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# Neoliberal Capitalism and the Evolution of the U.S. Healthcare System

Samantha Sterba

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**NEOLIBERAL CAPITALISM AND THE EVOLUTION OF THE U.S.  
HEALTHCARE SYSTEM**

A Dissertation Presented

by

SAMANTHA E. STERBA

Submitted to the Graduate School of the  
University of Massachusetts Amherst in partial fulfillment  
of the requirements for the degree of

DOCTOR OF PHILOSOPHY

SEPTEMBER 2020

Economics

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Approved as to style and content by:

---

David M. Kotz, Chair

---

Katherine Moos, Member

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Dean Robinson, Member

---

Léonce Ndikumana, Department Chair  
Economics

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## **ABSTRACT**

### **NEOLIBERAL CAPITALISM AND THE EVOLUTION OF THE U.S. HEALTHCARE SYSTEM**

SEPTEMBER 2020

SAMANTHA E. STERBA

B.A., ROANOKE COLLEGE

M.A., UNIVERSITY OF MASSACHUSETTS AMHERST

Ph.D., UNIVERSITY OF MASSACHUSETTS AMHERST

Directed by: Professor David M. Kotz

The U.S. economy has undergone dramatic restructuring since the 1970s. These structural changes have had profound implications for every sector of U.S. society, but their effects on the development of U.S. healthcare policy have not yet received adequate theoretical or empirical attention. My dissertation addresses this gap with a specific focus on the development of neoliberal capitalism. Using Social Structure of Accumulation (SSA) theory, I analyze three important cases of U.S. healthcare legislation: the establishment of the Medicare and Medicaid programs in 1965, the failed Clinton Health Security Act of 1994, and the recent Patient Protection and Affordable Care Act (ACA) of 2010.

I argue that these reforms must be understood in relation to its contemporary SSA—the set of dominant institutions and ideas that facilitates capitalist accumulation. I show how in each period, the structures of the proposed policies, as well as their support, opposition, and ultimate legislative outcomes, all reflect the concurrent restructuring of

U.S. capitalism. Chapter 1 offers an overview of the unique developments in U.S. healthcare. Chapter 2 categorizes and evaluates the existing literature on U.S. healthcare development and outlines the contributions of this dissertation. Chapter 3 presents a theoretical overview of social structure of accumulation theory and the concept of neoliberal capitalism. Chapter 4 analyzes the 1965 Amendments to the Social Security Act, which established the programs of Medicare and Medicaid and passed at the height of regulated capitalism. Chapter 5 analyzes the attempted Clinton healthcare reforms that occurred in the 1990s, when neoliberal capitalism was well entrenched. Chapter 6 analyzes the passage of the ACA, which was precipitated by the 2008 financial crisis, when neoliberal capitalism's institutions and dominant ideology were under threat. I analyze the ways in which this crisis facilitated the passage of the ACA, a healthcare reform with features significantly more statist than those that were blocked in the 1990s. This analysis of the interplay of neoliberal capitalism and the U.S. healthcare sector fills a gap in the existing literature on when and how the U.S. healthcare system is able to resist change.

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# CHAPTER 1

## INTRODUCTION

### Exceptionable Care

Healthcare in the United States is expensive, wasteful, and inaccessible. The average amount of healthcare spending per person in the U.S. is twice that of the average high-income country. This spending accounts for nearly 18 percent of the nation's GDP, double the share devoted in comparable countries. Despite the tremendous resources dedicated to healthcare, the system yields worse health outcomes relative to those of peer nations. (Sawyer and Cox 2018) Americans face the worst burden of disease, the lowest life expectancy, and the highest maternal mortality rates among rich countries (Tikkanen and Abrams 2020). The recent global pandemic of COVID-19 has magnified the depths of the system's failings and pervasive stratification. With only five percent of the world's population, the U.S. accounts for nearly twenty five percent of the pandemic's fatalities. Black Americans, over a quarter of those fatalities, are more than three times likely to die from coronavirus compared to white Americans. (American Public Media 2020)

The problems and disparities of the U.S. healthcare system are not modern developments. The healthcare system's undesirable distinctions were established early. Many countries, including Canada, Germany, Japan, Sweden, Italy, Australia, and the United Kingdom, established universal coverage prior to 1980. With neither a national health insurance program nor a national health service, the healthcare system in the U.S. has long been an outlier. The U.S. has spent the largest share of its GDP on healthcare spending since 1980, while maintaining the lowest or second lowest probability of

surviving to age fifty among 17 rich countries (National Research Council & Institute of Medicine, 2013).

In light of the system's persistent shortcomings, legislation creating universal health coverage for the nation has been a bedrock of political debate. Despite early indicators of the system's failure, the United States has only become more resolute in developing its divergent healthcare system. In its absence, the peculiar structure of the U.S. healthcare system has continued to expand and evolve. This dissertation analyzes the structural conditions that contribute to the major developments in U.S. healthcare. Below, I briefly discuss some of the major features of the development in the U.S. healthcare system before broadly outlining my analysis.

### **Features of U.S. healthcare**

One key feature of U.S. healthcare is the increasing individual responsibility for payment for healthcare services and products, to the detriment of broad-based access and positive health outcomes. Insurance plans featuring co-pays and deductibles are more common while these deductibles and co-pays themselves have increased over time as well. Even with employer-sponsored coverage, once considered the gold standard of private health insurance, insured workers now face growing financial instability in the event of a serious health problem (Rae, Panchal, and Claston 2012). The increased use of cost-shifting in healthcare leaves Americans financially vulnerable, especially as medical inflation rates have outpaced overall inflation.

Because of the increased financial responsibility associated with accessing healthcare, many insured Americans forgo necessary care and medications (Families USA 2015). The 2010 Affordable Care Act (ACA), has limited the out-of-pocket

payments for which individuals are responsible. However, medical bills remain the leading cause of bankruptcies in the United States (Khazan 2014).

The number of for-profit hospitals and other healthcare centers has increased dramatically. This change has occurred alongside an expansion in the number of for-profit insurers, who themselves are playing a larger role in healthcare. Many insurance companies restrict their enrollee's choice of healthcare provider by establishing networks of physicians and only covering services that are "in network." Physicians in the insurer's network may also face additional restrictions: specific courses of treatment recommended by the physician may be questioned or even overruled by insurance adjusters.

Over the last half century, the composition of the medical workforce and the nature of the work itself has also changed significantly. The role of non-physicians has increased. Workers such as certified nursing assistants, physician assistants, and registered nurses take on expanded roles in healthcare visits. Patient care has become increasingly regimented. Research has shown that doctors in emergency rooms spend more time with electronic medical records than with patients (Hill, Sears, and Melanson 2013). The pressure to increase patient turnover has also substantially changed. Physicians now see more patients, and on average spend less time with each (Chen 2013). As a result, patients on a whole feel that the quality of their care has deteriorated. Simultaneously, physicians are more likely to be dissatisfied with their work than workers in a variety of other fields (Wible 2014).

### **Understanding the Regressive Development**

Given the retrograde features of US healthcare, reform is a near constant topic of debate in U.S. politics. Reformers have met mixed success. Some periods, such the

Johnson (1965) and Obama (2010) administrations have been marked by the successes of significant healthcare reforms. In others, such as the Clinton administration of the 1990s, the U.S. healthcare system has blocked significant change.

How can we understand the distinctive features of the U.S. healthcare system? Why and how does the U.S. healthcare system yield to change? What factors influence the success or failure of healthcare reform? I argue that an analysis of the changing structures of capitalism yields critically important and new insights into these questions.

The U.S. healthcare system is deeply embedded in and reflects the existing economic relations. Thus, a full understanding of U.S. healthcare reforms must consider contemporary economic structure. Capitalism, the present dominant form of economic relations in the United States, is a dynamic system. The particular characteristics of capitalist economic systems evolve over time. However, the literature has not yet connected changes in healthcare policy and development to the structural changes that have occurred in the U.S. economy. In this study, I contribute to the existing literature with an analysis of how the developments in the U.S. healthcare system reflect the contemporaneous changes in capitalism.

In this dissertation, I consider three important legislative cases: Medicare and Medicaid in 1965, the Clinton Health Security Act in 1994, and the Patient Protection and Affordable Care Act (ACA) in 2010. These three health reforms are recognized as landmark events in the development of healthcare in the United States. Other incremental changes in healthcare legislation have taken place over the last 60 years, but these provide particularly appropriate case studies. Each characterized an era in U.S. healthcare, not only in the substantive changes they brought about in the provision of

health services but in their place in the public discourse and as objects of political debate. Each became a part of the larger culture of the times and a defining part of the administrations' legacies.

The timing of these three reforms presents an opportunity to compare the details of healthcare reform across changing capitalist structures. Each reflected the social structure of accumulation (SSA)—the era of capitalist development and institutional structure—in which it developed. Medicare and Medicaid were passed at the height of the era of regulated capitalism following World War II. The attempted healthcare reform in the early 1990s happened when neoliberal capitalism was well developed. The ACA emerged when neoliberal capitalism was under challenge following the economic crisis of 2008.

The case studies use a historical institutional approach to analyze how healthcare reforms are developed, passed, and enforced in different political, social, and economic contexts. Each case study explores how the structure of the proposed healthcare programs reflects the boundaries and influence of the existing stage of the social structure of accumulation of the time, and how the reforms reflect the healthcare system's adaptations to new institutional forms of capitalism. I identify the groups who supported and opposed the reform, their arguments, and evaluate why in each environment certain types of arguments were or were not effective. In each case study, I argue that the particular dynamics of capitalism are a predominant factor in explaining when and how U.S. healthcare policy has developed.

The rest of the dissertation is organized as follows. In the second chapter, I categorize and evaluate the existing literature on the development of the U.S. healthcare

sector. In the third chapter, I present the motivating framework for understanding the development of U.S. capitalism. The next three chapters apply this framework to analyze three major healthcare reform efforts. Chapter 4 analyzes the establishment of the Medicare and Medicaid programs in 1965. Chapter 5 analyzes the failed reforms of the Clinton administration in 1994. Chapter 6 analyzes the most recent major healthcare reform, the ACA of 2010. A final chapter recapitulates the major conclusions of the case studies and summarizes the study's contribution and significance.



## **CHAPTER 2**

### **LITERATURE REVIEW**

#### **Introduction**

The characteristics and shortcomings of the U.S. healthcare system described in the previous chapter beg the question of why and how the U.S. healthcare system exists and persists. A vast literature featuring critical studies of the U.S. healthcare system and welfare state yields insights into this puzzle. This chapter briefly describes key themes from that literature. I then review limitations of the existing studies before outlining this dissertation's contribution to the debate.

#### **Contributions of the existing literature**

The literature describing the U.S. welfare state and healthcare system draws from a variety of disciplines. Economists, historians, sociologists, and political scientists all contribute, often using distinct frameworks that defy simple categorization. Nonetheless, an imperfect and simplistic categorization of the literature provides a useful entry point to understanding the debate over the development of the U.S. healthcare system. The literature may be broadly described as largely featuring a combination of three overlapping genres of social explanation: (1) cultural characteristics, (2) intergroup conflict, and (3) institutions.

#### **Cultural Characteristics**

Many authors identify the relatively weak welfare state in the United States as the consequence of a set of distinctly American values. In a comparative study of the divergence between health insurance in Canada and in the United States, Boychuk (2008) highlights the ways in which racial politics were the key element in shaping attempts at

healthcare reform under Truman and Clinton, and in the development and implementation of Medicare and Medicaid. He argues the Canada's success in legislating universal health insurance was a result of the politics of territorial and linguistic integration in Canada.

Gordon's (2004) analysis emphasizes the limits of the New Deal legislation, which established a framework for the further development of the U.S. welfare state. Participation in the New Deal's social programs was restricted. Occupations with many Black workers, such as agricultural and domestic jobs, were excluded from benefits. Gordon also explores the ways that southern segregationists threatened and limited the creation and implementation of the Medicare and Medicaid programs. The expansion of employment-based health insurance repeated and magnified these dynamics. Positions that offered health insurance benefits remained often inaccessible for Black workers. Racial disparities have also been reinforced and magnified by enduring residential segregation, which limits access to the sites of healthcare—hospitals or public clinics.

Enduring racism has also shaped public perception of a selection of visible government programs. This coupling of race and government subsidy and spending is cited as helping to stave off national health reform in both the Clinton and Obama administrations (Gaffney et al. 2018; J. A. Morone 1995; Mulligan 2018). Recent dynamics of the ACA's retrenchment and the attempts at further retrenchment during the Trump era have also been analyzed using the lens of race and white nationalism (J. A. Morone and Blumenthal 2018).

Inequalities in family structures and gender inequalities have similarly been identified as an influence in the U.S. healthcare system's development. Due to the

employment-based health insurance system, women's health insurance coverage was often only accessed through their male partner. Expansions of the welfare state have also been connected to traditionally feminine concepts and thus expanding health insurance has also become synonymous with emasculation. (Folbre 2009; C. Gordon 2004; Mulligan and Castañeda 2018)

Lipsett (1996) takes a slightly different approach to describing the development of American health care. He argues that America's peculiar financing of healthcare and the underdevelopment of a health welfare state are the results of an "American exceptionalism." He notes that since the American Revolution, American culture has upheld the values of personal responsibility, freedom, and skepticism of government. He argues that these values have continually influenced Americans' unwillingness to subsidize others' healthcare. Thus, the lack of a welfare state reflects the so-called "American values" which have been a consistent part of U.S. culture since the colonies' revolution. Ideological rigidity is also highlighted in Morone (1990) and Fox (1986).

The belief that the desires of the American people are reflected in the development of medical institutions is also central to Starr's (1982) analysis in *The Social Transformation of American Medicine*, one of the most cited accounts of the history of the medical field. Starr attributes the failure of national health insurance before the First World War to Americans' lack of desire for national health insurance. The passage of Medicare and Medicaid, Starr argues, was Congress's response to the increased growing demands for access to healthcare of the 1960s (1982, 368). Future reforms were not able to expand coverage for additional groups because by the 1970s Americans' opinions had changed. The Reagan administration's proposed policy changes, consolidating federal

health programs in block grants to states and capping federal support for Medicare, each reflected this change in public opinion.

Starr presciently forewarns that this reprivatization will “accelerate the movement toward an entirely new system of corporate medical enterprise” (1982, 419). However, Starr asserts that the future developments of the healthcare sector and the possibility of the medical system transforming into a new system under corporate control ultimately “depends on choices that Americans have still to make” (1982, 449). Again, Starr leaves the final determinant for the direction of healthcare reform to decisions of the electorate.

### **Intergroup Conflict**

A related genre of explanation for the development of healthcare policy in the United States focuses on the role of group conflict. The unique system of healthcare financing and provision in the United States is credited as the outcome of struggles between groups with competing objectives and varying levels of influence. The divisions of the relevant groups and how each group’s influence is determined varies across researchers.

Often, the battle over national healthcare or national health insurance is depicted as a series of battles between various stakeholders within the healthcare industry (e.g. employers, physicians, hospitals, pharmaceutical companies, and health insurance companies). Quadagno (2006) argues that competing groups of healthcare stakeholders have had various levels of success in mobilizing important political allies. During each period of reform, the group that most successfully mobilized their allies is able to exert influence on healthcare policy. In each case, the successful group blocks any proposal perceived as harmful and ensures that any successful reform would be to their benefit.

Different groups' varying degrees of success in spearheading opposition to national health reform over time is central to Quadagno's argument. Quadagno labels the initial failures of national health insurance the result of successful organizing by physicians. However, rising medical costs in the 1970s and 1980s reduced physicians' public influence. In the employment-based health insurance system, as rising medical costs increasingly fell on employers, they were motivated to organize and challenge the power of physicians. Through business groups such as the Business Roundtable or Chamber of Commerce, employers enshrined their preferred healthcare reform policies. Private health insurance companies were similarly strengthened by the declining power of physicians and thus were subsequently able to successfully shape healthcare legislation in the 1990s to their interests.

Other accounts of the U.S. healthcare system organize the competing groups differently. Navarro (1993) argues that the defining characteristic motivating the group struggle over healthcare is class. He suggests that a struggle between the working class and the capitalist class has shaped the provision of healthcare and its financing in developed countries. Each class has competing goals for healthcare policy. The strength of each class to exert its demands determines its ability to influence public policy. Navarro identifies several factors that determine the strength of the working class, including its degree of unionization and linkage to a political party. Thus, the low unionization and weakness of the working classes, as well as the lack of a mass-based socialist political party, have resulted in the lack of a comprehensive national health insurance program.

Instead of viewing the healthcare system as a struggle between two classes with opposing goals, Swenson (2015) theorizes that it is agreement, not opposition, between labor and capital that shapes healthcare provision. He argues that social reforms only succeed when both the interests of business and labor have aligned such that they each benefit from progressive policy changes. The ultimate agency for these reforms is credited to elected officials, who undertake these reforms as “opportunities to get votes, serve objective business interests and [create] acts of social betterment” (p. 34). Thus, he credits the creation of Medicare and Medicaid and the success of the Affordable Care Act to the business community’s interests in reform.

In their seminal work *Regulating the Poor*, Piven and Cloward (1993) create an alternative framework for understanding the development of the U.S. welfare state in the context of capitalism and class conflict. They argue that the development of the U.S. welfare state is a means for the reproduction of the existing social order. Piven and Cloward connect public relief expansions after the Great Depression or during the Civil Rights Era, such as Medicare and Medicaid, as tools to mute civil disorder. Contractions in relief arrangements serve to reinforce work norms and regulate marginal labor to maintain capitalist hegemony.

Another variation of the group conflict literature highlights the importance of the medical-industrial complex (Burlage, Anderson, and Waitzkin 2018; Chernomas and Hudson 2013; Ehrenreich and Ehrenreich 1971; Estes, Harrington, and Pellow 2001; Himmelstein and Woolhandler 1990; Relman 1980; Waitzkin and Working Group for Health Beyond Capitalism 2018; Wohl 1984). The precise definition of the medical-industrial complex varies across researchers and through time. A common feature of

these analyses is the linkages and shared interests of a growing variety of healthcare corporations, such as medical device makers, hospital chains, nursing homes, private insurance companies, and pharmaceutical manufacturers, and the deepening integration of the not-for-profit, for-profit, and public systems. Studies that focus on the role of the medical-industrial complex analyze the various ways in which the growing political and economic power of these industrial actors shape the public discussion of healthcare and the perceived possibilities for change, such as through political donations and the “revolving door” between industry and state positions. This research is an important addition to the intergroup conflict analysis of healthcare development and places the intra- and inter-group battles within the complex site of capitalist economic relations.

### **Institutions**

Other researchers emphasize the importance of state structures in thwarting attempts to establish national health insurance in the United States. Steinmo and Watts (1995) argue that U.S. political institutions are structurally biased against comprehensive reform. They credit the failure of every attempt at national health insurance from Franklin D. Roosevelt to Bill Clinton as the result of these institutions. The level of consensus required by the American federal system of checks and balances is so arduous that “if this level of public consensus around particular reform proposals had been necessary in other democracies, no country would have ever developed an national health insurance system” (p. 339).

Amenta (1998) applies a similar explanation in his study describing the politics and origins of American public spending, which he notes is an outlier in many areas including healthcare. Amenta argues that features of the government in the United States

set the path for the current gaps in American social policy. He argues that the political institutions in the United States have “dispersed the power of pro-spending actors and placed greater obstacles in front of them than advocates of similar policies elsewhere” (p. 15).

In a similar comparison of the American and Canadian welfare systems, Maioni (1998) emphasizes the role of the political institutions in shaping political parties. Maioni explains the success of Canadian health care reform as due to institutions that permitted and fostered the development of a social-democratic third party capable of successfully lobbying for national health insurance. In the United States, there are several serious impediments to the formation of third parties. Without a unified political voice for the left, health reformers were forced to work with limited strategies focused on building a coalition within the Democratic Party and were ultimately unsuccessful.

Each of the analyses above identify how a specific feature or institution of the U.S. government limited the expansion of healthcare reform in the United States. Other variations of institutionalist literature highlight the dynamic and historically contingent nature of these institutions. Hacker (1998) is one such example of this genre of explanation. While emphasizing the importance of institutions in creating the prospects for change, Hacker also notes the important feedback effects that political decisions have on subsequent political structures. Thus, it is not just the political institutions themselves that are critical to developing a healthcare system, but also how those institutions shape future public views, interest-group strategies, market conditions, and the political and economic environment. Rather than solely focusing on institutions, Hacker adds the sequencing of policy changes as an important component in shaping healthcare reform.



Comparing the medical policies in the United States, Great Britain, and Canada, Hacker argues that the United States could not successfully implement a universal system because of critical sequencing problems that cemented the path to the American health system. Hacker argues that a national health insurance plan cannot be enacted if a significant portion of the population is already insured in private plans. By initially offering public insurance programs only to residual populations, like the very poor or elderly, and by building up the medical industry before providing universal access, Hacker argues, American reformers created additional insurmountable obstacles to national health insurance. Instead of paving the way for expanded universal care, Medicare and Medicaid instead created large groups of insured Americans who became fiercely protective of the programs and obstacles to its expansion.

Skocpol's (1997) research on the Clinton administration's healthcare reform in her book *Boomerang* also analyzes the dynamics of policy feedback. She explores how the effects of the large federal deficits generated from policies of the Reagan administration shaped the design of Clinton's healthcare reform proposal and helped facilitate its failure. Ultimately Skocpol argues that this fueled a profound anti-government backlash making future healthcare reforms difficult.

The relevant literature on the development of healthcare reform does not solely focus on major episodes of legislative successes or failures. Institutionalist literature on the development of U.S. healthcare also provides an account of how smaller or more incremental health policies are adopted. Pierson (1995) expanded the literature on the development of welfare state programs by arguing that they were not only resistant to expansion, but also resistant to retrenchment. Hacker (2004) clarified the ways in which a

“hidden retrenchment” in social policy occurs. Although important welfare programs such as Social Security and Medicare have never been successfully fully privatized, Hacker analyzes the ways Americans nonetheless became increasingly exposed to risk.

