, a combination the ACA would emulate. The Massachusetts experience suggested that such a model could provide a political blueprint for passing health reform through Congress and produce a workable approach to expanding insurance coverage.

Another lesson taken from the Clinton health care misadventure was the necessity of winning over interest-group support. The Clinton administration had fought an unsuccessful multi-front war against health care stakeholders, including the insurance industry and business interests, a battle the Obama administration very much wanted to avoid (Oberlander 2010; Brown 2011). That in turn meant constructing a reform plan that accommodated important interests, for example by building on private insurance and making a deal with the pharmaceutical industry to not pursue stronger cost controls in exchange for their support.

Democrats' reform vision in 2009–2010, then, ruled out more sweeping models, such as single-payer, Canadian-style national health insurance. Instead, the aim was to find ways to fold the uninsured into the prevailing US health insurance system, leaving its major pillars – Medicare, Medicaid, employer-sponsored private insurance – in place so as maximize the chances of securing both public and stakeholder support for reform. The ACA is ambitious in its scope and aspirations, yet its approach to health reform is also incremental in key respects. The

ACA represents an effort to place an additional series of patches on the existing patchwork of US health care (Marmor and Oberlander 2011).

In covering the uninsured, reformers confronted a formidable fiscal challenge, namely how to pay for expanding insurance. The Congressional Budget Office (CBO) would not credit much in the way of savings to politically appealing measures such as promoting prevention or paying on the basis of value rather than volume (in other words, changing the payment system for medical services to reward doctors and hospitals for better health outcomes and adherence to clinical guidelines, rather than reimbursing medical providers for each service provided regardless of its necessity or value). That left Democrats with an array of politically difficult and controversial options to pay for health care reform, from cutting Medicare payments to raising taxes on individuals. The Obama administration decided that politically it could not afford to spend more than \$1 trillion on health reform, which would have major implications for the type of coverage offered through the ACA (Oberlander 2014a). Further, the Democratic coalition in Congress contained a number of Blue Dogs, fiscal conservatives who insisted that any health reform plan not increase, and preferably decrease, the federal budget deficit. The administration promised to abide by PayGo principles, which meant they had to find about \$1 trillion in revenues and spending offsets over a decade to pay for the ACA.

Finally, the ACA relied extensively on states to implement health reform (Starr 2011). Many of the uninsured were to gain coverage through the state-administered Medicaid program. And states were given the opportunity to establish health insurance exchanges, purchasing pools where the uninsured and small business could go to obtain coverage (Jones, Bradley, and Oberlander 2014). Liberals had pressed for a national exchange, but Democrats' filibuster-proof majority of 60 in the Senate, which included Ben Nelson of Nebraska and others hostile to an expansionary federal role, made such a scheme impossible to pass; a Medicare-like public insurance option for the uninsured failed to clear the Senate for similar reasons. When the House passed the Senate bill in 2010 after Scott Brown's victory in a special Massachusetts election deprived Democrats of their filibuster-proof Senate majority, and reconciliation was then used to pass a "sidecar" bill to revise the law, the Senate's version of state-run exchanges remained intact. The federal government would instead serve as a backup, establishing exchanges in states whose governments declined to set up their own (McDonough 2011).

At the time of the ACA's enactment, that arrangement did not seem crucial, since the vast majority of states were expected to embrace the chance to craft their own exchanges, nor did the reliance on Medicaid appear problematic since all states were expected to expand it given the alternative of losing all of their federal Medicaid funding. Subsequent events, though, would underscore

just how crucial the reliance on state implementation was (Jones, Bradley, and Oberlander 2014).

