Quasi-Constitutionalism and Informal Legislative Entrenchment

Ranchordás, Sofia

Published in:
Quasi-constitutionality and Constitutional Statutes

Publication date:
2019

QUASI-CONSTITUTIONALISM AND INFORMAL LEGISLATIVE ENTRENCHMENT:

THE CASE OF THE AFFORDABLE CARE ACT

Sofia Ranchordás[1]

Preliminary Version

Forthcoming in

Richard Albert & Joel Colon Rios, *Quasi-Constitutionality and Constitutional Statutes: Forms, Functions, and Applications* (Routledge 2018)

Abstract

Quasi-constitutional statutes—at the resemblance of constitutions—aim to entrench core social values. Quasi-constitutional statutes are able to root these values because they persist through time and are able to stand up well to societal, political and economic changes and judicial challenges. Nonetheless, the legal literature has not attended to the informal forces that explain the entrenchment of legislation. These forces, however, are behind their long-lasting nature and the democratic acceptance of statutes that eventually acquire a quasi-constitutional character. In this book chapter, I draw on interdisciplinary literature and the specific case of the Affordable Care Act and other US health care programs to describe how certain statutes become informally entrenched and resist legislative reform. The slow-going changes in the US health care sector and the current difficulty in repealing or amending the Affordable Care Act can help us understand the role of social, political, and bureaucratic elements in the entrenchment of quasi-constitutional statutes.

1. Introduction

The ACA is here to stay,"[2] President Obama stated in the wake of the 2015 Supreme Court decision *King v. Burwell*.[3] In the year that two of America's most enduring social programs—Medicare and Medicaid—celebrated fifty years of existence and the presidential campaign for the next term

[1] Chair of European and Comparative Public Law & Rosalind Franklin Fellow, University of Groningen, The Netherlands.

[2] Ed O' Keefe, *Obama:* "The Affordable Care Act Is Here to Stay," Washington Post, 25 June 2015 at http://www.washingtonpost.com/blogs/post-politics/wp/2015/06/25/obama-the-affordable-care-act-is-here-to-stay/ ("The Affordable Care act is here to stay," President Obama declared.).

[3] King v. Burwell, 135 S. Ct. 2480 (2015).

started, the then still recent Patient Protection and Affordable Care Act (ACA)[4] aspired to become part of this panoply of long-lasting social reforms.[5] Indeed, part of the legacy of the ACA or of any significant legal reform is determined by its duration and how deeply it becomes entrenched in a legal order.[6] The entrenchment of this act would protect it partially against the winds of change and the promises of the Republican candidates to repeal this statute. Following *King v. Burwell* academic commentators discussed the U.S. conservatives' fear that the ACA would become a "super-statute," that is, a statute with quasi-constitutional character that is broadly accepted by the people, is able to resist reform attempts, and judicial challenges.[7] As winds of change are expected during the Trump Administration, this qualification might appear to be premature and unrealistic at the time of writing. However, the difficulties in amending the ACA and the lack of consensus in Congress on how to reform this statute has revealed thus far the existence of informal entrenchment forces that are typically observed in the context of quasi-constitutional statutes.

In theory, the phenomenon of legislative persistence or the resistance to legislative reform should not be regarded as an exceptional matter. But sometimes it is because it limits the power of newly elected parliaments to amend legislation. Indeed, legislative persistence is an important dimension of the principle of legal certainty which is regarded by many as a cornerstone of our legal orders.[8] However, our legal orders are also characterized by an important tension between

[4] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).
[5] Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (codified as amended in scattered sections of 42 U.S.C.). Edward Berkowitz, 'Medicare and Medicaid: The Past as Prologue' (2008) 29 *Health Care Financing Rev*. 81.
[6] Paul Starr, 'The Health-Care Legacy of the Great Society' 235 in Norman J. Glickman & Robert H. Vilson (Eds.), *LBJ's Neglected Legacy: How Lyndon Johnson Reshaped Domestic Policy & Government* (University of Texas Press, 2015) 235, 246.
[7] Jonathan Oberlander and Eric Patashnik, 'Conservatives Worry that Obamacare is a "Super-Statute." It Isn't Quite Yet." *Washington Post*, June 18, 2015, available at https://www.washingtonpost.com/blogs/monkey-cage/wp/2015/06/28/conservatives-worry-that-obamacare-is-a-super-statute-it-isnt-quite-one-yet/ (last accessed on December 1st, 2017).
[8] Patricia Popelier, 'Five Paradoxes on Legal Certainty and the Lawmaker'(2015) 2 *Legisprudence* 47.

past and future. On the one hand, legislators aim to secure legislative continuity and protect the legitimate expectations of citizens. On the other, if law is to remain aligned with the will of the people, legislative reform cannot be avoided. The entrenchment of quasi-constitutional statutes has a special place in this conflict.

Quasi-constitutional statutes—at the resemblance of constitutions—consecrate core values of society as they are able to stand up well to societal, political, judicial, and economic changes. Quasi-constitutional statutes are able to root these values because they persist through time. Nonetheless, the legal literature has not attended to the informal forces that explain the long-term persistence or entrenchment of legislation. These forces, however, are behind their long-lasting nature and the democratic acceptance of statutes that eventually acquire a quasi-constitutional character. In this book chapter, I draw on interdisciplinary literature to describe how these statutes become informally entrenched. Although each quasi-constitutional statute has a unique entrenchment story, several of these informal forces are visible in different fields (*e.g.*, sunk cost fallacy, bureaucracy). I rely on examples from the field of U.S. health care law to explain why certain statutes have become almost impermeable to change despite the absence of any formal or *de jure* obstacles. I discuss the entrenchment of Medicaid and Medicare as well as the conscious or unconscious attempt to entrench ACA. This subject is particularly relevant at the time of writing as the U.S. Congress has been trying to amend the ACA since the beginning of 2017. However, despite the promises of President Trump to repeal the act, this legislative change has been difficult to execute in practice. Regardless of the future outcome of this legislative reform, this academic contribution should remain relevant as it analyzes the socio-political forces that have been entrenching legislation for centuries.[9]

[9] *See*, *e.g.*, Niccolò Machiavelli, 'The Prince' 167, 173 *in* Mitchell Cohen & Nicole Fermon (Eds), *Niccolò Machiavelli, Readings in Political Thought: Essential Texts Since Plato* (Princeton University Press 1996) ("There is

In this book chapter, I draw on the antecedents of the ACA to demonstrate how the social and political processes can be conducive to informal legislative entrenchment, contributing to the qualification of a statute as quasi-constitutional. Informal entrenchment can be diagnosed not only in the context of quasi-constitutional statutes but also more generally whenever democratic or bureaucratic forces are able to resist legislative reform.[10] I argue that informal entrenchment is particularly visible in the health care sector where legislative change is generally difficult to achieve but once it is in place, adopted policies and statutes will on their turn be resistant to alterations. The informal entrenchment forces analyzed in this paper are characteristic of quasi-constitutional statutes which tend to persist since they are legitimized by broad legislative deliberation, fundamental principles, and popular support.[11]

This book chapter is organized as follows: section 2 distinguishes between formal and informal entrenchment; section 3 analyzes different informal entrenchment forces in US health care law; section 4 discusses the process of informal entrenchment in the context of quasi-constitutionalism.

