THE GHOSTS OF THE AFFORDABLE CARE ACT

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ABSTRACT

The Patient Protection and Affordable Care Act (ACA) is perhaps the most important piece of social legislation enacted in the United States in the last fifty years. Yet the ACA that exists today is not the same law that was passed by Congress in 2010. Rather, several of the most consequential provisions of the law have since been repealed or scaled back by Congress or the courts, some of them without having ever taken effect, and others with remarkably little fanfare. This Article offers an analysis of these "ghosts" of the Affordable Care Act. Appraising these ghosts together reveals that, in several respects, the law that exists today is far more modest in its scope and effects than the version originally signed into law.

Bringing these ghosts to light reveals a puzzle: the conventional wisdom is that it is incredibly difficult to dismantle social programs that confer benefits. Yet not only have significant sections of the ACA disappeared, but also the ACA itself came quite close to being invalidated on multiple occasions. So what happened? The ACA's ghosts can be traced in part to what this Article calls its "enactment-entrenchment tradeoffs": the tradeoffs that legislators were forced to make between enacting the law and ensuring its durability over time. The Article argues that such tradeoffs are not unique to the ACA, and in fact have become more pronounced over time. It revisits the conventional wisdom that social programs are difficult to dismantle and suggests that newly enacted programs are in fact quite vulnerable. It concludes by arguing that lawmakers must change the rules of the game that govern these tradeoffs if they wish to ensure that new social programs will survive.

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INTRODUCTION

On March 23, 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act (more commonly known as the "ACA" or "Obamacare").[1] The law has been described as "the largest reform of the nation's health care system since . . . Medicaid and Medicare,"[2] "the most

1. One week later, on March 30, 2010, the President signed the Health Care and Education Reconciliation Act (HCERA), which made several significant amendments to the Patient Protection and Affordable Care Act. In the main text of this Article, I will refer to the Patient Protection and Affordable Care Act, as amended by HCERA, as the "ACA," though I will occasionally refer to HCERA separately in the footnotes.

2. Sylvia Mathews Burwell, *Preface* to THE TRILLION DOLLAR REVOLUTION: HOW THE AFFORDABLE CARE ACT TRANSFORMED POLITICS, LAW, AND HEALTH CARE IN AMERICA 1, 1 (Ezekiel J. Emanuel & Abbe R. Gluck eds., 2020).

ambitious and significant piece of domestic legislation to pass in half a century,"[3] a "once-every-other or once-every-third generation achievement,"[4] "the Civil Rights Act of the 21st century,"[5] a "superstatute,"[6] and most memorably, a "big f***ing deal."[7]

The landmark law reshaped the structure and meaning of health insurance in the United States.[8] To cite only a few of the ACA's most well-known provisions: It transformed Medicaid from a safety net program that provided health insurance coverage only to certain categories of the "deserving poor" to one that creates a near-universal entitlement for low-income Americans.[9] It required that, with certain exceptions, Americans obtain minimum health insurance coverage or pay a penalty (the so-called "individual mandate").[10] It established new "exchanges" where individuals could compare private insurance plans, access subsidies, and purchase insurance coverage.[11] It generally required health insurance plans in the individual and small group markets to provide "essential health benefits,"[12] prohibited insurers from limiting annual or lifetime coverage expenses for such benefits,[13] and banned insurers from discriminating against individuals

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3. JONATHAN COHN, THE TEN YEAR WAR: OBAMACARE AND THE UNFINISHED CRUSADE FOR UNIVERSAL COVERAGE 334 (2021).

4. JOHN E. MCDONOUGH, INSIDE NATIONAL HEALTH REFORM 290 (2011) [hereinafter MCDONOUGH, INSIDE NATIONAL HEALTH REFORM].

5. James E. Clyburn, *ACA Is the Civil Rights Act of the 21st Century*, POST & COURIER (Jan. 16, 2017), https://www.postandcourier.com/opinion/commentary/aca–is–the–civil–rights–act–of–the–21st–century/article_572eaf52–dc13–11e6–8ad0–9ba57e5f8998.html [perma.cc/SJP3-5RFF].

6. *See* Abbe Gluck, *Obamacare as Superstatute*, BALKINIZATION (July 29, 2017, 10:18 AM), https://balkin.blogspot.com/2017/07/obamacare-as-superstatute.html [perma.cc/4NKX-WSQ2] ("The ACA seems to clearly satisfy the threshold criteria of superstatute theory."); Lindsay F. Wiley, Elizabeth Y. McCuskey, Matthew B. Lawrence & Erin C. Fuse Brown, *Health Reform Reconstruction*, 55 U.C. DAVIS L. REV. 657, 681 (2021) (describing the ACA as "a plausible super-statute"). *But see* Erin C. Fuse Brown, *Developing a Durable Right to Health Care*, 14 MINN. J.L. SCI. & TECH. 439, 444 (2013) [hereinafter Fuse Brown, *Developing a Durable Right to Health Care*] (making the case that the ACA is "more likely to end up as a quasi-superstatute than a superstatute"). *See generally* William N. Eskridge, Jr. & John Ferejohn, *Super-Statutes*, 50 DUKE L.J. 1215, 1216 (2001) (defining a super-statute as "a law or series of laws that (1) seeks to establish a new normative or institutional framework for state policy and (2) over time does 'stick' in the public culture such that (3) the super-statute and its institutional or normative principles have a broad effect on the law—including an effect beyond the four corners of the statute").

7. *Health Care Bill Signing Ceremony*, C-SPAN, at 07:45 (Mar. 23, 2010), https://www.c-span.org/video/?292681-1/health-care-bill-signing-ceremony [perma.cc/N2R8-AZ4Y].

8. *See* Tom Baker, *Health Insurance, Risk, and Responsibility After the Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1577 (2011); Allison K. Hoffman, *Three Models of Health Insurance: The Conceptual Pluralism of the Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1873 (2011) [hereinafter Hoffman, *Three Models of Health Insurance*].

9. *See* Baker, *supra* note 8, at 1584; Nicole Huberfeld & Jessica L. Roberts, *Medicaid Expansion as Completion of the Great Society*, 2014 U. ILL. L. REV. SLIP OPS. 1, 1.

10. ACA § 1501, 26 U.S.C. § 5000A.

11. *Id.* §§ 1311–1313, 1401(a), 42 U.S.C. §§ 18031–18033, 26 U.S.C. § 36B.

12. *Id.* § 1302(a)–(b), 42 U.S.C. § 18022(a)–(b).

13. *Id.* §§ 1001(5), 2711, 42 U.S.C. § 300gg–11.

based on their health status.[14] The ACA also included numerous provisions affecting other parts of the health care system, from the hospital industry to the pharmaceutical sector to the medical profession.[15]

Moreover, despite intense political and legal opposition to the ACA, the ACA has proven remarkably resilient.[16] In its first decade of existence alone, the ACA withstood more than 2,000 legal challenges (more than any other statute in American history), over 70 congressional attempts at repeal, and administrative sabotage by the Trump Administration.[17] Despite these challenges, many of the central pillars of the ACA remain intact, and indeed Congress has subsequently strengthened some of the law's provisions in important ways—in particular, by bolstering (albeit temporarily) the subsidies on the exchanges.[18] Moreover, after multiple near-death experiences in Congress and at the Supreme Court,[19] the law seems (at least for now) to have finally won enough public support to ensure its continued survival.[20]

This story has been well-chronicled, and it is accurate, so far as it goes. Yet it is also incomplete. In particular, it leaves out a key fact: namely, that the ACA that exists today is not the same ACA that was signed into law by President Barack Obama in 2010. Instead, due to a combination of judicial decisions and congressional actions, today's ACA is in several respects far more modest in its scope and effects than the law that was originally passed by Congress.

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14. *Id.* § 1201, 42 U.S.C. § 300gg–4.

15. *See generally* THE TRILLION DOLLAR REVOLUTION: HOW THE AFFORDABLE CARE ACT TRANSFORMED POLITICS, LAW, AND HEALTH CARE IN AMERICA, *supra* note 2, at 209–96 (assessing the ACA's impacts on access to health care, health care spending, and medical practice).

16. *See, e.g.*, Abbe R. Gluck & Thomas Scott-Railton, *Affordable Care Act Entrenchment*, 108 GEO. L.J. 495, 495 (2020) (describing the ACA as "the most challenged—and the most resilient—statute in modern American history"); Larry Levitt, *The Affordable Care Act's Enduring Resilience*, 45 J. HEALTH POL., POL'Y & L. 609, 609 (2020) ("The ACA is certainly still alive and has shown remarkable resilience since its enactment, reflecting its policy design, changes made legislatively and by the courts, and the politics surrounding it."); Gail Wilensky, *The Surprising Resiliency of the Affordable Care Act*, 320 JAMA 1423 (2018).

17. *See* Abbe R. Gluck, Mark Regan & Erica Turret, *The Affordable Care Act's Litigation Decade*, 108 GEO. L.J. 1471, 1472–73, 1488 (2020); Gluck & Scott-Railton, *supra* note 16, at 531–32, 548–50; *see also* David L. Noll, *Administrative Sabotage*, 120 MICH. L. REV. 753 (2022) (defining and exploring the phenomenon of administrative sabotage).

18. American Rescue Plan Act of 2021, Pub. L. No. 117-2, §§ 9661–9663, 135 Stat. 4, 182–84 (to be codified at 26 U.S.C. § 36(B), 36(B) note) (temporarily enhancing the premium tax credits offered on the ACA exchanges for 2021 and 2022); Inflation Reduction Act of 2022, Pub. L. 117-169, § 12001, 136 Stat. 1818, 1905–06 (extending the enhanced premium tax credits until 2025).

19. *See* Julie Rovner, *Obamacare's History Littered With Near-Death Experiences*, KFF HEALTH NEWS (July 28, 2017), https://khn.org/news/obamacares-history-littered-with-near-death-experiences-text/ [perma.cc/6BTA-2QBN].

20. *See* Sahil Kapur, *Republicans Abandon Obamacare Repeal*, NBC NEWS (Oct. 2, 2022, 6:30 AM), https://www.nbcnews.com/politics/congress/republicans-abandon-obamacare-repeal-rcna49538 [https://perma.cc/SCL7-7RU7].

Consider, first, the ACA's central objective: to provide financial security in the face of medical costs and a basic level of access to health care for all Americans.[21] In this regard, the ACA has achieved an important measure of success. The ACA has provided health insurance coverage to over 40 million Americans, helping to lower the uninsured rate in the United States to the lowest level in history.[22] The ACA's coverage expansion has in turn been linked to increased financial security, improved access to health care, improved health care outcomes, and even diminished mortality,[23] as well as a reduction in economic and racial disparities in access to care.[24]

Nevertheless, in several respects, the ACA that exists today does not provide the same level of financial protection and access to health care as the ACA that was passed in 2010 would have. Consider one well-known example: the Supreme Court's 2012 decision in *NFIB v. Sebelius*, which effectively rendered the ACA's Medicaid expansion optional.[25] As a result of this decision, nearly fourteen years after the passage of the ACA, about two million poor Americans living in ten states fall into the Medicaid "coverage gap" and are ineligible for Medicaid.[26] Or take another example: in December 2017, Congress passed legislation zeroing out the tax penalty for the ACA's individual mandate, effectively repealing the mandate.[27] The available evidence suggests this change has resulted in a larger number of uninsured Americans and in higher premiums on the ACA exchanges.[28]

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21. *See, e.g.*, *Health Care Bill Signing Ceremony*, *supra* note 7, at 24:03 ("And we have now just enshrined, as soon as I sign this bill, the core principle that everybody should have some basic security when it comes to their health care.").

22. *See* ASSISTANT SEC'Y FOR PLAN. & EVALUATION, OFF. OF HEALTH POL'Y, HEALTH COVERAGE UNDER THE AFFORDABLE CARE ACT: CURRENT ENROLLMENT TRENDS AND STATE ESTIMATES 1 (2023); AIDEN LEE, JOEL RUHTER, CHRISTIE PETERS, NANCY DE LEW & BENJAMIN D. SOMMERS, ASSISTANT SEC'Y FOR PLAN. & EVALUATION, NATIONAL UNINSURED RATE REACHES ALL-TIME LOW IN EARLY 2022, at 2 (2022).

23. *See* Katherine Baicker & Benjamin D. Sommers, *Insurance Access and Health Care Outcomes*, *in* THE TRILLION DOLLAR REVOLUTION: HOW THE AFFORDABLE CARE ACT TRANSFORMED POLITICS, LAW, AND HEALTH CARE IN AMERICA, *supra* note 2, at 209; Benjamin D. Sommers, Atul A. Gawande & Katherine Baicker, *Health Insurance Coverage and Health — What the Recent Evidence Tells Us*, 377 NEW ENG. J. MED. 586, 587–90 (2017).

24. *See* Kevin Griffith, Leigh Evans & Jacob Bor, *The Affordable Care Act Reduced Socioeconomic Disparities in Health Care Access*, 36 HEALTH AFFS. 1503, 1508 (2017); Thomas C. Buchmueller & Helen G. Levy, *The ACA's Impact on Racial and Ethnic Disparities in Health Insurance Coverage and Access to Care*, 39 HEALTH AFFS. 395, 399–400 (2020).

25. Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 575–88 (2012).

26. *See* Robin Rudowitz, Patrick Drake, Jennifer Tolbert & Anthony Damico, *How Many Uninsured Are in the Coverage Gap and How Many Could Be Eligible if All States Adopted the Medicaid Expansion?*, KFF (Mar. 31, 2023), https://www.kff.org/medicaid/issue-brief/how-many-uninsured-are-in-the-coverage-gap-and-how-many-could-be-eligible-if-all-states-adopted-the-medicaid-expansion/ [perma.cc/74FV-BMLN].

27. ACA § 1501(c), 26 U.S.C. § 5000A(c) (2011), *amended by* Tax Cuts and Jobs Act of 2017, Pub. L. No. 115-97, § 11081, 131 Stat. 2054, 2092.

28. *Cf.* Matthew Fiedler, *The ACA's Individual Mandate in Retrospect: What Did It Do, and Where Do We Go from Here?*, 39 HEALTH AFFS. 429, 433 (2020).

Several other important changes to the ACA have further limited its impact on Americans' access to health care and financial security.[29] Title VIII of the ACA, the Community Living Assistance Services and Supports (CLASS) Act, was supposed to establish a public long-term care insurance program. Yet in October 2011, the Obama Administration deemed the program fiscally unsustainable,[30] and Congress repealed it shortly thereafter.[31] As a result, millions of Americans still lack access to any kind of long-term care insurance, or are forced to "spend down" their savings and assets to qualify for Medicaid.[32] The Supreme Court's decisions in *Hobby Lobby* and *Little Sisters of the Poor* widened exceptions to the ACA's contraceptive coverage mandate, limiting affordable access to contraception.[33] The ACA's CO-OP program, which was supposed to provide more consumer-oriented health insurance alternatives, has virtually disappeared, due to various restrictions that undermined the program.[34] In addition, Congress has declined to fund the ACA's National Health Workforce Commission, so there is still no governmental entity in charge of coordinating the federal government's response to health care workforce issues, such as the lack of adequate access to primary care providers.[35]

A second key objective of the ACA was to reform the health care delivery system so that it delivers less costly, higher-quality care.[36] The ACA's record on this front is more ambiguous.[37] What is clear, however, is

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29. There have been other post-enactment changes to the ACA that could plausibly be characterized as "ghosts." *See, e.g.*, Matthew B. Lawrence, *Disappropriation*, 120 COLUM. L. REV. 1, 30–34 (2020) (describing how Congress declined to appropriate the necessary funds for the ACA's risk corridors program); Wiley et al., *supra* note 6, at 692 (describing how Congress depleted the ACA's $18.75 billion Prevention and Public Health Fund by using its funds for other purposes).

30. Letter from Kathleen Sebelius, Sec'y of Health & Hum. Servs., to John A. Boehner, Speaker of the House of Representatives (Oct. 14, 2011), https://www.kff.org/wp-content/uploads/sites/2/2011/10/boehner-.pdf [perma.cc/H84X-9J8V].

31. ACA § 8002, 42 U.S.C. § 300ll to ll–9 (2011), *repealed by* American Taxpayer Relief Act of 2012, Pub. L. No. 112-240, § 642, 126 Stat. 2313, 2358 (2013).

32. JOANNE KENEN, HEALTH AFFS., HEALTH POLICY BRIEF: THE CLASS ACT 1, 2 (2011).

33. Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682 (2014); Little Sisters of the Poor Saints Peter & Paul Home v. Pennsylvania, 140 S. Ct. 2367 (2020).

34. *See* Phil Galewitz, *Obamacare Co-Ops Down from 23 to Final '3 Little Miracles,'* KFF HEALTH NEWS (Sept. 9, 2020), https://khn.org/news/obamacare-co-ops-down-from-23-to-final-3-little-miracles/ [https://perma.cc/8NLR-RS3D].

35. *See* Peter I. Buerhaus & Sheldon M. Retchin, *The Dormant National Health Care Workforce Commission Needs Congressional Funding to Fulfill Its Promise*, 32 HEALTH AFFS. 2021, 2022–23 (2013).

36. *See* STAFF OF THE WASH. POST, LANDMARK: THE INSIDE STORY OF AMERICA'S NEW HEALTH-CARE LAW AND WHAT IT MEANS FOR US ALL 129 (2010); Barack Obama, *United States Health Care Reform: Progress to Date and Next Steps*, 316 JAMA 525, 526 (2016).

37. *Compare* Carrie H. Colla & Jonathan Skinner, *Has the ACA Made Health Care More Affordable?*, *in* THE TRILLION DOLLAR REVOLUTION: HOW THE AFFORDABLE CARE ACT TRANSFORMED POLITICS, LAW, AND HEALTH CARE IN AMERICA, *supra* note 2, at 262 ("[F]rom both a micro and macro perspective, the evidence suggests that the ACA has not been entirely successful at

that several of the ACA's most ambitious attempts to control health care spending have been repealed by Congress. The Independent Payment Advisory Board (IPAB), once hailed by Ezekiel Emanuel and Peter Orszag as "[t]he most important institutional change in the ACA,"[38] was eliminated in 2018.[39] In addition, the Cadillac tax, a tax on generous health insurance plans that was described by Jonathan Gruber as "one of the most significant provisions" in the Affordable Care Act,[40] was repealed in 2019.[41]

Finally, a third goal of the ACA was that it would not only pay for itself but eventually help reduce the deficit.[42] Yet this goal too has been undermined by the subsequent repeal of several tax provisions designed to help finance the law. It is estimated that the repeal of the Cadillac tax alone will add $91 billion to the federal budget deficit over the following decade.[43] In addition, Congress has also repealed two of the ACA's other taxes: one on health insurance companies and one on manufacturers and importers of certain medical devices.[44] By one estimate, the repeals of the Cadillac tax,

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bending the cost curve."), *and* Amitabh Chandra, Jonathan Holmes & Jonathan Skinner, *Is This Time Different? The Slowdown in Health Care Spending*, 2013 BROOKINGS PAPERS ON ECON. ACTIVITY 261, 261 (arguing that the ACA cannot "take credit" for the slowdown in health care costs), *with* COUNCIL OF ECON. ADVISERS, ECONOMIC REPORT OF THE PRESIDENT 195, 198 (2017) ("While multiple factors are likely playing a role, payment reforms introduced in the ACA have made substantial, quantifiable contributions to slowing the growth of health care costs in both Medicare and private insurance.").

38. Peter R. Orszag & Ezekiel J. Emanuel, *Health Care Reform and Cost Control*, 363 NEW ENG. J. MED. 601, 603 (2010).

39. ACA § 3403, 42 U.S.C. § 1395kkk (2011), *repealed by* Bipartisan Budget Act of 2018, Pub. L. No. 115-123, § 52001, 132 Stat. 64, 298.

40. Reed Abelson, *High-End Health Plans Scale Back to Avoid 'Cadillac Tax,'* N.Y. TIMES (May 27, 2013) [hereinafter Abelson, *High-End Health Plans*], https://www.nytimes.com/2013/05/28/business/cadillac-tax-health-insurance.html [https://perma.cc/EFC6-7ZUW].

41. ACA § 9001, 26 U.S.C. § 4980I (2011), *repealed by* Further Consolidated Appropriations Act, 2020, Pub. L. No. 116-94, § 503, 133 Stat. 2534, 3119–20.

42. *See* Barack Obama, President, Address Before a Joint Session of the Congress on Health Care Reform, 2009 DAILY COMP. PRES. DOC. 200900693, at 5 (Sept. 9, 2009), https://www.govinfo.gov/app/collection/cpd/2009/09#aboutDescription [https://perma.cc/F27A-8VLP]_("I will not sign a plan that adds one dime to our deficits, either now or in the future. I will not sign it if it adds one dime to the deficit, now or in the future, period."); COHN, *supra* note 3, at 135–36 ("[President Obama] was insistent that the program pay for itself and then start to reduce the deficit through some combination of new revenue and cuts to existing government health programs.").

43. Letter from Henry Aaron et al., to Orrin G. Hatch, Chairman, Senate Comm. on Fin., Ron Wyden, Ranking Member, Senate Comm. on Fin., Paul D. Ryan, Chairman, House Comm. on Ways & Means & Sander M. Levin, Ranking Member, House Comm. on Ways & Means (Oct. 1, 2015), https://www.cbpp.org/sites/default/files/atoms/files/cadillac_tax_letter.pdf [https://perma.cc/ZR53-WWD3].

44. ACA § 9009, 26 U.S.C. § 4191, 4221 (2011), *repealed by* Further Consolidated Appropriations Act, 2020, Pub. L. No. 116-94, § 501, 133 Stat. 2534, 3118–19; ACA § 9010, 26 U.S.C. § 4001 (2011), *repealed by* Further Consolidated Appropriations Act, 2020, Pub. L. No. 116-94, § 502, 133 Stat. 2534, 3119.

health insurance tax, and medical device tax will together decrease government revenues by around $375 billion over ten years.[45]

For advocates of the Affordable Care Act, taking stock of these changes is likely a disheartening enterprise. As a result of these ghosts of the Affordable Care Act, millions more Americans remain uninsured; tens of thousands of women have lost access to cost-free contraceptive services; premiums for health insurance on the exchanges will be higher; government coffers will be billions of dollars lighter; and overall health care spending will continue to grow, eating into workers' wages, families' budgets, and government resources.[46] In sum, when it comes to the main objectives of the ACA, the ACA that exists today is far less wide-ranging and ambitious than the law that was enacted in 2010 in several respects.