The ACA's Core Provisions

Given these assumptions, compromises, and constraints, what kind of health care reform did the US enact in 2010? The ACA contains a broad array of policies that aim to increase health insurance coverage, control health care spending, and transform how medical care services are delivered and paid for (McDonough 2011; Kaiser Family Foundation 2013; Oberlander 2014a). Obamacare seeks to enhance access to insurance by providing income-related subsidies to low- and middle-income Americans to help them purchase insurance (subsidies are available for persons up to 400% of the federal poverty level). Additionally, the ACA establishes health insurance exchanges (also known as marketplaces) where the uninsured can use their subsidies and choose from private insurance plans that offer varying levels of coverage. Private insurers are regulated so they cannot deny coverage or charge higher premiums to persons with pre-existing conditions. Annual and lifetime limits on benefits are prohibited. Minimum standards for insurance benefits are set and the ACA requires enhanced coverage of preventive services. Young adults can stay on their parents' insurance plans until age 26. The law also requires most individuals to obtain and larger employers to offer health insurance coverage or pay penalties. Finally, the ACA called for expanding Medicaid eligibility to all persons who earned <138% of the federal poverty level (\$16,243 for an individual in 2015), regardless of their demographic category. Previously, in order to qualify for Medicaid enrollees had to be in a specific demographic category, such as pregnant women and children, and income thresholds for eligibility for adults varied widely across states.

These provisions were expected to have a major impact on health insurance coverage. The Congressional Budget Office (2010) projected that the ACA would reduce the uninsured population by 30 million persons by 2016. The ACA funded this coverage expansion through a combination of new taxes and projected savings in federal health care expenditures (Kaiser Family Foundation 2013). Americans making over \$200,000 a year (\$250,000 for couples) must pay higher Medicare payroll taxes, and their investment income is now subject to the Medicare payroll tax. Penalties paid by individuals who do not obtain insurance and larger employers who do not offer coverage to their workers also are expected to contribute significantly to the ACA's financing. The ACA additionally imposes taxes on the health care industry, including medical device manufacturers, for-profit insurers, pharmaceutical manufacturers, and tanning salons. A tax

on high-cost private health insurance plans – the so-called “Cadillac tax” – is scheduled to go into effect in 2018. New limits on flexible spending accounts and the tax deductibility of health care expenses are also established (Kaiser Family Foundation 2013).

The ACA’s funding relies as well on substantial savings from reducing the projected rate of growth in federal health care spending (CBO 2010). The law restrains the growth rate in Medicare payments to hospitals and cuts payments to the private insurance plans (Medicare Advantage) that contract with Medicare. These policies, particularly the reduction in hospital payments, are expected to produce a significant slowdown in Medicare spending (indeed, there is evidence that these provisions are already generating savings). However, the ACA contained a back-up mechanism to restrain Medicare spending growth: the Independent Payment Advisory Board (IPAB). The IPAB was envisioned as a nonpartisan board comprised by health policy experts. If Medicare spending exceeded thresholds specified in the law, the IPAB would be empowered to make recommendations to reduce program expenditures and if Congress did not act, the IPAB’s recommendations would then become law (Oberlander and Morrison 2013).

While the ACA reduces the growth in Medicare payments to medical providers, it also aims to control costs by changing how hospitals, doctors, and other providers are paid, and by changing how medical care services are delivered, thereby impacting health care spending across the entire health care system. The ACA encourages a variety of experiments in health care payment and delivery, including Accountable Care Organizations, medical homes, penalties on hospitals for high readmission rates, payments to doctors and hospitals based on value (so-called pay for performance), and bundled payment (Oberlander 2011). Advocates of these strategies tout their potential to simultaneously control health care spending while improving the quality of medical care delivery and health outcomes. Additionally, within the ACA’s health insurance exchanges, reformers sought to control insurance costs by relying on a system of competition between health plans.

In sum, the ACA contains a wide array of policies that aim not simply to expand access to health insurance coverage, but also to control health care spending and improve the quality of medical care.

