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Journal of Health Politics, Policy and Law, Vol. 45, No. 4 (2020, August): 647-660. [DOI](#). This article is © Duke University Press and permission has been granted for this version to appear in [e-Publications@Marquette](#). Duke University Press does not grant permission for this article to be further copied/distributed or hosted elsewhere without the express permission from Duke University Press.

The Affordable Care Act in the States: Fragmented Politics, Unstable Policy

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Abstract

Many argue that the frustrated implementation of the 2010 Affordable Care Act (ACA) stems from the unprecedented level of political polarization that has surrounded the legislation. This article draws attention to the law's "institutional DNA" as a source of political struggle in the 50 states. As designed, in the context of US federalism, the law fractured authority in ways that has opened up the possibility of contestation and confusion. The successful implementation of the ACA varies not only across state lines but also across the various components of the law. In particular, opponents of the ACA have experienced their greatest successes when

they could take advantage of weak preexisting policy legacies, high levels of institutional fragmentation, and negative public sentiments. As argued in this article, the fragmented patterns of health care politics in the 50 states identified in previous research have largely persisted during the Trump administration. Moreover, while Republicans were unsuccessful at repealing the legislation, the administration has taken advantage of its structural deficiencies to further weaken the legislation's capacity to expand access to affordable, quality health insurance.

Keywords

Affordable Care Act, Obamacare, health care reform, Federalism, States, United States

The signing ceremony of the Affordable Care Act (ACA)—the most dramatic reform of the US health care system since the creation of Medicare and Medicaid—was a moment of almost unmitigated optimism. The law, President Obama said, was an affirmation of the “core principle that everybody should have some basic security when it comes to their core health care” and an “essential truth” that “we are not a nation that scales back its aspirations” (Stolberg and Pear 2010). Yet the law represented a series of scaled-back aspirations—an attempt to make real reforms while keeping the basic structure of American health care financing in place. Compromises with the insurance and pharmaceutical industries, as well as fiscal conservatives within the Democratic Party, resulted in a law that required many middle-income Americans to purchase insurance on confusing and glitch-laden marketplaces and that buried fiscal benefits in a tax-expenditure scheme. Before long, the Supreme Court had scaled back the effect of the law's most tangible and visible benefit, Medicaid expansion, by allowing state governments to opt out. In addition, while the US uninsured rate fell steeply following the passage of the ACA, 13.7% of the US population remained uninsured by 2019. This represented a 4-year high, suggesting that coverage gains made under the Obama administration have begun to recede slightly under Trump (Witters 2019).

Many argue that the ACA's frustrated implementation can be explained by the unprecedented level of political polarization that has surrounded the legislation. In our book *Obamacare Wars* (Béland, Rocco, and Waddan 2016), however, we draw attention to the law's “institutional DNA” as a source of struggle. As designed, the law fractured authority in ways that opened up the possibility of contestation and confusion. The successful implementation of the ACA varied not only across state lines but also across the various components of the law. In particular, opponents of the ACA experienced their greatest successes when they could take advantage of weak preexisting policy legacies, high levels of institutional fragmentation, and negative public sentiments.

The fragmented patterns of politics we identified have largely persisted during the Trump administration. Moreover, while Republicans were unsuccessful at repealing the legislation, the administration has taken advantage of its structural deficiencies to further weaken the legislation's capacity to expand access to affordable, quality health insurance.

Insurance Exchanges

The core objective of health insurance marketplaces is to offer affordable insurance packages tied to government subsidies. Both small businesses and lower-income people ineligible for Medicaid are targeted by these insurance marketplaces (Béland, Rocco, and Waddan 2016). As the name implies, marketplaces are market-friendly institutions, which is probably why the framers of the ACA did not expect a strong Republican backlash against them at the state level. Yet this political backlash did occur, and as of 2018, only 12 jurisdictions, including DC, operated state-based marketplaces. In contrast, federally facilitated marketplaces

were in place in 34 states. The last 5 states operated a state-based marketplace “using a federal platform” (Forsberg 2018: 2). This means that only a small minority of states elected to run their own health insurance marketplaces. This situation forced the federal government to spend much effort and money setting up marketplaces, a situation that further complicated the implementation of the ACA (Béland, Rocco, and Waddan 2016). Yet, at least the federal government could act on its own in this component of the ACA, a situation that contrasts with Medicaid expansion, which requires states to take the lead. Simultaneously, the extremely favorable fiscal incentives associated with Medicaid expansion nudged a greater number of states to participate in this other key component of the reform. Moreover, in contrast with other aspects of the law, outside of post-Romneycare Massachusetts, health insurance marketplaces appeared as a novelty states had no experience dealing with. Finally, because of their high public profile and their direct link with the controversial and widely debated “individual mandate,” health insurance marketplaces offered ACA opponents in the states an opportunity to demonstrate their opposition to the law by refusing to set up their own exchanges (Béland, Rocco, and Waddan 2016).

