Beyond Obamacare

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The Affordable Care Act commentariat—including those confidently awaiting the day when all its promises are vindicated, those rooting for its ignominious demise, and those of us in a separate camp—have been kept occupied in recent months. Between autumn's website drama and winter's enrollment saga, the news cycle has been full of stories of IT dysfunctions tackled, right-wing challenges thwarted, enrollment goals met, electoral prospects threatened, and individuals newly insured (or variously dissatisfied).

Yet however important such details, stories, and analyses may sometimes be, we lose sight of the larger meaning of the ACA if we narrow our vision to its technological travails or to the latest enumeration of the insured. For those of us who are seeking a more fundamental and egalitarian change within the U.S. health care system, it seems particularly important at the current juncture to instead take a step back and appreciate the larger political, historical, and health policy significance of the ACA, to appreciate how we've come to have it, what it achieves, and what it leaves entirely undone. Understanding where we are and where we came from is, however, only the beginning of the story.

Moving forward, a focus on alternatives to the ACA, and of ways to achieve them, must increasingly be at the forefront of our discussions. A crucial question in this regard relates to how the struggle for true universal health care could fit within—and potentially propel—a larger popular mobilization against inequality. But to ask these questions, we should begin by looking back, to understand the road already travelled, as we seek to break off on a new, and bolder, path.

The Politics of Passage

The ACA fell well short of what many of us had hoped for at the end of the hundred-year war for health care reform, which had begun with the Progressive-era campaign of the 1910s. It eliminates neither uninsurance nor underinsurance, as we shall soon examine in greater depth. It also leaves intact a grossly inefficient (if profitable) system of funding and organization.

But why did the ACA fail to achieve what most construe as "universal health care"? I would argue that there are two ways to interpret the outcome. The first is to emphasize the particular proximate political conditions at the time it was passed, namely the role of corporate interests, the machinations of partisan politics, and so forth. The second interpretation—and one that has received less attention—would be to understand the ACA in the context of the dynamics of a much larger and lengthier neoliberal turn within the United States—and, arguably, global—political economy of health care.

Now with respect to the first approach, it seems fair to conclude that disappointment could have been predicted before the health care reform brawl even broke out. The boundaries of health care reform had been largely drawn by the time that the 2008 election delivered the presidency and both houses of Congress to the Democratic Party (including, by July 2009, 60 votes in the Senate). As sociologist Paul Starr put it, Democrats had committed to only "minimally disruptive" reforms going into the election.[1] Obama's health care proposal during the primaries, for instance, was less expansive than that of Hillary Clinton, and in some respects narrower than the ACA itself.

But why? The role of the so-called "stake-holders" is one crucial factor here. In the years leading up to the election, a "rapprochement on health reform," as Starr calls it, had formed between mainstream liberal groups and key industries. The corporate interests within this rapprochement seem to have perceived that the status quo of rising costs and uninsurance was politically—and economically—unsustainable. In 2008 the Board of Directors of America's Health Insurance Plans (AHIP)—the national lobbying group for the health insurance industry—released a statement that actually endorsed "universal coverage," which it defined as a combination of "guarantee-issue coverage with no pre-existing condition exclusions with an enforceable individual mandate."[2] In other words, if the government required everyone to buy private insurance, the industry would be happy to provide it, and would even stop discriminating against the sick. The document additionally endorsed government subsidies for those making less than 400 percent of the federal poverty level to enable them to buy private health insurance. These proposals, ("guaranteed issue," an individual mandate, and subsidies for the purchase of private insurance) were core elements of the ACA, together with a limited employer mandate and a large expansion of Medicaid.

Other ideas that were not contained in the AHIP statement—for instance the proposal for a "robust" public option—had a less successful career. AHIP was, not surprisingly, rather lukewarm about the prospect of a competing public insurance plan, however "robust" or puny it might be. Though AHIP's president Karen Ignagni had earlier pledged support for Obama's health care reform, AHIP actually surreptitiously funneled some $86.2 million to the U.S. Chamber of Commerce for lobbying against the law in 2009 alone—just as debates about the "public option" got underway.[3] AHIP thereby succeeded in keeping its place at the bargaining table, while simultaneously working against the bill, which had the effect of making the final product more amenable to its interests.