The ACA’s Feedback Effects

The sheer magnitude of the ACA ensured that it would produce numerous and varied feedback effects. For all the controversy that has surrounded the ACA, it contains no shortage of self-reinforcing feedbacks. The law’s architects sought

to build popular support by selectively frontloading politically appealing policies (although the bulk of the ACA's major benefit and financing provisions came online simultaneously during 2013–2014). Provisions that were frontloaded in implementation – and began in 2010 after the law's passage – included requirements to allow parents to keep their children on their insurance plans until age 26 and prohibiting insurers from imposing pre-existing condition exclusions on children. Additionally, the ACA immediately enhanced Medicare coverage of prescription drugs and coverage of preventive services under both public and private plans. Other early policies (all implemented during 2010–2011) included the provision of health insurance tax credits to small businesses, a prohibition on lifetime caps on the dollar amount of coverage by private insurers, a requirement that insurers spend a specified portion of their premium dollars on medical services or provide rebates to consumers, and establishment of a new insurance program for Americans with pre-existing conditions who otherwise could not obtain insurance. States were also given the option of extending Medicaid coverage to childless adults ahead of the national expansion planned for 2014 (Kaiser Family Foundation 2015b).

In addition to these frontloaded provisions, the ACA contains a number of policies that began during 2013–2014 that extended benefits to millions of Americans, including federal subsidies for the uninsured to purchase coverage through state health insurance exchanges (later renamed marketplaces), expansion of Medicaid to low-income Americans, private insurance regulations that prohibited insurers from denying coverage or charging higher premiums to persons on the basis of their health status, and requirements that individual insurance plans cover maternity services, which heretofore many did not include (Kaiser Family Foundation 2015b).

The ACA, then, has a number of provisions aimed at providing new benefits to the already insured, improving access to health insurance for the uninsured, and protecting consumers from insurance company abuses, all measures that could be expected to strengthen both popular and policymaker support for the ACA.

Yet the ACA also contains many policies that are unpopular and impose costs on concentrated groups. In addition, regulatory decisions made by the Obama administration and problems in program administration have generated additional self-undermining feedbacks. Health care reform, which seeks to reconfigure a policy area that is thick with interest groups and beneficiaries of pre-existing programs and constitutes almost one-fifth of the American economy, is inherently disruptive (Feder 2014). Reform requires changes, and a reform as large as the ACA requires changes and redistribution that are controversial and creates losers as well as winners. Some of the self-undermining policy feedbacks in the ACA are predictable. For example, the Cadillac Tax, which imposes a 40% tax on

high-cost private health plans, is fiercely opposed by labor unions and unlikely to be popular with well-insured Americans. Although it is expected to generate large revenues for the federal government, it was not scheduled to go into effect until 2018, a back-loading that reflects its political liabilities (Oberlander 2011). And while the Cadillac tax is expected initially to affect a small percentage of Americans, its formula ensures that over time many more insurance plans will be subject to the tax, meaning that as it becomes more important as a financing mechanism it will simultaneously become more problematic politically.

The individual mandate – a requirement that individuals obtain health coverage or pay a penalty – is another policy that predictably could produce self-undermining effects. It imposes a direct financial loss on some Americans, although the actual percentage of the population subject to the penalty is modest: the Congressional Budget Office (2014) estimates that 4 million people will be subject to the penalty in 2016, with total federal revenues from the penalty averaging about \$5 billion per year during 2017–2022 (CBO 2014). The individual mandate makes health reform look punitive, and it has consistently proven unpopular with the public, despite its importance to ensuring that health insurance exchanges for the uninsured are stable and do not attract disproportionately sick, expensive populations. That the individual mandate is one of the policies most identified with the ACA has been a major political problem for the Obama administration. Reformers attempted to mute the negative political impact of the policy by phasing it in, with a modest monetary penalty for not obtaining insurance in 2014 that accelerates in subsequent years (Mach 2014). The Obama administration also has carved out numerous exceptions to the individual mandate that reduce the number of Americans who must pay the penalty: about 24 million of the 30 million Americans expected to be uninsured in 2016 are expected to be exempt from penalties (CBO 2014). Still, as the individual mandate penalty climbs in future years and it becomes a more potent motivator for healthier Americans to join the insurance exchanges, it is likely to become more controversial as a larger number of Americans pay the fine for not having insurance.