A fascinating aspect of the limited adoption of “homemade” marketplaces by the states is the fact that opposition to this policy tool emerged only after the ACA's enactment (Jones, Bradley, and Oberlander 2014). This is because, as suggested above, marketplaces are inspired by Romneycare and market-friendly policy ideas that Republicans had long embraced. Yet, once they became part of the ACA, exchanges suffered from “guilt by association,” as many GOP-governed states rejected the reform as a block (Jones, Bradley, and Oberlander 2014). Conversely, the widely publicized problems experienced by some health insurance marketplaces have been used to discredit the ACA as a whole, even if these exchanges are only one component of it (Altman 2016).

Here a double ideological simplification is taking place. First, the problems witnessed in some states are used to promote the idea that all state exchanges are dysfunctional. Second, the concept of the ACA as a whole is reduced to the system of health insurance marketplaces and to the “individual mandate” so central to the conservative rhetoric against the ACA. While the individual mandate was envisioned as an essential means of avoiding adverse selection in the marketplaces, it remained enduringly unpopular. This may explain why, of all the potential repeal-and-replace plans congressional Republicans introduced in 2017, the proposal to eliminate the individual mandate came closest to passing on its own, losing by a one-vote margin in the Senate (Béland, Rocco, and Waddan 2019). While it would never receive a public vote, the penalty for the individual mandate was later zeroed out by Republicans in omnibus tax overhaul legislation, setting the stage for new litigation on the constitutionality of the ACA in *Texas v. United States* (No. 19–10011, 5th Cir. 2019). Thus, while the marketplaces remained in place, the zeroing out of the mandate reveals how the sheer complexity of the ACA obscures the link between the law's popular and unpopular components (Altman 2016; on obfuscation, see Pierson 1994).

For the time being, like the ACA itself, health insurance marketplaces are here to stay, in part because they have created their own policy legacies over time. Interestingly, states that decided to implement their own marketplaces witness lower insurance premiums on average than do states that decided to let the federal government do all the work (Alberts and Cousart 2017; Hall and McCue 2018). This reality has a key political implication: the decision of many states to pass on the opportunity to set up their own exchanges has been detrimental to the residents of these states while contributing directly to weakening public support for the ACA. This is because exchanges, especially those that do not perform well, remain to the foreground of the ideological struggles over the ACA. Such a situation sharply contrasts with the situation prevailing in the field of health insurance regulation, where successful cooperation between the federal government and the states has been the norm rather than the exception (Béland, Rocco, and Waddan 2016).

Medicaid Expansion

The Supreme Court's decision in June 2012, which gave states a genuine choice about whether to join the Medicaid expansion, effectively changed the policy design of the ACA and made this aspect of the law a subject of ongoing political contestation. Nearly 6 years after the expansion came into effect, 14 states still refused to embrace the federal dollars on offer and extend health insurance to some of the poorest people in the state. Simultaneously, some states have sought to use the section 1115 waiver process to get leeway from the Trump administration to make Medicaid eligibility conditional on requirements in ways that the ACA's framers never intended. Hence, the Medicaid expansion has seen the noisiest ongoing politics—and this is not a symbolic politics, put on simply for performance, but is a politics where the results have grave real-world consequences.

Deeper policy legacies and lower levels of institutional fragmentation have helped encourage states to expand Medicaid. Unlike with the insurance exchanges, which asked states if they wanted to engage in building new institutions, all states already had experience with Medicaid. Certainly more states had joined the expansion by the end of Obama's time in office than had set up their own insurance exchange. Yet, reflecting existing policy trajectories, those states with more generous existing eligibility criteria were more likely to join the expansion than those with “stingier” requirements (Morone 2012).

Developments on a state-by-state level also hinged on institutional arrangements within states. One recurring, if not typical, occurrence was a battle between a state's governor and its legislature. Notably, some red states had joined the expansion in circumstances where the state's governor had taken control of the process and overridden opposition from the state legislature. In Ohio, Governor John Kasich used arcane rules to bypass the legislature, and in Arizona, Governor Jan Brewer, no friend to the Obama administration, effectively leveraged her powers to force the legislature to agree to join the expansion. In Florida, in contrast, the legislature was not to be bypassed, and Governor Rick Scott's flirtation with the idea of joining the expansion was squashed, and in Maine, Republican governor Paul LePage used his power to veto bills passed by the Democratic legislature to expand the state's Medicaid program.