2. Informal Entrenchment

Legislative entrenchment is the long-term persistence of legislation which is rooted in either democratic or bureaucratic forces. The causes of legislative entrenchment can be either legal (formal entrenchment) or social, political, or economic (informal entrenchment). Legislative entrenchment is a cross-temporal phenomenon that limits legislative change.

---

nothing more difficult to carry out, nor more doubtful of success, nor more dangerous to handle, than to initiate a new order of things. For the reformer has enemies in all those who profit by the old order, and only lukewarm defenders in all those who would profit by the new order.").

[10] Cf. Erin C. Fuse Brown, 'Developing a Durable Right to Health Care' (2013) 14 *Minnesota J. of Law, Science & Technology* 439.

[11] William N. Eskridge & John Ferejohn, 'Super-Statutes' (2001) 50 *Duke L.J.* 1215, 1216 (2001) *See also* William N. Eskridge & John Ferejohn, *A Republic of Statutes: The New American Constitution* (Oxford University Press 2013).

The term "legislative entrenchment" has received a great deal of negative attention in the literature in the last decades. It has been described as a "promiscuous word" and a synonym of outdated and ineffective legislation that reduces parliamentary sovereignty.[12] While common law jurisdictions might have a natural bias toward the maintenance of the status quo, *de jure* or formal entrenchment dispositions are void as current parliamentary majorities cannot prevent future ones from amending ordinary legislation.

Formal entrenchment is generally a premeditated and explicit practice, while informal entrenchment is often implicit and unpredictable, resulting from the well-known legislative inertia, unexpected events or an unpredictable assembly of forces that impede Congress from modifying an existing statute. [13] Legislative entrenchment implies that legislative change is difficult but not impossible. Any statute can potentially shift the burden of inertia from one legislature to the other to a greater or smaller extent.[14] Government contracts, treaties, and a number of other legislative actions with effects to third parties can impose costs on future majorities that seek to escape the consequences of the earlier action.[15]

From a functional perspective, legislative entrenchment can be divided into two categories. First, legislative entrenchment can be perceived as a part of the so-called agency problem of representative government, where elected representatives attempt to leave a legacy and perpetuate

[12] Eric A. Posner & Adrian Vermeule, 'Legislative Entrenchment: A Reappraisal' (2002) 111 *Yale L.J.* 1665; *see also* John O. McGinnis & Michael B. Rappaport, 'The Constitutionality of Legislative Supermajority Requirements: A Defense' (1995) 105 *Yale L.J.* 483, 503-507; Michael J. Klarman, 'Majoritarian Judicial Review: The Entrenchment Problem' (1997) 85 *Georgia L. Rev.* 491, 505-506; Catherine Fisk & Erwin Chemerinsky, 'The Filibuster' (1997) 49 *Stanford L. Rev.* 181, 247- 249; David Dana & Susan P. Koniak, 'Bargaining in the Shadow of Democracy' (1999) 148 *University of Pennsylvania L. Rev.* 473, 526-36; Stewart E. Sterk, 'Retrenchment on Entrenchment' (2003) 71 *George Washington L. Rev.* 231, 232; John C. Roberts & Erwin Chemerinsky, 'Entrenchment of Ordinary Legislation: A Reply to Professors Posner and Vermeule' (2003) 91 *California L. Rev.* 1775, 1778.
[13] Abbe R. Gluck, 'Symposium Issue Introduction: The Law of Medicare and Medicaid at Fifty' (2015) 15 *Yale J. of Health Policy, L. & Ethics* 1, 15.
[14] Eule, *supra* note 10, at 379, 384.
[15] Posner and Vermeule, *supra* note 10, at 1696

their preferences in detriment of their constituents.[16] Second, legislative entrenchment also serves cross-temporal purposes. Cross-temporal legislative entrenchment is a more neutral concept that refers sometimes to well-intended limitations on future parliaments.[17] This form of entrenchment is thus the result of the legal and non-legal instruments employed to guarantee that tomorrow's parliament will abide by the statutes enacted by today's majority. At first, this concept might seem equally objectionable on majoritarian grounds as the first type of entrenchment.[18]

The negative position of the literature toward legislative entrenchment has been explained by the need to avoid the adoption of formal legal dispositions that create formal obstacles to legislative amendment (*e.g.*, supramajoritarian requirements). These formal requirements are typically present in constitutions as they are aimed to create constitutional stability and protect fundamental rights. Despite the existence of an important body of literature on formal entrenchment, these clauses are rare sights. In the real world, legislation stays in place not because the "laws says so" but because of social, political, and economic obstacles to change.

In the scholarship of John Ferejohn and William Eskridge, informal entrenchment has been associated with the concept of super-statutes.[19] Although unknown in the international literature, the term of "super-statute" finds its equivalent in comparative literature in the concept of quasi-constitutional law and, in some legal systems, in the form of organic laws. A super statute is a law or series of laws that seeks to establish a new normative or institutional framework and over time "sticks" in the public culture having a broad effect on the law.[20] Examples of quasi-constitutional

[16] Samuel Issacharoff & Daniel R. Ortiz, 'Governing Through Intermediaries' (1999) 85 *University of Virginia L. Rev.* 1627.
[17] *See* Aaron-Andrew Bruhl, 'Using Statutes to Set Legislature Rules: Entrenchment, Separation of Power, and the Rules of Proceedings Clause; (2003) 19 *J. of Law & Policy* 345, 372.
[18] Klarman, *supra* note 10, at 504.
[19] William N. Eskridge & John Ferejohn, *A Republic of Statutes: The New American Constitution* (Yale University Press 2013).
[20] William N. Eskridge & John Ferejohn, 'Super-Statutes' (2001) 50 *Duke L.J.* 1215, 1216.

statutes that have become entrenched in the U.S. legal order are the 1965 Social Security Act which established the Medicaid and Medicare programs, the Voting Rights Act, and the Administrative Procedure Act.