Like the individual mandate, the requirement that larger employers offer coverage to their workers or pay a penalty is an ACA provision with predictably negative political effects. The employer mandate imposes (in the midst of a recovering economy) direct losses on some businesses, especially medium-sized firms, who did not previously offer insurance and it establishes new coverage standards that even some firms that had offered coverage do not meet. And it has unanticipated loopholes – that the Obama administration is trying to close – enabling large employers to satisfy the law’s requirements by offering their workers “bare bones” or “skinny” policies that have very limited benefits (Hancock 2013, 2014).

Business lobbying groups have strongly opposed the requirement to offer insurance, and critics argue it will lead to more part-time workers, though there is little evidence to date of that shift (Garrett and Kaestner 2014). Although the employer mandate remains popular with the public, its popularity is very susceptible to framing effects – support increases significantly if respondents are prompted with the information that most large employers already provide insurance and would not face a fine, and declines substantially when they are told that some employers might reduce employees from full to part time in order to avoid the fine (Kaiser Family Foundation 2014, p. 13).

Furthermore, the complicated nature both of the requirement and formula for calculating employer penalties – firms with 50 or more workers are liable only if one of their workers qualifies for a subsidy on the health insurance exchanges – as well as the reporting requirements on employers have made it difficult to implement. As a consequence of these fraught politics and technical issues, the Obama administration has twice delayed the onset of the employer mandate via executive orders (it is currently slated to start in 2015). Some health reform advocates, citing the complex rules and anticipated modest effect on employee coverage, are now calling for jettisoning the ACA's employer mandate altogether; doing so, however, would have a negative impact on the federal budget deficit, variously estimated at between \$46 and \$130 billion between 2014 and 2015 (Blumberg, Holahan, and Buettgens 2014; Cunningham and Cheney 2014).

Another ACA reform that has had difficulty getting off the ground is the Independent Payment Advisory Board (IPAB). Obama administration officials regarded the IPAB's enactment as an important step toward controlling Medicare spending and giving experts, rather than politicians, influence to set the direction of program policy. But 5 years after the ACA's enactment, IPAB exists only on paper; not a single member has been appointed to the board, indeed President Obama had not even nominated anyone to the board for Congressional approval. The Obama administration failed to anticipate the intense Republican opposition to IPAB, which has derailed its implementation. Instead of becoming an institutional buffer against rising health care costs, IPAB has become a non-factor in Medicare policy and a political liability. Opponents have portrayed IPAB as a "rationing board" that would deny services to Medicare enrollees and the embodiment of a real-life "death panel." Such allegations are, of course, absolutely false, yet IPAB's failed launch does reveal the Obama administration's obliviousness both to the partisan politics surrounding Medicare in an era of historic levels of polarization and to the political vulnerabilities of a plan to empower non-elected experts to make key decisions on Medicare policy would bind Congress (Oberlander and Morrison 2013).

Other ACA Medicare provisions have also proven highly controversial. Aware of the political sensitivity of Medicare for its beneficiaries, the ACA contained a number of specific policies that were designed to appeal to seniors, including free annual wellness visits, expanded coverage of screening services (e.g., colonoscopies and mammograms) and a shrinking of the Medicare Part D “doughnut hole” in prescription drug coverage. As with many other coverage provisions, these expanded Medicare benefits were front-loaded in their timing.