Later analyses, which centered the concepts of legislative drift, layering, and conversion, further clarified the mechanisms through which policy feedback occurs (Streeck and Thelen 2005). Legislative drift occurs when laws and policies are not formally altered but are changed through the shifts in the policy environment. Layering refers to institutional changes that result from gradual additions of new elements to existing institutions. Conversion refers to how a given policy may be used to achieve alternative outcomes depending on who is administering the law. (Hacker, Thelen, and Pierson 2013)

These perspectives on policy feedback effects have become an important part of the literature on health policy changes in the early twenty-first century. Researchers have identified some specific conditions that are conducive to certain types of these legislative adjustments. Hacker (2004) specifies that policies are likely to experience drift when there are high barriers to change and a high bias towards the status-quo. Policies develop through layering when barriers are high but there is less of a bias towards the status-quo. Conversion occurs when the barriers to change are low but the environment is biased towards the status-quo (p. 48). Hacker uses the changes in employer-provided health insurance in the 1990s and early 2000s as an example of a policy conversion. Hacker’s (2010) description of “Why Reform Happened” in the Obama administration credits the success of the Affordable Care Act as a result of a lowered bias towards the status-quo thanks in part to worsening economic conditions and rising healthcare costs. Tuohy

(2018) analyzes the Affordable Care Act as an example of a policy change through layering. She provides an alternative schema for understanding when policy changes happen at a fast pace but are smaller in scale. This framework has also been recently deployed in understanding the ongoing changes in implementation of the law (Béland, Rocco, and Waddan 2016; Burgin 2018).

The institutional analyses noted above specify how specific state structures affect healthcare reform and the importance of the feedback effects of pre-existing welfare policies. Other researchers have emphasized the role of specific legal institutions distinct from welfare policy that have influenced the development of the healthcare sector. Havirghurst (2001) describes how the 1975 Supreme Court decision of *Goldfarb vs Virginia State Legislature*, which brought an end to the decades-long exemption that allowed doctors to operate outside of the confines of anti-trust legislation, played a critical role in the development of American medicine. Havirghurst argues that after doctors were actively prohibited from collective action or collusion using the logic of market competition to organize the healthcare industry became viable.

Like Havirghurst, Ameringer (2008) also emphasizes the role of legal institutions, alongside group conflict, in shaping the development of American healthcare. He emphasizes the role of the Federal Trade Commission (FTC) and its use of anti-trust laws to explain the development of American healthcare since the 1970s. He frames the FTC's actions as a change from the public-interest theory of regulation to the Chicago school economic theory of regulation. The application of the economic theory of regulation to antitrust regulation spurred the healthcare system's development into a system dominated by market forces. Once the ideology of market forces was entrenched, Ameringer argues

that interest groups, such as organized medicine, began their struggle for control and influence over legislation.

Ameringer uses the example of changes in healthcare development to theorize more broadly why policy regimes arise and the processes through which they are changed. His argument is that both powerful ideas and private interests are central to understanding changes. Ideas became more central to change than private interests when the changes were non-incremental, and private interests are more important in change once a new regime has emerged. Thus, he argues that the economic theory of regulation and markets prompted the major changes in healthcare structure. Once a new healthcare regime was in place and market theory became a dominant ideology, special interests used this ideology to their advantage.

Gottschalk's (2000) account of the development of American healthcare also highlights the dialectical relationship between institutions and interest groups and the importance of institutional environment in shaping interest-group behavior. Gottschalk identifies three other institutions that were critical in shaping interest group strategy and in cementing the place of private health insurance in a private healthcare system in the United States: the Taft-Hartley plans under the Labor and Management Relations Act, the Employee Retirement Income Security Act, and the acceptance of experience-rated health insurance.

Once these institutions were in place, Gottschalk argues, business and labor's alliance was solidified. Instead of the concerns for social justice that motivated the fights for health care in the 1940s and early 1970s, the themes of business productivity and international competition dominated health reform discourse in the 1980s and 1990s.

Gottschalk argues that this choice of strategy, conditioned by legislation such as the Taft-Hartley Act, set the course for the exclusion of the health care in the American welfare state.

### **Limitations of the existing literature**

The existing literature provides a thorough description of the problems in the U.S. healthcare system and a history of its development. It includes persuasive analyses of the ways in which cultural characteristics, group conflict, and certain institutions have impacted the U.S. healthcare system. Further analyses have clarified and theorized the mechanisms of institutional changes and policy feedback effects.

However, the existing literature is so far incomplete. An enduring set of cultural characteristics does not adequately explain why the healthcare system has developed as it has. Pervasive racism and a mistrust in government, while certainly features of U.S. political debate, could manifest in various configurations of healthcare systems. Also, these explanations are insufficient given the variety of social programs in the United States and the tremendous amount of federal spending on American healthcare. Analyses like Starr's, which do not rely on stable characteristics, must explain why attitudes towards reform change in each period.

Similarly, if changes in the healthcare system are attributed to various groups' power waxing and waning over time, some explanatory framework for these shifts in power is required. What determines the relative strength and position of groups and stakeholders and the various strategies used by each? Existing accounts of class struggle in healthcare reforms neglect an analysis of how and why labor and capital may come to an agreement, as in the case of Swenson (2015; 2018). Navarro (1993) does not explain

why, in each period, a class is able to become dominant and successfully exert their demands in policy. Analyses of the medical industrial complex, which also analyze the profit motive in healthcare as it relates to class struggle, have not yet adequately explained the changing features within the medical industrial complex. Nor do they offer a coherent account of why the medical industrial complex supports or opposes specific reforms in different time periods.

Finally, analyses that focus on the political institutional features of the United States do not fully account for what made these political institutions amenable to the reforms of the Obama and Johnson administrations but not those of the Clinton administration. Analysis of legislative drift, layering, and conversion are similarly incomplete without an understanding of what determines the difficulty of barriers to change and shapes the bias towards the status-quo. Questions of what prompted the legal changes in the regulatory structure of the Federal Trade Commission and why these changes were not made earlier also remain unanswered.

### **Contributions of this dissertation**

I suggest that social structures of accumulation (SSA) theory, which analyzes the conditions of capitalist development and the dynamics of its contradictions, adds an important and separate explanation of the development of the U.S. healthcare system. The U.S. healthcare system is deeply embedded in and reflects the existing economic relations. A full understanding of U.S. healthcare reforms must consider contemporary economic structure. However, the literature has not yet connected the developments in healthcare to the major structural changes in the U.S. economy over the last fifty years.

In this study, I contribute to the existing literature with an analysis of how recent developments in the U.S. healthcare system reflect the contemporaneous changes in the characteristics of capitalism. SSA theory yields insights into how and why changes in institutions, ideas, and the relative power of groups discussed above come about. Most importantly for our purposes, SSA theory also offers an account of why and how these changes produced different outcomes for healthcare reform in different times.

A thorough presentation of a framework for understanding the changing ideas, institutions, and class relations of U.S. capitalism using SSA theory is discussed in the next chapter. Following that, I undertake three case studies to further explore the mechanisms through which changes in the structure of capitalism have shaped and limited reforms in the U.S. healthcare system. Specifically, these case studies explore the ways in which the United States' cultural characteristics and political institutions have been shaped by the SSA, as well as how competing interest groups have been compelled to operate within the existing stage of an SSA.

This analysis complements and fills a gap within the existing literature. Examining the complex interdependence of capitalism and the U.S. healthcare system will help elucidate the limited alternatives under which administrators and policy reformers operate.

**CHAPTER 3**  
**SOCIAL STRUCTURE OF ACCUMULATION THEORY AND THE CONCEPT**  
**OF NEOLIBERAL CAPITALISM**

**Introduction**

Previous chapters introduced the claim that the development in healthcare in the United States reflects the concurrent developments in capitalism. This chapter offers a brief overview of the framework through which I will analyze this claim. The goal of this chapter is to provide an overview of social structure of accumulation theory and define the concept of neoliberal capitalism. I then offer a general summary of the relationship between the healthcare sector and capitalist development.

**Origins of SSA Theory**

Social structure of accumulation theory was developed by political economists in the late 1970s and early 1980s. The analysis provides a framework for understanding two distinct characteristics of capitalism's dynamics. First, why does capitalism experience alternating periods of stability and crises? Secondly, why capitalism has had distinct characteristics over time? Gordon, Reich, and Edwards (1982) presents the first systematic definition of social structures of accumulation. Their work explores the relationship between the dynamics of capitalism and changes in the labor process and labor markets. Social structure of accumulation theory has since been further developed and clarified in the works of Bowles et al. (1990), Kotz and McDonough (1994), and McDonough et al. (2010). I draw from this series of books to present the main characteristics of SSA theory below.



## **Theoretical Overview**

Capitalism is an economic system characterized by the production of workers hired in exchange for a wage by a smaller population of employers. These employers, or capitalists, take ownership of the final products of the workers. If a capitalist is successful, the final product is then sold for a higher price than that of the workers' labor and input costs. If the revenue gained from the sale is greater than the cost of producing the good, then the successful capitalist is also entitled to distribute the surplus generated from that sale.

These basic mechanics of the wage-labor relation have persisted throughout all periods of capitalist accumulation. However, the history of capitalism is far from unchanging. This wage-labor relationship has existed in many different forms. The relationship between workers and their employers, the nature of the labor process, and the role of the government in the economy, have all varied throughout history.

SSA theory analyzes the various distinct forms of capitalism that have arisen as comprising of a cohesive set of long-standing practices or behavioral patterns. According to SSA theory, a rich set of institutions emerges in each period to support the process of capitalist profit-making. These institutions are economic, political, and cultural in nature. Along with the dominant ideas in each period, these institutions are required to ensure the existence and reproduction of the capitalist economic system.

As detailed by Marxian and Keynesian economic theories, the successful generation of profits through the wage-labor process are never fully guaranteed. Conflicts may emerge between the capitalists and the workers, there may be insufficient demand for the final products, and the return of capitalists' investments are fundamentally

unpredictable. According to SSA theory, these problems of capitalism are temporarily mitigated by the emergence of a coherent set of mutually enforcing institutions and dominant ideas. This set of institutions and ideas, referred to as the social structure of accumulation, regulate key processes and relationships in the capitalist economy. Jointly, these aspects of the SSA helps promote a positive rate of profit, maintains total demand growth, and creates stability and predictability for the investment decisions.

However, the success of an SSA is limited. The history of capitalism is punctuated with economic crisis and recession. SSA theory understands these occurrences as distinct phases within an SSA. Each SSA is marked by a period of consolidation and a period of decay. In the initial consolidation period of an SSA, the joint set of economic, political, and cultural institutions and dominant ideas effectively promotes stability and profit-making. The institutions are mutually reinforcing. Over time they become further entrenched in the society. Eventually, the institutions will stop working effectively and the SSA enters a period of decay. The problems of capitalist accumulation reemerge, and the economy enters a period of long-run economic crisis. Only the construction of a new SSA and its new corresponding set of institutions can resolve such a crisis and accommodate continued capitalist accumulation.

Because an economic crisis can only be solved through the emergence of a new set of institutions that permit continued accumulation, the crisis prompts a prolonged conflict in society over how to best restore the conditions of profitability. The crisis will destabilize a variety of institutions, and as various groups take advantage of that destabilization to pursue their own interests, each becomes an area of competition. Ultimately the successful restoration of capitalist accumulation requires a new cohesive

set of institutions, which will include political, cultural, ideological, and economic institutions.

### **Post-war capitalism in the U.S.**

It should be noted that SSA theory does not provide a framework for dating the arrival or decay of an SSA. Nonetheless, within the literature it is widely accepted that since World War II, there have been two distinct SSAs in the United States: regulated capitalism and neoliberal capitalism, both of which proved stable for decades. Below, I briefly review the major characteristics of each period of capitalism identified in the SSA literature.

#### **Regulated Capitalism**

Regulated capitalism emerged in the 1940s. Bowles et. al (1990, chap. 5) provide an account of the emergence and the decay of this initial institutional structure of postwar capitalism. They argue that capitalism in this period was marked by a limited capital-labor accord, a capitalist-citizen accord, the containment of intercapitalist rivalry and a particular relationship between U.S. capital and actors outside the country. These institutions secured the conditions for capitalist accumulation for decades and led to high rates of profit and rapid growth of hourly income. Chapter 4 discusses how the characteristics of regulated capitalism shaped the creation of Medicare and Medicaid.

Each of the institutions that emerged in the 1940s eventually became an obstacle to continued economic growth and accumulation. Bowles et al. describe the mechanisms through which conflicts arose within each of these institutions and destabilized the postwar SSA. The conflicts ultimately lead to the slow productivity growth, accelerating inflation and unemployment, and international monetary instability of the 1970s. The

stagflation and instability of the 1970s are interpreted as a structural crisis of the regulated capitalist SSA.

### **Neoliberal Capitalism**

Kotz (2015, chaps. 2, 3) argues that during the late 1970s and early 1980s, a new form of capitalism, neoliberal capitalism, emerged to successfully restore capitalist accumulation. This new SSA was marked by a distinct set of institutions. Kotz identifies five dimensions through which neoliberal capitalism differed from its preceding SSA: the corporate sector, the capital-labor relation, the role of government in the economy, the global economy, and in the dominant economic ideology. In all five aspects of the economy, market forces and market relations played a stronger role in the neoliberal SSA than they did in the regulated capitalist SSA.

While the regulated capitalist era was marked by restrained intercapitalist rivalry, in the neoliberal era capitalists faced unrestrained competition. Market principles were applied to the organization of the firms and in the hiring of corporate CEOs. Financial institutions and financial markets also played a bigger role in nonfinancial businesses, while the activities of financial institutions deviated from their roles under regulated capitalism as the trading of financial assets rapidly expanded.<sup>1</sup>

The capital-labor accord of the previous regulated capitalist era, under which collective bargaining was accepted in many workplaces, ended. The relationship adjusted to one in which capital more fully dominated labor. Workers' power declined, wage growth stagnated, and the nature of jobs changed as well. Unlike the relatively stable

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<sup>1</sup> Epstein (2005) and Krippner (2012) analyze the increasing dominance of finance during this period.

employment of the regulated capitalist SSA, under neoliberal capitalism jobs are more likely to be contingent or part-time work.

The dominance of market forces also became more meaningful in the government's role in the economy. Kotz identifies several instances of the state's transformed relationship with the economy, including in the state's deregulation of basic industries and finance, the erosion of social welfare programs, enactment of tax cuts, and the weakening of consumer product safety, job safety, and environmental regulations.

The particular relationship identified by Bowles et. al (1990) between U.S. capitalists and actors in other countries as critical to the success of the regulated capitalist era eroded in the late 1960s and early 1970s. The Bretton Woods system, which had governed the postwar international economy, collapsed. In its place, a new system that promoted the free movement of goods, labor, and capital became entrenched, aided by the creation of the World Trade Organization.

Each change noted above is coherent. They all involve the promotion of market forces and market regulations. As such, these institutions became mutually reinforcing. They were further strengthened by the change in dominant economic ideas in each period. Under the regulated capitalist SSA, Keynesian economic theory prevailed. The government was understood to have an important role in aggregate demand management and in promoting employment. In the new SSA of the late 1970s and early 1980s, however, neoliberal economic theories became the dominant framework. Neoliberal economic theories celebrate individual choices and the role of the market in creating optimal outcomes. Chapter 5 discusses how the institutions and ideas of neoliberal capitalism affected healthcare reform in the early 1990s.

## **Neoliberalism Under Challenge**

In 2008, the United States economy plunged into a severe financial crisis and economic recession. Major financial institutions, including banks, mortgage lenders, and insurance companies faced insolvency. Unemployment soared while hundreds of thousands of jobs disappeared. Domestic consumption and investment plummeted while the financial crisis spread globally.

Kotz (2015, chap. 5) argues that the financial crisis and economic recession is best understood as a crisis in the institutional structure of neoliberal capitalism. That analysis identifies how the set of institutions and dominant ideas of the neoliberal SSA created the conditions which led to the financial and economic crises in 2008. Chapter 6 discusses how the temporary destabilization of neoliberal institutions and ideas contributed to the success of the Affordable Care Act.<sup>2</sup>

### **Healthcare in the SSA framework**

SSA theory provides a framework for analyzing how capitalism has developed in the United States following the Second World War. The following three chapters present case studies of how this understanding of the U.S. economy can be applied to an analysis of the development of the healthcare sector. What is the relationship between a healthcare system and the social structure of accumulation? Previous researchers using SSA theory have identified the role that social welfare programs and government regulations have within an SSA. This analysis is the first to systematically integrate an analysis of the U.S. healthcare system within SSA theory. Below, I explore mechanisms through which the

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<sup>2</sup> For the purposes of this dissertation, it is not necessary to theorize the current state of the neoliberal SSA beyond 2010. However, that is an important question for future researchers in SSA theory and for health economics to consider.

healthcare system functions within the framework of the SSA theory. As noted earlier, capitalism is a dynamic system and as such some of these mechanisms may become more important than others in certain periods of an SSA. Analyzing the healthcare system within the logic of capitalism helps us understand the specific ways that in which they mutually reinforce or contradict each other.

First, the U.S. healthcare system is an important employer, site of investment, and arena of consumption in the United States. Over 17 percent of US Gross Domestic Product is spent on healthcare (Hartman et al. 2020). In 2017, healthcare became the largest employer in the United States, following 27 years of increasing employment (Bureau of Labor Statistics 2020). The healthcare system also operates as a site of capitalist accumulation and profit-making. Although industries like hospitals and health insurance companies originally started as predominantly nonprofit organizations, each industry has become increasingly characterized by more for-profit organizations. In the United States, hospitals and medical insurance companies are two of the most profitable industries (IBIS World 2020). Aspects that influence the profitability of the healthcare sector are government subsidies, antitrust, patent, tax, and regulatory laws, as well as rules about where new medical facilities be built.

The healthcare system in the United States also has an important role in maintaining labor discipline. The employment-based health insurance system contributes to what has come to be known as “job lock.” Because most private health insurance is provided through employment, workers who leave or lose their job must secure an alternative means of health insurance. Job lock refers to this extra cost of leaving or changing employment for workers. Although workers may be happier or more productive

in other careers, the additional uncertainty of finding new health insurance may keep workers' in suboptimal positions. As the prices of healthcare, pharmaceuticals, health insurance premiums, and insurance co-pays increase, the threat of losing a job becomes costlier. Having an increasingly inaccessible healthcare system helps maintain labor discipline and keeps workers attached to their jobs.

Beyond its role its disciplinary roles, the healthcare system reinforces divisions among workers. Employer-based health insurance remains the most popular way for people to access private insurance, however, the number of jobs offering comprehensive health insurance benefits has declined. Workers who can access health insurance through their jobs are more likely to be in positions that require higher levels of credentials and are paid higher wages. The integration of the healthcare system and employment in the U.S. thus helps reproduce and magnify inequalities and divisions within the working class. Similarly, the healthcare system maintains and reproduces society's inequalities based on racism, sexism, biphobia, transphobia, able-ism, and fat phobia.

The healthcare system helps perpetuate the dominant ideology of the SSA. As noted above, two important aspects of neoliberal ideology are the importance of individual choices and free markets. The configuration of healthcare in the United States helps to perpetuate the highly individualist conception of society. Maintaining one's health is viewed as a responsibility that every body must achieve independently. Individual actions and choices, such as diet and exercise, are considered as the most important factors in health along with genetics. The role that other larger social forces has, like the effects of class, race, residential segregation, and wage-labor on health, are largely overlooked in medicine.



## **SSA Case Studies**

The previous discussion describes some of the major mechanisms through which the healthcare system and the social structure of accumulation are linked. In the three following chapters, I analyze in more detail how these interconnections affected and influenced three major episodes of healthcare reform. Legislative battles have been critical to the development and expansion of healthcare in the United States. Highlighting the ways in which these legislative attempts were shaped and conditioned by the existing SSA yields new insights into how and why the U.S. healthcare system develops.

Previous histories of healthcare reform, such as the ones highlighted in the previous chapter, exclude an analysis of the dynamics of capitalism. The following case studies provides a coherent explanation for some questions that the existing literature leaves unanswered. The deep interconnections between the social structure of accumulation and the development of the healthcare sector helps illuminate why stakeholder groups changed their positions towards healthcare reform in different periods, how they articulated these reforms, and why they were successful. The healthcare system is entrenched in capitalism. Thus, the history of capitalist development is deeply relevant to understanding how healthcare policy and the development of the healthcare sector.

## CHAPTER 4

### CASE STUDY: CREATION OF MEDICARE AND MEDICAID (1965)

#### Introduction

Although the battle for a federal guarantee of healthcare for all had been ongoing throughout the twentieth century in the United States, it was not until the mid-1960s that reformers partially achieved this goal. The passage of the Social Security Amendments of 1965, which created the programs now known as Medicare and Medicaid, catalyzed a huge expansion in the government guarantee of healthcare, which was unprecedented at the time. Since the mid-1960s, the United States has been unable to achieve another gain in healthcare access of this magnitude.

There are many theories of why Medicare and the various efforts to expand healthcare access that followed have been successful or unsuccessful. The thesis of the present study is that this historic expansion of the government's role in providing health insurance reflects the set of economic, political, and cultural institutions and dominant ideas that existed when the Social Security Amendments of 1965 were created.

This case study proceeds as follows. First, I summarize research on the defining characteristics of the regulated capitalist era. Following a brief description of the Medicare and Medicaid programs created by the Social Security Amendments of 1965, I analyze the ways in which these programs reflect the regulated capitalist era. I then analyze how certain key interest groups responded to legislative proposals expanding public health insurance. For each group, I explore how their reactions to public health insurance programs were shaped by the coherent and complex set of institutions of the period.

### **Defining Features of Regulated Capitalism**

As discussed in the third chapter, the form of capitalism that arose in the United States in the late 1940s is referred to as regulated capitalism. Kotz (2015 ch. 3) defines key features of the cohesive set of institutions that supported capitalist accumulation in this period. In this era, many jobs were stable and long-term positions. Collective bargaining, though not a feature of every workplace, was a widely accepted practice. The government was viewed as an important element of the “mixed economy” of the United States. The government was responsible for the regulation of key industries, as well as for the provision of a wide array of public goods and services. Keynesian economic theory, which originated during the global Great Depression, became dominant after World War II. Accordingly, the government had an accepted role in promoting low unemployment and stable price levels.

The features of regulated capitalism were critical to the establishment of the Medicare and Medicaid programs. Within this set of economic, political, and cultural institutions and dominant ideas, the U.S. Congress was able to pass legislation creating large social welfare programs, which guaranteed a federal role in the provision of healthcare for civilians.

### **The Social Security Amendments of 1965**

Before discussing the ways in which the Medicare and Medicaid programs reflect the institutions of regulated capitalism, it is necessary to briefly describe the overall structure of the legislation that created these programs. The Medicare and Medicaid

programs were created as amendments to the Social Security Act of 1935.<sup>3</sup> This act was signed by President Franklin D. Roosevelt during the Great Depression as part of his New Deal legislation and established mandatory federal social insurance programs. Although the legislation excluded provisions for health insurance, the legislation did create a pension system and unemployment insurance. Workers receive a monthly pension payment, funded from compulsory payroll taxes, after retiring. The Medicare and Medicaid programs were created in 1965 as two titles amended to the original 1935 legislation.

