The Affordable Care Act and Polarization in the United States

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We argue that partisan polarization in public support of the Affordable Care Act (ACA) is affected not only by policy design but also by which party makes those decisions. Using an innovative dataset that measures state-level quarterly ACA support from 2009 through the start of the 2016 presidential election, we find that opinions toward the ACA are less polarized in states with misaligned partisan environments where Republican governors support Medicaid expansion. We also find evidence that Republican opposition intensifies when a Democratic governor supports expansion. We do not find consistent evidence of such patterns for governors' positions on state health insurance exchanges. Our research sheds light on a key aspect of how health policy preferences respond to shifting political contexts in a polarized, federated polity.

Keywords: ACA, public support of ACA, polarization, public opinion, state policy

President Barack Obama's decision to devolve policymaking related to the Affordable Care Act (ACA) to the subnational level and the Supreme Court's decision to grant states the choice to refuse Medicaid expansion have led to a checkerboard of ACA policy designs across the fifty states. Most notably, states were given autonomy over two major policy choices: whether to implement the Medicaid expansion and whether their health insurance exchange is established and managed by the state, the federal government, or a mixture of both. The most common explanation for variation in these choices is elite partisanship. Republican-led, conservative states have tended to delay decisions, default to a federal marketplace, and opt out of Medicaid expansion. In contrast, more liberal Democrat-led states have been more likely to establish their own insurance marketplace and expand Medicaid (Barrilleaux and Rainey 2014; Callaghan and Jacobs 2014; Lanford and Quadagno 2016; Rigby and Haselswerdt 2013; Jones, Singer, and Ayanian 2014). States continue to experiment with ACA policy designs. At the time of this writing, eighteen states—the majority being conservative—have

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approved or pending provisions for Medicaid work requirements.[1]

Some instances, however, have been surprises—when Republican-led, conservative states proceed with expansive policy choices. For example, Iowa, Michigan, Arizona, and Indiana adopted Medicaid expansion early.[2] More recently, ACA advocacy groups have used the ballot initiative to expand Medicaid in previously non-expansion, conservative states such as Idaho, Utah, and Nebraska.[3]

Despite the willingness of some Republican policymakers to implement parts of the law, the partisan split in attitudes toward the ACA has been one of the most salient and crucial aspects of U.S. politics (Jacobs and Mettler 2011, 2016, 2018). To the extent that political elites are responsive to public opinion, the partisan chasm in ACA attitudes has implications for policy outcomes. Alternatively, to the extent that elites play a role in driving public opinion, partisan attitudinal differences are instructive indicators of policymakers shaping the political context and potentially affecting electoral outcomes. Either way, partisan attitudes toward the ACA have implications for policy feedback processes and democratic responsiveness (Jacobs and Mettler 2011, 2018). We argue that ACA polarization—the partisan gap in public support for the ACA—is affected not only by the decisions states make about implementing parts of the ACA, but also by which party makes those decisions. We expect ACA opinion polarization to be largest in states with aligned partisan environments, where Democratic policymakers support and Republican policymakers oppose ACA implementation, and lowest in misaligned partisan environments, where Republican policymakers support some aspects of implementation.

Understanding variation in state-level ACA attitudes among partisans has significant implications for health policy. Although both the public and politicians have been highly polarized on health reform at the national level, state-level exceptions have been large and consequential. Such subnational dynamics have the potential to reshape national politics from the bottom up (Pacheco and Maltby 2019). However, whether and when this happens depends upon how citizens respond to shifting political contexts in a polarized, federated polity (Jacobs and Mettler 2018; Lerman and McCabe 2017; Michener 2018). Our research sheds light on a key aspect of this larger picture by investigating how health policy preferences are affected by partisan political environments.

We use an innovative dataset that measures Republicans' and Democrats' state-level quarterly ACA support from 2009 through the start of the 2016 presidential election. Our approach differs from previous research using small area estimation techniques in that we include partisanship in the poststratification stage and estimate ACA support among Democrats and Republicans within each state. To do this, we gathered monthly data from national surveys including the Kaiser Family Foundation (KFF),

1. This includes Arkansas, Kentucky, and New Hampshire, but court orders in these states have halted implementation of work requirements. In addition, several states have received approval for work requirements but have delayed implementation, in some cases due to administrative and political hurdles (Arizona, Utah, Wisconsin, and Michigan). Most generally, decisions about work requirements are in flux, messier, occur at a later point in the policy process than we focus on in this article, and operate based on a distinct set of processes that are in part affected by the patterns we study but also driven by separate processes. For insights on this, see Fording and Patton 2020. For the most recent developments, see Kaiser Family Foundation, "Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State," December 20, 2019, https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state (accessed December 27, 2019).

2. These states expanded in the context of Section 1115 demonstration waivers (Grogan, Singer, and Jones 2017) that included relatively restrictive provisions such as premiums, increased copayments, the reduction of retroactive eligibility and later in the policy process—work requirements (for insights on the political processes that drive such provisions, which are distinct from what we explore, see Fording and Patton 2020).

3. Legislators in Utah and Idaho subsequently took measures to attenuate the reach and generosity of these expansions.

Gallup, Pew, and CBS/NYT. We then measure the percentage of state residents who favor the ACA and identify with the Republican (or Democratic) party, which allows us to quantify partisan polarization on the ACA in each state over twenty-seven time points.

Drawing on such rich data, we find that ACA attitudes are less polarized in states where Republican governors have announced support for Medicaid expansion. We also find suggestive evidence that opinion is more polarized in states where Democratic governors announce support for a state-based health insurance exchange, but here the case is less clear cut. Although we implement a number of empirical strategies to rule out issues of endogeneity, it is entirely possible that Republican governors had more leeway in political environments where mass polarization was particularly low. We contextualize this finding in a broader theoretical framework, describe it in more detail, make the case for why it matters, and outline the additional questions it raises going forward, including how to interpret our results in the face of endogeneity.

MISALIGNED PARTISAN ENVIRONMENTS

Misaligned partisan environments at the state level (when state political elites adopt a salient policy position that does not align with partisan expectations) are theoretically and substantively consequential. In an era of intense partisan polarization, it is risky and difficult for state partisan elites to make decisions that run counter to the expectations of either their elite copartisans (at the state or national level) or their core constituencies. Nonetheless, a misaligned partisan environment is indicative of precisely such a paradoxical political position. With respect to the ACA, scholars have now begun to consider the reasons why state political elites have pursued policy routes that rub against popular partisan expectations and expose them to various kinds of risk (Fording and Patton 2020; Jacobs and Callaghan 2013; Nicholson-Crotty 2012; Rose 2015; Scott 2013). In this article, we turn to another question: what are the consequences of misaligned partisan environments for mass public opinion?

Investigating the effect of misaligned partisan environments on popular political attitudes opens a crucial avenue for advancing understanding of the complex relationships between democracy, public policy, and public opinion in a polarized, federated polity. Scholars have increasingly discovered that the linkages between public opinion and public policy are not at all straightforward. Policymakers do not simply respond to public preferences. Instead, democratic responsiveness is conditioned by a number of factors including class, race, electoral context, partisan alignments, and much more (Canes-Wrone 2015; Bartels 2008; Grogan and Park 2018). Moreover, the relationship between public opinion and political responsiveness can be reciprocal: cues from political elites shape public attitudes (Zaller 1992; Jacobs and Shapiro 2000). Notwithstanding these broad strokes, much is still unknown about the conditions under which elites sway mass attitudes. We highlight an especially illuminating line of inquiry by investigating how state contexts of partisan misalignment affect popular policy attitudes.

We expect misaligned partisan environments to influence public opinion on the ACA. More precisely, we hypothesize that opinions toward the ACA will be most polarized in states with aligned partisan environments (where Democrat officials support expansion and state exchanges and Republican officials oppose them) and least polarized in states with misaligned partisan policy environments (where Republican officials support at least some form of implementation). Our arguments rest on two assumptions. First, that state-level policy cues influence ACA attitudes at all. This assumption is corroborated by existing evidence that the adoption of the ACA influenced support for spending on health care at the national level (Morgan and Kang 2015) and that the timing and type of gubernatorial announcements of marketplace ACA decisions is related to state-level ACA attitudes (Pacheco and Maltby 2017, 2019).

The second assumption—which we empirically test in this article—is that partisanship affects the way that citizens react to state-level policy decisions made by political elites. The ACA is both a source of salient partisan debate and a policy that varies widely across states

(Richardson and Konisky 2013). This suggests that state-level partisan cues should be particularly influential in shaping ACA policy preferences. Especially for complex policies like the ACA, citizens likely rely on partisan cues for information. Partisanship, thus, informs popular ideas about policies through selective information processes. One such process is motivated reasoning (Bolsen, Druckman, and Cook 2014; Druckman, Peterson, and Slothuus 2013; Leeper and Slothuus 2014; Taber and Lodge 2006). Motivated reasoning refers to the tendency to seek out information that confirms prior beliefs . . . view evidence consistent with prior opinions as stronger or more effective . . . and spend more time arguing and dismissing evidence inconsistent with prior opinions" (Druckman, Peterson, and Slothuus 2013, 59). Motivated reasoning is the psychological mechanism by which partisans often discount, counterargue, or ignore new information that challenges existing beliefs. Contrastingly, when citizens are presented with information congruent with predispositions, the information will be easily accepted because "it requires no effort to accept what one already knows is true" (Redlawsk 2002, 1023).

Given existing knowledge of motivated reasoning processes, we expect asymmetric shifts in ACA support based on partisanship. More precisely, Republicans in states where Republican governors announce pro-ACA decisions (misaligned partisan environments) will be uniquely motivated to reason more favorably about the ACA because an important Republican figure in their state has signaled that aspects of the law are acceptable. Also possible, though we suspect much less likely, is a backfire effect for Democrats against the ACA in states with Republican governors who push for implementation.

MEASURING ACA PARTISAN POLARIZATION IN THE STATES

To test our hypotheses about partisan polarization, we need measures of state-level ACA support over time among partisans. We start by gathering monthly data from national surveys, including the Kaiser Family Foundation (KFF), Gallup, Pew, and CBS/NYT. We selected these surveys for two reasons. First, the survey questions have similar wording. This increases our confidence that changes in opinion are not due to shifts in questionnaire design. Second, by combining questions across surveys, we increase the amount of information and therefore the reliability of our estimates both across states and over time.

We use the following question to measure support for the ACA: "As of right now, do you generally support or generally oppose the health care proposals being discussed in Congress?" Respondent answers ranged from strongly support to strongly oppose. As the ACA became law, the question stem changed slightly to "As you may know, a new health reform bill was signed into law." In the end, we collected data on 122,103 respondents from 2009 to 2016. This tracks opinion a few months before the ACA became law through the beginning of the 2016 presidential election. We use an increasingly popular small area estimation technique called multilevel regression and poststratification (MRP) to estimate state opinions toward the ACA (Gelman and Little 1997; Park, Gelman, and Bafumi 2004, 2006). We are able to get subgroup opinion by augmenting the traditional approach and including partisanship in the poststratification stage (more details follow).

The MRP approach uses national surveys to produce accurate estimates of public opinion at low levels of aggregation such as the state (Lax and Phillips 2009) or congressional district (Warshaw and Rodden 2012). Multilevel modeling increases the reliability of less populous units via shrinkage toward the mean. Indeed, the MRP approach is superior to the aggregation method in terms of reliability, particularly when sample sizes are small, for instance, when N is less than 2,800 across all units (Lax and Phillips 2009). Traditional poststratification corrects for nonrepresentativeness due to sampling designs by adjusting estimates using census information.

Adding a Time Component

We add a time component by pooling surveys across a small time frame; in the following example, we use a three-quarter moving average to estimate quarterly opinion toward the ACA. For instance, to get point estimates for Q1 in 2014 using a three-quarter pooled window, we

combine all available surveys from Q4 in 2013, Q1 in 2014, and Q2 in 2014 and then perform the MRP technique on this pooled dataset. We use all available surveys in each month. We want to be clear that we do not perform MRP on each month individually; this is not a two-staged approach. Instead, we pool individual level surveys three months at a time and repeat the MRP process for each pooled time window. By pooling and taking the median estimate, the first and last quarters are missing. This approach has been used in previous research to measure state opinion over time (see Pacheco 2012; Pacheco and Maltby 2017, 2019).

Modifying MRP to Estimate State Opinion for Subgroups

MRP is the "gold standard" by which public attitudes have been measured at the subnational level since its introduction in the late 1990s (Gelman and Little 1997), yet scholars continue to advance the method in a number of ways (Caughey and Warshaw 2019). One especially fruitful modification is to estimate subnational opinion for nondemographic subgroups (Kastellec et al. 2015; Caughey, Dunham, and Warshaw 2018). By estimating attitudes at the subnational level broken down by important subgroups, for instance, by partisanship, ideology, self-interest, or knowledge, scholars can explore whether policy designs affect certain segments of the population more than others or whether officials are responsive only to certain, select subconstituents. These types of explorations contribute to our understanding on policy feedback and representation more generally.

However, a major challenge with modifying MRP to estimate subgroup opinions is the lack of nondemographic variables in the census for poststratification. The traditional MRP approach uses population frequencies of states overall (for instance, the count of white, males, age eighteen to twenty-nine with a college degree in California) to improve the representativeness of the estimates in each state. Thus, one can estimate the level of ACA support among college-educated black males ages eighteen to twenty-nine in California, but cannot accurately estimate the level of support among partisans of the same demographic and state profile.

Jonathan Kastellec and colleagues (2015) tackle this challenge by using a two-stage MRP technique where in the first stage they use MRP to estimate partisanship as the response variable. Doing so simulates the number of partisans by each demographic type in each state. In the second MRP, they use the synthetic partisan-demographic geographic types created in the first stage for poststratification after fitting a multilevel model to their main variable of interest, which is public support for judicial nominees.

We take a different, much simpler approach and use a number of large-scale academic surveys to weight our MRP estimates for each partisan-demographic geographic type rather than the census. We first batched the multilevel model estimation into different groups, essentially splitting the analyses based on partisanship. For example, to estimate state opinion toward the ACA for Democrats in each state, we limit the multilevel regression model to include those individuals who identified with the Democratic Party (this includes leaners). To obtain estimates for Republicans, we redo the estimates after selecting only individuals who identified with the Republican Party (including leaners). Next, we use MRP to estimate ACA support separately for Democrats and Republicans using traditional demographic and state-level covariates (Lax and Phillips 2009). Specifically, at the individual level, we use gender, race, age, and education; at the state level, we include region and state presidential vote share in 2012. We do this for each period (described earlier).

We then use a conglomerate of large national surveys to estimate the counts of the demographic and geographic types for each partisan group. These surveys include the cumulative Cooperative Congressional Election Surveys from 2006 to 2014 (N = 279,226), CBS surveys from 2009 to 2011 (N = 51,809), the 2008 and 2012 American National Election Surveys (ANES) (N = 8,015), and the 2006 to 2008 Annenberg Surveys (N = 25,235). We include these surveys for several reasons. First, all of the surveys include questions about partisanship and have the necessary individual level covariates needed in the poststratification stage. Next, the surveys boast large sample sizes; this helps ensure that

our estimates are as accurate as possible across all states, but especially for the least populated ones. Finally, we select surveys to match the time frame of our ACA surveys, again, to help increase accuracy.

For this strategy to be successful, we must assume that counts obtained from these surveys approximate the actual population counts of each state. This assumption is a bold one, especially given that the surveys used in the poststratification stage were developed to be representative at the national, not the state, level. It is possible, for instance, for the raw, unweighted data to be quite unrepresentative at the state level. If true, the implication is that our estimates also fail to be an accurate representation of public opinion toward the ACA among partisans in the fifty states.

One way to check this assumption is to compare the demographic and geographic counts obtained from the combined surveys to the census files. Here, we temporarily ignore partisanship and look at how closely counts from the combined surveys are to census-based population targets for gender, race, education, and age in each state. We use the American Community Survey (ACS) five-year estimates for our comparison.

