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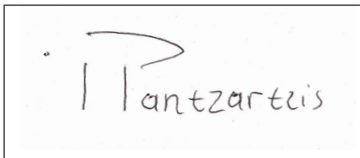

Student's signature

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U.S. healthcare reform and policy feedback: Some fancy subtitle

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Abstract

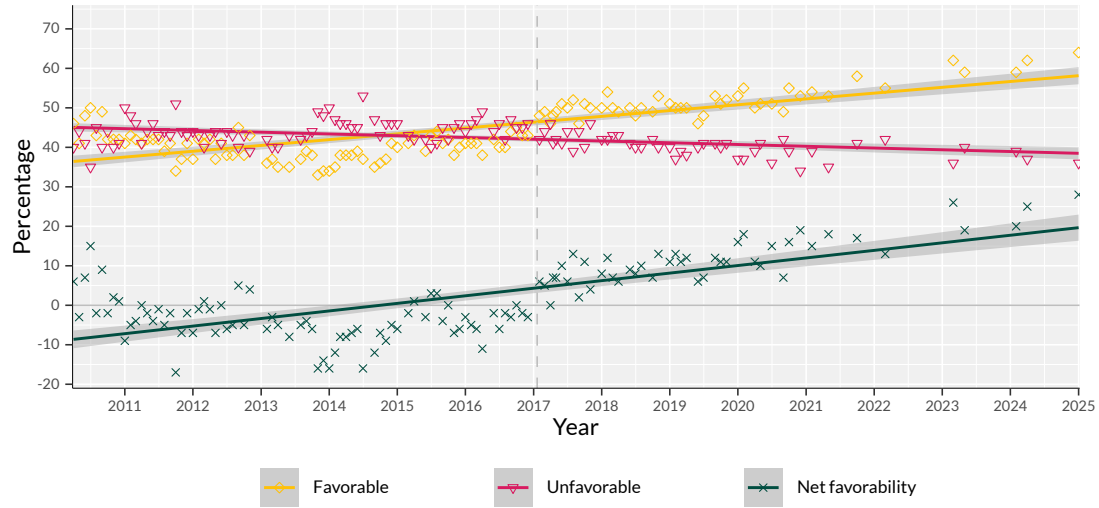
Placeholder

Keywords: healthcare, policy feedback

Introduction

When (then candidate) Donald Trump was asked in his, first and only, presidential debate with Democratic opponent Kamala Harris what his plans for healthcare reform were, his response that he had "concepts of plan" (Trump, 2024) rekindled some discourse as to the future of American healthcare and potential reforms in that sector. Ever since it was passed, Republican lawmakers, in conjunction with candidate and president Trump, have at times alternately advocated for – and attempted – repealing President Barack Obama's signature healthcare reform, the Patient Protection and Affordable Care Act (abbreviated as ACA, commonly also referred to as "Obamacare"), outright, or making major modifications to the law (Armour et al., 2024). However, neither a repeal or a major modification ever came to pass, despite Republicans gaining control of the White House and both Houses of Congress following the 2016 general election (Federal Election Commission, 2017). Three Republican Senators voted to *not* repeal Obamacare, Senator John McCain, as was highly publicized at the time, voting no via thumbs-down on the Senate floor, less than two days after receiving surgery for brain cancer (**Davis2016**). Beyond any individual-level intuitions for this specific legislative outcome, this suggest the question *why were Republicans unable to repeal or reform the ACA?* One explanation might be public response – in the time since its passage, the ACA's popularity has somewhat transformed, from being viewed rather controversially in the beginning, to now (early 2025) enjoying its largest net positive favorability ever (see Figure 1):

Figure 1. ACA favorability (2010–2023)



Data source: Kaiser Family Foundation (2025)

As Busemeyer et al. (2019) have noted, already during Trump's first term, this leads credence to the idea that policy feedback follows a *thermostatic* (Wlezien, 1995), or negative, pattern, wherein (proposed) policy change in any direction is *counterbalanced* by the public's response. In this view, *policy stability* is the consequence of negative feedback. At the same time, Busemeyer et al.

(2019) also point out that this same empirical artefact may support a Historical Institutionalist interpretation. In contrast to the thermostat view, Historical Institutionalists propose that policies, once adopted, create support for themselves, i.e. *positive feedback* (see e.g. Pierson, 1993; Pierson, 2000). This post-Trump development in U.S. healthcare politics motivates Busemeyer et al. (2019) to streamline the concept of policy-feedback in general for all kinds of policies. Sticking with healthcare policy, however, pre-Trump, the more germane empirical puzzle related to why healthcare reform happened in 2010, both (1) why it happened at all and (2) why not before. Jacobs and Weaver (2014) argue that, unlike in the thermostatic view, negative feedback drove *policy change* in 2010, rather than policy stability. More specifically, they develop an extension to Historical Institutionalism that incorporates a notion of *self-undermining* negative feedback as a driver of policy change, where Historical Institutionalism usually emphasizes explaining long-term policy stability due to positive feedback.

In this paper, I will first discuss Jacobs and Weaver's (2014) theoretical conception of self-undermining negative feedback effects, and their case study, in which they employ their newly developed framework to explain why healthcare reform was passed in the US in 2010, but not in the 1990s, the previous high-profile attempt to do so on the Federal level. In doing this, I will attempt to replicate the data they authors present. Finally, I will extend their analysis into the present and discuss the concept of self-undermining feedback in the current political context.

Theory

In this section, I'll first give an overview of the Historical Institutionalist foundation Jacobs and Weaver (2014) build their argument upon. Then follows an outline of the authors' conception of their theoretical innovation – self-undermining feedback – and mechanisms by which it operates.

Positive and negative Feedback in Historical Institutionalism

In abstract terms, in a (political) system, negative feedback can be conceptualized as a "self-correcting" (Baumgartner & Jones, 2002, p. 8) process that "reacts to counterbalance, rather than reinforce, any changes coming in from the environment" (p. 9). Thus, negative feedback is likened to a thermostat, that acts to revert the temperature of the room (the political environment) to some predefined temperature (the political status-quo), whenever the room gets colder *or* warmer (Wlezien, 1995).

Conversely, positive feedback is a process by which a change to the system is self-reinforcing, i.e. it *reproduces* itself. With positive feedback exact conceptualizations slightly differ based on theory. Pierson (2000), representing what Jacobs and Weaver (2014) call the classical Historical Institutionalist approach to policy feedback, for instance, borrows from economic theory. In economic terms, policy decisions generate *increasing returns* (for economic discussion see Arthur, 1994). In political terms, past policy choices create the very political conditions that make it more likely that those choices will be maintained – even in the face of overall suboptimal outcomes compared to some other alternative – by "*[reshaping] social and state actors' interests and capacities over long periods of time*" (Jacobs & Weaver, 2014, p. 443, original emphasis). To illustrate, assume some current status-quo policy regime A and some

alternative policy regime B, wherein regime B would generate markedly greater overall net utility than regime A for hypothetical polity. At some past point in time the polity chose regime A, it could now switch to regime B, but doing so incurs a cost. As time passes, actors under regime A adapt to the policy regime, i.e. change their behavior such that actors that previously may have suffered negative utility under regime A come to slightly profit under regime A. Regime A's utility increases over time, but remains below the total utility that could be hypothetically achieved under regime B. Even though there is some cost to actors for adopting to regime A, it is more cost-effective to maintain regime A, assuming some adaptation has taken place – undoing all that adaptation and re-adapting to regime B, were it to be instituted, will always be higher than maintaining and further adapting to regime A. Furthermore, the cost of adapting to some alternative regime B increases over time, ever decreasing the likelihood of moving away from regime A as they go.

Still within a Historical Institutionalist framework, but somewhat departing from the, as Jacobs and Weaver (2014) put it, *classical* approach, Punctuated Equilibrium Theory (Baumgartner & Jones, 2009; Baumgartner & Jones, 2002) adapts its conceptualization of positive feedback to fit its aim to better explain policy change. From a Punctuated Equilibrium point of view, positive feedback is defined as when "a change, sometimes a fairly modest one, causes future changes to be amplified" (Baumgartner et al., 2018, p. 61), what, in colloquial terms, may be referred to as "'feeding frenzy,' 'cascade,' 'tipping point,' 'momentum,' or 'bandwagon effect'" (p. 61).

Self-undermining feedback effects

Overall, Jacobs and Weaver (2014) argue, feedback effects have been "persuasive" (p. 441) in explaining long-term policy development across different policy fields. They aim to add to the literature on long-term policy dynamics by more closely examining the role of feedback effects, specifically as they relate to *policy change*. As the authors note, "Historical Institutionalist (HI) analyses centered around a logic of self-reinforcement and path-dependent development have, quite naturally, had far more success explaining stability than in accounting for change" (Jacobs & Weaver, 2014, p. 443). Policy change and stability are, of course, two sides of the same medallion, but the way different theories emphasize one over the other will impact their explanatory power when applied to any given empirical phenomenon.