Rather than securing senior support for the ACA, however, public debate has been more focused on the ACA’s reliance on Medicare reimbursement changes as a central mechanism – estimated at approximately half a trillion dollars in the 2010–2019 period – to finance its expansion of insurance coverage to the uninsured. Such provisions, including slowing down the rate of increase in Medicare payments to hospitals, were necessary to get “CBO-scoreable” savings that would allow the ACA to be presented as paying for itself and actually reducing the federal deficit over the ensuing two decades (CBO 2010; Oberlander 2011). However, relying on Medicare savings to help fund the law played into the hands of ACA opponents who claimed that Obamacare was being financed on the backs of seniors and demanded that government “keep its hands off my Medicare.” The use of Medicare savings as a central funding mechanism for the ACA allowed opponents to scare seniors who feared that that Medicare cuts that would harm them were being used to provide benefits to others. Even if such fears were not justified – in fact, the ACA expanded Medicare benefits and slowing down the growth in Medicare spending helps program enrollees by making co-payments and other program costs more affordable – they were nonetheless politically potent.

As noted earlier, the ACA relies on myriad tax increases to fund part of its expansion of insurance coverage. Some of these increases, such as the Medicare payroll surtax for higher-income Americans, are already in effect and have yet to generate much controversy. However, the tax on medical device manufacturers has caught the industry’s attention, and it has lobbied aggressively for repealing the tax. Indeed, there is bipartisan support for overturning the device tax in response to complaints from the medical device industry, a classic illustration of the politics of concentrated interests (Millman 2014). That the tax is actually only marginally important to the ACA’s funding – an estimated net revenue of \$29 billion over 10 years (Gravelle and Lowry 2014) – probably increases its likelihood of repeal, since it can be removed without jeopardizing the law’s major benefit provisions (Oberlander 2014b).

During the ACA’s implementation the limits of its insurance coverage also has emerged as an issue. Many plans offered through the health insurance exchanges have limited provider networks where only select hospitals and doctors are included, and carry high deductibles and cost-sharing. The cost-sharing amounts

in these ACA plans are much higher than in the average employer-sponsored plan, though lower-income persons can obtain subsidies from the federal government to defray the costs. The limits of ACA coverage have become a political issue for the administration, as critics have charged Obamacare with offering inadequate coverage (ironically, conservative critics heretofore supported high-deductible plans). To be sure, there are real policy tradeoffs: limited networks allow plans to offer less expensive premiums. But the source of the limited coverage is the fiscal constraints faced and compromises made by the Obama administration and Congressional Democrats to pass the ACA (Oberlander 2014). A health reform plan with more money dedicated to its financing would have allowed for more generous plans, and perhaps such plans would generate a stronger political constituency of beneficiaries.

The aforementioned self-undermining policy feedbacks were all arguably predictable. But the ACA has also encountered unexpected problems that were not apparent at the time of the law's enactment. The disastrous rollout of *healthcare.gov* in the fall of 2013, beset by technical glitches that prevented people from enrolling in coverage, handed ACA opponents evidence that seemed to confirm their predictions of the program's unworkability, further eroded public confidence in the federal government's administrative abilities, and initially reduced enrollment in the new health insurance exchanges run by the federal government dramatically (because of unexpected state opposition to establishing health insurance exchanges, Washington was responsible for their operation in about three dozen states, amplifying the scope of the fiasco). The administration eventually repaired the major glitches and by the end of the 2014 enrollment period, enrollment had actually met projections. Yet the political damage to the ACA had already been done.

Another unanticipated negative feedback arose when private insurers started cancelling private policies on the individual insurance market in the fall of 2013. Prior to the ACA's enactment, about 5% of Americans obtained health coverage directly on what is known as the individual or non-group insurance market. That market had a poor reputation among most health reformers: it was administratively expensive with high marketing costs, persons with preexisting medical problems often were charged exorbitant premiums through medical underwriting or denied coverage altogether, and individual insurance policies had a high turnover rate. Problems with the individual market provided the impetus for establishing new health insurance exchanges where the uninsured could pool their purchasing power, insurers would be strictly regulated, and marketing costs would be lowered (McDonough 2011).