We find that the correlation between the population weights created from the combined surveys to those obtained from the census is a healthy 0.89 across all states and demographic types. Utah has the highest correlation ($r = 0.95$) and Mississippi the lowest ($r = 0.78$). When we take the difference for each demographic and geographic type between the population weights created from the combined surveys and those obtained from the census, the mean difference is very small (8.9×10^{-12}) with a range of −0.04 to 0.05. Differences for only 157 of the 3,264 possible demographic and geographic types fall outside the 0.02 margin of error. Via these diagnostics, we are confident that using the combined surveys to weight our opinion estimates across demographic and geographic types across partisans is a reasonable approach.

Validity Check

State opinions toward the ACA across partisan groups, if valid as we have measured them, should correlate with other variables that attempt to measure the same concept. Two state surveys asked residents about ACA favorability and partisanship: the Kentucky Health Issues Poll (KHIP) 2010–2014 and the Ohio Health Issues Poll (OHIP) 2011. Both surveys were conducted by the Institute for Policy Research at the University of Cincinnati and funded by the Foundation for a Healthy Kentucky and the Healthy Foundation of Greater Cincinnati.[4] When used with proper weights, aggregate estimates from KHIP and OHIP are representative of state populations. A key difference between our estimates and KHIP and OHIP is that the latter are yearly surveys, while our surveys are quarterly. Additionally, recall that our estimates are based off a small moving average, which introduces additional error, albeit to improve reliability. Given this, it would be unlikely for our estimates to correspond exactly with measures from KHIP or OHIP. Nonetheless, we can still get a sense of how well MRP performs by comparing our subgroup estimates with those obtained from KHIP and OHIP.

Table 1 shows the percentage of Kentucky and Ohio Democrat and Republican residents who support the ACA according to KHIP or OHIP relative to the MRP subgroup estimates. We find that the correlation between the MRP subgroup estimates and the estimates from KHIP is 0.82 (very strong) for Republicans and 0.39 (moderate) for Democrats, if the most dissimilar estimate in 2010 is excluded. MRP does a worse job for Democrats than Republicans in both states; this may have to do with the fact that multilevel regression pulls state averages toward the national mean in order to increase reliability. This suggests that it will be more difficult to obtain statistical significance in dy-

4. The sample size for KHIP varies across time, but averages around 1,500 with statewide estimates being accurate to plus or minus 2.5 percent (for more information, see http://www.healthy-ky.org). The sample size for the 2011 OHIP survey is 908; statewide estimates will be accurate to plus or minus 3.3 percent (for more information, see "Ohio Health Issues Poll," https://www.interactforhealth.org/whats-new/category/ohio-health-issues-poll).

Table 1. Partisans Favoring the ACA in Kentucky and Ohio Relative to MRP Subgroup Estimates

	2010	2011	2012	2013	2014	2015
Democrats (including leaners)						
KHIP	61	64	69	70	73	73
MRP	72	67	67	67	66	71
OHIP		66			71	73
MRP		73			72	75
Republicans (including leaners)						
KHIP	12	21	15	13	19	22
MRP	10	11	9	9	9	11
OHIP		12			14	19
MRP		14			11	14

Source: Authors' calculations.

Note: Numbers in percentages. Higher values indicate more polarization in ACA attitudes among partisans. Estimates are calculated using multilevel regression, imputation, and post-stratification. KHIP refers to the Kentucky Health Issue Poll and OHIP refers to the Ohio Health Issue Poll. KHIP and OHIP estimates are calculated using survey weights.

namic analyses that use these estimates, providing a more stringent test of the hypotheses outlined in this article.[5]

Descriptive Analyses of ACA Partisan Polarization in the States

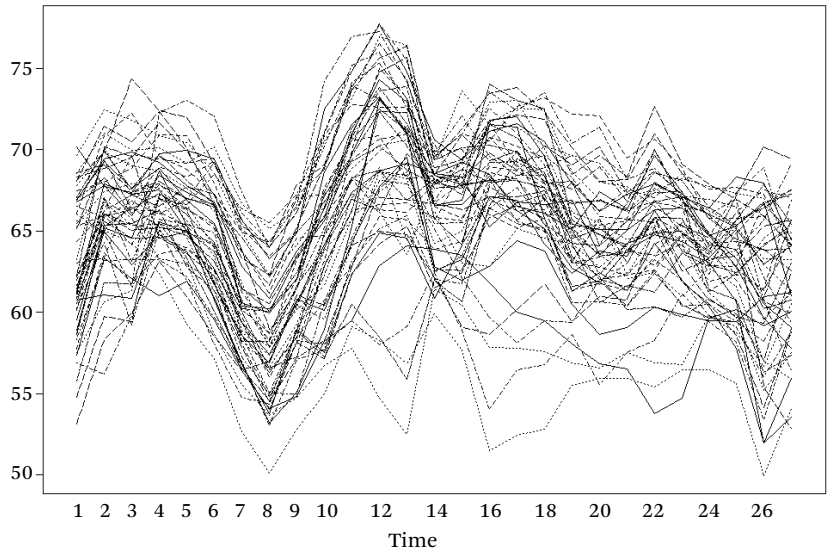
We quantify partisan polarization on the ACA—our dependent variable—by taking the difference in ACA favorability between the Democrats and the Republicans. Higher values indicate higher polarization in ACA attitudes. Figure 1 shows variation both across states and time in partisan polarization toward the ACA. ANOVA analyses confirm significant variation at both units of analyses with 55 percent of the variance within states and 45 percent of the variance between states.

Substantively, figure 1 shows significant partisan polarization toward the ACA. At no point is any state below the 50 percent mark, indicating large differences across partisans in their favorability toward the ACA. At the same time, several states have much higher levels of partisan ACA polarization than others. New Mexico exhibits the highest level of partisan polarization, in the third quarter of 2012, for instance, and West Virginia the lowest, in the first quarter of 2016. To explore the demographic correlates of partisan polarization toward the ACA, we present an exploratory random-effects regression. We include region, percentage of state residents who are uninsured, household median income, natural log of population, percentage of state residents who are nonwhite, and time. These variables are obtained from the Census Bureau's ACS one-year estimates. Even though our unit of analysis is state by quarter, the majority of our independent variables vary at the year level. Given the time dependence of the outcome variable, we also include a lagged dependent variable. Results are presented in table 2.

Table 2 shows that partisan polarization toward the ACA is unrelated to several of the traditional demographic state variables that are of importance to scholars of state politics. Partisan polarization toward the ACA is not statistically related to region, the percentage of uninsured state residents, or state population. According to the model, state partisan polarization to the ACA is higher in states that have a higher percentage of nonwhite residents; it is also higher in states that have a higher household median income, which is consistent with the findings of Elizabeth Rigby and Gerald Wright (2013). Finally, the model in table 2

5. In addition to overall polarization, we also analyze the opinions of each partisan subgroup separately. The analysis of Republican opinion is not affected by the lower reliability of the Democratic measure.

Figure 1. ACA Partisan Polarization Across the Fifty States from Q4 2009 to Q2 2016



Source: Authors' calculations.
Note: Higher values indicate more polarization in attitudes among partisans. Estimates are calculated using multilevel regression, imputation, and poststratification.

Table 2. Random-Effects Regression of Partisan Polarization

Partisan polarization (t–1)	0.80***	(0.02)
South	–0.37	(0.29)
West	–0.14	(0.27)
Midwest	–0.15	(0.24)
Percentage uninsured	0.04	(0.03)
Household median income	0.00002*	(0.00001)
Population (natural log)	0.01	(0.08)
Percentage nonwhite	1.72**	(0.74)
Time	–0.04**	(0.01)
Constant	11.63***	(1.56)
N	1,298	

Source: Authors' calculations.
Note: Dependent variable is the difference in ACA favorability between the Democrats and the Republicans in each state from the fourth quarter in 2009 to the second quarter in 2016. Higher values indicate more polarization in ACA attitudes among partisans. Estimates are calculated using multilevel regression, imputation, and poststratification. Standard errors in parentheses.
*p < .1; **p < .05; ***p < .001 with a two-tailed test

shows that partisan polarization has generally declined from the fourth quarter in 2009 to the second quarter in 2016.

CAPTURING THE STATE PARTISAN POLICY ENVIRONMENT

We are interested not only in descriptively exploring the state correlates of ACA partisan polarization, but also in how state policy decisions influence public opinion. Recall that we expect the gap between partisans' evaluations of the ACA to be larger in aligned partisan environments (states where Democrats have pushed for implementation and Republicans have opposed it) and smaller in misaligned partisan environments (states where Republicans have backed implementation).

This requires time-varying indicators of the stated policy positions of key state partisan elites. In this study, we focus on governors. As the most visible state public officials and the most important to implementation of both the exchanges and Medicaid expansion, governors have the greatest potential to move public opinion with their stated positions. Starting with the policy briefs provided by the Kaiser Family Foundation, we tasked trained research assistants with verifying (through media reports) when governors in each state made clear public announcements of their preferred policy for both the exchanges and Medicaid expansion. For the exchanges, we created dichotomous variables for gubernatorial announcements in favor of state-run exchanges (the most "pro-ACA" implementation option, implemented in eleven states and the District of Columbia), federally run exchanges (which amount to a refusal to commit state resources to implementation, implemented in twenty-eight states), and state-federal "partnership" exchanges (a hybrid model between the two, implemented in the remaining eleven states). For Medicaid expansion, we created a single variable capturing whether the governor announced support for any variant of Medicaid expansion, whether the full expansion envisioned under the original law, or the compromised Section 1115 waiver versions negotiated by most Republican-controlled states that went forward with expansion.[6]

Our theoretical framework assumes that a high-profile announcement by a key partisan figure such as a governor creates a lasting change in the political environment in a state. Thus, in states where the governor expressed support for a particular policy option, the relevant variable is coded 0 for all quarters before the announcement and 1 for the quarter in which the announcement was made and in all quarters thereafter. For each of these variables, the baseline is a low-information environment in which the governor has not yet taken a position on implementation.

Because we expect the effect of cues to differ based on the partisanship of the governor, we also include a dichotomous variable indicating whether the governor in each state was a Republican in each quarter. By interacting this variable with the announcement variables, we are able to differentiate between aligned and misaligned partisan policy environments. The constituent terms for the state exchange, partnership exchange, and Medicaid expansion variables indicate that a Democratic governor has made the announcement in question (aligned partisan policy environment). The interaction terms of each of those variables with the Republican governor variable identifies the difference between that scenario and one in which a Republican governor made the same announcement (misaligned partisan policy environment). The interaction term of the Republican governor variable and the federal exchange announcement variable identifies another aligned partisan policy environment.[7]

6. Although it would be interesting to distinguish between statements in favor of full implementation and those in favor of waiver implementation, too few Republican governors supported the former to allow for comparisons.

7. Each interaction term is coded based solely on the partisanship of the announcing governor. For example, in Massachusetts, Democratic Governor Deval Patrick's announcement of support for Medicaid expansion is coded 0 for the Republican governor and Medicaid expansion interaction term even after Patrick left office in the first quarter of 2015 and Republican Governor Charlie Baker took over.

Control Variables and Fixed Effects

We include a number of time-varying control variables. The most important of these is a one-quarter lag of our ACA polarization measure, because we expect some degree of "stickiness" in public attitudes about the law. We also control for whether and when the state filed or joined an anti-ACA lawsuit, most of which were eventually consolidated into the *NFIB v. Sebelius* case.[8] The decision to file or join such a suit is itself a signal of a state government's intentions toward the ACA, albeit a more ambiguous one, given that in many states the initiator was not the governor but the state attorney general. Because anti-ACA and Republican state governments were more likely to file or join lawsuits, failing to account for this variable could bias the polarizing effect of governors' later announcements on Medicaid expansion or the exchanges. This variable is coded similarly to the announcement variables, in that it is equal to 0 until the quarter the state filed or joined a suit, and 1 thereafter.

We also control for state economic and demographic characteristics and trends using data from the American Community Survey. Specifically, we include estimates of population (logged), the percentage of the population that lacks health insurance, the median household income (in thousands), and the nonwhite percentages of the population given that state race and diversity have been shown to play a role in ACA politics (per Grogan and Park 2018). Because the ACS provides only annual estimates, we "smooth" changes in these variables across the quarters of each year.

Of course, this set of control variables is unlikely to properly account for the heterogeneity between states. In addition to random-effects models that examine variation both within and between states, we also specify state fixed-effects models that focus strictly on within-state variation.

We also account for time in two ways. In some models, we include a linear time trend to account for secular trends, ACA polarization having declined somewhat over time. We also include a specification with quarter fixed effects, which should account for both long-term trends and any state-level responses to national events.

RESULTS

Table 3 displays the results of our analysis of state-level ACA polarization. Because our dependent variable is continuous, we use linear regression with both random and fixed effects to account for the panel structure of the data. The regression includes clustered robust standard errors to account for both heteroskedasticity and within-cluster serial correlation (Arellano 1987), the latter of which would also be mitigated by the lagged dependent variable. The results suggest some qualified support for our expectations. First, the constituent term for state exchange announcement is associated with a statistically significant increase in partisan polarization on the ACA, but only in the random-effects specifications. These results suggest a Democratic governor announcing support for a state exchange (establishing an aligned partisan policy environment) increases the gap between Republicans and Democrats by about half of a percentage point in the short run. Although this is a modest effect, the strong positive effect and statistical significance of the lagged dependent variable indicate that the polarization gap between states where governors announced support for a state-based exchange and those where they did not should grow over time, if the random-effects result is valid. In the fixed-effects models, this apparent effect vanishes. In another scenario indicating an aligned partisan policy environment, a Democratic announcement of support for Medicaid expansion (identified by the Medicaid expansion announcement constituent term), we do not see evidence of a polarizing effect in any specification.

Because we are interested in the effects of misaligned as well as aligned partisan policy environments, we now turn to the variables indicating a Republican governor announcing support for a state exchange and Medicaid expansion. Again, the results are mixed. We see no evidence in any specification that a Repub-

8. *National Federation of Independent Business v. Sebelius*, 567 U.S. 519 (2012).