The longstanding nature of a law does not convert it automatically into a quasi-constitutional statute. As Vermeule has explained, while first degree murder rules have persisted longer than a number of laws and policies that are often qualified as entrenched statutes and super statutes (*e.g.*, the 1965 Social Security Act), this does not necessarily mean that the Congress' hands were tied regarding the amendment of those rules. In this case as in many others, legislation remains because "people like them," they are deemed to be still reasonably effective or there are no alternatives.

Informal entrenchment does not implicate the adoption of any formal entrenchment clause but rather that the existence of informal entrenchment mechanisms which sustain a statute beyond the ravages of time. The importance of informal entrenchment has been visible in the endurance of legislation in the health care sector. Both Medicaid and Medicare have been able to resist several repeal attempts,[21] even though the 1965 Social Security Act did not include any *de jure* entrenchment clauses.[22]

In this book chapter, I identify a number of informal entrenchment forces that typically contribute to the long-term persistence of both quasi-constitutional and ordinary statutes.

3. Informal Entrenchment Forces in U.S. Health Care Law

[21] Medicaid and Medicare are two public health insurance programs. While Medicare is a federally-run program that provides healthcare insurance primarily to the aged (65 years or older) without regard to financial need, Medicaid is a joint federal-state insurance designed to provide medical care to low-income individuals. *See John E. Steiner, Jr., Problems in Health Care Law: Challenges for the 21st Century* (Jones & Bartlett, 2014) 309.

[22] Ken Wing, 'The Impact of Reagan-era Politics on the Federal Medicaid Program' (1983) 33 *Catholic University L. Rev.* 1; Robert C. Lieberman, 'Ideas, Institutions, and Political Order: Explaining Political Change' (2002) 96 *American Political Science Rev.* 697.

The natural bias of legal orders toward the status quo can be reinforced by the characteristics of the sector. While technological and educational sectors (*e.g.*, telecommunications, biotechnology) are characterized by fast changes; others like health care, are slow-going and impermeable to sudden course corrections.[23] A change in these fields is often analyzed from the perspective of the ordered and patterned regularity that characterizes them.[24] Health care, for example, is a "glacial field".[25] In the particular case of the American health care system, Theodore Ruger has explained this feature in light of the "remarkably slow pace of change, reform, [and] systematic federal involvement."[26] In addition, these slow changes of the American healthcare system are also attributed to the sedimentary legacy of prior legal regimes which are present in the attitudes of both physicians and patients.[27]

In 1967, Time magazine ironically entitled an article "Medicare: Expensive, Successful, Medicaid; Chaotic, Irrevocable." [28] More than fifty years later, we are able to say that some of these predictions proved to be accurate. Despite the attempted repeals and amendments of the Reagan Administration, Medicare and Medicaid are still alive and well.[29] Medicare, in particular, has become a highly popular and bipartisan program. This example introduces the essence of informal entrenchment which refers to a situation "in which the possibility of amendment is virtually impossible because of exceptionally high procedural [but non-legal] barriers to change."[30]

---

[23] *See* Lyria Bennett Moses, 'Recurring Dilemmas: The Law's Race to Keep Up with Technological Change' (2007) 2 *J. of Law, Technology. & Policy* 239.
[24] Lieberman, *supra* note 21, at 700.
[25] Theodore W. Ruger, 'Of Icebergs and Glaciers: The Submerged Constitution of American Healthcare' (2012) 75 *L. & Contemporary Problems* 215.
[26] *See id.* at 219.
[27] *See id* at 219.
[28] 'Medicare: Expensive, Successful; Medicaid: Chaotic, Irrevocable' (1967) *Time Magazine* (October 6, 2017).
[29] Diane Rowland, Barbara Lyons & Jennifer Edwards, 'Medicaid: Health Care for the Poor in the Reagan Era' (1988) 9 *Ann. Rev. of Pub. Health* 427, 430.
[30] Melissa Schwartzberg, *Democracy and Legal Change* (Oxford University Press 2009) 12.

These barriers do not result from the legal text but from the social, economic, and political obstacles that I shall analyze in the following subsections.

3.1. Sunk Costs

Conventional wisdom in political science says that policies are hard to terminate: Once policies are introduced, they are likely to persist.[31] Policy persistence, or the tendency of policies to change slowly, if at all, is often regarded as the outcome of political inertia. As laws and policies have an instrumental relationship, a similar reasoning tends to apply to legislation. Policy persistence becomes a "problem" when there are no rational reasons to maintain a policy in place.[32] This occurs, for example, when suboptimal policies are not timely terminated or when they become superfluous because the problem they aimed to address no longer exists.[33] The existence of monetary or psychological sunk costs is often invoked as a reason to justify the persistence of suboptimal policies.[34]

In a study on the closure of Marine Hospitals in the United States, Janet Franz demonstrated that while public policy termination can save costs in the long-run; in the short-run the termination process involves considerable and dissuasive costs to prevent damages to communities, constituents, and staff.[35] The Marine Hospitals were originally established in the eighteenth century to provide medical assistance to disabled sailors in the United States. As their work conditions improved and the economy evolved, the protection of this particular class of

[31] *See generally* Stephen Coate & Stephen Morris, 'Policy Persistence' (1999) 89 *Am. Econ. Rev.* 1327.
[32] Iris Geva-May, 'When the Motto is 'Till Death Do Us Part': The Conceptualization and the Craft of Termination in the Public Policy Cycle' (2001) 24 *Int'l J. of Pub. Admin.* 263.
[33] *See* Mark R. Daniels, *Terminating Public Programs: An American Political Paradox* (Routledge 1997) 31.
[34] Peter DeLeon, 'Policy Evaluation and Program Termination' (1983) 2 *Policy Studies Rev.* 631.
[35] Janet E. Frantz, 'The High Cost of Policy Termination' (1997) 20 *Int. J. of Pub. Admin*. 2097, 2010-11.

workers stopped being prioritized. In 1981, a program was initiated to terminate health care programs for merchant sailors. Franz found that although the termination of this program was technically successful, it came at a high cost.[36] In addition, the sunk costs related to the investment in human capital often are an important concern—despite being a typical case of a sunk cost fallacy—when agencies are terminated and highly specialized staff must be discharged or transferred to other functions.[37]

3.2. Path Dependence in Health Care Reforms

The well-known theory of path dependence has explained for decades how past decisions tend to constrain our present and future. Legislators—like many of us—tend to be risk-averse and thus avoid radical policy changes. Path dependence explains the type of health care services we receive and how laws and policies evolve to meet the changing needs of society (*e.g.*, new medical conditions associated with aging) and the sector (*e.g.*, the rising costs of health care services). Considering this path-dependence constraint, policy and legislative changes tend to be incremental rather than disruptive.