Why have so many key provisions of the ACA fallen by the wayside? And why did the ACA as a whole prove to be so vulnerable? These questions present a puzzle in light of the conventional wisdom that legislation which confers major social benefits is incredibly difficult to dismantle.[47] An influential body of work in political science offers a few interrelated reasons why dismantling social legislation is difficult[48]: First, most obviously, social programs tend to be popular, and democratically

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45. Jeff Stein & Yasmeen Abutaleb, *Congress Showers Health Care Industry with Multibillion-Dollar Victory After Wagging Finger at It for Much of 2019*, WASH. POST (Dec. 20, 2019, 8:20 PM), https://www.washingtonpost.com/business/economy/congress-showers-health-care-industry-with-multi-billion-victory-after-wagging-finger-at-it-for-much-of-2019/2019/12/19/9422aa6a-2028-11ea-9146-6c3a3ab1be6c_story.html [https://perma.cc/2FQ9-ZS3S].

46. Of note, these changes take different forms: some are the result of congressional repeals, some are the result of judicial decisions, and some are the result of other congressional actions. These forms have distinctive characteristics. *See, e.g.*, JORDAN M. RAGUSA & NATHANIEL A. BIRKHEAD, CONGRESS IN REVERSE: REPEALS FROM RECONSTRUCTION TO THE PRESENT 9–11 (2020) (discussing why repeals are distinct from other forms of statutory revisions). Yet only by lumping these "ghosts" together is it possible to appreciate the full extent to which the ACA that exists today differs from the law that was enacted in 2010. *See generally* LEE ANNE FENNELL, SLICES AND LUMPS: DIVISION AND AGGREGATION IN LAW AND LIFE (2019) (exploring the importance and challenges of reconfiguration).

47. *See, e.g.*, MCDONOUGH, INSIDE NATIONAL HEALTH REFORM, *supra* note 4, at 154 ("It is a truism that public programs, once established, are difficult to eliminate."); RAGUSA & BIRKHEAD, *supra* note 46, at 55 ("[S]ocial programs are believed to be uniquely resistant to change."); Jacob S. Hacker & Paul Pierson, *The Dog that Almost Barked: What the ACA Repeal Fight Says about the Resilience of the American Welfare State*, 43 J. HEALTH POL., POL'Y & L. 551, 554 (2018) [hereinafter Hacker & Pierson, *The Dog that Almost Barked*] ("Today, it is conventional wisdom to describe major social programs as a 'third rail'—touch and die."); Julian Zelizer & Eric Patashnik, *Why Even the Strongest Republican Efforts Can't Defeat the Welfare State*, WASH. POST (Dec. 12, 2016, 9:13 AM), https://www.washingtonpost.com/posteverything/wp/2016/12/12/why-even-the-strongest-republican-efforts-cant-defeat-the-welfare-state/ [https://perma.cc/H4G2-BP8D] ("[C]onservatives in power have traditionally found that dismantling existing programs can be daunting even under favorable circumstances.").

48. For the foundational work on this topic, see generally PAUL PIERSON, DISMANTLING THE WELFARE STATE?: REAGAN, THATCHER, AND THE POLITICS OF RETRENCHMENT (1994); Paul Pierson, *The New Politics of the Welfare State*, 48 WORLD POL. 143 (1996). *See also* John D. Stephens, *Revisiting Pierson's Work on the Politics of Welfare State Reform in the Era of Retrenchment Twenty Years Later*, 48 PS: POL. SCI. & POL. 274 (2015) (concluding that, twenty years later, Pierson's arguments "have withstood the test of time").

elected representatives are incentivized not to take very unpopular actions if they wish to remain in office.[49] Second, interest group dynamics tend to make undoing social programs difficult: once these programs are established and implemented, they provide concentrated benefits, while their costs are dispersed much more broadly.[50] As such, social programs aid in the formation of well-organized constituencies (both direct beneficiaries as well as industry groups) who mobilize to defend these programs when they are threatened, whereas those who might oppose such programs have greater trouble organizing.[51] Third, people tend to react more strongly to the prospect of losses than they do to the prospect of equivalent gains, meaning that those who would lose out from potential cutbacks in social programs tend to be more motivated than the potential winners.[52]

To make the experience of the ACA even more surprising, the conventional wisdom about the durability of social legislation seems especially ironclad when it comes to health insurance programs. In a recent survey of eleven different countries' health care systems, Ezekiel Emanuel concluded that: "except for a brief, 2-year moment in Australia, there is no case in which universal [health insurance] coverage, once achieved, has been undone."[53]

Nevertheless, in spite of this conventional wisdom, but for Chief Justice John Roberts's reportedly changing his mind during deliberations over *NFIB v. Sebelius*,[54] and but for Senator John McCain's famous "thumbs down" vote on the Senate floor, the ACA might not have survived at all.[55]

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49. Hacker & Pierson, *The Dog that Almost Barked*, *supra* note 47, at 554.

50. PIERSON, DISMANTLING THE WELFARE STATE?, *supra* note 48, at 2. *See generally* MANCUR OLSON, JR., THE LOGIC OF COLLECTIVE ACTION: PUBLIC GOODS AND THE THEORY OF GROUPS (1965).

51. *Cf.* Hacker & Pierson, *The Dog that Almost Barked*, *supra* note 47, at 554–55.

52. *See, e.g.*, PIERSON, DISMANTLING THE WELFARE STATE?, *supra* note 48, at 2; Fuse Brown, *Developing a Durable Right to Health Care*, *supra* note 6, at 481; Russell Korobkin, *The Endowment Effect and Legal Analysis*, 97 NW. U. L. REV. 1227, 1266–67 (2003).

53. EZEKIEL J. EMANUEL, WHICH COUNTRY HAS THE WORLD'S BEST HEALTH CARE? 359 (2020).

54. *See* JOAN BISKUPIC, THE CHIEF: THE LIFE AND TURBULENT TIMES OF CHIEF JUSTICE JOHN ROBERTS 221–48 (2019). According to Biskupic, a majority of justices initially voted to declare the individual mandate unconstitutional and to uphold the Medicaid expansion, before Chief Justice Roberts ultimately changed his mind. *Id.* at 222. It is less clear what the precise fallout would have been if Roberts had not changed his mind. Four justices reportedly would have held that the individual mandate was inseverable from the rest of the ACA and therefore struck down the whole law, while Roberts reportedly would have limited the damage to the ACA's community rating and guaranteed issue provisions. *Id.* at 234. Regardless, the damage to the ACA would have been substantial.

55. Although the so-called "skinny repeal" bill that Senator John McCain—together with Senators Lisa Murkowski and Susan Collins—helped derail would not have repealed the ACA in its entirety, it may well have had a transformative impact on the law. For one thing, some Republican Senators who voted for the bill only did so on the notion that it would be significantly amended in a conference committee. *See* Robert Pear & Thomas Kaplan, *Senate Rejects Slimmed-Down Obamacare Repeal as McCain Votes No*, N.Y. TIMES (July 27, 2017), https://www.nytimes.com/2017/07/27/us

The more challenging questions, then, are not how did the ACA survive, but rather, how did it come so close to dying, and why has so much of it been dismantled?[56] These questions are of both theoretical and practical importance. In recent years, an interdisciplinary group of social scientists and legal scholars have tried to understand why some laws are repealed or scaled back, while others become *entrenched*—that is, become resistant to change.[57] This literature suggests that although there are a variety of determinants of a law's longevity, it is—at least in part—a result of "policy feedback effects," that is, changes to the political environment caused by features of the law itself.[58] Consistent with this view, canny political actors have long tried to design legislation strategically so that it stands a better chance of winning enough political support to endure over time.[59] In one

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/politics/obamacare-partial-repeal-senate-republicans-revolt.html [https://perma.cc/Y2HS-E5KZ]. Moreover, the bill would have established a waiver process for states that could have indirectly undermined some of the ACA's major consumer protections. *See* Nick Bagley, *Waivers Are Dead, Long Live Waivers*, TAKE CARE (July 27, 2017), https://takecareblog.com/blog/waivers-are-dead-long-live-waivers [https://perma.cc/QV9M-ZTMH].

56. *See* Hacker & Pierson, *The Dog that Almost Barked*, *supra* note 47, at 553 ("[T]he mystery is not why Republicans came up short [in their 2017 attempts to repeal the ACA] but why they barreled forward despite the risks and came within a few votes of victory despite the obstacles."); Jonathan Oberlander & R. Kent Weaver, *Unraveling from Within? The Affordable Care Act and Self-Undermining Policy Feedbacks*, 13 FORUM 37, 38 (2015) ("Given the scope of [the ACA's] benefits, and the experience of programs like Medicare that outgrew their controversial origins to attain mass popularity and robust political status, the Obama administration and Congressional Democrats could reasonably expect the ACA's coalition to strengthen substantially over time. But to date that has not happened – and that is the fundamental political puzzle surrounding Obamacare.").

57. *See, e.g.*, LIVING LEGISLATION: DURABILITY, CHANGE, AND THE POLITICS OF AMERICAN LAWMAKING (Jeffery A. Jenkins & Eric M. Patashnik eds., 2012); *see also* PAUL STARR, ENTRENCHMENT: WEALTH, POWER, AND THE CONSTITUTION OF DEMOCRATIC SOCIETIES 1–2 (2019) [hereinafter STARR, ENTRENCHMENT] (defining entrenchment as "any process whereby an institution, a technology, a group, or a cultural form—any kind of social formation—becomes resistant to pressures for change").

58. *See, e.g.*, Jeffery A. Jenkins & Eric M. Patashnik, *Living Legislation and American Politics*, *in* LIVING LEGISLATION: DURABILITY, CHANGE, AND THE POLITICS OF AMERICAN LAWMAKING, *supra* note 57, at 3, 15–16 [hereinafter Jenkins & Patashnik, *Living Legislation and American Politics*] (describing how laws can—but do not always—create positive feedback effects that help to entrench them); ERIC M. PATASHNIK, REFORMS AT RISK: WHAT HAPPENS *AFTER* MAJOR POLICY CHANGES ARE ENACTED 29 (2008) ("[T]he sustainability of . . . [general-interest reform laws] hinges on the reactions, expectations, and behavioral change they generate over time."); Andrea Louise Campbell, *Policy Makes Mass Politics*, 15 ANN. REV. POL. SCI. 333, 334 (2012) ("Existing policies define the political environment, shaping the capacities, interests, and beliefs of political elites and states and therefore the outcomes of subsequent rounds of policy making. Such policy feedback effects influence political behaviors and attitudes among the public as well, and these in turn also have consequences for subsequent policy outcomes."); Suzanne Mettler, *The Policyscape and the Challenges of Contemporary Politics to Policy Maintenance*, 14 PERSPS. ON POL. 369, 371 (2016) ("[P]olicies' own intrinsic characteristics and tendencies can explain why some eventually flourish while others underperform or otherwise fail to function as intended.").

59. *See* Daryl Levinson & Benjamin I. Sachs, *Political Entrenchment and Public Law*, 125 YALE L.J. 400, 430–56 (2015) (describing and offering examples of three different strategies that political actors use to "functionally entrench" their policies); *see also* STARR, ENTRENCHMENT, *supra* note 57, at 5–6 (referring to this as "strategic entrenchment").

particularly well-known example, President Franklin D. Roosevelt defended the use of a payroll tax to finance Social Security on the grounds that it would create a sense of entitlement among its beneficiaries, remarking, "[w]ith those taxes in there, no damn politician can ever scrap my [S]ocial [S]ecurity program."[60]

This view is the key to understanding why pieces of social legislation like the ACA are in fact more vulnerable than has been generally recognized. This Article contends that to understand the ACA's ghosts, it is necessary to examine the legislative strategies that the ACA's architects employed to enact the law in the first place. The ACA's architects faced three key obstacles which had thwarted previous health care reform efforts: fiscal constraints, interest group opposition, and wariness from the majority of Americans who already had health insurance coverage. Compounding these challenges, the ACA was passed during an era characterized by political polarization, and not a single Republican member of Congress ultimately voted for the final legislation.[61]

To overcome these obstacles, reformers adopted legislative strategies designed to increase the likelihood that the ACA would be enacted. However, these strategies undermined political support for the law and exposed it to greater legal risk post-enactment, increasing the likelihood that the ACA would be repealed, invalidated, or scaled back, and in several cases directly leading to the ACA's ghosts. The ACA's ghosts then illustrate the extent to which legislators must grapple with what I refer to as "enactment-entrenchment tradeoffs": that is, the tradeoffs between the legislative decisions necessary to enact legislation, versus increasing the odds that it will survive post-enactment.

This Article further argues that it is time to revise the conventional wisdom that social legislation is difficult to dismantle, at least when it comes to newly enacted legislation. Enactment-entrenchment tradeoffs are not unique to the ACA. To the contrary, there are reasons to believe such tradeoffs have become more pronounced over time with regard to social legislation, and that newly established social programs are, in fact, quite vulnerable.[62] During the COVID-19 pandemic, the federal government enacted a sweeping set of expansions to safety net programs, which initially drew comparisons to the New Deal and the Great Society.[63] Yet these

60. ARTHUR M. SCHLESINGER, JR., THE COMING OF THE NEW DEAL 308–09 (1958).

61. Hacker & Pierson, *The Dog that Almost Barked*, *supra* note 47, at 558–63.

62. *See infra* Section IV.A.

63. *See, e.g.*, Greg Iacurci, *How Biden's $3.5 Trillion Economic Plan Compares to LBJ's Great Society and FDR's New Deal*, CNBC (Oct. 2, 2021, 9:00 AM), https://www.cnbc.com/2021/10/02/how-bidens-economic-plan-compares-to-the-great-society-and-new-deal.html [https://perma.cc/G9CQ-5K4Q]; Ashraf Khalil & Alan Fram, *Covid Relief Bill Could Permanently Alter Social Safety Net*,

expansions have, for the most part, proven short-lived.[64] To take one prominent example, Congress enacted an expanded Child Tax Credit as part of the American Rescue Plan Act in March 2021, which advocates and scholars hailed as a revolutionary new way to reduce child poverty, but Congress allowed it to expire the following December.[65]

The Article proceeds in four parts. Parts I and II of this Article lay bare the ghosts of the Affordable Care Act, and show how the many post-enactment changes to the law have together undermined the ACA's effectiveness in achieving its central goals. Part I focuses on the lost coverage provisions: the individual mandate, the Medicaid expansion, the CLASS Act, the contraceptive coverage mandate, the insurance CO-OP program, and the National Health Workforce Commission. Part II focuses on the lost cost and deficit provisions: the Cadillac tax, the Independent Payment Advisory Board, and the taxes on the health insurance and medical device companies. Part III tries to solve the puzzle of why the ACA appears to have been quite vulnerable, despite the conventional wisdom about social legislation. It argues that the ACA's vulnerability can be traced in part to its enactment-entrenchment tradeoffs—that legislative strategies viewed as necessary to enact the law ended up undermining political support for the law and exposing it to greater legal risk post-enactment. Finally, Part IV revisits the conventional wisdom that major social programs are difficult to dismantle, and argues that this view no longer holds true with regard to newly enacted legislation. It suggests that enactment-entrenchment tradeoffs have grown more pronounced over time with regard to social legislation, and argues that legislators must change the rules of the game to enact more durable social legislation.

I. THE LOST COVERAGE PROVISIONS

The central goal of the ACA was to ensure a basic level of access to health care and financial security from medical costs.[66] The primary ways

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ASSOCIATED PRESS (Mar. 11, 2021, 11:31 PM), https://apnews.com/article/covid-19-relief-bill-social-safety-net-3bff45f1be9d5f7eb8cd7c14a51c6732 [https://perma.cc/9JVX-JDDZ].

64. *See* Andrew Hammond, Ariel Jurow Kleiman & Gabriel Scheffler, *The Future of Anti-Poverty Legislation*, 112 GEO. L.J. (forthcoming 2023); Claire Cain Miller & Alicia Parlapiano, *The U.S. Built a European-Style Welfare State. It's Largely Over.*, N.Y. TIMES (May 11, 2023), https://www.nytimes.com/interactive/2023/04/06/upshot/pandemic-safety-net-medicaid.html [https://perma.cc/T99A-5PDS].

65. American Rescue Plan Act of 2021 § 9611, 26 U.S.C. 24(i); *see* Ariel Jurow Kleiman, *Revolutionizing Redistribution: Tax Credits and the American Rescue Plan*, 131 YALE L.J.F. 535, 554 (2021).

66. *See, e.g.*, PAUL STARR, REMEDY AND REACTION: THE PECULIAR AMERICAN STRUGGLE OVER HEALTH CARE REFORM 241 (2011) [hereinafter STARR, REMEDY AND REACTION] ("The Affordable Care Act restructures health insurance so as to achieve for all Americans the aims it has been

through which the ACA attempted to do this were: offering free or subsidized insurance coverage for low-income Americans (through the Medicaid expansion and subsidies to purchase private coverage on the ACA exchanges); imposing new regulations to make it easier for people to obtain insurance coverage, and to make that coverage more comprehensive; and requiring that most people obtain insurance coverage or pay a penalty.[67] In addition, there were other, less widely discussed provisions in the law, such as provisions trying to bolster the supply of health care providers and health insurers.

This Part examines several provisions of the ACA affecting coverage and access that have been repealed, struck down, or scaled back since the law was enacted: the Medicaid Expansion, the individual mandate, the CLASS Act, the contraceptive coverage mandate, the CO-OP Program, and the National Health Workforce Commission. For each provision, I briefly describe the history and rationale for the provision, how Congress or the Supreme Court has changed the provision since the ACA was enacted, and the effects of these post-enactment changes.

A. The Medicaid Expansion

The Medicaid expansion was one of the key mechanisms through which the ACA increased health insurance coverage. Before the ACA, Medicaid coverage was generally limited to certain categories of "deserving" poor people, such as persons with disabilities, pregnant women, and low-income children.[68] The ACA dramatically altered the Medicaid program by offering states a generous level of funding in exchange for their expanding coverage to all adults up to 138% of the Federal Poverty Level.[69] States' refusal to adopt the expansion could theoretically result in the loss of federal Medicaid funding, though the federal government had never actually imposed that

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serving only for some—to provide access to health care and protection against the risk of being bankrupted by medical costs."); Isaac D. Buck, *Affording Obamacare*, 71 HASTINGS L.J. 261, 271 (2020) ("The ACA came on the scene on March 23, 2010 with one main goal: to increase access to health insurance, and ultimately, health care, for its populace."); *see also* Gabriel Scheffler, *Equality and Sufficiency in Health Care Reform*, 81 MD. L. REV. 144, 174 (2021) (discussing the ACA's reflection of "the Right to a Decent Minimum" and the notion that everyone should have sufficient access to health care).

67. *See* Hoffman, *Three Models of Health Insurance*, *supra* note 8, at 1886–87.

68. *See* Sara Rosenbaum, *Medicaid at Fifty*, *in* THE OXFORD HANDBOOK OF U.S. HEALTH LAW 763, 773 (I. Glenn Cohen, Allison K. Hoffman & William M. Sage eds., 2017); Nicole Huberfeld, *Federalizing Medicaid*, 14 U. PA. J. CONST. L. 431, 432 (2011).

69. ACA § 2001(a)(1)(C), 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII). The eligibility standard actually specified in the ACA is 133%, but HCERA added a 5% income disregard, effectively raising the eligibility threshold to 138% of FPL. HCERA § 1004e, 42 U.S.C. §1396a(e)(14).

penalty in the past for failure to meet other conditions of participation in the Medicaid program.[70]

Nevertheless, in 2012, the Supreme Court in *NFIB v. Sebelius* held that this arrangement was unconstitutionally coercive of states, and thus effectively made the Medicaid expansion optional.[71] Although this aspect of the Court's decision came as a surprise to many observers, it has proven to have important lasting effects.[72] As of July 2023, ten states still had not adopted the Medicaid expansion.[73] As a result, around two million poor Americans—disproportionately people of color—today fall into what has become known as the "Medicaid coverage gap."[74] These Americans remain uninsured, even though they were initially supposed to be covered by the ACA. They cannot get coverage through Medicaid because the Supreme Court rendered the Medicaid expansion optional, and they reside in one of the remaining states that has chosen not to expand Medicaid coverage. At the same time, perversely, their incomes are too low to qualify for subsidies to purchase private insurance on the exchanges that the law established.

The Court's decision in *NFIB v. Sebelius* has significantly undermined the ACA's primary goal of ensuring a basic level of access to health care and financial security, and has magnified inequalities along geographic, racial, and economic lines.[75] An impressive body of empirical research has found that state Medicaid expansions have led to increased health insurance coverage, improved access to health care, and better health outcomes.[76] For instance, one study estimated that state decisions to expand Medicaid averted around 19,200 deaths over just a four-year period, and that, conversely, 15,600 older adults died prematurely during this period due to

70. Sara Rosenbaum & Timothy M. Westmoreland, *The Supreme Court's Surprising Decision on the Medicaid Expansion: How Will the Federal Government and States Proceed?*, 31 HEALTH AFFS. 1663, 1665 (2012).

71. Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 581 (2012).

72. *See* Nicole Huberfeld, Elizabeth Weeks Leonard & Kevin Outterson, *Plunging into Endless Difficulties: Medicaid and Coercion in* National Federation of Independent Business v. Sebelius, 93 B.U. L. Rev. 1, 3–4 (2013); Rosenbaum & Westmoreland, *supra* note 70, at 1663.

73. *Status of Medicaid Expansion Decisions: Interactive Map*, KFF (July 27, 2023), https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/ [https://perma.cc/6HDS-2Y5R].

74. *See* Rudowitz et al., *supra* note 26; Rachel Garfield, Anthony Damico & Robin Rudowitz, *Taking a Closer Look at Characteristics of People in the Coverage Gap*, KFF (July 29, 2021), https://www.kff.org/policy-watch/taking-a-closer-look-at-characteristics-of-people-in-the-coverage-gap/ [https://perma.cc/F43W-LZXR].

75. *See* JAMILA MICHENER, FRAGMENTED DEMOCRACY: MEDICAID, FEDERALISM, AND UNEQUAL POLITICS 47–55 (2018).