Table 3. State-Level Polarization on the Affordable Care Act

	(1)	(2)	(3)	(4)
Lagged ACA polarization	0.82***	0.79***	0.66***	0.62***
	(0.02)	(0.02)	(0.01)	(0.02)
Republican governor	−0.15	−0.12	−0.19	−0.21
	(0.17)	(0.19)	(0.25)	(0.22)
Medicaid expansion governor announcement	−0.24	−0.27	0.47	0.13
	(0.29)	(0.31)	(0.35)	(0.31)
Medicaid expansion Republican governor announcement	−0.21	−0.35	−0.92*	−0.72*
	(0.29)	(0.29)	(0.48)	(0.42)
State exchange governor announcement	0.52*	0.58**	−0.05	0.22
	(0.27)	(0.28)	(0.38)	(0.39)
State exchange Republican governor announcement	−0.04	−0.39	0.00	0.95
	(0.27)	(0.25)	(0.50)	(0.69)
Partnership exchange governor announcement	−0.10	−0.02	−0.09	−0.00
	(0.32)	(0.37)	(0.54)	(0.36)
Partnership exchange Republican governor announcement	0.75*	1.15**	1.10	0.95**
	(0.40)	(0.47)	(0.67)	(0.46)
Federal exchange governor announcement	0.18	0.46	−0.32	0.36
	(0.28)	(0.37)	(0.35)	(0.37)
Federal exchange Republican governor announcement	−0.05	−0.33	0.57	0.28
	(0.27)	(0.35)	(0.41)	(0.41)
Time (quarterly)	−0.04**	−0.04*	0.12***	
	(0.02)	(0.02)	(0.04)	
State joined anti-ACA lawsuit		−0.00	−1.55***	−0.32
		(0.23)	(0.34)	(0.35)
Percentage uninsured		0.04	0.41***	0.16**
		(0.03)	(0.07)	(0.07)
Logged population		−0.01	1.90	−15.31**
		(0.07)	(6.34)	(5.73)
Median household income (thousands)		0.03**	−0.35**	0.10
		(0.01)	(0.15)	(0.09)
Percentage nonwhite		1.85***	−2.29	9.33
		(0.52)	(13.93)	(9.90)
Constant	12.46***	12.27***	6.93	249.82***
	(1.21)	(1.54)	(100.02)	(86.20)
Observations	1,300	1,300	1,300	1,300
State fixed effects	No	No	Yes	Yes
Quarter fixed effects	No	No	No	Yes

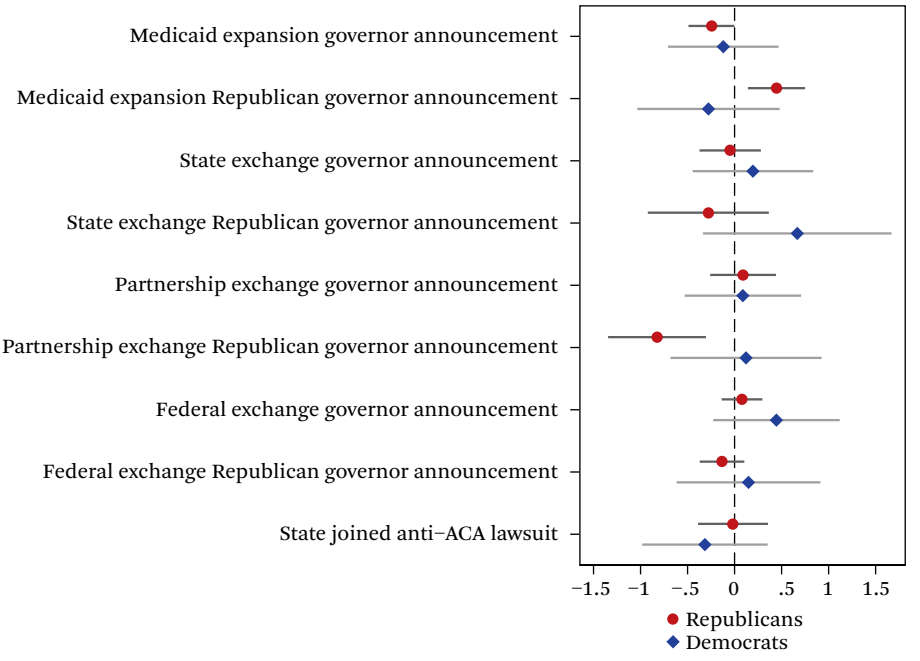
Source: Authors' calculations.
Note: State-clustered robust standard errors in parentheses
*$p < .1$; **$p < .05$; ***$p < .001$

lican governor announcing support for a state exchange reduced polarization. On the other hand, the Republican governor Medicaid expansion variable is consistently negatively signed, as predicted, and is statistically significant at the $p < .1$ level in the fixed-effects specifications. When a Republican governor announces support for expansion, the fixed-effects models predict that polarization will decrease about three-quarters to 1 full percentage point in the short term, an effect that should grow over time due to the significant effect of the lagged dependent variable. The fact that his effect is stronger in the fixed-effects than the random-effects specification suggests that a Republican governor announcing support for Medicaid expansion has a stronger effect on public opinion over time within a state than it does in a comparison of states where this did and did not occur.

We also note a puzzling finding—in three of the four specifications, the increase in polarization when a Republican governor announces support for a partnership exchange is statistically significant. Given the ambiguous political signal sent by the partnership exchanges, and that we did not predict such an effect ex ante, we are reluctant to speculate about the mechanisms that might be driving this apparent correlation.

Because the findings of our polarization analyses are ambiguous, we go one step further in table 4 by treating Republican support and Democratic support for the ACA as separate dependent variables. For the sake of space, we use the most rigorous of our specifications, with state and quarter fixed effects, for both dependent variables. We also display the coefficients with 95 percent confidence intervals in figure 2. The results provide some more support for our theoretical expectations in the case of Medicaid expansion: among Republicans, a Democratic governor announcing support for Medicaid expansion decreases ACA support by a quarter of a percentage point, while a Republican governor backing expansion increases sup-

Figure 2. Marginal Effects of Gubernatorial Announcements on Affordable Care Act Support



Source: Authors' calculations.
Note: Support is among partisans at the state level (with 95% confidence intervals).

Table 4. State-Level Support for the Affordable Care Act

	Republicans	Democrats
Lagged support among Republicans	0.62***	
	(0.03)	
Lagged support among Democrats		0.60***
		(0.02)
Republican governor	0.07	−0.14
	(0.10)	(0.19)
Medicaid expansion governor announcement	−0.25**	−0.12
	(0.12)	(0.29)
Medicaid expansion Republican governor announcement	0.45***	−0.28
	(0.15)	(0.38)
State exchange governor announcement	−0.05	0.20
	(0.16)	(0.32)
State exchange Republican governor announcement	−0.28	0.67
	(0.32)	(0.50)
Partnership exchange governor announcement	0.09	0.09
	(0.17)	(0.31)
Partnership exchange Republican governor announcement	−0.82***	0.12
	(0.26)	(0.40)
Federal exchange governor announcement	0.08	0.45
	(0.11)	(0.33)
Federal exchange Republican governor announcement	−0.13	0.15
	(0.12)	(0.38)
State joined anti-ACA lawsuit	−0.02	−0.32
	(0.18)	(0.33)
Percentage uninsured	−0.17***	−0.01
	(0.05)	(0.06)
Logged population	5.87*	−9.56**
	(3.04)	(4.42)
Median household income (thousands)	0.03	0.13*
	(0.06)	(0.07)
Percentage nonwhite	8.01	18.27**
	(7.15)	(8.14)
Constant	−84.69*	168.17**
	(45.43)	(65.66)
Observations	1,300	1,300
State fixed effects	Yes	Yes
Quarter fixed effects	Yes	Yes

Source: Authors' calculations.
Note: Support is among partisans at the state level (with 95% confidence intervals). State-clustered robust standard errors in parentheses.
*$p < .1$; **$p < .05$; ***$p < .001$

port by a little less than half a percentage point ($p < .05$ in both cases). In short, Republicans appear to respond to both "aligned" and "misaligned" partisan policy environments as the theory predicts, at least where Medicaid expansion is concerned. For Democrats, we see no effects that come close to statistical significance.

For the exchanges, we do not observe any significant effects in any announcement scenario, aside from the significant negative effect for Republicans of a Republican governor supporting a partnership exchange, which accords with the puzzling polarization finding.

In terms of magnitude, what statistically significant effects we do observe are modest. Although the lagged dependent variable suggests these effects will compound over time, even the long-run effects would be in the range of a few percentage points, not enough to bridge the formidable gap between the parties, which approached 80 percentage points in some states. The relevance of these effects will differ with the size of partisan subgroups; a percentage point bump in support from Republicans in Alabama, where Republicans dominate, means more than a similar bump in Connecticut where they are relatively scarce.

LIMITATIONS

Although our over-time measures provide unique data on how state partisans change their opinions of the ACA, our results are mixed. We encourage scholars to continue exploring how preferences respond to shifting political contexts in a polarized, federated polity. Yet we also are cognizant of the limitations of our analyses.

The MRP approach is limited in a number of ways, which also limits the confidence of our inferences. Although when combined with a three quarter moving average it helps solve issues of reliability, our estimates still vary in reliability in connection with state population (see Pacheco 2012). In addition, we are likely smoothing over short-term shifts in ACA opinion that occur month by month. As important, MRP may not be the best approach to studying policy feedback effects. As Devin Caughey and Christopher Warshaw (2019) note, coefficients are generally biased toward zero in models where MRP is used to measure the dependent variable (see also Clinton and Sances 2018). This bias may account for the small or nonexistent effects of state policy decisions on ACA polarization that we observe in our paper. If there is more error in our estimates of Democratic opinion, as our validation exercise in table 2 suggests, this bias toward null findings is likely greater in the Democratic subgroup, which is consistent with the results in table 4 and figure 2.

Last is an issue of endogeneity. We do not claim that governors are unmoved movers in this story—it is likely that many or most of them considered public opinion about the ACA in their states before staking out their positions on the law. The findings of Richard Fording and Dana Patton (2020) on governors' decisions to pursue Medicaid work requirements suggest that implementation decisions respond to public opinion. By including lagged dependent variables and state fixed effects, we are able to partially address this concern; both approaches narrowly focus the analysis on quarter-to-quarter change and make it more likely that the coefficients for the announcement variables reflect causal effects rather than artifacts of past public opinion.[9] Because the measures themselves are imperfect, however, we cannot completely rule out the endogeneity issue. Governors and their advisors have access to infor-

9. Lagged dependent variables may bias the coefficients of other independent variables in random- and fixed-effects models toward zero, militating against finding significant effects. Excluding the lagged dependent variables from the analyses reported here generally leads to larger and more significant effects that are consistent with our hypotheses (for example, larger effects for both Democratic and Republican Medicaid expansion announcements, most of which are statistically significant at the $p < .01$ level), and some that are not (for example, the counterintuitive findings for the partnership exchange announcements grow stronger). In this article, we err on the side of caution and report the more conservative lagged dependent variable estimates.

mation (including internal polling) and insights about the political climate in their states that go beyond the simple survey questions we use in our analyses.

DISCUSSION AND CONCLUSION

Do state political elites shape mass polarization in their states by taking positions on policy? Our results suggest that they may, in some circumstances. In the case of the ACA, a highly polarized topic nationally, Republicans seem to respond negatively when a Democratic governor announces support for Medicaid expansion, and positively when a Republican governor does so. Democrats appear unmoved in either scenario, but these Republican subgroup effects could have a modest effect on the overall level of polarization. Some evidence also indicates that a Democratic governor supporting a state-based health insurance exchange may increase polarization, but this effect does not hold up to the most rigorous specifications. Overall, we find scant evidence that governors announcing their positions on the exchanges drove opinion in either partisan subgroup.

Given these results, we assert a basic "proof of concept" for the notion that state-level partisan political elites may shape polarization on policy issues in their states. The overall picture, though, is one of fairly consistent national polarization on the ACA. If governors play a role in this story, they do so at the margins. It may be that the statements and actions of governors or other state-level figures have larger effects on the opinions of partisan subgroups on issues that are less polarized at the national level.

Although this study focuses on the role of governors' announcements in shaping such opinions, this is just one possible application. Future work should incorporate other relevant actors, such as state legislators, and explore the possibility of policy feedbacks following implementation. State-level public opinion also has explanatory power as an independent variable, as Fording and Patton (2020) show in this issue, and using MRP to estimate opinion among partisan subgroups offers the potential for a more complete view of whether and how officials respond to different constituents.

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Storm rising! The Obamacare exchanges will catalyze change: why physicians need to pay attention to the weather

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INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) of 2010, commonly known as Obamacare has had a large effect on healthcare delivery to millions of Americans.[1–3] There are many elements of the ACA that could impact NeuroInterventionalists. One prominent example is the formation of independent boards with the power to unilaterally modify physician payment structures and use comparative effectiveness research to change medicine and healthcare delivery.[4 5]

Additionally, the ACA established a formal framework for considering the transition from 'volume to value-based' healthcare through the creation of the Innovation Center.[6] Among the seven broad approaches for achieving this migration, two methodologies were of particular relevance to NeuroInterventionalists; the Bundled Payment for Care Improvement Initiative and Accountable Care Organizations, with both approaches remaining active elements into the present day.[7–11] Prior to passage of the ACA, the problem of Americans lacking adequate health insurance coverage (absent or insufficient) grew worse each year. In 2010, 55.3% of Americans were covered by employer-based insurance.[12] The elderly and poor, as well as some additional vulnerable groups, were already covered by Medicare and Medicaid (14.5% and 15.9% [13] of the population respectively).[13] Additional programs, such as the Veterans Health Administration, provided coverage to a small proportion of the population. Shockingly, by 2010, almost 50 million Americans had no form of medical insurance. The drafters of the ACA legislation considered expanding coverage to be mission-critical. Ultimately, they decided on two main strategies to achieve that goal.

The first strategy was Medicaid expansion. By increasing the number of patients eligible to receive Medicaid, many more people would obtain insurance coverage. To enable this expansion, the ACA loosened the criteria required for becoming a Medicaid beneficiary and millions of additional patients signed up for the program. Nonetheless, a large cohort of patients remained uninsured because they lacked employer-based coverage and remained ineligible for either Medicare or expanded Medicaid. How would these patients obtain coverage? The second strategy sought to address this challenge. The ACA provided for the creation of a marketplace for health insurance for those individuals, that is, the healthcare exchanges.

The first strategy: Medicaid expansion

Medicaid is a 'safety net' program.[14] The ACA expanded Medicaid by requiring that states which participate in the program extend coverage to patients with incomes at or below 133% of the poverty line. New categories of eligible individuals were also created, most significantly, childless adults. The federal government would initiate the program by paying for 100% of the expansion costs, gradually dropping that payment to 90% of eligible costs. The National Federation of Independent Business (NFIB) sued the federal government, and in 2014 the Supreme Court in NFIB v. Sebelius decided that states did not have to participate in Medicaid expansion to continue to receive their pre-existing level of federal support for their state's Medicaid program. Seventeen states chose not to participate in Medicaid expansion. These states were generally led by Republican governors and legislators, underscoring the deep political divide concerning the ACA. Concerns raised included the philosophical (eg, the expansion went beyond the initial scope of Medicaid as a safety net program) as well as the practical (eg, the ultimate cost for the states of the uncovered portion of Medicaid expansion).

Medicaid expansion succeeded in expanding the number of patients with coverage. In a March 2016 report, the Congressional Budget Office (CBO) confirmed in that there has been a significant reduction in the number of uninsured individuals with Medicaid and the Children's Health Insurance Program (CHIP) covering an estimated 17 million more people in 2016 than the CBO's earlier assessment.[15] As a result, Stuart Butler suggested in an article in *JAMA* that a more fitting name for the ACA would have been the 'Medicaid Expansion Act'.[16]

The second strategy: healthcare exchanges

Healthcare exchanges first emerged decades prior to the passage of the ACA. The concept was simple, that is, improve one's position by using economies of scale and the enhanced negotiating power of a large group. If relatively small businesses came together, they could enhance their offerings, better negotiate terms for their beneficiaries, and reduce costs through pooling. The ACA sought to expand on this fundamental concept of insurance by granting greater access to this type of pooled resource. If a person or family lacked coverage, they could go to what was expected to be a vibrant exchange market and purchase the plan best suited to their needs. These insurance plans would have to conform to certain minimum Obamacare requirements. The ACA intended to use state-based exchanges rather than a single national exchange or public option. For those states that opted not to establish healthcare exchanges, the federal government filled the void by managing the exchanges in those states. Patients with a household income between 133% and 400% of the poverty line received subsidies to cover part of the premium when they bought coverage on one of the exchanges.

The Obamacare Health Insurance Exchange Marketplace opened on October 1 2013. The exchanges constituted

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online markets for purchasing health insurance. The hope was that Americans would use their state's 'Affordable' insurance exchange (marketplace) to obtain coverage from competing private healthcare providers.[17] Shoppers (sic) were encouraged to use an online price calculator to see if they qualified for cost-assistance subsidies as well as Medicaid and CHIP. They could see side-by-side comparisons of qualified health plans, with the goal of helping them to find the best coverage circumstance. At that time, the administration estimated that there would be up to 29 million people enrolled in the exchanges by 2019. This projection proved wildly optimistic. Early on, as the marketplaces became active, other issues were raised. These included: the high price of plans for healthy young adults; employers opting out of providing health insurance for part-time workers; and narrow networks for beneficiaries.