To start with, the authors tout theoretical advancements made by Baumgartner and Jones (2002) and Punctuated Equilibrium Theory, which models how *exogenous shocks*, e.g. can lead to rapid change between long phases of policy stability. Unlike in Historical Institutionalism, in the Punctuated Equilibrium framework long periods of policy-stability are regulated by thermostatic, i.e. negative, feedback, while exogenous shock induce a process of positive feedback, where some initial disturbance to the status-quo is quickly exploited by policy entrepreneurs. Still, both classical Historical Institutionalist approaches as well as Punctuated Equilibrium Theory primarily envision *exogenous shocks* to be the main drivers of policy change, the authors see a need in expanding on efforts in the Historical Institutionalism literature which aim to explain *endogenously* driven change, i.e. "processes deriving from policy itself – that frequently generate strong pressures, and expand the political opportunities, for policy change" (Jacobs & Weaver,

2014, p. 442).

For this purpose, Jacobs and Weaver (2014) pick up on Greif and Laitin's (2004) commentary on both the Game Theory and Historical Institutionalist literature, maligning that these two disciplines leave no room for the idea of endogenously driven institutional/policy change and even effectively render the idea a "contradiction in terms" (Greif & Laitin, 2004, p. 633). Neither Jacobs and Weaver (2014) nor Greif and Laitin (2004) present an explicit empirical motivation, as their concerns are somewhat intuitively reasonable, but, formulated in Game Theory terms, Greif and Laitin (2004) argue: "Institutions influence factors such as wealth, identity, ability, knowledge, beliefs, residential distribution, and occupational specialization that are usually assumed as parametric in the rules of the game. Even if not possible to prove that institutions generally have such ramifications, it is difficult to think of any institution that in the long run does not have implications beyond the behavior in the transaction it governs" Greif and Laitin (2004, p. 636). Take the example of large scale government social security/pension programs. Major reforms of pensions programs are rare and usually highly controversial (see e.g. recent attempts in France to raise the retirement age Leali, 2023).

Referring specifically to classical Historical Institutionalist approaches, here Pierson (2000), as Greif and Laitin (2004) illustrate it, the introduction of a national pension program will lead to (1) greater life-expectancy and (2) lower birth-rates as income in old age aids to prolong health and disincentives having children as old-age insurance, relatively to a situation without a pensions scheme. These demographic changes *caused by the policy* (i.e. endogenous changes) in turn, over-time, will lead to a decrease in average pension payouts as the ration of young working people to old age recipients shifts. At the same time, however, support for the pension program will likely increase, as the relative share of the population that economically benefits as a consequence of the same demographic trends that cause the decline in payout, i.e. more pensioners relative to the working population. Classical Historical Institutionalist approaches, which theorize *increasing return*, not *decreasing returns* over time, poorly explain this phenomenon.

From a Punctuated Equilibrium point of view, the general lack of pension reform can be straightforwardly interpreted as a case of negative feedback, i.e. without a significant disturbance in the status quo that opens a windows of opportunity for change, feedback behaves thermostatic and will counterbalance any attempt at reform. However, even though Punctuated Equilibrium Theory can be drawn upon to explain *why and how* a shock to the system allows for rapid policy change where there was long-lasting policy stability before, it makes no statement as to how such disturbances come about. As a consequence, such critical junctures can only be identified ex post. Jacobs and Weaver's (2014) central contention is that *the status quo policy itself* brings about the conditions of its rollback. They propose three types of mechanisms that, over-time, may increase the likelihood of moving away from some past policy decision: (1) Emergent losses, (2) losses in mass cognition and (3) menu expansion.

Emergent losses

As states previously, classical Historical Institutionalist accounts Pierson (2000) assume increasing returns, but Jacobs and Weaver (2014) propose "there are equally important reasons why policy

will often generate mounting losses over time for powerful actors" (p. 445). It is plausible that actors may not be able to adopt to the status quo for reasons that cannot be anticipated during policy selection and enactment, due to (1) impure policy design (2) layering of new policies over an existing body of policies (3) actor short-sightedness. As a consequence of the collective nature of decision making processes in democracies, most new policy can't follow a perfectly consistent, pure policy logic and therefore will contain ambiguity and contradictions that produce unforeseen results. Similarly, new policy may interact unexpectedly with any existing policy it is layered on top of. Finally, actors may value short- over long-term gains, even if a long-term loss is foreseeable at time of policy selection and enactment.

Policy losses in mass cognition

Though distinct from Rational Choice Institutionalism (see e.g. Hall & Taylor, 1996), Historical Institutionalism generally conforms with Rational Choice Institutionalism on the idea of rational actors who single-mindedly and strategically act to maximize their material utility, in the pursuit of which they have perfect information and clear preference hierarchies in any decision scenario. However, beyond a policy's actual material payoffs, in a democratic setting with competitive elections, the public's *perception* of a policy is elementary for both maintenance or reform of that policy. Now, even within the field of economics, the assumptions of single-minded utility-maximizing, perfect information and clear preferences are routinely challenged in an attempt to account for human cognitive psychology, i.e. irrational human behavior resulting from humans' use of decisions heuristics and the accompanying *biases in perception and behavior* (see e.g. Kahneman et al., 1982). Classical Historical Institutionalist approaches (e.g. Pierson, 2000) are primarily concerned with explaining *prima facie irrational policy developments* within a rationalist framework, or, put differently, explaining how maintaining overall suboptimal policies in the face of alternatives with higher utility can be rational. Nevertheless, Pierson (1994), for instance, has made reference to cognitive biases, arguing that due to *negativity bias*, the prospect of losses for welfare beneficiaries weighs more heavily in the mind of constituents than gains from lower taxes when welfare cutbacks are promised. Punctuated Equilibrium Theory assumes boundedly rational actors (Simon, 1955), i.e. actors are not assumed to have perfect knowledge and preference hierarchies at all times on every issue, because (individual and organizational) actors have finite resources and therefore can only focus their attention on so many issues at a time. Still, Punctuated Equilibrium places more of an emphasis on boundedly rational behavior specifically by *organized actors and the government* and the serial processing of information (see Baumgartner et al., 2018, p. 65). Jacobs and Weaver (2014), on the other hand, specifically aim to elaborate on the link between policy and *mass attitudes* and integrate with cognitive psychology and the behavioral economics.

One overarching operative mechanism Jacobs and Weaver (2014) propose is *salience of losses*, i.e. whether the policy status-quo is perceived as a loss or a gain by the public. The authors draw on Prospect Theory (Kahneman & Tversky, 1979) which argues that people are *loss averse* (Tversky & Kahneman, 1991): In a decision situation, when primed to perceive themselves to be in the domain of losses, people will be more risk-seeking in order avoid the loss, conversely if they perceive themselves to be in the domain of gains, the act risk-averse in order

to safeguard any perceived gains (the latter phenomenon being know as the endowment effect, see Kahneman et al., 1991). Importantly, perceptions of loss and gain can be manipulated: "The mere existence of losses guarantees neither that citizens will notice those losses nor that they will attribute those losses to current policy" (Jacobs & Weaver, 2014, p. 447). The policy status quo may, therefore, self-enforce when the status quo can successfully be framed as the safer option compared to any reform to the public, or it may *undermine itself* when political elites succeed in framing the status quo as a loss. Jacobs and Weaver (2014) outline two scenarios when the latter is more likely: Elites can more credibly frame the status quo as a loss when (1) losses *concentrate cross-sectionally*,i.e. "have a heavy per capita burden or incidence on well-defined and tightly networked groups", and when (2) they *concentrate temporally*, i.e "erupt into dramatic focussing events" (Jacobs & Weaver, 2014, p. 448).

Expanding menu options

Where classical Historical Institutionalist approaches propose that, over time, the menu of plausible alternatives to the status quo policy narrows, as switching away from the status quo gets increasingly costly – even if the overall utility of the alternatives would be much greater than the status quo –Jacobs and Weaver (2014) argue that, in fact, not only *can* the menu expand as new policy and technological innovations expand the horizon of plausible alternatives – if the status quo is perceived as deficient, this in-itself induces an intensification in the search for alternatives: "Where status quo policy is perceived to generate adverse social outcomes, politicians, bureaucrats, and policy experts become more likely to undertake a search for new alternatives to address those problems. Thus, the policy menu is not forever narrowing" (p. 449). Compounding this, the search for policy alternatives can shift political coalitions "by altering the social and political costs of change" (Jacobs & Weaver, 2014, p. 449). Furthermore, supporters of reform, encouraged to search alternatives to a deficient status quo, may specifically seek policy alternatives that deliberately mask the costs of policy change. Jacobs and Weaver (2014) cite the introduction of *notional-defined contribution* pensions in some European countries, which effectuated a retrenchment in welfare spending, but by pegging cuts to pensions spending to e.g.future economic development, costs (and responsibility) are not apparent at the time of policy selection. Factors such as (1) a society's specific makeup of policy expertise (e.g. very diffuse network of think-tanks in the U.S.) and (2) institutional "porousness" (Jacobs & Weaver, 2014, p. 449) (centralized agenda-setting and strictly hierarchical flow of information hinder the penetration opf new policy ideas into the mainstream and vice versa) and (3) previous successful implementation of a policy idea in a *relevant* reference polity (e.g. implementation in a U.S. State) aid expansion of the policy menu in self-undermining ways.