76. For a summary of this vast empirical literature, see Madeline Guth, Rachel Garfield & Robin Rudowitz, *The Effects of Medicaid Expansion Under the ACA: Studies from January 2014 to January 2020*, KFF (Mar. 17, 2020), https://www.kff.org/804edicaid/report/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/ [https://perma.cc/EU48-6C7D].

state decisions *not* to expand Medicaid.[77] State Medicaid expansions have also improved financial security, resulting in lower eviction rates, improved credit scores, and reduced medical debt.[78] Yet because of the Supreme Court's decision, nearly fourteen years after the passage of the ACA, around two million Americans remain without Medicaid coverage.

B. The Individual Mandate

The individual mandate (technically known as the "Requirement to maintain minimum essential coverage") is the ACA's requirement that most Americans must either obtain health insurance or pay a penalty.[79] The idea of a mandate to obtain health insurance was developed by economist Mark Pauly in the 1980s, and was initially promoted by the conservative Heritage Foundation (and even at one point endorsed by Milton Friedman).[80] Massachusetts's 2006 health care reform plan—enacted under then-Governor Mitt Romney—demonstrated proof of concept, by combining subsidized coverage for low-income individuals and an individual mandate with guaranteed issue (requiring insurers to offer coverage to all those willing to purchase it) and community rating (prohibiting insurers from discriminating based on health status).[81] After initially opposing the idea of a mandate, President Barack Obama eventually embraced the mandate as a key element of federal health care reform.[82]

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77. MATT BROADDUS & AVIVA ARON-DINE, CTR. ON BUDGET & POL'Y PRIORITIES, MEDICAID EXPANSION HAS SAVED AT LEAST 19,000 LIVES, NEW RESEARCH FINDS (2019), https://www.cbpp.org/sites/default/files/atoms/files/11-6-19health.pdf [https://perma.cc/N7NK-BFVC] (citing Sarah Miller, Norman Johnson & Laura R. Wherry, *Medicaid and Mortality: New Evidence from Linked Survey and Administrative Data*, 136 Q.J. ECON. 1783 (2021)).

78. Kenneth Brevoort, Daniel Grodzicki & Martin B. Hackmann, *The Credit Consequences of Unpaid Medical Bills*, 187 J. PUB. ECON. 104203 (2020); Naomi Zewde, Erica Eliason, Heidi Allen & Tal Gross, *The Effects of the ACA Medicaid Expansion on Nationwide Home Evictions and Eviction-Court Initiations: United States, 2000–2016*, 109 AM. J. PUB. HEALTH 1379 (2019).

79. ACA § 1501, 26 U.S.C. § 5000A.

80. *See* MCDONOUGH, INSIDE NATIONAL HEALTH REFORM, *supra* note 4, at 121; John E. McDonough, *The Tortured Saga of America's Least-Loved Policy Idea*, POLITICO (May 24, 2021, 2:22 PM), https://www.politico.com/news/magazine/2021/05/22/health-care-individual-mandate-policy-conservative-idea-history-489956 [https://perma.cc/AC2R-7EG8].

81. An Act Providing Access to Affordable, Quality, Accountable Health Care, 2006 Mass. Acts 77. For a description of the 2006 Massachusetts health care reform that served as a model for the ACA, see Christie L. Hager, *Massachusetts Health Reform: A Social Compact and a Bold Experiment*, 55 KAN. L. REV. 1313 (2007). Guaranteed issue and community rating were already in place before the 2006 reform. *Id.* at 1323.

82. Ryan Lizza, *The Mandate Memo: How Obama Changed His Mind*, NEW YORKER (Mar. 26, 2012), https://www.newyorker.com/news/news-desk/the-mandate-memo-how-obama-changed-his-mind [https://perma.cc/CS5C-38K4].

The mandate serves two related purposes: to expand health insurance coverage and to increase the pooling of risk.[83] In particular, the mandate was believed by many economists to be necessary to mitigate the "adverse selection" problem that would otherwise result from imposing guaranteed issue and community rating alone.[84] The problem, they feared, was that relatively healthy people would refrain from obtaining health insurance until they became sick or injured, leading to higher premiums and fewer people covered.[85] In the worst case scenario, economists worried that imposing guaranteed rating and community issue provisions without a mandate could result in a "death spiral," wherein insurers charged higher premiums for the insured as a result of the adverse selection problem, causing more healthy people to go without health insurance, causing more rate increases, and so on.[86] This concern was not merely theoretical: a handful of states tried to implement guaranteed issue and community rating reforms without implementing a mandate, and this resulted in higher premiums, and in some cases, caused the states to abandon their reforms.[87] By contrast, analyses of the 2006 Massachusetts reform found that its mandate was essential in driving up enrollment.[88] It was understandable then that many health scholars viewed the mandate as essential.

The mandate ignited fierce legal and political controversy, and served as the focal point of opposition to the ACA. In 2012, the Supreme Court held that the mandate exceeded Congress's powers under the Commerce Clause, but it upheld the mandate under its taxing powers.[89] Five years later, however, President Trump signed legislation that zeroed out the tax penalty for the mandate.[90] Technically the legislation left the mandate in place, but it meant that there is no longer any penalty for failing to comply with the mandate (a fact which spawned a subsequent round of litigation over the ACA's legality).[91] The best available evidence suggests that this removal of

83. *See* Fiedler, *supra* note 28, at 429–30; *see also* Allison K. Hoffman, *Oil and Water: Mixing Individual Mandates, Fragmented Markets, and Health Reform*, 36 AM. J.L. & MED. 7 (2010) (showing how the use of the mandate might be justified on paternalistic, efficiency, or redistributive grounds).

84. *See* LIRAN EINAV, AMY FINKELSTEIN & RAY FISMAN, RISKY BUSINESS: WHY INSURANCE MARKETS FAIL AND WHAT TO DO ABOUT IT 151–55 (2022).

85. *See* Brief of Amici Curiae Economic Scholars in Support of Petitioners Urging Reversal on the Minimum Coverage Issue, at 17–18, Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519 (2012) (No. 11-398).

86. *Id.* at 16–18.

87. *See* MCDONOUGH, INSIDE NATIONAL HEALTH REFORM, *supra* note 4, at 41 (describing this history).

88. Amitabh Chandra, Jonathan Gruber & Robin McKnight, *The Importance of the Individual Mandate – Evidence from Massachusetts*, 364 NEW ENG. J. MED. 293 (2011).

89. *See generally Sebelius*, 567 U.S. 519.

90. *See* ACA § 1501(c), 26 U.S.C. § 5000A(c) (2011), *amended by* Tax Cuts and Jobs Act of 2017, Pub. L. No. 115-97, § 11081, 131 Stat. 2092.

91. *See* California v. Texas, 141 S. Ct. 2104 (2021).

the mandate penalty has increased the number of uninsured Americans and resulted in higher premiums on the ACA exchanges,[92] though the feared death spiral never ultimately materialized.[93] In stark contrast to the controversy surrounding the mandate in 2012, the mandate died a quiet death: as of early 2018, less than one-third of the U.S. public was even aware that the mandate penalty had been eliminated.[94]

C. The CLASS Act

Millions of Americans are in need of long-term care services, due to a chronic illness or physical or mental disability.[95] At the same time, there is limited public support for long-term care.[96] Medicaid is the primary payer for long-term care services,[97] but its income limitations mean that people must either be low-income to qualify or must "spend down" their assets to qualify.[98] Medicare covers long-term care only "temporarily and tangentially."[99] At the same time, private insurance for long-term care is too costly for many people, and few Americans can afford to pay out-of-pocket.[100] As a result, many Americans in need of long-term care are forced to rely on family members or friends, at great financial and emotional cost

92. *See* Fiedler, *supra* note 28, at 433 ("Repeal of the individual mandate appears likely to increase the uninsurance rate, although the precise magnitude of that increase is uncertain—as is its timing."); Aparna Soni, *The Impact of the Repeal of the Federal Individual Insurance Mandate on Uninsurance*, 22 INT'L J. HEALTH ECON. & MGMT. 423 (2022) (finding that zeroing out the mandate penalty increased the probability of being uninsured by twenty-four percent, or about 0.5 percentage point).

93. One interpretation of this latter fact is that, in retrospect, economists overestimated the importance of the individual mandate. Alternatively, it's possible that the individual mandate was in fact initially necessary to make obtaining health coverage more of a norm, but that once this norm was established, the mandate became less necessary. *See, e.g.*, Sarah Kliff, *Republicans Killed the Obamacare Mandate. New Data Shows It Didn't Really Matter.*, N.Y. TIMES (Sept. 21, 2020), https://www.nytimes.com/2020/09/18/upshot/obamacare-mandate-republicans.html [https://perma.cc/TMQ8-4Y2K]; Tyler Cowen, **Risky Business**, MARGINAL REVOLUTION (Oct. 30, 2022, 1:06 AM), https://marginalrevolution.com/marginalrevolution/2022/10/risky-business.html [https://perma.cc/7XFE-QMK5].

94. Ashley Kirzinger, Liz Hamel, Cailey Muñana & Mollyann Brodie, *Kaiser Health Tracking Poll - March 2018: Non-Group Enrollees*, KFF (Apr. 3, 2018), https://www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-march-2018-non-group-enrollees/ [https://perma.cc/7UF2-SVSQ].

95. KENEN, *supra* note 32, at 1.

96. *See id.* at 2.

97. ERICA L. REAVES & MARYBETH MUSUMECI, KAISER COMM'N ON MEDICAID & THE UNINSURED, MEDICAID AND LONG-TERM SERVICES AND SUPPORTS: A PRIMER 1 (2015).

98. MCDONOUGH, INSIDE NATIONAL HEALTH REFORM, *supra* note 4, at 243; KENEN, *supra* note 32, at 2.

99. Rachel M. Werner, Allison K. Hoffman & Norma B. Coe, *Long-Term Care Policy After Covid-19 — Solving the Nursing Home Crisis*, 383 NEW ENG. J. MED. 903, 903 (2020).

100. REAVES & MUSUMECI, *supra* note 97, at 4–5.

to the caregivers themselves.[101] These burdens fall disproportionately on women.[102]

In response to this longstanding problem, Title VIII of the ACA, the Community Living Assistance Services and Supports (CLASS) Act, established a voluntary, self-funded, publicly administered long-term care insurance program. The CLASS Act was championed by Senator Ted Kennedy, who was a longtime and forceful advocate in favor of expanding long-term care insurance.[103] The CLASS Act was designed to pay a minimum cash benefit of $50 per day, indexed for inflation, which recipients could use to help pay for care at a nursing home care or assisted living facility, a home health aide, or even in-home care from a family member.[104] Although the CLASS Act was not expected to single-handedly resolve the problem of long-term care, its supporters saw it as an important step toward that goal.[105]

Even before the CLASS Act was enacted, however, it was evident that it had serious flaws that threatened its viability.[106] First, premiums were set at a very low level—only $30 per month for most enrollees.[107] Second, participation in the CLASS program was voluntary, because it was deemed politically infeasible to enact a second insurance mandate on top of the ACA's individual mandate to purchase health insurance.[108] This opened it up to a serious adverse selection problem, where the people most likely to enroll in the program were those most likely to have large expenditures.[109] Third, the program allowed anyone to sign up, and there was a relatively short waiting period—only five years—between enrolling in the program and becoming eligible for benefits, which were then available for life.[110] These features further exacerbated the adverse selection problem.[111] Finally, the CLASS program was required to be actuarially sound for at least

101. *See generally* Allison K. Hoffman, *The Reverberating Risk of Long-Term Care*, 15 YALE J. HEALTH POL'Y, L. & ETHICS 57, 57 (2015); Allison K. Hoffman, *Reimagining the Risk of Long-Term Care*, 16 YALE J. HEALTH POL'Y, L. & ETHICS 239, 243 (2016).

102. *See* JACOB S. HACKER, THE GREAT RISK SHIFT 103–05 (2006); Allison K. Hoffman, *The Neglect of Long-Term Care*, LPE PROJECT (Dec. 5, 2019), https://lpeproject.org/blog/the-neglect-of-long-term-care/ [https://perma.cc/XPA6-JFRB].

103. MCDONOUGH, INSIDE NATIONAL HEALTH REFORM, *supra* note 4, at 243–44.

104. KENEN, *supra* note 32, at 3.

105. MCDONOUGH, INSIDE NATIONAL HEALTH REFORM, *supra* note 4, at 239–40.

106. *See* Gardiner Harris & Robert Pear, *Still No Relief in Sight for Long-Term Needs*, N.Y. TIMES (Oct. 24, 2011), https://www.nytimes.com/2011/10/25/health/25seniors.html [https://perma.cc/AC7M-JWNR].

107. ROBERT P. SALDIN, WHEN BAD POLICY MAKES GOOD POLITICS: RUNNING THE NUMBERS ON HEALTH REFORM 8 (2017).

108. John E. McDonough, *Lost in the ACA: Bit Parts in a Landmark Law*, 45 J. HEALTH POL., POL'Y & L. 533, 540 (2020) [hereinafter McDonough, *Lost in the ACA*].

109. *See* SALDIN, *supra* note 107, at 78–79.

110. Harris & Pear, *supra* note 106.

111. KENEN, *supra* note 32, at 3–4.

seventy-five years, meaning that the premiums it charged (plus associated interest) had to cover the expenses of the benefits it paid out, and that it couldn't be covered by general revenues.[112]

Initially, the Obama Administration insisted that the program would be solvent, but internal documents revealed that HHS officials were quietly expressing doubts about its fiscal viability.[113] In October 2011, only around a year after the Affordable Care Act was signed into law, HHS Secretary Kathleen Sebelius sent a letter to Congress that she "do[es] not see a viable path forward for CLASS implementation at this time."[114] Shortly thereafter, Congress repealed the CLASS Act entirely, leaving many American families to shoulder the burden of long-term care on their own.[115]

D. The Contraceptive Coverage Mandate

The contraceptive coverage mandate has a complex origin story. As part of the ACA, the employer mandate requires large employers to offer "minimum essential coverage" or pay a penalty.[116] The ACA requires that the coverage offered by large employers, like other forms of non-grandfathered private coverage, must include certain categories of "preventive care and screenings" without any cost-sharing.[117] These include those women's clinical preventive services designated by the Health Resources and Services Administration (HRSA).[118] HRSA decided to base its recommendations on those of the Institute of Medicine (IOM),[119] and the IOM (now known as the National Academy of Medicine) in turn concluded that the list should include "[t]he full range of Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling."[120]

In 2012 and 2013, the Departments of HHS, Labor, and Treasury promulgated regulations that listed contraceptive services and counseling as

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112. SALDIN, *supra* note 107, at 80.

113. Harris & Pear, *supra* note 106.

114. Letter from Kathleen Sebelius to John A. Boehner, *supra* note 30, at 1.

115. ACA §§ 8001–8002, 42 U.S.C. § 300ll to ll-9 (2011), *repealed by* American Taxpayer Relief Act of 2012, Pub. L. No. 112-240, § 642, 126 Stat. 2313, 2358 (2013).

116. ACA § 1513, 26 U.S.C. § 4980H.

117. *Id.* §§ 1001, 2713, 42 U.S.C. § 300gg-13.

118. *Id.*

119. HEALTH RES. & SERVS. ADMIN., WOMEN'S PREVENTIVE SERVICES GUIDELINES: AFFORDABLE CARE ACT EXPANDS PREVENTION COVERAGE FOR WOMEN'S HEALTH AND WELL-BEING (2022), https://www.hrsa.gov/womens–guidelines/index.html [https://perma.cc/A7CL-QT47].

120. COMM. ON PREVANTITIVE SERVS. FOR WOMEN & BD. ON POPULATION HEALTH & PUB. HEALTH PRAC., INST. OF MED., CLINICAL PREVENTIVE SERVICES FOR WOMEN: CLOSING THE GAPS 10 (2011), https://nap.nationalacademies.org/download/13181 [https://perma.cc/UJK9-VUXV]; *see also* Timothy Jost, *Implementing Health Reform: Contraceptive Coverage Final Regulations*, HEALTH AFFS. (June 29, 2013), https://www.healthaffairs.org/do/10.1377/forefront.20130629.032622 [https://perma.cc/8LJ3-L7KT].

required services, while at the same time providing exemptions for certain religious employers.[121] In particular, the rules exempted houses of worship such as churches from the contraceptive coverage mandate, and provided an accommodation for certain religious non-profits (such as hospitals or charities) that object to providing contraceptive coverage.[122] They did not, however, provide a similar religious accommodation for for-profit employers.[123]

In two different decisions, however, the Supreme Court widened the scope of the exemptions to the contraceptive coverage mandate. First, in 2014, the Court held in *Burwell v. Hobby Lobby* that under the Religious Freedom Restoration Act of 1993 (RFRA), closely held, for-profit employers that object to providing contraceptive coverage for their employees on religious grounds cannot be required to provide such coverage.[124] Rather, the Court suggested that there was an alternative means of ensuring access to contraceptives that placed less of a burden on the plaintiffs' exercise of religion: namely, to extend the accommodation that HHS had developed for religious non-profits to religious for-profits as well.[125] Then in 2017, the Trump Administration issued rules broadening the exemptions for employers with religious and moral objections to the mandate, and the Supreme Court upheld these rules in *Little Sisters of the Poor*.[126]

The exceptions to the contraceptive coverage mandate upheld in *Little Sisters of the Poor* are so broad as to effectively render it optional.[127] Although the precise effects of this decision are uncertain, the Trump Administration estimated that the decision would immediately cause between 70,500 and 126,400 women to lose access to cost-free contraceptives, and it could potentially affect up to 2.9 million

121. *Id.*

122. Timothy Jost, *Implementing Health Reform: The Supreme Court Rules on Contraception Coverage (Updated)*, HEALTH AFFS. (July 1, 2014), https://www.healthaffairs.org/do/10.1377/forefront.20140630.039846/full/ [https://perma.cc/274D-87FZ].

123. *Id.*

124. *See* Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682 (2014).

125. *Id.* at 730.

126. Little Sisters of the Poor Saints Peter & Paul Home v. Pennsylvania, 140 S. Ct. 2367 (2020); *see also* Cary Coglianese, Gabriel Scheffler & Daniel E. Walters, *Unrules*, 73 STAN. L. REV. 885, 936–38 (2021) (showing how the *Little Sisters of the Poor* case is illustrative of a larger trend in administrative law of imposing less oversight on agencies when they alleviate obligations than when they impose them).

127. Gregory Curfman, *The Contraceptive Coverage Mandate Is Urgently Needed*, BILL OF HEALTH (Dec. 9, 2021), https://blog.petrieflom.law.harvard.edu/2021/12/09/contraceptive-coverage-mandate-dobbs/ [https://perma.cc/HB82-F9YA].

Americans.[128] These effects are likely to fall disproportionately on poor women and women of color.[129]

E. The Consumer Operated and Oriented Plan Program

The origins of the Consumer Operated and Oriented Plan (CO-OP) program date back to the debate over whether to include a "public option"—a government-run insurance program—that would compete with private insurers to offer coverage on the new ACA exchanges.[130] Proponents of the public option made the case that it would improve competition in the health insurance marketplace (particularly in places that lacked many insurers) and help to drive down health care costs.[131] A public option was included in the version of the health care reform bill that passed the full House of Representatives in November 2009, but it was doomed when Senators Joe Lieberman and Ben Nelson announced their opposition to it, forcing Democratic leadership to drop it from the bill.[132] Yet as a kind of "consolation prize," Senator Kent Conrad proposed the idea of using non-profit insurance cooperatives to enhance competition in insurance markets and include more consumer-oriented alternatives.[133] In the end, the ACA authorized up to $6 billion in funding for the CO-OP program.[134]

Yet the CO-OP program faced several headwinds from the start. Congress reduced the federal funding for the program from $6 billion to $2.4 billion, and converted the funding from grants to loans.[135] The ACA also imposed various restrictions on the program, including prohibiting the use of federal funds for marketing, prohibiting persons employed in the health insurance industry from serving on a co-op's board of directors, and

128. *Little Sisters of the Poor*, 140 S. Ct. at 2401, 2408 (Ginsburg, J., dissenting) (citing Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 83 Fed. Reg. 57536 (Nov. 15, 2018) (codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, 45 C.F.R. pt. 147)); *see also* THE BIDEN ADMINISTRATION MUST ENSURE THE AFFORDABLE CARE ACT CONTRACEPTIVE COVERAGE REQUIREMENT IS WORKING FOR ALL, NAT'L WOMEN'S L. CTR. 4 (2021), https://nwlc.org/wp-content/uploads/2021/11/NWLC_BC_AffordCareAct-Oct_2021.pdf [https://perma.cc/B6G7-ZRHM] ("[H]undreds of thousands of people do not have birth control coverage because of sweeping exemptions put in place by the Trump administration.").

129. Comment, *Affordable Care Act — Contraceptive Mandate — Religious Exemptions* — Little Sisters of the Poor Saints Peter and Paul Home v. Pennsylvania, 134 HARV. L. REV. 560, 567 (2020).

130. Michael S. Sparer & Lawrence D. Brown, *Why Did the ACA Co-Op Program Fail? Lessons for the Health Reform Debate*, 45 J. HEALTH POL., POL'Y & L. 801, 802 (2020).

131. *See, e.g.*, JACOB S. HACKER, THE CASE FOR PUBLIC PLAN CHOICE IN NATIONAL HEALTH REFORM: KEY TO COST CONTROL AND QUALITY COVERAGE (2008), https://healthcarefinancials.files.wordpress.com/2010/11/jacob-hacker-public-plan-choice.pdf [https://perma.cc/WXN4-LALL].

132. *See* COHN, *supra* note 3, at 186–87; MCDONOUGH, INSIDE NATIONAL HEALTH REFORM, *supra* note 4, at 136–37; Helen A. Halpin & Peter Harbage, *The Origins and Demise of the Public Option*, 29 HEALTH AFFS. 1117, 1119–20 (2010).