THE OBAMA ADMINISTRATION STAKES ITS CLAIM ON HOW TO OBTAIN GREATER VALUE IN HEALTHCARE

Having passed the ACA at the start of the decade, former Health and Human Services Secretary Sylvia Burwell recounted her perspective on where Medicare was headed in a 2015 article in the *New England Journal of Medicine*.[18] That article was notable for the speed with which the Obama administration anticipated the introduction of alternative payment models (APMs) would take place (30% of Medicare payments by 2016, and 50% by 2018).[19] Burwell's article highlighted how determined her former agency was to move away from fee-for-service (FFS). Despite the administration's enthusiasm, limited information was available about how to chart that course.[20 21]

Enter the MACRA

Just a few months' later, the Medicare Access and CHIP Reauthorization Act (MACRA) of 201[22]was passed with strong bicameral, bipartisan support. The legislation included a permanent and welcome repeal of the Sustainable Growth Rate methodology for controlling Medicare costs and balancing the federal budget.[23 24] The MACRA also included additional critical elements that would redefine payment policy for years to come by transitioning away from the traditional FFS paradigm[25 26] familiar to NeuroInterventionalists[27 28] to a new value-based paradigm up to, and including, advanced APMs.[29–31] Even the component most similar to FFS, the Merit-Based Incentive Payment Program (MIPS) includes a value purchasing backdrop.[32 33] The MACRA, now known as the Quality Payment Program (QPP), has been updated through various rulemaking exercises and readers of *JNIS* and other specialty journals have been apprised of these developments.[32 34–36] As QPP is fundamental to the physician fee schedule, in July 2019 the Medicare Physician Fee Schedule proposed rule from CMS included ideas for changing QPP.[37]

NARROW NETWORKS AND NEUROINTERVENTIONALISTS

There is limited data in the peer-reviewed literature specific to NI specialists and the exchange marketplace. It is likely that elective cerebrovascular cases are impacted by narrow networks in general. What is less clear is how narrow networks might impact the most rapidly growing area in neuroIntervention: treatment of Emergent Large Vessel Occlusion (ELVO).[38] With presentations beginning in late 2014 and papers published in early 2015, mechanical thrombectomy for stroke became the standard of care[39] and this has led to a dramatic expansion in the number of cases performed.[40–43] While substantial conversations have taken place on the type of center EMS should bring patients for evaluation and treatment, there has been seemingly less conversation on the impact of insurance markets.[44] Further study will need to be performed in order to determine the role, if any, insurance coverage plays in directing ELVO patients.

WHAT ARE CURRENT EXPENDITURES?

National health expenditures (NHEs) have grown, reaching $3.3 trillion in 2016. NHEs constitute a 17.9% share of the gross domestic product. Medicare spending also reached a historic $672.1 billion comprising 20.36% of total NHEs. Medicaid spending grew almost as high as Medicare to $565.5 billion in 2016, a 17.1% share of total NHE.[45] Without question, recent growth in Medicaid and resultant costs are in large part due to the ACA.

NOVEMBER 2016 AND ITS IMPLICATIONS REGARDING HEALTHCARE POLICY

Counter to expectations from many pollsters and pundits, Donald J. Trump was elected to the presidency in November 2016. He made a variety of policy statements regarding healthcare throughout the lengthy presidential campaign. To some observers, some elements seemed contradictory or unrealistic, for example, insurance coverage for all with no diminution in service and lower cost. Other observers saw his apparent divergence from traditional Republican orthodoxy as an opportunity to move forward with unique pathways toward healthcare reform.[46]

The Republican position was generally hostile to the ACA, which was a signature legislation of a Democratic president. On January 12 and 13 2017, in the Senate and House respectively, Republicans cast votes that would allow subsequent legislation to remove large elements of the ACA using a preexisting budget reconciliation process.[47] On January 20, only hours after being sworn into office, President Trump signed the Executive Order Minimizing the Economic Burden of the Patient Protection and ACA Pending Repeal, his first executive order, and in doing so established interim procedures in anticipation of repeal of Obamacare.[48]

Congress passed the ACA along strict party lines in 2010. Republicans made the legislation and its imperfections part of a clarion call against the Obama administration. Indeed, 'repeal and replace', which at times seemed very unrealistic, likely helped drive an expansion of the Grand Old Party (GOP) in statehouses across the country and both houses of Congress in the years since 2010. With the election of Donald J. Trump to the highest office in the land and Republican control of both houses of Congress, Republicans had a unique opportunity to put in place their promise of repeal and replace. At first, contemplating the position of Democrats in red States, there was discussion about the possibility of some level of bipartisan support for making meaningful changes to the ACA. However, a variety of factors relating to the Trump administration's first term and polarized congressional politics on both sides of the aisle soon signaled that 'repeal and replace' would be a strictly partisan affair.

On May 4 2017, after substantial work and legislative maneuvering, the House of Representatives passed the American Healthcare Act by 217 votes to 213, aiming to repeal those portions of the ACA within the scope of the federal budget (via the budget reconciliation process), and thus gut the ACA. The bill was sent to the Senate for deliberation.[49] The Senate opted to create its own bill and created a 13-person working group. Despite close calls, the Senate was never able to pass any legislation rejecting the ACA. Ultimately, in the summer of 2017, Congress opted to move on from outright efforts to repeal and replace.

While the Republican-driven legislative efforts to repeal the entire ACA failed to make their way into law, most observers agree that there were, and are, legitimate problems with the ACA.[50 51] The major difference between the perspective of Republicans and Democrats was whether the ACA should have large parts repealed or be fundamentally repaired. While there were nascent efforts at bipartisan compromise, the present political environment rendered them all short-lived.[52]

'Obamacare is imploding'

President Trump was likely not the first to state that 'Obamacare is imploding', but he was certainly the most prominent. Critics of the ACA argued that Obamacare would collapse under its own weight if left to its own devices. What reason did people cite for making this statement? As outlined earlier, a critical component of the ACA was the development of healthcare exchanges: 'marketplaces' where individuals could purchase what was to be 'affordable' insurance. The Trump administration eliminated federal reimbursements to insurers for cost-sharing reductions they must provide to lower-income enrollees arguing that they were a subsidy to the insurance industry. Moreover, repeal of the individual mandate in the 'Tax Cuts and Jobs Act' means that fewer young people will voluntarily join the exchange marketplace (healthy people are desirable from an actuarial perspective because they contribute to exchanges, but relatively infrequently use healthcare services).[53] This anticipated dearth of youthful or healthy participants will cause premiums to rise further. Moreover, the administration decreased the open enrollment window by 50% from 90 to 45 days, and reduced the advertising budget to inform patients about open enrollment by 90%. Navigators who facilitate purchasing within the exchanges were cut by 42%.[54] An additional point worth noting is that the administration approved waivers that enable states to impose work requirements on Medicaid recipients, further restricting participation.[55] Another reality impacting exchange enrollment is that some Republican states that had previously declined to participate in Medicaid expansion are amending that decision.[56]

A tale of two populations in the exchanges…

When one considers the circumstances outlined above, it is not surprising that the cost of insuring people through exchanges has increased dramatically since the inception of the ACA. For most exchange beneficiaries, this cost remains invisible because it is funded in large part by the US taxpayer. This explains how the market can sustain up to triple digit rate increases in various locales. The premium tax credit in the ACA de facto limits how much money many individuals or families spend because the benefit covers escalating costs. For those who are not benefiting from this subsidy (ie, enrollees with income over 400% of the federal poverty line), the costs can be prohibitive. In these groups, enrollment is diminishing. There is virtually no chance under current legislation that the legislative goal of reaching 29 million covered lives by 2019 will be achieved. Indeed, there were 500 000 fewer customers enrolled in 2017 plans compared with 2016.

…with expanding insurer exchange participation

While healthcare exchange enrollment is coming under pressure from legislation and is diminishing overall, a surprising counter phenomenon is developing. Specifically, more carriers are likely to offer exchange-related plans in 2019, reversing a downward trend.[57] States seeing new insurers enter their exchanges include Arizona, Florida, Iowa, Maine, Michigan, New Mexico, North Carolina, Ohio, Oklahoma, Tennessee, Utah, Virginia, and Wisconsin.[58]

Why the change? We speculate that multi-year rate increases, particularly in calendar year 2018, have stabilized insurers' medical loss ratios on the exchanges. The carrier strategy has thus been to dramatically increase the rates, knowing that the US taxpayer is covering

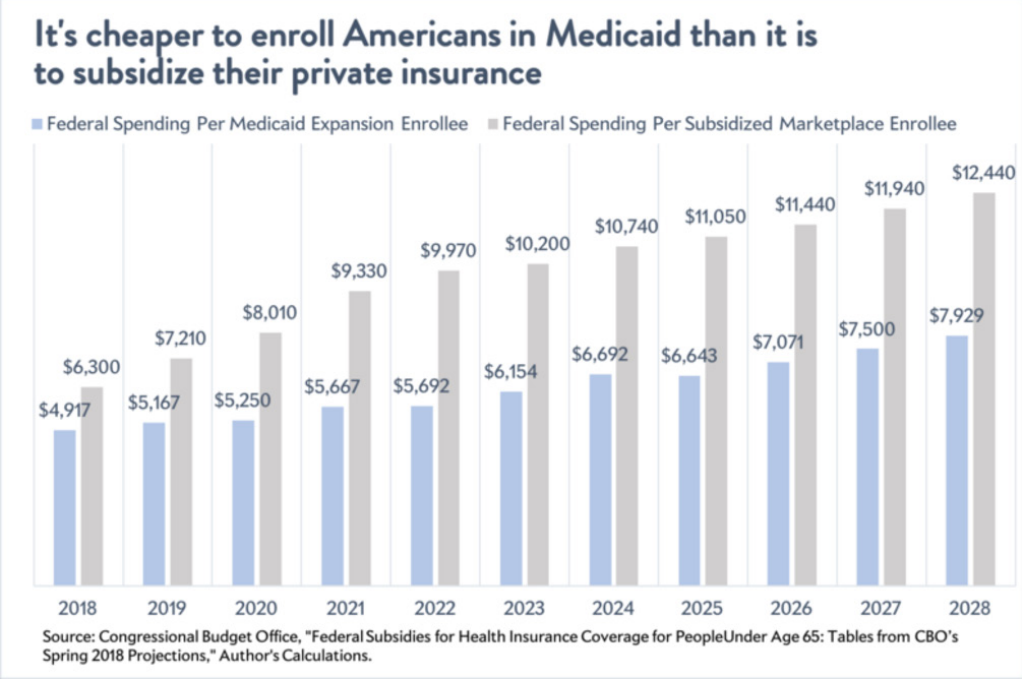

Figure 1 Comparison of cost to the federal government of Medicaid vs. marketplace exchanges[62]Reprinted with permission of Jordan Weissman at Slate.com.

the brunt of this cost through federal government subsidies. Of note, this distortion of the market in the exchanges is narrowly focused on the 'silver' plans. While premium subsidies apply to bronze, silver, and gold plans, the cost-sharing reductions (CSRs) are only offered in the silver plans. The changing status of federal CSR subsidies has led to a variety of practices, for example, 'silver loading' which keep insurers whole that go beyond the intended focus of this commentary.[59]

Per the CBO, this marketplace now costs much more on average per enrollee than people or families covered by Medicaid or Medicaid expansion.[60] The Congressional Budget Office's latest projections demonstrate that the federal government is paying out an average of $6300 annually for every subsidized enrollee in marketplace exchanges for fiscal year 2018. It estimates that number will rise to nearly $12 500 in 2028 (figure 1). In contrast, Medicaid spends $4230 per non-disabled adult, set to inflate at 5.2% annually to just over $7000 per person in 2028.[61 62]This trend is expected to further exacerbate with policy shifts designed to undermine the viability of the exchanges.

POLITICS AT PLAY

The ACA was passed along strict party lines and has lived a highly political life from the time it was introduced. Since its passage, Republicans have used its provisions to mobilize their base. This has been a successful tactic for putting more Republican legislators into power. Over the years, there were numerous votes in Congress to repeal the ACA and detailed plans were put forward for what might come next. These plans had a unique safety valve, that is, the Obama administration would be unlikely to sign onto a law that repealed its signature legislation.

The situation changed dramatically when in January of 2017, the Republicans found themselves in control of both houses of Congress as well as the Executive Branch. Aligning candidate Trump's healthcare delivery proposals with Republican orthodoxy was challenging. The Republican-led Congress sought to address this multi-year ambition of repealing and replacing the ACA. The AHCA and Better Care Reconciliation Act of 2017 (BCRA) were largely constructed using traditional Republican elements in addressing repeal and replace.[4963] The BCRA or its analogs such as the Obamacare Repeal Reconciliation Act or the Healthcare Freedom Act could not muster the votes necessary to pass the Senate to reach a conference committee. Given the rules of reconciliation and other political realities, legislative efforts at repeal and replace receded into the background.

In the wake of the failure to achieve 'repeal and replace' the Trump administration and Congress have made additional changes, which have further destabilized the ACA. These maneuvers have had dramatic implications regarding shifting perspectives on who is to blame for the challenges of the ACA. A telling Kaiser Family Foundation Poll suggests that Americans now largely consider President Trump and the Republicans to be responsible for the ACA moving forward[63] (figure 2). The dynamic has thus dramatically shifted in that healthcare delivery, a topic that had galvanized the Republican base for years, now has the potential to negatively impact November elections for the GOP.

Political pundits lost credibility in the 2016 presidential election. Comments about expected political outcomes should therefore be taken with a healthy dose of skepticism. Famed pollster Nate Silver of FiveThirtyEight predicts a three in four chance of Democrats taking control of the House of Representatives[64 65] The Cook Political Report would suggest that Republican control of the Senate is more likely to remain intact after November.[66]The outcome of this election cycle could have major implications on the course forward for the ACA particularly as a predictor of 2020.

Should the Republicans keep both legislative houses and in particular if they increase their slim majority in the Senate they might consider a further effort at repeal and replace.[67] Should the

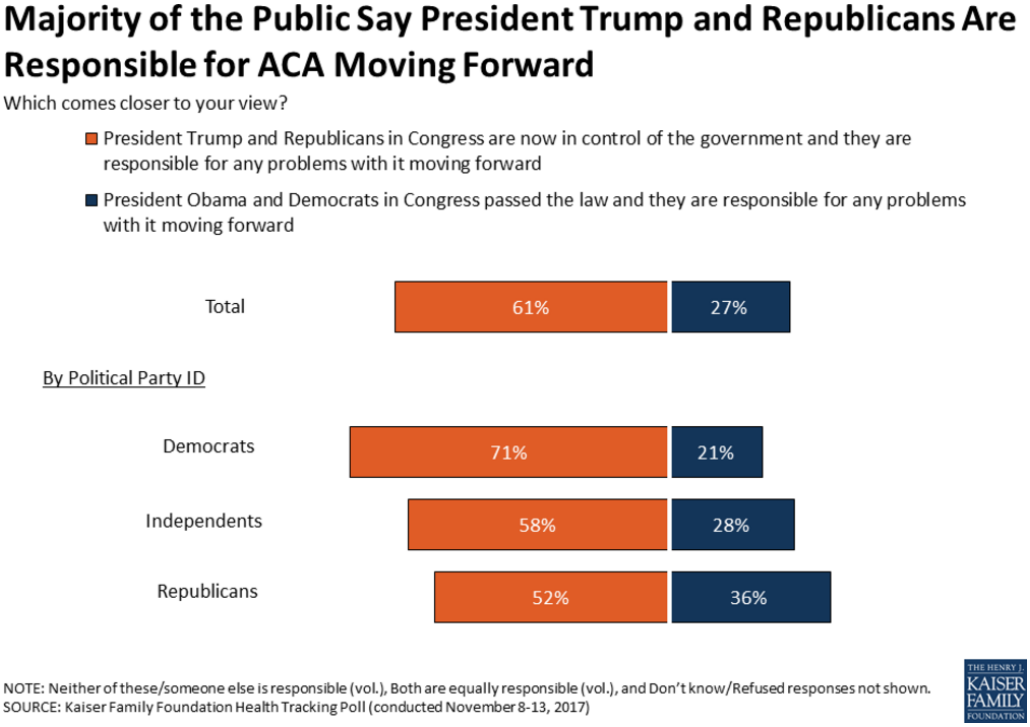

Figure 2 American attitudes for which President and party are responsible for problems associated with the ACA[63] Reprinted with permission from the Kaiser Family Foundation.

Democrats take control of the House, it is difficult to imagine movement forward on healthcare delivery policies that would be agreeable to both parties unless the market continues to destabilize and threatens collapse. In 2020 and beyond, should Democrats return to the White House with some level of control of the federal legislatures, they will be confronted with significant decisions that could prove challenging at that time.

While scholars might disagree with the inherent versus the policy-based instability of the ACA marketplace, we believe the current healthcare exchange marketplace to be unsustainable in the long term without additional health transformation efforts. Subsidized beneficiaries are unreasonably expensive for the US taxpayer and unsubsidized participants are confronted with unacceptably high out-of-pocket costs.[68] Emboldened by the largely Republican debate regarding repeal and replace, the Democratic base is in many cases openly calling for an end to Obamacare and replacement with options such as single payer, Medicare Extra, Medicare for all, and other government-directed programs. These options are all forms of healthcare delivery that would likely have been unthinkable for a major political party to champion just a few years ago.[69] The implications for the Democratic party supporting a shift to 'single payer' in a system currently dominated by employer-based insurance is unclear.