The pharmaceutical industry similarly perceived it could both win and lose through health care reform. Most importantly, the industry needed to protect the great and treasured prize it had won in 2003, namely the clause in George W. Bush's Medicare Modernization Act (MMA) that explicitly prohibited Medicare from bargaining with insurance companies over drug prices. By some estimates, the elimination of that clause could have saved the public purse—and cost the industry—upwards of $500 billion over a decade.[4] The other option would have been to re-import drugs—allowing them to be purchased much more cheaply abroad where such negotiations do take place—which would be a more roundabout way to achieve a portion of these savings. However, after some tense negotiations between the drug industry lobby group (the Pharmaceutical Research and Manufacturers of America, known as PhRMA) and the administration, neither Medicare-drug negotiation nor re-importation was included in the ACA.[5] This was, one supposes, the "politics of the possible," though this merely speaks to the sadly impoverished range of possibilities in a political system permeated by corporate dollars.

Neoliberalism and the Political Economy of American Health Care

While these machinations (and many others) are important to appreciate, it's also worth evaluating the Affordable Care Act in the context of the much longer neoliberal turn in American health care policy and thought. Though this is a separate and much larger story than can be told here, we can capture a glimpse of this multi-decade transformation simply by looking at the shift of the health care political center. In 1969, Edward Kennedy proposed legislation that would have created a program of national health insurance, with no copays, means testing, or cost sharing of any type. Nixon's counterproposal in 1971, on the contrary, looked very much like the ACA, with an employer mandate and an expanded Medicaid-like program for the poor. Like the ACA, it also involved copayments and cost sharing, not just to save money, but as a "matter of principle." To paraphrase the historian Beatrix Hoffman, health care couldn't be made a right; it had to remain something you paid for.[6]

But as corporate and business interests began their powerful push for renewed preeminence in the late 1970s, the Democratic health care proposal—which in 1969 was basically a social-democratic universal system in line with those enacted by left and labor governments in Europe—quickly transmogrified into Nixon's plan. Jimmy Carter, though he argued in an interview in late March 2014 that "Medicare-for-all" would have been preferable to the ACA, during his presidency actually made no substantial effort to pursue health care reform. Health care reform didn't return to the national agenda until the administration of Bill Clinton, who again didn't seriously consider a national health insurance system. Even his less ambitious plan for universal coverage via way of "managed competition" sunk. Mitt Romney's health care reform in Massachusetts, which drew heavily from Nixon's "mandate model" plan, was, conversely, successful.

However, evaluating the rise and fall of the health care reform agenda only tells part of the story. These same decades, as the work of Thomas Piketty has so clearly laid out, were also characterized by soaring inequalities in income and wealth; this was the result, in part, of amplified corporate dominance of the political system and the interrelated decline of the power of labor. It would almost be surprising if alongside these dynamics there *had not* been a corresponding shift within health care thought, policy, and organization that favored these ascendant interests. Such a shift is indeed visible, and the manifestations of it are multifold: the corporate takeover of the Health Maintenance Organization (HMO) during the 1980s and 1990s; a move by health policy experts and economists away from support for universal national health insurance to an obsession with the "moral hazard" of free health care; the growth of for-profit health care companies (hospices, hospitals, dialysis-centers, nursing homes); and soaring profits for pharmaceutical companies, which was mediated by key legislative victories (for instance, the Bayh-Dole Act of 1980 and the MMA of 2003).[7]

As the result of these changes, by the twenty-first century, the corporate health care sector had both unprecedented capital to spend and imperative interests to defend: there shouldn't be any surprise that lobbying money would flood—and not merely season—the health care reform debate of 2009. According to the Center for Responsive Politics, lobbying from the health industry reached an all-time high of $554 million in 2009 alone. Physicians' organizations—which once were *the* central lobby that could single-handedly make or break a health care reform initiative—were relegated to a bit part. Yet though it placated powerful interests, the ACA still contained some redistributionist elements, particularly with respect to the Medicaid expansion. In yet another sign of the shift of the political center, it thereby managed to deeply offend the Republican Party, even though (as Obama pointed out) its roots were to be found on their side of the aisle. To summarize, after all was said and done, a social-democratic alternative was barely considered, a Nixonian health care plan was barely passed, and more stayed the same than changed.

The ACA:
Accomplishments and Shortfalls

Among those working towards more fundamental health care change (for instance, as I'll discuss below, a single-payer system), an assessment of the overall impact of the ACA is a frequent cause for disagreement. Is the law a (possibly wobbly) step in the right direction to be embraced and expanded, a harmful compromise to be denounced and discarded, or something in between? My own sense here is that global assessments are problematic and not that helpful: the massive law does many different things for many different people, and so is better dissected (and criticized) with respect to its specific effects and shortcomings rather than rejected or championed *in toto*.