Other more recent examples have reinforced the importance of the willingness and capacity of a governor to wield executive power to push through the expansion. Louisiana was the first, and remains the only, Deep South state to adopt the expansion following the election of Democrat John Bel Edwards to the governorship. On his second day in office Edwards issued an executive order to set the expansion process in motion (Miller 2016), despite the fact that the GOP retained comfortable control of both chambers of the state legislature. By February 2017, over 400,000 people had enrolled and the state's uninsured rate had fallen from 21.7% in 2013 to 12.5% (Louisiana Department of Health 2017). Meanwhile in Virginia, Democratic governor Terry McAuliffe was thwarted in his efforts to expand the state's Medicaid program by the state legislature, despite 4 years of trying. In the end, his successor, Democratic governor Ralph Northam, was able to sign an expansion into law in June 2018 after Democrats gained several seats in the state's House of Delegates elections in 2017 (Goodnough 2018). This was also predicted to cover up to 400,000 people. In contrast, in Kansas in 2017, both chambers of the Republican-controlled legislature voted to accept the expansion, if with caveats, but Governor Sam Brownback vetoed that move.

In addition to policy legacies and institutional fragmentation, public sentiments are a crucial factor that has shaped ACA politics. We define public sentiments as “*issue salience* and *public support*” for policy initiatives (Béland, Rocco, and Waddan 2016: 33; on public sentiments, see also Campbell 2004). Since 2017, the question of public support has been tested explicitly on Medicaid, as several states have seen referenda on the matter. In 2017, in Maine 59% of voters approved expanding the state's Medicaid program, though Governor Le Page yet again stood in defiance. Finally, in January 2019, new Democratic governor Janet Mills called for the expansion to be implemented.

One analysis of the votes cast in Maine, however, suggested that this was not necessarily a pattern that would be widely repeated. Matsa and Miller (2019) tentatively concluded that, if a similar exercise in direct democracy were conducted in the 18 states that had not at that point expanded their Medicaid program, only 5 would have a pro-expansion majority.¹ Yet, showing broader support, or at least more mobilized support, than implied in that model, in November 2018 three red states, Idaho, Nebraska, and Utah, voted to expand their Medicaid programs with 61%, 53%, and 54% of voters, respectively, supporting expansion (Kliff 2018).² Further, Clinton and Sances (2018: 183) suggest some, if quite modest, increase in political participation resulting from the expansion “concentrated among potential beneficiaries” (see also Michener 2017)

The story told so far is suggestive of some momentum, if very halting and far from comprehensive, edging toward an expansion of the expansion. But even such a heavily qualified narrative is too one-dimensional. No state has repealed its expansion outright, even in cases where the expansion was pushed through in red-leaning states by a Democrat governor who was then succeeded by a conservative Republican. Perhaps most starkly, in Kentucky in 2015, Republican Matt Bevin campaigned on repealing the Medicaid expansion pushed through by his Democratic predecessor Steve Beshear.³ In fact, even before Election Day, Bevin, presenting himself as a Tea Party conservative, was walking back that commitment, given the ramifications of taking away the coverage of about 400,000 of the state's population (Pradhan and Demko 2015). Yet, the state has aggressively pursued the application of work requirements in a manner that undermines key principles of the ACA.

One of the novel features of the ACA's version of expansion, in contrast to the existing Medicaid rules, was that it set out to determine eligibility simply according to income, at least up to its floor of 138% of the poverty level, without additional judgment on the “moral worthiness” of beneficiaries. In addition, the Obama administration made it clear that it was unwilling to allow states much discretion to veer from that unconditional standard. For example, Indiana was allowed to introduce a monthly copayment for Medicaid recipients, but this was limited to a minimum of \$1 rather than the \$3 requested by the state (Samuels 2016). In addition, work requirements were not permitted. The Trump administration, however, has taken quite a different path in allowing states to employ section 1115 waivers to impose tougher conditions for people to qualify for access to the expanded program.⁴

In this context, efforts to roll back statewide expansions have taken the form of applying work requirements and other conditions to encourage “personal responsibility” rather than simple repeal. Arkansas was the first state to forcefully implement work-reporting requirements, and between June 2018 and January 2019, 18,000 people had lost their entitlement to Medicaid because of failing to meet the new standards (Schneider 2019). To counter these actions, advocates of more unconditional Medicaid expansion turned to a tactic aggressively and repeatedly used by the ACA's opponents by challenging these moves in court. This resulted in Arkansas and Kentucky having their actions suspended for conflicting with the Administrative Procedure Act (Schneider 2019). Nevertheless, with Trump's Department of Health and Human Services willing to grant states considerable autonomy in devising their Medicaid expansion programs, this type of policy redesign of the original ACA is likely to feature across a number of states.