CONCLUSION

The ACA has been a galvanizing element in US political debate since its passage in 2010. In the current political climate, achieving bipartisan support for healthcare legislation seems an unlikely goal. Republicans rode a wave of resentment regarding the ACA and its party line passage into large-scale political victories from 2010 through, and including, the November 2016 elections. Elements of the ACA have become ingrained (eg, insuring patients with pre-existing conditions) and it is unlikely efforts at repeal and replace would ever remove all elements of this landmark legislation. One of many provisions within the legislation, the healthcare exchange marketplace, is charting an unsustainable path requiring large taxpayer subsidies without which coverage would be unaffordable for many potential participants. This minority segment of the beneficiary market has, and likely will continue, to result in a greater level of angst than its relatively small numbers might have suggested it would. Solutions vary widely between the two political parties, but it would seem clear that we as healthcare providers must anticipate significant changes in the ever-present goal of providing health coverage for all Americans.

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The Commonwealth Fund

Getting Ready for Health Reform 2020: What Past Presidential Campaigns Can Teach Us

June 26, 2018 | **Jeanne M. Lambrew**

ABSTRACT

- **Issue:** The candidates for the 2020 presidential election are likely to emerge within a year, along with their campaign plans. Such plans will include, if not feature, health policy proposals, given this issue's general significance as well as the ongoing debate over the Affordable Care Act.
- **Goal:** To explain why campaign plans matter, review the health policy components of past presidential campaign platforms, and discuss the likely 2020 campaign health reform plans.
- **Methods:** Review of relevant reports, data, party platforms, and policy documents.
- **Findings and Conclusions:** Proposals related to health care have grown in scope in both parties' presidential platforms over the past century and affect both agendas and assessments of a president's success. Continued controversy over the Affordable Care Act, potential reversals in gains in coverage and affordability, and voters' concern suggest a central role for health policy in the 2020 election. Republicans will most likely continue

to advance devolution, deregulation, and capped federal financing, while Democrats will likely overlay their support of the Affordable Care Act with some type of Medicare-based public plan option. The plans' contours and specifics will be developed in the months ahead.

This report is the first in a series on health reform in the 2020 election campaign. Future papers will delve into key reform design questions that candidates will face, focusing on such topics as: ways to maximize health care affordability and value; how to structure health plan choices for individuals in ways that improve system outcomes; and how the experience of other nations' health systems can inform state block-grant and public-plan proposals.

Introduction

During the 2020 presidential campaign, which begins in earnest at the end of 2018, we are sure to hear competing visions for the U.S. health system. Since 1988, health care has been among the most important issues in presidential elections.[1] This is due, in part, to the size of the health system. In 2018, federal health spending comprises a larger share of the economy (5.3%) than Social Security payments (4.9%) or the defense budget (3.1%).[2] Moreover, for the past decade, partisan disagreement over the Affordable Care Act (ACA) has dominated the health policy debate. If health care plays a significant role in the 2018 midterm elections, as some early polls suggest it will,[3] the topic is more likely to play a central role in the 2020 election.

This report on health reform plans focuses on policies related to health insurance coverage, private insurance regulation, Medicare and Medicaid, supply, and tax policy. It explains why campaign plans are relevant, their history since 1940, the landscape for the 2020 election, and probable Republican and Democratic reform plans. The Republican campaign platform is likely to feature policies like those in the Graham-Cassidy-Heller-Johnson amendment: a state block grant with few insurance rules, replacing the ACA's coverage expansion. The Democratic platform will probably defend, improve, and supplement the ACA with some type of public (Medicare-like) health plan. The exact contours and details of these plans have yet to be set.

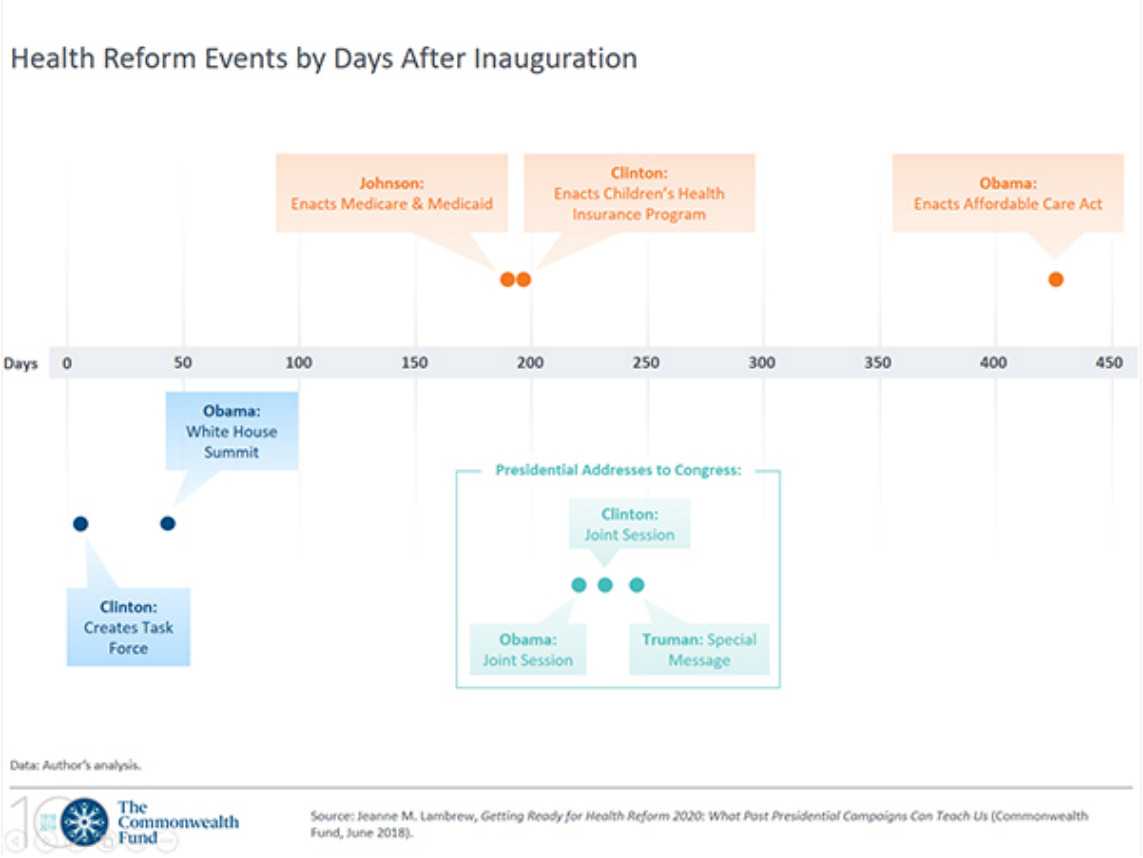
Importance of Campaign Plans

Campaign promises, contrary to conventional wisdom, matter.[4] During elections, they tell voters each party's direction on major topics (e.g., health coverage as a choice or a right in 1992). In some cases, candidates or party platforms include detailed policies (reinsurance

in Republicans' 1956 platform, prospective payment in Democrats' 1976 platform). Campaign plans tend to be used to solidify party unity, especially in the wake of divisive primaries (2016, e.g.).[5] Election outcomes are affected by such factors as the state of the economy, incumbency, and political competition rather than specific issues.[6] That said, some exit polls suggest that candidates' views on health policy can affect election outcomes.[7]

Campaign plans also help set the agenda for a president, especially in the year after an election. Lyndon B. Johnson told his health advisers, "Every day while I'm in office, I'm gonna lose votes. . . . We need . . . [Medicare] fast."[8] Legislation supported by his administration was introduced before his inauguration and signed into law 191 days after it (Exhibit 1). Bill Clinton, having learned from his failure to advance health reform in his first term, signed the bill that created the Children's Health Insurance Program (CHIP) 197 days after his second inauguration. Barack Obama sought to sign health reform into law in the first year of his first term, but the effort spilled into his second year; he signed the ACA into law on his 427th day in office. These presidents, along with Harry Truman, initiated their attempts at health reform shortly after taking office.

In addition, campaign plans are used by supporters and the press to hold presidents accountable. For instance, candidate Obama's promises were the yardstick against which his first 100 days,[9] first year,[10] reelection prospects,[11] and presidency were measured.[12] Though only 4 percent of likely voters believe that most politicians keep their promises, analyses suggest that roughly two-thirds of campaign promises were kept by presidents from 1968 through the Obama years.[13]



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Health as a Campaign Issue (1912–2016)

The United States has had public health policies since the country's founding, with its policy on health coverage, quality, and affordability emerging in the twentieth century. Teddy Roosevelt supported national health insurance as part of his 1912 Bull Moose Party presidential bid.[14] Franklin Delano Roosevelt included "the right to adequate medical care and the opportunity to achieve and enjoy good health" in his 1944 State of the Union address, although it was not mentioned in the 1944 Democratic platform.[15] Harry Truman is generally credited with being the first president to embrace comprehensive reform. He proposed national health insurance in 1945, seven months after F.D.R.'s death, and campaigned on it in 1948 as part of a program that would become known as the Fair Deal, even though it was not a plank in the Democratic platform. Legislation was blocked, however, primarily by the American Medical Association (AMA), which claimed that government sponsoring or supporting expanded health coverage would create "socialized medicine."[16] Health policy became a regular part of presidential candidates' party platforms beginning about this time (Exhibit 2).

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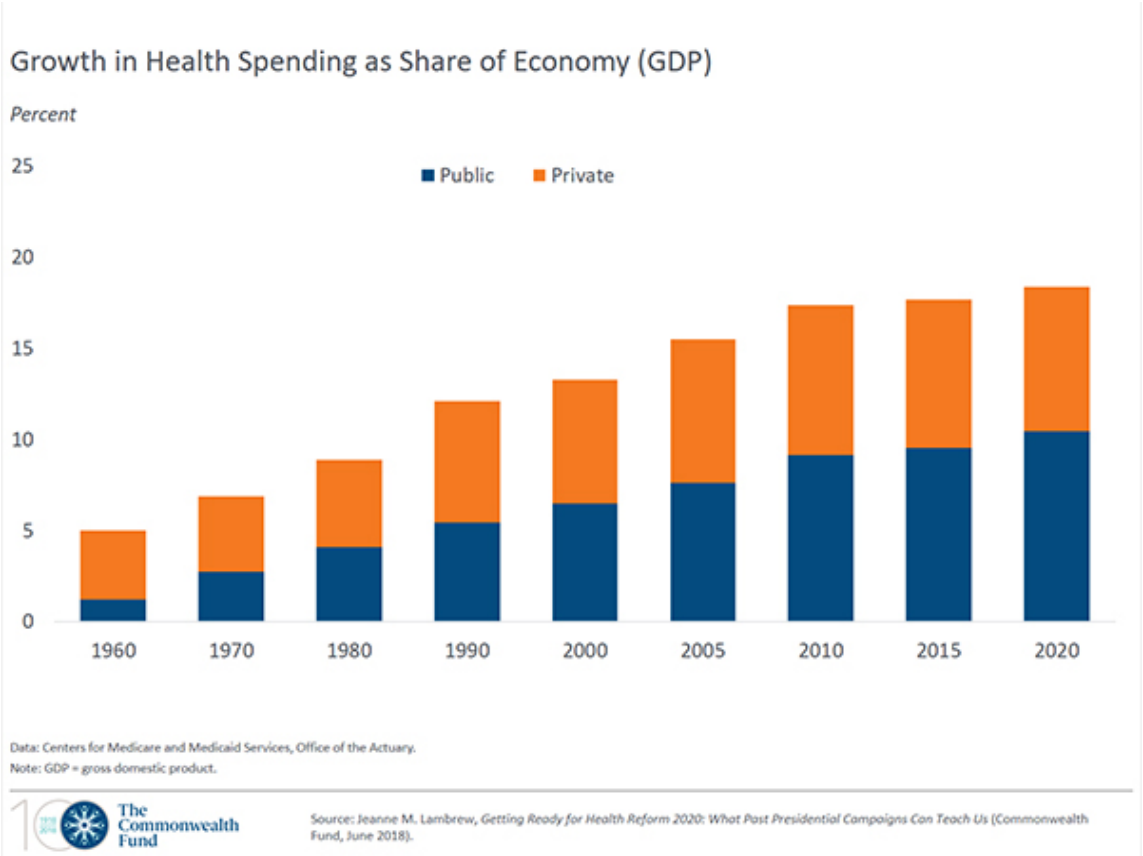
After Truman's failure, the next set of presidential candidates supported expanding capacity (e.g., workforce training, construction of hospitals and clinics) and making targeted coverage improvements. In 1960, John F. Kennedy campaigned on a version of Medicare legislation: extending Social Security to include hospital coverage for seniors. It was opposed by the AMA as well, whose spokesman, the actor Ronald Reagan, claimed socialized medicine would eventually limit freedom and democracy.[17] It took the death of Kennedy, the landslide Democratic victory in 1964, and persistence by Lyndon B. Johnson to enact Medicare and Medicaid, in 1965. This was about 20 years after Truman introduced his proposal; President Johnson issued the first Medicare card to former President Truman.

Shortly after implementation of Medicare and Medicaid, how best to address rising health care costs became a staple subject in presidential campaigns. Between 1960 and 1990, the share of the economy (gross domestic product) spent on health care rose by about 30 percent each decade, with the public share of spending growing as well (Exhibit 3). In his 1968 campaign, Richard Nixon raised concerns about medical inflation, and subsequently proposed his own health reform, which included, among other policies, a requirement for employers to offer coverage (i.e., an employer mandate).[18] Nixon's proposal was eclipsed by Watergate, as Jimmy Carter's health reform promises were tabled by economic concerns. Presidents and candidates in the 1980s set their sights on incremental health reforms.[19]



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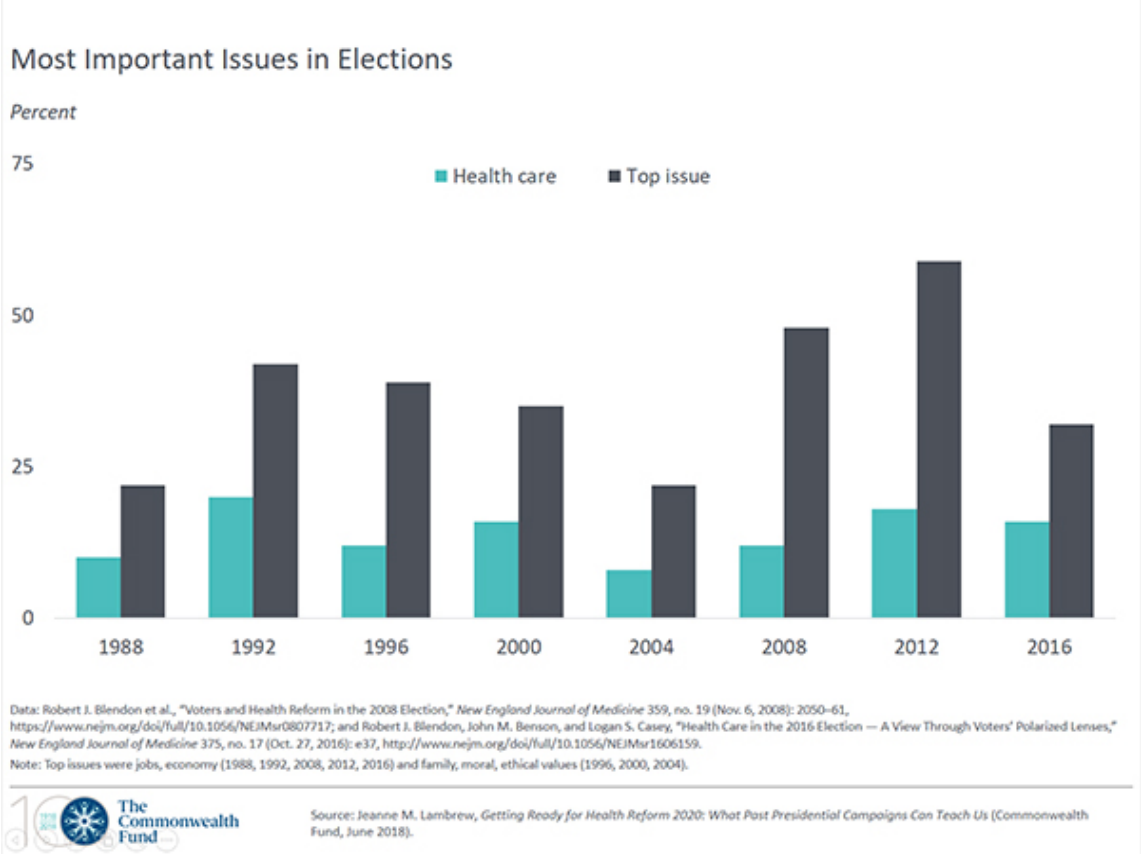
In 1991, comprehensive health reform helped Harris Wofford unexpectedly win a Pennsylvania Senate race. In 1992, it ranked as the second most important issue to voters.[20] Democratic candidates vied over health reform in the 1992 primaries, with Bill Clinton embracing an employer "pay or play" mandate. George H. W. Bush developed his own plan, which included premium tax credits and health insurance reforms. Five days after his inauguration, President Clinton tasked the first lady, Hillary Clinton, with helping to develop health care legislation in the first 100 days. Yet, mostly because he prioritized economic and trade policy, Clinton did not address a joint session of Congress until September and did not send his bill to Congress until November of 1993. Key stakeholders (including the AMA and the Health Insurance Association of America) initially supported but ultimately opposed the legislation. In September 1994, the Senate Democratic leadership declared it could not pass a bill.[21] Less than two months later, Democrats lost their majorities in the House and the Senate, and did not regain them for over a decade. This created a view that comprehensive reform of the complex health system was politically impossible.[22] Indeed, presidential candidates in 1996, 2000, and 2004 did not emphasize major health policies. That said, by 2004, health system problems had escalated and, at least on paper, the candidates' plans addressing them had expanded.[23]