In the 1990s, path dependence was believed to be not very auspicious for future efforts to reform American health care. Instead, it was then clear that there was a path to be followed in order to reform health care and achieve universal coverage.[38] This tendency to maintain the status quo has also been explained in light of the multiple barriers to lawmaking in Congress, namely the challenge of gathering political consensus, and the design of federal statutes that rely on state

[36] *Id*. at 2109.
[37] *See* Iris Geva-May, 'Till Death Do Us Part: The Conceptualization of Policy Termination' (2001) *24 Int. J. of Pub. Admin*. 263; Eugene Bardach, 'Policy Termination as Political Process' (1976) 7 *Political Science* 126.
[38] *See* World Health Org., *Health Systems Financing: The Path to Universal Coverage* (WHO 2010) 7.

administration for its implementation.[39] The ACA is a good example of the tension between past paths and the wish to build a new one in order to expand access to health care.

The ACA has been characterized as the "most monumental piece of health care legislation" in the last decades.[40] However, the ACA is not as disruptive as one might think. It does not include an explicit and public utility regulatory vision of health care at the resemblance of other countries. Citizens will not find a right to health or healthcare posited in this statute. Rather, the ACA builds upon decades of reforms by improving access to health insurance for many—but certainly not all—citizens. This improvement resides in the introduction of a subsidy program that aims to provide access to health care insurance to those who would not have the means to pay for medical care.[41] This statute fills existing gaps, namely by changing the way health care is financed.[42]

The ACA is new and old at the same time. The truth is that this statute had been "in the making" for almost eighty years: In 1932, the Committee on the Costs of Medical Care released a report, recommending the creation of a program which would include the utilization of provider groups, preventive care services, universal coverage, and significant investment in provider training.[43] These suggestions were not adopted in the 1930s but they might sound familiar to us as several of them were recently embraced by the ACA. However, the first steps toward the reform of the U.S. health care system were given in the 1930s during the Roosevelt Administration.[44]

---

[39] Abbe R. Gluck, 'Federalism from Federal Statutes: Health Reform, Medicaid, and the Old-Fashioned Federalists' Gamble' (2013) 81 *Fordham L. Rev*. 1749, 1761.
[40] Rene Bowser, 'The Affordable Care Act and Beyond: Opportunities for Advancing Health Equity and Social Justice' (2013) 10 *Hastings Race & Poverty L. J*. 69, 71.
[41] Abigail R. Moncrieff, 'Regulation: What the Obama Administration Should Have Said in NFIB V. Sebelius' (2013) 39 *Am. J. of L. & Med.* 539, 541.
[42] *See* Starr, *supra* note 6, at 246.
[43] Simon F. Haeder, 'Beyond Path Dependence: Explaining Healthcare Reform and Its Consequences' (2012) 40 *Policy Studies J.* 65 (2012).
[44] Everette James & Arthur S. Levine, 'The Inevitability of Health Reform' (2012) 50 *Duquesne L. Rev*. 235. *See also* James A. Morone, 'President and Health Reform: From Franklin D. Roosevelt to Barack Obama' (2010) 29 *Health Affairs* 1096; M. M. Matusiak, 'A National Health Insurance System/Program: A Review of US History and Current Debate' (2005) 3 *Internet J. Of Healthcare Administration* (2005), §14, available at http://www.ispub.com/journal/the-internet-journal-of-healthcare-administration/volume-3-number-2/a-national-

During many decades, health care reforms tended to be received with animosity. Before the enactment of the ACA, there were already several programs designed to increase access to health care. This was the case of Medicare, Medicaid, EMTALA, TRICARE, COBRA, the Federal Employee Health Benefits Program, CHIP, and the Veterans Administration. Besides these federal government programs, there were also federal-state programs, the most significant of which is Medicaid.[45] Medicaid became the third largest entitlement program in the United States, preceded by Social Security and Medicare. This public insurance program together with Medicare replaced two previously existing programs of federal grants to states to provide health care assistance to low-income citizens.[46] One program guaranteed medical care to welfare recipients and the other to the elderly.

In 1971, President Nixon's National Health Strategy proposed new measures to improve the efficiency of the American health care system while expanding access to health care. In theory, the "Nixon-plan" greatly resembled the ACA.[47] The proposal was however at that time not well received. An important step in the direction of the expansion of the access to health care services was given in 1986. Congress enacted the Emergency Medical Treatment & Labor Act (EMTALA) to guarantee public access to emergency services regardless of ability to pay. Section 1867 of the Social Security Act created a federal right to emergency medical treatment.[48] All these programs seem to have laid out a certain path for health care reform.

---

health-insurance-system-program-a-review-of-us-history-and-current-debate.html#e-3

[45] John E. Steiner, Jr. (Eds.), *Problems in Health Care Law: Challenges for the 21st Century* (Jones & Bartlett 2014) 305.

[46] Jonathan Gruber, 'Medicaid' in Robert A. Moffitt (eds), *Means-Tested Transfer Program in the United States* (University of Chicago Press, 2003).

[47] Wesley J. Smith, 'It's not Obamacare, It's the Nixon Plan' (2013) *National Review*, October 23, 2013, available at http://www.nationalreview.com/corner/362362/its-not-obamacare-its-nixon-plan-wesley-j-smith (last visited July 10, 2017).

[48] W. David Koeniger, 'The Statute Whose Name We Dare Not to Speak: EMTALA and the Affordable Care' (2013) 16 *J. of Gender, Race & Justice* 139.