133. Sparer & Brown, *supra* note 130, at 802; COHN, *supra* note 3, at 263.

134. ACA § 1322, 42 U.S.C. § 18042; McDonough, *Lost in the ACA*, *supra* note 108, at 538.

135. Sparer & Brown, *supra* note 130, at 803–04.

limiting the co-ops' ability to enter the more profitable large employer market.[136] In addition, two ACA programs designed to compensate insurers who enrolled unexpectedly costly enrollees (the "risk corridor" program and the "risk adjustment" program) ended up providing insufficient financial protection for the co-ops.[137]

After some early success, the CO-OP program has virtually disappeared. Initially, twenty-three co-ops emerged in twenty-six states,[138] and enrollment grew from 460,000 in 2014 to more than a million in 2015.[139] However, many of the co-ops ran into solvency problems shortly thereafter, and state regulators were forced to close a dozen of the plans by the end of 2015.[140] As of September 2023, only three of the original twenty-three nonprofit co-ops remained in existence.[141]

F. The National Health Workforce Commission

Modeled on the Medicare Payment Advisory Commission (MedPAC), the National Health Workforce Commission was designed as a nonpartisan group of experts who would collect data on the health care workforce and offer recommendations to Congress on issues affecting the health workforce.[142] Described by one health scholar as the "crown jewel of Title 5, the health workforce part of the law,"[143] the Commission enjoyed bipartisan support and was viewed as an important tool to address persistent concerns about shortages in the health care workforce (particularly in

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136. SABRINA CORLETTE, SEAN MISKELL, JULIA LERCHE & JUSTIN GIOVANNELLI, WHY ARE MANY CO-OPS FAILING? HOW NEW NONPROFIT HEALTH PLANS HAVE RESPONDED TO COMPETITION 9 (2015); Sparer & Brown, *supra* note 130, at 804.

137. Sparer & Brown, *supra* note 130, at 805–07. Part of the problem was that in December 2014, Senator Marco Rubio inserted a rider into an appropriations bill prohibiting HHS from using general funds to cover the excess risk corridor claims (claims from health insurance plans that had costs that were 3% over a target amount). *Id.* at 804–05. As a result, when health plans submitted $2.87 billion in risk corridor requests, they ended up receiving only 12.6 cents on the dollar. *Id.* at 806 (citing Moda Health Plan, Inc. v. United States, 892 F.3d 1311 (Fed. Cir. 2018), *rev'd by* Me. Cmty. Health Options v. United States, 140 S. Ct. 1308 (2020)); *see also* Lawrence, *supra* note 29, at 30–34 (describing the risk corridor saga and its financial and political consequences). Although the insurers sued the government seeking the excess payments and the Supreme Court ultimately sided with them in *Maine Community Health Options v. United States*, 140 S. Ct. 1308 (2020), by that time several CO-OPs had already gone out of business. Sparer & Brown, *supra* note 130, at 806.

138. McDonough, *Lost in the ACA*, *supra* note 108, at 537.

139. Sparer & Brown, *supra* note 130, at 804.

140. *Id.*

141. Paul Demko, *This Obamacare Disaster Had a Surprising Turnaround*, POLITICO (Sept. 13, 2023, 5:00 AM), https://www.politico.com/news/2023/09/13/this-obamacare-disaster-had-a-surprising-turnaround-00115387 [https://perma.cc/JCZ7-LYZQ]. That being said, these three remaining co-ops have recently reported growing enrollment and are said to be "in solid financial shape." *See id.*

142. ACA § 5101, 42 U.S.C. 294q; MCDONOUGH, INSIDE NATIONAL HEALTH REFORM, *supra* note 4, at 201–02.

143. McDonough, *Lost in the ACA*, *supra* note 108, at 538.

primary care) and inadequate access to providers.[144] These shortages were expected to worsen due to millions of Americans gaining health insurance coverage under the ACA.[145]

However, because the Commission enjoyed bipartisan support, it was thought unnecessary to guarantee its funding, which was instead left subject to the annual appropriations process.[146] Yet because the ACA became so politically toxic, Congress never in fact appropriated funding for the body, and as of the time of writing, its members have still never convened. The Government Accountability Office labels it as "inactive," and its own chairperson has described it as "dormant,"[147] though some advocacy organizations have not yet given up hope that it will be resuscitated at some point.[148]

G. Summary

Altogether, the actions by Congress and the Supreme Court described above have undermined the ACA's objectives to ensure adequate access to health care and financial security in the face of medical costs. The Supreme Court's decisions in *NFIB v. Sebelius*, *Hobby Lobby*, and *Little Sisters of the Poor* have left around two million poor Americans without any form of health insurance coverage, undermined access to contraceptive coverage for thousands of women, and exacerbated racial, economic, and gender-based inequalities. Congress's decision to simply repeal the CLASS Act, without coming up with any alternative, left Americans without any form of viable long-term care coverage. Its zeroing out of the individual mandate has likely increased the uninsured rate and raised premiums on the ACA exchanges. Meanwhile, Congress's refusal to adequately fund the CO-OP program and the National Health Workforce Commission has reduced the availability of health insurance coverage options and left Congress without an advisory body focusing on provider shortages and other health care workforce issues.

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144. John E. McDonough, *Old Wine in a New Bottle—Time for a National Health Care Workforce Commission*, MILBANK Q. (Sept. 15, 2021) [hereinafter McDonough, *Old Wine in a New Bottle*], https://www.milbank.org/quarterly/opinions/old-wine-in-a-new-bottle-time-for-a-national-health-care-workforce-commission/ [https://perma.cc/3MMP-F6JA]; Buerhaus & Retchin, *supra* note 35, at 2022–23.

145. *See* Nicholas Bagley, *Medicine as a Public Calling*, 114 MICH. L. REV. 57, 63 (2015).

146. McDonough, *Old Wine in a New Bottle*, *supra* note 144.

147. McDonough, *Lost in the ACA*, *supra* note 108, at 539.

148. *See, e.g.*, Marina Zhavoronkova, Bradley D. Custer, Anona Neal, Justin Schweitzer & Marcella Bombardieri, *How to Ease the Nursing Shortage in America*, CTR. FOR AM. PROGRESS (May 23, 2022), https://www.americanprogress.org/article/how-to-ease-the-nursing-shortage-in-america/ [https://perma.cc/NE3W-4HPB] (recommending that "Congress should fund the National Health Care Workforce Commission").

II. THE LOST COST AND REVENUE PROVISIONS

A second priority of the ACA was to reform the health care delivery system so that it would deliver less costly, higher-quality care.[149] To achieve this objective, the ACA included an array of different initiatives, such as the establishment of Accountable Care Organizations, bundled payment programs, pay-for-performance programs, comparative effectiveness research bodies, the Independent Payment Advisory Board (IPAB), and the so-called "Cadillac tax."[150]

A tertiary goal of the ACA was to reduce the deficit. Although this goal in part reflected political calculations about what was necessary to enact the ACA, it was also considered substantively important in its own right, as President Obama and several of his advisors believed that reducing the size of the federal deficit was important for bolstering economic growth.[151] This belief was, at the time, widely held in policy circles in Washington, if not in the public at large.[152] Some of the ACA's cost-control provisions, such as the Cadillac tax, were also aimed at reducing the federal deficit. In addition, the ACA imposed several new taxes that were aimed at reducing the deficit through raising revenue, including the taxes on insurers and medical devices.

This Part examines several provisions of the ACA affecting health care costs and the deficit that have been repealed, struck down, or scaled back since the ACA was enacted: the Cadillac tax, IPAB, and the medical device and insurance taxes. As in Part II, for each provision, I briefly describe the history and rationale for the provision, how Congress or the Supreme Court has changed the provision since the ACA was enacted, and the effects of these post-enactment changes.

A. The Cadillac Tax

One of the most important of the ACA's ghosts is the Cadillac tax (officially known as the "Excise tax on high cost employer-sponsored health coverage").[153] To understand the origins and purpose of the Cadillac tax, it is first necessary to have a little background about the United States' system

149. *See* STAFF OF THE WASH. POST, *supra* note 36, at 129; Obama, *supra* note 36, at 526.

150. For overviews and critiques of the ACA's various cost control initiatives, see, for example, Barry R. Furrow, *Cost Control and the Affordable Care Act: CRAMPing Our Health Care Appetite*, 13 NEV. L.J. 822 (2013); Erin C. Fuse Brown, *Health Reform and Theories of Cost Control*, 46 J.L., MED. & ETHICS 846 (2018); Jonathan Oberlander, *Throwing Darts: Americans' Elusive Search for Health Care Cost Control*, 36 J. HEALTH POL., POL'Y & L. 477 (2011).

151. *See* COHN, *supra* note 3, at 145–46.

152. *Id.*

153. ACA § 9001, 26 U.S.C. § 4980I (2011), *repealed by* Further Consolidated Appropriations Act, 2020, Pub. L. No. 116-94, § 503, 133 Stat. 2534, 3119–20.

of employer-sponsored insurance. In 2021, almost 155 million nonelderly Americans received health insurance coverage through their employer.[154] This rather peculiar arrangement is at least partially attributable to the fact that, since the 1950s, the United States has exempted employer-provided health insurance from federal income and payroll taxes.[155]

Although the tax exclusion for employer-sponsored health insurance served to promote health insurance coverage in the United States, economists have long criticized it as inefficient. This is because the exclusion creates an incentive for employers to provide compensation to workers in the form of health benefits instead of raising their wages, resulting in wages that are artificially low and health insurance plans that are arguably too generous.[156] Economists argue that these so-called "Cadillac plans" in turn serve to inflate overall health care spending by causing employees to use unnecessary or low-value health care.[157] Yet even though political leaders have proposed changing the federal tax treatment of health care since at least the 1980s, the idea proved so unpopular as to be a nonstarter.[158]

The Cadillac tax was intended to be a more politically palatable compromise that would partially offset the tax-preferred status of employer-provided health insurance. It imposed a 40% excise tax on employer plan costs above certain thresholds, which were initially roughly $10,200 for individual coverage and $27,500 for family coverage.[159] These thresholds were indexed to rise with inflation, but because inflation tends to rise more slowly than health spending, the percentage of plans—and plan costs—that were subject to the tax was expected to grow over time.[160] The rationale was to incentivize employers to alter their health insurance plans to avoid paying the tax by adopting innovative plan designs and reducing the generosity of health insurance benefits.[161]

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154. GARY CLAXTON ET AL., KFF, EMPLOYER HEALTH BENEFITS: 2021 ANNUAL SURVEY 6, 55 (2021), https://files.kff.org/attachment/Report-Employer-Health-Benefits-2021-Annual-Survey.pdf [https://perma.cc/G87A-UAVU].

155. *See* Melissa A. Thomasson, *The Importance of Group Coverage: How Tax Policy Shaped U.S. Health Insurance*, 93 AM. ECON. REV. 1373, 1373 (2003).

156. *See generally* Katherine Baicker & Amitabh Chandra, *The Labor Market Effects of Rising Health Insurance Premiums*, 24 J. LAB. ECON. 609 (2006).

157. Jason Furman & Matthew Fiedler, *The Cadillac Tax — A Crucial Tool for Delivery-System Reform*, 374 NEW ENG. J. MED. 1008, 1008 (2016).

158. *See* MCDONOUGH, INSIDE NATIONAL HEALTH REFORM, *supra* note 4, at 260.

159. ACA § 9001, 26 U.S.C. § 4980I (2011), *repealed by* Further Consolidated Appropriations Act, 2020, Pub. L. No. 116-94, § 503, 133 Stat. 2534, 3119–20.

160. HENRY J. AARON, LINDA J. BLUMBERG, PAUL B. GINSBURG & STEPHEN ZUCKERMAN, BROOKINGS, BUILDING A BETTER "CADILLAC" 1, 6 (2017), https://www.brookings.edu/wp-content/uploads/2017/01/cadillac_final.pdf [https://perma.cc/TY5F-DJZ3].

161. *See* MCDONOUGH, INSIDE NATIONAL HEALTH REFORM, *supra* note 4, at 259; Furman & Fiedler, *supra* note 157, at 1009.

Economists of all stripes considered the Cadillac tax to be one of the most important cost-control provisions in the ACA, if not the most important of those provisions.[162] One study by the Congressional Research Service projected that it would reduce health care spending by roughly 2.2% to 3.2% in 2025, translating to a reduction of $47.6 billion to $69.2 billion in that year alone.[163] It also was expected to help rein in the federal deficit: the Joint Committee on Taxation estimated that it would bring in $32 billion over ten years, the third-most important source of revenue in the ACA.[164]

Politically, however, the Cadillac tax never had many allies. An unusual coalition of employers, health plans, and unions formed the "Alliance to Fight the 40," an organization seeking to repeal the Cadillac tax.[165] Perhaps the only prominent external supporters of the Cadillac tax were economists.[166] In 2015, with momentum growing for repealing the Cadillac tax, a group of 101 prominent health economists signed a public letter "urging Congress to take no action to weaken, delay, or reduce the Cadillac tax."[167]

Ultimately, the tax never took effect. It was originally scheduled to go into effect in 2018, a full eight years after the ACA was passed.[168] However, Congress delayed the tax twice, pushing its implementation date back to

162. *See, e.g.*, Abelson, *High-End Health Plans*, *supra* note 40 ("'It's really one of the most significant provisions' in the Affordable Care Act, said Jonathan Gruber, the M.I.T. economist who played an influential role in shaping the law."); N. Gregory Mankiw & Lawrence H. Summers, *Uniting Behind the Divisive 'Cadillac' Tax on Health Plans*, N.Y. TIMES (Oct. 24, 2015), https://www.nytimes.com/2015/10/25/upshot/uniting-behind-the-divisive-cadillac-tax-on-health-plans.html [https://perma.cc/JG3V-TCZJ] ("[A]lmost every expert agrees that containing health care costs is essential and that the Cadillac tax will help in the future."); Janet Weiner, Clifford Marks & Mark Pauly, *Effects of the ACA on Health Care Cost Containment*, PENN LEONARD DAVIS INST. HEALTH ECON., Feb. 2017, at 1, 4 ("The most significant provision targeting long-term cost growth is the tax on high-cost health plans, known as the 'Cadillac Tax.'").

163. JANE G. GRAVELLE, CONG. RSCH. SERV., R44159, THE EXCISE TAX ON HIGH-COST EMPLOYER-SPONSORED HEALTH INSURANCE: ESTIMATED ECONOMIC AND MARKET EFFECTS 5 (2017).

164. JOINT COMM. ON TAX'N, 111TH CONG., ESTIMATED REVENUE EFFECTS OF THE AMENDMENT IN THE NATURE OF A SUBSTITUTE TO H.R. 4872, THE "RECONCILIATION ACT OF 2010," AS AMENDED, IN COMBINATION WITH THE REVENUE EFFECTS OF H.R. 3590, THE "PATIENT PROTECTION AND AFFORDABLE CARE ACT ('PPACA')," AS PASSED BY THE SENATE, AND SCHEDULED FOR CONSIDERATION BY THE HOUSE COMMITTEE ON RULES ON MARCH 20, 2010 (2010).

165. *See* Reed Abelson, *Health Care Tax Faces United Opposition from Labor and Employers*, N.Y. TIMES (July 21, 2015), https://www.nytimes.com/2015/07/22/business/labor-and-employers-join-in-opposition-to-a-health-care-tax.html [https://perma.cc/P358-K9JR].

166. Carolyn Y. Johnson, *101 Economists Just Signed a Love Letter to the Obamacare Provision Everyone Else Hates*, WASH. POST (Oct. 1, 2015, 2:21 PM), https://www.washingtonpost.com/news/wonk/wp/2015/10/01/101-economists-just-signed-a-love-letter-to-the-obamacare-provision-everyone-else-hates/ [https://perma.cc/HY99-4RH8].

167. Aaron et al., *supra* note 43.

168. MCDONOUGH, INSIDE NATIONAL HEALTH REFORM, *supra* note 4, at 259.

2022.[169] Finally, Congress repealed the tax permanently in December 2019 as part of an omnibus appropriations legislation.[170]

B. The Independent Payment Advisory Board

The Independent Payment Advisory Board (IPAB) was another one of the ACA's most prominent cost-control provisions.[171] IPAB was designed as a fifteen-member body of experts, who would have the authority to make potentially binding changes to the Medicare program to reduce spending growth, under certain conditions. If Medicare spending growth exceeded the ACA's target growth rate, then IPAB would be required to develop and submit recommendations to reduce Medicare spending growth—accompanied by implementing legislation.[172] The Secretary of HHS would then be required to automatically enact IPAB's recommendations, unless Congress passed legislation (using special fast-track procedures) that would achieve equivalent savings.[173]

The theory underlying IPAB was to take the issue of Medicare payment policy out of the hands of politicians and special interest groups, and turn it over to a body of technocrats.[174] In this way, it was intended to operate like the Base Realignment and Closure Commission, which Congress established to identify which military bases should be closed.[175] IPAB represented a substantial delegation of power: the Secretary's decision to implement an IPAB proposal was immune from judicial review, and it would take a supermajority vote in the Senate for Congress to override such

169. Stan Dorn, *The Cadillac Tax: It's Time to Kill This Policy Zombie*, HEALTH AFFS. (June 18, 2019), https://www.healthaffairs.org/content/forefront/cadillac-tax-s-time-kill-policy-zombie [https://perma.cc/3J5C-JA5T]; Julie Rovner, *'Cadillac Tax' on Generous Health Plans May Be Headed for Repeal*, NPR (Aug. 14, 2019, 5:00 AM), https://www.npr.org/sections/health-shots/2019/08/14/750859901/cadillac-tax-on-generous-health-plans-may-be-headed-to-congressional-junkyard [https://perma.cc/NJ2S-5VTD].

170. ACA § 9001, 26 U.S.C. § 4980I (2011), *repealed by* Further Consolidated Appropriations Act, 2020, Pub. L. No. 116-94, § 503, 133 Stat. 2534, 3119–20.

171. ACA § 3403, 42 U.S.C. § 1395kkk (2011), *repealed by* Bipartisan Budget Act of 2018, Pub. L. No. 115-123, § 52001, 132 Stat. 64, 298.

172. *Id.*

173. *Id.*

174. *See* Press Release, Sen. Jay Rockefeller, Rockefeller MedPAC Bill Gains Support (June 29, 2009), https://web.archive.org/web/20101106094129/http://rockefeller.senate.gov/press/record.cfm?id=315230&& [https://perma.cc/UX4E-6YQ6] ("It is long past time that Medicare payment policy is determined by experts, using evidence, instead of by the undue influence of special interests."); Jonathan Oberlander & Marisa Morrison, *Failure to Launch? The Independent Payment Advisory Board's Uncertain Prospects*, 369 NEW ENG. J. MED. 105, 106–07 (2013) [hereinafter Oberlander & Morrison, *Failure to Launch?*] ("The board's appeal lies largely in its aspiration to remove politics from Medicare — to create a policymaking process that is informed by experts and insulated from electoral pressures, interest-group demands, financial considerations, and partisan divisions.").

175. Jonathan Oberlander & Steven B. Spivack, *Technocratic Dreams, Political Realities: The Rise and Demise of Medicare's Independent Payment Advisory Board*, 43 J. HEALTH POL., POL'Y & L. 483, 486–87 (2018).

a proposal in a way that did not meet the same cost-reduction goals.[176] To render IPAB politically acceptable, however, Congress limited its authority in various ways. In particular, the ACA prohibited the Board or Secretary from recommending changes that would "ration health care, raise revenues or Medicare beneficiary premiums . . . increase Medicare beneficiary cost-sharing . . . or otherwise restrict benefits or modify eligibility criteria."[177]

Several prominent health scholars and policymakers hailed IPAB as one of the most important cost control reforms in the Affordable Care Act.[178] For instance, former Senate majority leader Tom Daschle referred to it as the ACA's "most promising device" to control costs,[179] while Ezekiel Emanuel and Peter Orszag hailed it as "[t]he most important institutional change in the ACA."[180] The Congressional Budget Office initially estimated that it would save $15.5 billion between 2010 and 2019.[181]

At the same time, IPAB generated fierce opposition from a broad swathe of provider groups, who were concerned that it would result in reimbursement cuts (the main tool left available to the Board to reduce health care spending).[182] In addition, political conservatives—most famously Sarah Palin—claimed that it licensed "death panel[s]," even though the statutory language explicitly forbade rationing.[183] Ultimately, IPAB never had the opportunity to enact any policies since Medicare spending never met the target threshold level during its brief life. The

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176. ACA § 3403, 42 U.S.C. § 1395kkk (2011), *repealed by* Bipartisan Budget Act of 2018, Pub. L. No. 115-123, § 52001, 132 Stat. 64, 298; *see* Timothy Stoltzfus Jost, *The Real Constitutional Problem with the Affordable Care Act*, 36 J. HEALTH POL., POL'Y & L. 501, 503 (2011); Timothy Stoltzfus Jost, *The Independent Payment Advisory Board*, 363 NEW ENG. J. MED. 103, 104 (2010).

177. ACA § 3403, 42 U.S.C. § 1395kkk (2011), *repealed by* Bipartisan Budget Act of 2018, Pub. L. No. 115-123, § 52001, 132 Stat. 64, 298.

178. *See, e.g.*, Ann Marie Marciarille & J. Bradford DeLong, *Bending the Health Cost Curve: The Promise and Peril of the Independent Payment Advisory Board*, 22 HEALTH MATRIX 75, 78 (2012) (describing IPAB as "[t]he principal instrumentality" for the ACA's goal of controlling health care costs). *But see* Oberlander & Morrison, *Failure to Launch?*, *supra* note 174, at 106–07 (suggesting that IPAB's savings would in fact be negligible).

179. TOM DASCHLE & DAVID NATHER, GETTING IT DONE: HOW OBAMA AND CONGRESS FINALLY BROKE THE STALEMATE TO MAKE WAY FOR HEALTH CARE REFORM 300 (2010).

180. Orszag & Emanuel, *supra* note 38, at 603.

181. Letter from Douglas W. Elmendorf, Dir. of the Cong. Budget Off., to Nancy Pelosi, Speaker of the House of Representatives 6 tbl.5(III)(E) (Mar. 20, 2010), https://www.cbo.gov/sites/default/files/111th-congress-2009-2010/costestimate/amendreconprop.pdf [https://perma.cc/4KNR-53LU].

182. *See* John E. McDonough, *In Defense of the Independent Payment Advisory Board*, 95 MILBANK Q. 466, 467 (2017) [hereinafter McDonough, *In Defense of the Independent Payment Advisory Board*] ("IPAB [was] a major target for repeal by nearly every major medical provider and manufacturing organization in America, including hospitals, physicians, pharmaceutical, biotechnology, medical device, and insurance companies, home health agencies, and many more.").