In 2008, health reform was a dominant issue in the Democratic primaries and platform. Hillary Clinton supported a requirement for people who could afford it to have coverage (i.e., the individual mandate). Barack Obama limited his support to a requirement that all children be insured. Both candidates supported an employer mandate.[24] John McCain countered with a plan whose scope exceeded those of many Republican predecessors: it would cap the tax break for employer health benefits and use the savings to fund premium tax credits for the individual market.[25] Attention to health reform waned during the general election, as the economy faltered. Even so, the stage was set for a legislative battle. President Obama opened the door to his rivals' ideas at a White House summit in March 2009.[26] After more than a year of effort, he signed the Affordable Care Act into law.[27] Obama said that he did so "for all the leaders who took up this cause through the generations — from Teddy Roosevelt to Franklin Roosevelt, from Harry Truman, to Lyndon Johnson, from Bill and Hillary Clinton, to one of the deans who's been fighting this so long, John Dingell, to Senator Ted Kennedy."[28]

Nonetheless, the partisan fight over the ACA extended into the 2012 and 2016 presidential elections. Despite the ACA's resemblance to his own 2006 reform plan for Massachusetts, Mitt Romney, as the 2012 Republican presidential candidate, vowed to repeal the ACA before its major provisions were implemented; Republicans would subsequently replace it with conservative ideas (mostly to be developed). Four years later, even though the health system landscape had dramatically changed following the ACA's implementation, the Republicans' position had not altered.[29] Candidate Donald Trump joined his primary rivals in

pledging to "repeal and replace Obamacare" (he also embraced unorthodox ideas such as Medicare negotiation for drug prices). Democratic candidate Hillary Clinton proposed a wide array of improvements to the ACA rather than a wholesale replacement of it with a "Medicare for All" single-payer proposal, as did her Democratic primary rival, Bernie Sanders.[30] The intra-party differences among primary candidates in 2016 increased attention to the party platforms relative to previous elections.[31] But despite continued voter interest (Exhibit 4), differences in health policy were not credited with determining the outcome of the 2016 election.



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Setting the Stage for 2020

President Trump's attempt to fulfill his campaign promise to repeal and replace the ACA dominated the 2017 congressional agenda. In January 2017, the Republican Congress authorized special voting rules toward this effort, while President Obama was still in office. On the day of his inauguration, Trump signed an executive order to reduce the burden of the law as his administration sought its prompt repeal.[32] Yet among other factors,[33] the lack of a hammered-out, vetted, and agreed-upon replacement plan crippled the Republicans' progress.[34] Speaker Paul Ryan had to take his bill off the House floor on

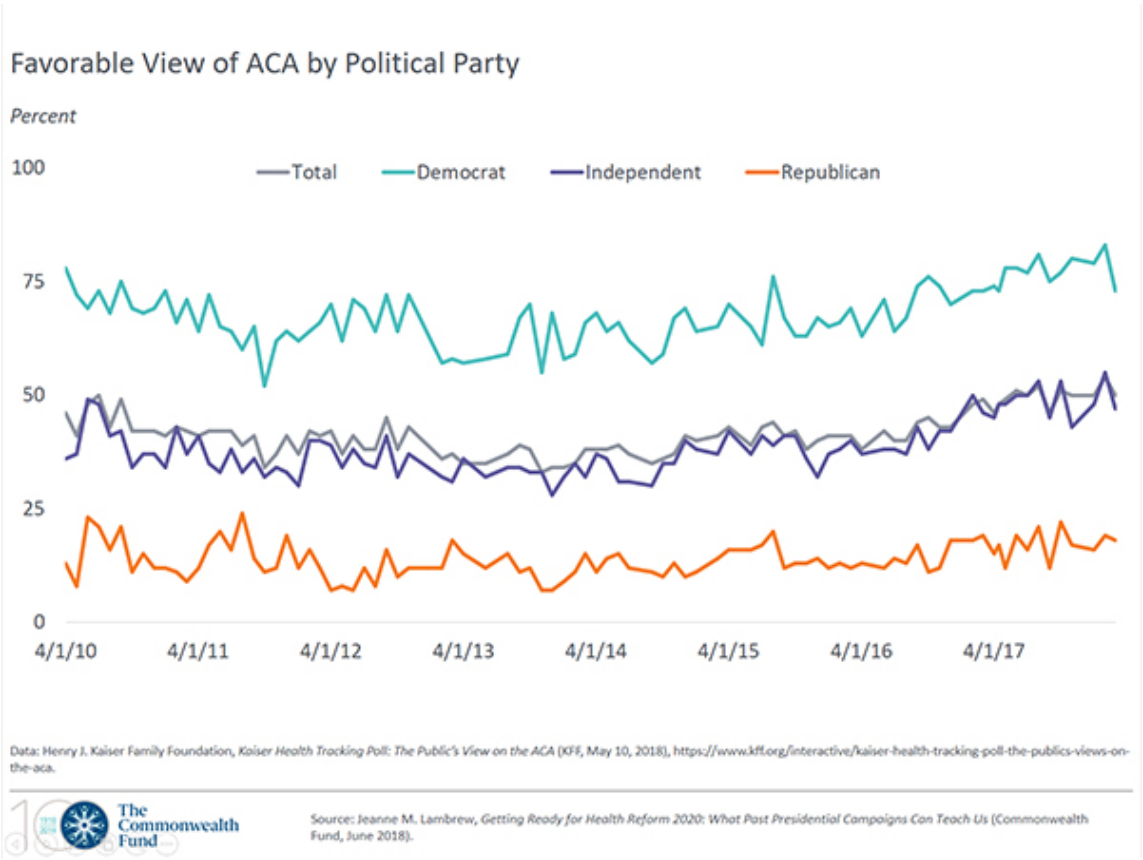
March 24, 2017, because it lacked the necessary votes; the House passed a modified bill on May 4. Senator Mitch McConnell's multiple attempts in June and July to secure a majority in favor of his version of a health care bill failed on July 26, when Senator John McCain cast the deciding vote against it. In September, Senators Lindsey Graham, Bill Cassidy, Dean Heller, and Ron Johnson failed to get 50 cosponsors for their amendment, the prerequisite for its being brought to the Senate floor.[35] The Republicans subsequently turned to tax legislation and, in it, zeroed out the tax assessment associated with the ACA's individual mandate. At the bill's signing on December 22, Trump claimed that "Obamacare has been repealed,"[36] despite evidence to the contrary.[37]

A different type of legislative effort began in mid-2017: bipartisan attempts to improve the short-run stability of the ACA's individual market. This was in part necessitated by the Trump administration's actions pursuant to the Inauguration Day executive order: reductions in education efforts, marketing funding, and premium tax credits, among others.[38] On October 12, 2017, the president signed a second ACA executive order, directing agencies to authorize the sale of health plans subject to fewer regulatory requirements.[39] On the same day, his administration halted federal funding for cost-sharing reductions, a form of subsidy, claiming the ACA lacked an appropriation to make such payments. Concerns that these actions would increase premiums, reduce insurer participation, and discourage enrollment prompted coalitions of bipartisan lawmakers to introduce bills. Most notable was a bill by Senators Lamar Alexander and Patty Murray; their proposal, released October 18, 2017, had 12 Republican cosponsors and implicit support from all Democrats, giving it the 60 votes needed in the Senate to overcome a filibuster.[40] Yet the version that Senator McConnell ultimately brought to the floor for a vote, in March 2018, included changes that repelled Democrats, preventing its passage.[41] Partisans on both sides have blamed this failure, in part, for emerging increases in health insurance premiums.

Indeed, benchmark premiums in the health insurance marketplaces rose by an average of over 30 percent in 2018 and are projected to increase by 15 percent in 2019, largely because of policy changes.[42] Some data suggest that the growth in health care costs may be accelerating as well.[43] This may have contributed to an increase in the number of uninsured Americans. One survey found that the number of uninsured adults, after falling to a record low in 2016, had risen by about 4 million by early 2018.[44] These statistics could heighten candidates' interest in health policy in 2020.

Public opinion, too, could help health reform gain traction. Tracking polls suggest that concerns about health care persist, with 55 percent of Americans worrying a great deal about the availability and affordability of health care, according to a poll from March

2018.[45] Interestingly, while the partisan differences of opinion on the ACA continue, overall support for the ACA has risen, reaching a record high in February 2018 (Exhibit 5).



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This concern about health care has entered the 2018 midterm election debate. It is currently a top midterm issue among registered voters, a close second to jobs and the economy.[46] Some House Republicans who formerly highlighted their promise to repeal and replace the ACA no longer do so in light of the failed effort of 2017.[47] Democrats, in contrast to previous elections, have embraced the ACA, unifying around its defense in the face of Republican "sabotage."[48] The debate also has been rekindled by Trump's decision to abandon legal defense of key parts of the ACA.[49] Regardless of what happens in the courts, this signifies his antipathy toward the law. Barring a midterm surprise, the next Congress is unlikely to succeed where the last one failed. As such, "repeal and replace" would be a repeat promise in Trump's reelection campaign.

Likely 2020 Campaign Plans

Against this backdrop, presidential primary candidates and the political parties will forge their health care promises, plans, and platforms. Common threads from past elections are likely to be woven into the 2020 debate. The different parties' views of the balance

between markets and government have long defined their health reform proposals.[50] Republicans will most likely still be against the ACA as well as uncapped Medicare and Medicaid spending, and for market- and consumer-driven solutions. Democrats will most likely blame Republicans' deregulation for rising health care costs; defend the ACA, Medicare, and Medicaid; and advocate for a greater role for government in delivering health coverage and setting payment policy. Potential policies for inclusion in candidates' plans have been introduced in Congress (Exhibit 6). But major questions remain, such as: how will these campaign plans structure choices for individuals and employers, promote efficient and high-quality care, and learn from the experience of local, state, national, and international systems?

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LIKELY REPUBLICAN CAMPAIGN PLAN: REPLACE THE ACA WITH DEVOLUTION AND DEREGULATION

President Trump has indicated he will run for reelection in 2020.[51] His fiscal year 2019 budget included a proposal "modeled closely after the Graham-Cassidy-Heller-Johnson (GCHJ) bill." It would repeal federal financing for the ACA's Medicaid expansion and health insurance marketplaces, using most of the savings for a state block grant for health care services. It would also impose a federal per-enrollee spending cap on the traditional Medicaid program. States could waive the ACA's insurance reforms.[52] The congressional bill also would repeal the employer shared responsibility provision (i.e., the employer mandate) and significantly expand tax breaks for health savings accounts, among other policies.[53] The framework for this proposal — repealing parts of the ACA, replacing them with state block grants, reducing regulation, and expanding tax breaks — is similar to the 2016 Republican platform.

Trump may continue to express interest in lowering prescription drug costs. In 2016 and early 2017, he supported letting Medicare negotiate drug prices[54] — a policy excluded from the 2016 Republican platform and his proposals as president. His 2019 budget seeks legislation primarily targeting insurers and other intermediaries that often keep a share of negotiated discounts for themselves.[55] On May 11, 2018, he released a "blueprint" to tackle drug costs, including additional executive actions and ideas for consideration. Polls suggest that prescription drug costs rank high among health care concerns.[56]

One policy initiative in the recent Republican platforms but not embraced by the president is Medicare reform. The idea of converting Medicare's defined benefit into a defined contribution program and raising the eligibility age to 67 was supported by Vice President

Mike Pence when he was a member of Congress and by Speaker of the House Paul Ryan.[57] Major Medicare changes were excluded from the 2017 ACA repeal and replace proposals. In contrast, versions of Medicaid block grant proposals appeared in various bills, including the GCHJ amendment, as well as numerous Republican presidential platforms.

Historically, presidents running for reelection have limited competition in primaries. Those challengers, by definition, emphasize their differences with the incumbent, which may include policy. It may be that John Kasich will run on maintaining the ACA Medicaid expansion but otherwise reforming the program (his position as governor of Ohio throughout 2017). Or, Rand Paul could campaign on his plan to repeal even more of the ACA than the Republicans' 2017 bills attempted to do. Incumbents tend to have slimmer campaign platforms than their opponents in general and primary elections, since their budget proposals, other legislative proposals, and executive actions fill the policy space (see Reagan, Clinton, George W. Bush, Obama). Exceptions include George H. W. Bush, who in 1992 developed a plan given voters' concerns about health; and Nixon, who offered a proposal for health reform at the end of his first term.

LIKELY DEMOCRATIC CAMPAIGN PLAN: IMPROVE THE ACA AND ADD A PUBLIC PLAN

It is possible and maybe probable that the ultimate Democratic Party platform in 2020 will resemble that of 2016: build on the ACA and include some sort of public plan option. Legislation has been introduced during this congressional session that builds on the law by extending premium tax credits to higher-income marketplace enrollees (e.g., Feinstein, S. 1307), lowering deductibles and copayments for middle-income marketplace enrollees (e.g., Shaheen, S. 1462), providing marketplace insurers with reinsurance (e.g., Carper, S. 1354), and strengthening regulation of private market insurance (e.g., Warren, S. 2582). Some proposals aim to increase enrollment following the effective repeal of the individual mandate, by, for example, raising federal funding for education and outreach, and testing automatic enrollment of potentially eligible uninsured people (e.g., Pallone, H.R. 5155). These proposals would have different effects on health insurance coverage, premiums, and federal budget costs.[58]

The Democrats will inevitably discuss a public plan in their platform, although the primary contenders will most likely disagree on its scale (e.g., eligibility) and design (e.g., payment rates, benefits).[59] In September 2017, Senator Bernie Sanders introduced the Medicare for All Act (S. 1804). It would largely replace private insurance and Medicaid with a Medicare-like program with generous benefits and taxpayer financing. "Medicare for more" proposals have also been introduced: Medicare Part E (Merkley, S. 2708), an option for individuals and small and large businesses; Medicare X (Bennet, S. 1970), which is available starting in areas

with little insurance competition or provider shortages; and a Medicare buy-in option, for people ages 50 to 65 (Higgins, H.R. 3748). A Medicaid option (Schatz, S. 2001), similar to Medicare Part E, offers a public plan choice to all privately insured people, aiming to capitalize on the recent popularity of that program. Publicly sponsored insurance plans have long been included in Democratic presidents' platforms, although the government's role has ranged from regulating the private plans (Carter, Clinton) to sponsoring them (Truman, Obama). It may be that the candidate who prevails in the primaries will determine whether the Democratic platform becomes "Medicare for all" or "Medicare for more."