In 1990s, President Clinton also tried to reform the American health care system. The Clinton Plan was radically new and was not incremental in its design or implications for health policy. The "Clintoncare" aimed to expand health care coverage by creating regional health alliances, imposing more burdensome employer and individual mandates. The Clinton health plan was essentially regulatory.[49] In addition, it represented a major policy change that did not fit well with American political institutions which struggle to accommodate large-scale reform.[50]

In 2009, almost 50 million persons in the United States did not have access to health insurance coverage.[51] According to recent OECD studies, even relatively advantaged and college-educated Americans seemed to be worse off than other peers in other OECD countries.[52] "Obamacare", as it is commonly known, does not solve entirely the problem, but it makes an important incremental improvement. The enactment of the ACA is the mere starting point of a thorough reform of the American health system.[53] This begs however the following question: If the path to health reform was already being paved for decades, why was only President Obama successful in passing such a health reform and coining it? Four main reasons explain this puzzle: the economic crisis, that is, the recovery from the 2008 recession which had exacerbated the hardship faced by a vast part of the population; the political momentum with the initial Democratic

[49] Abigail R. Moncrieff, 'Regulation: What the Obama Administration Should Have Said in NFIB V. Sebelius' (2013) 39 *Am. J. of L. & Med.* 539, 543.
[50] David Wilsford, 'Path Dependency, or Why History Makes It Difficult but Not Impossible to Reform Health Care Systems in a Big Way' (1994) 14 *J. of Public Policy* 251.
[51] Kaiser Family Foundation, *Health Insurance Coverage in the United States* (2009), available at http://kff.org/other/state-indicator/total-population/
[52] Elizabeth Bradley & Lauren A. Taylor, *The American Health Care Paradox: Why Spending More Is Getting Us Less* (PublicAffairs 2013).
[53] Ezekiel J. Emanuel, *The Beginning of a Health Care Revolution,* N.Y. TIMES, Mar. 20, 2014 at http://www.nytimes.com/roomfordebate/2014/03/20/obamacares-four-year-checkup/the-beginning-of-a-health-care-revolution.

takeover of Congress; the rising costs of health care services; and the enactment of a path-dependent program.[54]

In the 1930s and the 1970s, a healthcare reform would have been too precocious as a number of required steps had to be taken first in order to pave the way for universal coverage. The system introduced by the ACA is built on existing structures, institutions and policy programs, such as health insurances, employer-based insurance, and Medicaid. This statute introduces nonetheless a number of novelties including the prohibition of discrimination on preexisting conditions and the health insurance premiums subsidies.[55] The ACA is therefore a compromise between the new model which aims to expand coverage and guarantee affordable health care insurance and the old model governed by private and for-profit insurers as the primary providers of access to health care.[56] The ACA initiates nevertheless the realignment of the health-care system for long-term changes in health-care quality, the organization and design of health-care practice, and health information transparency.

The ACA follows a long path which started being paved by President Roosevelt. There is thus a conservative and a progressive side to the ACA. On the one hand, the ACA does not change the whole system, it seeks to improve it. On the other, it tries to change the way Americans perceive health and their entitlement to health care. In this sense, the ACA aims to go further than any previous legislative act and federally-run programs such as Medicare and Medicaid; but at the same time it is path-dependent.

[54] Jacob Hacker, 'The Road to Somewhere: Why Health Reform Happened' (2010) 8 *Perspectives on Policy* 861, 863.
[55] Sarah Rosenbaum, 'The Patient Protection and Affordable Care Act: Implications for Public Health Policy and Practice' (2010) 126 *Public Health Reports* 130.
[56] *See* Jessica L. Roberts, "Healthism": A Critique of the Antidiscrimination Approach to Health Insurance and Health-Care Reform' (2012) *U. Illinois L. Rev.* 1159 (2012).

The historical antecedents of the ACA demonstrate the path dependence of this ACA and its clear place in history. However, the resemblance of the ACA with previous Republican proposals and the limited and incremental reforms are justified not only by path dependence but also by the entrenched power of constituencies and institutions from past policy decisions.[57] For example, one of the pillars of the ACA is the expansion of Medicaid.[58] The ACA maintains the structure of this program as well as the traditional paths into Medicaid for pregnant women, children, caretakers of children, and disabled persons.[59] But, as Chief Justice John Roberts suggested in *NFIB v. Sebelius,*[60] the ACA abandons the traditional concept of "the deserving poor," that is, Medicaid is no longer a "privilege" of the "neediest among Americans." Instead, it suffices to be poor—from a purely neural perspective—to be eligible for Medicaid.[61]

3.3. Entrenchment and Interest Groups

The influence of interest groups on policies and regulation has been widely discussed in the Public Choice literature.[62] Public choice theorists have discussed how special interest groups develop rent-seeking strategies to lobby for regulation that is more favorable to them and oppose any kind of reform that would equal to loss of benefits for a special group. To illustrate, after defending universal coverage during his campaign, President Carter advanced a more modest

[57] Simon F. Haeder, 'Beyond Path Dependence: Explaining Healthcare Reform and Its Consequences' (2012), 40 *Policy Stud. J.* 65, 69; Jacob Hacker, 'The Road to Somewhere: Why Health Reform Happened' (2010) 8 *Perspectives on Policy* 861.
[58] *See* however Nat'l Fed'n of Indep. Bus. (NFIB) v. Sebelius, 132 S.Ct. 2566 (2012).
[59] ACA 42 U.S.C. §1396a(a)(10)(A)(i), §2581 (2012).
[60] Nat'l Fed'n of Indep. Bus. v. Sebelius (NFIB), 132 S.Ct. 2566, 2606 (2012). *See* David Orentlicher, 'Medicaid at 50: No Longer Limited to the "Deserving" Poor?' (2015) 15 *Yale J. of Health Policy L. & Ethics* 185 (2015).
[61] The ACA expanded the Medicaid program to all persons up to 138% of the federal poverty level.
[62] *See, e.g.*, Sam Peltzman, 'Toward a More General Theory of Regulation' (1976) 19 *J. of L. & Econ.* 211; George J. Stigler, 'The Theory of Economic Regulation' (1971) 2 *Bell J. of Econ. & Management Science* 3; Richard Posner, 'Theories of Economic Regulation' (1971) 5 *Bell J. of Econ. & Management Science* 335.

proposal to reform the health care system by introducing a plan for an across-the-board cap on hospital charges. This would limit annual increases to one-and-a-half times any rise in the consumer index.[63] The Federation of American Hospitals rapidly formed a coalition to lobby against this plan. This Federation established a well-organized committee that sent thousands of letters to every hospital administrator in the country. In addition, this organization developed an alternative "voluntary" cost containment plan. As a consequence of this action, the Carter plan never left the Senate Finance Committee.[64]

Depending on the benefits at stake, the influence of special interests on legislative entrenchment can be symmetric and it can be exerted either *ex ante* or *ex post* on any great reforms that may endanger vested interests. To illustrate, in 1965, Medicare faced fierce opposition from the American Medical Association. At that time, physicians feared that Medicare would influence general medical practices.[65] Congress responded by prohibiting Medicare of "exercis[ing] any supervision or control over the practice of medicine or the manner in which medical services are provided."[66] Instead, the common practices developed by the Blue Cross and Blue Shield organizations were borrowed, determining the separate payment of hospitals and physicians for single episodes of care.[67] More than fifty years later, not only is Medicare still standing but its inefficiencies have been sheltered from proposed reforms by thousands of physicians behaving like street-level bureaucrats.[68]