Methodology and Case Study

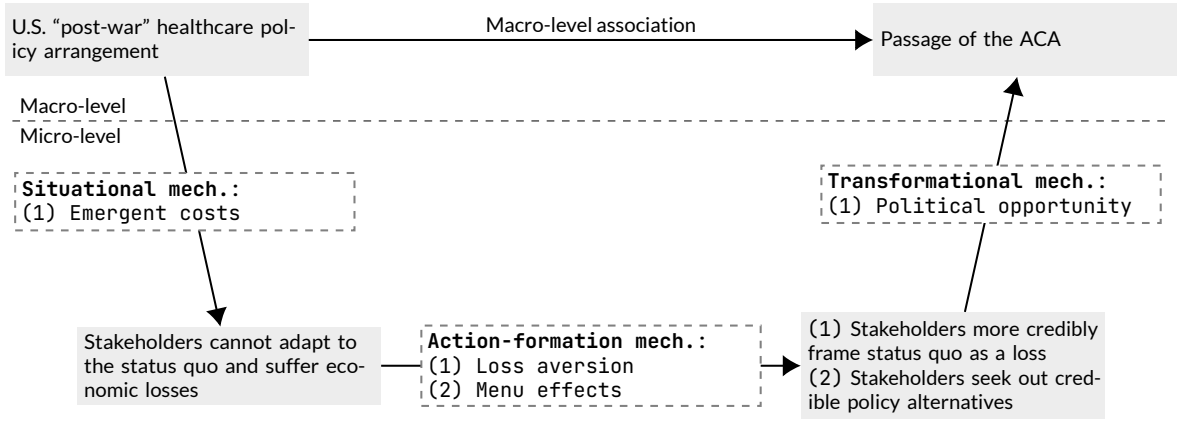
Having laid out the authors' theoretical argument, in this section I will outline how I will reexamine their case study applying their theoretical framework to healthcare reform (or the lack thereof) in the US and how I will conduct an analysis of contemporary feedback dynamics. Jacobs and Weaver (2014) note that their case study is not necessarily to be understood as en

exhaustive and in-depth analysis, but as an illustration of a plausible novel account of reform in U.S within a Historical Institutionalist framework, primarily attempting to show that there is some evidence that self-undermining feedback played a role in the ACA. To lend an analysis of their case study in this paper a stronger methodological foundation, however, I will first turn to the pertinent qualitative literature and describe my methodological approach.

Methodology

To replicate Jacobs and Weaver's (2014) case-study I study I will employ *process-tracing* to analyze the question why healthcare reform was possible in 2010 but not in the 1990s. The goal of an *explaining-outcome process tracing* (Beach & Pedersen, 2019) is to establish *case-specific*, *minimally sufficient* explanation of the causal mechanisms that caused some outcome Y. I argue this is very similar to the way Jacobs and Weaver (2014) proceed anyway, even if they do not explicitly call their approach process-tracing. Nevertheless, their approach can be accurately described as an attempt to construct a case-specific explanation of an outcome that stand in contravention to some prominent Historical Institutionalist theoretical expectations and tracing the specific mechanisms by which it came about. Beach and Pedersen (2019) employ a *mechanistic* understanding of causal mechanisms, they conceptualize causal mechanisms as "composed of entities that undertake activities", wherein "activities are the producers of change, or what transmits causal forces through a mechanism" (p. 49). An explanation of an outcome Y is *minimally sufficient* if all components ad an explanation are necessary conditions of the emergence of the outcome, and together sufficient to bring it about (see e.g. Goertz & Levy, 2007). In its simplest form such an explanation may be expressed as a causal chain where one causal mechanism leads into another. More interestingly, Hedström and Swedberg (1998) develop an extension of Coleman's (1986) macro-micro-macro model, colloquially also knows the bathtub model, that more granularly differentiates different types of relationships and causal mechanisms by their level of analysis (macro vs. micro level) and role in the causal chain (see Figure 2 for a graphical depiction of the description that follows). First there is the overall macro-relationship of interest from some input X to some Outcome Y, in this case, how the policy status quo of American healthcare affects reform in 2010. Since process-tracing employs a mechanistic understanding of causal mechanism, and methodological individualism is generally desirable in most cases in political science, it is first necessary to establish how the overall social situation (here the healthcare status quo) affects individuals' perceptions and preferences (so-called *situational mechanism* $s \rightarrow$). In a next step, *action-formation mechanisms* $a \rightarrow$ determine how those perceptions and preferences are transformed into individual action. Finally, *transformational mechanisms* $t \rightarrow$ determine how individual actions are aggregated into collective outcomes, intended or unintended. Figure 2 plots how Jacobs and Weaver's (2014) argument maps onto this model. In the following sections I will go into detail for each step in the model and examine the empirical evidence the authors present for the presence of each causal mechanism they stipulate.

Figure 2. *Bathtub* model of American healthcare reform



Political Context before the ACA

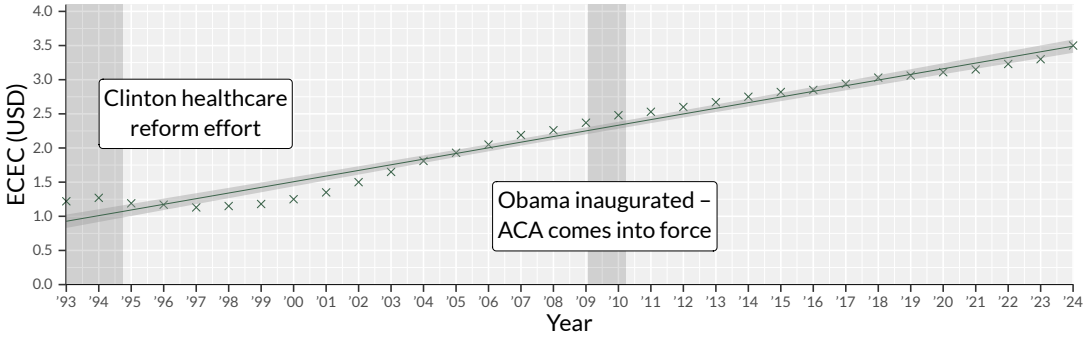
Jacobs and Weaver (2014) characterize the U.S. health care system pre ACA as a "public-private patchwork" (p. 451), with, on the one hand, government programs for low-income Americans (Medicaid) and old-age Americans (Medicare), while working-age Americans are generally expected to obtain healthcare privately (mostly employer-provided). As Jacobs and Weaver (2014) themselves point out, while the ACA was not a fundamental shift in policy paradigm (away from what the authors refer to as the "postwar" model p. 450), it is nevertheless significant for greatly expanding the role of the federal government in (1) providing healthcare for low-income-households or those who do not obtain healthcare via their employer for some reason or another and (2) regulating market activities in the healthcare sector, and, most controversially, (3) introducing a penalty-enforced requirement for individuals to obtain healthcare (known as the individual mandate). The authors ask two interrelated questions: Why did major policy change take place in the face of "powerful self-reinforcing feedback effects" (Jacobs & Weaver, 2014, p. 451), and, more pointedly, why did the U.S. not institute policy change during the previous large scale attempt to do so under president Clinton in 1993/1994. The authors' answer to the first question unsurprisingly is *self-undermining* feedback effects, but the answer to the second question is much less clear-cut, as the authors themselves observe: "Self-undermining feedback was not a novel feature of American health politics in 2009. Indeed, self-undermining feedback effects were already on prominent display during the Clinton reform effort of 1993-1994" (Jacobs & Weaver, 2014, p. 451). I will, therefore, first in n this section proceed by laying out what the authors would need to prove to substantiate their first argument, that self-undermining feedback drove political reform in 2010 and then present their argument as it relates to those criteria. In the next section I will do the same thing as it relates to that second question, of why reform did not happen in the 1990s.