### **Title XVIII: Health Insurance for the Aged**

Title XVIII of the Social Security Act establishes a health insurance program for adults over the age of 65. Subtitle A of the legislation creates what has come to be known as Medicare part A, which establishes a compulsory hospital insurance program. Like the original public pension system, Medicare part A is financed through payroll tax contributions from employers and workers. These payments become part of the newly created Federal Hospital Insurance Trust Fund. Payments from this trust are then sent to hospitals and providers to cover the cost of hospitalizations, outpatient hospital diagnostic services, and post-hospitalization care. The original legislation requires no premium payments and calls for a deductible of 40 dollars. Inpatient hospitalizations and stays at skilled nursing facilities require a daily coinsurance.

The second subtitle establishes Medicare part B, a voluntary medical insurance program to cover the cost of physician services. Individuals over age 65 are not required,

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<sup>3</sup> For information on the passage of the Social Security Act of 1935, including interest group support and opposition, see: (C. Gordon 1994; Klein 2003; McQuaid 1982; Quadagno 1988; Skocpol 1992).

but may choose to, enroll in this program. Revenue is collected via enrollee premiums and federal tax revenues. Enrollees also pay a deductible and coinsurance. A separate trust fund is established for the supplementary medical insurance payments to providers.

### **Title XIX: Grants to States for Medical Assistance Programs**

A separate title establishes the program now known as Medicaid. This title provides federal grants for states to establish medical assistance programs for families with dependent children, as well as people who are aged, blind, and permanently disabled if their income and resources are insufficient to cover the costs of medical care. To receive federal funds, states submit a plan for approval of the Secretary of Health, Education, and Welfare. Each state's plan must meet certain federal criteria, but states have broad flexibility in choosing the beneficiaries and benefits covered under the plan. The amount that the federal government provides to states depends on a state's per-capita income. States with an average per-capita income equal to that of the national average per-capita income receive a federal payment of equal to 55 percent of the state's expenses. States with the lowest per-capita income level receive as much as 83 percent of expenses.

### **SSA Analysis**

The Medicare and Medicaid programs are uniquely structured. No previous proposals for reform called for the public health insurance benefits offered through three separate programs, each with a distinct financing mechanism. The Medicare and Medicaid programs are also unlike the national health insurance systems or national health programs in other developed countries. There are other detailed accounts of the

iterations of legislative compromise that preceded the law's creation.<sup>4</sup> This case study explores how the unique structure of the Medicare and Medicaid programs were shaped by the set of institutions supporting capitalist accumulation in this period.

### **Reflections of Regulated Capitalism**

It is significant that Medicare and Medicaid were created as amendments to the Social Security Act of 1935, a piece of legislation central to the New Deal enacted within the throes of the Great Depression. As a quarter of the workforce became unemployed and millions of dollars of wealth generated from the stock market disappeared, the future sustainability of capitalism was called into question. The social reforms of the New Deal played a critical role in reversing the economic instability following the Depression. The full set of institutions of regulated capitalism, which would eventually promote capitalist accumulation and profitmaking, had not yet emerged in the mid-1930s. However, the Social Security Act was an important precursor to the regulated capitalist SSA, which was firmly entrenched when Medicare and Medicaid were passed.

Following World War II, the full set of cohesive institutions promoting capitalist accumulation and profit-making emerged. This set of institutions featured a reliance on the state for stabilizing demand, regulating finance, and providing strong levels of public goods. Under these conditions, the Social Security Act was expanded to include public health insurance programs. The federal pension program established by the Social Security Act required a massive expansion of the government's administrative capacity. The program also reaffirmed the state's commitment to "relieving the vicissitudes of economic life." Both elements of the Social Security Act reflected the dominant ideology

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<sup>4</sup> See, for instance: (Corning 1969; Feingold 1966; Marmor 2000)

of the regulated capitalist era and were helpful in facilitating the new health insurance programs.

Following the precedent established by the federal pension system, Medicare part A mandates that all workers and employers contribute to the program via increased taxes and receive a standardized set of benefits after reaching age sixty-five. The legislation expands government duties in the realm of private provision. The U.S. federal government certifies providers as eligible for reimbursement, determines the benefits that are covered under Medicare and determines the methods and rates of reimbursements for care.

Nevertheless, within this massive expansion of the government's role, there is an accompanying role for private organizations as well. Instead of mandating the expansion of a federal bureaucracy to handle the administration of payments and benefits, the legislation allows providers to select a private organization to handle and review payments. The Secretary of Health, Education, and Welfare has the legal authority to determine the amounts paid to the providers for covered services. But it also encourages the Secretary "to the extent possible" contract with private organizations to perform the administrative duties of the program. Such duties include making decisions on the amounts of payments required, as well as receiving, disbursing, and accounting for the funds to make the payments, and auditing provider records. This reflects the importance of the mixed economy in the regulated capitalist SSA. In this era, there was not complete state control over the provision of public goods and services in the economy. However, there was an accepted role for the federal government to work with private businesses in overseeing their provision.

## **Limitations of Regulated Capitalism**

As noted above, a key feature of the regulated capitalist era was the acceptance of social provisioning and government regulation. Accordingly, Medicare and Medicaid, the largest expansions of government guaranteed healthcare in the United States, integrate the government involvement in the provision of healthcare services offered by private providers. However, the programs are still far more limited than the programs established by other developed nations during this time. Unlike the programs established previously in Canada or the United Kingdom, Medicare and Medicaid neither guaranteed universal health insurance coverage nor nationalized medical care. Instead, each program serves a limited population: individuals over 65 or people deemed medically indigent. The program also relies on the employment-based health insurance system.

These limitations reflect the boundaries of the specific form of regulated capitalism in the United States during this period. The dominance of Keynesian ideas and the accepted role of public provision were important elements of the SSA that helped to promote capitalist accumulation and profit-making while also expanding guaranteed access to healthcare in the United States. Nevertheless, the form of regulated capitalism in the United States was less statist and accorded a big role for private businesses in public provision than was the case in other developed countries.

## **Interest Groups**

The economic, political, and cultural institutions and dominant ideas of regulated capitalism shaped the Medicare and Medicaid programs. This cohesive set of institutions and ideas also provided the context in which various stakeholder groups perceived and



articulated their interests. Below, I analyze the response of selected stakeholder groups in the context of the regulated capitalist SSA.

## **Health Insurers**

### **Commercial health insurance**

In testimony and written statements submitted to Congressional Committees considering healthcare legislation, insurance executives maintained a dispassionate opposition. H. Lewis Rietz spoke on behalf of the Health Insurance Association of America (HIAA), the American Life Convention, Life Insurance Association of America, and the Life Insurers Conference and claimed to represent 525 insurance companies which underwrote 90 percent of private health insurance plans. He introduced the industry's opposition plainly, referring to all variations of public health insurance as "unnecessary and undesirable"(Committee on Ways and Means 1963, pt. 2, p. 1127).

Private health insurance coverage for the aged had rapidly increased over the last decade due to "public demand and keen competition" (p. 1129). Thus, government intervention was unnecessary since private health insurance plans could be expected to cover 80 percent of the elderly population within a few years if they were able to continue to develop and sell private policies. The expansion of private benefits was preferable to the expansion of public programs since private insurers were better suited to meet the diverse needs of the elderly population. Rietz questioned the capability of the government to forecast the costs of their proposal accurately. He noted that the actuaries of the companies he represented predicted much larger costs than what the government actuaries had calculated.

Rietz also argued that the financial problems of senior citizens were overstated and not a problem that required a federal solution:

“... our aged are not destitute old people and they can provide their majority of their needs. We have an element of family responsibility. I do not think this is anything we ought to be ashamed of in the society we live in” (*ibid.*, p. 1157).

Robert Neal, the chief lobbyist of the Health Insurance Association of America, later described his organization’s subtle campaign against reform:

“We felt our only defense to it [a Medicare law] was performance. Companies don’t have very much political leverage. So our effort was to try to supply what information we could on probable costs and what we were doing – in terms of how fast we were getting people covered ... We felt with time on our side ... we could eventually get the job done privately” (Neal 1967).

Private health insurance executives did not support any proposal for healthcare reform in this period. They also notably did not launch a public campaign against reform in this period. Individual health insurance companies continued to run advertisements for their private health insurance plans, specifically targeted to expanding coverage to older people.<sup>5</sup> Post card campaigns, political organizing, and public campaigns on behalf of the industry were considered “a waste of time” according to Neal (Neal 1967, 42). Instead the trade organizations encouraged insurance executives to contact their Congressional representatives to register individual opposition to public programs.<sup>6</sup>

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<sup>5</sup> These advertisements were not always directed towards elderly audiences. One advertisement, which was referenced in Congressional testimony, was directed to adult children of elderly people. They were encouraged to “give mother a policy for Mother’s Day” (Committee on Ways and Means 1963, pt. 2, p. 1157).

<sup>6</sup> In an interview following the enactment of Medicare, Robert Neal described this action as part of a “grass roots” organizing strategy (Neal 1967, 42–43).

Commercial insurer's reactions to proposals to create a federally funded program to finance health insurance for senior citizens reflect the set of institutions that jointly promoted capitalist accumulation in this period. Insurance executives opted to lobby privately and without a public campaign. There is evidence that the subtle lobbying technique of health insurers in this period was because of their assumption that a public campaign to defend against federal intervention would garner their organization a negative public opinion and ultimately would hurt their business. Chapin (2010, 156) argues that avoiding a negative perception was a critical part of the organization's strategy fighting healthcare reform during the Truman administration. Similarly, Gordon (2004, 240) cites internal communication of HIAA members noting that "few politicians will want to take on the doctors, but this same restraint will not apply in the case of large insurance corporations."

The insurer's perception of the risks of public lobbying against healthcare reform for seniors by insurance companies is consistent with the set of economic, political, and cultural institutions and dominant ideas of the regulated capitalist era. Reviving capitalist accumulation and economic stability following the Great Depression required the establishment of a cohesive set of institutions, of which a central feature was the acceptance of the state's role in the provision of goods and services. In these conditions, private insurance companies worried about the adverse consequences for their industry if they were perceived as overstepping their role. Accordingly, their opposition to healthcare reform in this period was muted.

Because of the important role of the state in regulated capitalism, market forces were not automatically presumed to be a superior method of allocation. As noted by Kotz

(2015), the U.S. economy in this period was often referred to as a “mixed economy.” This term highlights the importance of private market forces operating alongside of, and regulated by, the state. This helps to explain the arguments used by insurance executives in this period. Insurance executives dedicated a large portion of their testimony explaining their opposition to public health insurance programs in this period with explanations of their industry’s successes. Unlike in other periods of healthcare reform, simply identifying a reform proposal as a “government run” program was not considered an effective criticism by HIAA representatives. Instead, insurance executives presented data on the rapid growth of their industry within the last two decades. They argued that although they had not yet sold adequate private insurance coverage to people over 65 years old, that their business could do so with time.

Some insurance companies responded to legislative discussion of public health insurance programs by creating new products and new ways of selling these products. In 1961, two insurance companies, Continental Casualty and Mutual of Omaha, introduced new health plans for people over 65 on an area-wide basis with a minimum of underwriting restrictions.<sup>7</sup> As the legislative pressure continued for expanding public health benefits, insurance companies began to work together to expand private coverage for the aged within their states. In 1961, insurance companies in Connecticut lobbied their state legislature for the ability to pool their resources so that they could cooperate to sell health insurance to the aged. Having succeeded in gaining approval from the State, over forty Connecticut-based insurance companies pooled their resources and staffs to

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<sup>7</sup> This history and discussion of these health plans, often known as the State 65 health plans, is drawn from Morton Miller’s description of the plans to Peter Corning (Miller 1967, 17–40).

create the Connecticut 65 Health Insurance Association. Because of the regulatory structure of insurance markets, insurance companies in each state had to lobby their state legislatures for the legal authority to form such cooperative ventures. By the time Medicare was passed in July 1965, there were seven such cooperative plans operating in eight states.

On behalf of all the member companies, one company was selected to run the Association and issue health insurance policies to people over 65. Each member company put in funds to launch the Association and pay for initial advertising campaigns. Risk was shared between all companies in proportion to the size of their business within the state.

Morton Miller, the chief insurance executive of Equitable Insurance Company and President of the New York 65 Health Insurance Association, described the development and promotion of these State 65 plans as an “immediate response” to the AFL-CIO’s support of social insurance for the elderly (Miller 1967, 18). He expected that this cooperative solution could potentially forestall public health insurance reform:

“...if we had been given time and if the legislative situation hadn’t changed, undoubtedly, in my opinion, we would have done this country wide—to be able to combine the companies in a pool to do this” (*ibid.*, p. 20).

In fact, the New York 65 health insurance plans were selected by a few districts as a mechanism for providing benefits for certain welfare beneficiaries. Morton also thought the State 65 health plans could be adapted as part of potential reforms (*ibid.*, p. 29).

The defense of private insurance companies against federal reforms in this period reflect the concurrent set of institutions supporting capitalist accumulation. In the period of regulated capitalism, having a privately oriented market was not understood to be an obviously superior to federal intervention. Insurance executives argued that their

industry could and would expand to provide coverage to most of the elderly population. Instead of pooling their resources to finance a campaign to persuade the public of the dangers of public insurance or the benefits of the private markets, insurance executives in this period used a historically unique strategy. They pooled their resources and worked cooperatively, rather than in competition with each other, to establish a broader private market in health insurance. Yet their efforts and arguments were not convincing in the regulated capitalist period. Instead of waiting for the private insurance market to continue to expand, as it had done over the last two decades, the Congress ultimately passed legislation, which would establish a public insurance program.

Of course, not all health insurance executives joined cooperative insurance alliances to try to delay federal reforms. There is evidence that other insurance executives were ambivalent or even welcomed public intervention in this period. For instance, Gordon (2004, 240) finds that some HIAA members thought supporting Medicare proposals would prove to ultimately beneficial in helping to stave off future reforms for people under age 65. The enactment of a national health insurance program was a reasonable fear. President Truman strongly supported such a proposal in 1948. By 1952, the Democratic Party platform included discussion of the prohibitive costs of medical care. The 1960 and 1964 platforms explicitly called for the public provision of medical care benefits through the Social Security system. (Peters and Woolley n.d.) Thus, health insurance executives had reason to support Medicare reforms. Not only would the reforms subsidize the most expensive group of insurance beneficiaries, but it might also help protect the industry against the viable threat of more comprehensive future reforms.

In a November 1963 hearing, the positive positions of several insurance company executives towards proposals for medical care for the aged are recited as well.

Representative King references statements from officials of the Nationwide Insurance Company and Continental Insurance Company, which each suggest that the health insurance industry would not be hurt, and could possibly be stimulated by, a public program (Committee on Ways and Means 1963, pt. 2, p. 1202).

These views are dismissed by the representative of the Health Insurance Association of America as “minority views of a very limited group of people” (*ibid.*) It is worth considering the possibility that other insurance executives may have held a secret affinity for reform. Even if such a view were widely believed by all insurance executives in this period, it is still compatible with the established social structure of accumulation.

As noted above, at that time large expansion of the private health insurance industry had occurred within the last two decades, simultaneous with the entrenchment of the institutions of regulated capitalism. Thus, it is reasonable for health insurance executives in this period to not immediately couple a stronger state role in insurance with the demise of their industry. The deepening of regulated capitalism had so far proved compatible with the expansion and growing profitability of their industry. The subtle opposition of insurance executives such as Rietz and Miller reflects this knowledge. Their testimony did not imply that federal intervention would be detrimental to their industry or threaten mass lay-offs. Their arguments acknowledged the recent success of the industry and promised future expansions.

## **Blue Cross and Blue Shield**

Neither Blue Cross nor Blue Shield were members of the Health Insurance Associate of America, but the companies covered a large share of the privately insured. The two companies, often jointly referred to as the Blues, lobbied and operated distinctly from the rest of the private insurance market. The Blues' health plans covered hospital services (Blue Cross) and physician services (Blue Shield) using community rating, meaning that all local enrollees were charged the same rates. Because the other insurance companies did not have status as a tax-exempt organization, they were not required to use community rating and could charge enrollees different rates. This allowed the non-tax-exempt private insurance companies to charge higher rates to the enrollees who were expected to use more healthcare.<sup>8</sup>

Accordingly, commercial insurers appealed to enrollees who were not expected to use many healthcare services, often younger people without chronic illnesses. Experience rating allowed them to receive the same insurance benefits, but with lower premium costs. As more commercial insurers followed the Blues into the market, the Blues were faced with a cycle of higher medical costs, higher premiums, and an increasingly expensive population to insure.

This situation placed the Blues in a unique position during the battles for national health insurance reform. Competition with the experience-rated plans left the community-rated plans, and many of their beneficiaries, in precarious financial positions. The Blues had to defend themselves from possibility of a national health insurance plan but also

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<sup>8</sup> In this discussion, I use the term commercial insurers to refer to the non-tax-exempt private insurance companies.



knew that the current status-quo in private insurance markets might not be viable. Thus, they had to maintain the dual position of promoting private insurance over public insurance, while simultaneously defending themselves from the private competition.

Their lobbying strategy in the years preceding Medicare's passage responded to both threats. Like the commercial insurers, the Blues publicly contended that the recent increase in private insurance coverage proved that any expansions to federal health insurance program were unwarranted and unwanted. In January of 1962, Blue Cross announced "a historic decision ... to finance a program of comprehensive health-care benefits for the aged." Later in the year, the organization followed up with large advertisements in several major publications, announcing their expanded health plans for people over 65. However, unlike the commercial insurers' State 65 plans, the increased plans for the elderly never materialized (Harris 1966a, 135–50).

While promising future private benefits and coverage to the elderly, the executives of the Blues plans also positioned themselves to administer any future expansions in public health insurance benefits. The 1960 Kerr-Mills bill, a precursor to Medicaid program that provided limited federal funding for state and local governments to provide insurance to elderly poor citizens, was sufficient and "essentially right" according to the Executive Director of the National Association of Blue Shield Plans (Committee on Ways and Means 1963, pt. 4, p. 1945). Any further legislation, in the opinion of both Blue Cross and Blue Shield executives, should focus on improving the existing Kerr-Mills program. The Blue Shield executive suggested a possible means of improving the program:

"We can demonstrate the practicality of utilizing Blue Shields Plans as underwriters of the services to be provided the needy elder citizens

through the Kerr-Mills program. We in Blue Shield would welcome a much broader opportunity to make our contribution to this program.” (*ibid.*).

The Blues were unsuccessful in expanding private health insurance coverage to the elderly, but ultimately shifted their strategy of protecting their industry in the 1960s to promoting their capability for administering federally funded health insurance plans. The Blues emphasized their institution’s civically driven branding and their history and knowledge of the industry. From their perspective, an ideal policy would not expand federal coverage for the entire over-65 population, but only those who were unable to purchase private insurance. Such a program would be financed by the government but underwritten and administered by the private Blue Cross and Blue Shield plans (*ibid.*).

As private insurers, the Blues were undermined by their inability to use experience-ratings. Yet, as tax-exempt non-profit institutions, the Blues were well-positioned to solicit a large role in administering a public insurance program. Like commercial insurers, threat of legislation in this period did not incite the insurers into a public campaign against reform. Facing the problems of the competitive marketplace, the Blues were more explicit in identifying the possible advantages of an expanded public role in their industry. They were able to more effectively shape the Medicare and Medicaid program to their interests. The institutions of the regulated capitalist era, under which the government was understood to have a major role in providing public goods alongside of private companies, was critical to the Blues’ success despite their disadvantages in the private insurance market.

## Medical Providers

The American Medical Association (AMA), a professional organization representing doctors, opposed all variations of national health insurance proposals in the first half of the twentieth century. Starr (1982) argues that the medical profession's long-standing dedication to the principle of doctor-patient sovereignty led them to fear federal health reform. The AMA protested that government interventions threatened their professional autonomy. In the early 1960s, as several bills establishing Medicare-type programs were discussed in the Congress, the doctors maintained a fierce opposition.

The AMA, originally founded in 1847, had deep-rooted institutional advantages in their fight against government insurance for the aged. By the early 1960s, the organization of two hundred thousand members had established a political action committee, a Washington, D.C. lobbying office with twenty-three staff members, and a Chicago headquarters with nine hundred other employees, including seventy publicists (Harris 1966a, 2). The well-resourced group took the opposite approach from health insurers and deployed an aggressive and very public campaign against healthcare reform.

The AMA's Operation Coffee Cup is one such example of the organization's educational campaigns to dissuade the public against publicly financed medical care for the aged. Doctors' wives were encouraged to invite friends and neighbors over for coffee and cookies. While guests snacked, the host would play a vinyl recording of Ronald Reagan excoriating the evils of government interference in medicine:

“One of the traditional methods of imposing statist socialism on a people has been by way of medicine. It's very easy to disguise a medical program as a humanitarian project.” (qtd. in *ibid.*, p. 139).

The organization also used traditional media methods. They ran full page ads in every major city's daily newspaper and in the major weekly magazines. Quarter-page ads ran in hundreds of smaller cities' daily newspapers. Similarly, the AMA purchased hundreds of local television advertisement spots to run along with national one minute advertisements (C. Gordon 2004, 235).

Their opposition was resolute, even proposals that subsidized the elderly's purchase of private health insurance benefits underwritten by private health insurers was considered "essentially the same as compulsory health insurance" and the end of free enterprise in medicine (qtd. in *ibid.*, p. 234). It was not until 1962 that the organization indicated a possible willingness to accept federal subsidies to the non-profit Blue Cross and Blue Shield health plans to expand coverage for the needy aged (Corning 1969). Any government intervention beyond assistance to those with the most need was not only deemed socialist, but also unnecessary and harmful.

Like the private insurers, in Congressional hearings the AMA took issue with the premise that there was any problem in the distribution of healthcare. Private markets, they claimed, already provided the correct amount of paid care work at the highest quality. Dr. Edward Annis, president of the organization, argued that the current private health insurance system was sufficient since more than half of Americans over 65 had met "individual responsibilities without recourse to a broad Federal aid program" (Committee on Ways and Means 1963, pt. 2, p. 644). Further, the tales of financial vulnerability of elderly Americans were dramatically overstated. Although they conceded that elderly Americans do experience a decline in family income, they reasoned that they also had fewer expenses, since "many of the aged have retired and thus escape expenses

for transportation, lunches, clothing, and other needs incident to employment” (*ibid.*, p. 645).

Doctors also predicted that government involvement in medicine would have adverse effects on the quality of care for all people. Instead of helping people, the AMA argued that Medicare would “impos[e] centralized direction which would frustrate the striving for professional excellence” and “result in a loss of able entrants to the healthcare field because of Government controls over medicine” (*ibid.*, p. 649). The doctors argued that public payment for healthcare would cause American doctors “to feel there is less need for them to give of their talent and time to help the needy” and thus would cause an “incalculable loss” to older patients (*ibid.*).