183. *See* Sarah Palin, *Why I Support the Ryan Roadmap*, WALL ST. J. (Dec. 10, 2010, 12:01 AM), https://www.wsj.com/articles/SB10001424052748703766704576009322838245628 [https://perma.cc/AK9R-38JY]; ACA § 3403, 42 U.S.C. § 1395kkk (2011), *repealed by* Bipartisan Budget Act of 2018, Pub. L. No. 115-123, § 52001, 132 Stat. 64, 298.

Obama Administration and Congress never appointed any members to IPAB due to its political toxicity,[184] and it was quietly repealed in 2018.[185]

C. The Health Insurance and Medical Device Taxes

In addition to the Cadillac tax, the ACA imposed a variety of other targeted taxes to finance the law. Two of the most important taxes were an annual fee on health insurance providers and a tax on manufacturers and importers of certain medical devices. These taxes were difficult to justify on economic or policy grounds; their main rationale was simply to raise federal revenue to offset the costs of the ACA.[186]

The insurance tax was the second-largest revenue-generating provision in the ACA, estimated by the Joint Committee on Taxation (JCT) in 2010 to bring in $60.1 billion over ten years.[187] The medical device tax was somewhat smaller than the health insurance tax: it was the sixth-largest revenue-generating provision in the ACA, and was initially estimated to bring in $20 billion over ten years.[188]

Both industries aggressively lobbied for the repeal of these taxes after the ACA was passed.[189] The Medical Device Manufacturers Association reportedly spent $1.2 million lobbying Congress in 2015 and 2016, more than that organization had spent in any previous year recorded by the non-profit organization OpenSecrets.[190] Many members of Congress proved quite receptive to their efforts. Republican members of Congress included the repeal of the medical device tax as one of their demands in exchange for funding the government during the 2013 budget debate.[191] Several liberal democrats from states with large medical device industries also supported repeal, including Senators Amy Klobuchar, Al Franken, and Elizabeth Warren.[192] The health insurance tax and medical device tax were first

184. Oberlander & Spivack, *supra* note 175, at 498 ("[I]t was politically impossible for the White House to appoint members to [IPAB].").

185. ACA § 3403, 42 U.S.C. § 1395kkk (2011), *repealed by* Bipartisan Budget Act of 2018, Pub. L. No. 115-123, § 52001, 132 Stat. 64, 298.

186. JANE G. GRAVELLE & SEAN LOWRY, CONG. RSCH. SERV., R43342, THE MEDICAL DEVICE EXCISE TAX: ECONOMIC ANALYSIS (2014).

187. MCDONOUGH, INSIDE NATIONAL HEALTH REFORM, *supra* note 4, at 256.

188. *Id.* (listing the top thirteen revenue-raising provisions in Title IX of the ACA).

189. *See* Stein & Abutaleb, *supra* note 45.

190. Sarah Kliff, *Obamacare's Medical Device Tax — and How It Became a Repeal Target — Explained*, VOX (July 27, 2017, 11:30 AM), https://www.vox.com/policy-and-politics/2017/7/27/16049892/obamacare-medical-device-tax [https://perma.cc/2YHC-4G6W].

191. *Id.*

192. *Id.*

suspended,[193] and then ultimately repealed in late 2019 as part of the same legislation that repealed the Cadillac tax.[194]

D. Summary

Altogether, the repeals of IPAB, the Cadillac tax, and the medical device and health insurance taxes removed some of the most important cost-control and revenue-generating provisions of the ACA. The Cadillac tax and IPAB were considered by many non-partisan observers to be two of the most important and effective cost-control provisions in the ACA. The medical device tax and health insurance taxes were two important means of ensuring that the law did not add to the deficit. According to one estimate, the repeals of those two taxes along with the Cadillac tax will together decrease government revenues by around $375 billion over ten years.[195]

III. THE ACA'S ENACTMENT-ENTRENCHMENT TRADEOFFS

What accounts for the ACA's ghosts? And why did the ACA prove to be so vulnerable, given the conventional wisdom about the durability of social legislation? This Part contends that to understand the ACA's ghosts and its surprising vulnerability, it is necessary to recognize a complex set of tradeoffs that the law's architects were forced to make between enacting the ACA and ensuring its survival over time.

I first examine existing explanations for the ACA's vulnerability. I separate these explanations into "exogenous" ones (that is, explanations that focus primarily on factors other than the ACA itself) and "endogenous" ones (that is, explanations that focus on features of the ACA). I then make the case that although these exogenous and endogenous factors played important roles, one cannot fully understand the ACA's vulnerability—and its ghosts—without exploring the tradeoffs that legislators faced between enacting the law and entrenching it.

In making this argument, I rely on a certain understanding of entrenchment, a term that has been used in different ways.[196] To say that a law has become entrenched, in the way I understand that term, does not mean that it must endure in exactly its original form: rather, it is to say that the constitutive features of the law have become difficult to undo, and that

193. *See* TAX POL'Y CTR., BRIEFING BOOK, WHAT TAX CHANGES DID THE AFFORDABLE CARE ACT MAKE? (2020), https://www.taxpolicycenter.org/briefing-book/what-tax-changes-did-the-affordable-care-act-make [https://perma.cc/AT5N-GWFX].

194. Further Consolidated Appropriations Act, 2020, Pub. L. No. 116–94, §§ 501–502, 133 Stat. 2534, 3118–19.

195. Stein & Abutaleb, *supra* note 45.

196. *See* Eric A. Posner & Adrian Vermeule, *Legislative Entrenchment: A Reappraisal*, 111 YALE L.J. 1665, 1666 (2002) ("'Entrenchment' is a promiscuous word in the academic literature.").

they constrain further change.[197] Understood in this general sense, entrenchment is neither per se good nor bad; yet understanding how laws become entrenched is of immense importance for anyone who supports the existing legal framework or seeks to change it.[198] As Daryl Levinson and Benjamin I. Sachs make clear, laws can be entrenched either *formally* through changing the formal legal rules governing political change (e.g., legislative procedures or electoral rules) or *functionally* through how they reconfigure the political environment (i.e., through their policy feedback effects).[199] In this Article, I will primarily use the term "entrenchment" in the latter sense of functional entrenchment. Functional entrenchment is "a matter of degree," not an all-or-nothing condition.[200] Indeed, all federal legislation may be said to be functionally entrenched to some extent, because Congress has a well-documented status quo bias.[201] Yet some laws are less well-entrenched—i.e., more vulnerable—than others.

A. Exogenous Factors

Various exogenous factors can affect the extent to which a law is entrenched, including changes in economic conditions, demographic shifts, elections, and retirements of politicians.[202] In the case of the ACA, health scholars and political scientists have focused on two exogenous factors that help to explain why the law was so politically vulnerable. The first is the rise of so-called "asymmetric polarization."[203] Over the past several years, a bevy of political scientists and commentators have documented how the Republican party has increasingly moved to the right, away from bipartisan

197. *See* STARR, ENTRENCHMENT, *supra* note 57, at 2–3; Jenkins & Patashnik, *Living Legislation and American Politics*, *supra* note 58, at 10–11.

198. *See* STARR, ENTRENCHMENT, *supra* note 57, at xii. I take no position on the hotly debated question of whether certain controversial forms of formal entrenchment are normatively desirable or not. *Compare* Posner & Vermeule, *supra* note 196, at 1666 ("[E]ntrenchment is both constitutionally permissible and, in appropriate circumstances, normatively attractive."), *with* John C. Roberts & Erwin Chemerinsky, *Entrenchment of Ordinary Legislation: A Reply to Professors Posner and Vermeule*, 91 CALIF. L. REV. 1773, 1777 (2003) ("One legislative majority should never be able to bind future legislative majorities by means of ordinary legislation."), *and* Stewart E. Sterk, *Retrenchment on Entrenchment*, 71 GEO. WASH. L. REV. 231, 252 (2003) ("[A] regime that permits absolute entrenchment is inferior, from a normative point of view, to alternatives that relieve subsequent legislatures from some of the commitments made by their predecessors.").

199. *See* Levinson & Sachs, *supra* note 59, at 407.

200. *See* STARR, ENTRENCHMENT, *supra* note 57, at 3.

201. *See* Rebecca M. Kysar, *Dynamic Legislation*, 167 U. PA. L. REV. 809, 836 (2019).

202. *See* Eric M. Patashnik & Julian E. Zelizer, *The Struggle to Remake Politics: Liberal Reform and the Limits of Policy Feedback in the Contemporary American State*, 11 PERSPS. ON POL. 1071, 1074 (2013).

203. Hacker & Pierson, *The Dog that Almost Barked*, *supra* note 47, at 553.

compromise.[204] Jacob Hacker and Paul Pierson have argued that the rise of asymmetric polarization made the ACA more vulnerable since it meant that Republican politicians were less moved by public opinion, and so were more willing to make deeply unpopular cuts to social programs.[205]

The second factor, related to the first, is racial resentment and hostility toward the country's first Black President.[206] The Tea Party movement of 2009 and 2010 featured both explicit racist hostility toward President Obama,[207] as well as more subtle undertones of racial resentment at the prospect of "forc[ing] hardworking and hard-pressed citizens and businesses to pay higher taxes to provide health insurance to younger, less well-to-do, and often 'undeserving' people."[208] These attitudes likely played a role in the ACA's relative unpopularity: one study found that the Black-White divide over President Obama's health care reform proposals was twenty percentage points larger than it was over President Clinton's reform plan in the 1990s, despite the fact that it was a more politically conservative reform.[209] Racial resentment has also likely played a more specific role in some of the ACA's ghosts, in particular some states' decisions not to expand their Medicaid programs.[210]

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204. *See, e.g.*, THOMAS E. MANN & NORMAN J. ORNSTEIN, IT'S EVEN WORSE THAN IT LOOKS: HOW THE AMERICAN CONSTITUTIONAL SYSTEM COLLIDED WITH THE NEW POLITICS OF EXTREMISM (rev. ed. 2016); EZRA KLEIN, WHY WE'RE POLARIZED (2020). *But see* Cynthia R. Farina, *Congressional Polarization: Terminal Constitutional Dysfunction?*, 115 COLUM. L. REV. 1689, 1693 (2015) ("[T]he rhetoric around congressional polarization . . . is far more negative than the existing evidence can justify.").

205. *See* Hacker & Pierson, *The Dog that Almost Barked*, *supra* note 47, at 553, 562–63; Jacob S. Hacker & Paul Pierson, *Policy Feedback in an Age of Polarization*, 685 ANNALS, AAPSS 8, 20 (2019) [hereinafter Hacker & Pierson, *Policy Feedback in an Age of Polarization*]; *see also* Paul Starr, *Built to Last? Policy Entrenchment and Regret in Medicare, Medicaid, and the Affordable Care Act*, *in* MEDICARE AND MEDICAID AT 50: AMERICA'S ENTITLEMENT PROGRAMS IN THE AGE OF AFFORDABLE CARE 319, 327 (Alan B. Cohen, David C. Colby, Keith A. Wailoo & Julian E. Zelizer eds., 2015) [hereinafter Starr, *Built to Last?*] ("[A]s a result of the growing ideological distance between the parties, shifts in party control of the federal government are now more likely to result in substantial changes in national policy.").

206. *See, e.g.*, Eric D. Knowles, Brian S. Lowery & Rebecca L. Schaumberg, *Racial Prejudice Predicts Opposition to Obama and His Health Care Reform Plan*, 46 J. EXPERIMENTAL SOC. PSYCH. 420 (2010); Michael P. Jeffries, *Obamacare Repeal Is Based on Racial Resentment*, BOS. GLOBE (May 5, 2017, 12:39 PM), https://www.bostonglobe.com/opinion/2017/05/05/obamacare-repeal-based-racial-resentment/iVNtB9fpr3JNm7IKfYyorK/story.html [https://perma.cc/66QS-6YNU].

207. COHN, *supra* note 3, at 163 ("The racial subtext to the conservative backlash was impossible to miss, in part because sometimes it was the text.").

208. Vanessa Williamson, Theda Skocpol & John Coggin, *The Tea Party and the Remaking of Republican Conservatism*, 9 PERSPS. ON POL. 25, 35 (2011); *see also* LAWRENCE R. JACOBS & THEDA SKOCPOL, HEALTH CARE REFORM AND AMERICAN POLITICS: WHAT EVERYONE NEEDS TO KNOW 77 (2010) ("Tea Partiers . . . . hold views on race and immigration considerably more negative toward nonwhites than the views [of] other citizens, including other Republicans.").

209. Michael Tesler, *The Spillover of Racialization into Health Care: How President Obama Polarized Public Opinion by Racial Attitudes and Race*, 56 AM. J. POL. SCI. 690, 691 (2012).

210. *See, e.g.*, Mark A. Hall, *States' Decisions Not to Expand Medicaid*, 92 N.C. L. REV. 1459, 1464–65 (2014); Jamila Michener, *Race, Politics, and the Affordable Care Act*, 45 J. HEALTH POL., POL'Y & L. 547, 551 (2020).

Although these exogenous explanations are important, they cannot by themselves fully account for the ACA's ghosts. For one thing, several of the ghosts of the ACA—the individual mandate penalty, the Cadillac tax, the health insurance and medical device taxes, and IPAB—were repealed by Congress on a bipartisan basis, with large numbers of Democrats voting in their favor.[211] In addition, at least during its early post-enactment years, the ACA experienced not only intense opposition from the Republican party, but also relatively lackluster support from Democrats and Independents.[212] What's more, while the individual mandate and Medicaid expansion were high-profile and politically divisive, several other ghosts of the ACA were notably technical and obscure, making it somewhat mystifying why these provisions were targeted for repeal, if polarization and racial resentment were the driving factors. Finally, and perhaps most fundamentally, one cannot fully account for political attitudes toward the ACA without examining the law's design, since its design in turn affected those attitudes.[213] It is, therefore, to these "endogenous" factors that we now turn.

B. Endogenous Factors

Social scientists have long recognized that "[n]ew policies create a new politics."[214] That is, laws and policies are not only products of their political environment, but also they have feedback effects that reconfigure that environment.[215] In recent years, a number of social scientists have begun to explore how these effects can in turn help to determine whether a law endures over time.[216] These effects can occur through different channels: for instance, through empowering (or disempowering) existing interest groups; creating new constituencies that have a vested interest in preserving the status quo; establishing support among the general public; or enhancing the

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211. *See, e.g.*, Yasmeen Abutaleb, *House Democrats Join Republicans to Repeal Obamacare's 'Cadillac Tax,'* WASH. POST (July 17, 2019, 7:36 PM), https://www.washingtonpost.com/health/house-democrats-join-republicans-to-repeal-obamacares-cadillac-tax/2019/07/17/f8acb86e-a8cc-11e9-a3a6-ab670962db05_story.html [https://perma.cc/75RL-4FEJ].

212. *See, e.g.*, CARROLL DOHERTY, ALEC TYSON & SETH MOTEL, PEW RSCH. CTR., MIDTERM ELECTION INDICATORS DAUNTING FOR DEMOCRATS 11 (2014), https://www.pewresearch.org/politics/2014/05/05/views-of-the-affordable-care-act-and-its-future/ [https://perma.cc/6G6R-ZHBT] (finding that "[a]s in earlier surveys, opposition to the law is more intense than support").

213. *Cf.* Josh Chafetz, *The Phenomenology of Gridlock*, 88 NOTRE DAME L. REV. 2065, 2075 (2013) ("[T]here is no such thing as public opinion, distinct from policy; both are endogenous to the political process. . . . Politics is nothing if not dialogic. Institutional structures both participate in the development of opinion formation and affect the terms on which opinion is translated (or not) into policy.").

214. E. E. SCHATTSCHNEIDER, POLITICS, PRESSURES AND THE TARIFF 288 (1935).

215. *See* Jamila Michener, *Medicaid and the Policy Feedback Foundations for Universal Healthcare*, 685 ANNALS, AAPSS 116, 116 (2019) [hereinafter Michener, *Medicaid and the Policy Feedback Foundations for Universal Healthcare*].

216. *See supra* note 58 and accompanying text.

capacity of government agencies themselves to defend the law.[217] Furthermore, these feedback effects can either be self-sustaining, in the sense that they help a law to endure over time, or they can be self-undermining, in the sense that they undermine political support for the law or render a law legally vulnerable.[218] The effects of large, complex laws like the ACA may be transmitted via different channels in multiple directions, generating both self-sustaining feedback effects and self-undermining feedback effects.[219]

Although the social science literature does not specifically focus on the ghosts of the ACA, it does discuss one key reason why the ACA was politically vulnerable: namely, that it was "under-entrenched."[220] That is, several aspects of the law generated self-undermining feedback effects. Some of these were clearly "self-inflicted wound[s]," as President Obama later described them.[221] Perhaps most infamously, the failed launch of the federal health insurance exchange platform, healthcare.gov, in October 2013, created a massive amount of negative publicity.[222] In addition, a legislative drafting error reportedly led to the lawsuit that came close to unwinding the ACA in *King v. Burwell*.[223] Yet other self-undermining effects were the result of intentional policy choices: for instance, the law's primary coverage provisions weren't implemented until nearly four years after the law was enacted into law, and its design was sufficiently complex and obscure that many Americans did not recognize the law's various benefits.[224]

Nevertheless, recognizing the ACA's under-entrenchment only raises a further question: why was the ACA under-entrenched? Do these features of the law merely reflect short-sightedness on the part of the ACA's architects?

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217. *See, e.g.*, Eric M. Patashnik & R. Kent Weaver, *Policy Analysis and Political Sustainability*, 49 POL'Y STUD. J. 1110, 1113 (2021); ALEXANDER HERTEL-FERNANDEZ, HOW POLICYMAKERS CAN CRAFT MEASURES THAT ENDURE AND BUILD POLITICAL POWER 6 (2020).

218. *See generally* Alan M. Jacobs & R. Kent Weaver, *When Policies Undo Themselves: Self-Undermining Feedback as a Source of Policy Change*, 28 GOVERNANCE 441 *passim* (2015).

219. Daniel Béland, Philip Rocco & Alex Waddan, *Policy Feedback and the Politics of the Affordable Care Act*, 47 POL'Y STUD. J. 395, 396 (2019).

220. Hacker & Pierson, *The Dog that Almost Barked*, *supra* note 47, at 564; *see also* Oberlander & Weaver, *supra* note 56, at 37 ("We suggest that one reason for the ACA's unsettled fate is the role of policy feedbacks that undermine public support for and opponents' acceptance of the program.").

221. COHN, *supra* note 3, at 327.

222. Jonathan Cohn, *The ACA, Repeal, and the Politics of Backlash*, *in* THE TRILLION DOLLAR REVOLUTION: HOW THE AFFORDABLE CARE ACT TRANSFORMED POLITICS, LAW, AND HEALTH CARE IN AMERICA, *supra* note 2, at 118, 124.

223. 576 U.S. 473 (2015); Robert Pear, *Four Words That Imperil Health Care Law Were All a Mistake, Writers Now Say*, N.Y. TIMES (May 25, 2015), https://www.nytimes.com/2015/05/26/us/politics/contested-words-in-affordable-care-act-may-have-been-left-by-mistake.html [https://perma.cc/6E34-ZK36].

224. *See* Starr, *Built to Last?*, *supra* note 205, at 328; Fuse Brown, *Developing a Durable Right to Health Care*, *supra* note 6, at 469–70.

Or were there deeper constraints that made the ACA's architects *unable* to entrench the ACA more effectively?

The policy feedback literature is equivocal on this point. This literature acknowledges that the ACA's architects were constrained in terms of their ability to entrench the law.[225] Yet it still leaves open the possibility that lawmakers could have entrenched the ACA more effectively if they had been more attentive to feedback effects.[226] For instance, after conducting interviews with congressional staff involved with the ACA, Eileen Burgin concludes that "policy makers were broadly oblivious to the ACA's future," and that "congressional actors were not focused on [the ACA's] self-reinforcing and self-undermining feedback potential."[227] Nevertheless, she concludes that it is "unknowable" whether a greater focus on the ACA's policy feedback effects at the time the law was being enacted could "have succeeded in diminishing some of the ACA's troubles after passage."[228]

In the following sections, I argue that the ACA's architects were more deeply constrained in their ability to entrench the law than has been previously recognized. I show that the very same strategies that were deemed essential to enact the ACA also created self-undermining feedback effects that limited political support for the law and made it more vulnerable to legal challenges. In making this argument, I draw on some of the exogenous and endogenous factors described above and show how they influenced one another, and I also point out several other factors.

C. Legislative Strategies and Feedback Effects

When President Obama took office in January 2009, the stars were aligned for health care reform.[229] The Democrats controlled both chambers

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225. *See, e.g.*, Oberlander & Weaver, *supra* note 56, at 44; Eileen Burgin, *Congress, Policy Sustainability, and the Affordable Care Act: Democratic Policy Makers Overlooked Implementation, Post-Enactment Politics, and Policy Feedback Effects*, 45 CONG. & PRESIDENCY 279, 303–05 (2018); Daniel Béland, Michael Howlett, Philip Rocco & Alex Waddan, *Designing Policy Resilience: Lessons from the Affordable Care Act*, 53 POL'Y SCIS. 269, 284 (2020) [hereinafter Béland et al., *Designing Policy Resilience*]; Patashnik & Weaver, *supra* note 217, at 1128–29.

226. For one notable exception, see Hacker & Pierson, *The Dog that Almost Barked*, *supra* note 47, at 564 ("[M]any of these features of the ACA that weakened entrenchment were forced on, rather than pursued by, the designers of the law.").

227. *See* Burgin, *supra* note 225, at 306.

228. *Id.*; *see also* Oberlander & Weaver, *supra* note 56, at 56 ("The degree to which these policy feedbacks, and the ensuing conflict, were inevitable or reflect poor strategic choices by the Obama administration and its political allies is certainly debatable."); Béland et al., *Designing Policy Resilience*, *supra* note 225, at 284 ("Our examination of policy resilience suggests that policy makers, *at least to the extent possible in the cauldron of a high stakes political fight*, still need to take into account what the post-enactment phase of policy implementation will look like and how to make a policy mix have public appeal and a legal status that can deflect political and judicial attack." (emphasis added)).