The Role of Emergent Costs

The first mechanism of self-undermining feedback the authors present is that of emergent costs which hinders actors from adapting to the policy status quo and causes them economic losses. To prove self-undermining emergent losses, the authors must show that (1) the status-quo policy arrangement is a loss for a significant number or class of actors as a result of that policy and

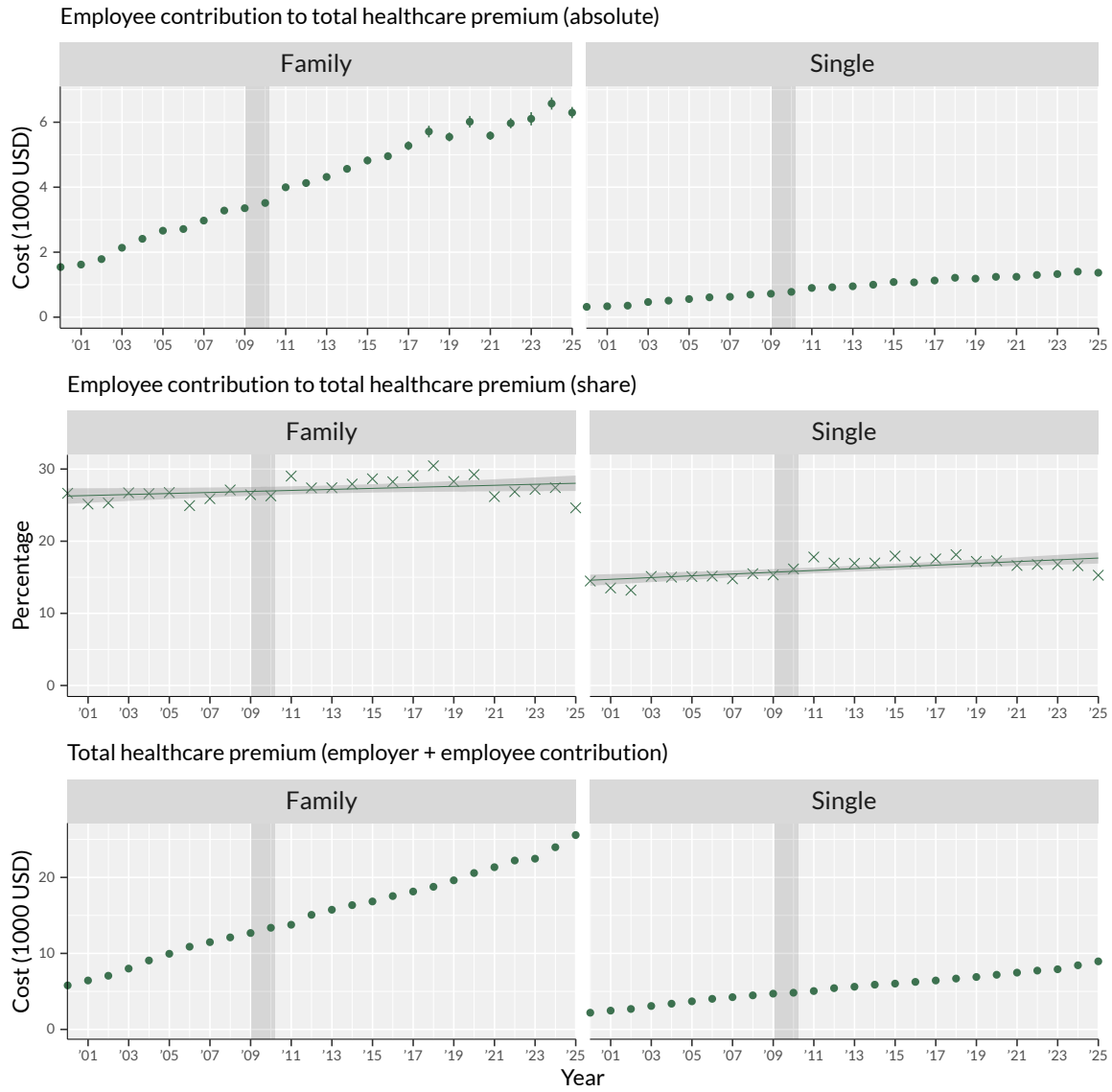
(2) losses were not anticipated at time of policy enactment. As relates to the (1), the authors identify 4 types of affected actors: employers, governments, the medical sector as a business sector (doctors, hospitals) and insurance holders. To investigate *employer costs*, the authors cite Claxton and Damico (2011) who assemble National Compensation Survey data for mean health insurance costs per worker hour. Claxton and Damico (2011) present data that shows that employers' cost had doubled in 2010 ($1.60) compared to 1999 ($3.35). However, there appear to be some issues with the data: First, Jacobs and Weaver (2014) cite this change as "more than 50%" (p. 451), which is technically correct, but odd considering the increase is greater than 100%. Second, I was not able to reproduce the exact values reported by Claxton and Damico (2011) using, to the best of my knowledge, the same data source (Employer Cost for Employee Compensation data derived from the National Compensation Survey (ECEC); Bureau of Labor Statistics, n.d.), as they do not clearly state how they compiled their data. Nevertheless, using the ECEC data I was able to retrieve, the finding for the relative increase of employer health insurance cost per hour per worker still holds, more than doubling from $1.18 in 1999 to $2.48 in 2010 (see Figure 3).

Figure 3. Employer Costs for Employee Compensation (ECEC), 1993–2024



For insurance holders costs increased in several ways. First, insurance premiums and workers' contribution rise sharply Second, the number of Americans without any healthcare at all rose (see Figure 4, using data from Kaiser Family Foundation, 2024). According to Jacobs and Weaver (2014), referencing Starr (2011), "the number of Americans without insurance coverage grew from 10% to 12% of the population in the 1970s to 16.7% by 2009" (Jacobs & Weaver, 2014, p. 451-452; see also Figure 5).Data reaching back to the 70s, unfortunately, are not easily accessible, but compiling from statistics from the U.S. Census Bureau's annual reports on healthcare coverage (DeNavas-Walt et al., 2013; see the supplemental matieral of Keisler-Starkey & Bunch, 2024, note that the methdology of these studies has been slightly adjusted over-time somewhat limiting comparability between the two study periods), Figure 3 gives an overview reaching back to 1986. Figure 3 also shows the share of Americans who have employment-based insurance, which Jacobs and Weaver (2014) characterize as having "declined sharply in the 2000s" (p. 451). Using the U.S. Census Bureau data, there is argument to be made, this claim is born-out: The share of Americans with employer-based healthcare does fall from a high of 65.1% in 2001 to 59.8% in 2008 (election year) and further down to 56.6% by the

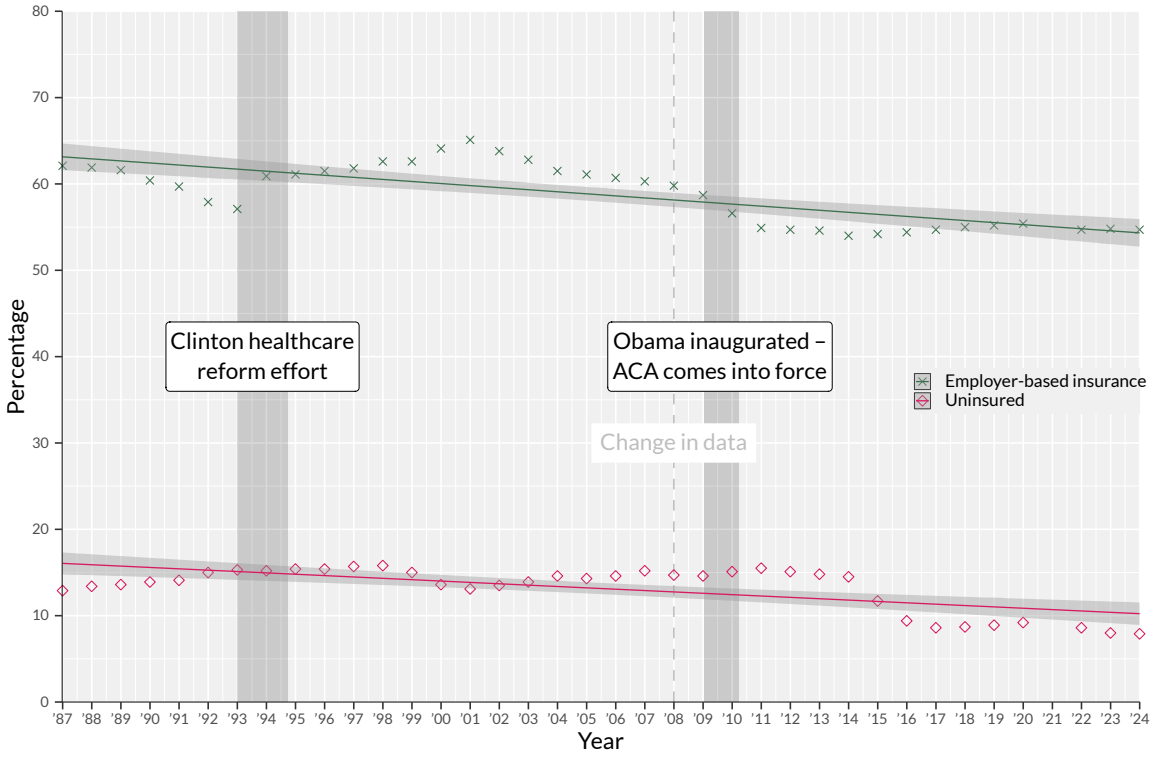
Figure 4. Healthcare premiums, 1999-2023



end of decade and passage of Obamacare (56.1% using data from DeNavas-Walt et al., 2013), almost a 10 point drop (see Figure 5).