Despite the advantages of their industry and the pervasiveness of their public campaigns, the AMA faced new obstacles in the early and mid-1960s. The set of institutions underpinning capitalist accumulation had transformed and were no longer compatible with many of the AMA’s arguments. The claims of the private market’s ability to solve problems in healthcare were no longer effective. During this period, the need for government intervention to correct market failures and regulate major industries was well established. Arguments connecting healthcare reforms to socialism were similarly futile. The Social Security Program, a federal pension system established after the Great Depression, had proven successful and dependable and had so far not ushered in a socialist regime. Alternatively, over the last two decades, the U.S. economy had fared well. Profits were up and incomes rose for the lowest and highest earners (Kotz 2015).

By the fall of 1964, the Medicare-like proposal of the King-Anderson bill pass in both the House and the Senate but could not be settled in conference committee (Corning 1969).<sup>9</sup> Undeterred, in a December 1964 meeting, the AMA voted and recommitted to another public campaign opposing the legislation. Yet early in 1965, the AMA switched their tactics and introduced their first formal counterproposal. Their proposal, named Eldercare, would use general federal and state revenues to subsidize private health insurance policies for elderly people. Although the proposal itself was not revolutionary, the AMA surprised observers by advertising their proposal as more generous than the other Medicare proposals being considered.<sup>10</sup> At a special session of the AMA House of Delegates, the legislation was introduced as

“... founded on a concept that a broad spectrum of benefits should be included in any health care program for the elderly, and those who require assistance in financing their health care expenses should receive whatever help may be needed” (“AMA House Backs Eldercare Program, Asks Study of Kerr-Mills Expansion” 1965).

The organization’s change in attitude towards government funded health benefits for the elderly did not go unnoted. Congressman Udall from Arizona mocked the group’s transformed beliefs:

“Friends, you know that problem we said didn’t exist? Well, it does exist and it is very, very serious. While we told you that Medicare was socialized medicine and should be defeated, we now recognize that it should be defeated only because it doesn’t go far enough. The Congress should do more for our older citizens and pass our Eldercare bill instead” (Udall 1965).

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<sup>9</sup> H.R. 11865 The bill proposed to expand the Old Age Survivor and Disability Insurance program to cover hospital benefits for all people over 65, with an increase in the social security taxes.

<sup>10</sup> Corning (1969) notes that such a plan was originally proposed in the Taft-Smith-Hartley bill of 1946.

The group's inconsistency did not seem to hurt the public popularity of the Eldercare proposal: it was given wide publicity and immediately introduced in the House of Representatives (Corning 1969). The President of the AMA later described the proposal as "the most successful we ever had" and claimed that

"the mail was running as much as 15 to 1 in some states to as high as 50 to 1 against King-Anderson Medicare in favor of Eldercare" (Annis 1967, 43).

The organization may have intended for their Eldercare proposal to be a replacement for bills financing a universal benefit for aged people financed out of social security. However, the universal hospital care benefit financed out of social security taxes became Medicare part A. Historians have noted that the other parts of the bill, Medicare part B and Medicaid, reflect parts of the Eldercare proposal. Corning (1969) recalled that the claims that Eldercare had more comprehensive benefits "served to goad the Ways and Means Committee into expanding the scope of the Medicare bill." Eldercare is also reflected in Title 19 of the legislation, which provides broad hospital and physician care for poor people without financing from Social Security Act (Cohen 1985).

The later success of the AMA's Eldercare proposal is consistent with the established regulated capitalist SSA. Having spent the first few years of the Medicare debate comparing the legislation as a communist threat to free enterprise, the organization's active publicity and lobbying earned them few inroads with politicians and public sentiment. In a last-minute effort, the organization supported federally subsidized comprehensive health benefits for all the elderly through private insurers. The more generous plan raised their public and political support but was ultimately melded with the more statist Medicare proposal the group hoped to avoid.

## Big Business

Representatives from large corporations do not appear on the lists of public witnesses at the 88th or 89th Congressional Ways and Means Committee's hearings regarding medical care for the aged. Big business groups also did not send any representatives to the Senate Finance Committee's hearings or submit written material for any of the accompanying public records. Outside the Congressional testimonies, an established record of big business's opinions on Medicare proposals remains difficult to locate. A description of the Committee for Economic Development (CED)'s statements and research reports include no mention of proposals for medical care for the aged. As Swenson (2015) and others demonstrate, big business groups, who had previously supported Republican candidates, lent a lot of financial support to Johnson's campaign in the 1964 election. Many authors discuss the close relationship that President Johnson maintained throughout his presidency with these groups, specifically the Business Council, an organization of CEOs from the largest firms in the country. However, within these histories there are no specific details on how the logistics of healthcare reform played into this relationship.

Even without explicit references to Medicare programs, many journalists of the era commented on what they considered an unexpected shift in big business's attitudes towards the Great Society programs or government intervention more broadly. A 1966 *Fortune* article that discusses a "rapprochement" between government and business makes the following observation:

"Today the scope of federal action cannot be specifically defined by categories (e.g., defense and foreign affairs). The federal government may have a proper function in almost any field of action" (Ways 1966, 228).



In a 1967 *Harvard Business Review* article, Thomas Levitt makes a similar point regarding a new and unexpected relationship between government and business, naming it “the almost total reversal of the business community’s attitudes” (p. 118). His article, “The Johnson Treatment,” emphatically makes the case:

“It may seem the height of grandiloquence to say so, but there is abundant evidence that the American business community has finally and with unexpected suddenness actively embraced the idea of the interventionist state. ... [I]mportant elements of American business have now come to the clear conclusion that the federal government can and probably should be an active agent of social and economic betterment – not just that big government is here to stay, but that government bigness is not automatically badness and that the rising governmentalization of our social and economic affairs can indeed ameliorate our lives and improve our society” (Levitt 1967, 114).

This sentiment, as well as the divide between small and large businesses, is further articulated in a 1966 article of *The New Republic*:

“A new breed of corporate executive is on the scene, professionally trained and more oriented to the science of management than to the perpetuation of an ideology which looks upon government as intrinsically evil. The modern company officer accepts government (much like he accepts the labor union) and works actively with it, seeking to take full advantage of the opportunities it offers and striving to influence the policies it adopts” (Harris 1966b).

Big business representatives did not aggressively campaign either for or against, but tacitly accepted, government provision of health insurance for older Americans. Swenson himself notes that big business had little to lose from offering explicitly public support for Medicare but “only social and economic risks of looking too liberal in the eyes of much of the business community” (Swenson 2015, 10). Gordon (2004, 238 n70)

identifies large employer's foresightedness in wanting to maintain the insurance and pharmaceutical agencies as political allies for future battles.

The following exchange between an AFL-CIO representative from New York a member of the Congressional Ways and Means Committee at the 1964 hearings on the King-Anderson legislation supports the tacit agreement of big business. The King-Anderson bill called for hospital insurance for the aged financed through increased social security tax revenues split between employer and employees. The AFL-CIO representative from District 65 of the Retail, Wholesale, and Department Store Union read a statement in support of the immediate passage of the King-Anderson legislation with the goal "that provision ultimately be made for every aspect of medical service and techniques and facilities involved in maintaining people in good health" (Committee on Ways and Means 1963, 334). Afterward the statement, Mr. Curtis, a Representative from Missouri on the committee, asks the union representative, "Let me ask one question. I want to be sure that you are speaking for the union and not the 1,500 employers, or are you speaking for both?" (p. 336). The union representative responds:

"I believe I can say reliably, however, that this view generally represents the feelings of most of our employers. This matter has been discussed at meetings of our labor-management board of trustees. While they have not gone on record officially, I believe that is their general feeling" (p. 336).

Features unique to the regulated capitalist era of this time made this unspoken agreement possible. After the period of labor strife in the early twentieth century, a capitalist-labor accord as well as the accepted role for government regulation was required for continued capitalist accumulation.

This logic corresponds to several of the features of the era of regulated capitalism and supports the thesis that the dominant form of capitalism shaped group's arguments and attitudes regarding health care reform. In the SSA of the regulated capitalist era, even though big business owners were not enthusiastic about the proposed healthcare reforms, they did not publicly oppose the legislation. Public opposition from large business owners would have been antithetical to the era's compromise between big business and labor. As was noted above, after a period of labor strife following the 1930s, the leaders of big businesses accepted unions and the norms of collective bargaining as well as existing social programs such as social security, unemployment insurance, and a Keynesian low-unemployment program (Kotz, 2015, p. 58). Since labor and consumer groups, such as the AFL-CIO, were strongly supportive of Medicare, a public campaign from large business owners against the legislation would have been threatening to the stability of the compromise. Having determined that Medicare did not pose a threat to their profits, big business leaders, including those in the health insurance industry, apparently decided that risking the stability of the compromise that underpinned the successful capitalist accumulation of this era was not in their interest.

### **Small Business**

Small businesses did not join the capital-labor compromise and did not have the power or influence that big businesses had.<sup>11</sup> They were also ineffective in their fight against healthcare reform. Representatives from small business organizations made

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<sup>11</sup> Small businesses face different conditions than large businesses, which explains their absence from the capital-labor compromise. Small businesses face low profit rates and fierce competition. Unlike big business they do not expect to have much influence over a government that becomes interventionist.

several statements before the committee hearings on the King-Anderson legislation. Representatives from the Chamber of Commerce, National Association of Manufacturers (NAM), and National Restaurant Association (NRA) shared similar arguments. These representatives from small businesses argued that the proposed additional tax burden of the legislation was not only excessively heavy, but also unfair in principle.

Karl Schlotterbeck, representative from the Chamber of Commerce, argued that because Medicare benefits would be available to people who were still working, that this redistribution was inappropriate (Committee on Ways and Means 1963, pt. 3, p. 1622). Representatives from the NRA and the American Hotel and Motel Association argued that their profit rates were so small that the additional payroll taxes would put them out of business, force employee layoffs, and encourage the use of automation to replace labor costs (Committee on Ways and Means 1963, 2459 part 5). Representatives from the NAM warned that this legislation would usher in a new era of “socialized medicine” (p. 2450). The Junior Chamber of Commerce feared that the government provision of healthcare benefits would “push private enterprise out” of the United States entirely (Committee on Ways and Means 1963, pt. 4, p. 2008)

Many representatives from small businesses argued that the proposed government legislation demonstrated a lack of trust for individual Americans. A representative from the Junior Chamber of Commerce articulated this viewpoint emphatically:

“We believe the overwhelming majority of Americans hunger and thirst for someone who will recognize their moral, spiritual, and physical strength, who will treat them not as vassals or helpless dependents, but as self-reliant, self-supporting freemen with the courage to adventure and to stand on their own two legs in the mainstream of life” (p. 2008).

Representatives from the National Retail Federation repeated the argument that the King-Anderson legislation

“is nothing more than a basic mistrust of individual choice ... saying that individuals cannot be trusted to provide voluntarily for their own medical care when confronted with other temptations” (Committee on Ways and Means 1963, pt. 5, p. 2459).

But in the era of regulated capitalism, small business owners did not have the same political power and weight of the large business groups. The argument that publicly provided health insurance for elderly people constituted a gross violation of individual rights was ineffective. The importance of individual decision-making was important but limited under the regulated capitalist SSA. Their arguments ran counter to the dominant ideas of the SSA, which supported a social safety net for individuals who did not fare well in the market economy.

### **Labor and Citizen Groups**

Another key part of regulated capitalism that was critical to the creation of Medicare and Medicaid was the heightened power of organized labor. Following the Second World War, a new set of power relations governed the relationship between capital and labor in the United States (D. Gordon, Weisskopf, and Bowles 1996). This new set of power relations is often referred to as the capital-labor accord. Kotz (2015) argues that renewed labor militancy during the Great Depression, along with other factors after World War II, led a critical mass of big business leaders to agree to a compromise with organized labor. The compromise accepted collective bargaining and supported government efforts to maintain a low unemployment rate (p. 58).

Gordon, Weisskopf, and Bowles (1996) analyze empirical evidence of the degree of power exerted by labor over capital during this period. The authors calculate an index of the capitalist's power over labor from the expected reduction in income following job loss. They compare this to an index of worker's resistance to capital, based on the percentage of union members involved in strikes, the ratio of quits to layoffs in manufacturing, and the proportion of strikes primarily motivated on issues of workplace demands. Tracking these indicators over time, the authors conclude that capitalists lost considerable power over workers during the 1960s, which they were able to begin to recapture in the 1970s and 1980s (pp. 141-142).

Thus, the capital-labor accord was not a period of tranquility and total agreement between classes; labor strife continued. However, the accepted role of labor in collective bargaining made it possible for labor to win important concessions during this period. A stronger working class shifted the income distribution in its favor during this period. Quadagno (2006) describes how the newly merged American Federal of Labor and Congress of Industrial Organizations (AFL-CIO) was at the forefront of fighting for expanded federal disability benefits in 1956. In the early 1960s, the United Auto Workers (UAW) successfully negotiated for the full payment of health insurance premiums for retirees in the early 1960s.

Following these victories, organized labor prioritized guaranteed health insurance for the aged. The AFL-CIO offices became a self-described headquarters for the cause. Their Social Security Department worked on crafting a Medicare bill, as well as drafting speeches and talking points for members of Congress who supported the cause (Quadagno, 2006, p. 53). The AFL-CIO also created and financed the Physician's

Committee, an organization of doctors that supported Medicare and rebuked the fierce opposition of the American Medical Association (AMA). The National Council of Senior Citizens, another group organized by the AFL-CIO, represented the main beneficiaries of a possible Medicare program. The group organized effective petition drives and letter-writing campaigns, published campaign materials on the details and necessity of Medicare, and organized testimony for related Congressional hearings (pp. 52-55).

Organized labor played a large role in formulating what became Medicare part A. Quadagno notes, “there is little doubt trade unions paved the way for the final Medicare vote” (p. 56). Yet their role was limited in several ways. Ultimately, labor groups had little say in the creation of Medicare part B or the Medicaid program, which were the result of a last minute legislative compromise by Wilbur Mills (Quadagno, 2006).

Following the ousting of communist labor leaders in the 1940s, trade unions fought cautiously for health insurance for the aged. They were careful to frame their demands without threatening the order of the capital-labor accord. The testimony of the President of the AFL-CIO, George Meany, to the Ways and Means Committee hearings on Medicare legislation in 1964 reflects their submission. Meany argued that private health insurance plans were expanding but were doomed to fail to ever provide affordable enough coverage for elderly people. He argued that a government program was necessary “not for its own sake” but “only when other means have proved to be inadequate” (Committee on Ways and Means 1963, pt. 3).

The boundaries and institutions of the regulated capitalist era are reflected in labor’s fight and support for health insurance for the aged. Just as workers accepted capitalists’ control and management over production in exchange for bargaining power,

they also continued to accept private health insurance benefits in exchange for guaranteed public provision of benefits for the aged. Similarly, big business groups were also cautious to not threaten the capital-labor accord. Many big business leaders neither openly advocated for nor against federally funded medical insurance for the aged.

### **Conclusion**

Histories of the passage of Medicare miss the importance of the regulated capitalist era on the passage of this legislation. Understanding the institutions of regulated capitalism helps explain why it was at this particular time that the U.S. was able to successfully pass major public healthcare legislation. In this era, Keynesian ideas were prominent, there was an accepted role for government in social provisioning and regulating, and labor unions had an acknowledged role in bargaining with capitalists as well. Each of these institutions shaped the environment in which Medicare was passed and enacted. Warnings about of socialized medicine or government control over doctors were ineffective. Understanding the private market as unable to offer a private insurance coverage for elderly people was compelling. Labor and citizen groups effectively organized for and promoted increased public benefits and security. This joint constellation of institutions was effective in allowing for the greatest expansion of publicly provided U.S. health insurance. Examining the relationship between regulated capitalism and Medicare is also helpful for explaining the quite different outcomes for major healthcare reforms considered in the era of neoliberal capitalism.



## **CHAPTER 5**

### **CASE STUDY: THE FAILURE OF THE HEALTH SECURITY ACT 1993-1994**

#### **Introduction**

On September 23 of 1993, President Clinton addressed the U.S. Congress to announce his promised proposal for healthcare reform. His proposal, called the Health Security Act (HSA), became a center of political debate for the next ten months. However, it ultimately never made it to a floor vote in the House or Senate. In this case study, I analyze how the set of economic, political, and cultural institutions and dominant ideas of the period contributed to the health reform's defeat.

The case study is organized as follows. The first section briefly discusses the characteristics of the neoliberal SSA. I then consider the ways in which the institutions and ideas of neoliberal capitalism shaped and limited the discussion of healthcare reform in the 1990s, particularly the Clinton administration's proposal for reform. Next, I analyze how certain key groups, representing insurance companies, businesses owners, and labor and citizen groups participated in the discussion of healthcare reforms in this period. I show how the neoliberal SSA shaped these groups' perceived interests, the ways in which they articulated these interests, and their ultimate degree of success.

#### **Neoliberal Capitalism**

As discussed in chapter three, the neoliberal SSA emerged out of the crisis of the regulated capitalist SSA. In the conflict that followed the destabilization of the institutions and ideas of the previous era, a coalition of small and large business groups coalesced to reverse the concessions of regulated capitalism and to restore their profitability (Kotz 2015). By the late 1970s, the U.S. economy had undergone structural

changes. A cohesive set of economic, political, and cultural institutions and ideas of the neoliberal SSA, which would successfully restore capitalist accumulation for the coming decades, were consolidated.

The new SSA was markedly different from its predecessor: Keynesian economic theories were displaced in favor of neoliberal economic theories that emphasized individual choice and the uninhibited operation of markets. The privileged role of market forces in allocation replaced the role of the state and collective bargaining, which had been central to the allocation of resources in the regulated capitalist SSA. The capital-labor relation had been transformed to one in which labor is fully dominated by capital. By the early 1990s, when the details of the Clinton Health Security Act were announced, each of these institutions was well entrenched.

### **Clinton Health Security Act**

Although ultimately unsuccessful, the Health Security Act became a defining part of the Clinton administration's legacy. The thirteen-hundred-page proposal would have dramatically changed the financing and delivery of private and public healthcare. The legislation was never voted on, much less enacted, but it nevertheless remains a landmark event in the development of U.S. health policy. The design of the HSA was the focal point of the healthcare debate; many of the competing healthcare bills debated simultaneously were modifications of the system proposed by President Clinton.

This episode of healthcare reform has motivated a large body of research into the causes and consequences of its demise. However, the existing literature has not yet analyzed this episode of healthcare reform in the context of the changing structures of

capitalism. Before proceeding to this analysis, it is necessary to broadly describe major policy elements of the Clinton Health Security Act.<sup>12</sup>

### **Title I: Health Care Security**

The first title of the HSA consists of ten subtitles, which specify the proposals that have become the law's hallmarks. Title I defines the new responsibilities that insurers, states, the federal government, and employers would be responsible for under the new law.

There are major new regulations for private health insurance. The law establishes a mandatory comprehensive benefit package that all health plans must offer to anyone who enrolls. No exclusions or limitations of coverage for pre-existing conditions or other reasons would be allowed. Each health plan would use community rating to price their insurance. They would also need to offer three schedules for cost sharing. The lowest cost schedule includes no deductible or copayment for any in-network providers. Enrollees in this cost sharing plan may see out-of-network providers with a coinsurance of no less than twenty percent of the cost of the visit.<sup>13</sup> The higher cost sharing plan charges a deductible and coinsurance for services. The final plan, called the combination plan, uses the low-cost sharing schedule for in-network providers and the high-cost schedule for out-of-network providers. In all schedules, enrollees would face the same out-of-pocket limits.

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<sup>12</sup> Unless otherwise stated, when I refer to the Health Security Act, I am specifically referencing H.R. 3600/S. 1757.

<sup>13</sup> The newly established National Health Board would determine the rate of the coinsurance percentage.

Each state would be responsible for establishing a regional health alliance. These alliances could be operated as non-profit organizations, an independent state agency, or an agency of the state. Each alliance would be governed by a Board of Directors, which would be made up of equal numbers of employers and employees who purchase healthcare from the alliance. The health alliances would be responsible for establishing and publishing the criteria used to certify which insurers could sell their health plans within the region. Every alliance would offer a traditional fee-for-service plan and establish a fee schedule.

Ultimately each regional health alliance facilitates the purchase of health insurance through private insurance companies. The alliance issues each enrollee's health security card and reviews consumer information and marketing materials used by the health plans to ensure that they meet the standardized criteria. The alliances would also function as a clearinghouse: they would collect the health insurance premiums and ensure that families with income less than 150 percent of the poverty level received premium reductions. Families with income less than 250 percent of the poverty level would qualify for a reduction in cost-sharing liabilities, which the regional health alliance would also oversee.

A new National Health Board would be established. Seven members would be appointed by the President with Senate confirmation and a chairperson would be selected by the President. The National Health Board would be responsible for implementing the policies of the HSA. They would define the comprehensive benefit package and would recommend future changes of that package. They would also establish the financial requirements for health plans and health alliances, determine the risk-adjustment

methodology for reinsurance across health plans, and oversee the development of a national health care information system.

Employers would also have new responsibilities under the HSA. An employer would be responsible for paying 80 percent of the premiums for their employees. Large employers with over five thousand employees would be able to create their own corporate health alliances and contract with health plans in similar ways to regional health alliances.

#### **Title IV: Medicare and Medicaid**

The HSA proposed major changes public health insurance programs as well. The legislation would modify when and how people joined Medicare. People would not be eligible for Medicare until after turning 65 and stopping work. Employees who were over 65 would continue to enroll in the health alliance plans. Upon stopping work, Medicare beneficiaries could elect to continue to stay in the alliance plan. The government in this case would pay the health alliances 95 percent of expected spending for a comparable individual enrolling in regular Medicare coverage. States could also elect to enroll some or all their Medicare beneficiaries in the regional health alliances. The federal government would pay the states 100 percent of the annual per capita cost for Medicare eligible individuals for the costs of their care.

The HSA would also alter how Medicaid beneficiaries receive their coverage. Beneficiaries of Medicaid who did not also receive cash welfare assistance through Assistance for Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) would enroll in health plans offered by alliances either as an individual or

as part of their corporate alliance. Those with incomes less than 150 percent of the federal poverty line would be eligible for cost-sharing and premium discounts.

Medicaid beneficiaries who did receive welfare cash assistance payments through AFDC or SSI would also be enrolled in regional health alliances. They would not be obligated to pay for premiums<sup>14</sup> and would receive a reduction in cost sharing. The amount of any copayment (other than hospital emergency room services for which there is no emergency medical condition) would be limited to 20 percent of the copayment amount otherwise applicable.<sup>15</sup>

#### **Title VI: Premium Caps; Premium-Based Financing; and Plan Payments**

Title VI of the HSA described an enforceable cap that would limit the growth of insurance premiums and eventually limit premiums from rising faster than the rate of inflation. Health insurance companies would submit bids to the regional health alliances for offering coverage within the alliance. In each alliance, the average premium across plans would need to be lower than the average premium cap calculated by the National Health Board.<sup>16</sup> If the average premium exceeds the alliance's premium target, then the health plans that proposed excessive premium increases would be required to lower their premiums.