229. *See* STAFF OF THE WASH. POST, *supra* note 36, at 14 ; Mark A. Peterson, *It Was a Different Time: Obama and the Unique Opportunity for Health Care Reform*, 36 J. HEALTH POL., POL'Y & L. 429, 435 (2011).

of Congress, including a super-majority in the Senate, and were led by a popular President. The Democrats were also more homogenous, and more liberal, than they had been in the past, and they were no longer held back by the Southern conservative bloc that had blocked previous health care reform efforts.[230] Furthermore, the Great Recession had intensified the urgency to enact health care reform.[231] Powerful interest groups such as the American Medical Association that had stymied past health care reform efforts were increasingly reliant on government funding, and were no longer as opposed to health care reform as they had been in years past.[232] There was also a consensus both within the leadership of the Democratic party and among several powerful interest group leaders regarding the general direction that the health care reform effort should take, modeled on Massachusetts's 2006 health care reform.[233]

Even so, some of the same obstacles that had foiled previous attempts to reform the health care system still stood in the way. The first obstacle was the existence of fiscal constraints: that is, persistent concerns about the ACA's cost and its effects on the federal deficit.[234] The second was potential resistance from key health care interest groups.[235] The third was what Paul Starr refers to as the United States' health care "policy trap": the fact that previous incremental coverage expansions had undercut political support for any major overhaul of the health care system.[236] Compounding these challenges, as discussed above, the ACA was passed during an era characterized by asymmetric polarization.[237] This intense partisan divide meant that, even though Democrats controlled the legislative and executive branches, they ended up being unable to win any Republican support to pass the law.

I argue in the sections to follow that, in order to overcome these obstacles, the ACA's architects made several legislative choices to increase its odds of being enacted into law. However, these choices rendered the ACA less well-entrenched by undermining political support for the law and making it more vulnerable to legal challenge.

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230. Jacob S. Hacker, *Why Reform Happened*, 36 J. HEALTH POL., POL'Y & L. 437, 437 (2011) [hereinafter Hacker, *Why Reform Happened*].

231. *See id.* at 438; William M. Sage & Timothy M. Westmoreland, *Following the Money: The ACA's Fiscal-Political Economy and Lessons for Future Health Care Reform*, 48 J.L., MED. & ETHICS 434, 437 (2020) [hereinafter Sage & Westmoreland, *Following the Money*].

232. Hacker, *Why Reform Happened*, *supra* note 230, at 438–39.

233. MCDONOUGH, INSIDE NATIONAL HEALTH REFORM, *supra* note 4, at 35–37.

234. *See infra* Section III.C.1.

235. *See infra* Section III.C.2.

236. *See infra* Section III.C.3; STARR, REMEDY AND REACTION, *supra* note 66, at 41.

237. Hacker & Pierson, *The Dog that Almost Barked*, *supra* note 47, at 558–63. My description of polarization above as an "exogenous" factor is, therefore, oversimplified. As Hacker and Pierson argue, polarization made the ACA more vulnerable not only because it made politicians more willing to cut popular social programs, but also because it influenced the ACA's own design. *See id.* at 565.

1. Fiscal Constraints

Perhaps the most obvious legislative constraint on the ACA was its cost. The fiscally conservative "Blue Dog" Democrats in the House of Representatives, as well as deficit hawks in the Senate, were concerned about both the cost of the ACA and its impact on the federal deficit, and President Obama and congressional leaders could ill-afford to lose these members' support.[238] In addition, "Pay-as-You-go" (PAYGO) requirements embedded in statutes and parliamentary rules meant that the ACA could not increase the deficit over a ten-year period, after accounting for the level of projected spending under current law.[239]

To address concerns about the ACA's fiscal impact, President Obama publicly promised that the law would pay for itself, and that total expenditures for the ACA wouldn't exceed around $900 billion over a ten-year threshold.[240] The Congressional Budget Office (CBO) served as the primary arbiter of whether the ACA would in fact live up to these commitments. Established by the Congressional Budget and Impoundment Control Act of 1974, the CBO is an independent agency staffed with economists, charged with analyzing ("scoring," in Washington argot) how all legislation affects the federal budget.[241] The CBO is enormously influential, and its analyses reverberate throughout Washington, often shaping legislative debates—and legislation itself.[242] Indeed, some observers have credited the CBO's analyses during the 1990s with killing the Clinton health care reform effort.[243]

This legislative strategy—of placing a ceiling on the total cost of the law and promising the law would pay for itself—proved very influential in determining the structure of the ACA.[244] In the lead-up to the passage of the ACA, Senate Majority Leader Harry Reid submitted different variants of the bill to the CBO for weeks to try to find a version that would meet

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238. *See* COHN, *supra* note 3, at 145.

239. Timothy Westmoreland, *Invisible Forces at Work: Health Legislation and Budget Processes*, *in* THE OXFORD HANDBOOK OF U.S. HEALTH LAW, *supra* note 68, at 873, 880–81 [hereinafter Westmoreland, *Invisible Forces at Work*].

240. Obama, Address Before a Joint Session of the Congress, *supra* note 42, at 6–7.

241. Congressional Budget and Impoundment Control Act of 1974, Pub. L. No. 93-344, 88 Stat. 297. The CBO scores spending proposals, but for revenue proposals, they work together with the Joint Committee on Taxation (JCT). Westmoreland, *Invisible Forces at Work*, *supra* note 239, at 881.

242. *See* Sage & Westmoreland, *Following the Money*, *supra* note 331, at 435.

243. Westmoreland, *Invisible Forces at Work*, *supra* note 239, at 882; *see also* PHILIP G. JOYCE, THE CONGRESSIONAL BUDGET OFFICE: HONEST NUMBERS, POWER, AND POLICYMAKING 1 (2011) (quoting Senator Ron Wyden saying "the history of health reform is congressmen sending health legislation off to the Congressional Budget Office to die").

244. *See* COHN, *supra* note 3, at 145.

President Obama's spending and deficit goals.[245] If the CBO said that some version of the bill did not meet those goals, the bill was "tweaked" until it did.[246] Yet although this strategy was viewed as necessary to enact the ACA, it also ended up influencing the law in ways that undermined its political support, made it more legally vulnerable, and ultimately contributed to the ACA's ghosts.

Consider first the most obvious way that Congress attempted to meet President Obama's fiscal commitments: by limiting funding for the law. During the legislative process, Congress slashed the proposed subsidies for private insurance policies offered on the ACA exchanges and decreased the generosity of the exchange policies.[247] These steps had the effect of making the policies offered on the exchanges less affordable, which in turn bred resentment among exchange enrollees facing significant out-of-pocket costs.[248] Budgetary constraints also reportedly prompted Congress to leave states on the hook for funding a small share of the Medicaid expansion, despite state governors' objections, and this in turn set up the Supreme Court's decision in *NFIB v. Sebelius*, which made the Medicaid expansion optional.[249] If the federal government had instead fully funded the Medicaid expansion, then the states likely would not have had standing to sue the federal government and claim that they were being unconstitutionally coerced.[250] Likewise, limited funding also contributed to the failure of the ACA's CO-OP program,[251] and explains why the National Health Workforce Commission has never gotten off the ground.[252]

President Obama's fiscal commitments also affected the structure of the ACA in a more subtle way: by leading Congress to backload some of the ACA's most important spending provisions. Because CBO generally scores legislation over a ten-year window,[253] this provides an incentive for lawmakers to adjust spending to fall outside of the window, and to move

245. Sheryl Gay Stolberg, *Capital Waits as Budget Chief Crunches Numbers*, N.Y. TIMES (Nov. 16, 2009), https://www.nytimes.com/2009/11/17/us/politics/17elmendorf.html [https://perma.cc/J27Y-AUPX].

246. JOYCE, *supra* note 243, at 2.

247. *See* MCDONOUGH, INSIDE NATIONAL HEALTH REFORM, *supra* note 4, at 126.

248. *See* Michener, *Medicaid and the Policy Feedback Foundations for Universal Healthcare*, *supra* note 215, at 121–22.

249. 567 U.S. 519, 575–85 (2012); Westmoreland, *Invisible Forces at Work*, *supra* note 239, at 889 ("Initially . . . . [t]he federal government was to pay 100% of the costs of this 'expansion population,' and the states were to pay nothing. But when scorekeeping revealed a need for further budget reductions, the decision was made to limit that federal payment.").

250. Sage & Westmoreland, *Following the Money*, *supra* note 231, at 438.

251. CORLETTE ET AL., *supra* note 136, at 20.

252. McDonough, *Old Wine in a New Bottle*, *supra* note 144.

253. Westmoreland, *Invisible Forces at Work*, *supra* note 239, at 884–86.

revenues into the window.[254] One way in which the ACA's architects did this was by delaying the implementation of the main health insurance coverage provisions (the Medicaid expansion and the subsidies on the ACA exchanges) until 2014, nearly four years after the law was enacted.[255]

Backloading the ACA's benefits had the effect of limiting political support for the law during its initial years, since its benefits were not tangible to many Americans.[256] Social scientists have long recognized that once benefits are granted, it is difficult to take them away, since voters develop a sense that they are entitled to them, and this leads to the formation of interest groups that support the preservation of benefits.[257] Thus, it seems likely that if the ACA had implemented its major coverage provisions more quickly after it was signed into law, then the law would not have been as legally and politically vulnerable as it was during the first few years after its enactment.[258] In fact, Abbe Gluck and Thomas Scott-Railton have written that if the Medicaid expansion had been implemented prior to the Court's decision in *NFIB v. Sebelius*, then "it would have been very difficult for the Court to render it optional as it did."[259]

Another glaring way in which the ACA backloaded spending was in the structure of the CLASS Act. The CBO estimated that in its first ten years, the CLASS Act would reduce the deficit by around $70 billion—which accounted for just over half of the ACA's entire budget savings over that period.[260] However, the CBO also estimated that CLASS "would add to future federal budget deficits in a large and growing fashion beginning a

254. COMM. FOR A RESPONSIBLE FED. BUDGET, PLAYING BY THE (BUDGET) RULES: UNDERSTANDING AND PREVENTING BUDGET GIMMICKS 12–13 (2018), https://www.crfb.org/papers/playing-budget-rules-understanding-and-preventing-budget-gimmicks [https://perma.cc/U3MJ-F2F2].

255. *See* STARR, REMEDY AND REACTION, *supra* note 66, at 276 ("The Democrats had also created a huge political problem for themselves by delaying the major benefits of the legislation for four years, mainly to be able to show that it would reduce the deficit."). The Senate HELP Committee and House each considered bills with earlier start dates but were forced to push back the start date of the law after President Obama announced his pledge that the ten-year cost of the bill would not exceed $900 billion. *See* MCDONOUGH, INSIDE NATIONAL HEALTH REFORM, *supra* note 4, at 126; Robert Pear, *Senate Health Care Bill Faces Crucial First Vote*, N.Y. TIMES (Nov. 19, 2009), https://www.nytimes.com/2009/11/20/health/policy/20health.html [https://perma.cc/9QQ5-WQGJ]. That being said, some delay may have also been necessary to give the Obama Administration time to implement the law (as well as to give states and private entitles time to adjust). *See* Kathleen Sebelius & Nancy-Ann DeParle, *Present at the Creation: Launching the ACA—2010 to 2014*, *in* THE TRILLION DOLLAR REVOLUTION: HOW THE AFFORDABLE CARE ACT TRANSFORMED POLITICS, LAW, AND HEALTH CARE IN AMERICA, *supra* note 2, at 83, 83–84.

256. *See* STARR, REMEDY AND REACTION, *supra* note 66, at 269; Béland et al., *Designing Policy Resilience*, *supra* note 225, at 284; Patashnik & Zelizer, *supra* note 202, at 1080.

257. *See* Oberlander & Weaver, *supra* note 56, at 39.

258. *See* Béland et al., *Designing Policy Resilience*, *supra* note 225, at 283.

259. Gluck & Scott-Railton, *supra* note 16, at 554.

260. MCDONOUGH, INSIDE NATIONAL HEALTH REFORM, *supra* note 4, at 245.

few years beyond the 10-year budget window."[261] Nevertheless, despite the CBO's disclaimer, and despite concerns about CLASS's long-term fiscal viability, congressional leadership and the White House reportedly decided to include it in the bill because it reduced the deficit in the short-term, thus improving the CBO's estimate of the ACA's savings over its first decade.[262]

This was no accident. In the most comprehensive study of the CLASS Act to date, Robert Saldin concludes that the program "was a carefully planned and remarkably adroit response to political reality and the institutional rules under which the congressional policymaking system now operates."[263] Advocates for long-term care had learned from previous reform attempts that CLASS's CBO score would be crucial to whether it was enacted, and furthermore, that that score could be manipulated by taking advantage of the 10-year budget window.[264] While they recognized the program's design flaws, they viewed these flaws as politically necessary concessions to get the law enacted, and hoped that they could improve the program down the road.[265] In a calculated (but ultimately failed) gamble, its designers prioritized the program's ten-year CBO score over ensuring that the program was truly fiscally sustainable.[266] Ultimately, then, the need to ensure that the ACA would be deficit-neutral not only led to the enactment of the CLASS Act, but it also sowed the seeds for its eventual repeal.

2. *Interest Group Opposition*

The second major obstacle to enacting the Affordable Care Act was potential opposition from health care interest groups. Famously, opposition from the American Medical Association (AMA) had helped to torpedo reform efforts early in the twentieth century,[267] while opposition from health care interest groups—and in particular health insurers—was credited with having doomed the Clinton health care reform efforts.[268] Even though, during the period when the ACA was being drafted, interest groups were less adamantly opposed to health care reform than they had been in the past, they still wielded powerful influence and most observers agree that they

261. Letter from Douglas W. Elmendorf, Dir. of the Cong. Budget Off., to Kay R. Hagan, Sen. 3 (July 6, 2009), https://www.cbo.gov/ftpdocs/104xx/doc10436/07-06-CLASSAct.pdf [https://perma.cc/Q6SZ-24FJ].

262. MCDONOUGH, INSIDE NATIONAL HEALTH REFORM, *supra* note 4, at 245–47; SALDIN, *supra* note 107, at 122.

263. SALDIN, *supra* note 107, at 11.

264. *Id.* at 12.

265. *Id.* at 117.

266. *Id.* at 125–26.

267. *See* BEATRIX HOFFMAN, HEALTH CARE FOR SOME: RIGHTS AND RATIONING IN THE UNITED STATES SINCE 1930, at xxxiv–xxxv, 61 (2012).

268. *See* STARR, REMEDY AND REACTION, *supra* note 66, at 204–05.

needed to be accommodated to some extent in order for any reform to be enacted.[269]

In response, Democrats developed a strategy of negotiating with health care interest groups.[270] The idea was that these groups would be getting more paying customers as the ACA increased the number of people with insurance coverage, so in return, they should help pay for the cost of the coverage expansion.[271] The threatened alternative, if they did not agree to help pay for the coverage expansion, was that "they could expect harsh new regulations and steep cuts in government payments."[272] The Democrats' slogans, in dealing with these interest groups, were "[a]t the table or on the menu," and "[o]n the bus or under the bus."[273]

Senate Finance Committee staff, sometimes with participation from White House Staff, struck deals in closed-door meetings with representatives from the pharmaceutical and hospital industries.[274] Pharmaceutical Research and Manufacturers of America (PhRMA) agreed to provide $80 billion in cost savings on drugs and to fund an advertising campaign to support the ACA, while the American Hospital Association "agreed to accept payment reductions that would save the government $155 billion over 10 years."[275] The White House and congressional leaders also eventually struck a deal in January 2010 with the labor movement to scale back the Cadillac tax. Labor unions had been supportive of the Affordable Care Act since the beginning, but "went ballistic" after they got wind of the Cadillac tax's inclusion in the Senate bill.[276] To appease them, the White House and congressional leaders agreed to reduce the size and scope of the tax, and to delay its implementation.[277]

By contrast, the medical device industry was put "on the menu," albeit in a limited way. The Advanced Medical Technology Association (AdvaMed) declined to negotiate over the ACA, instead simply opposing

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269. *See id.* at 205; Allison K. Hoffman, *What Health Reform Reveals About Health Law*, *in* THE OXFORD HANDBOOK OF U.S. HEALTH LAW, *supra* note 68, at 49, 61.

270. *See* STAFF OF THE WASH. POST, *supra* note 36, at 15–16.

271. *Id.* at 19; COHN, *supra* note 3, at 143.

272. STAFF OF THE WASH. POST, *supra* note 36, at 17.

273. COHN, *supra* note 3, at 143.

274. STARR, REMEDY AND REACTION, *supra* note 66, at 203; *see also* MCDONOUGH, INSIDE NATIONAL HEALTH REFORM, *supra* note 4, at 76 (wryly observing that "[a]ll participants rejected the word *deal* to describe their deals").

275. STARR, REMEDY AND REACTION, *supra* note 66, at 205; COHN, *supra* note 3, at 144.

276. STARR, REMEDY AND REACTION, *supra* note 66, at 230.

277. *See* Robert Pear & Steven Greenhouse, *Accord Reached on Insurance Tax for Costly Plans*, N.Y. TIMES (Jan. 14, 2010), https://www.nytimes.com/2010/01/15/health/policy/15health.html [https://perma.cc/BE9S-N3DM]. Before that deal could be enacted into law, Senator Ted Kennedy died, meaning the Democrats lost their supermajority in the Senate. STARR, REMEDY AND REACTION, *supra* note 66, at 230–31. As a workaround, the Democrats included a provision in HCERA that scaled back the tax. *Id.* at 234.

any tax or fee imposed on the medical device industry.[278] Ultimately, the ACA included a tax estimated to bring in $20 billion over ten years, a substantially smaller amount than that which was proposed.[279] Likewise, AHIP (formerly American Health Insurance Plans) initially agreed originally to play a cooperative role, but it "never made a deal with the Senate Finance Committee or the White House," and relations between the two sides ultimately soured.[280] The insurance industry, meanwhile, was in a poor position to resist the imposition of the health insurance tax discussed above, given that they had circulated a pair of reports predicting dire premium increases if the ACA were passed, which Democrats interpreted as an underhanded way to sabotage the legislation.[281] Finally, IPAB was requested by the Blue Dog Democrats to ensure that the bill addressed deficits and rising health care costs,[282] and so it was added to the ACA despite opposition from a wide swathe of provider groups and members of Congress.[283]

The legislative approach of "at the table or on the menu" may well have been necessary to enact the ACA. For instance, the pharmaceutical industry alone reportedly "had a $200 million war chest ready to spend on health care reform."[284] Billy Tauzin, the then-President of PhRMA, attested that he "knew [the Democrats] could never get sixty votes in the Senate if the drugmakers switched sides and began financing a different set of ads."[285] Likewise, John McDonough concludes that the deal with the pharmaceutical industry was necessary since it "turned a potentially fatal reform opponent into a crucial reform supporter. . . . [and that] it is hard to imagine a successful legislative outcome had the pharmaceutical industry been on the other side."[286]

Nevertheless, this approach had two vulnerabilities that undermined the ACA post-enactment. First, the deals with industry groups—in particular the one with PhRMA—generated a lot of negative media coverage, and created the perception among many that the law was a special interest giveaway.[287] These deals also struck many observers as a betrayal of

278. STEVEN BRILL, AMERICA'S BITTER PILL: MONEY, POLITICS, BACKROOM DEALS, AND THE FIGHT TO FIX OUR BROKEN HEALTHCARE SYSTEM 109–10 (2015); MCDONOUGH, INSIDE NATIONAL HEALTH REFORM, *supra* note 4, at 262.

279. MCDONOUGH, INSIDE NATIONAL HEALTH REFORM, *supra* note 4, at 262.

280. STARR, REMEDY AND REACTION, *supra* note 66, at 218–19.

281. COHN, *supra* note 3, at 182; MCDONOUGH, INSIDE NATIONAL HEALTH REFORM, *supra* note 4, at 258–59.

282. Oberlander & Spivack, *supra* note 175, at 488.

283. *Id.* at 489; McDonough, *In Defense of the Independent Payment Advisory Board*, *supra* note 182, at 467.

284. COHN, *supra* note 3, at 144.

285. BRILL, *supra* note 278, at 126.

286. MCDONOUGH, INSIDE NATIONAL HEALTH REFORM, *supra* note 4, at 77.

287. *See* COHN, *supra* note 3, at 145; STARR, REMEDY AND REACTION, *supra* note 66, at 205.

President Obama's pledges to conduct the negotiations over the Affordable Care Act in a public and transparent fashion.[288]

Second, because this strategy was (of necessity) formulated solely with enactment and not entrenchment in mind, it was especially vulnerable to "legislative drift"—that a future Congress would not maintain the arrangements struck by the Congress that enacted the ACA.[289] As Eric M. Patashnik has written, "reforms must continuously generate political support if they are to stick."[290] Otherwise, changes in the composition of Congress or the Presidency, or changes in the preferences of members of Congress or the President, can leave any provisions vulnerable to repeal.[291] The medical device tax, health insurance tax, Cadillac tax, and IPAB did not generate their own political support. These provisions were intensely unpopular among health care industry groups, and there were no powerful countervailing groups that supported these provisions (unless one counts economists and policy wonks).[292] Indeed, these provisions were only enacted because they were tied together with the law's other, more popular, provisions.[293] Once the ACA was enacted, however, these provisions could be individually repealed without dooming the law as a whole.[294] Thus, although industry groups had grudgingly acceded to some of these provisions before the ACA was enacted, it was foreseeable that they would lobby for the provisions' repeal post-enactment.[295] Although the threat of President Obama's veto held efforts to repeal these provisions at bay for a

288. *See* BRILL, *supra* note 278, at 101; COHN, *supra* note 3, at 145.

289. Jonathan R. Macey, *Separated Powers and Positive Political Theory: The Tug of War over Administrative Agencies*, 80 GEO. L.J. 671, 673 (1992) (defining "legislative drift").

290. Eric M. Patashnik, *Why Some Reforms Last and Others Collapse: The Tax Reform Act of 1986 Versus Airline Deregulation*, *in* LIVING LEGISLATION: DURABILITY, CHANGE, AND THE POLITICS OF AMERICAN LAWMAKING, *supra* note 57, at 146, 148 [hereinafter Patashnik, *Why Some Reforms Last and Others Collapse*].

291. *Cf. id.* at 156.

292. Margot Sanger-Katz, *Another of Obamacare's Unloved Provisions Is Gone*, N.Y. TIMES (Feb. 9, 2018), https://www.nytimes.com/2018/02/09/upshot/obamacare-ipab-medicare-congress.html [https://perma.cc/7638-ANQK].