Furthermore, even for those who stayed on employment-based insurance, Jacobs and Weaver (2014) observe that the emergence of so-called *managed care* insurance schemes in the 1990s – once envisioned as the critical tool to cut healthcare costs for the Clinton reform effort – lead to a decrease in satisfaction with healthcare quality (see Thorpe, 1999). In addition to lower satisfaction among those who have coverage, the share of covered, but *underinsured* Americans almost doubles between 2003 and 2010, (from 12.3% to 22%, Schoen et al., 2011). Turning now to state governments' costs, the authors assert, "state budgets, meanwhile, strained under the weight of growing Medicaid costs" (Jacobs & Weaver, 2014, p. 451). Additionally, both governments and the medical sector "were increasingly saddled with the burden of providing services to individuals lacks insurance while doctors' incomes were falling" (p. 452). However, it should be noted that Seabury et al. (2012), who Jacobs and Weaver (2014) cite for that

Figure 5. Percentage of workers with employment-based healthcare & percentage of uninsured 1986–2024 (2020 data not available)



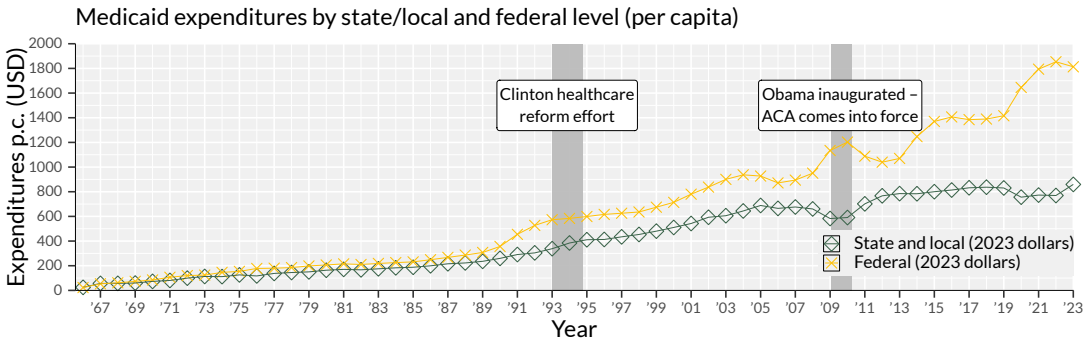
latter claim, report no actual statistically significant decrease in doctors' pay, but do find that physicians' pay stagnates in real dollars when comparing the two time periods 1996-2000 and 2006-2010 – at the same time finding that physicians' pay had previously grown about 20% between the two time periods 1987-1990 and 1996-2000. Still, even doctors' incomes stagnating is a significant development, as previously the medical profession, in form of the American Medical Association (AMA), has been often cited as a major road block to reform (Hacker, 1998). For instance, in the up until 1965 (the introduction of Medicare), the AMA's stated policy position on compulsory health insurance read:

> "[...] The American Medical Association declares its opposition to the institution of any plan embodying the system of compulsory contribution insurance" ("Proceedings of the New Orleans Session", 1920 as cited in Anderson, 1990, p. 79).

The authors provide not direct evidence for the claim that state budgets were straining under the cost of Medicaid, but using National Health Expenditure Accounts data (Centers for Medicare & Medicaid Services, 2024), this is somewhat supported (see Figure 6). Adjusting for inflation, states today pay more than 80 times more per capita in Medicaid in 2010 compared to 1967, two years after the introduction of Medicaid. However, even more striking is the more than twice as great increase in federal spending on Medicaid in that same time period, at 170-fold.

On the other hand, since taxes in the US are on average lower than in many other industrialized economies (see e.g. Jarass et al., 2017), the question of hwo much of a burden Medicaid is to the states, is underexplored. As relates to (2), losses being *unanticipated*, Jacobs

Figure 6. Healthcare expenditure (Medicaid), 1965-2023



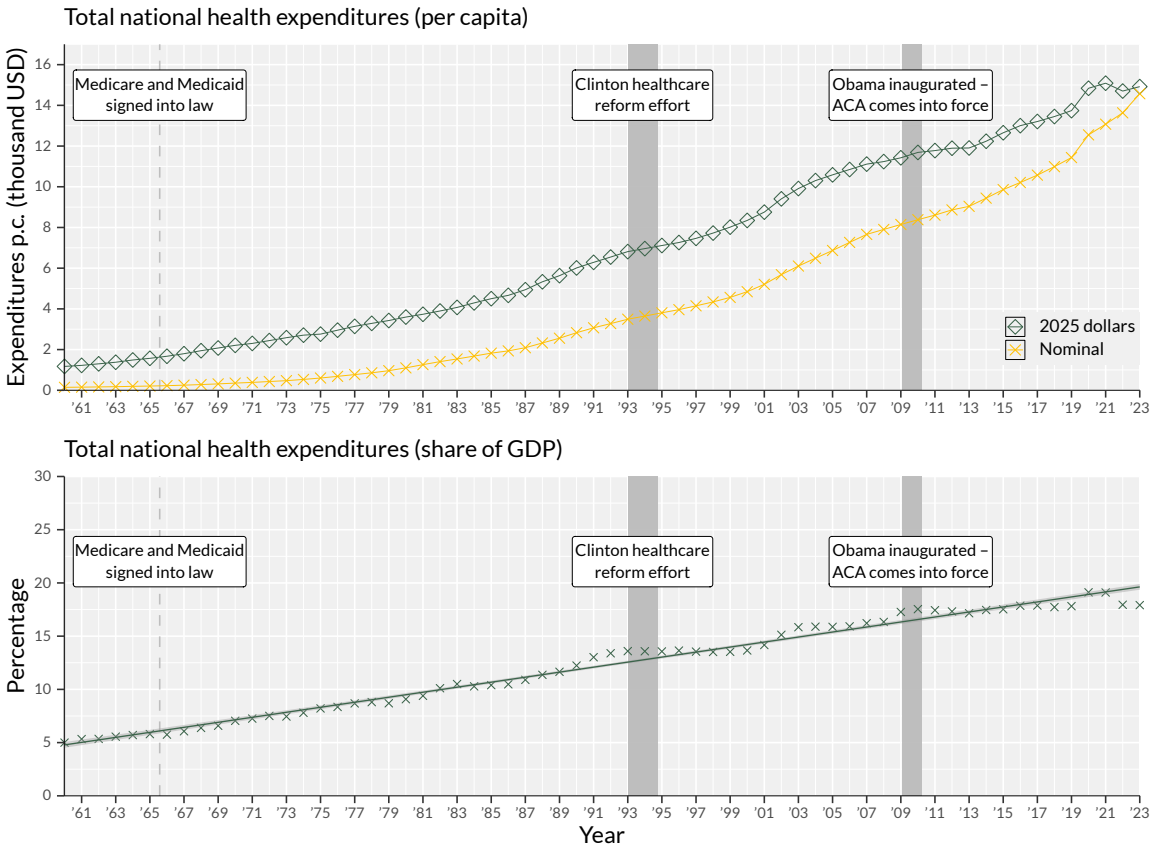
and Weaver (2014) cite Hacker (1998) who gives a historical account of how U.S. health care developed over time, illustrating how different policies where *layered* on top of each other, interacting in unpredictable ways, with the general synopsis:

> Massive subsidies for medical technology and infrastructure, tax and labor policies promoting employment-based insurance, and a framework of government health insurance that removed from the market the most vulnerable and difficult to insure segments of society –- these public initiatives gave rise to a costly, complex, and deeply embedded private insurance market that resisted government efforts at reform while slipping from the control of the medical profession and into the hands of profit-driven corporations (Hacker, 1998, p. 107).

This is, of course, is an account of *positive, self-reinforcing* feedback, why substantial healthcare reform became increasingly difficult over time in the U.S. and the how the private model reproduced and reinforced itself, not how it undermined itself. Nevertheless, the authors presumably were most interested in the prima facie contradiction of how the introduction of government healthcare for the elderly and poor was followed by the further entrenchment, and worsening, of private insurance model. According to Hacker (1998), Medicaid, the program for low-income households, was initially envisioned to limit the expected expansionary pressure compared to if Medicare, the program for the elderly and retired, had been passed on its own. But, eventually "the cost of the program outstripped even the most expansive expectations voiced before passage" (p. 118). So, somewhat paradoxically, despite removing the most difficult to insure (the poor and the elderly) from the larger insurance market, private health insurance has only increased in cost since the passage of Medicare and Medicaid. Again, this is not directly evidenced in the either authors' argument, but using National Health Expenditure Accounts (NHEA) data (Centers for Medicare & Medicaid Services, 2024), we can in general investigate theoretical/empirical claims that relate to healthcare costs. Figure 7, for instance, shows yearly total national health expenditures per capita and as share of GDP, beginning in 1960 up until 2023. Total per capita national health expenditures rise approximately sixfold compared from the year Medicare and Medicaid were introduced to 2010 (adjusted for inflation). Measured as a share of economic output the increase isn't as sharp, but still sizeable at about triple.

Figure 8 shows total national *private* health insurance expenditures in the same time period. The increase in per capita private healthcare closely follows that of total spending.