Title VI also specifies the premium shares and possible discounts available for individuals and employers. Employers would be responsible for 80 percent of the

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<sup>14</sup> (§ 6104 p1037)

<sup>15</sup> (§ 1371 p185)

<sup>16</sup> Premium limits would not be uniform across all regional alliances. The legislation specifies a process through which changes in demographic factors, socio-economic characteristics, and regional price levels would be included in calculating each alliance's premium caps.

premium cost for their employees. However, their share would be limited: these payments could not go over a specified maximum for the payroll. The largest employers would only be responsible for 7.9 percent of their payroll costs. For small employers, the share shrinks to a maximum of 3.5 percent of their payroll.

The legislation also proposed the creation of a committee to recommend policy proposals to eliminate the variations in health expenditures across alliances, which were not the result of healthcare prices or demographic factors.

### **Title VII: Revenue Provisions**

Financing for the legislation would come from the savings generated from the changes to the Medicare and Medicaid programs. Any large employer that established a corporate alliance would also be responsible for a surcharge to help finance the system. The law would also increase the tobacco excise tax rates.

### **Title VIII: Health and Health-Related Programs of the Federal Government**

Title VIII of the HSA allows the Secretary of Defense to develop a plan for implementing healthcare reform for military personnel. The Secretary of Defense could establish Uniformed Services Health Plans, which would automatically enroll active-duty service members. Family members would be able to choose between enrolling in the military health plan or a civilian health plan sold on the exchanges. The Uniformed Services Health Plans would be allowed to contract with civilian healthcare providers.

The HSA would also implement changes to the healthcare available to veterans. The Secretary of Veterans Affairs (VA) would be required to organize health plans and operate VA facilities as or within plans under the HSA. Facilities owned by Veterans Affairs could be contracted out as part of other private managed health care plans. The

HSA would expand eligibility of VA benefits to all service-connected veterans and their dependents. It would also expand the benefits available to these enrollees to include all the benefits under the comprehensive benefit package, as well as any benefits previously guaranteed to veterans that were not included in the comprehensive health benefit.

Veterans and their dependents would have options for how to receive their benefits. Employed veterans could choose to receive care through their regional or corporate health alliance, with the employer paying the employer share and the veteran paying the remainder of their premiums and copays. Severely disabled veterans with service-related injuries would not be liable for premiums or cost sharing. Veterans could also elect to enroll in VA health plans. In this case, the employer would pay the employer share to the regional health alliance and veterans would be responsible for either remaining share of the premium as well as copayments.

The Act would repeal the Federal Employees Health Benefits Program. Federal would instead enroll in health plans offered in the alliance area where they reside. The Indian Health Service would operate outside of the alliance system but would be required to offer the comprehensive benefit package specified by the HSA. Individuals eligible to enroll in the programs of the Indian Health Service could elect to join a regional health plan. Conversely, the legislation would also allow local people who were previously ineligible for healthcare from Indian Health Services to receive care from the Indian Health Services facilities.

### **The HSA and the Neoliberal Capitalist SSA**

Using the defining characteristics of the neoliberal SSA in the early 1990s provides a useful lens for analyzing the Clinton administration's complex healthcare



reform. Hacker (2011), Skocpol (1997), and Altman et. al (2011) each comment on the unfamiliar approach that the Clinton administration selected for their model of healthcare reform. But understood through the lens of SSA theory, the Clinton Health Security Act maintained close fidelity to the economic, political, and cultural institutions and dominant ideology that underpinned capitalist accumulation in this period. In this era, health policy reforms were limited to those that were consistent with the characteristics of the neoliberal SSA. These concepts were by no means new or specific to the 1990s. However, this change in ideology was one important component of the overall structural change that occurred between the regulated capitalist and the neoliberal SSA.

### **The HSA's Neoliberal Underpinnings**

#### **Modifying patient and provider behavior**

The HSA uses three strategies for reforming the healthcare system to a more competitive market system. The first strategy focuses on targeting patient and provider behavior to make both parties more responsive to market forces. The opening sentences of an overview of the HSA from the White House Domestic Policy Council illustrate the law's emphasis on health insurance as a commodity and market competition as the appropriate means to allocate this commodity:

The Health Security Act rejects the idea of a government-run health care system. Health care will remain rooted in the private sector. ... The Health Security Act seeks to build on what works best in the American economy and fix what is broken. What works best is a competitive market that provides products and services to Americans at the highest quality and lowest price (1993, 26–27).

Healthcare has characteristics that make market allocation difficult.<sup>17</sup> For example, using the traditional assumptions regarding consumption and production decisions, medical providers are expected to provide too much healthcare. Doctors are often paid according to a fee for service (FFS) scheme. In this scenario, the provider is paid for every test or intervention that they prescribe. This payment system may motivate providers to prescribe more care than what is truly needed, since ordering further exams means providing more services, charging more fees, and ultimately earning a higher income.

While these motivations are not exclusive to a healthcare market, in healthcare often the provider has a lot more information than their patient on what interventions are necessary and which may be extraneous. Without this same level of information, it is possible that an individual may be persuaded to consent to more care than they would prefer otherwise. Economists see this additional care, or supplier-induced demand for healthcare, as a market inefficiency and loss of welfare.

Similarly, insured patients are likely to overconsume medical care. When individuals have health insurance, they are not liable for some (or all) of their healthcare costs. Instead, in exchange for a monthly premium, the health insurance company pays some portion (or all) of the healthcare bills. Thus, individuals are shielded from the true price of their healthcare. As a result of this distortion, an individual blinded from the “true” cost of their healthcare may choose to use more healthcare services than they would have otherwise. Insured individuals will act according to the lower insured price of

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<sup>17</sup> These characteristics are explored in (Arrow 1963), a seminal article in the field of health economics.

healthcare instead of the “true” uninsured price of healthcare. This over consumption of healthcare resources creates a loss of welfare in society since individuals will be consuming healthcare that offers a smaller marginal benefit than its marginal cost.<sup>18</sup>

The insurance reforms in the HSA were designed to attenuate these market imperfections that commonly arise in healthcare. To motivate patients and providers to behave in a cost-conscious manner, Title I of the HSA mandates that all insurers offer a specific structure of healthcare plans, often called managed care plans.

Managed care plans were a predominant feature of a healthcare reform proposal published by the Jackson Hole Group, a coalition of academic experts, government officials, and business and healthcare executives that began meeting in the 1970s. The Clintons were explicit in their use of the Jackson Hole Group’s plan. The White House spokesperson for the Health Care Task Force, Bob Boorstin, identified the group as “the intellectual brain trust for the managed care model” and credited them with a “very, very strong indirect role” in the development of the President’s healthcare plan (Toner 1993).

Managed care plans merge the insurer and provider roles. Instead of allowing an insured individual to select any provider and allow that provider to select any course of treatment and set their own prices, managed care plans contract with individual or groups of healthcare providers. The healthcare providers and the health insurers selling managed care plans would negotiate the details of the payment schemes.

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<sup>18</sup> This logic is often referred to as a moral hazard argument. When paired with the supplier-induced demand argument, they seem to contradict each other. The moral hazard argument is based on a consumer’s knowledge of their preferences, while the other claims that consumers of health care do not know which tests they need. However, the two arguments work in tandem. Even if consumers had all the information about what tests were necessary, they would not select the optimal number of tests unless they were exposed to the full cost.

Under the HSA, each health plan selling in the health alliances would be required to offer two health plans with two different payment schemes. Some plans would use a fee-for-service payment scheme and pay according to a set of previously agreed on prices. Other plans could use a capitation arrangement, in which the insurer pays the provider for a specified number of individuals that the provider agrees to treat. Under both variations of managed care plans, providers may receive bonuses for providing efficient care and/or the providers may agree to additional checks on the services that they order for their patients, frequently called utilization reviews. The overconsumption of healthcare services would be remedied by requiring individuals to be responsible for a share of their care: the legislation mandates that all enrolled individuals pay part of their health insurance premium and specify a co-insurance for most medical visits or procedures.

It is worth noting that by the 1990s, many of these principles of managed care plans had been tested. These principles had been at the center of the incremental healthcare reforms that took place since 1965, such as the Health Maintenance Organization Act of 1973. The popularity of managed care plans had skyrocketed between the 1970s and the 1990s, yet prices of healthcare continued to grow faster than the rate of inflation for consumer goods. The goal of slower healthcare inflation had not been achieved after the implementing greater cost-sharing and other measures to make physician behavior more cost conscious. Besides the issue of healthcare inflation, the U.S. also had worse health outcomes and lower utilization than other developed countries.

Despite the apparent failure in remedying the problems in U.S. healthcare, the faith in the discipline of market forces to remedy healthcare problems had not yet abated. The dedication to markets as a means of distribution had only strengthened. Alain Enthoven, a founding member of the Jackson Hole Group, articulates this in a 1992 lecture: “Some say, ‘competition failed.’ I say ‘competition has not been tried’” (Enthoven 1992). Enthoven defends his arguments concerning the possibility of managed care plans to bring competition into the health insurance markets and argues that further changes are needed:

“Competition will not work to provide [health plans] effective incentives to cut cost and price unless demand is quite price elastic. Price-inelastic demand is not an interchangeable law of nature. It is the consequence of many policies pursued by healthcare financing and delivery plans, providers, purchasers, and government” (ibid.).

### **Bringing competition to insurance markets**

The second strategy of the Clinton administration reforms was to make the markets for insurance more competitive through the establishment of a network of healthcare sponsors. By acting as an informed large collective purchasing agent for health insurance, sponsors would be able to solve the problems that the existing health insurance market at the individual level had not yet remedied. By only contracting with private health insurance plans that used community ratings and accepted every eligible person without limits or exclusions for pre-existing conditions, sponsors would establish and enforce rules of equity in the market for private health insurance. Insurance plans would be unable to cancel an insurance policy before the end of term. Sponsors would also simplify the administrative bureaucracies of private insurance plans by being responsible for managing enrollment and collecting premiums. The necessary price-elasticity in

demand for health insurance by providing information on outcomes and prices, would be achieved through sponsors standardizing coverage contracts and by offering a choice of plans at the individual level.

The Clinton administration incorporated this element of the Jackson Hole Group's proposal in the HSA. They referred to the sponsors as regional health alliances (or health insurance purchasing cooperatives). As a result of the combined purchasing power of sponsors, firms and individuals participating in the alliances would have the bargaining power that was only available to large corporations before.

### **Shifting public programs into the private sector**

The first two strategies of the HSA focused on creating more competitive markets for healthcare and health insurance. The third element of the Clinton health reform focused on shifting elements of public health insurance programs into the private sector. The Federal Employees Health Benefit Program would be repealed entirely.

Changes to Medicaid would dramatically reduce the role of the federal and state governments in the provision of the program. Since all Medicaid beneficiaries would be enrolled in the regional health alliances, employers would become responsible for 80 percent of the premium payments for employed beneficiaries. This redistributes a large share of the healthcare costs previously paid by state and federal governments to the employer. Any Medicaid recipient who did not receive cash payments, such as AFDC or SSI, and whose income exceeded 150 percent of the poverty level would become individually responsible for their healthcare costs. State governments would continue to pay their previous expenditures for these Medicaid recipients to the regional exchanges.

The federal government would not make payments to the alliances for this purpose.<sup>19</sup> The exchanges would then distribute the payments to the health plans (private companies), which would in turn pay the providers.

Only Medicaid recipients who did receive cash payments or whose income did not exceed the limit would continue to have their premiums paid publicly and would receive reductions in cost sharing. They would not be obligated to pay for premiums and would receive a reduction in cost sharing.<sup>20</sup> The amount of copayment to any item (other than hospital emergency room services for which there is no emergency medical condition) would be limited to 20 percent of the copayment amount otherwise applicable.<sup>21</sup> On behalf of these individuals the Federal and state governments would provide payments, equal to 95 percent of their previous spending for AFDC/SSI recipients to the state alliances.<sup>22</sup> Instead of providers receiving these payments directly from the government, the providers would receive their payments from their health plan. This reroutes dollars, which would have formerly been paid directly from the government to the provider, instead through alliances.

Similarly, the Clinton Health Security Act also substituted federal spending on Medicare payments to employers and private individuals. People would not become Medicare eligible after turning 65 but would only be eligible for Medicare after turning 65 and stopping work. Employers would pay the 80 percent premium share until the beneficiary stopped working. After working, Medicare beneficiaries could elect to stay in

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<sup>19</sup> § 4201 p810

<sup>20</sup> § 6104 p1037

<sup>21</sup> § 1371 p185

<sup>22</sup> § 4201 p809, §9011 p1286

their health plan. In this case, the government would pay the health alliances 95 percent of what it would have spent on a comparable individual enrolling in regular Medicare coverage.<sup>23</sup> States could also elect to enroll some or all their Medicare beneficiaries in regional health alliances. The federal government would pay the states 100 percent of the annual per capita cost for Medicare eligible individuals for the costs of their care, rerouting payments originally provided from the Federal government to providers through the regional health alliances.

The ability of veterans to choose whether to receive their HSA benefits through the VA or through the alliances would force the VA to compete for enrollees. For the VA to be able to compete in the alliances, the VA would be able to contract with private facilities. The VA would be transformed into a series of managed care plans. Instead of the veterans exclusively receiving care from VA providers paid by the federal government, the Veterans Health Administration may contract with private providers to offer all the services in the comprehensive benefit package to their enrollees. While the VA facilities would remain government owned facilities, they would become open to private payers as well as part of other managed healthcare plans. For the VA facilities to remain operative, they would rely on private payers.

### **The HSA's Conflicts with Neoliberal Ideas**

The discussion above analyzed how the HSA was designed to preserve and strengthen a private model of health insurance and healthcare in the United States. The legislation's three strategies for preserving the private health insurance industry were consistent with the institutions and dominant ideology of the neoliberal SSA. However,

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<sup>23</sup> §§ 4001-4003, p809



there are important ways in which aspects of the HSA seemed to counter neoliberal ideology. Many criticisms and opponents of the HSA centered on these aspects of reform.

### **Price caps and budgeting**

As noted above, the Clinton administration explicitly defined and defended their proposal as one “rooted in the private sector” and “rejecting government run healthcare”. However, there were some tensions between the administration’s goal and the process that the healthcare reform used to achieve the goals. The use of price caps and budgeting described in Title VI of the legislation is one such key example.

The price cap element of the proposal was designed to reverse the trend of rapidly increasing healthcare prices. The rapid growth of healthcare prices had two effects that the Clinton administration sought to reverse. The rapidly increasing premium rates of private health insurers had made buying private health insurance impossible for many individuals and businesses. For a private health insurance system to work, individuals could not be priced out of the market. The premium price caps were intended as tools to maintain the private market.

Secondly healthcare inflation had important consequences to federal and state budgets. The share of public money being spent on the Medicare and Medicaid programs had consistently increased. As the share of national and state budgets being spent on healthcare costs grew, the private health insurance system became increasingly reliant on public funding. By limiting the amount that premiums could initially grow, the HSA comported with the Clinton administration’s goal of reducing budget deficits.

The Clinton administration described their use of premium caps as an “emergency brake” and “back-up” measure, written in only in case that the competition and increased

efficiency aspects of the healthcare reform did not control costs (Department of Commerce and Technology Administration 1993). However, the contradiction between price controls and market forces undercut the effectiveness of this argument. The group of academics, business owners, and representatives from the healthcare industry that had worked on initial Jackson Hole Group proposal, publicly rejected the premium caps as incompatible with their model (Ellwood 1993).

### **The employer mandate**

Another feature of the HSA that countered neoliberal ideology was the employer mandate. The employer mandate included in the HSA required all employers to pay 80 percent of their employee's premium costs, subject to a cap as a percentage of payroll. The requirement for employers to help subsidize the costs of private health insurance for their employees could be interpreted as an additional tax or regulation on employers. Like their arguments for premium caps, the Clinton administration also framed their inclusion of the employer mandate as an avenue to maintain the private health insurance system using the language of neoliberal ideology:

“The vast majority of money comes from the same place it comes from today: employers and individuals. But under the health security plan, every employer and every individual will be asked to contribute to health care. Everyone takes responsibility, and everyone gets security.” (Department of Commerce and Technology Administration 1993, 28)

At this time during the 1990s, the majority of privately insured people insurance received that coverage through their workplace. Having explicitly rejected a “government-run” healthcare system, expanding health insurance coverage through workplaces was an obvious alternative. Employment-based health insurance was the bedrock of the private health insurance system that the Clinton proposal aimed to

preserve. The employer mandate was a means for the Clinton administration to reform and expand private health insurance coverage. However, to achieve this goal, the administration proposed a requirement on all private businesses to help their employees purchase insurance.

### **Interest Groups**

The healthcare debate of the 1990s occurred in a much different context than the earlier debate on Medicare and Medicaid in the 1960s. The set of institutions and dominant ideas of the regulated capitalist SSA, which led to economic crisis in the 1970s, were replaced with the neoliberal capitalism's institutions and ideas. These changes in the structure of the economy were reflected in how the group conflict over the HSA played out. The conditions of neoliberal capitalism shaped the perceived interests of each group, how those interests were articulated, and the success of their strategies.

### **Health Insurance Association of America**

The health insurance industry established their major lobbying group, the Health Insurance Association of America (HIAA), in 1956. From the outset, the group was explicit in their objectives: to establish the insurance model of healthcare in the United States and to preserve the role of private industry and block federal involvement. To achieve goals, the organization adopted a two-pronged strategy. They aggressively promoted the success and growth of the private insurance industry, while attempting to avoid a negative public perception as a corporate influencer by lobbying covertly.

(Chapin 2010)

In the early 1990s, the organization maintained their aggressive public promotion of the success of the private health insurance industry. However, the group seemed less

concerned with the need to lobby covertly. The group departed from their usual protocol and for the first time released their own proposal for health insurance reform. The proposal was covered extensively in public media. Reporters speculated that the move indicated a new willingness to work with the administration and compromise their previous stance against reform. The front page of the *New York Times* declared that the “Embrace of Universal Insurance Signals Industry’s Resolve to Work with Clinton” (Pear 1992). The article optimistically describes the announcement as a signal of a “willingness to accept sweeping changes.” However G. David Hurd, the chairman-elect of the HIAA described the announcement as “certainly not an altruistic act” but an enlightened-self-interest” (Stout and Steinmetz 1992). The chairman confirmed:

“There is a general recognition within the industry that we had an image problem and needed to address it. The desire to be regarded more favorably by the public has led to a lot more receptivity to change. We recognize ... that the defense of the status quo is just not a viable strategy” (qtd. in Pear 1992).

His comments suggest that in the early 1990s, at the height of neoliberal capitalism and its attendant praise of market allocation, the organization no longer believed publicly discussing healthcare reform proposals were strategic error. Instead, the organization adjusted their strategy and became a public and active participant in healthcare reform. The HIAA’s vision for reform called for universal coverage, a requirement for employers to offer a benefit package, cost containment measures, and a tax on employees who were insured beyond the basic benefit package.<sup>24</sup>

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<sup>24</sup> This tax is commonly referred to as the “Cadillac Tax.”

The organization did not shy away from public discussion of healthcare reform in the months following President Clinton's inauguration and his promise to deliver comprehensive healthcare reform. However, the HIAA did experience a major change in their membership. By January 1993, four of the largest insurance companies CIGNA, Aetna, Travelers, and MetLife had defected from the group (Brostoff 1993). CIGNA cited a need to "eliminate all but 'absolutely essential expenses'" for their departure. Aetna and MetLife explained their interest in forming broader coalitions for healthcare reform as the reason for the withdrawal. (Hoffman 1992)

Under the new leadership of former Representative A. Willis "Bill" Gradison, and without their largest companies, the organization continued to publicly promote themselves as proponents of comprehensive reform. At the initial White House Task Force public hearing on March 23, Gradison repeated the organization's belief "that our industry must change the way we do business" and continued to tout the principles for reform the group released the previous year. He was careful to specify the organization's explicit rejection of the limits on insurance premiums and the use of strict community ratings, two elements of the HSA with close relation to how health insurers do business.

In the build up to the Clinton administration's announcement of the HSA, the HIAA continued publicly representing themselves as leaders in reform efforts. On behalf of the HIAA, Chairman David Hurd testified to Congress:

"The Health Insurance Association has been actively working on reform beginning in 1990. We constructed a set of initiatives to be enacted at the State level and those have progressed so that now 40 States have enacted them in whole or in part ..."

However, later remarks from Gradison revealed that the HIAA's public statements were part of a strategy of blocking reform, not signals of the group's "willingness to accept significant changes," as the *New York Times* had previously speculated (Pear 1992). In a keynote address, Gradison commented that:

"From a political point of view, you can vote against another plan and convince your constituents that you want something done about healthcare reform as long as you have a plan you are for" (Gradison 1993).

In the same address, Gradison also suggested that the organization's public dedication to state level reforms, which helped the HIAA credibly say that it was working towards reform, was a means to obstruct national healthcare reform:

"... the states are not waiting [to enact healthcare reform]. Maryland has acted in a major way, and so has Florida. It will be more difficult, not less, to come up with a national plan ... The more states devise their own plans, the more general the federal plan will have to be, or it will cause real confrontation" (Gradison 1993).

In the context of the new phase of capitalism, the HIAA no longer felt that their public reputation would be best managed by remaining on the sidelines of the healthcare debate. The new dominance of market forces over state allocation allowed the insurers the possibility of publicly participating in the debate. They used that opportunity to cultivate an image of an industry working to reform itself. Such an outcome was not considered impossible. On the contrary, the dominant neoliberal ideology supported the claim that private businesses that did not adjust to meet public needs would go out of business.

There was a third element of the HIAA's strategy to fight healthcare reform in the 1990s. While the insurers ran a public campaign cultivating an image of supporting

aspects of reform, the insurers simultaneously offered subtle criticisms of the reform. They subtly but publicly prompted doubt in the government's capability to enact reform. A November 1993 press release issued by HIAA Executive Vice President Charles N. Kahn III demonstrates how the insurers walked this line:

“HIAA is foursquare in favor of comprehensive reform of the healthcare system. We agree that all Americans should have health coverage – coverage that they can get, keep, and take with them wherever they go. We want Congress to act on healthcare reform and meet the President's objective before the end of the next year. But we have raised and will continue to raise questions about the President's plan – questions that the American public need answer. In particular, we wish to take the President at his word that he wants a reformed health care system based upon a private/public partnership. However we find it difficult to see how this partnership can work with mandatory government-run alliances ...”.