293. *See id.*

294. *Id.*

295. *See* Patashnik & Zelizer, *supra* note 202, at 1076. In fact, some health scholars and policymakers were dubious that some of these provisions would be implemented even around the time that the ACA was being enacted. *See, e.g.*, Douglas Holtz-Eakin & Michael J. Ramlet, *Health Care Reform Is Likely to Widen Federal Budget Deficits, Not Reduce Them*, 29 HEALTH AFFS. 1136, 1139 (2010); *see also* Christina S. Ho, *Budgeting on Autopilot: Do Sequestration and the Independent Payment Advisory Board Lock-In Status Quo Majority Advantage?*, 50 TULSA L. REV. 695 (2015) (critiquing precommitment devices like IPAB as disingenuous, in part because they purport to be binding when they are not).

while, the dam broke once he left office and the provisions were repealed in fairly quick succession.[296]

3. *The United States' Health Care Policy Trap*

One last major obstacle to health care reform was what sociologist Paul Starr has referred to as the United States' health care "policy trap": the ways in which the United States' history of incremental coverage expansions impeded further reform efforts.[297] By the time the ACA was being considered, most Americans—whom Starr refers to as the "protected public"—already had some kind of health insurance coverage, either through their employer, or programs like Medicare, Medicaid, or the Veterans Health Administration.[298] Although some members of the protected public may have been sympathetic toward extending insurance coverage to the forty-seven million or so people who were uninsured prior to the passage of the ACA, they were also wary of any reform that could potentially jeopardize their own coverage.[299] Further compounding this problem, the design of Medicare contributed to the feeling among many beneficiaries that they had earned their coverage (in contrast to the remaining uninsured), and industry groups had built profitable arrangements based on the structure of the current system.[300]

The ACA's architects were well aware of this problem. Many of them had worked on the Clinton health care reform, which had "burned [the] lesson into the minds of would-be reformers [that] Americans with private insurance from their employers were reluctant to give it up."[301] With that lesson in mind, a "rough consensus . . . [developed] within the Democratic establishment" that health care reform needed to "minimiz[e] disruption to existing insurance arrangements."[302] This meant adopting an incremental approach that built on the existing health care financing system to extend

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296. Sarah Ferris, *White House Would 'Strongly Oppose' Cadillac Tax Repeal*, HILL (Dec. 9, 2015, 3:08 PM), https://thehill.com/policy/healthcare/262666-spokesman-white-house-would-strongly-oppose-cadillac-tax-repeal/ [https://perma.cc/FNS2-DSGR]; Jerry Geisel, *Obama Threatens Veto on Medical Device Tax Repeal*, BUS. INS. (June 16, 2015), https://www.businessinsurance.com/article/00010101/NEWS03/150619877/Obama-threatens-veto-on-medical-device-tax-repeal [https://perma.cc/UX65-7UXB].

297. STARR, REMEDY AND REACTION, *supra* note 66, at 41; *see also* JACOB S. HACKER, THE DIVIDED WELFARE STATE: THE BATTLE OVER PUBLIC AND PRIVATE SOCIAL BENEFITS IN THE UNITED STATES (2002); Jacob S. Hacker, *The Historical Logic of National Health Insurance: Structure and Sequence in the Development of British, Canadian, and U.S. Medical Policy*, 12 STUD. AM. POL. DEV. 57 (1998).

298. STARR, REMEDY AND REACTION, *supra* note 66, at 7.

299. *Id.*; *see also* Arnold J. Rosoff, *Of Stars and Proper Alignment: Scanning the Heavens for the Future of Health Care Reform*, 159 U. PA. L. REV. 2083, 2104 (2011).

300. Starr, *Built to Last?*, *supra* note 205, at 322–23.

301. COHN, *supra* note 3, at 45.

302. *Id.* at 74.

coverage to the uninsured, but did not radically disrupt the existing system.[303] Congress and the Obama Administration ultimately settled on a multi-pronged approach that expanded Medicaid coverage and subsidized private coverage for low-income Americans, established new health insurance exchanges, imposed new mandates on individuals and employers, and adopted a suite of other regulations designed to make health insurance coverage more accessible and generous.[304]

This strategy had an obvious downside: complexity. The U.S. health care financing system was already notoriously complex even before the enactment of the ACA, stitching together what are effectively single-payer programs (Medicare Parts A and B), socialized systems (the Department of Veterans Affairs), and several different flavors of private insurance (employer-sponsored coverage, individual market coverage, Medicare Advantage, Medicaid managed care, and supplemental private insurance).[305] The ACA's intricate structure, which relied on an array of new mandates and subsidies, as well as both state and federal exchanges, only exacerbated this complexity.[306] This complex architecture in turn likely undermined political support for the law by making it more difficult for its supporters to explain its benefits,[307] and opening the law up to confusion and misrepresentation.[308]

Yet the problem runs even deeper than that: the ACA's own design operated to conceal the role of government in producing the benefits it provides. The ACA was, to a large extent, erected upon what Suzanne Mettler calls the "submerged state": "a conglomeration of federal policies that function by providing incentives, subsidies, or payments to private organizations or households to encourage or reimburse them for conducting activities deemed to serve a public purpose."[309] Many of the ACA's reforms work by requiring private health insurance coverage to be more generous, accessible, and affordable.[310] Yet most people are likely unaware of many

303. *See* Theodore R. Marmor & Jonathan Oberlander, *The Health Bill Explained at Last*, N.Y. REV. BOOKS, Aug. 19, 2010, at 2.

304. *See* Hoffman, *Three Models of Health Insurance*, *supra* note 8, at 1886–87.

305. *See* EMANUEL, *supra* note 53, at 365 ("The complex US system has every kind of financing arrangement.").

306. *See* Allison K. Hoffman, *Health Care's Market Bureaucracy*, 66 UCLA L. REV. 1926, 1963–67 (2019) (describing how the ACA's exchanges necessitated a whole new regulatory structure).

307. Fuse Brown, *Developing a Durable Right to Health Care*, *supra* note 6, at 487; William M. Sage, *Brand New Law! The Need to Market Health Care Reform*, 159 U. PA. L. REV. 2121, 2130–31 (2011).

308. *See* STARR, REMEDY AND REACTION, *supra* note 66, at 10.

309. SUZANNE METTLER, THE SUBMERGED STATE: HOW INVISIBLE GOVERNMENT POLICIES UNDERMINE AMERICAN DEMOCRACY 4 (2011).

310. *See* Baker, *supra* note 8, at 1579–80; Erin C. Fuse Brown, Matthew B. Lawrence, Elizabeth Y. McCuskey & Lindsay F. Wiley, *Social Solidarity in Health Care, American-Style*, 48 J.L., MED. & ETHICS 411, 412 (2020).

of these reforms, even those who directly benefited from them.[311] Even some people who obtain health insurance coverage on the ACA's exchanges may not be aware that the ACA was responsible for their coverage. Unlike Medicare, where recipients receive a card that says "Medicare," Americans who obtain coverage on the ACA exchanges do so through private health insurance companies or state Medicaid programs.[312]

In sum, an incremental approach may have been necessary to enact the ACA, but it resulted in a complex and submerged structure that undermined political support for the law post-enactment. For years after the ACA was enacted, polls consistently found a striking lack of public awareness about the ACA's benefits.[313] This lack of awareness provided an opening for Republicans trying to repeal the law: in 2017, a poll found that only sixty-one percent of adults were aware that many people would lose coverage through Medicaid or subsidized private coverage in the event that the ACA were repealed.[314] The Obama Administration was well-aware of the obscurity of the ACA's benefits, and did its best to educate the public about the law.[315] However, it wasn't until President Obama left office and President Trump and congressional Republicans tried to repeal the law that there began to be a wider appreciation of its benefits.[316]

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311. *See* Gluck & Scott-Railton, *supra* note 16, at 554; Patashnik & Zelizer, *supra* note 202, at 1079; Starr, *Built to Last?*, *supra* note 205, at 328.

312. Perry Bacon, *Obama May Call It 'Obamacare,' But Not People Promoting It on the Ground*, NBC NEWS (Sept. 26, 2013, 10:21 AM), https://www.nbcnews.com/news/world/obama-may-call-it-obamacare-not-people-promoting-it-ground-flna8c11263390 [https://perma.cc/7ZF5-S3DJ]. The ACA's federalist structure likely also inhibited public awareness about its benefits. Indeed, some state policymakers in states that were strongly opposed to the President took advantage of the ACA's complex federalist model and intentionally rebranded their state exchanges to disguise their relation to Obamacare. *See id.*; Starr, *Built to Last?*, *supra* note 205, at 328. Yet this same federalist structure also served to entrench the ACA, as it enabled state and local policymakers in areas that were deeply opposed to President Obama to expand coverage and ensure that their constituents reaped the law's benefits. *See* Abbe R. Gluck & Nicole Huberfeld, *What Is Federalism in Healthcare For?*, 70 STAN. L. REV. 1689, 1700–01 (2018) (describing the "'secret boyfriend model' of state-federal relations").

313. *See, e.g.*, Sarah Kliff, *Poll: Obamacare's Biggest Beneficiaries Are Skeptical of Obamacare*, WASH. POST (Feb. 22, 2013, 2:05 PM), https://www.washingtonpost.com/news/wonk/wp/2013/02/22/poll-obamacares-biggest-beneficiaries-are-skeptical-of-obamacare/ [https://perma.cc/QZ5H-9G3F]; HENRY J. KAISER FAM. FOUND., HEALTH TRACKING POLL: JANUARY 2014 (2014), https://www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-january-2014/ [https://perma.cc/WX6N-AE6Z].

314. Kyle Dropp & Brendan Nyhan, *One-Third Don't Know Obamacare and Affordable Care Act Are the Same*, N.Y. TIMES (Feb. 7, 2017), https://www.nytimes.com/2017/02/07/upshot/one-third-dont-know-obamacare-and-affordable-care-act-are-the-same.html [https://perma.cc/QF6P-FUPL].

315. Barack Obama, President, Remarks on the Patient Protection and Affordable Care Act in Miami, Florida, *in* 2016 DAILY COMP. PRES. DOC. No. 201600712, at 3 (Oct. 20, 2016), https://www.govinfo.gov/content/pkg/DCPD-201600712/pdf/DCPD-201600712.pdf [https://perma.cc/9RA8-TDFF] ("So you're getting better quality even though you don't know that Obamacare is doing it.").

316. *KFF Health Tracking Poll: The Public's Views on the ACA*, KFF (May 31, 2023), https://www.kff.org/interactive/kff-health-tracking-poll-the-publics-views-on-the-aca/#?response=Favorable--Unfavorable&aRange=all [https://perma.cc/XN5E-UXWZ]; *see also* Gluck & Scott-

Finally, another aspect of the incremental approach—namely, its reliance on mandates for individuals and employers—also made it more vulnerable both politically and legally. The individual mandate and the contraceptive coverage mandate proved to be two of the most controversial parts of the ACA, and served as focal points for opposition to the law. Moreover, as Justice Ginsburg recognized in her partial concurrence in *NFIB v. Sebelius*, the Court majority's narrow reading of the Constitution's Commerce Clause in that case (which nearly doomed the ACA) implied that a single-payer program would have actually been less legally vulnerable.[317] Likewise, in *Hobby Lobby*, Justice Alito wrote that the government failed to use the least-restrictive-means of ensuring cost-free access to contraception, since it could have publicly funded the provision of contraceptives, rather than relying on an employer mandate.[318] The perhaps surprising implication from both decisions is that if Congress had taken a more radical approach by directly providing health care benefits, rather than relying on an incremental combination of mandates and subsidies, then it would have been on firmer legal footing.

D. Summary

The ACA's ghosts illustrate the extent to which legislators must grapple with "enactment-entrenchment tradeoffs": that is, tradeoffs between the legislative provisions necessary to enact legislation and those that increase the odds that it will survive post-enactment.

The ACA's architects faced three key obstacles which had thwarted previous health care reform efforts: fiscal constraints, interest group opposition, and the United States' health policy trap. In addition, a polarized political environment meant that they had to rely solely on Democrats to pass the legislation. In response, reformers adopted legislative strategies aimed at overcoming these obstacles. However, each of these strategies had feedback effects that undermined the law post-enactment, and ultimately contributed to the ACA's ghosts.

Railton, *supra* note 16, at 535 ("Ironically, it took a change in administration to really entrench the law, or at least reveal how entrenched it already had become.").

317. *See* 567 U.S. 519, 589 (2012) (Ginsburg, J., concurring and dissenting).

318. Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682, 728–29 (2014).

TABLE 1: THE AFFORDABLE CARE ACT AND ENACTMENT-ENTRENCHMENT TRADEOFFS

Legislative Obstacles	**Enactment Strategy**	**Self-Undermining Feedback Mechanisms**
Fiscal Constraints	Deficit Neutrality $900 Billion Cap	Under-Funding Backloaded Benefits
Interest Group Opposition	"At The Table or On The Menu"	Bad Optics Legislative Drift
The U.S. Health Care Policy Trap	Incrementalism	Complexity The Submerged State Reliance on Mandates

Table 1 summarizes these enactment-entrenchment tradeoffs. First, to address lawmakers' and the public's concerns about fiscal constraints, President Obama pledged that the law would not exceed around $900 billion in costs and that it would pay for itself. To fulfill these pledges, Democrats limited the generosity of the benefits the ACA provided and backloaded the main insurance coverage benefits, which had the effect of undermining political support for the law, increasing the risk of legal challenges, and prompting the inclusion of the fiscally unsustainable CLASS Act. Second, to avoid large-scale opposition from powerful interest groups, reformers adopted the strategy of alternately negotiating with key interest groups and pushing through reforms over their objections. This approach turned into a public relations fiasco, and led to the inclusion of several cost-control and revenue provisions that lacked political support to survive once they were no longer tied to the rest of the ACA. Third, to address the U.S. health care policy trap, reformers settled on an incremental approach designed to patch the holes in the existing system, rather than completely overhauling it. The resulting complexity and submerged design of the ACA diminished the salience of the law's benefits, and further made the law more politically and legally vulnerable through relying on mandates rather than direct spending.

To be sure, this analysis is oversimplified in certain respects. For one thing, the enactment strategies described above were sometimes geared toward addressing more than one legislative obstacle. For instance, the ACA's incremental approach was aimed at overcoming not only the United States' health care policy trap, but also fiscal constraints *and* potential resistance from interest groups who would be opposed to more radical

changes in the health care system.[319] Likewise, each of these enactment strategies likely had more self-undermining feedback effects than is represented by the Table. For instance, the necessity of designing the ACA in a deficit neutral manner and minimizing its cost also contributed to the law's reliance on legally and politically vulnerable mandates, rather than on public spending.[320] Yet the purpose of this Article is not to chart out all of the reverberations of these different effects in a comprehensive manner, nor is it to suggest that these are the only reasons for the ACA's vulnerability. It is, rather, to illustrate how the legislative strategies that were deemed necessary to enact the ACA also served to make the law more politically and legally vulnerable post-enactment.

IV. THE VULNERABILITY OF NEWLY ENACTED SOCIAL LEGISLATION

A. *Is the Truism Still True?*

In one sense, the experience of the ACA substantiates the conventional wisdom that laws establishing social programs are incredibly difficult to dismantle.[321] The ACA has reshaped the health care system in important ways,[322] and has improved financial security, access to health care, and health outcomes for millions of Americans.[323] Despite 2,000 legal challenges, over 70 congressional attempts at repeal, and administrative sabotage by the Trump Administration, the ACA is still the law of the land, and Republicans have (at least for the time being) apparently given up trying to repeal it.[324] Moreover, Congress has since passed legislation that has temporarily strengthened the subsidies on the ACA exchanges,[325] and the

319. *See* METTLER, *supra* note 309, at 104. In an interview with Paul Pierson, journalist Dylan Matthews seems to suggest that the ACA's incremental approach was primarily aimed at overcoming interest group resistance, and that this approach made the law more politically vulnerable post-enactment. Dylan Matthews, *A Political Scientist Explains the Real Reason Obamacare Repeal Is So Hard*, VOX (July 28, 2017, 10:23 AM), https://www.vox.com/2017/3/24/14953202/obamacare-repeal-ryan-trump-paul-pierson-retrenchment [https://perma.cc/NJK8-472Z] ("[A version of the ACA] that had done less to appease [] interest groups — maybe by doing more to expand public insurance programs like Medicaid and Medicare — might have been harder to pass initially, but once passed might have been better at creating its own constituencies.").

320. *See* Sage & Westmoreland, *Following the Money*, *supra* note 231, at 437–41.

321. *See* Dylan Matthews, *Who Killed the Expanded Child Tax Credit?*, VOX (Apr. 18, 2022, 8:30 AM), https://www.vox.com/future-perfect/2022/4/18/23026908/child-tax-credit-joe-manchin-policy-feedback-partisan [https://perma.cc/N549-EAYM] ("The 2017 rescue of Obamacare was a great illustration of a classic political science theory from Berkeley's Paul Pierson.").

322. *See supra* notes 8–15 and accompanying text.

323. *See supra* notes 21–24 and accompanying text.

324. *See supra* notes 17, 20 and accompanying text.

325. *See supra* note 18.

Biden Administration has fixed the so-called "family glitch" that made some families ineligible for subsidized coverage on the exchanges.[326]

Upon closer inspection, however, the experience of the ACA does not align so neatly with the conventional wisdom. After all, the ACA did not escape unscathed, to say the least. Nearly fourteen years after the ACA was signed into law, around two million poor Americans, mostly people of color, are still without life-saving Medicaid coverage. The individual mandate, once thought to be so central to the ACA that the law could not survive without it, is effectively gone, further increasing the number of uninsured. Several other provisions intended to improve access to health care and financial security, control health care costs, and reduce the deficit are gone as well. Moreover, if just a few things had gone differently, the whole ACA might no longer be around at all today.[327]

To be sure, the ACA ultimately survived. Yet as noted earlier, the experience of the recently expanded Child Tax Credit seems to contradict this conventional wisdom even more directly. In March 2021, Congress temporarily expanded the Child Tax Credit as part of the American Rescue Plan Act.[328] This expanded Child Tax Credit was groundbreaking in extending substantial cash support to nonworking families and childless workers,[329] and was credited with lifting 3.7 million children out of

326. Kaye Pestaina & Karen Pollitz, *Navigating the Family Glitch Fix: Hurdles for Consumers with Employer-Sponsored Coverage*, KFF (Nov. 21, 2022), https://www.kff.org/health-reform/issue-brief/navigating-the-family-glitch-fix-hurdles-for-consumers-with-employer-sponsored-coverage/ [https://perma.cc/9F25-TPSS]. It's also conceivable that some of the ACA's ghosts could be "resurrected," at least in part. For instance, advocates are still working to convince policymakers in the remaining holdout states to implement the ACA's Medicaid expansion. *See* Krista Mahr & Daniel Payne, *The Medicaid Expansion Holdouts*, POLITICO (Mar. 24, 2023, 10:00 AM), https://www.politico.com/newsletters/politico-pulse/2023/03/24/the-medicare-expansion-holdouts-00088622 [https://perma.cc/K666-WFMV]. In addition, in early 2023, the Departments of Health and Human Services, Labor, and Treasury issued a proposed rule that, if finalized, would, among other things, rescind the moral exemption to the contraceptive coverage mandate. Coverage of Certain Preventive Services Under the Affordable Care Act, 88 Fed. Reg. 7236 (proposed Feb. 2, 2023) (to be codified at 26 C.F.R. pt. 54; 29 C.F.R. pt. 2590; 45 C.F.R. pts. 147, 156).

327. One might object that the conventional wisdom does not apply to the ACA's cost-control and deficit-control provisions, but rather only to its coverage provisions. It is not clear to me that that is correct as a description of the conventional wisdom, since I'm not sure that the the conventional wisdom is well-specified on this point. In any case, the ACA's cost and deficit ghosts do serve to undermine a "strong" version of the conventional wisdom that predicts that major benefit-conferring provisions in a piece of legislation will be entrenched, *together with the rest of the legislation (or at least with its other central provisions)*. Furthermore, the ACA's coverage ghosts—as well as the near-death experiences of the ACA as a whole—would also serve to undermine even a "weak" version of the conventional wisdom that predicts that only the benefit-conferring provisions will be entrenched (and not necessarily the rest of the legislation that they comprise).

328. American Rescue Plan Act of 2021 § 9611, 26 U.S.C. § 24(i).

329. *See* Jurow Kleiman, *supra* note 65, at 536.

poverty.[330] To limit the cost of the law and because there likely wasn't political support to enact a permanent expansion, Congress only funded the program for that tax year, but supporters gambled that the provision would prove so politically popular that Congress would ultimately extend it.[331] Yet this political calculation proved incorrect and Congress let the expansion expire at the end of the year.[332] Likewise, during the COVID-19 pandemic, the federal government enacted a sweeping set of temporary expansions to other social safety net programs (including cash transfers, food assistance, health insurance, housing assistance, and job-related support), yet these expansions have—for the most part—lapsed.[333]

Some large-scale empirical research also provides support for the notion that social legislation in the United States is vulnerable, at least during the first few years after its enactment. Although this research is focused on federal programs generally, not social programs in particular, it finds that there is a non-negligible probability that federal programs will be repealed within the first decade after enactment.[334] This in turn is consistent with the finding in the policy feedback literature that it takes time for government programs to become entrenched.[335] Putting all of these pieces together, it seems like the conventional wisdom may need to be revised: newly enacted social legislation, such as the ACA or the expanded Child Tax Credit, is in fact vulnerable to being repealed or invalidated.

Was previous research wrong that social programs are difficult to eliminate, or is the vulnerability of such programs a new phenomenon? Paul Pierson and Jacob Hacker suggest that the latter is the case: they theorize that, as a result of the rise of asymmetric polarization, "efforts at retrenchment that could not have survived in the past now have some prospect of success."[336] This theory seems borne out by the near-repeals of the ACA, where the Republican party turned opposition to the ACA into a "loyalty litmus test,"[337] despite the fact that their efforts to repeal the ACA

330. Leah Hamilton et al., *The Impacts of the 2021 Expanded Child Tax Credit on Family Employment, Nutrition, and Financial Well-Being: Findings from the Social Policy Institute's Child Tax Credit Panel (Wave 2)* 3 (Brookings Glob., Working Paper No. 173, 2022).

331. *See* Rachel M. Cohen, *Can the Expanded Child Tax Credit Come Back From the Dead?*, VOX (Apr. 29, 2022, 6:30 AM), https://www.vox.com/23040707/child-tax-credit-ctc-midterms [https://perma.cc/23T5-FPDR].