Figure 7. Healthcare expenditures (total), 1960-2023

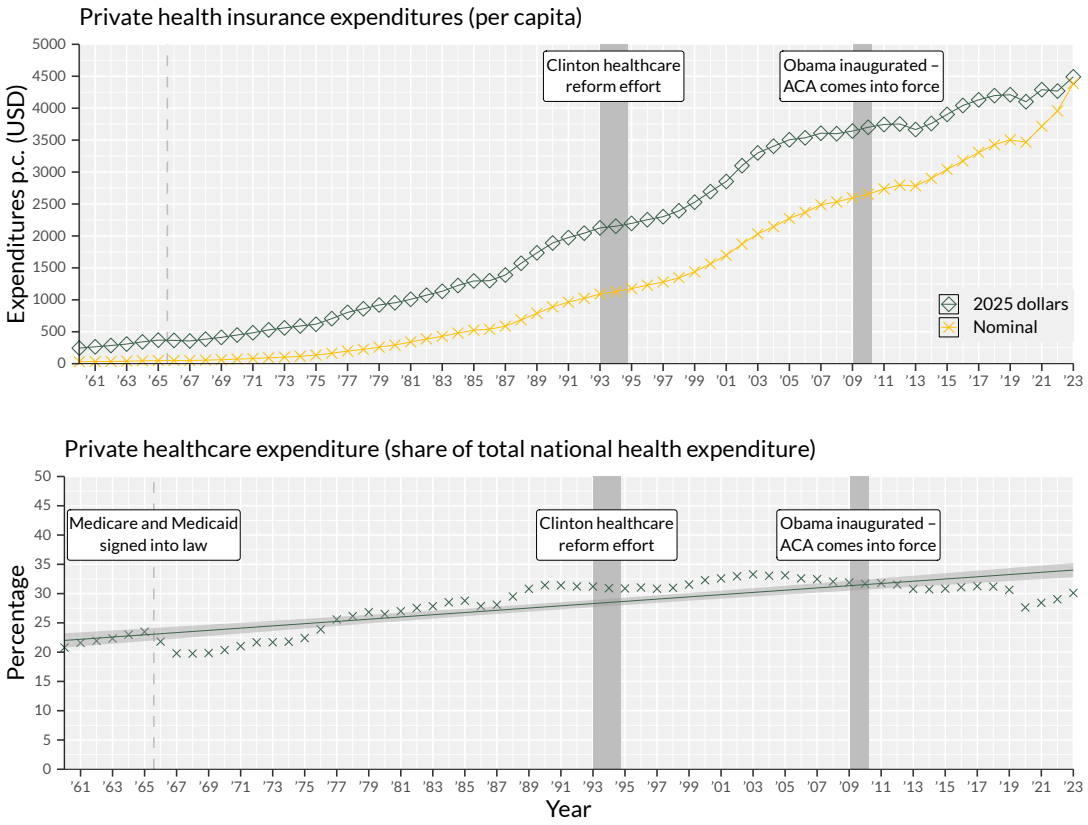


The proportion of total national health expenditures attributed to private insurance rises by ca. 50% from ca. 20% in 1967 (notice the immediate dip after the introduction of Medicare and Medicaid) to about 33% by 2010. On the one hand this implies increasing costs of health services for private health insurance companies, viewed from the perspective of insurance holders and employers who pay the premiums to those companies, on the other hand, the picture looks somewhat similar.

Figure 9 plots out-of-pocket costs over time. Inflation adjusted per capita out-of-pocket costs, though also rising, rise much less steeply than private insurance expenditures, and as a proportion of total health expenditure their share actually drops considerably, from almost representing 50% of all health expenditure a few years before the passage of Medicare to below 15% in 2023. Additionally, the imposed linear trend does not fit the data very well, suggesting a non-linear decrease that appears to have been stronger beginning in the 60s lasting to approximately the mid-90s, from which point forward the proportion has stayed more constant.

Turning to government funding, Figure 6 previously showed, specifically, Medicaid expenditures divided by federal and state/local, Figure 10 plots per capita expenditures and share of total national health expenditures for the entirety of the programs respectively. Like private insurance expenditures, both programs show a large increase in per capita expenditures over time. In contrast, when measured as a proportion of total health spending, there is a very sharp initial rise in the late 60s, followed by a proportionally much more gradual rise from 17%

Figure 8. Healthcare expenditure (private health insurance), 1960-2023



in the mid 1980s to 22.5% in 2023. Figure 11 gives a summary of private, government, and out-of-pocket expenditures as a share of GDP.

In sum, the macro-level data do support Jacobs and Weaver's (2014) argument to a some extent. The data very clearly shows that the policy status quo presented an economic loss for all major relevant stakeholders. There is also some evidence to suggest that these losses were not foreseeable, for instance private health insurance expenditures rising despite the policy status quo deliberately removing the most difficult to ensure from the market points to a contradiction. But the authors do show little specific evidence tho show that this paradox was a direct results of the specific policy status quo, that is the mixed public-private patchwork of U.S. healthcare. They cite Hacker's (1998) account of the development of U.S. healthcare, but he in turn also does not show in depth (i.e. beyond the the quotes I have included), how *specifically* the U.S.' patchwork system worked to undermine itself. In this regard the authors' analysis does not satisfy a mechanistic understanding of an explanation of causal mechanism.

The Role of Mass Cognition

Jacobs and Weaver (2014) show mass cognition had solidly shifted in favor of reform by 2008. Citing election polling from the time, a plurality of 39% rated the country's healthcare system as poor (the worst rating on the scale; the difference to the next largest proportion, who also give the next best rating, *fair* at 30%, is statistically significant; Blendon et al., 2008, p. 2052). A super-majority of 68% favor major or radical change (Blendon et al., 2008, p. 2058). They