The fate of the individual market did not receive substantial attention during the 2009–2010 health reform debate, probably because a relatively small proportion of the country has such plans. Health policy analysts presumed that

this market would largely be displaced by the new health insurance exchanges, where enrollees would have access to subsidized coverage. However, there were some individuals on the individual market who were getting a good deal on their coverage and wanted to keep it, a reality the Obama administration discovered when insurers cancelled their policies in the fall of 2013. President Obama had promised that “if you like your plan, you can keep it,” a promise broken by the cancellations. The ensuing political furor, amplified by ACA opponents, contributed to the notion that the ACA was hurting insured Americans, and forced the administration to backtrack and permit states to allow such individual policies to continue. Disruption of the individual market was inevitable – and in many cases, such disruption benefited those persons with access to subsidized coverage on the exchanges (Feder 2014). But the administration could have mitigated the fallout associated with this issue by writing looser standards to “grandfather” in enrollees in the individual market.

Finally, arguably the most important unanticipated policy feedback associated with the ACA is its vulnerability to legal challenges. The administration and other reformers did not believe that the individual mandate would face serious constitutional jeopardy, yet the Supreme Court came within one vote (saved only by Chief Justice John Roberts joining the court’s four liberals in a highly unusual coalition) in 2012 of invalidating the individual mandate – and the entire law. Nor did the administration, or any other reformers, foresee a ruling by the Court that effectively made Medicaid expansion optional for the states. That ruling opened a new front in the battle over Obamacare, and even with the lure of federal financing, to date 22 states have rejected Medicaid expansion. Consequently, the ACA’s effort to cover low-income Americans has suffered a serious blow since uninsured persons living below the federal poverty level in states that do not expand Medicaid have no access to affordable coverage. Moreover, the Supreme Court will rule in the summer of 2015 on a case – *King v. Burwell* – challenging the legality of providing subsidies to the uninsured in states where the federal government operates exchanges. A ruling that declares those subsidies illegal would deal a major blow to Obamacare in about three-dozen states (Oberlander 2014b). The unanticipated legal challenges to the ACA have threatened (and in the case of Medicaid expansion, undercut) its core provisions to expand coverage, kept the health reform debate going, and contributed to undermining the law’s legitimacy.

Conclusions

Examining the enactment and subsequent implementation of the Affordable Care Act provides important insights not only into its own difficult history but

also into the complex dynamics of policy feedbacks in general, and how they can vary even within a single policy sector. Five years after the 1965 enactment of Medicare, few politicians could imagine the repeal of that program, and fewer still would advocate it. Five years after enactment of the Medicare Catastrophic Coverage Act of 1988, it was only a painful memory for those who enacted it. Five years after passage of the Affordable Care Act, its fate is still very much up in the air.

These differing fates reflect, in part, these programs' different policy feedbacks. Medicare provided enormous immediate benefits to the elderly for a modest price, and followed the established and popular social insurance arrangements of Social Security, including payroll tax financing. The Medicare Catastrophic Coverage Act also sought to extend benefits to seniors, but it departed from traditional social insurance and Medicare arrangements by having seniors self-finance the benefits (rather than relying on contributions from the working public) and imposing high, visible, and immediate costs on more affluent Medicare enrollees while delaying benefits. As a consequence, it triggered intense opposition: even Medicare beneficiaries who would have benefited from the law were confused by its financing mechanism, and the program quickly imploded politically (Himelfarb 1995; Oberlander 2003; Patashnik 2008).

The Affordable Care Act lies in between these two extremes. In contrast to Medicare, the ACA is not a social insurance program with a clearly identified constituency that has a clear connection to benefits (Marmor and Oberlander 2011). The ACA treats different groups of Americans in different ways at different times, and that fragmented structure makes it harder to build support for the law, harder to recognize benefits that do exist, and easier to attack, since the law's constituency is diffuse and many intended beneficiaries, including many of the uninsured, do not understand the benefits available to them.