---

[63] Tom Daschle Et. Al., *Critical: What We Can Do about the Health Care Crisis* (St. Martin's Griffin 2009) 66.
[64] Jill Quadagno, 'Institutions, Interest Groups, and Ideology: An Agenda for the Sociology of Health Care Reform' (2010) 51 *J. of Health and Social Behavior* 125, 129; *See also* Jill Quadagno, 'Why the United States Has No National Health Insurance: Stakeholder Mobilization Against the Welfare State, 1945-1996' (2004) 45 *J. of Health and Social Behavior* 25 (2004).
[65] Nicholas Bagley, 'Bedside Bureaucrats: Why Medicare Reform Hasn't Worked' (2013) 101 *Georgetown. L. J*. 519, 521.
[66] Social Security Amendments of 1965, Pub. L. No. 89-97, sec. 102(a), § 1801, 79 Stat. 291 (codified at 42 U.S. C. § 1395 (2006).
[67] Bagley, *supra* note 65, at 526.
[68] Bagley, *supra* note 65, at 522.

Legislative change can be difficult to achieve not only because of the presence of special interests but also because of the existence of divergent interest groups. Health care reforms such as the one introduced by the ACA requires extensive negotiation with a variety of self-interested groups who do not agree on a number of topics: Small businesses that do not offer or do not wish to offer health insurance to their employees; hospitals and health care providers that are skeptical of health reforms since they are afraid of repercussions on the prices of their services; religious groups and unions that seek to shape their members even through the delivered health care services; constituents with divergent preferences and needs; and pharmaceuticals that are interested in marketing their products.[69]

Despite the difficulty in uniting diverse groups, there are examples that show that when legislative change is perceived as a common enemy, more and less privileged interest groups might be more inclined to form coalitions. For example, in the 1990s, physicians joined patient groups to lobby state legislatures against managed care firms.[70] Different special interest groups have also tried to maintain the status quo in detriment of the evidence or the disclosure of information regarding the most effective treatments. In 2009, the inclusion of the so-called comparative effectiveness approach in the economic stimulus package to fund studies evaluating treatments for several diseases, became an important source of concern for pharmaceuticals and medical devices producers. Patients also feared that comparative effectiveness, which aims to identify the most effective treatment for a certain disease, would mean that patients would be denied specific care on the grounds of its costs.[71] A number of pharmaceuticals formed a coalition with the National

[69] *Lawrence R. Jacobs & Theda Skocpol, Health Care Reform and American Politics: What Everyone Needs to Know* (Oxford University Press 2012) 57-58.
[70] Quadagno, *supra* note 64, at 129.
[71] David Orentlicher, 'Rationing Health Care: It is a Matter of the Health Care System Structures' (2010) 19 *Annals Health L.* 449, 455.

Health Alliance for Hispanic Health and the National Alliance on Mental Illness, both subsidized by them, to attempt to reject the comparative effectiveness approach, arguing the underrepresentation of Hispanic in comparative effective research.[72]

3.4. Citizen Mobilization

Informal entrenchment tends to be a bottom-up process which can be triggered by social movements which can both license or limit legislative change.[73] In the process of entrenchment of the ACA we observe both trends.

The ACA started developing institutions that could generate constituencies that, over time, may guarantee reiterated political support.[74] On January 2, 2014, an optimistic article in the Washington Post declared the end of the fight against Obamacare as 6 million previously uninsured citizens started to benefit from the expansion of Medicaid. In 2017, former President Obama still uses social media to urge uninsured Americans to register for a health plan. At first sight—and perhaps in a country with different demographics and political tradition—these actions could lead to a point of no return for the entrenchment of the ACA since newly registered citizens would oppose any attempt to reduce their benefits. In the United States, this number might not necessarily suffice to stop the legislative reform attempts initiated in the first year of the Trump

[72] Barry Meier, 'New Effort Reopens a Medical Minefield', *New York Times*, May 7, 2009, available at http://www.nytimes.com/2009/05/07/business/07compare.html?_r=0; Quadagno, *supra* note 64, at 129.
[73] *See* Reva Siegel, 'Constitutional Culture, Social Movement Conflict and Constitutional Change: The Case of the de facto ERA' (2006) 94 *California L. Rev.* 1323, 1327 (2006).
[74] *See* Mark Tushnet, 'The Affordable Care Act and American Constitutional Development' (2014) 62 *Drake L. Rev.* 1079.

Administration. Participatory or democratic entrenchment mechanisms are more complex than they seem. This is particularly true in the case of the ACA which establishes a redistributive system, creating both winners and losers.[75] The ACA redistributes health costs in an attempt to concretize a universal right to basic coverage. It prohibits health insurance companies to discriminate on the grounds of preexisting conditions and requires most Americans to obtain health insurance for themselves and their dependents ("individual mandate").[76] This imposes costs on the healthy citizens who could have benefited from more competitive but more discriminatory health insurance.[77]

However, informal entrenchment—in particular of quasi-constitutional statutes—can also reflect a gradual process of democratic acceptance of legislation. This acceptance or resistance to reform can be determined by citizen mobilization and other forms of formal and informal interaction between citizens and officials.[78] *De facto* entrenchment might then occur, if the statute is able to create a unified group of beneficiaries willing to express their opposition to significant future changes affecting the benefits originally conferred by this statute. The Obama Administration and a part of the literature appeared to be hopeful regarding the entrenchment of the ACA on these participatory grounds.[79] The creation of new political constituencies could theoretically be a source of opposition to any form of future repeal or amendment. This would

[75] *See generally* Douglas A. Kahn & Jeffrey H. Kahn, 'Commentary, Free Rider: A Justification for Mandatory Medical Insurance Under Health Care Reform?' (2011) 109 *Mich. L. Rev. First Impressions* 78, 81, 84-85.
[76] ACA sec. 1501 (this Section requires the "Maintenance of Minimum Essential Coverage").
[77] Jessica L. Roberts, "Healthism": A Critique of the Antidiscrimination Approach to Health Insurance and Health-Care Reform (2012) *U. Illinois L. Rev.* 1159, 1187.
[78] On public participation in the legislative process, *see generally* Peter M. Shane, 'Deliberative America' (2005) 1 *J. Pub. Deliberation* 10; Ethan J. Leib, Deliberative Democracy in America: A Proposal for A Popular Branch Of Government (Penn State University Press, 2004). Cf. Reva Siegel, 'Constitutional Culture, Social Movement Conflict and Constitutional Change: The Case of the de facto ERA' (2006) 94 *California L. Rev.* 1323.
[79] *See* Bowser, *supra* note 144.