However, the organization did simultaneously take some efforts to distance themselves from active criticisms. The HIAA relayed many of their efforts to build doubt on the reform events through the Coalition for Health Insurance Choices (CHIC), an organization funded by the HIAA. Documents released by Families USA, a consumer group supporting reform, revealed that coalition members were given a monthly list of tasks and resources to impede health reform's success. For example, CHIC members were given sample scripts for speeches, for letters, and for editorial pages, which each presented the HIAA's view on reforms, along with instructions to “act like regular folks when giving it.” (*St. Louis Post-Dispatch* 1993)

CHIC also bankrolled a television advertisement campaign to continue stoking doubt over the potential for healthcare reform. The series of ads featured a middle-class middle-aged couple discussing the details of healthcare reform at their kitchen table. Repeating the HIAA's views, the characters express their support for comprehensive

insurance reform, but with reservations on provisions such as the premium caps and mandatory alliances. In one version of the advertisement, the couple discusses healthcare reform over breakfast:<sup>25</sup>

Harry: I'm glad the President's doing something about health care reform.  
Louise: He's right. We need it.  
Harry: Some of these details.  
Louise: Like a national limit on health care?  
Harry: Really.  
Louise: The Government caps how much the country can spend on all health care and says, "That's it!"  
Harry: So what if our health plan runs out of money?  
Louise: There's got to be a better way.

Another version of the ad features Harry and Louise discussing their future choices over health insurance plans:

Harry: (*kissing Louise*) Find more you like in the president's health plan?  
Louise: (*reading the President's Health Security Plan*) Yeah.  
Harry: And?  
Louise: (*showing Harry the book*) Well, it just doesn't have the choice we want. Look at this – [*chyron: President's Plan Page 66*] the government picks health plans, then we have to pick a plan from their list. That's the choice we get.  
Harry: (*taking the book*): What if we don't like their choices?  
Louise: (*throwing book on table*): If it's not on their list ...  
Harry: (*folding his arms on his chest*): There's got to be a better way. (White House Health Care Task Force and Walter Zelman).

It is worth noting that neither Harry nor Louise, nor the narrator at the end of the scene, who encourages viewers to call their Congressional representatives, specifies any alternative plan for reform.

The arguments struck central to the importance in the neoliberal era of individual choice, responsibility, and fear of government. None of these arguments were new to the

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<sup>25</sup> The characters in the advertisements were unnamed, however, they have become known by the first names of the actors playing them, Harry and Louise.



public debate over healthcare reform. They were features of all the previous discussions over Medicare and Medicaid. However, Harry and Louise's conversations are considered among the most persuasive arguments against healthcare reform in the neoliberal era. Senator Rockefeller described the ads as "the single most destructive campaign I've seen in 30 years" (qtd. in The Center for Public Integrity 1994, 8). An investigation by the Center for Public Integrity credited them as "almost single-handedly responsible" for a 20-point drop in public opinion regarding the Clinton healthcare reform plans (p. 8). The arguments were not unique in history but uniquely provocative in the early 1990s.

Although the HIAA purchased no national ad time, the ads gained national attention after eliciting responses from the Clintons. In a speech to a group of pediatricians, Hillary Clinton responded:

"They [private insurers] like being able to exclude people from coverage because the more they can exclude, the more money they can make. Now they have the gall to run TV ads that there is a better way, the very industry that has brought us to the brink of bankruptcy because of the way they have financed health care" (Clymer 1993).

In the same speech she said:

"It is time for ... every American to stand up and say to the insurance industry, 'Enough is enough. We want our health care system back'" (Clymer 1993).

The comments were printed on the first pages of *The Washington Post* and *The New York Times* the following day, igniting national news coverage of the advertisements. Besides adding more publicity to the HIAA's television advertisements, the First Lady's comments backfired in another crucial way in the neoliberal era. Her comments were further marshaled as evidence that Health Security Act was not a means

to reduce the government budget deficit, spur economic growth, and ensure universal coverage for Americans. Opponents of reform used her public comments railing against private insurance and calling them liars as unmasking the HSA's identity as a means for a "government run healthcare plan".

The contradictory strategy of the Clinton administration to simultaneously recommend a health insurance reform based on expanding private health insurance while also publicly condemning the industry was unsuccessful. The inconsistency highlights the conflicting institutions of the neoliberal era. After having adhered to the economic logic that private markets are the socially optimal means of allocation, the Clinton administration's attempts to establish the reforms as the means to perfect market allocation were ineffective. Hillary Clinton demonstrated the contradictions in remarks she delivered to a group of healthcare professionals in Philadelphia:

"You know, the vast majority [of waste] comes from the private sector ... It's also rife with fraud, waste, and abuse. What we're really trying to do is build on the private sector. This is not a government run healthcare plan" (Priest, 1994).

The specific conditions of capitalist accumulation altered the lobbying strategy of health insurance companies. Market forces, as opposed to the state or unions, were thought of as the optimal means for allocation. The HSA proposal accordingly held an important role for private insurers. In these conditions, the HIAA conducted a very public but subtle attack against the Clinton HSA, a reform that was less statist than the Medicare proposal that they faced thirty years earlier. Their attacks were not unique but were enormously effective in the neoliberal era.

## **The Business Roundtable**

### **Early support**

The new structural changes in the U.S. economy also affected how big business groups participated in reform. Like the insurance companies, big business groups were not active participants in discussions of healthcare reform under the Johnson administration. In discussions of healthcare reform in the 1990s, however, big business groups played an extremely important role. As the neoliberal SSA emerged from the crisis of regulated capitalism, big business owners had gained a tremendous amount of lobbying power and became actively involved in shaping the state. In the new climate, legislation was thought unlikely to pass without capitalist support. The Clinton administration accordingly was persistent in their efforts to work with big business groups and offer a proposal for healthcare reform that would be amenable to their interests.

One such important group lobbied by the Clinton administration was the Business Roundtable. The organization, formed in 1972, had a membership of the chief executive officers (CEOs) of large U.S. corporations. The group created a Business Roundtable Task Force on Health, Welfare, and Retirement Income in 1985. During the early years of the Clinton administration Robert Winters, the CEO of Prudential Insurance Company, chaired the taskforce.

Because of the growing expenses that employers paid for health insurance, it was widely expected that significant reform would pass with the support of big businesses. The Business Roundtable confirmed these suspicions in February of 1993, when the organization released a one-page position statement urging the White House Task Force

to act to address the healthcare system's "need of significant structural reform". The Roundtable also specified suggestions for the redesign, including a standardized set of benefits, promotion of managed care plans, income-based subsidies, and group purchasing arrangements to assist small groups and individuals with purchasing private health insurance. ("Health Care - HRC Transcripts" 1993)

Records from the First Lady's Office and the records of the Health Care Task Force indicate that between the February public statement and President Clinton's Congressional address on September 22 of that year, members of the Business Roundtable met with the Clinton administration (Ira Magaziner, a Senior Advisor to the President, Hilary Clinton, or the President himself) officials on four occasions. There is significant evidence that aspects of the HSA were explicitly created to meet the Business Roundtable's requests. During remarks to the organization, Ms. Clinton outlined major elements of the reform, then adds:

"...if they sound familiar to some of you, they should. They were the nine parts of the Business Roundtable goals for health care reform that were adopted in February of this year. And they, along with the work of a number of other organizations, both in public and private sectors, have served as the basis for the efforts that we have undertaken". ("Health Care - HRC Transcripts" 1993)

Her remarks close with additional emphasis on the administration's desires to work with members of the Business Roundtable and requests for their specific goals for healthcare reform:

"We particularly think [our proposal] is good for big business ... we want you to be our partners and we want you to support this, and we need your advice and guidance" (ibid.)

Evaluations of the HSA by consultants supported Clinton's claims. One such study, by A. Foster Higgins & Co. Inc., examined the potential effects on the benefit plan costs of four companies of varied sizes, with between 1,200 and 14,500 employees nationwide. Their study concluded that the largest employers would each save over \$2 million in benefit costs within the first year of the HSA's enactment and cumulatively over \$50 million over ten years by joining the regional purchasing alliances. The smaller companies, including a hotel operator that offered only limited benefits to its employees, were also projected to save over \$250,000 within the first year and \$1 million over ten years (Mandelker & Findlay, 1994). Firms also conducted their own internal projections of the proposed healthcare reform. Union Pacific's estimates found that healthcare reform would save them millions annually (Judis, 1994).

### **Retracted support**

Despite the advantages to reform in the healthcare industry and the persistent efforts of the Clinton administration to work with big business groups like the Business Roundtable, ultimately the influential group of business executives distanced themselves from the Clinton reform. According to Mike Lux, the special assistant to President Clinton for the Office of Public Liaison, General Electric CEO Jack Welch also expected that healthcare reform would save him millions, but that fact did nothing to sway his position towards reform. Lux recalls Welch as saying, "I don't care [about the savings] ... I can't support it because this is socialism" (qtd. in Corrado 2004, 16).

Saving millions of dollars on their healthcare costs was not a compelling enough reason for CEOs of large companies to support healthcare reform. The neoliberal SSA had ushered in a period of long economic expansion, which was extremely beneficial for

U.S. companies.<sup>26</sup> Big business executives also enjoyed privileges of growing political strength.

The Clinton administration at times tried to warn big business about the consequence of the failure of their market-based health care reform, suggesting that if comprehensive healthcare reform was not achieved in the near future, that pressure for a more interventionist state-run plan might arise. In a speech at the Business Roundtable that Hillary Clinton gave to gather support for the Clinton Health Plan, the First Lady argues that:

“...if we do not move in the next year to deal with this, or if we only make marginal, tinkering changes, then I think the status quo will not remain in place; it will deteriorate. It will be a very much more difficult task to take on, and the political pressure will build for the single-payer government solution, because people will be fed up and frustrated. The more layoffs, the more aggregations of contracts, the more employers pulling out, the more political pressure there will be” (First Lady’s Office, First Lady’s Press Office, and Lisa Caputo 1993).

Clinton suggests that constituents will become increasingly frustrated with the existing healthcare system. However, her effort to threaten big business with the specter of more radical health care reform was not a plausible threat in that period. Big business had no obvious competition from groups with opposing goals, and there was no indication that other groups, such as labor or consumers were likely to gain enough strength so as to influence reforms that could pass without big business input.

Despite the increasing healthcare costs and number of uninsured individuals, business leaders did not fear negative repercussions for maintaining the status quo. In February 1994, the Roundtable endorsed a competing and more limited healthcare reform

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<sup>26</sup> See (Kotz 2015)

bill, sponsored by Rep. Cooper.<sup>27</sup> The reform bill was often referred to as “Clinton-lite.” Only businesses with fewer than 100 employees would be mandated to participate in the alliances and all employers would have to offer, but not pay for, health insurance in an alliance. Despite the endorsement, the Roundtable took no actions to ensure the passage of any piece of legislation.

The 1990s were characterized by mounting problems in U.S. healthcare and a simultaneous period of political will and public desire for healthcare reform. However, the institutions and dominant ideas of the neoliberal SSA were well entrenched. These institutions jointly created unfavorable conditions to healthcare reform. The diminished power of citizen and labor groups in this period relieved big business organizations of the pressures to go along with major political changes -- even when the changes would be beneficial to them.

### **Small Businesses**

Like the large business owners, small business owners ostensibly stood to benefit from healthcare reform. Small businesses typically face smaller profit margins and fierce competition, two factors that make it difficult for them to absorb shocks such as healthcare costs. Indeed, rising healthcare costs were often identified as the “single biggest problem in 1992” for small business owners (Greco, 1992). Offering employment-based health insurance could help small business owners recruit and retain the best employees. Small businesses that sponsored health insurance coverage for their employees, as around 60 percent of small business owners with less than 500 employees did, would benefit from lower healthcare costs (Saddler 1993).

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<sup>27</sup> H.R. 3222/S. 1579

Small businesses typically faced higher premium prices for health insurance than large business did. National Small Business United, estimated that the premium costs were 40 percent higher and that they grew 50 percent faster compared to larger businesses (National Small Business United 1993). According to the National Federation for Independent Businesses, the faster rates of healthcare inflation for small businesses led to increases of “30 percent to 300 percent annually” of their premiums annually (Walker 1992). Without a larger group of enrollees, small businesses were at a disadvantage in negotiating insurance plan, or had their pre-existing conditions excluded from the health plan. (National Small Business United 1993)

Besides lowering their overall costs for healthcare and expanding their workers’ access to healthcare, the HSA also included limits on how much an employer could spend on their premiums. Even the maximum amount, intended for the largest businesses with the highest wages, would have their premium costs capped at 7.9 percent of their payroll. The HSA originally included a maximum 3.5 percent cap for the smallest businesses. Variations of reform bills considered at the same time would have cut the cut to just one percent of payroll for the smallest businesses (Spencer 1994). As a point of comparison, the National Federation of Independent Businesses estimated that their members were “spending anywhere from 11 percent to 24 percent of payroll on health insurance premiums and co-payments” (Walker 1992).

Despite the potential advantages for their bottom-line, many small business organizations maintained their strong opposition to reform, as they did in the 1960s. Lobbyists promised their usual predictions: job loss, lost wages, and slow economic growth would result from any employer mandate to pay for their workers’ insurance. The



same would be true of any increased payroll tax to help finance public insurance for unemployed workers. A representative from the National Restaurant Association, who described his organization as “dominated by small businesses” with “extremely slim profit margins,” testified that

“We are not engaging in hyperbole when we say that mandated employer-provided coverage or higher payroll taxes to pay for health benefits would literally sound the death knell for thousands of restaurants – and discourage thousands of other restaurants from ever opening up” (Clinton Presidential Records 1993)

In defense of their opposition to the employer-mandate, representatives from small businesses relied on the language of the neoliberal SSA. The representative from the National Restaurant Association described himself as “paranoid” about the possibility of the employer mandate, saying “If I give up an inch, I am terribly concerned about that inch” (ibid.). The executive vice president of National Small Business United described an “ideal” system of health insurance as companies purchasing insurance for catastrophic illnesses

“with individual employees paying for basic preventative care and *whatever other medical treatment they choose to buy*” (emphasis added).

He continued discussing health insurance reform in the context of a consumer’s “choice” to buy healthcare. He went on to predict that insured workers “are going to go out and create that expense simply because it’s available to them” (Caspar 1990). These arguments reflect the market-centric and highly individualistic institutions and ideas of the neoliberal SSA.

Representatives from the National Federation of Independent Businesses also maintained a fierce opposition to healthcare reform, particularly the employer mandate.

The organization even refused an invitation to appear the White House Task Force's initial public hearing in February of 1993. The organization's chief lobbyist, John Motley, described his organization's "early strategic decisions" to "play on public fears that jobs would be lost if employers had to absorb added insurance costs" (Clymer, Pear, and Toner 1994). In January, the National Federation of Independent Businesses and the National Restaurant Association publicly supported the Cooper legislation. Like their big business counterparts, members of the organization recognized the potential savings of more significant reforms:

"I don't care what the subsidy scheme is. This is the government taking total and complete control." (Wartzman and Saddler 1994)

Other small business organizations, such as the Chamber of Commerce and the National Association for Manufacturers, took a softer stance to healthcare reform and initially. Both organizations expressed qualified support for an employer mandate, but later publicly changed their mind. In one interesting example, a prepared statement from the Chamber of Commerce, which supported an employer mandate with employers paying a maximum of 50 percent of the premium cost, was submitted to a Congressional committee ahead of a hearing in February 1994. However, at the hearing, the Chamber of Commerce representative testified in opposition of the HSA and "any of the mandate proposals" (qtd. in Mathis 1994). He later renounced the advance statement and claimed not have never reviewed it (ibid.). Shortly after the Chamber's announcement, the National Association for Manufacturers also announced they could not support the Clinton healthcare plan (Uchitelle 1994).

Later reports indicated that a Republican Representative, John A. Boehner, had accused the Chamber of Commerce of “sell[ing] out its members for 30 pieces of silver” and had influenced the organization’s decision to oppose the healthcare bill (Priest 1994). A mid-Western telecommunications company, Ameritech, was similarly admonished by Republican politicians after publicly supporting employer mandates (Weisskopf 1994). A letter signed by the Minority Leader and Minority Whip expressed “strong displeasure” with the endorsement and referenced current telecommunications legislation:

“From our recent discussions with you on telecommunications legislation, we were under the impression that you believed that government hindered competitiveness and true competition. Thus your support for a proposal that will result in a tremendous burden on American business is surprising” (qtd. in *ibid.*).

By April, the Chamber of Commerce was repeating the arguments of the National Federation for Independent Businesses and the National Restaurant Association. The chamber stated that universal coverage was no longer a policy goal for the organization and that “consumers should pay a larger portion of the cost ... to discourage unnecessary utilization” (Pearlstein 1994; Priest 1994).

Small business groups stuck to their previous arguments against healthcare reform in the 1990s, as they did in the 1960s. In many cases, business owners predicted reform would benefit them from financially. However, the threat of government intervention is heightened for small businesses, who assume that they will have little control over the way that the strengthened state will intervene. is than for large businesses. This threat may have carried extra weight in this context with indications from Republican party members that support for significant healthcare reform would be interpreted by Republican party members as a show of support for greater regulation and a rejection of

market principles. Ultimately small business groups did not support reforms and repeated the usual refrains of the negative consequences of any reform: government takeovers, lost jobs, and limited freedoms. These arguments were especially effective in the neoliberal SSA, especially when big business groups such as the Business Roundtable echoed their concerns.

### **Labor and Citizen Groups**

Long before the healthcare debate emerged in the early 1990s, the limited capital-labor accord of the previous SSA had been replaced by a partnership between big and small businesses. Kotz (2015) provides evidence of the joint effort that owners of small and large businesses to establish the neoliberal capitalist SSA. The celebration of market allocation, a key feature of the new set of institutions and ideas under neoliberal capitalism, had weakened the strength and power of unions and collective bargaining agreements. In the previous SSA, labor and citizen groups successfully pushed for the expansion of the public welfare state. Although labor and citizen groups continued to support healthcare reform in the neoliberal period, their arguments were ineffective. The institutions and ideas of the new SSA had undermined these group's positions, their arguments, and their ability to effectively organize.

Many labor groups supported a single-payer healthcare reform or an expansion of the public Medicare programs. These proposals also had significant popular support. A survey conducted by CBS News and the *New York Times* found that 56 percent of U.S. adults surveyed favored a tax financed national health insurance system in 1990 (CBS News/New York Times, 1990). Each of these policy proposals, which were more compatible with the institutions and ideas of the regulated capitalist SSA, were

summarily dismissed by policymakers. In a May 1993 memo Mike Lux, a Special Assistant to the President, states: "... the single-payer no deductible/co-pay position in my view is absurd..." (Lux 1993). Other reports from those close to the Clinton administration revealed single-payer style health insurance reform was never seen as a realistic option (The Center for Public Integrity 1994).

Perhaps the most public exhibit of the dismissal of single-payer advocates occurred in a October 1993 Ways and Means Committee hearing. Following testimony supporting a single-payer system from the policy manager from Consumers Union, the nonprofit organization that publishes Consumer Reports, Representative Thomas replied that

"But if you want to hang on the position ... you are not going to be a player in this initial round of trying to determine how we change the health care system. And if that is going to be your position, fine. Then I understand and how I need to deal with you. That is, you're not going to be a player" (Subcommittee on Health 1993a, 279).

The dismissal of the single-payer option, despite the significant public and labor support, speaks to the strength and cohesion of the institutions and ideas of the neoliberal SSA.

The minimal attention given by the administration to a single-payer system did not launch labor and citizen groups into a united campaign against the Clinton HSA.<sup>28</sup> Some groups, such as the Oil, Chemical, and Atomic Workers union, maintained strict support for single-payer reforms and could not support the HSA. Other organizations, like the AFL-CIO, SEIU, Families USA, and Citizen Action, offered support of the

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<sup>28</sup> For more detailed accounts of the single-payer versus HSA debate in the left, see (Klein 2003; Gottschalk 2000; Lenz 2010).

Clinton health plan. Their members' testimonies in support of the Clinton HSA often mentioned a preference for a single-payer style system.<sup>29</sup>

However, even these organizations' arguments in support of the HSA were ineffective in the neoliberal SSA. As noted by Gottschalk (2000), labor's simultaneous campaign against the North American Free Trade Agreement (NAFTA) disrupted their support of healthcare reform. Some legislators implied that their opposition to NAFTA rendered to their arguments in favor of healthcare less compelling. For instance, John J. Sweeney, testifying on behalf of the AFL-CIO's support of healthcare reform was asked,

“Would you please explain to me why your organization supports a plan which will raise the costs to 80 percent of employers in the United States and arguing that, in fact, it will produce jobs when you are opposing the North American Free Trade Agreement, when the economy of Mexico is 4.5 percent of the United States—smaller than the State of Illinois—but argue that NAFTA is going to lose hundreds of thousands of jobs over the same period?” (Subcommittee on Health 1993b, 28)

The strength of the institutions and the dominant ideas of the neoliberal SSA rendered the preferred healthcare reform approach of organized labor and citizen groups to be considered unviable in this period – despite the significant public support for such a system. In this context healthcare reform was limited to approaches that relied on private market institutions and business support. Organized labor, already embattled in trade policy negotiations, offered qualified support of the Clinton HSA. The organizations also consistently opposed many legislative alternatives to the HSA, like the Cooper legislation supported by business groups. Yet their positions did little to sway big business

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<sup>29</sup> For a few examples, see the testimony of Ms. Shearer, Mr. Kirsch, Mr. Dornon, and Ms. Porter in (Subcommittee on Health 1993a).

executives, who had abandoned the prior capital-labor accord to work with small business owners.

### **Conclusion**

Histories of the demise of the Clinton health plan are ubiquitous.<sup>30</sup> They demonstrate the ineffectiveness of the administration's communication strategies, outreach, and the personal political struggles of the administration. The above discussion deepens our understanding of the reasons for a failure of this major attempt at healthcare reform. Belief in unregulated markets and a distrust of the government has not been a consistent feature of American culture that can be held responsible for cases of health reform's failure. However, these ideas were compatible with the dominant ideology of the neoliberal SSA. As such, the Clinton administration crafted and marketed their healthcare reforms centering on the virtues of markets and individual responsibility. The expected that appealing to business's bottom lines would gain support from the business owners.

However, the crisis of regulated capitalism in the early 1970s catalyzed business leaders to abandon their previous alliance with labor and instead join with small business owners. The complex set of mutually reinforcing institutions and beliefs that capitalist accumulation requires shifted the attitudes of interest groups towards social programs. In the heyday of neoliberal capitalism, neither big business executives or small business owners could be persuaded to support significant healthcare reform. The health insurance industry's lobby, no longer limited by the public's lack of tolerance for the interference

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<sup>30</sup> See, for instance: (Altman and Schactman 2011; Clymer, Pear, and Toner 1994; Corrado 2003; Gottschalk 2000; Hacker 1997; Johnson and Broder 1997; Judis 1994; Lenz 2010; Quadagno 2006; Skocpol 1997; Starr 2011)

of corporations in politics, launched an extremely public campaign against healthcare reform. Labor and citizen groups, which played an important role in the success of Medicare and Medicaid, felt limited in the reforms they could support and had their positions undermined by their weakening economic power. The analysis of this chapter draws attention to the importance that the conditions of capitalism in each period has on reform, adding to the existing literature on this history.



