Review Article

Polarized Stakeholders and Institutional Vulnerabilities: The Enduring Politics of the Patient Protection and Affordable Care Act

Daniel Béland, PhD[1]; Philip Rocco, MA[2]; and Alex Waddan, PhD[3]

[1]Johnson-Shoyama Graduate School of Public Policy, Saskatoon, Saskatchewan, Canada; [2]Charles and Louise Travers Department of Political Science, University of California, Berkeley, California; and [3]Department of Politics and International Relations, University of Leicester, Leicester, United Kingdom

ABSTRACT

Purpose: We conducted a comparative study of how state-level political stakeholders affected the implementation of 3 major reforms within the Patient Protection and Affordable Care Act (ACA). Our goal was to analyze the effects of policy legacy, institutional fragmentation, and public sentiments on state obstruction of the reform.

Methods: We gathered quantitative and qualitative evidence to generate cross-case comparisons of state implementation of 3 reform streams within the ACA: health insurance exchanges, Medicaid expansion, and regulatory reform. Our sources included secondary literature, analysis of official decisions, and background interviews with experts and public officials.

Findings: We found that state-level opponents of the ACA were most likely to be successful in challenging reforms with few preexisting policy legacies, high institutional fragmentation, and negative public sentiments. Reforms that built on existing state legislation, avoided state veto points or offered lucrative fiscal incentives, and elicited less negative public reaction were less likely to be contested.

Implications: Our findings point to the importance of institutional design for the role of political stakeholders in implementing reforms to improve the cost, quality, and availability of medical treatments. Although other research has found that political polarization has shaped early ACA outcomes, comparative analysis suggests political stakeholders have had the highest effect on reforms that were particularly vulnerable. (*Clin Ther*. 2015;37:720–726)

Key words: health care reform, health insurance exchanges, Medicaid expansion, Obamacare, Patient Protection and Affordable Care Act, regulatory reform.

INTRODUCTION

Making the Patient Protection and Affordable Care Act (ACA) function, as other contributions to this special issue suggest, depends crucially on stakeholders, such as hospital associations, pharmaceutical companies, and private insurance providers. It is not merely health care stakeholders who will influence the ACA's outcomes, however. This article argues that *political* actors, particularly elected officials, play leading parts, although they do not always share the incentives and preferences of other stakeholders. In particular, partisan and ideological opponents of the ACA have sought to obstruct the implementation of the reform at the state level rather than negotiate how best to put it into practice. Drawing on publicly available data, government documents, news reports, and interviews conducted by one of the coauthors, we found that their success hinges critically on several institutional

Accepted for publication March 6, 2015.
http://dx.doi.org/10.1016/j.clinthera.2015.03.005
0149-2918/$ - see front matter

vulnerabilities that vary across 3 major reform streams within the ACA: health insurance exchanges (or marketplaces, as they are currently known), the proposed expansion in Medicaid coverage, and, finally, regulatory reform.

Polarized Stakeholders and Institutional Vulnerabilities

The political context for implementing the ACA is marked by sharp polarization. Even as beneficiaries, payers, and providers are becoming acclimated to the law's changes, opposition remains strong, with challenges to the law in the courts and the US Congress.[1,2] Yet challenges to implementation at the *state* level are especially consequential because the ACA's institutional core—composed of insurance exchanges, Medicaid expansion, and regulatory reforms—is crucially dependent on decisions made by state governments.[3,4] With sizable wins in state elections since 2010, conservatives have successfully thwarted implementation efforts by refusing to execute key sections of the law, which has major implications for the quality and affordability of health insurance, including access to prescription drug coverage, for many Americans.[5–8]

Although we agree with existing scholarship that partisanship and political polarization are driving forces behind the state-level reaction to the ACA, a comparative analysis of intergovernmental politics reveals major differences in the vulnerability of the ACA to the threat of obstruction. Because challenging the reform requires opponents to engage in costly collective action, they are most likely to succeed in challenging the ACA at the state level when 3 conditions are met. First, they are likely to succeed when *policy legacies*—pre-existing institutions and intergovernmental relationships that predate the passage of a reform—are weak.[9] When policies lack strong legacies, opponents have an advantage because they have no existing policy constituencies or implementation networks to contend with.

Second, political opponents benefit from *institutional fragmentation*, when a policy divides authority and resources among multiple actors.[4,10] Institutional fragmentation empowers opponents of reform at the state level by reducing the costs of collective action. If state legislatures must go to greater lengths to approve state participation in federal reforms, and especially if the federal government lacks resources to entice them to do so, opponents may be able to fight back without assembling legislative coalitions to block policy changes. By contrast, reforms that can be adopted more seamlessly by state agencies rather than legislatures, or with the help of strong federal incentives, may be more difficult for opponents to challenge.

Third, reforms are easier to obstruct at the state level when they are salient to the public and carry a negative connotation in terms of public sentiments.[11] If this is the case, even if opponents must engage in collective action to contest a reform, it may not be difficult to generate a coalition. The following sections, summarized in **Table I**, reveal that each of the 3 reform streams we analyze has a distinctive mix of policy legacies, institutional fragmentation, and public sentiments that have shaped opponents' ability to obstruct the implementation of the ACA in the states.

Health Insurance Exchanges

Health insurance exchanges constitute the component of the ACA with the lowest level of state consent and cooperation of our 3 reform streams. In terms of policy legacies, health insurance exchanges are both recent and undeveloped. Before the ACA, only Massachusetts had a working health insurance exchange, so this policy stream is relatively new, especially compared with Medicaid. In this policy context, coordination and cooperation mechanisms between the federal government and the states did not exist before the enactment of the ACA, a situation that posed a challenge that was absent from both the Medicaid and the regulatory streams.

Regarding institutional fragmentation, health insurance exchanges constitute the most decentralized stream at hand.[4] This is because the ACA left states to set up their own exchanges rather than creating a centralized federal network. Observers initially expected that most states would establish their own exchange,[12] but many states, partly because of the lack of strong financial incentives to create their own exchanges, chose to adopt a confrontational stance within this policy stream. Thus, even if exchanges were initially part of a bipartisan approach to health care reform, many Republican-controlled states used the issue to convey their general opposition to the ACA. They were able to do this because, in contrast to the situation prevailing in the Medicaid stream, the ACA gave states the institutional autonomy to refuse to create their own exchanges, leaving the federal