Figure 9. Healthcare expenditure (out-of-pocket), 1960-2023

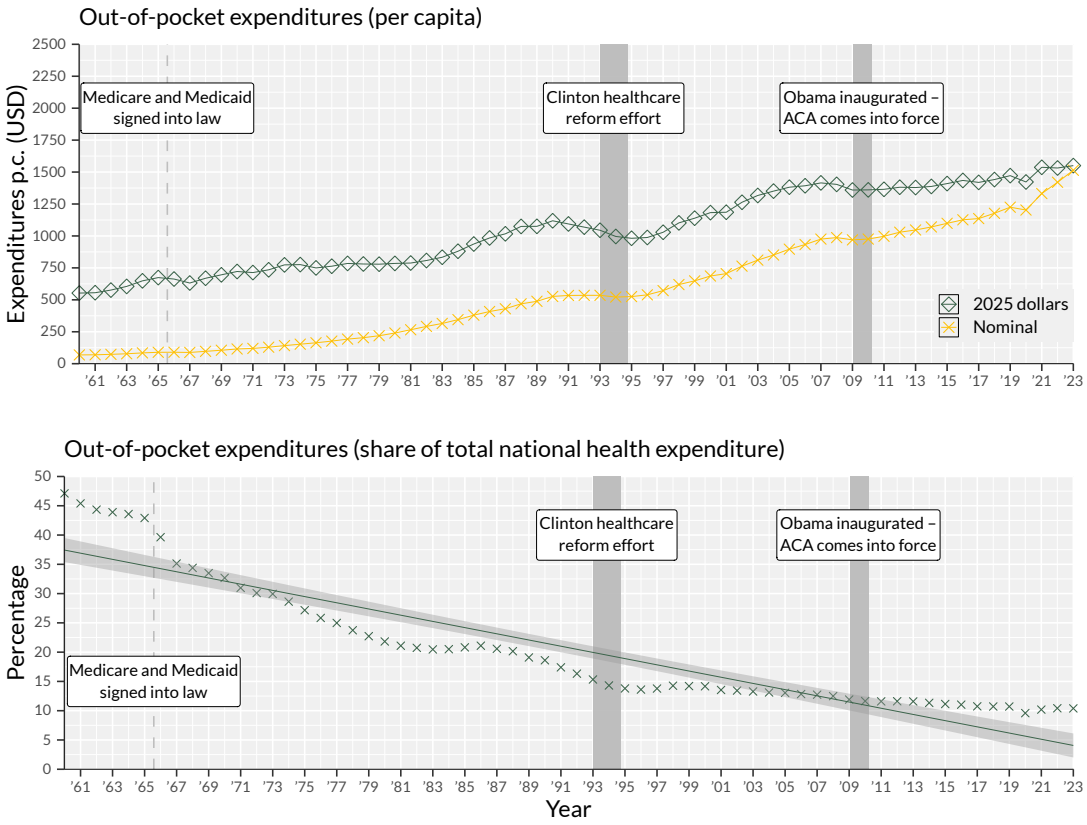


Figure 10. Healthcare expenditure (Medicare and Medicaid), 1965-2023

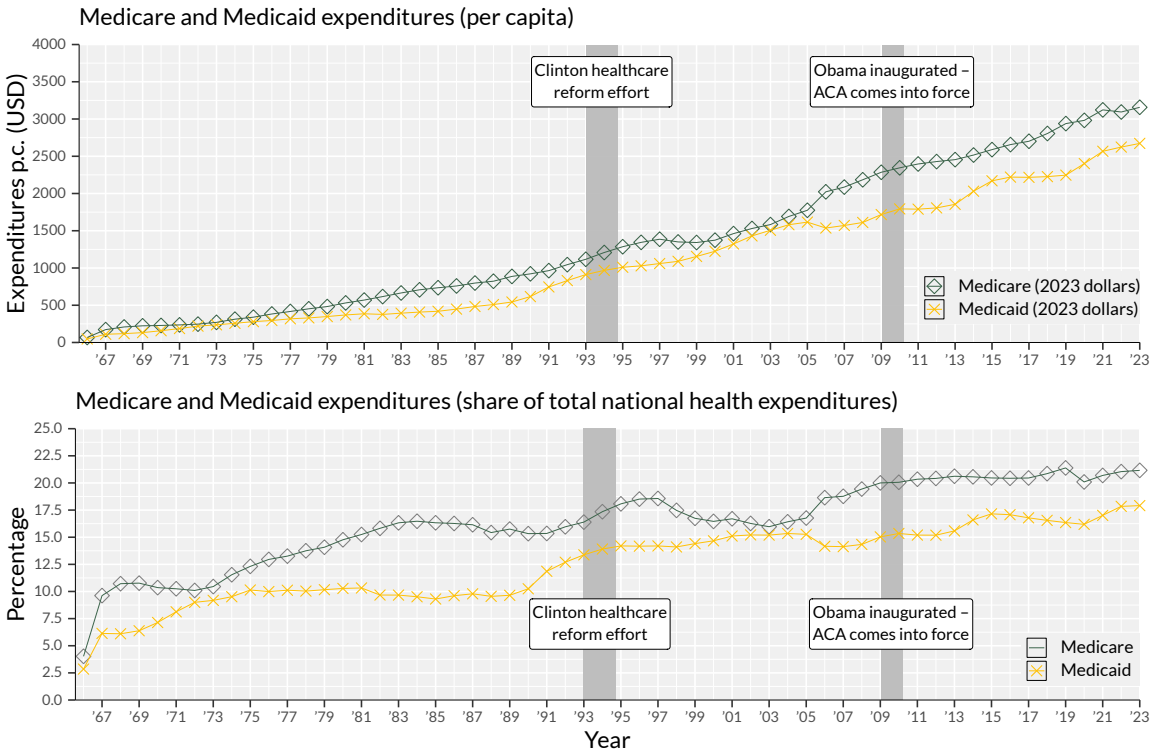
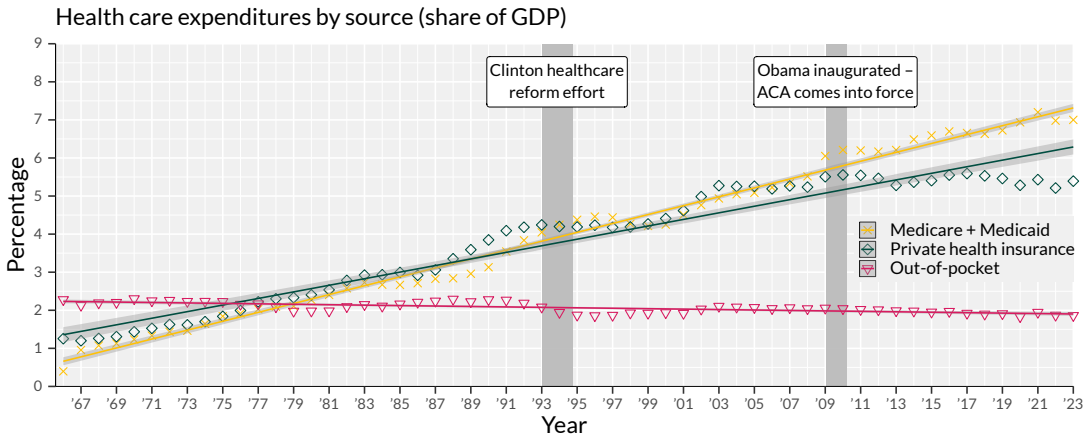


Figure 11. Healthcare expenditures (private, government, out-of-pocket), 1960-2023



argue, "as workers' premiums and out-of-pocket medical costs rose and employers withdrew coverage, even those who like their current health coverage were at increasing risk of losing it" (p. 452), with these fears being further focussed by the specter of job loss, and therefore health coverage loss, due to the Financial Crisis. Thus, "Democratic leaders were now better able to harness voters' loss aversion to depict reform as *protection* against harms that were likely to emerge under the status quo" (p. 452). As an example of Democrats credibly framing the status quo as a loss situation, they cite President Obama's 2009 speech to Congress:

> Everyone in this room knows what will happen if we do nothing. Our deficit will grow. More families will go bankrupt. More businesses will close. More Americans will lose their coverage when they are sick and need it most. And more will die as a result. We know these things to be true (Obama, 2009).

Taking a more birds-eye view, however, using data from the General Social Survey (Davern et al., 2024), Figure 12, Figure 13, and Figure 14, paint a less clear picture. Specifically, Figure 12 and Figure 14, which plot data reaching back to 1970s, show that support for a departure from the status quo (here proxied by agreement if government should be more active in healthcare) has always been high and has not been moving very much. Furthermore, Jacobs and Weaver (2014) do not present any data *on the voters' side*, whether loss framing was actually a contributing factor in their vote choice and or other political activity related to advocacy for healthcare reform, like calling their representative, etc.

The Role of Menu Effects

Jacobs and Weaver (2014) propose that the costly status quo of healthcare bred the policy innovation that acted self-undermining, as status quo had "led to decades-long search for new reform alternatives that could address coverage gaps and skyrocketing costs while overcoming strong opposition from entrenched interests as well as public resistance to new taxes" (p. 453), thus expanding the menu of conceivable alternatives and making reform more likely. Specifically the *individual mandate* as a policy-innovation is considered the key that unlocked support for (or lack of opposition to) reform by the insurance industry. The effectiveness of the individual

Figure 12. Should government help pay for medical care?

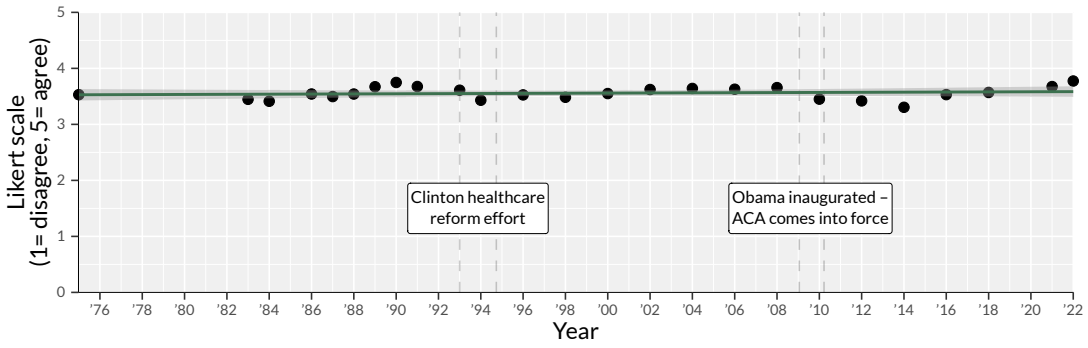


Figure 13. Should government be responsible for providing healthcare for the sick?

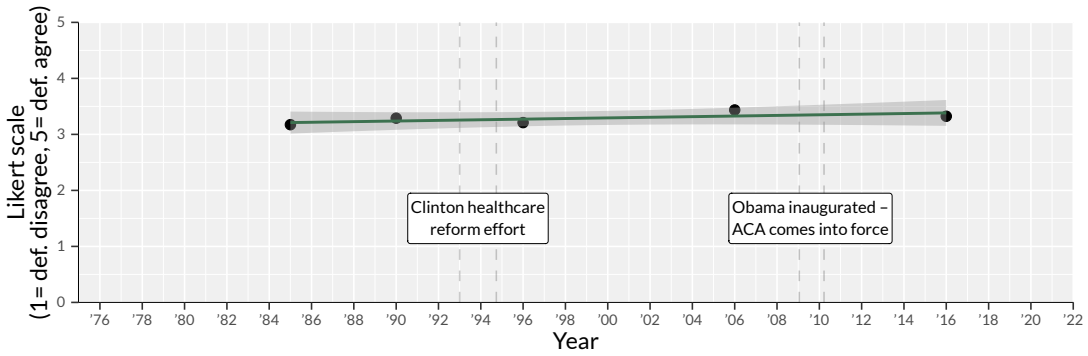
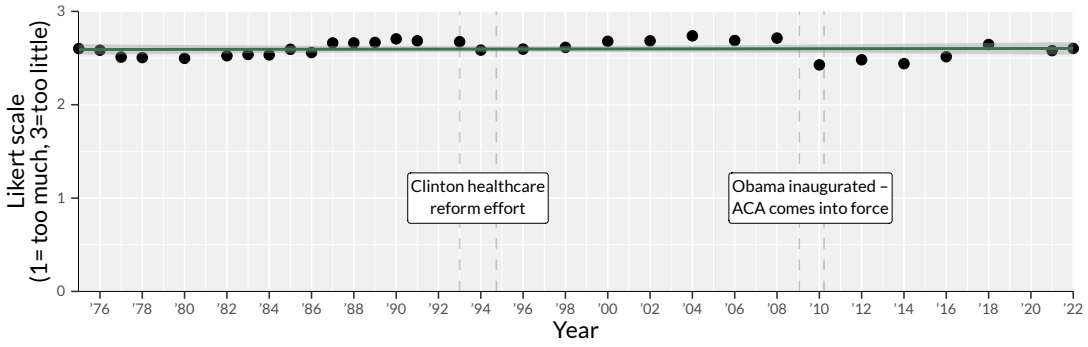


Figure 14. Is government doing enough the improve the nation's health?



mandate had been previously implemented in Massachusetts, lending it more credibility as a plausible policy alternative.