## CHAPTER 6

### CASE STUDY: THE PASSAGE OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010

#### Introduction

Fifteen years after the rejection of the Health Security Act, President Obama signed the Patient Protection and Affordable Care Act (ACA), a law that altered the financing, structure, and delivery of healthcare in the United States. Many accounts of the law's passage attribute the Obama administration's success after the failure of the HSA to the President's superior adeptness as a politician. Stuart Altman, a member of the health policy team for the Obama administration, and Paul Starr, senior advisor to President Clinton on healthcare policy, both document how the Obama administration intentionally developed their healthcare policy strategy as the antithesis of Clinton administration's strategy (Altman and Schactman 2011; Starr 2011). Brill (2015) focuses on the compromises the Obama administration worked out with industry stakeholders and interest groups that facilitated the law's passage. Skocpol and Jacobs (2010) offer a more historical analysis. They highlight the role that increasing economic inequalities played in the law's success. In this case study, I explore how a change in the phase of the neoliberal SSA created institutional conditions that were favorable for passage of the Obama administration's healthcare reform.

This chapter is organized as follows. First, I return to a brief discussion of SSA theory to situate the events of 2008 within the SSA framework. I offer evidence of the changing and unstable dynamics of capitalism. Next, I analyze the ways in which the changing economic conditions and destabilization of neoliberal institutions and ideas are

reflected in the content and structure of the major proposals for healthcare reform. This discussion specifically examines the ways in which the ACA defies the trends of the neoliberal era. I then present evidence of major stakeholder's support for or opposition to the legislation and consider the ways in which the SSA shaped their interests both the effectiveness of their arguments.

### **The Neoliberal SSA in the Crisis Phase**

The previous case study examined healthcare reform in the consolidation phase of the neoliberal SSA, in which a coherent set of institutions and ideas that sustains capitalist accumulation develops and becomes further entrenched in society. This case study examines healthcare reform in the second phase of the neoliberal SSA, in which the contradictions of the joint set of institutions emerge and obstruct capitalist accumulation.

#### **Identifying a Crisis**

Identifying an exact starting or end point for each phase of an SSA is difficult. Changes do not occur at the same pace across all institutions or within all industries. For the purposes of this case study, we will consider the financial crisis and global recession that emerged in the fall of 2008 as a manifestation of the destabilization of the institutions of neoliberal capitalism. The analysis of Kotz (2015 ch. 4, 5), supports this interpretation. I draw from that analysis of the ways in which the institutions of neoliberal capitalism promoted decades of stable economic growth before creating the conditions which led to the global financial crisis.

The financial crisis caused immediate economic instability. In the fall of 2008, Merrill Lynch was sold, Lehman Brothers went bankrupt, and the American Insurance Group and several of the largest banks were bailed out with public funds. The global

crisis catalyzed a remarkable response from U.S. policymakers that moved beyond the previous constraints of neoliberal capitalism. Keynesian ideology was resurrected, and the government took a strong role in stabilizing the financial markets.

On October 3 of 2008, the U.S. Congress authorized 700 billion dollars investment in purchasing toxic financial assets from struggling financial institutions. A few weeks later, CEOs of the nine largest financial companies all accepted a government bailout and acquiesced to a government stake in their companies. The American Reinvestment and Recovery Act was signed in February of 2009, injecting 787 billion dollars into the U.S. economy through government spending as well as cutting taxes.

These massive interventions by the federal government became a frequent topic in popular discourse, alongside poor conditions in the U.S. labor market and an increasing number of foreclosures. Concerns and doubts of the capitalist economic system were printed in mainstream media outlets. For example, an October 10 *Washington Post* headline, titled “The End of American Capitalism,” asserted that “The worst financial crisis since the Great Depression is claiming another casualty: American-style capitalism” (Faiola 2008). The *Guardian* described “How the collapse of Lehman Brothers pushed Capitalism to the Brink” (Clark 2009). The *Financial Times* initiated a series titled “The Future of Capitalism.” The journal’s chief economics editor, Martin Wolf, opens the first installment of the series with a remarkable description of the fall of neoliberal capitalism:

Another ideological god has failed. The assumptions that ruled policy and politics over three decades suddenly look as outdated as revolutionary socialism (Wolf 2009).

Former Federal Reserve Chair Alan Greenspan confirmed the failure of neoliberal ideology. Greenspan, a well-known acolyte for market principles, testified at Congressional hearings on the causes of the financial crisis. When facing questions about how he had contributed to the crisis as the preceding Fed Chairman, Greenspan explained that he had found a “fatal flaw” in his previously held ideology (Andrews 2008).

The flawed ideology that Greenspan was referencing was the efficiency of unregulated markets. The logic of the market underpins the entire neoliberal social structure of accumulation. Without the belief that unregulated markets are the best way to serve the societal interest, the arguments that promoted the major economic developments over the last thirty years had no basis. Greenspan’s questioning of the economic canon contributed to the discrediting of the logic of neoliberalism.

Outside of the headlines of major mainstream newspapers and Congressional hearings, there were other indications of a changing public sentiment. Surveys by the Pew Research Center in 2009 described Americans as “increasingly skeptical about the power and profits of large companies and business corporations” (Pew Research Center 2008). This rapidly changing economic landscape, and the resulting discrediting of the previously dominant ideas, had important implications for this period’s attempt at healthcare reform. It was in the wake of the financial crisis and Great Recession that the ACA was able to pass the U.S. House and Senate and was signed into law in March of 2010.

## **The Patient Protection and Affordable Care Act**

Over one-thousand pages long, the full scope of the ACA<sup>31</sup> reaches nearly every aspect of healthcare delivery and finance in the United States. This case study does not attempt a comprehensive discussion of all provisions of the bill. Instead, the analysis highlights the aspects of the law which were particularly relevant to the groups considered in these case studies: health insurers, employers, and labor and citizen groups.<sup>32</sup> There are three titles of the ACA that are most relevant for these stakeholders: Titles I, II, and IX. I briefly summarize some important aspects of each of these titles below.

### **Title I: Quality and Affordable Health Care for All Americans**

The first title of the law mandates important changes in the private health insurance industry. Subtitles A, B, and C specify new regulations for the insurance industry: what kind of insurance is sold, who it is sold to, and how the insurance plans are sold. Health plans must fully cover, without any cost sharing, a set of federally mandated benefits including those recommended by the U.S. Preventative Services Task Force. Insurance coverage must be guaranteed: exclusions for pre-existing conditions are forbidden, as is any discrimination in issuing insurance based on health status. Only once

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<sup>31</sup> Unless otherwise stated, when I refer to the ACA I am specifically referencing the nine titles of the Patient Protection and Affordable Care Act (H.R. 3590) as amended by the one title of the Reconciliation Bill (H.R. 4872).

<sup>32</sup> As can be expected in a bicameral legislature, there were several iterations of healthcare proposals considered in Congress between January 2009 and March 2010. Lawsuits following the law's enactment have also changed the law significantly. The variations of the bill that were considered at different stages and its variations since enactment are detailed in other accounts. See, for example: (Starr 2011), (Jacobs and Skocpol 2010), (Brill 2015), (The Washington Post 2010), (Altman and Schactman 2011).

dependents are twenty-six years old may they be barred from their parent's health plan. The law limits consumer's out-of-pocket costs, disallows health plans from using annual or lifetime bans, and forbids rescissions (canceling a member's coverage) except in the case of outright fraud.

Insurance companies face restrictions on their premiums. At least eighty percent of premiums must be spent on medical costs and this "medical loss ratio" must be publicly reported each year. If the plan does not spend at least eighty percent of its premiums on medical costs, a rebate is returned to the enrollees. Older enrollees cannot be charged more than three times that of the premiums of younger people. The law also legislates how health plans may market their plans, including the language used in describing the plan, and mandates additional annual reporting from health insurance companies on the quality and cost of their coverage.

Subtitle D mandates the creation of the American Health Benefit Exchange in each state, through which businesses and individuals may purchase health plans. All health plans sold on the exchanges must meet standardized minimums regarding the essential health benefits covered. The fifth subtitle, E, creates a series of tax credits to help assist individuals and small businesses paying for the health insurance premiums, specifies maximum for premiums and cost-sharing, and provides for cost-sharing subsidies for individuals enrolled in plans sold on the exchanges.

The law also levies penalties for individuals who do not carry adequate health insurance for the year. Subtitle F requires employers with over two-hundred employees to automatically enroll new employees in exchanges. Employers with fifty or more

employees must pay a penalty if any worker qualifies for a subsidy to purchase health insurance on the newly created exchanges.

### **Title II: Role of Public Programs**

The second title mandates significant changes to Medicaid and sets a new national income standard for Medicaid eligibility. All individuals and families with incomes less than 133 percent of the federal poverty level may enroll. The law also increases support for the Children's Health Insurance Program and makes the enrollment process for these programs simpler.

### **Title IX: Revenue Provisions**

The provisions in Title IX account for nearly one half of the revenue needed to pay for the premium subsidies, cost sharing reductions, and Medicaid expansions specified in the first two titles. Estimates from the Congressional Budget Office predicted that most of this revenue would be raised from raising the Medicare hospital insurance tax base for the high-income taxpayers. Other revenue raising provisions include annual fees for health insurance companies and companies that manufacture or import branded pharmaceuticals. High-cost health plans, manufacturers and importers of medical devices, and indoor tanning services are taxed at higher rates.

### **The ACA and Neoliberalism Under Challenge**

In signing the ACA, President Obama accomplished what many of his predecessors had attempted and failed: he signed a piece of major healthcare legislation with ramifications for the system's structure, regulation, and financing. Although the ACA continues to develop the idiosyncratic and piecemeal nature of the U.S. healthcare system, the law's passage defied trends of recent history. In many important ways, it also

defied hallmarks of the neoliberal SSA. In this section, I analyze the relationship between the institutions and dominant ideas of the neoliberal SSA and selected aspects of the Affordable Care Act.

### **Contradictions of the ACA with the Neoliberal SSA**

Title I of the ACA includes many features that run contrary to the cohesive set of institutions and dominant ideas that promoted the growth of and stability of the neoliberal era. For example, one major characteristic of the neoliberal SSA is the increasing reliance on market forces and an accompanying decrease in the role of government regulation. The regulations described in Title I, however, represent significant increases in the regulatory requirements of health insurance plans. To be sold on the exchanges, all health insurance plans must meet standardized requirements concerning their product. They face restrictions on the pricing of the product, as well as how product is marketed, and how the revenue they collect in selling their product is used.

Another critical aspect of the neoliberal SSA is the emphasis on individual decisions and consumer sovereignty. The first title of the ACA deviates from this principle. The individual mandate penalizes all individuals who do not carry adequate health insurance throughout the year. Thus, a consumer's decisions concerning whether to purchase health insurance and, if so, what type of health insurance to purchase is superseded.

The first title of the law also includes a massive expansion in public provisioning, which again is antithetical to market allocation and individual decision making. The cost-sharing subsidies and premium tax credits represent an increased responsibility of the federal government to purchase private health insurance for individuals. Although the law



does not create a government-run health insurer or government-owned healthcare system, these transfers increase the public provision of private health insurance plans.

Similarly, the creation of the American Health Benefit Exchange signifies an important expansion in the role of the government in the provision of private health insurance. States are required to create institutions that facilitate the purchase of private health insurance by individuals and employers. These exchanges, which the law specifies may be run by either a state agency or nonprofit organization, are gatekeepers to the market for private health insurance that individuals are legally required to purchase.

The exchanges only permit plans which meet certain standards benefits and levels of coverage to be sold. Of the plans that meet these requirements, an insurance plan may be barred from the exchange if state regulators conclude that the insurer has raised prices too high. In addition, every state's exchange must sell two health insurance plans selected by the federal government. The exchanges also determine whether consumers are qualified to buy through an exchange and their eligibility for federal subsidies. A quality-rating system, created by the federal government, is made available on the exchanges for each health insurance plan to assist with comparison shopping.

The exchanges increase the scope of the government's role in the provision of private health insurance. Even within that reduced role of the market provisioning, the design of the exchanges still further represents an important shift away from the set of institutions and ideas that define the neoliberal SSA. The design of the exchanges promotes social pooling: the medical risks of people who would otherwise be purchasing insurance as individuals or in small groups of workers are pooled together in the exchanges.

One of the most visible ways that the ACA defies the limits of the neoliberal SSA is its massive expansion of the Medicaid program. The Congressional Budget Office predicted that if the ACA were implemented as it was written, that enrollment in Medicaid and the Children's Health Insurance Program would increase by roughly 16 million (Congressional Budget Office 2010). The ACA is the largest increase in the public provision of health insurance for lower-income people since Medicaid's creation in 1965. This expansion reversed many of the trends of the neoliberal era, in which social provisioning became less popular and less comprehensive. Government programs are considered inherently inefficient according to the dominant ideas of the neoliberal SSA. Adding an additional 16 million of people to these programs, equivalent to over thirty percent of the average 2009 monthly enrollment in these programs, is a significant strengthening of the public welfare state (Centers for Medicare & Medicaid Services 2009 Table I.16).

This expansion in coverage in the private and public health insurance programs corresponded with a massive expansion in public revenues to provide the premium and cost-sharing subsidies to families with incomes up to four hundred percent of the federal poverty level. A major source of these expansions come from increases in Medicare payroll taxes for high income earners and from an additional tax on investment income. The increase in public funding redistributes income and effectively shields individuals from the cost of their health insurance and health treatments. These two trends further defy the primacy of market forces. They are also a reversal of many previous policy trends, which lowered taxes for high earners and attempted to increase efficiency in the

health insurance market by shifting financial responsibility for payments to healthcare consumers.

### **The ACA's Adherence to the Neoliberal SSA**

Despite the notable deviations, it would be inappropriate to describe the ACA as a radical departure from the set of institutions and ideas that define the neoliberal SSA. As discussed above, there is evidence of a meaningful shift in terms of the role of the government and the primacy of market forces following the financial crisis. However, a new social structure of accumulation and its corresponding set of institutions and dominant ideas did not immediately emerge to replace the neoliberal SSA. Many aspects of the ACA are compatible with the characteristics of neoliberalism.

The first title of the law, despite its regulations on health insurers, falls within the broader neoliberal era in its commitment to maintain private health insurance. The individual mandate violates the sanctity of individuals to make their own purchasing decisions. Yet it also supports a system of health insurance that relies on individual choices, for example between different tiers of health insurance plans. Health insurance continues to be framed as a commodity available through several alternative plans, not as a right equally available to all.

Although the expansion of public revenues for premium and cost-sharing subsidies reverse the trends of weakening welfare programs, it should also be noted that an increase in public spending itself is not a rejection of the neoliberal SSA. Neoliberal ideology does not prescribe an erasure of the state; it requires public spending to function. However, much of the state spending in the neoliberal era is somewhat obscured, while the expanded spending called for in the ACA is visible.

## The Public Option

The ACA is neither purely market-based nor socialized health insurance. Its combination of promoting a private industry by mandating and subsidizing individuals' purchase of health insurance and its expansion of government-funded health insurance reflect the unique economic restructuring of the time. The marriage between market competition and public provision was also reflected in the debate over the creation of a publicly health insurance plan, often called the public option. In some variations of the public option, this government run health insurance plan would be compete with the private plans sold on the exchanges.

The public option had not been a dominating feature of previous debates over healthcare reform.<sup>33</sup> However, in the wake of the financial crisis and Great Recession, it became an important point of debate in the lead up to the passage of the ACA and emerged as a serious possibility for reform. It was ultimately excluded from the final legislation, but some version of the public option was included in bills passed by three House committees and a Senate committee. Even more striking, the full House of Representatives passed a bill in November of 2009 that included the creation of the public option. (Halpin and Harbage 2010)

Despite its ultimate exclusion, the serious consideration of the public option further exemplifies the ways in which the broader context of economic restructuring and uncertainty of the time helped facilitate healthcare legislation that moved beyond the previous constraints of the neoliberal SSA. A government health insurance plan

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<sup>33</sup> Two healthcare proposals from 2001 are credited with developing the public option. See (Halpin and Harbage 2010) for a more thorough history of the policy.

ostensibly could outcompete and entirely eliminate the private the health insurance industry. The omission of the public option reflects the aspects of neoliberal capitalism that were able to withstand the challenge of the crisis.

### **Interest Groups**

Following the challenge to neoliberal capitalism, the organizations representing insurance companies and big business executives took a much different approach to healthcare reform than they did in the 1990s. As described in the previous case study, in the 1990s the HIAA successfully launched a very public attack against healthcare reforms. In 2008, their successor organization, America's Health Insurance Plans (AHIP) expressed public support for specific proposals, even those that would increase their industry's regulatory requirements and change their business. Similarly, the Business Roundtable publicly supported the ACA, but it had opposed the Clinton health reform and offered only mild vocal support for the most conservative alternatives to the Clinton health plan.

Why would these organizations publicly oppose the Clinton health reforms, but then support reforms in 2008? Did employers and insurance companies become more generous than their 1990s counterparts? Was the ACA more beneficial to their industry's bottom line? Or was the Obama administration more effective at negotiating with these groups? The discussion below analyzes how the passage of the ACA was conditioned by the concurrent threat to the existing neoliberal SSA.

## **Health Insurance Companies**

### **Contradictions of the Neoliberal SSA**

Although the institutions of neoliberal capitalism created a profitable health insurance industry over the 1980s and the 1990s, these same institutions began to create some problems for insurers in the mid-2000s. For example, the neoliberal era is characterized by a class relationship in which capital dominates labor. Labor's decreased bargaining power in the neoliberal SSA helped facilitate insurers and businesses passing over rising shares of healthcare costs onto families and workers. As healthcare costs continued to rise and labor's power declined, employment-based health insurance became increasingly rare. Some employers defied these trends and continued to offer employment-based health insurance, but these companies became more likely to self-insure. Large employers increasingly used health insurance companies solely as third-party administrators. Employers would collect premiums, manage a trust that paid the healthcare costs, and use a stop-loss insurance policy to prevent unexpectedly high medical costs from wiping out their trust. Self-insuring allows firms to maintain greater control over their cash flow.

The trend of self-insurance is a manifestation of the development of the institutions and ideas of neoliberal capitalism. The form of health insurance that developed following the failure of the Clinton healthcare plan made employment-based health insurance increasingly rare. In the cases where it continued, employers took on the additional risk of paying for their workers' healthcare costs. As argued in Hacker (2019), under neoliberal capitalism, people and firms take on more risk.

Only offering administrative services generated less money for insurance plans relative to their underwriting services for risk-based insurance. Declining revenues necessitated a shift in business models for insurers. Major health plans shifting to devoting a larger share of their services to administering government programs, such as Medicare and Medicaid. Sue Peters, president of government health plans for Aetna, confirmed the strategy:

“...as we look from a macroeconomic point of view, we know the government sector is growing at a faster rate than commercial or employer-based healthcare” (qtd. in Berry 2008, 200).

The CEO and president of Humana was similarly optimistic about increasing government revenues:

“Medicare continues to show that it is the best near-term opportunity for significant growth in the industry. Medicare, however, is not just a near-term growth opportunity. It will be a growth opportunity for many years to come” (qtd. in Berry 2008).

Beyond Medicare, insurance plans also specifically targeted veterans’ care as a growth business. A HealthNet CEO commented that,

“the demand [for mental health services], fueled by the large number of Iraq and Afghanistan war veterans, [is] a positive surprise, which I think we anticipate to be ongoing” (qtd. in Berry 2007).

By November 2007, three major health insurance companies, WellPoint, UnitedHealth Group, and Coventry, each reported that the growth in their government-related earnings outpaced the decline in the commercial sector. The health insurance industry’s increasing reliance on government spending reflects another way that the

industry has developed under neoliberalism.<sup>34</sup> In the United States, total privatization of government services like Social Security, Medicare, and the Veterans Health Administration have not occurred. Instead certain aspects of these services are outsourced to private companies. Davis (2009, 37) describes this development as the creation of a “portfolio society” in which the state functions as a “portfolio of object and functions that can be sliced off and privatized.”

Beyond adjusting their business models to administer more government financed healthcare services, insurers also diversified their business by offering money management and banking services as well. Their increased involvement in financial services also reflects their adaption to neoliberal institutions and norms. As the costs of healthcare were shifted to consumers, the growth of health savings accounts increased. Large health plans accordingly established FDIC-approved banks to manage these accounts. An August 2007 report released by Diamond Management & Technology Consultants estimated that by generating revenues from asset management and transaction and maintenance fees, the “health/wealth” market could generate \$40 billion of revenue within the next five years. As of December 2008, WellPoint, UnitedHealth Group, and the BlueCross BlueShield Association had each established a bank. (Berry 2008)

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<sup>34</sup> This integration of government public spending into the business model of private health insurers may appear contradictory during the neoliberal era. However, as noted above, neoliberal ideology does not advocate for the erasure of the state. Even during the neoliberal era, the U.S. pays large and increasing portions of spending on public healthcare programs. The state has important roles in neoliberalism for helping to promote economic stability and enforcing private property contracts.



The development of the health insurance industry in the early 2000s reflects the unique environment of the neoliberal SSA. As the set of institutions and dominant ideas became more entrenched, they also created the conditions that forced the industry to adapt. Large insurance companies expected their business to come from handling public revenues and from marketing financial products. It was this context – needing to structurally adjust how they made profits – in which insurers began to offer their proposals for healthcare reforms.

### **AHIP's initial stance towards healthcare reform**

The initial proposals offered by AHIP, the lobbying organization representing the largest health insurance plans, matched the changing conditions of the health insurance industry that developed under the neoliberal SSA. In November of 2006, the AHIP board of directors announced a proposal to expand accessibility to health insurance to uninsured Americans. The proposal's key elements included two federal tax initiatives: establishing a health tax credit for children and the creation of universal health accounts (UHAs). These new accounts would be a vehicle for pre-tax payment of medical expenses. The organization proposed a 50% federal match for individuals' contributions to their UHAs (America's Health Insurance Plans, 2006). The proposals matched the changing realities in the insurance industry, reflecting both an expanding reliance on government revenue for health insurers as well as their growing interest in managing health accounts.