occur since citizens who benefit from a fading policy would have incentives to become organized and try to maintain the status quo.[80]

Medicare beneficiaries, for example, have demonstrated on several occasions against the ACA, asking the government to "keep its hands off their Medicare." Medicare has become entrenched up to the point that senior citizens seem to be willing to mobilize against any potential change to their benefits. This discontentment resulted from the ACA plans to reduce Medicare costs over a period of ten years and the controversies surrounding the Independent Advisory Board, which rapidly and erroneously became known as "death panels."[81] The ACA threatened to change the structure of Medicare, allowing for the coexistence of three divergent payment models (*e.g.*, fee-for-service based on the traditional patient-health care provider relationship, and the new Accountable Care Organizations which is being tested as a pilot and aims to integrate and consolidate services). The mentioned collective action initiated by Medicare beneficiaries translated however the concern of beneficiaries that Medicare might not be as deeply entrenched as they would like to.

Popular support and resistance to change can be translated into demonstrations, voter turnout, mass social media actions or the expression of citizens' preferences in opinion polls. These elements have been thoroughly analyzed in the literature on popular constitutionalism, where popular mobilization is regarded as a driver of constitutional change.[82] Rebecca Zietlow has argued that the ACA can be qualified as a product of popular constitutionalism since it expands access to health care paving the way for the acceptance of the right to health care.[83] This claim would also

---

[80] Christoph Knill & Jale Tosun, *Public Policy: A New Introduction* (Palgrave 2012) 264.
[81] Paul Starr, 'Law and the Fog of Healthcare: Complexity and Uncertainty in the Struggle over Health Policy' (2013) 6 *Saint Louis U. J. of Health L. & Policy* 213.
[82] *See generally* Mark Tushnet, *Taking the Constitution Away from the Courts* (Princeton University Press, 1999). Larry D. Kramer, *The People Themselves: Popular Constitutionalism and Judicial Review* (Oxford University Press 2005).
[83] Rebecca E. Zietlow, 'Democratic Constitutionalism and the Affordable Care Act' (2011) 72 *Ohio St. L.J.* 1367,

support the idea that the ACA could be qualified as a quasi-constitutional statute. Nevertheless, the ACA might encounter obstacles in conquering weaker forms of social mobilization and voter turnout since it is in general difficult to guarantee the creation of new political constituencies when a policy program has an unclear identity and diffuse or ill-defined population of beneficiaries.[84] One of the weak points of the ACA is precisely that "it treats different groups of Americans in different ways at different times, which complicates efforts to mobilize public support."[85] While a number of citizens now has access to health insurance, another group of citizens benefiting from the former health insurance policies became displeased with the ACA since it raised the underlying costs of less expensive health insurance policies.[86]

Although the popularity of "Obamacare" grew in the last year of President Obama's Administration, the public support of this statute has not increased dramatically in the last years. In 2013, opinion polls revealed that the greatest beneficiaries of the ACA, low and middle income citizens, were very skeptical of some aspects of the system established by the ACA, notably the health insurance exchanges.[87] A number of reasons explain this lack of strong support. First, partisanship still seems to determine citizens' opinion on equal access to health care services.[88] Second, only a small part of the voting population has been positively affected by the ACA.[89] However, despite the small victories and changes, the political support of the ACA is not sufficient

1368. Cf. David Orentlicher, 'Rights to Healthcare in the United States: Inherently Unstable' (2012) 38 *Am. J. of L. & Med*.326.

[84] Jonathan Oberlander, 'The Future of Obamacare' (2012) 367 *New Eng. J. Med.* 2165.

[85] *Id*.

[86] Mark Blumenthal & Jonathan Colin, *The Surprising Reason So Many People Still Don't Like Obamacare*, Wash. Post., June 21, 2015, at http://www.huffingtonpost.com/2015/06/21/obamacare-approval-polls_n_7632070.html

[87] Sarah Kliff, 'Poll: Obamacare's Biggest Beneficiaries Are Skeptical of Obam*acare'*, Wash. Post, Feb. 22, 2013 at http://www.washingtonpost.com/news/wonkblog/wp/2013/02/22/poll-obamacares-biggest-beneficiaries-are-skeptical-of-obamacare/.

[88] *Id.*

[89] Blumenthal & Colin, *supra* note 88.

to argue that citizens might be willing to mobilize to protect the statute in the future, at the resemblance of what might happen to Medicare if the danger of repeal would arise.

3.5. *Agency implementation*

Professors Eskridge and Ferejohn have argued that single-agency implementation is a requirement for the qualification of a law as a super-statute.[90] The ACA has also embraced the potential entrenchment force resulting from agency insulation by creating the controversial Independent Payment Advisory Board (IAB). This independent agency was created to control the costs of Medicare and it was granted powers to require the Secretary of Health and Human Services (HHS) to implement its recommendations unless Congress passes an alternative plan to reduce Medicare costs. This agency has received great opposition and there have been recent Congressional attempts to repeal the IAB. At the time of writing, an important actor in the American health care system is the Center for Medicare & Medicaid Services (CMS), previously known as Health Care Financing Administration (HCFA), which is located within the HHS. The CMS implements policy changes through regulations and manages day-to-day program operations.

III. Informal Legislative Entrenchment and Quasi-constitutionalism

At the quasi-constitutional and constitutional levels, formal entrenchment has been regarded as a synonym of widespread public consensus and preservation of fundamental rights and principles. The attempt to entrench constitutions, constitutional and quasi-constitutional statutes has not only

[90] William N. Eskridge, Jr. & John Ferejohn, *A Republic of Statutes: The New American Constitution* (Yale University Press 2010) 115.

been common but it has also been welcomed in several jurisdictions where rigid constitutions, eternity clauses, and complex amendment procedures are institutionalized in order to limit constitutional change.[91] This has been argued not only in the United States but also in other common law jurisdictions such as Canada, New Zealand, and the United Kingdom, in the context of the consolidation of fundamental rights, free exercise of religion and protection of minorities, particularly in times of economic distress and emergencies.[92]

Constitutional entrenchment performs a preservationist function, safeguarding against the usurpation of constitutional principles by ordinary legislation.[93] It generates legal pre-commitment to constitutional values not only by explicitly limiting constitutional change but also through the delegation of the enforcement of self-binding mechanisms to external agents, in particular judges that guarantee the preservation of the People's will. As Bruce Ackerman explains, ordinary legislation does not echo the People's will but that of political agents who speak while "We the People" is silent. [94]

