

Who Killed Obamacare?

Nelson Lichtenstein

LICHTENSTEIN

Republicans, both of the Trump variety and otherwise, are finding that efforts to “repeal and replace” the Patient Protection and Affordable Care Act (ACA or Obamacare) are proving legislatively complex and politically fraught. It is hard to destroy a program that has expanded medical insurance coverage to 20 million citizens, regulated health provision for tens of millions more, and materially transformed the entire medical-hospital industry. Democrats have mobilized themselves to resist, GOP Congressmen face angry constituents at town hall meetings, and popular support for the ACA is actually inching upward. But despite some GOP wavering, it seems likely that after seven years of intransigent hostility to Obamacare, Republicans can maintain the discipline and momentum necessary to deregulate the insurance industry, curtail Medicaid expansion, and slash subsidies to those of modest income buying policies on the state insurance exchanges. Whether all this will amount to a rapid collapse of the ACA, especially the exchanges, or a more protracted devolution and defunding remains the only question.

How did the Republicans get their chance? Why did this health insurance plan, the first substantial expansion of the U.S. welfare state in nearly half a century, fail to win over a constituency commensurate with the impressive transformation it made in American healthcare provision?

There are four reasons. First, Obamacare was thoroughly politicized by its opponents from day one. GOP Senate Leader Mitch McConnell successfully made this expansion of the welfare state an utterly partisan phenomenon. And in an era of intense partisanship, such labeling was enough to divorce the actual social and economic impact of the scheme from the political allegiances one might expect it to generate, certainly among those who proposed to preserve and expand it. In Kentucky, observed the former Democratic Governor Steven Beshear, “demonizing the phrase Obamacare” created such toxicity that the ACA had to fly under the label Keynet, a home-grown moniker that backers kept carefully divorced from the president’s signature program. “So I think you find a reluctance on the part of

people, even though the law is benefiting them, to publicly acknowledge it,” said Beshear.

Second, the corporatist deal-making that helped give birth to Obamacare continued to impact the program throughout its short history. Many identified the concessions made to Big Pharma, the insurance companies, and the rest of the health industrial complex with the extraordinarily unpopular bailouts of the big financial institutions that inaugurated the Obama presidency. Republican Senator John McCain called all this “unsavory deal-making,” a charge amplified at scores of Tea Party protests and citizen confrontations with Democratic legislators during home district meetings in 2009 and 2010. The insurance exchanges did work, but they were cumbersome to use, they enrolled far fewer people than expected, and they represented a wager on the efficient functioning of the insurance marketplace, which, in effect, made a core welfare state provision dependent upon an oligopolistic set of for-profit businesses whose financial health stood in fundamental tension with the social purposes of the ACA.

Third, Obamacare, unlike its Clintonite predecessor, had been designed to have as little impact as possible on the workings of the employer-provided system through which most Americans still found their health insurance. When President Obama asserted “If you like your health care plan, you can keep it,” Republicans pounced, accusing him of a policy lie because the ACA cancelled perhaps 4 million substandard policies that failed the test of real health insurance. But Obama was largely right: most Americans kept their existing insurance and any changes that were imposed, such as the elimination of life-time reimbursement caps, went unnoticed. Some liberals had expected a steady migration of individuals from the world of employer-provided health insurance to the exchanges, but this did not happen, possibly because of the economic recovery that gained momentum after 2013. This meant that for good or ill, the ACA barely touched the lives of the vast majority of employed Americans or those on Medicare. For them, the ACA was an abstraction that merely heightened the extent to which a preexisting, partisan disposition colored opinions of the program. Indeed, few ordinary Americans can explain how the insurance exchanges work or what is involved in the extension of Medicaid to newly eligible individuals.

And the very progressiveness of the ACA worked against it. The people who were helped the most, those enrolled in Medicaid or those who received generous subsidies on the insurance exchanges, were the least vocal, the least engaged, and the least likely to vote, which Republican governors and legislators were well aware of. After visiting Kentucky, where right-wing Republican Matt Bevin won the governorship in 2015, reporter Alec MacGillis explained the dramatic conservative tilt of eastern Kentucky and other impoverished counties in the *New York Times*. He wrote that “the people who most rely on the safety-net programs secured by Democrats are, by and large, not voting against their own interests by electing

Republicans. Rather, they are not voting, period. They have, as voting data, surveys and my own reporting suggest, become profoundly disconnected from the political process.” Republican politicians understood this all too well. When a top advisor to Senator McConnell was asked if Republicans in Kentucky were afraid of the electoral consequences of depriving health insurance to the approximately 500,000 people newly covered by Obamacare, he replied, “People on Medicaid don’t vote.”