332. *See* Hammond, Jurow Kleiman & Scheffler, *supra* note 64.

333. *See id.*

334. *See* Christopher R. Berry, Barry C. Burden & William G. Howell, *After Enactment: The Lives and Deaths of Federal Programs*, 54 AM. J. POL. SCI. 1, 6 (2010) ("In its first 10 years of life a program has a 4–5% chance of either mutating or dying, and a 1% chance of outright termination *every year*. Having survived for roughly a decade, however, programs become increasingly likely to continue without alteration.").

335. Béland, Rocco & Waddan, *supra* note 219, at 396.

336. *See* Hacker & Pierson, *The Dog that Almost Barked*, *supra* note 47, at 574.

337. Gluck & Huberfeld, *supra* note 312, at 1759.

quickly proved deeply unpopular.[338] Nor is polarization merely an "exogenous" factor: it also serves to shape the design of legislation. Again, in the case of the ACA, because polarization made it more difficult to enact the bill, it also limited lawmakers' ability to strategically design it so that it stood the best chance of becoming entrenched.[339]

Polarization has also made social legislation more legally vulnerable. Judges have become more closely aligned with political ideologies and parties,[340] enabling even legal challenges to the ACA that were widely viewed as frivolous to come remarkably close to toppling the law.[341] The advent of "judge shopping" has further enabled litigants to bring their arguments before a judge likely to be predisposed in their favor.[342] For instance, a single federal judge in the Northern District of Texas, Judge Reed O'Connor, has been responsible for issuing some of the most high-profile rulings against the ACA, and has been described as the "go-to judge for Obamacare's legal opponents."[343] By contrast, some conservative lower-court judges who declined to strike down the ACA reportedly lost favor as potential Supreme Court nominees.[344]

That being said, polarization alone does not fully account for why social legislation has become more vulnerable. In particular, there are at least three other developments that appear to have intensified the tradeoffs between enacting and entrenching major social legislation. Because of these developments, the strategies involved in enacting major social legislation today tend to shape legislation in ways that create self-undermining feedback effects.

One such development is the rise of budgetary constraints. Prior to 1974, Congress did not have a formal budgetary process, and budgeting was done

338. Hacker & Pierson, *The Dog that Almost Barked*, *supra* note 47, at 573.

339. *See id.* at 565.

340. *See, e.g.*, Richard L. Hasen, *Polarization and the Judiciary*, 22 ANN. REV. POL. SCI. 261, 263–70 (2019).

341. *See, e.g.*, Allison K. Hoffman, *Giving* California v. Texas *the Attention It Deserved*, REGUL. REV. (July 20, 2021), https://www.theregreview.org/2021/07/20/hoffman-california-v-texas [https://perma.cc/447L-KJ7R] (decrying "how much time, energy, and attention a frivolous case such as *California v. Texas* has absorbed").

342. *See* Jonas Anderson, *Judge Shopping in the Eastern District of Texas*, 48 LOY. U. CHI. L.J. 539, 546 (2016); Alex Botoman, Note, *Divisional Judge-Shopping*, 49 COLUM. HUM. RTS. L. REV. 297, 298 (2018); Adam Liptak, *Texas' One-Stop Shopping for Judge in Health Care Case*, N.Y. TIMES (Dec. 24, 2018), https://www.nytimes.com/2018/12/24/us/politics/texas-judge-obamacare.html [https://perma.cc/9H77-X5S8].

343. Tierney Sneed, *Judge Notorious for Anti-Obamacare Rulings Has Another Crack*, CNN POL. (Jan. 28, 2022, 7:56 AM), https://www.cnn.com/2022/01/28/politics/obamacare-reed-oconnor-biden-doj-health/index.html [https://perma.cc/7MPX-TY64]. Most recently, Judge O'Connor held part of the ACA's preventive services requirement unconstitutional. Braidwood Mgmt. Inc. v. Becerra, 627 F. Supp. 3d 624 (N.D. Tex. 2022).

344. Gluck & Scott-Railton, *supra* note 16, at 518.

on an ad hoc basis.[345] Thus, when Congress enacted Medicare and Medicaid in 1965, it did not need to grapple with these programs' ten-year CBO scores, since the CBO did not yet exist.[346] Tim Westmoreland has shown how the enactment of the Congressional Budget and Impoundment Control Act of 1974, together with subsequent budgetary measures such as PAYGO, have not only made it harder to enact legislation,[347] but have also served to skew legislation in ways that are "counterintuitive, inefficient, and unfair."[348] When it comes to health care policy, budgetary constraints tend to distort health care policies by favoring "policies that let sick people die rather than incur future government-financed health costs," as well as "policies that keep expenses off the federal books by working through mandates rather than spending."[349]

These same budgetary constraints have also made it more difficult to entrench social legislation, since the options that legislators have to reduce the cost of social legislation tend to render it more vulnerable post-enactment. For instance, legislators can, as the ACA's architects did, reduce the generosity of the law's benefits or extend those benefits further out into the future, thus diminishing political support for the law during the early years when it is most vulnerable.[350] Alternatively, legislators can, as the architects of the expanded Child Tax Credit did, fund the law's benefits only temporarily, running the risk that they will not be extended.[351] In addition, to the extent that Westmoreland is correct that fiscal constraints make social legislation more reliant on mandates, that only makes such legislation more politically and legally vulnerable.[352]

A second development is that interest groups have become more powerful over time, as economic inequality has soared.[353] This in turn has made it more difficult for lawmakers to enact major social legislation, since many interest groups have a strong interest in preserving the status quo.[354] And as is illustrated by the history of the ACA, each of the two main options that lawmakers have for overcoming interest group resistance carries the

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345. SALDIN, *supra* note 107, at 20; Tim Westmoreland, *Standard Errors: How Budget Rules Distort Lawmaking*, 95 GEO. L.J. 1555, 1560 (2007) [hereinafter Westmoreland, *Standard Errors*].

346. *See* Sage & Westmoreland, *Following the Money*, *supra* note 231, at 435.

347. Tim Westmoreland, *Can We Get There from Here? Universal Health Insurance and the Congressional Budget Process*, 96 GEO. L.J. 523, 533 (2008) [hereinafter Westmoreland, *Can We Get There from Here?*]; Westmoreland, *Invisible Forces at Work, supra* note 239, at 882.

348. Westmoreland, *Standard Errors*, *supra* note 345, at 1583.

349. Westmoreland, *Can We Get There from Here?*, *supra* note 347, at 525.

350. COMM. FOR A RESPONSIBLE FED. BUDGET, *supra* note 254, at 12–13.

351. *See supra* notes 328–33 and accompanying text.

352. *See* Sage & Westmoreland, *Following the Money*, *supra* note 231.

353. Hacker & Pierson, *Policy Feedback in an Age of Polarization*, *supra* note 205, at 21.

354. *See generally* FRANK R. BAUMGARTNER, JEFFREY M. BERRY, MARIE HOJNACKI, DAVID C. KIMBALL & BETH L. LEECH, LOBBYING AND POLICY CHANGE: WHO WINS, WHO LOSES, AND WHY (2009).

risk of making social legislation more politically vulnerable. For instance, lawmakers can put these groups "at the table" by making concessions to them, but doing so may erode political support for the legislation by creating the appearance of favoritism or even corruption—and there is no guarantee that these groups will adhere to such agreements indefinitely. Alternatively, lawmakers can simply override interest groups' objections and put them "on the menu," but that strategy too carries the risk that interest groups will subvert the legislation post-enactment.

A third development is the ascendance of the submerged state, the array of important yet largely imperceptible government benefits that are channeled through the tax code or through private organizations. Suzanne Mettler has documented how in recent decades, more visible government programs (such as Pell Grants and welfare) have diminished, while the submerged state has grown.[355] Today, legislators trying to enact new social programs must navigate amidst a thicket of existing programs, many of which obscure the role of government from the public. Because institutions tend to be resistant to change, American policymakers designing social legislation are often constrained to operate in a path-dependent manner, building on these programs, rather than wiping the slate clean and enacting ambitious new programs from scratch.[356] This in turn has the effect of making newly enacted social programs less salient.[357] Also, to the extent that—as in the case of the ACA—this incremental approach makes lawmakers more reliant on mandates, as opposed to direct spending, it makes social legislation more politically and legally vulnerable.[358]

B. Playing the Game Better

How can lawmakers better entrench social legislation so that it endures over time? Some policy feedback scholars have encouraged lawmakers to give more consideration to feedback effects, and in particular, to design legislation in ways that will maximize self-sustaining effects and minimize self-undermining ones.[359] These scholars have emphasized various general

355. METTLER, *supra* note 309, at 15–22; *see also* Gabriel Scheffler & Daniel E. Walters, *The Submerged Administrative State*, 3 WIS. L. REV. (forthcoming 2024) (on file with author) (making the case that administrative agencies have become increasingly submerged as well).

356. Berry et al., *supra* note 334, at 4. On the concept of path dependence and its applications to politics, see generally PAUL PIERSON, POLITICS IN TIME: HISTORY, INSTITUTIONS, AND SOCIAL ANALYSIS 17–53 (2004).

357. *See supra* Section III.C.3.

358. *See supra* Section III.C.3.

359. *See, e.g.*, HERTEL-FERNANDEZ, *supra* note 217, at 28 ("One goal of this brief is . . . to provide a framework for building in explicit processes to encourage greater consideration of feedback loops into policy proposal design and evaluation."); Patashnik & Weaver, *supra* note 217, at 1129 ("Many, though certainly not all, threats to political sustainability can be predicted in advance, if policymakers make feedback anticipation a critical element of the design process.").

features of a law that can help to entrench or undermine legislation, including phasing in benefits quickly and designing them so that they are both visible and traceable to the government.[360]

Could the ACA's architects really have avoided some of the law's ghosts simply by being more attentive to policy feedback effects (i.e., by "playing the game better")? Again, some scholars and commentators have suggested that if the ACA's main coverage provisions had been implemented more quickly and had been more generous, then the ACA would have benefitted from stronger political support early on, when it was most vulnerable.[361] Likewise, it seems plausible that the ACA's architects could have anticipated the vulnerability of its main cost-control provisions (such as IPAB, the Cadillac tax, and the industry taxes), since it was foreseeable that interest groups would continue to lobby for the repeal of these provisions after the ACA was enacted.[362] Thus, perhaps if the ACA's architects had been more attentive to concerns about legislative drift, then they could have better entrenched these provisions. For instance, perhaps they could have designed these provisions so that industry groups would have had to make costly up-front investments to conform to them in a way that gave these groups a stake in preserving the reforms.[363]

However, this Article provides reason to be skeptical of this approach: rather, it suggests that prioritizing entrenchment would likely have come at the cost of making the ACA less likely to be enacted in the first place. For example, it would have been difficult for the ACA's architects to have implemented the law's main insurance coverage provisions more quickly and to have made them more generous, without upsetting the careful calibration necessary to make the ACA deficit neutral and to meet President Obama's spending pledge. Likewise, if the ACA's cost-control provisions had imposed greater initial costs on interest groups, then these groups would likely have had greater incentive to oppose the ACA's enactment. In a zero-sum game where the strategies deemed best-suited to entrench social legislation are often directly at odds with those necessary to enact this legislation, legislators are highly constrained in their ability to prioritize

360. Béland et al., *Designing Policy Resilience*, *supra* note 225, at 283–84.

361. *See id.* at 283 ("Were the ACA to have delivered a larger number of salient benefits during the early years of implementation, Republicans may have found it more difficult (though likely not impossible) to reframe the law in purely partisan and racialized terms."); Ezra Klein, *Democrats, Here's How to Lose in 2022. And Deserve It.*, N.Y. TIMES (Jan. 21, 2021), https://www.nytimes.com/2021/01/21/opinion/biden-inauguration-democrats.html [https://perma.cc/Z9NK-92GW] ("Obamacare eventually became a political winner for Democrats, but it took the better part of a decade. A simpler, faster, more generous bill would have been better politics and better policy.").

362. *See supra* note 295 and accompanying text.

363. *Cf.* Patashnik, *Why Some Reforms Last and Others Collapse*, *supra* note 290, at 151–53 (describing, in general terms, how post-reform paths can vary depending on how reforms affect interest groups' investments).

entrenchment.[364] Thus, there is limited value in simply exhorting policymakers to pay greater attention to policy feedback effects.

C. Changing the Rules of the Game

Enactment-entrenchment tradeoffs are not the inevitable result of immutable laws of nature. Rather, they are the contingent products of laws and institutions. These laws and institutions represent the "rules of the game," or what Paul Starr (drawing on H.L.A. Hart) refers to as "rules of change." These are the "secondary or meta-rule[s] determining how changes are made."[365] In the United States, the rules of the game have evolved so as to make enactment-entrenchment tradeoffs more pronounced over time, particularly when it comes to enacting new social programs.

To minimize enactment-entrenchment tradeoffs then, lawmakers then must change the rules of the game.[366] There are at least two general ways in which this might be done: First, lawmakers could target the specific obstacles (e.g., budgetary constraints, interest group resistance, the U.S. health care policy trap) that cause lawmakers to resort to legislative strategies that undermine entrenchment. There are a variety of reforms that could potentially accomplish this aim. For instance, Tim Westmoreland has proposed changing the PAYGO process so that it does not impede enacting legislation that entails so-called "survivors' costs" (i.e., fiscal costs that result from prolonging people's lives).[367] Others have proposed making it harder to manipulate the CBO's scoring rules by requiring that the CBO use a broader array of time-windows instead of a ten-year window, or even setting restrictions on backloaded spending.[368] Loosening budget constraints in these ways could have the effect of diminishing, at least to some degree, the incentive to delay the implementation of benefits or reduce the generosity of benefits, both of which are at odds with entrenchment. Likewise, stronger campaign finance legislation could reduce the ability of interest groups to impede enactment, obviating the need to negotiate with

364. I am indebted to Erin Fuse Brown for formulating my argument in roughly this way.

365. STARR, ENTRENCHMENT, *supra* note 57, at 7. Although Starr is specifically referring to rules and procedures, the concept he articulates seems applicable to institutions as well. *See* Jenkins & Patashnik, *Living Legislation and American Politics*, *supra* note 58, at 14 ("Institutions allocate authority, enforce norms and duties, and determine the 'rules of the game.' It is therefore unsurprising that a law's development and downstream effects turn in part on how the law recasts, and is recast by, surrounding public authority.").

366. Or, to put it another way, "for 'things to stay as they are, things have to change.'" STARR, ENTRENCHMENT, *supra* note 57, at 3 (citing GIUSEPPE DI LAMPEDUSA, THE LEOPARD 40 (Archibald Colquhoun trans., 1960) (1958)).

367. Westmoreland, *Can We Get There from Here?*, *supra* note 347, at 536–37.

368. SALDIN, *supra* note 107, at 124; Arnold Kling, *The Congressional Budget Office and the Demand for Pseudoscience*, 36 YALE L. & POL'Y REV. 1, 13 (2017).

interest groups, and impeding their ability to undermine reforms post-enactment.[369]

Such proposals have been discussed in much greater detail elsewhere, and it is not within the purview of the Article to recapitulate their merits or demerits. What has not (to my knowledge) been discussed elsewhere, is that in addition to making it easier to enact legislation or harder to manipulate CBO's scoring rules, these proposals would also likely have the secondary effect of making it easier to entrench social legislation so that it endures over time. Again, this is because such proposals, if they were successful, would diminish the need to resort to enactment strategies that have self-undermining feedback effects.

Second, lawmakers could reduce the number of "vetogates" that bills must pass through in order to be enacted into federal law. The United States has more vetogates than any other large wealthy democratic country.[370] These include not only the constitutional requirements of bicameralism and presentment, but also rules and processes that Congress has imposed on itself, including—most importantly and controversially—the Senate filibuster.[371]

It might seem paradoxical to suggest that reducing the number of vetogates could make it easier to entrench social legislation, since the general assumption is that having a large number of vetogates makes legislation harder to repeal.[372] However, because vetogates give disproportionate power to a few members of Congress, they render the legislative obstacles described in this Article more potent, and make it more necessary to resort to legislative strategies that have self-undermining feedback effects. For instance, if not for the Senate filibuster, the budget hawks in the Senate would have had less leverage during the development of the ACA, and it might not have been necessary for President Obama to pledge to cap the ACA's cost at around $900 billion. This would in turn have had all kinds of ripple effects: for instance, congressional leaders might not have found it necessary to push back the implementation date of the main insurance coverage provisions until 2014, to slash the subsidies on the ACA exchanges, or to only partly fund the Medicaid expansion. If not for

369. *See* Ashley Balcerzak, *Could Campaign Finance Overhaul Help Solve Congressional Gridlock?*, OPEN SECRETS (Dec. 8, 2016, 5:28 PM), https://www.opensecrets.org/news/2016/12/could-campaign-finance-overhaul-solve-gridlock/ [https://perma.cc/MUQ4-FZZP].

370. *See* Alfred Stepan & Juan J. Linz, *Comparative Perspectives on Inequality and the Quality of Democracy in the United States*, 9 PERSPS. ON POL. 841, 844–45 (2011) (book review).

371. *See* William N. Eskridge, Jr., *Vetogates,* Chevron*, Preemption*, 83 NOTRE DAME L. REV. 1441, 1444–46 (2008) (describing nine different vetogates).

372. William N. Eskridge Jr., *Vetogates and American Public Law*, 31 J.L., ECON. & ORG. 756, 764 (2015) ("If vetogates make highly regulatory statutes hard to enact, they make highly regulatory laws doubly hard to repeal because most statutes create constituencies and reliance interests that engender extra opposition to changing or abandoning the statutory policy.").

the filibuster, health care interest groups would also likely have had less influence on the ACA, since winning the support of one Senator would not necessarily be enough.[373]

In short, even though eliminating the filibuster would mean that it would only take fifty-one votes in the Senate to repeal the ACA instead of sixty, it would also likely have resulted in health care reform legislation that was more popular and less legally vulnerable than the ACA proved to be. The pro-entrenchment effects of the latter would, in my view, likely outweigh the anti-entrenchment effects of the former. After all, Republicans failed to muster even the fifty-one votes in the Senate necessary to repeal those parts of the ACA that they could repeal through the budget reconciliation process.

Again, the costs and benefits of eliminating the Senate filibuster have been discussed extensively elsewhere, and it is not within the scope of this Article to recapitulate these tradeoffs.[374] Yet my hope is that calling attention to the problem of enactment-entrenchment tradeoffs, and the vulnerability of new social legislation, will bring to light a dimension of such proposals that has not yet been adequately recognized.

CONCLUSION

This Article attempts to solve a puzzle: what happened to the ACA's ghosts? And why did the ACA as a whole prove so vulnerable, given the conventional wisdom that social legislation is nearly impossible to dismantle?

The Article suggests that the answer lies, at least in part, in the tradeoffs that the ACA's architects were forced to make between enacting the law and ensuring its entrenchment. In order to enact the ACA, its architects were forced to pursue a legislative strategy that undermined the law politically and rendered it legally vulnerable.

All this is not to suggest that entrenchment of health care reforms is always normatively desirable.[375] In previous work, I have discussed circumstances under which entrenchment of health care laws may be undesirable,[376] for instance, if it prevents policymakers from updating these

373. *Cf. id.* at 762.

374. *See, e.g.*, Gerard N. Magliocca, *Reforming the Filibuster*, 105 NW. U. L. REV. 303 (2011); ALEX TAUSANOVITCH & SAM BERGER, CTR. FOR AM. PROGRESS, THE IMPACT OF THE FILIBUSTER ON FEDERAL POLICYMAKING (2019), https://www.americanprogress.org/article/impact-filibuster-federal-policymaking/ [https://perma.cc/LM3H-PWWT]; Ezra Klein, *The Definitive Case for Ending the Filibuster*, VOX (Oct. 1, 2010, 7:30 AM), https://www.vox.com/21424582/filibuster-joe-biden-2020-senate-democrats-abolish-trump [https://perma.cc/CP3G-8M5P].

375. *See supra* note 198 and accompanying text.

376. Gabriel Scheffler, *The Dynamism of Health Law: Expanded Insurance Coverage as the Engine of Regulatory Reform*, 10 U.C. IRVINE L. REV. 729 (2020).

laws in light of new information about the effectiveness of these schemes,[377] or in light of changes in the surrounding policy environment.[378]

That being said, none of these accounts seems clearly applicable in this context. The ACA's ghosts do not seem to have been largely prompted by new information coming to light about the optimal way to reform the health care system, nor do they appear to represent good-faith efforts to update the law in light of changes in the health care system. To the contrary, it is notable that leading health care policy experts were, for the most part, opposed to most of these changes.[379] Moreover, several of the ghosts of the ACA were removed from the law or rendered inoperative in circumstances characterized by a lack of deliberation and intense interest group lobbying.[380]

Although the ACA's history is unique, enactment-entrenchment tradeoffs are not. To the contrary, there are reasons to believe they have become more important over time. These tradeoffs—together with the rise in political polarization—mean that newly enacted social legislation is more vulnerable than previously thought. Greater attention to policy feedback effects alone will be insufficient to ensure that such legislation endures over time. To achieve that end, lawmakers must also change the rules governing enactment-entrenchment tradeoffs.

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377. *See, e.g.*, Charles E. Lindblom, *The Science of "Muddling Through,"* 19 PUB. ADMIN. REV. 79 (1959); Yair Listokin, *Learning Through Policy Variation*, 118 YALE L.J. 480, 534 (2008).

378. *See* David Kamin, *Legislating for Good Times and Bad*, 54 HARV. J. ON LEGIS. 149, 151–52 (2017) (defining policy drift as "the problem of policies remaining in place even as evolving conditions justify updating and fine-tuning those policies—with the result running contrary to the interests of most in the country").

379. *See supra* Part III.

380. For instance, Andy Slavitt, a former Acting Administrator of the Centers for Medicare and Medicaid Services during the Obama Administration, characterized the legislation that repealed the Cadillac tax, medical device tax, and health insurance tax as "the 'no special interest left behind bill' of 2019," saying "[t]here's no other explanation." Stein & Abutaleb, *supra* note 45; *see also* RAGUSA & BIRKHEAD, *supra* note 46, at 130 ("[W]e doubt the rhetoric of Republican lawmakers that their actions can be explained as sincere efforts to fix a defective law.").