For instance, whatever the failures of the law may be and whatever injustices will persist, moving individuals out of the vulnerable ranks of the uninsured is clearly a good thing, and no amount of political analysis should belittle the benefit to—and relief felt by—these individuals. The ACA reduces uninsurance mainly via two mechanisms. First, as mentioned, it expands Medicaid to

everyone below 138 percent of the federal poverty level. Unfortunately, as a result of the June 2012 Supreme Court ruling that made state participation optional, only 26 states (and the District of Columbia) are participating in the expansion, excluding millions from the benefits of Medicaid. Second, the ACA requires the establishment of an insurance "exchange" where private insurance can be sold to those without Medicare, Medicaid, or employer-based insurance; those with incomes below 400 percent of the federal poverty level will receive government subsidies to purchase insurance on these exchanges. However, between these programs and the employer and individual mandate, the ACA will still leave an estimated 31 million uninsured (compared with an estimated 57 million without it).[8] In other words, triumphant proclamations notwithstanding, the ACA does not create universal health care in the United States.

Now if eliminating the problem of uninsurance was our only goal, it seems that the ACA would be at least be a clear step in the right direction. Unfortunately, however, there is another phenomenon that has been evolving for some time, that the ACA neither created nor fixed but to some extent codifies, and which confers a highly inegalitarian element to our health care system: underinsurance. Underinsurance is often defined as having insurance but still having substantial out-of-pocket costs for medical care (i.e. greater than 10 percent of family income after premiums); it's clearly a growing problem, and it is by no means eliminated by the ACA.[9] The plans on the exchanges, for instance, incorporate high levels of cost sharing, or copays, deductibles, and coinsurance. They are graded into four metallic tiers based on their actuarial value (i.e. the percent of your health care expenses that insurance covers), beginning at a paltry 60 percent for the "bronze plans." Putting aside the deeply inegalitarian concept of dividing a population into different grades of metal (the allusion to Plato's *Republic* has somehow not yet been made), such plans fulfill the long-held concern of health policy "experts" that patients need more "skin in the game" (i.e. cost exposure), such that they don't whimsically procure medically unnecessarily procedures and diagnostic studies. Families will be subject to as much as $12,700 annually in additional out-of-pocket costs for health care (*after* premiums are paid) to keep the dreaded "moral hazard" of "free care" at bay.[10]

Putting aside what happens to the level of strictly defined "underinsurance," I would argue that there is a larger problem on the rise, which one might call "malinsurance," namely insurance that compromises the physical and economic health of the bearer. Malinsurance encompasses an even broader scope of problematic insurance plans: insurance where the price of the premiums impinges on a reasonable standard of living; insurance with unequal and inferior coverage of services, drugs, or procedures; insurance with "cost sharing" that forces individuals to decide between health care and other necessities; insurance with inadequate and inequitable access to providers or facilities; and insurance that insufficiently protects against financial strain in the case of illness.

Today, many (if not most) of us could in some ways be considered underinsured, while most (or maybe all) of us might be considered malinsured. This will, unfortunately, remain the case in coming years, even with the full and unimpeded enforcement of the ACA.

But what are the alternatives, and are they viable?

Moving Forward:
A Single-Payer Solution?

A "single-payer system" is probably the best-studied alternative for the United States. Conceptually, it is quite simple: national health insurance, with a single entity (the government) providing health insurance for the country. Its core principles (as generally agreed upon within the single-payer movement) can be briefly summarized. First, everyone in the country would be covered by national health insurance. Second, the system wouldn't impose "cost sharing," so health care would be free

at the point of care, with underinsurance thereby eliminated (assuming an adequate level of funding). Third, it would drastically reduce spending on health care administration and bureaucracy through elimination of the fragmented multi-payer system, and also through the global budgeting of hospitals. It would also contain costs through health care capital planning, and through other measures like direct negotiations with pharmaceutical companies over drug prices. Putting this together, a single-payer system would constitute a markedly egalitarian turn in American health care. Access to health care would be made not only universal but also *equal,* with free choice of provider and hospital to everyone in the country, provided as a right.

Now, in light of the formidable resistance that could be expected from a wide-spectrum of powerful and well-funded "stake-holders" (for instance, AHIP and PhRMA), the actual realization of such a system is, to put it mildly, daunting. We can predict that the impressive resources that have been deployed in opposition to the ACA might be multiplied many times to counter even the specter of true universal health care. However, while our political prospects must always be judged soberly, there are also reasons for guarded optimism. The confluence of several of the following dynamics (and many others) may, for instance, create a political opening for such a project in the coming years.

First, dissatisfaction with our health care system will almost certainly rise, which I think will occur as we become more and more a "copay country," with high-deductible, high-premium, and narrow-network health plans becoming the new normal. One could imagine considerable public outrage and mobilization against this new commodified status quo, just as there was against corporatized HMOs in the 1990s.