This may be the extent of Medicare policies in the 2020 Democratic platform. Relatively high satisfaction and low cost growth in Medicare have limited Democratic interest in Medicare policy changes in recent years. Similarly, Democrats have not introduced or embraced major reforms of Medicaid. However, the public concern about prescription drug costs has fueled Democratic as well as Republican proposals, some of which target the drug companies (e.g., addressing "predatory pricing," allowing Medicare rather than prescription drug plans to negotiate the prices for the highest-cost drugs).[60]

Discussion

Predictions about presidential campaigns have inherent limits, as many experts learned in the 2016 election. Events concerning national security (e.g., conflict), domestic policy (e.g., a recession), or the health system (e.g., a disease outbreak) could alter the policy choices of presidential candidates. New ideas could emerge, or candidates could take unconventional approaches to improving the health system. And, while campaign plans have relevance, the long history of attempts at health reform underscores that by no means are promises preordained.

That said, perennial policies and recent political party differences will likely figure in 2020. Republican presidential candidates, with few exceptions, have adopted a small government approach to health reform: shifting control to states, cutting regulation, preferring tax breaks and block grants over mandatory federal funding, and trusting markets to improve access, affordability, and quality. Democratic presidential candidates have supported a greater government role in the health system, arguing that market solutions are insufficient, and have defended existing programs like Medicare, Medicaid, and, now, the ACA. Some will probably support the government's taking a primary role in providing coverage given criticism of the efficacy and efficiency of private health insurers. The direction and details of the campaign plans for 2020 will be developed in the coming months and year. Given such plans' potential to shape the next president's agenda, now is the time to scrutinize, modify, and generate proposals for health reform.

ACKNOWLEDGMENTS

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Topics

Health Care Coverage and Access
Health System Performance and Costs
Health Insurance Marketplaces
Health Care Delivery Reform

Tags

Health Reform Legislation

Experts

Jeanne M. Lambrew
Commissioner, Maine Department of Health and Human Services

It is important to note that legislation is required for the major healthcare reforms proposed by Biden and Trump. The makeup of Congress will impact how much of the President's agenda is actually enacted into law.

Key: ✓ represents policies supported by the candidate in campaign and other written materials
— represents policies not included in campaign platform statements or that the candidate is likely to oppose
X represents policies actively opposed by the candidate.

Position	 ***Joe Biden***	 ***Donald Trump[1]***
	Healthcare Reform	
Preserve and Protect the ACA	✓ Defend the ACA from congressional and legal challenges	**X** Supports a lawsuit in the Supreme Court to repeal the ACA
Promote Non-ACA-Compliant Plans	—	✓ Encourage short-term, limited duration health plans and Association Health Plans
Changes to the ACA Marketplace	✓ Eliminate 400% income cap on tax credit eligibility; lower maximum income cost contribution; base subsidies on higher-value plans	✓ Reduce enrollment support for consumers; restrict silver-loading; end auto-re-enrollment
Changes to the Medicare Program	✓ Extend Medicare eligibility to Americans aged 60–64	✓ Expand the use of private insurers in Medicare Advantage; move away from fee-for-service; implement new consumer-transparency measures
Changes to Surprise Billing	✓ Curtail surprise billing	
Implement a New Federal Public Option Healthcare Plan	✓ Offer a Medicare-like public insurance option in the Marketplace	—
	COVID-19 Response	
Testing and Treatment	✓ Provide free testing, treatment and future vaccine for all regardless of insurance	✓ Encourage states to develop their own testing plans and the federal government's role as the "supplier of last resort." Launch "Operation Warp Speed" to accelerate the development, manufacturing and distribution of COVID-19 vaccines, therapeutics and diagnostics by January 2021.

[1] In this infographic, Donald Trump's positions are based on campaign statements as well as executive activity during his first term that is expected to continue; legislative activity supported by the Administration is noted specifically.

Position	 Joe Biden	 Donald Trump
Economic Reopening	✓ Increase federal resources to state and local emergency funds to give local leaders economic assistance	✓ Advance a three-phase approach to reopen the economy, get people back to work and protect American lives
Expand Health Capacity	✓ Increase hospital capacity and strengthen the Strategic National Stockpile	
State Fiscal Relief	Increase Medicaid Federal Medical Assistance Percentages (FMAP) by at least 10% for all states during the crisis, with upward adjustments for states that are facing particularly high unemployment rates	—
Prescription Drug Pricing		
Import Drugs From Other Countries	✓ Allow the importation of some drugs	
Use International Reference Pricing	✓ Establish an independent review board to recommend reasonable prices for new drugs	✓ Explore an International Pricing Index Model for Medicare Part D
Remove Coverage Barriers	✓ Prevent insurance companies from using "fail first" protocols	—
Limit Drug Price Increases	✓ Restrict price increases relative to the inflation rate	✓ Limit price increases in exchange for lower cost-sharing in Part D; require Medicare rebates for increases above inflation
Redesign Medicare Part D	—	✓ Reduce out-of-pocket costs in Part D
Negotiate Drug Prices	✓ Repeal law explicitly barring Medicare from negotiating lower prices with drug companies	? *President Trump previously voiced support for Medicare negotiation of drug prices, but cited a proposal to allow the Health and Human Services Secretary to negotiate drug prices as the reason he would veto a House bill*[2]

[2] H.R. 3, the Elijah E. Cummings Lower Drug Costs Now Act

Position	 *Joe Biden*	 *Donald Trump*
	Substance Use Disorders and the Opioid Crisis	
Reduce Supply of Illicit Drugs	—	✓ Increase efforts by the Department of Justice to stop opioid sales online; strengthen criminal penalties for dealing and trafficking
Hold Companies and Individuals Accountable	✓ Hold pharmaceutical companies, manufacturers and distributors accountable for inappropriate practices	✓ Prosecute corrupt or criminally negligent doctors, pharmacies and distributors
Implement Advertising Oversight	✓ Encourage the Federal Trade Commission and the Food and Drug Administration to "crack down" on misleading advertisements	—
Reduce Opioid Prescriptions and Promote Alternative Pain Treatment	✓ Develop less-addictive pain medications and alternative pain treatments	✓ Require best practices for opioid prescriptions; transition states to nationally interoperable network of Prescription Drug Monitoring Programs; research alternative treatments
Decriminalize Addiction	✓ Require federal courts to divert individuals charged with drug offenses to drug courts	—
Fund Local Intervention	✓ Secure funding for new grants to state and local entities to address prevention, treatment and recovery activities	
Increase Access to Treatment	✓ Expand health insurance coverage; expand funding for mental health services and providers; enforce mental health parity laws	✓ Remove Institution for Mental Diseases exclusion to allow residential treatment facilities with more than 16 beds to receive Medicaid reimbursements

Position	 *Joe Biden*	 *Donald Trump*
	Health Equity	
Improving Rural Health	✓ Provide rural hospitals with funding and flexibilities to identify, test and deploy innovative approaches to provide care to rural communities; double funding for community health centers and equip them to be hubs for health communities; deploy telehealth	✓ Expand access to broadband and telemedicine services; modify payments to Rural Health Clinics;[3] remove requirements on rural hospitals to address trends in hospital closures; maintain funding for Rural Health Outreach grants
Improve Racial and Gender Health Disparities	Invest in expanded healthcare coverage and expand resources to train black healthcare workers in order to end racial health disparities Support legislation to establish a permanent Infectious Disease Racial and Ethnic Disparities Task Force Improve health for women, Native Americans, LGBTQ+ Americans and people with disabilities[4]	—

[3] Note that the President's proposed budget included a $1.8 billion cut to Medicare payments to Rural Health Clinics over ten years.
[4] Details can be found in the specific plans listed on the resources page.

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RAND CORPORATION HEALTH CARE

The Future of U.S. Health Care: Replace or Revise the Affordable Care Act?

The *Affordable Care Act* (ACA), enacted in 2010, dramatically changed the U.S. health care landscape. The law's goals were to reduce the number of uninsured, make coverage more affordable, and expand access to care. To accomplish this, the law expanded eligibility for Medicaid and created new marketplaces where people without employer coverage could buy policies directly from insurers. It uses a carrot and stick approach to promote enrollment. Most adults are required to have health coverage or pay a fine; and moderate-income individuals receive premium subsidies to buy policies in the new marketplaces.

Since the ACA's adoption, an estimated 20 million people have become newly insured, and approximately 24 million people have gained access to subsidized or free care through marketplace tax credits and Medicaid expansion. Despite these successes, the law faced strong political headwinds from the outset. There have been repeated calls

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from both sides of the political spectrum to repeal the law and replace it with alternative reforms or to modify the law to address other goals.

RAND research offers insights about the likely impact of repealing or revising the ACA. RAND's research on the ACA makes use of an updated version of the RAND COMPARE microsimulation model, which predicts the effects of health policy changes at state and national levels. Using COMPARE, researchers have examined the impact of many configurations of health insurance in the United States, including:

- maintaining the ACA with no changes
- repealing the law with no replacement
- replacing the law with a single payer system
- replacing the law with other measures that address coverage expansions through Medicaid and the individual market

RAND research has also examined the impact of retaining the ACA while modifying key provisions, including:

- repealing the individual mandate
- modifying tax credit subsidies
- revising market regulations
- modifying Medicaid expansion

Below, we summarize the impacts of these alternatives, focusing on the effect of potential changes to the ACA on the number of uninsured and consumer out-of-pocket costs.

If the ACA were repealed, with no replacement, the number of insured Americans would drop by 19.7 million.

Replacing the ACA

Photo by Brian Synder/Reuters

The ACA remains in effect as of this writing. Under the status quo, analysis conducted in 2015 estimates that 251.6 million Americans will have health insurance in 2017. The number of uninsured is estimated at 26 million. Out of pocket costs for an enrollee in the individual insurance market average $3200 for the year.

As noted earlier, RAND has modeled three alternatives to the ACA and a fourth that makes substantial changes (the American Health Care Act [AHCA]). The first would repeal the ACA with no replacement; the second would replace it with a single-payer approach; the third (the CARE Act), would overhaul the ACA's market regulations and Medicaid expansion, as would the AHCA.

Repealing the ACA with No Replacement

If the ACA were fully and immediately repealed, with no replacement, the number of insured Americans would drop by 19.7 million to 231.9 million in 2017 as estimated by analysis conducted in 2016. Out-of-pocket costs for an enrollee in the individual market would average $7400 annually, an increase of $4200 over the status quo. Repeal would increase the federal deficit by $33.1 billion annually compared with the status quo, largely because it would eliminate the ACA's revenue-raising provisions.

Replacing ACA with a Single Payer Plan

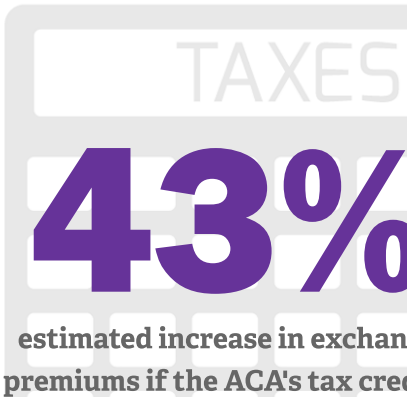
RAND research has also examined the impact of replacing the ACA with single-payer plans. The analysis looked at two scenarios:

1. Adopting the **American Health Security Act**, introduced by Senator Bernie Sanders in 2011. The plan is a Medicare-for-all proposal that would replace the ACA as well as Medicare, Medicaid, and SCHIP with uniform, single-tiered coverage managed by the federal government. The plan would not allow private health insurance. There is little or no cost sharing for enrollees.
2. The **Health-Insurance Solution**, a plan focused on catastrophic coverage in which Medicare and Medicaid continue and all other legal U.S. residents have income-dependent coverage. Individuals also have the option to purchase supplemental private coverage.

The analysis, conducted in 2015, assumed that a comprehensive single-payer plan would provide all 311 million legal residents of the United States with coverage in 2017. The only uninsured would be 11 million undocumented immigrants. Relative to estimated spending under the ACA in 2017, this scenario would increase national health care spending by $435 billion and increase federal health care spending by

By the Numbers

$1 trillion. When other potential savings and costs (i.e., administrative and implementation costs, reductions in drug and provider prices), the average net effect on national health care expenditures was $556 billion in savings, but with a very large range—from a savings of over $1.5 trillion to increased spending of $140 billion, depending on the actuarial value of the coverage and other design and implementation details.



Under the catastrophic-plan scenario, the same total number of Americans would have coverage—311 million in 2017—as under the comprehensive plan, but would have coverage through a variety of sources. An estimated 203 million Americans would have coverage under the single payer plan, with other Americans covered by Medicare, Medicaid, and other sources. This scenario reduces national health care expenditures by $211 billion and federal expenditures by $40 billion relative to the ACA.

The study's dollar estimates are not comparable to the other results presented in this paper because they refer to a different baseline. However, in sum, the comprehensive scenario with generous benefits would be very expensive, while the catastrophic scenarios with income-dependent coverage would be cost-saving but provide fewer health insurance benefits.

The Patient CARE Act

The *Patient Choice, Affordability, Responsibility, and Empowerment Act* (CARE) was an alternative to the ACA offered by Sens. Richard Burr (R–N.C.) and Orrin Hatch (R–Utah) and Rep. Fred Upton (R–Mich.) in 2016. It proposed:

- eliminating the ACA's individual and employer mandates,
- loosening regulations on insurers,
- rolling back funding for Medicaid expansion, and
- eliminating the ACA's taxes and fees.

It also offered tax credits to low-income individuals to help them purchase insurance, but using a structure different from the tax credits under the ACA. The CARE Act would offer a "premium support" type tax credit, meaning that—even though they are based on income and family size—they are not adjusted to account for regional variation in premium levels or health care cost growth, and thus enrollees are responsible for any difference between the amount of the tax credit and the cost of the premium.

We analyzed the effects of the CARE Act on insurance enrollment, premiums, federal spending, and out-of-pocket costs, relative to current law. Based on modeling conducted in 2016, the analysis

estimated that, in 2018, the CARE Act would reduce federal spending but increase the deficit by $17 billion, relative to current law. This increase results from the Act's elimination of many revenue-generating mechanisms built into the ACA. The CARE Act would increase the number of uninsured individuals by 9 million, and leave some population segments, including low-income individuals and older adults, with substantially higher costs for health insurance and medical care.

The American Health Care Act

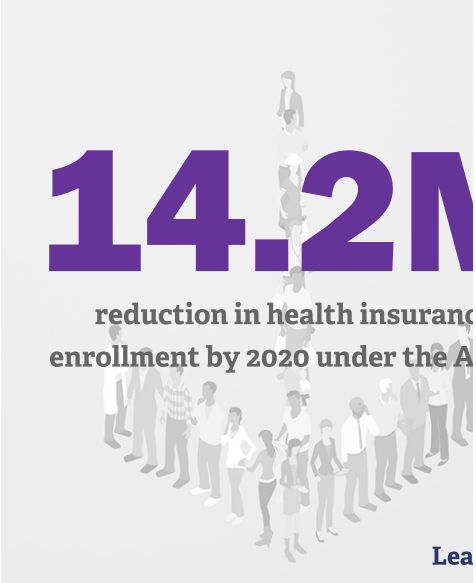
U.S. Speaker of the House Paul Ryan speaks to the media about the American Health Care Act at the Capitol in Washington, D.C., March 15, 2017
Photo by Aaron P. Bernstein/Reuters

The *American Health Care Act* (AHCA) is an alternative to the Affordable Care Act, first introduced in the House of Representatives in March 2017, and eventually passed by the House, with amendments, in May 2017. Though not technically a repeal, the AHCA makes sweeping changes to the ACA. Its main features include:

- Repealing the individual and employer mandates
- Instituting a continuous coverage requirement under which individuals must maintain coverage without a gap else face an automatic one-year premium surcharge of 30 percent
- Changing the ACA's age-based rate banding from 3:1 to 5:1
- Replacing income-based subsidies in the individual market with fixed, age-based subsidies whose generosity increases with age
- Converting federal Medicaid funding to a per-capita allotment, ending the option for states to expand Medicaid in 2019, and, after 2020, providing new enrollees with the same per-capita allotment as adults who were eligible before 2014

The key amendment to the bill as passed in May 2017, would allow states to apply for waivers in order to:

By the Numbers



1. Set age rating at higher than 5:1
2. Define their own essential health benefits rather than using the 10 set forth in the ACA and preserved in the AHCA
3. Let insurers use health status to set premium prices for those who allow their coverage to lapse

The amendment also included additional funding for states that receive waivers to provide financial support to high-risk, high-cost enrollees to obtain coverage in the individual market.