Overall, in the years since it was implemented, the Medicaid expansion has become a source of both health and economic security, covering nearly 12.7 million newly eligible Americans by 2017 (Kaiser Family Foundation, n.d.). Even since then, the number of states participating in one form or another of Medicaid expansion has crept up, yet policy routes taken across states remain quite diverse. As described by Richardson (2019: 448), we should acknowledge that there are effectively “three Medicaid policy trajectories in the states—full ACA expansion, section 1115 waivers with personal responsibility features, and nonexpansion states with limited Medicaid coverage for able adults.”

Regulatory Reforms

While not as salient as the exchanges or the Medicaid expansion, the ACA's suite of regulatory reforms has been a political and policy backbone for the law. These include the law's prohibition on preexisting condition exclusions, its guaranteed-issue requirement, and its community-rating provisions, as well as a number of other consumer protections aimed at both expanding access to insurance regardless of health status and mandating essential health benefits.

The politics of implementing the ACA's regulatory reforms at the state level have differed from the insurance exchanges and the Medicaid expansion in three important ways. First, unlike the exchanges, the ACA's regulatory reforms built on preexisting policy legacies in the states. To be sure, few if any states maintained the elaborate consumer protections developed by the ACA, but most had laid down policy frameworks on consumer protection, review of insurer rates, and medical loss ratios on which the ACA's new regulations could be built. Second, the ACA's regulatory reforms employed a less fragmented set of consent procedures than other components of the law (see also Fahey 2014). For example, whereas the creation of insurance exchanges and the expansion of Medicaid generally required some combination of gubernatorial and legislative action, many states came into compliance with the ACA's early market reforms (e.g., the ban on preexisting condition exclusions) without any formal legislative or regulatory action. Rather, insurance commissioners issued subregulatory guidance or indicated that they were reviewing insurance policies in accordance with the ACA's new standards (Béland, Rocco, and Waddan 2016: 133–35). Those who wished to block them at the state level were forced to use the legislative process to claw back consumer protections. But such actions were not likely to produce political rewards. While the regulatory reforms were among the more popular of the ACA's provisions, they were not as politically salient as either the exchanges or the Medicaid expansion.

In one sense, the speedy implementation of regulatory reforms has been a source of political stability for the ACA. While the law's protections for individuals with preexisting conditions were not initially salient, the threat of repeal that followed Republicans' 2016 election victory helped enhance their visibility and public approval, even as other dimensions of the law remained controversial (Peterson 2018). While less visible than the consumer protections, the ACA's medical loss ratio reforms delivered rebates to consumers as insurers raised rates and profits increased (Hall and McCue 2019). Moreover, even as the Trump administration has sought to undermine the ACA in other ways, it has generally enforced existing consumer protections, even threatening to take over enforcement in states that have attempted to skirt compliance (Pear 2018).

Yet, as our earlier research noted, it is not enough to analyze the formal stability of these reforms (Béland, Rocco, and Waddan 2016: 150–52). Rather, retrenchment can occur in the absence of formal repeal, through gradual institutional changes (Hacker, Pierson, and Thelen 2015). In the case of the ACA's regulatory reforms, gradual change occurred not through state action but through the Trump administration's conversion of federal regulations. Five examples stand out.

First, the Trump administration expanded the availability of short-term limited-duration insurance, which the Obama administration determined was adversely affecting risk pools in individual markets (Keith 2018b). Whereas the ACA's medical loss ratio rule requires insurers to spend at least 80% of their premiums on delivering services to customers, the top three issuers of short-term insurance collectively spent less than 43.8% (Livingston 2019). Second, a 2018 labor department rule significantly relaxed the regulation of association health plans, despite objections from state insurance regulators and evidence that it would lead to premium increases and higher levels of uninsurance (Keith 2018a). Third, under rules that will become effective in 2020, the Trump administration is allowing states to alter requirements on essential health benefits and diminish individual-market medical loss ratios (Keith 2018c). Fourth, the Trump administration has proposed rules that will loosen the ACA's prohibitions on language-, sex-, and disability-based discrimination (Keith 2019). Finally, the Trump

administration refused to intervene to defend the ACA against new constitutional challenges posed by Judge Reed O'Connor's sweeping decision in *Texas v. United States* (No. 4:18-cv-167-O, N.D. Tex., 2018), which held that the entire ACA is unconstitutional. While the Fifth Circuit Court of Appeals upheld O'Connor's decision on the individual mandate, it punted on the issue of severability—effectively asking O'Connor to “parse through” the law with a “finer-toothed comb” to determine which sections may be severable from the individual mandate.