The authors would have to demonstrate that lawmakers and other key stakeholders specifically sought policy alternatives (1) due to their frustration with the status quo and (2) sought alternatives that target the context of the status quo policy, i.e. its specific adverse social outcomes and larger political environment in which it is entrenched. At first glance, this appears self-evident, but finding concrete, direct evidence of diffuse stakeholders' motivations is rather difficult and may often lead to post-hoc rationalization, i.e. actors' motivations are inferred

post-hoc from the outcome, even though there is good reason to operate from the assumption that political outcomes are *not* translated 1:1 from their proponents' motivation, a point which Jacobs and Weaver (2014) make themselves with their notion of emergent costs. The authors do not provide such evidence.

Conclusion and the 1990s reform effort

In summary, Jacobs and Weaver (2014) layout a sound and compelling theoretical part for creating a causal explanation of healthcare reform in the U.S., however, in this, more theory-focussed paper, they do not provide the necessary evidence to craft a minimally sufficient causal explanation of how self-undermining feedback effects led to reform in 2010, employing a mechanistic conception of causal mechanisms. As an extension, unsurprisingly, I must conclude that they also do not present the necessary empirical evidence to craft a minimally sufficient explanation why reform happen in 2010 but not previously in the 1990s.

Outlook post-ACA, post-Trump

Busemeyer et al. (2019) presents an attempt at unifying different conceptions of feedback effects, so they refactor the concept of feedback effects from the classical dichotomy of positive and negative feedback into three types of feedback: accelerating (create support for further expansion of a policy), self-reinforcing (create support for continued provision) and self-undermining (create opposition to further provision). They conduct an analysis of how previous levels of spending in a given policy field (education, health, retirement and unemployment) affects future support for spending in that field. This point in time particularly presents a challenge in crafting an explanation of why no reform of the post-ACA status quo happened after 2016, as major change might be on the horizon (see e.g. recent proposal to cut almost all Medicaid spending via budget reconciliation, Sheidlower & Dorman, 2025). Still, circling back to the introduction, in this post-ACA, post-Trump era we can observe that...

(1) ... there is a concerted effort to abolish the ACA or make major modifications or cuts to it, effectively abolishing it.

(2) ... there is, and has been perviously, windows of ample political opportunity to enact major reform and changes.

(3) ... the ACA has has not been has not been abolished, neither formally via the legislative process, nor in effect via the courts (Liu et al., 2021) or budget cuts.

Considering all this, the political outcome of interest can be specifically stated as "Republicans *fail* to institute major changes to the healthcare policy status quo". With this we can attempt to process-trace this outcome (see 15). If we apply Busemeyer et al.'s (2019) conceptualization of feedback effects, there appears to be some evidence of *both* self-reinforcing and self-undermining feedback effects.

The ACA was an attempt to lower healthcare prices and expenditure by (1) increasing competition among health care providers through regulating more transparency and standardization for healthcare plans and (2) increasing the number of people with coverage via the individual

mandate. However as is evident from the previously presented data of healthcare expenditure (see Figure 3, 5, 8, 9), this did not happen, so there is again an argument to be made that emergent (unanticipated) costs inhibit some of the significant stakeholders from adapting to the new policy status quo, thus incurring unexpected economic losses. Notably, costs once again rose for all relevant stakeholders, though it could be argued as it relates to the federal government (see 6, Figure 10), costs aren't emergent, bus expected, as the ACA explicitly expanded Medicaid to the states. Then again, in light of this, the increased Medicaid expenditures on the state and local level can be considered an emergent cost.

Then in the next stage, somewhat more interestingly, there is evidence to suggest that loss aversion once again acted as the action-formation mechanism, but acting *self-reinforcing*, rather than self-undermining. Mettler et al. (2022) conduct a longitudinal study of the ACA's favorability and find that those who perceive themselves to have gained access to health insurance as a consequence of the ACA are significantly more likely to support it, controlling for partisanship and other relevant individual level predictors. Importantly, even among those that had not perceivably benefitted in from the ACA in terms of healthcare access, the increasingly plausible likelihood of policy reversal during the 2017 attempt to repeal the ACA, support for the ACA increased over time. This finding is crucial to understand why, despite self-undermining emergent costs, support for the ACA increased with time, with the loss framing reinforcing the status quo. There is, however, also a null finding by Haeder and Sylvester (2024), who implement a survey experiment which includes a manipulation that primes respondents to perceive a potential abolition of the ACA as a loss, triggering loss aversion. They present respondents with a survey vignette that informs them that the Supreme Court may declare the ACA unconstitutional, and do not find that framing the abolition of the ACA as a loss has a significant impact on ACA favorability. Despite this null, I argue the evidence presented by Mettler et al. (2022) can be given more weight, as they employ a longitudinal study design, and in the case of Haeder and Sylvester (2024) there is the possibility that the loss framing manipulation failed, either because respondents simply did not change perception or because respondent were already thinking of a potential abolition of the ACA in terms of loss-aversion.

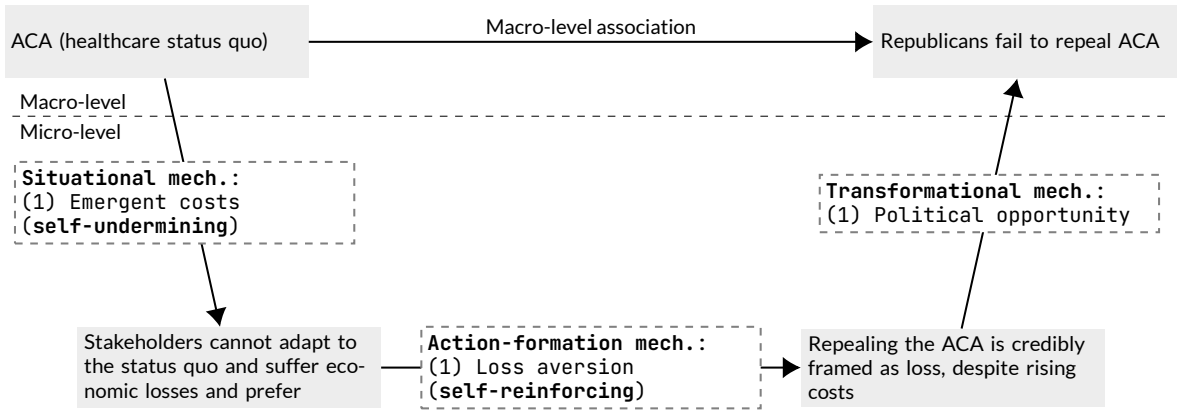
Public preferences alone are, of course, not a sufficient condition for either policy change or policy stability. The question still remains why Republicans failed to enact change, despite the window of opportunity in 2017, when they controlled both houses of Congress and the presidency. Here the empirical evidence is the most ambiguous. On the one hand there is a case to be made or an idiosyncratic, i.e. unsystematic, mechanism: Senator John McCain's voting no, despite being a fiscal conservative (John McCain 2008, n.d.), was motivated by personal reasons, relating, for one, two his personal dislike of Donald Trump (see e.g. Everett, 2016), and for two, his ill health (see Davis & Montanaro, 2017), which may have led him to take greater political risks. Though in the end the effort to repeal the ACA was defeated 51-49, i.e. two votes short, McCain alone was not the deciding vote, but either Republican colleague Lisa Murkowski or Susan Collins. Then again, it is also likely that had McCain been persuaded to vote to repeal, The other two Senators would not have defected either. I argue, this is would be enough to form a valid minimally sufficient and case-specific explanation, but of course somewhat unsatisfactory.

More systematically, the question at hand could be rephrased as *why did enough Senators defect from their party's line, leading to legislative defeat?* Put this way, the question becomes about party discipline. Generally, majoritarian legislative systems are theorized to have weaker party discipline (see e.g. Kam, 2014). Consequently, this line of inquiry would be more fruitful if the question at hand related to explaining diverging political outcomes between different political systems, but the question refers to one political system at different points in time. Taking a look at McCain's official statement as to the reason of his no vote:

> From the beginning, I have believed that Obamacare should be repealed and replaced with a solution that increases competition, lowers costs, and improves care for the American people. The so-called 'skinny repeal' amendment the Senate voted on today would not accomplish those goals. While the amendment would have repealed some of Obamacare's most burdensome regulations, it offered no replacement to actually reform our health care system and deliver affordable, quality health care to our citizens. The Speaker's statement that the House would be 'willing' to go to conference does not ease my concern that this shell of a bill could be taken up and passed at any time (**QUELLE**)

The question then becomes "why weren't Republicans able to formulate an acceptable alternative to the ACA?" Republicans' proposed replacement of the ACA, the American Health Care Act 2017,

Figure 15. *Bathtub* model of American healthcare reform post-ACA



Discussion

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