In December 2007, the board of directors expanded their proposal and offered their recommendations for reforms in the individual market, despite their observation that “individually purchased health care coverage is more affordable and accessible than may

be widely known” (America’s Health Insurance Plans, 2007). Nevertheless, to address the problem of people who cannot purchase health insurance coverage in the individual market, the board recommended that creation of state Guarantee Access Plans (GAP) to provide coverage for uninsured individuals with the highest expected medical costs. Once all individuals with the highest medical costs were covered by the state government, health plans guaranteed to issue coverage to anyone who was ineligible for GAP, with premium rates limited at 1.5 times the standard market rates. The board of directors also proposed that health plans limit rescissions only in cases of fraud. They also proposed that rescission decisions and pre-existing condition exclusions should be subject to a third-party review process, provided by the states. Their proposal is not an offer to sincerely adjust the practices of the industry, but a means to formally remove unprofitable individuals from participating in the individual markets, protecting private profits in the market.

### **After the Financial Crisis**

Following the financial crisis, AHIP dramatically expanded their proposals for healthcare reform. In November 2008, AHIP Board of Directors released a statement on healthcare reform, which departed from their statements in the three years prior. Insurers announced that they would support guarantee issue for private health insurance coverage without pre-existing condition exclusion alongside a mandate for individuals to purchase insurance. Their proposal for universal coverage no longer included any mention of Guaranteed Access Plans, nor of lowering the cost of healthcare, or eliminating unnecessary healthcare services (America's Health Insurance Plans, 2008).

In December, the group formally released their plan, titled “Now is the Time for Health Care Reform: A proposal to achieve universal coverage, affordability, quality improvement and market reform.” The report featured strong language committing health insurers to participating in the process of healthcare reform and acknowledged their role in deterring past reforms. The opening of their statement notes “Although health care reform has been on the nation’s agenda for many years, the varied interests of stakeholders have held back progress” (America's Health Insurance Plans, 2008).

However, AHIP promises in the following sentence:

“Next year provides a new opportunity to transcend these traditional barriers and achieve a more sustainable health care system that provides affordable, high-quality coverage for all Americans.”

The health plans no longer only pledged that they “welcomed the challenge of working with policy makers and our stakeholder partners to improve the health care system and extend coverage to all Americans,” as they did in their three previous proposals (America's Health Insurance Plans, 2008). Instead, the health plans called for a more inclusive process:

“[We] offer our proposals with a pledge to work in a spirit of cooperation and determination, with physicians, hospitals, consumers, employers, unions, lawmakers, and government leaders who want to work toward the day when all Americans can count on being served by a health care system second to none. Working together – starting in 2009 – can achieve the goal.”

The language suggests a change in intention to be a part of the process of healthcare reform alongside a confession that they had not fully committed themselves to cooperating with reform earlier. The rest of the proposal includes several more substantial changes. Unlike the plan released in May 2008, which outlined a plan to cut

healthcare costs by \$145 billion by 2015, in the December 2008 proposal, health insurers propose savings of over \$500 billion over five years. No longer are Universal Health Accounts or Guaranteed Access Plans promoted to achieve the savings. In its place, AHIP suggests that “insurance market rules need to be reformed” and calls for a “public-private advisory group representing a broad range of stakeholders with relevant policy experience” to develop proposals to eliminate wasteful spending. The December 2008 press release also calls for the creation of an essential benefit plan.

In the beginning of the new year, AHIP seemed to follow through on its promise to work towards healthcare reform. In March 2009, at President Obama’s first public event regarding health care reform, AHIP president Karen Ignani made a public commitment to constructively work towards health care reform:

“We want to work with you. We want to work with the members of Congress on a bipartisan basis here. You have our commitment. We hear the American people about what’s not working. We’ve taken that seriously. You have our commitment to play, to contribute, and to help pass health care reform this year” (The White House 2009).

As the debate over healthcare reform continued in the first few months of President Obama’s term, insurers continued to indicate a willingness to participate in major reforms in their industry. On June 19, AHIP announced their support for discontinuing rating based on health status or gender (America's Health Insurance Plans, 2009). The switch away from experience rated premiums had long been a controversial aspect of healthcare reform. Experience ratings allow insurance companies to charge individuals based on their characteristics as consumers in a market transaction. By not charging individuals based on their gender or health status, the insurers were supporting a

move to a system that socialized the costs of providing to care to people likely to need more.

In the 1990s, AHIP's predecessor organization argued that without being able to price individuals according to their risk, that the insurance industry would be no longer profitable. Notably AHIP announced their support for not having ratings based on health status or gender in the same press release that they publicly announced their opposition to the public option:

“We share the concerns that providers, employers, and patients have raised about the significant unintended consequences of a government-run plan. It would dismantle employer-based coverage, add additional liabilities to the federal budget, and turn back the clock on efforts to improve quality and safety” (America's Health Insurance Plans, 2009).

The language and tone used in this announcement is mild. There are no threats of a “socialist takeover” by the government and the organization notes that they are only echoing others' concerns. They do not include any concerns that are industry-specific to insurers competing against a government plan. This sharply differs from the language of the 1990s, when health insurers argued that would no longer be profitable without experience ratings and they could use the rallying cry of markets and private innovation to defend themselves.

A concern that a public plan would “dismantle employer-based coverage and add additional liabilities to the federal budget” is much more muted than the “they choose, we lose” slogan from decades previous. Their relatively subdued language against the possibility of a government-run health insurance plan is striking and speaks to the changed institutions under which insurers were now fighting.

Even though the government run competitor was potentially a graver threat to the private health insurance industry than many elements of the Clinton Health Plan, rejecting healthcare reform outright was not an option for the industry in 2008 as it was in 1990s. It was no longer a safe strategy for insurers to fight openly against being pitted against a government run healthcare plan, which was significantly more statist than any element of the Clinton Healthcare Plan. Following the financial crisis, while faced with questions over the future of capitalism more broadly, insurers considered it unwise to appear as oppositional to reform.

Like the banking industry, their industry needed reforms to continue. Private health insurance would not be as profitable in the future without increased public spending. This was partly because private health insurers were themselves challenged with the contradictions of neoliberal capitalism within their industry. The institutions and ideology that had promoted profits in their industry previously had failed them and significant changes were needed for their existence to continue.

### **The Business Roundtable**

The Business Roundtable, an organization representing the CEOs of large corporations, also signaled willingness to support healthcare reform in the lead up to the 2008 elections. Their proposals echoed or complemented their insurer's proposals. Like the health insurers, the Business Roundtable published proposals for healthcare reform that conceded no meaningful increased regulatory requirements or increased responsibility for healthcare coverage.

Their recommendations included removing regulatory barriers that limit insurance options, offering more consumer-centric health plans, investing in health information

technology, promoting comparative effectiveness research, changing provider reimbursement structure and medical liability laws, and promoting end-of-life care options. Each recommendation focuses on two important elements of market efficiency: reducing regulation and increasing the information available to consumers and producers. Faced with the failure of market logic to rectify the problems of increasing costs and rising numbers of the uninsured the Business Roundtable acknowledged the need for reforms.

The Business Roundtable also meaningfully expanded their commitment to healthcare reform following the financial crisis. Instead of repeating their support for consumer-centered and market-focused reforms, the organization signaled an openness towards guarantee issue and eliminating exclusions for pre-existing conditions. Instead of remaining on the sidelines of reform, as they had in the 1990s, in August of 2009 the organization said they were actively supporting and working towards reform:

“To achieve this [reform] we have been working closely with all players on a bipartisan basis to change the system. We’ve been in near constant communications with the White House and Congress and we believe we’re working as an honest broker to bring about reform” (Business Roundtable, 2009).

In the same conference, John Castellani, the president of the Business Roundtable, indicated for the first time that they could support an employer-mandate for healthcare reform: “We know the direction they’re going and we think it could be worked out to be acceptable for us.”

The group’s language supporting other aspects of healthcare reform became even stronger as the healthcare debate continued. In a letter to President Obama, Castellani emphasized that his organization “strongly” supports guaranteed issue as well as limiting

plans' ability to set ratings. None of their previously released statements indicated support for regulations on insurance pricing. The organization followed these statements with a report titled "Health Care Reform: The Perils of Inaction" which predicted dire consequences for employment-based health insurance if no reform was passed. They abandoned promoting the multi-state plans from their previous statements and urged legislators to "support aggressive insurance market reforms" to solve the rapidly increasing costs of health insurance, which they described as a "real problem from not just a social perspective but also an economic viewpoint".

The public comments, reports, and advertisements from the Business Roundtable are all significant changes from the 1990s struggle over healthcare reform. The lobbying organization was warned by the Clinton administration that failure to enact healthcare reform could lead to the passage of a single-payer healthcare reform. However, this threat did not seem credible at the height of neoliberal capitalism when the dominant ideology and institutions were supporting an expanding U.S. economy. In that context, the Business Roundtable distanced themselves from reform and objected to the Clinton's proposals.

Employers did not universally support all aspects of healthcare reform in this period, however. They maintained a strong opposition to the public option, despite the potential advantages for their bottom line. When a reporter commented that an expanding government plan could ultimately rid employers of the increasing costs of health insurance, the president of the Business Roundtable indicated that the executives opposed this proposal based on anticipated future expansions of a government-run plan. "The institution itself seeks ways for it to grow," Castellani said, "It's just the nature of the



way things work” (Business Roundtable, 2009). The language suggests that the organization viewed the public option as a potential catalyst for more significant government intervention and regulation.

In November 2009, the full House of Representatives passed a healthcare bill that included the public option. Notably, its passage still did not launch the Business Roundtable into a public fight against healthcare reform. The Roundtable released a relatively mild public statement expressing disapproval for the established public option:

“We are disappointed by the passage of a House bill that we cannot support. The House legislation contains many provisions that will threaten the coverage that 177 million Americans currently have through the employer-based system. Not only does it establish a government-run health plan, but it includes a “play or pay” mandate for employers that would limit the flexibility employers have to develop innovative plans for our employees” (Business Roundtable, 2009).

A few days after this announcement, the Business Roundtable, released a study supporting the passage of healthcare reform. The study concluded that “if enacted properly, the right reforms” could save employers \$3,000 of healthcare costs for each employee (2009). The study drew immediate attention from the Obama administration and the President cited the Business Roundtable Study in speeches to rally support for the legislation.

Even though the public option would be a massive expansion in state power, the organization was much more restrained in its public opposition to the reform. The destabilization of the market ideology, the threat of potential increased power of labor and citizen groups, and the slackening benefits of neoliberal capitalism all created an environment where the threat of more significant government action was more credible in the immediate aftermath of the financial crisis.

On December 19, after it became clear that a public option would not pass the Senate, John Castellani sent a letter to Senate Majority Leader Harry Reid thanking him for his “efforts to improve the health care reform legislation currently being considered by the United States Senate” (Business Roundtable, 2009). He articulated his group’s approval of Senate’s bill and reiterated their opposition to the House bill:

“The proposed legislation is a step toward our shared goal of providing high quality, affordable health care for all Americans. As background, we have been very clear that the legislation which passed the House earlier this year went in the wrong direction and would have serious negative consequences for America’s health care system. We need to continue to take further steps in the right direction and not erode the improvements that have been made to the Senate bill during the process of conference with the House and enactment” (ibid).

After opposing the House bill, the BRT dropped their opposition to the Senate bill after it became clear that the public option would not pass in the Senate. This indicates that the group feared that the public option could lead to a government takeover of healthcare provision. While such a direction did not seem plausible in the 1990s, this threat now seemed possible. Thus, the BRT and insurers focused not on rejecting all reforms, but instead on stopping the public option. Passing a major reform was necessary to stave off this bigger threat of an eventual government takeover of health insurance, a precedent that they had good reason to fear in 2010. Their ultimate support of healthcare reforms following the removal of the public option in the Senate was influential in the final passage of the bill.

### **Chamber of Commerce and the National Federation of Independent Businesses**

The Business Roundtable was not the only group lobbying on behalf of business owners on issues of healthcare reform. The U.S. Chamber of Commerce and the National

Federation of Independent Businesses, two organizations that identify themselves as representing small businesses, also testified and ran ads regarding health reform in these periods. As in prior discussions of healthcare reform in the 1990s, both organizations remained steadfast in their opposition to reform in 2010.

Their arguments echoed that of their previous campaigns. The National Federation of Independent Businesses threatened that an employer mandate would lead to economic recession, discouraged production, and job loss for the most vulnerable employees (*Roundtable Discussions on Health Care Reform* 2009, 241). The Chamber of Commerce described an employer mandate as a “job-killer” and the public option as a “backdoor way to bring single-payer, socialized medicine” (p. 321). Both arguments were successful in stopping the Clinton administration’s healthcare legislation. However, the existing challenges to the neoliberal SSA in this period created the conditions where big business groups and health insurance companies were willing to accept healthcare reform. Without the additional support of big business groups, their opposition to major healthcare reforms was unheeded.

The change in the phase of the SSA did not affect these organization’s arguments against healthcare reform. However, there is a significant difference in the Chamber of Commerce’s role in healthcare reform in this period. After the law’s passage in March of 2010, a journalist from *Bloomberg* broke the news that AHIP, the lobbying organization for health insurance companies, had donated over \$86 million to the Chamber of Commerce (Armstrong 2010). The funds, which the Chamber of Commerce confirmed paid for advertisements and grassroots events to oppose the healthcare bill, exceeded the group’s entire budget from the previous year.

Some commentators have suggested that this action by insurers means that all their comments supporting healthcare reform were disingenuous, and that they maintained the fierce opposition to healthcare reform in 2008-2010 as they did in the early 1990s. However, even though the health insurance companies were secretly funding advertisements to delay or block healthcare reform, it does not indicate that the insurers were merely repeating their previous ploys. In the nineties, Chip Kahn and the HIAA did not have to secretly fund television advertisements. The Harry and Louise ads were explicitly funded by the Coalition for Health Insurance Choices, a group that HIAA publicly addressed creating. The fact insurers kept these payments in secret speaks to the transformed environment after the financial crisis where industry executives were more fearful of public backlash.

Even though the government-run competitor was potentially a graver threat to the private health insurance industry than many elements of the Clinton Health Plan, rejecting healthcare reform outright was not an option for the industry in 2008 and the two following years in which the struggles played out, as it was in 1990s. It was no longer a safe strategy for insurers to fight openly against being pitted against a government run healthcare plan. Following the financial crisis, while faced with questions over the future of capitalism more broadly, insurers considered it unwise to appear as oppositional to reform. Thus, they had to relay their arguments against reform through other organizations that had maintained consistent opposition.

### **Labor and Citizen Groups**

Like the organizations representing small business groups, labor and citizen groups also maintained their stance on healthcare reform across each period of the SSA.

Unions and public-interest groups were vocal proponents for many aspects of healthcare reform, including regulations on insurers, the establishment of the exchange, the expansion of Medicaid, subsidies for lower and middle-income families, and a mandatory employer contribution. These groups were also among the most active supporters of the public option.

In previous debates, which did not feature discussions of a public option, the labor unions and citizen groups demanded the establishment of a single payer healthcare system. Some groups, for example Disabled for Action, California Nurses Union, and Physicians for a National Health Plan maintained a strict devotion to the establishment of a single-payer healthcare plan. Some labor organizations, such as the AFL-CIO, continued to voice support for single-payer but viewed the public option as consistent with their long-term support of universal coverage based on a social insurance model (*Health Care Reform Roundtable (Part I)* 2009, 44). Health Care for Action Now (HCAN), a coalition of the American Federation of State, County, and Municipal Employees, the Service Employees International Union, and the United Food and Commercial Workers, and the Association of Community Organizations for Reform Now explicitly supported and organized in favor of the public option.

In the period after the financial crisis and Great Recession, the arguments used to support the establishment of a public option gained credibility. The language of competitive and deregulated markets were no longer effective slogans to stir opposition for healthcare reform. The deregulation of the financial industry was considered a precipitating factor in the financial crisis and Great Recession. Supporters compared

opposition towards health insurance reform to support for the earlier financial services deregulation that had helped devastate the economy.

Public option supporters also benefitted from a resentment towards the tremendous profits of health insurance companies. Health insurance executives were compared to the bankers receiving bonuses after their bailouts. HCAN staged a mass citizen's arrest of insurance company executives at a conference in March of 2010. The conference hotel was covered with banners reading "Corporate Crime Scene." Attendees were deputized to arrest the insurance executive CEOs,

"whose greed, corporate abuses, and craven lobbying pose a mortal threat to our democracy and the health and well-being of our people" (Kirsch 1997, 335).

Opponents of health reform repeatedly named the public option as a Trojan horse policy, which would ultimately lead to creation of a single-payer or nationalized healthcare system. However, the establishment of a government-run health insurer was no longer exclusively considered as a radical option guaranteeing government take over. Some supporters of the public option saw the policy as an opportunity to give people choice and a chance to "vote with their feet" on whether private health insurance system could be sustainable. Leadership from the AFL-CIO argued that it was no longer credible to believe that the current private health insurance system would be able to contain costs and promote universal coverage:

"We think that, as soon as feasible, an immediate implementation of a public health insurance plan option is essential. The private insurers have had plenty of opportunity to [put competition into the insurance market] on their own and they have failed to do it ... We need to keep them honest" (*Health Care Reform Roundtable (Part I)* 2009, 50).

The discussion of healthcare reform in this period following the financial crisis included another feature new to the debate: a stronger focus on the macroeconomy. It became common to associate healthcare reform with the reinvigoration of the economy. Proponents of healthcare reform compared their proposals to Keynesian policies to increase aggregate demand. At a Senate hearing concerning healthcare reform and the overall state of the U.S. economy, economist Uwe Reinhardt explained the economic consequences of healthcare reform, by comparing universal coverage to tax cuts:

“The problem with a tax cut is, you do not know how the people who get it will spend it. Will they put it into offshore mutual funds? Will they buy a Ferrari? You have no control. But, if you put it into health care, it will, in fact, create American jobs because we do not import healthcare ... It turns out health care is the job machine in the U.S.” (*Health Care Reform: An Economic Perspective* 2008)

President of the Service Employees International Union Andy Stern used similar logic. He described universal health care as an opportunity for training workers and creating jobs. He also cited the necessity of universal healthcare coverage to increase spending:

“But more importantly, if people do not have a sense of health care security they are not going to purchase at the levels we need to revive consumer spending ... we need people to be secure and feel like they can spend” (ibid.).

Senator Rockefeller made the most explicit comparison between the financial crisis and U.S. healthcare:

“The current economic crisis ... is also a crisis of healthcare. They are one and the same. Stabilizing our health care system is a critical component of putting our economy back on track. Leading economists have all agreed that our costly and inefficient healthcare system is perhaps the biggest threat to the Nation’s budget. So health care is not just health care, ... it is also, as I say, stability for our country” (ibid.).

By November 2008, connecting what was described as the worst depression since the Great Depression to the problems in U.S. healthcare is a remarkable comparison. Lehman Brother's collapse in September and the fragility of the financial system, has no obvious tangible connection to the problems of U.S. healthcare. Politicians usually discussed the problems of healthcare in the United States in terms of the increasing numbers of uninsured individuals and the rising costs of healthcare. These trends had been in place prior to the problems in the financial industry. However, the health insurance and the financial markets are connected in their reliance on the institutions and ideas of neoliberal capitalism, currently under significant challenge. The unique economic moment strengthened the arguments of proponents of healthcare reform.

### **Conclusion**

Although the legislation disappointed many who had hoped for more significant change, the ACA is a major piece of legislation with important consequences for the entirety of U.S. healthcare. Previous histories and accounts of the Affordable Care Act have not systematically analyzed how the changing conditions of capitalism played an important role in shaping this legislation. This case study analyzed how the dynamics of capitalism and its historically specific set of institutions and corresponding ideas helped shape the Affordable Care Act.

I argue that the contradictions of the neoliberal SSA helped create the conditions that primed the insurers for structural changes to the organization of their industry. Great Recession, the worst the U.S. economy experienced since the Great Depression, severely weakened the established institutions and ideas of the neoliberal SSA. In the context of these changing and unstable dynamics, interest groups and arguments that previously did



not hold power gained credibility. Industry stakeholders were threatened with the possibility of significant industry restructuring. The possibility of a government-run health insurance plan was plausible. In this context, these stakeholders, who successfully and steadfastly and successfully had previously opposed healthcare reform despite its being beneficial to their interests in some respects, softened their approach and conceded major demands.

## **CHAPTER 7**

### **CONCLUSION**

These case studies provide a framework for understanding the history of healthcare reform in the United States that complements and extends the existing literature. They highlight the role that the changing conditions of capitalism have played in the development of healthcare reforms. This helps explain why particular interest groups were effective when they were and why the ineffective arguments of one time period became an effective means to deter healthcare reform in the next.

Medicare and Medicaid were passed in the postwar period, in which citizen and labor groups were more powerful in pushing for the expansion of the U.S. welfare state. During this period, memories of the Great Depression and the increased threat of socialism conditioned U.S. businesses to be more accepting of government regulation and involvement in the economy. By the 1990s, this form of postwar capitalism was long gone. A decades-long campaign led by a united coalition of large and small businesses helped shift the class relation back in capital's favor. The realm of market relations usurped what had previously been in the purview of the government and unions.

In this era the goals of healthcare reform were to provide expanded access and quality of care to a larger group of Americans. But healthcare reform in this period was also seen as a means to further promote market relations within the industry and to roll back the fiduciary responsibility of the federal and state government in healthcare. The Clinton administration's proposal for healthcare reform was designed to shift the large public programs of the U.S. welfare state, Medicare, Medicaid, and the Veterans Health Administration into private competitive health plans. Yet even these reforms were not

acceptable to business groups or insurers. Maintaining the status-quo healthcare system was permissible in this period when the threat of government takeover or single-payer healthcare reform was negligible.

These conditions dramatically changed in the context of the global financial crisis of 2008. With the largest banks in the country failing or coming under government control and unemployment numbers rising into the millions, the neoliberal structure of the 1990s was temporarily but severely weakened. The threat of a national government-run insurance plan seemed plausible to many stakeholders. Insurers and businesses made large concessions and dropped their strong public resistance, infallible in the 1990s, to prevent major reforms such as the establishment of the public option.

The shifting conditions of capitalism have had a major role in shaping healthcare reform. Previous histories of the U.S. healthcare system have neglected this important component. This analysis builds on SSA theory's focus on the role that the rate of capitalist accumulation has on the pace of the economy and the cohesive set of institutions that is needed to stabilize and sustain accumulation. These dynamics and the historically specific set of institutions have played a critical role in shaping U.S. healthcare and its continued adaptation to the changing economic system.

By highlighting the complex interconnections between capitalism and healthcare in the United States, this research suggests that contemporary battles over health care reform will not be settled exclusively by political will, or even by moralistic or economic arguments. The healthcare system is embedded within and deeply reflects the overall economic structure. A restructuring of the healthcare system to one which responds to the needs of society and makes use of possible advances in medicine and technology is

possible within the context of a broader restructuring of the economic, political, and cultural features of U.S. society.

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