Second, though politics at the federal level may remain inhospitable to the cause for some time, single-payer campaigns at the state government level may provide an opening for the construction of more limited single-payer state systems, while also providing an opportunity for grassroots organizing and movement building that would, in turn, strengthen the larger national campaign.[11]

Third, support for a single-payer system among physicians (which already has majority support in some polls) might be translated into more vocal outrage in coming years. In particular, as patients pay more and more out-of-pocket at the time of care, physicians will increasingly be forced into the role of "merchants of health,"[12] basing medical decisions not only on clinical evidence, but on their patients' income and wealth. I believe—and deeply hope—that such class-based medicine will be rejected by the profession.

Fourth, and perhaps most important, a broader mobilization against the politics of inequality now seems to be in the making. As it is perceived that the excessive costs of American health care are actually contributing to the problem of inequality—for instance, insofar as high premiums indirectly reduce income or as cost sharing directly consumes a greater portion of already stagnant wages—one can imagine that the drive for a single-payer system might become closely linked with a much larger, and more powerful, political mobilization.

Of course, the precise road by which fundamental change in the health care system could be achieved remains obscure. Currently, the ACA remains at center stage, drowning out discussions of alternatives. With time, however, the changes instituted by the ACA will become subsumed within the fabric of the health care system: we'll no longer be debating the benefits or shortcomings of Obama's signature legislation; we'll be declaiming the persistent injustices of our overall health care system. However powerful the opposition, if allied with a larger popular movement against ever-rising inequality, true universal health care may yet have its day in the sun.

At the same time, I believe that the struggle for health care justice—the fight for universal and *equal*

health care for all—could, in turn, powerfully inform, and bolster, this larger movement. In polls, universal health care (and single-payer) garners support from a surprisingly large proportion of the country, generally a majority. In addition, Medicare has long remained a highly popular program, even (to some extent) across class and political lines. Perhaps, one might conjecture, this is because the need for health care speaks to our intuitive commonalities as human beings.

We may have soaring inequality and a political system more and more indebted to corporate sponsors. But I believe that we'll ultimately reject the notion of class-based health care. The ideal of universalism still has great potential power; in time, we'll learn to harness it.

Footnotes

1. Paul Starr, Remedy and Reaction: The Peculiar American Struggle over Health Care Reform (New Haven: Yale University Press, 2011), 195.
2. "Board of Directors' Statement: Now Is the Time for Health Care Reform: A Proposal to Achieve Universal Coverage, Affordability, Quality Improvement and Market Reform.," (America's Health Insurance Plans, 2008).
3. Drew Armstrong, "Insurers Gave U.S. Chamber $86 Million Used to Oppose Obama's Health Law," Bloomberg.
4. Dean Baker, "Reducing Waste with an Efficient Medicare Prescription Drug Benefit" (Center for Economic and Policy Researcb, 2013).
5. Peter Baker, "Obama Was Pushed by Drug Industry, E-Mails Suggest," New York Times, June 9, 2012.
6. Beatrix Rebecca Hoffman, Health Care for Some: Rights and Rationing in the United States since 1930 (University of Chicago Press, 2012).
7. On the Bayh-Dole Act, see H. Markel, "Patents, Profits, and the American People—the Bayh-Dole Act of 1980," New England Journal of Medicine 369, no. 9 (2013). On moral hazard, a good review can be found in J. A. Nyman, "American Health Policy: Cracks in the Foundation," Journal of Health Politics, Policy and Law, vol. 32, no. 5 (2007).
8. "Effects of the Affordable Care Act on Health Insurance Coverage—Baseline Projections," ed. Congressional Budget Office (2014).
9. The devil is very much in the definition here (i.e. what arbitrary cutoff defines sufficient versus insufficient coverage); using a conservative threshold, a recent study found that 12 percent of the U.S. population was insured but underinsured (in addition to the 18 percent uninsured). C. Schoen et al., "America's Underinsured: A State-by-State Look at Health Insurance Affordability Prior to the New Coverage Expansions," (The Commonwealth Fund, 2014).
10. In all fairness, however, we were already becoming a "copay country" even before the ACA. Those of us with employer-provided health insurance have, for instance, seen growing copay and deductibles in recent years. G. Claxton et al., "Health Benefits in 2013: Moderate Premium Increases in Employer-Sponsored Plans," Health Affairs, vol. 32, no. 9 (2013). I discuss the issue of "copay country" in greater depth in "Your doctor copays are too high!" Salon, August 5, 2013.
11. That being said, state single-payer requires federal waiver to allow for the incorporation of Medicare into the system, and so requires federal cooperation.
12. The phrase is from N. Tomes, "Merchants of Health: Medicine and Consumer Culture in the United States, 1900-1940," *Journal of American History,* vol. 88, no. 2 (2001).