Within this fragmented programmatic structure, the Obama administration and its allies did seek to manipulate the ACA's feedback effects in ways that would benefit their political and policy interests, notably in frontloading some concentrated benefits and back-loading some important concentrated costs. However, they were highly constrained in how much they could do so by super-majority requirements to enact controversial legislation in the Senate, as well as by fiscal rules and Congressional Democrats' internal divisions on substance and strategy. The complex history and many compromises needed to win congressional passage of the ACA embedded many self-undermining feedbacks – socio-political, financial, and administrative – and left it vulnerable to even more negative feedbacks encouraged by forces hostile to the ACA who could both challenge its legality and affect the way it was implemented. Reformers and the Obama administration, then, underestimated the impact of self-undermining policy feedbacks

and overestimated the extent to which the ACA would be politically institutionalized quickly and transform its political fortunes as Medicare did. Why did this occur?

The degree to which these policy feedbacks, and the ensuing conflict, were inevitable or reflect poor strategic choices by the Obama administration and its political allies is certainly debatable. Blaming poor strategy suggests that if the Obama administration and its allies had been more prescient and more politically savvy, they could have avoided many of the problems that the ACA subsequently encountered. This explanation requires that the administration (1) failed to see warning signs of trouble ahead that could have reasonably been anticipated, and (2) failed to take actions in light of those warning signs that would have made a difference.

Certainly, if Democrats had noticed the problematic wording in the ACA's text related to the availability of subsidies in federally sponsored exchanges, they could have taken steps to revise the legislative language in ways that would have never allowed a legal challenge like *King v. Burwell* to emerge. The cancellation of individual insurance policies during the fall of 2013 is one key area where the Obama administration appears to have overlooked the potential fallout of their own actions and the loss-imposing nature of some ACA provisions. Additionally, the ACA's individual and employer mandates were highly controversial even before they went into effect. Indeed the political dynamic of the individual mandate strongly underlines how resourceful messengers can build strong opposition to a policy even before it has gone into effect. In a political environment that is both highly polarized and lacking slack resources to provide new benefits to attract voters, negative messaging becomes the major coin of political discourse in both politics and policymaking (Weaver 1986; Lee forthcoming). These negative messages can undermine the capacity of new policy to become popular and politically institutionalized, leaving program more vulnerable to challenges.

ACA proponents also underestimated the ability of critics to frame critiques (some more honest than others) about negative effects. ACA opponents in the Republican Party and their media allies repeated and amplified concerns from the real (cancellation of individually purchased policies, the troubled launch of *healthcare.gov*) to the mythical (death panels, cuts in Medicare benefits) and wove them into a broader narrative of Obama administration duplicity and widespread loss imposition (Eckles and Schaffner 2010).

The Obama administration, Congressional Democrats, and health reform advocates appear to have badly miscalculated the political environment. Partisan polarization explains much of the ACA's enduring political problems, as partisans framed debate around ACA's negative impacts, real and imagined, emphasized loss-imposing policy consequences rather than the law's beneficial impacts, and

resisted the ACA's implementation at the state and federal level. Because of compromises made in the Senate and the 2012 Supreme Court ruling, states play a crucial role in health reform implementation – a role far greater than the ACA's architects anticipated. ACA proponents underestimated state resistance to both exchanges, which had been an idea previously supported by many Republicans, and Medicaid expansion. After the 2010 elections and rise of the Tea Party, state politics moved to the right and GOP governors had a stronger incentive to boycott Obamacare and Medicaid expansion (Jones, Bradley, and Oberlander 2014). They have done so, despite, in the case of Medicaid, financial lures from the federal government: ideology and partisanship has trumped fiscal pragmatism in many states. Federalism clearly provided an opportunity for opponents to undermine the law's implementation and operation, and to emphasize and indeed create both real and apparent loss-imposition.

It is less clear, however, what ACA proponents could have done to avoid the law's federalism-related problems. While strategic mistakes certainly added to the self-undermining feedbacks of the ACA and added to its political and legal problems, most of its problems either seem difficult to anticipate or are due to constraints imposed by the political environment and the legacy of past policies that gave the ACA's proponents limited room to maneuver. The rise of the Tea Party and its effect on forcing Republican officeholders into ever more intransigent stances on implementation of and legal challenges to the ACA could hardly have been anticipated in 2009.