States' responses to policy changes brought about by the Trump administration vary significantly. While many states came into compliance with the ACA without extensive legislative or gubernatorial involvement, protecting consumers from new substandard plans may take a greater level of positive action. As Giovanelli, Lucia, and Corlette (2018) highlight, fewer than half of the states set stricter limits on short-term, limited-duration insurance than the federal government. At present, fewer than five states have statutes that specifically enshrine essential health benefits, prohibit annual or lifetime limits on benefits, require preventive services without cost sharing, and incorporate the ACA's nondiscrimination provisions (Corlette and Curran 2019).

States are also underprepared for the existential threat to the ACA posed by *Texas v. United States*. If the district court's decision is ultimately upheld, numerous states will find themselves without statutory support for the ACA's regulatory reforms. While less fragmented consent procedures helped with implementation of these reforms, fewer than half the states have enacted legislation specifically enshrining community ratings, guaranteed issue, and bans on preexisting condition exclusion (Corlette and Curran 2019). If the ACA is ultimately struck down, state lawmakers will obviously experience political pressure to reauthorize these protections. Nevertheless, that will require a greater degree of institutional action than was required when the ACA was initially implemented. Most important, in the absence of federal payments, state fiscal capacities will be inadequate to subsidize coverage on the marketplaces, rendering them dysfunctional. In short, the judicial invalidation of the ACA would result in a fair amount of chaos and confusion in state insurance regulations.

Conclusion

There are few easy historical parallels to the postenactment life of the ACA. Enacted on a party-line vote and in a context of intense polarization, its implementation could not be expected to resemble that of Medicare, or even of Medicaid, half a century earlier. Nor does the ACA's postenactment politics resemble that of the Medicare Catastrophic Coverage Act, which Congress quickly repealed after enactment (Peterson 2018). Rather, the ACA's fragmented structure has produced multiple political dynamics across various dimensions of the law. Indeed, the turbulence that has defined policy making in the Trump era, variations policy legacies, institutional fragmentation, and public sentiments have continued to matter.

While the ACA continues to display multiple political dynamics, the Trump administration's assault on the law has had an effect on how these dynamics play out. Although the law's regulatory reforms were quickly implemented through subregulatory guidance and consultation, few states have put in place legislation to preserve them should the law be struck down in *Texas v. United States*. Procedural tools like waivers, which helped promote Medicaid expansion during the Obama years, have been used by the Trump administration as a means of policy retrenchment, both of Medicaid expansion and of benefits created prior to the passage of the ACA. Individual marketplaces created by state governments may be resilient, even if constitutional challenges to the law succeed. Yet the fact that few states created these marketplaces in the first place remains a source of vulnerability for the endurance of the law.

For the reader interested in a neat description of “where we are now,” none of these conclusions will be satisfactory. Nor is it wise to make broad pronouncements about the future of the ACA. Even so, there are clear lessons here for those who design and implement major reforms. In environments of intense political

contestation, designing policy with weak legacies and fragmented institutional designs opens up vulnerabilities that are not easily addressed with traditional policy tools. Intergovernmental grants, consultation procedures, and regulatory clarity still matter, of course. However, when intense political conflict persists after enactment—and especially when implementation is decentralized—the task of political persuasion and coalition building remains. No reform—and certainly not one as significant as the ACA—has ever been self-implementing.

Notes

1. This was a hypothetical analysis assuming that all the states could conduct a referendum, which was not the case. The analysis was conducted before Virginia expanded its program.
2. Matsa and Miller's (2019) model predicted that Utah would support expansion but that Idaho and Nebraska would not.
3. Beshear relied on executive authority to expand Medicaid in Kentucky, though at the time the Democrats also controlled the state House.
4. Some nonexpansion states have also sought waivers to apply work requirements to the pre-ACA Medicaid population. Two such states, Alabama and Mississippi, have adult Medicaid eligibility levels set at 18% and 26% of the federal poverty level, respectively, meaning that an adult working even part-time would possibly become ineligible for Medicaid (Garfield et al. 2019: 5).

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