In the last decade, British courts have acknowledged that constitutional statutes are more difficult to repeal than ordinary statutes.[95] In 2012, the Administrative Court decided in the case of *Thoburn v Sunderland City Council* that, contrary to ordinary statutes, constitutional statutes can only be repealed expressly or by necessary implication, raising the bar in comparison to the

[91] *See*, *e.g*., David Landau and Rosalind Dixon, 'Constraining Constitutional Change' (2015) 50 *Wake Forest L. Rev.* 859; Richard Albert, 'The Difficulty of Constitutional Amendment in Canada' (2015) 55 *Alberta L. Rev.* 86.
[92] *See*, *e.g.*, Douglas A. Schmeiser, 'The Entrenchment of a Bill of Rights' (1981) 19 *Alberta L. Rev.* 381; Ian McLean & Scott Peterson, 'Entrenching the Establishment and Free Exercise of Religion in the Written U.K. Constitution' (2011) 9 *Int. J. Const. L.* 230 (2011); Jerome B. Elkind, 'A New Look at Entrenchment' (1987) 50 *Modern L. Rev.* 158 (1987).
[93] *See* Richard Albert, 'Constitutional Handcuffs' (2010) 42 *Arizona State L.J.* 663, 678 (2010).
[94] *See* Michael J. Klarman, 'Review: Constitutional Fact/Constitutional Fiction: A Critique of Bruce Ackerman's Theory of Constitutional Moments' (1992) 44 *Stanford L. Rev.* 759, 761; Bruce Ackerman, *We the People: Foundations* (Harvard University Press, 1993) 262.
[95] Adam Perry, 'Constitutional and Quasi-Constitutional Statutes' (2015) Int. J. of Const. L. Blog, at: http://www.iconnectblog.com/2015/04/constitutional-and-quasi-constitutional-statutes

ordinary repeal by implicit implication.[96] In the 2012 decision of *H v Lord Advocate*, the Supreme Court remarked that the Scotland Act, qualified as a constitutional statute, could not be altered by any type of implication. Adam Perry has explained that this "does not mean constitutional statutes are fully entrenched, because they can still be repealed expressly. Instead constitutional statutes are "quasi-entrenched".[97] Entrenchment is accepted in this context to preserve the fundamental values set forth in several fundamental statutes, including the Petition of Right 1628, the Bill of Rights 1689, the Act of Settlement 1701, the Act of Union 1707, the Treaty of Union with Ireland Act 1800, the Representation of the People Acts 1832-84, and the Human Rights Act 1998.[98]

At the level of quasi-constitutionalism, Professors Eskridge and Ferejohn have contributed to the study of non-legal dimensions of entrenchment in the United States with their research on "super-statutes."[99] These statutes are fundamental pillars of the U.S. legal order which have acquired a quasi-constitutional status by resisting judicial challenges and being able to establish a new normative or institutional framework for state policies.

As Professors Eskridge and Ferejohn explain in their scholarship on "super-statutes," quasi-constitutional statutes become entrenched not because they were granted a constitutional or quasi-constitutional status *ab initio* but because they "earned it." In other words, the ability to resist reform shows broad social, political, and judicial consensus about the fundamental value of these statutes. While this last perspective offers a useful framework to understand legislative continuity of quasi-constitutional statutes, not all statutes that endure fulfil Eskridge and Ferejohn's criteria.

---

[96] [2002] EWHC 195 (Admin), [2003] QB 151, [2002] 3 WLR 247.

[97] Adam Perry, 'Constitutional and Quasi-Constitutional Statutes' (2015) *Int. J. of Const. L. Blog* (2015) at: http://www.iconnectblog.com/2015/04/constitutional-and-quasi-constitutional-statutes. *See* Farrah Ahmed & Adam Perry, 'The Quasi-Entrenchment of Constitutional Statutes' (2014) 73 Cambridge L.J. 514.

[98] For a thorough analysis of constitutional statutes, *see* Farrah Ahmed & Adam Perry, 'Constitutional Statutes' (2017) 37 *Oxford. J. Legal Studies* 461.

[99] William N. Eskridge & John Ferejohn, *A Republic of Statutes: The New American Constitution* (Yale University Press 2010).

In addition, it is unclear whether this perspective on entrenchment should always have a normative value and will either improve lawmaking or favor the development of quasi-constitutionalism.[100] Moreover, the qualification of a law as a super-statute does not guarantee full judicial impermeability: in *Shelby County v. Holder*, the U.S. Supreme Court struck down the important coverage formula of section 5 of the Voting Rights Act, limiting the practical implementation of parts of this super-statute. Therefore, even if the ACA is partially revised in the coming years, its ability to resist reform and maintain its core values (e.g., prohibition to discriminate on the grounds of preexisting conditions) might mean that the ACA has acquired a quasi-constitutional character. This entrenchment does not mean that the problems that characterize US health care have been solved but rather that 'Obamacare' has captured the main institutions, constituencies, and stakeholders in this field.

IV. Conclusion

In this book chapter, I have drawn on the case of the US health care system and particularly on the Affordable Care Act to discuss the social, political, economic, and bureaucratic forces that contribute to the entrenchment of a statute. The long-term persistence of a law is one of the features of quasi-constitutional statutes which shows that legislative entrenchment is not necessarily a problematic phenomenon. Rather, a certain degree of stability is required to guarantee structural reforms and allow for the gradual democratic acceptance of quasi-constitutional statutes.

The ACA was the result of a long path of legislative reforms that sought to change the US health care system and expand access to health care. This act offered small incremental changes

[100] Mathew D. McCubbins & Daniel B. Rodriguez, 'Superstatutory Entrenchment: A Positive and Normative Interrogatory' (2011) 120 *Yale Law Journal Online* 387, 404.

that were likely to assist millions of Americans. A future classification of the ACA as a quasi-constitutional statute remains uncertain but at the time of writing it is clear that a number of informal entrenchment forces have been active and have made legislative reform more difficult than the Trump Administration could have predicted.

Legal scholarship still lacks an overarching theory of legal change applicable to constitutional, quasi-constitutional, and legislative entrenchment. Constitutional entrenchment is accepted because the traditional idea of a constitution implicates the long-term persistence of constitutional values and principles that inform the legal order. By contrast, ordinary legislation is traditionally expected to change in the aftermath of policy reforms and elections. Quasi-constitutionalism is situated somewhere in the middle. The long-term persistence of quasi-constitutional statutes is often the result of social, political and economic forces that are active when formal or legal entrenchment forces are not allowed to be.