Our analysis estimates that, exclusive of waivers, the *American Health Care Act* (AHCA) would reduce health insurance enrollment by 14 million people in 2020, and the loss of health insurance would increase to 20 million people by 2026. The AHCA would have increased the federal deficit by $38 billion in 2020 while reducing the deficit by $5 billion in 2026.

Most adults ages 50 to 64 and most people with incomes under 200 percent of the federal poverty level (FPL) would have paid more for individual-market insurance under the AHCA than under current law. The higher costs for older adults partly reflect that the AHCA's tax credits do not increase as steeply with age as premiums.

Modifying the ACA

Repealing or Replacing the Individual Mandate

The ACA uses a carrot-and-stick approach to promote enrollment. The carrot is the tax credit that subsidizes premiums for low to moderate income people who buy insurance in the marketplaces. These subsidies are progressive, providing the largest amounts to low-income individuals. The stick is the individual mandate, which requires most adults to obtain coverage or pay a fine. In 2017, the fine for not having coverage was $695 per adult and $347.50 per child or 2.5 percent of income, whichever is larger.

The individual mandate has generally been unpopular and has been criticized and challenged by opponents, sometimes on grounds that it is intrusive and burdensome, sometimes on more pragmatic grounds that it is ineffective as a spur to enroll. Proponents argue that it is critical to promoting enrollment, especially in the marketplaces.

Senator Ron Johnson (R-WI), accompanied by Senator Lindsey Graham (R-SC), speaks during a press conference about their resistance to the so-called Skinny Repeal of the Affordable Care Act on Capitol Hill in Washington, July 27, 2017

Photo by Aaron P. Bernstein/Reuters

Repeal with no replacement

Analysis conducted in 2015 estimated that that 12 million fewer people would have insurance in 2017 if the individual mandate were repealed, and no other provision (such as a continuous coverage requirement) replaced it. Individual-market enrollment would decline by about 25 percent, with the largest losses among the young and healthy. Premium prices in the individual market would increase by 8 percent. These results are consistent with findings from other research organizations, which have estimated coverage reductions in the range of 8 million to 16 million following repeal of the individual mandate.

Replace with a continuous coverage provision

Several Republican proposals, including the AHCA, have replaced the individual mandate with a requirement that people maintain continuous insurance coverage or face a penalty. Like the individual mandate, a continuous coverage requirement is intended to discourage individuals from waiting until they get sick to buy insurance. Under this requirement, individuals who let their coverage lapse risk being denied coverage in the future. When these individuals attempt to re-enter the market, insurers can charge higher prices, refuse to cover specific health conditions, or deny coverage altogether. It is likely that repealing the individual mandate would tend to cause healthier people to drop coverage in the individual market, which would also lead to an overall increase in premiums. At the same time, the continuous-coverage provision would likely cause some others to stay enrolled, particularly older adults for whom the 30 percent upcharge represented a larger amount relative to that faced by younger enrollees. We estimate that the net effect of this change would be 4 million fewer people insured in the individual market.

Revising the Premium Tax Credit

A key target in the ACA for those seeking change is the ACA's progressive formula for determining tax credits in the marketplaces. It works like this: enrollees must contribute a maximum amount toward their premium, based on their income. If the benchmark plan premium exceeds that amount, enrollees receive the difference in the form of a tax credit. The logic of this approach is that enrollees are shielded from sharp increases in premiums. Critics, however, contend that this formula will be fiscally unsustainable over the long run. Several alternative proposals, including the AHCA, have advanced a "premium-support" model, which sets tax credits independently of the premium.

RAND researchers evaluated two types of proposed tax credits

1. **Flat-rate tax credit**. We modeled the impact of a flat tax credit of $2,500 for an individual or $5,000 for a family. This kind of provision generally shifts costs from older to younger individuals compared with the ACA. A 60-year-old with income at 350 percent of the federal poverty level (FPL) would see his or her annual premium contribution increase from $3,700 under the ACA to $5,300 under the flat tax credit. A 27-year old with the same income would see his or her annual premium contribution drop from $3,000 to $500. The number of uninsured would increase by approximately 6 million, mostly among people in the 50-64 age range. In addition, this provision in effect shifts the costs of premium increases from the federal government to consumers, whose contributions are no longer capped. A flat rate tax credit could also have an upside. It would reduce firms' incentives to cut their work force and increase most consumers' incentives to keep spending down.

2. **Age-adjusted tax credit**. A variation of the flat tax credit offers fixed subsidies that increase with enrollees' age. We have modeled this provision in the context of the Patient CARE Act and the AHCA, but not as a standalone provision. Evidence suggests that this approach can improve affordability for older enrollees compared with the basic flat-tax credit, but it also shifts the cost of premium increases onto consumers.

Changing Market Regulations

The ACA sets standards for minimum benefit generosity health plans may offer. Plans must include 10 essential health benefits; must provide benefits with a minimum actuarial value of at least 60 percent of expected costs for an average population; and must cap annual out-of-pocket limit for the consumers.

The ACA also changed rating regulations. Plans cannot charge different prices based on gender or health status. Prices can vary only by age and tobacco use status. Older consumers can be charged a maximum of three times more than younger ones (this is known as 3:1 rate banding).

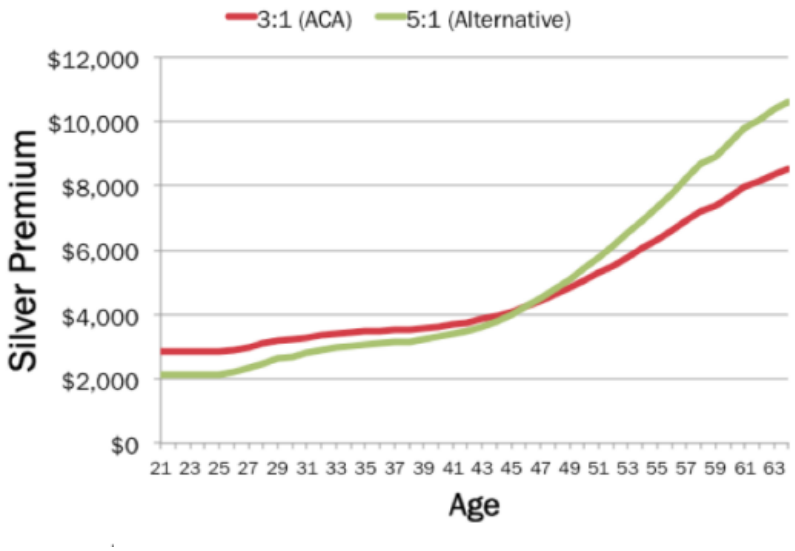
ACA's 10 Essential Health Benefits

1. Ambulatory patient services (outpatient care you get without being admitted to a hospital)
2. Emergency services
3. Hospitalization
4. Pregnancy, maternity, and newborn care
5. Mental health and substance use disorder services
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

Changing Age Rating

Some reform plans, such as the recent GOP House Plan – the American Health Care Act – have proposed allowing plans to charge older consumers five times more than younger ones. This change would benefit younger consumers at the expense of older ones. This change would cut annual premiums for a 24-year-old from $2,800 to $2,100, while premiums for a 64-year-old would rise from $8,500 to $10,600. Such a move would likely increase the number of younger people buying insurance, but also decrease the number of older people who do so. In general, average premiums would go down for people under age 47 and up for those over age 47.

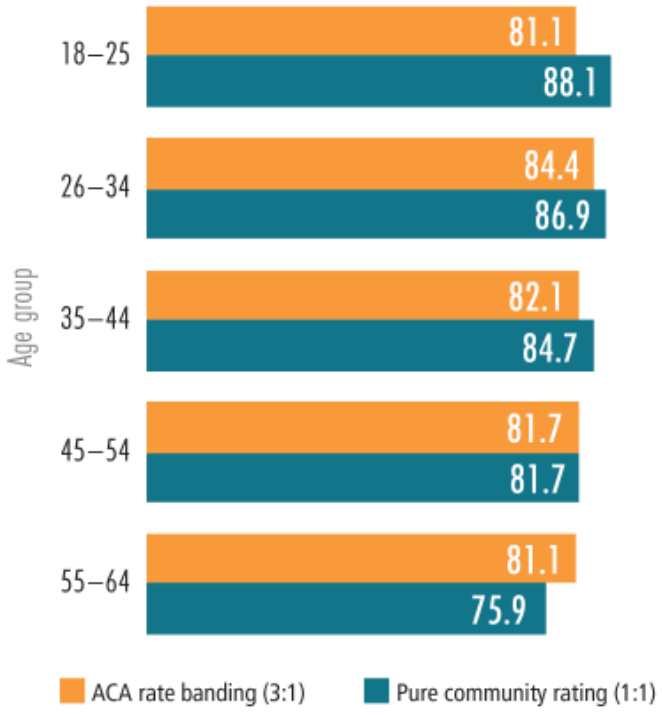
Fig 1. **Relaxing Age Bands Would Reduce Premiums for Younger People and Increase Premiums for Older People**



SOURCE: Eibner C and Saltzman E. "What Happens if the ACA's tax Credits are Replaced with Premium Support?" Commonwealth Fund, 11-4-2015.

The focus on enrollees' age can obscure the fact that age does not always correlate with health status. In fact, the majority of adults at all ages are in good health and thus are all good insurance risks. Insurers have an interest in keeping these "good risk" adults enrolled. When costs increase for older enrollees, these healthier adults are the most likely to drop coverage.

Fig 2. Percent of Enrollees with Expenditures Below the Age-Rated Amount



NOTE: We assume premiums are actuarially fair (that is, premiums are set so that insurers' collections are exactly equal to total spending in the risk pool, plus allowed administrative costs). Data come from COMPARE model estimates for 2015. We assume that the individual mandate is in effect, tax credits and subsidies for marketplace coverage are available for qualifying individuals, and Medicaid expansion has occurred in participating states.

Ending Essential Minimum Benefits

From a policy perspective, the ACA benefit design has both an upside and downside.

The Upside

Guarantees that people who need benefits have access to affordable care

The Downside

Can make others pay for benefits they don't necessarily need

Can potentially increase the cost of coverage

Various repeal and replacement proposals, including the version of the AHCA passed by the House of Representatives in May 2017, would allow states to waive or redesign the ACA's essential minimum benefit requirement. RAND analysis found that in general eliminating essential benefits would reduce premiums overall but also sharply increase costs for consumers who need those services. For example, removing maternity and mental health benefits from coverage would likely lower premiums in the individual market premiums by about 5 percent overall; but out-of-pocket spending for women in need of maternity care could rise by $7,894 if maternity benefits were dropped. For a typical consumer of mental health and substance abuse services, out-of-pocket spending would increase by $1,088.

Changes to Medicaid Financing

Medicaid expansion has accounted for most of the newly insured under the ACA – approximately 14 million, according to the Kaiser Family Foundation. Medicaid and the Children's Health Insurance Program (CHIP) is jointly funded by states and the federal government. The federal government currently contributes 50 percent to 75 percent of total costs for Medicaid enrollees who were eligible prior to the ACA, higher amounts for CHIP enrollees, and higher amounts for those made eligible for Medicaid because of the ACA. Concerns about the potential long-term costs of this arrangement have fueled proposals to modify financing for Medicaid.

Change Medicaid to a Block Grant Program

Some proposals would convert Medicaid financing to a block grant to states. Under this plan, states would receive a lump sum federal payment for Medicaid, indexed to inflation. The payment is fixed

regardless of enrollment. We estimated the block grants as a component of the Trump campaign platform.

Change Medicaid Expansion to a Per Capita Grant Program

Under this arrangement, the federal government sets a limit on how much to reimburse states per enrollee. Cost growth per enrollee is indexed to inflation. We estimate that under one such proposal (the AHCA) Medicaid enrollment would fall by nearly 10 million people by 2020. The impact becomes more pronounced over time, with Medicaid enrollment falling by nearly 14 million.

We also estimate that this change will shift costs to the states over time, as recent growth in per capita Medicaid costs exceeds the Medical Consumer Price Index, and this trend may continue. Under the AHCA, states that expanded Medicaid will face lower contributions for adults made eligible by the ACA. This is not an inherent effect of per capita caps, but as implemented under the AHCA, the caps would reduce funding for the Medicaid expansion population. States could respond in several ways:

- Pay the difference out of state funds
- Reduce eligibility
- Reduce provider reimbursement
- Institute cost sharing requirements and/or premiums for some enrollees
- Add work requirements

The net effect of these provisions will most likely translate into some combination of lower Medicaid enrollment and less generous coverage.

The Cadillac Tax Versus Limiting Tax Breaks for Employer-Sponsored Insurance

Of the various mechanisms for raising revenues in the ACA, one of the most debated has been the "Cadillac tax," scheduled to take effect in 2018. The Cadillac tax consists of a 40 percent tax on premiums for employer-sponsored plans in excess of a dollar limit ($10,200 for a single plan, and $27,500 for a family plan in 2018). The tax would be jointly paid by employers and workers on their respective contributions.

The Cadillac tax seeks to address problems with the tax advantage for employer-sponsored insurance (ESI), which allows premiums to be paid with an unlimited amount of pre-tax dollars. The current tax break has been criticized for encouraging overly comprehensive benefits and promoting overconsumption of care. The tax break also

costs the federal government roughly $323 billion each year. However, the Cadillac tax has also been criticized for making high-cost plans too expensive, particularly for firms with older and sicker workers, and because the flat 40 percent excise tax is not progressive, like federal income tax.

A third option that could address both sets of concerns is a cap on the tax advantage for ESI (known as an "exclusion cap"). Under this cap, individuals in employer plans could exclude premiums from their taxable income up to a dollar limit. Premiums in excess of the cap would be treated as taxable income and, therefore, subject to federal and state income taxes. The same limits would apply to employers. Like the Cadillac tax, an exclusion cap addresses the problem of ESI's open-ended tax advantage, but would be more equitable because the impact is smaller for people with lower incomes.

We compared the effect of the Cadillac tax and an exclusion cap that treats individual contributions to health premiums above $10,451 and family contributions above $28,178 as income. For families in all income categories, spending for health benefits declines, but the declines are larger for the Cadillac tax than for the tax cap. But when changes in health benefits are combined with changes in take-home pay, the differences in progressivity between the Cadillac tax and the tax cap were small.

The research also suggested that employers might respond to either the Cadillac tax or the exclusion cap by reducing their health benefits for employees. To avoid paying the 40 percent excise tax or the amount above the exclusion cap, employers may reduce the generosity of the health insurance plans that they offer. In turn, they might increase wages, leaving employees' compensation largely unchanged. Because wages are subject to income and payroll tax, these changes would increase federal revenue.

Conclusion

As policymakers weigh the choices ahead, it is clear that tensions exist between many health policy goals—for example, expanding coverage versus reducing costs; targeting tax credits effectively versus incentivizing work; protecting the sickest and most expensive patients versus preserving choice among the majority of patients who may not need comprehensive coverage; and limiting the federal government's cost liability versus minimizing cost-shifting to consumers and states. Deciding among these goals or striking a balance across them will involve political and value calculations about what the U.S. health care system should look like.

Researcher Spotlight

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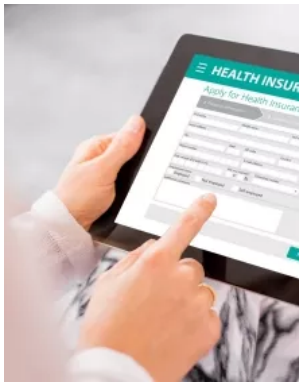

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