Even if ACA proponents had anticipated these problems, it is unlikely that they could have done much about them that would have fundamentally altered outcomes. Perhaps their most significant failure was not realizing that the ACA really would inevitably impose costs (e.g., cancelled insurance policies) as well as benefits in the short term. As noted earlier, politicians tend to minimize negative feedbacks at the time of a program's enactment because they are focused on getting legislation through the Congressional gauntlet and on mobilizing public support. The ACA's architects faced extraordinary obstacles to enacting health reform, which created strong incentives for them to minimize the law's self-undermining feedbacks. But if Democratic lawmakers had perfect political foresight – given the large number who subsequently lost their seats – it is likely that some never would have voted for the ACA in the first place and it would not have passed Congress.

As noted at the outset of this article, public opinion on the ACA has been remarkably stable over last 5 years: despite initial problems with the rollout of the health insurance exchanges during 2013–2014 and subsequent successes in enrollment, public support for the ACA is quite similar to that in 2010 and consistently more negative than positive. Even if healthcare.gov's opening had been smooth and nobody had individual policies cancelled, it is not clear that the

ACA be much more popular and under significantly less attack: healthcare.gov is working well now, millions of Americans have gained insurance coverage, and yet the ACA still draws tepid public support and remains in a precarious political position. The importance of partisan polarization (McCarty, Poole, and Rosenthal 2006) in producing this prolonged uncertainty and conflict surrounding the ACA is impossible to overstate. Polarization has served as a crucial mediating factor in the politics of Obamacare, amplifying self-undermining feedbacks while obscuring self-reinforcing policies and benefits.

In sum, we have emphasized that (1) policies may generate self-reinforcing and self-undermining feedback effects simultaneously, (2) the balance of these feedback effects may shift over time; (3) it is the balance of these effects that matters politically, with blame-avoiding and blame-generating politicians paying particular attention to policy consequences that appear to generate losses for particular groups; (4) feedback effects, especially socio-political feedbacks, are in part social constructs that reflect the framing that key shapers of opinion convey to the public about the impact of those policies, and they are mediated by external factors like the level of partisan polarization; and (5) while self-undermining policy feedbacks may shape the political debate over revising a policy, the final outcome depends heavily on the political bargaining leverage of key actors and the institutional rules involved in changing policy. This case study of the Affordable Care Act suggests a number of extensions of this argument. For example, not all self-undermining effects are equivalent: some, like the costs imposed by the individual mandate, risk undermining an entire reform package of which they are one component. Others, like the Cadillac tax, mostly undermine themselves without jeopardizing the whole law.

The Democrats' initial calculation in passing the Affordable Care Act was that if they could get a policy of "near" universal coverage in place, offer benefits to both large numbers of uninsured and insured Americans, pay off the states, neutralize key interest groups, and backload at least some of the concentrated costs, the policy would be impossible to get rid of. Rather than being a slam dunk, however, the ACA's avoiding repeal or major rollback for the past 5 years has depended on maintaining veto power in the presidency and (through the supermajority required for cloture) the Senate.

Republicans continue to push for Obamacare's repeal. But Republicans have their own political problems: a pre-ACA *status quo ante* with many highly visible defects, and no credible alternative that would not make many individuals worse off (Pear 2015). If the Supreme Court upholds the government's position in *King v. Burwell*, the GOP will confront a political reality where millions of Americans, and the insurance and hospital industries, are benefiting from subsidized insurance coverage and Medicaid expansion. The longer the ACA goes on,

the more beneficiaries it gains, and the more the medical care industry comes to depend on it for revenue, the harder it will be for Republicans to dislodge Obamacare, even if the GOP wins the White House in 2016 (Oberlander 2014b). Still, the past 5 years have shown just how difficult it is to institutionalize a major new social program with complicated and mixed policy feedbacks in a polarized partisan environment. The fight over Obamacare is not over.

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