Meanwhile, those with the most difficult relationship to the new program—families earning above \$92,000 a year—pay unsubsidized insurance premiums that bought them policies that often included high deductibles and co-pays as well as insurance rate hikes, which they paid in full. But these are precisely the families and individuals who are the most engaged voters, certainly far more than those whose ACA benefits are more generous. Moreover, reporting from Kentucky and other Medicaid-dependent regions indicates that those whose incomes are high enough to put them on the exchanges actually resent those on Medicaid, not only because the latter pay nothing—no deductibles, no co-pays, and open enrollment all year long—but because Medicaid remains stigmatized as “welfare,” a demonization many conservative politicians continue to advance.

Obamacare never generated the “third rail” sensitivity that has long protected and sustained other welfare state programs, not just Social Security and Medicare for the aged, but the Children’s Health Insurance Program passed in 1997 and Medicare Part D (cheaper drug prices for most seniors), passed during the administration of George W. Bush. Regardless of the manifest benefits delivered by the ACA, almost all Republicans have declared it a “disaster” or in a “death spiral,” while repeated public opinion surveys taken over the last seven years have, at least until very recently, shown that while many Americans support key provisions of the law, only about half endorse the ACA as a whole, especially when it is labeled Obamacare. More importantly perhaps, Republican officeholders have paid no political penalty when they declare their intention to abolish the program, even among constituents who have benefited greatly from its provisions.

All this seems to fly in the face of both welfare state history and conventional political wisdom. In the summer of 1993, when some congressional Republicans seemed on the verge of working with the Democrats to put President Bill Clinton’s healthcare program into law, William Kristol, the neoconservative strategist, wrote a memo to GOP legislators and activists that remains perhaps the single most important document laying out the rationale for wall-to-wall conservative opposition to healthcare reform, both in the early 1990s and in the years since 2009.

Kristol argued that any Republican compromise with Clinton would “likely make permanent an unprecedented federal intrusion into and disruption of the American economy.” It would help Democratic electoral prospects in forthcoming contests, but of even more ideological and cultural

consequence, warned Kristol, a successful Clinton plan “will revive the reputation of the party that spends and regulates, the Democrats, as the generous protector of middle-class interests.” Republicans had to therefore “adopt an aggressive and uncompromising counterstrategy” to “delegitimize” the Clinton plan and bring about its “unqualified political defeat.”

The Kristol strategy had a long afterlife. In subsequent years, Republicans would be willing to expand the welfare state, as with the subsidy for prescription drugs passed during the administration of George W. Bush, but they sought to root such initiatives as much as possible in the private insurance market, not a benevolent state. Hence, in both the 1990s and throughout the Obama years, we find that in a world of extreme partisanship, Republicans—in the legislature, the states, and the courts—often sought not only to block passage of most health insurance laws but to sabotage their implementation.

During the 2009 debate over the Obama health insurance reform, when some Republicans toyed with compromise and co-sponsorship, Senate Minority Leader Mitch McConnell made clear that a unified opposition was a ruthless but imperative political tactic. He later said, “It was absolutely critical that everybody be together because if the proponents of the bill were able to say it was bipartisan, it tended to convey to the public that this is OK, they must have figured it out.” McConnell’s hardball strategy worked. The idea that Obama and the Democrats steamrolled Congress and enacted a hyper-partisan, if not outright socialist, law proved decisively successful in stimulating conservative anger and Republican solidarity.

Democrats took Kristol to heart as well. If Republicans were so afraid of an expansion of the welfare state under Democratic Party auspices, seeing it as a game-changing ideological repudiation of Reaganism, why then, the Democrats would proceed full steam ahead. They were reasonably certain that once something approaching universal health insurance was in place, its roots would sink as deeply into the body politic as Social Security and Medicare. The settled existence of these programs naturalized both the taxes needed to pay for them and the benefits more than 100 million citizens enjoyed and expected. Political scientists have long made this point: an innovative new public policy, no matter how initially divisive, creates its own mass constituency and therefore a “feedback loop” that in turn sustains the policy and the loyalty of the electorate that benefits from it. “New policies create a new politics” is the way some social scientists have put it.

Thus when Obama and the Democrats got their chance to pass a healthcare program in 2009 and 2010, they were convinced that whatever the sausage-making character of its origins, once in place, the new law would create its own powerful constituency. This would be true both among the population at large as well as the interest groups that had bargained with the administration during the months when the ACA was being negotiated through Congress.



At a rally to Save the ACA, San Francisco, January 15, 2017. Photo by Tom Hilton.

At first, prospects looked good. Obama had a much bigger electoral mandate than Clinton and the Democrats fifteen years before, and his congressional majorities were much larger and more ideologically united. Conservative “blue dog” Democrats knew that legislative failure on the healthcare front spelled their certain electoral defeat, as it had for Democratic moderates from Southern districts in 1994. And party unanimity, especially in the Senate, was essential if the Democrats were to retain a filibuster-proof sixty-vote majority, even if only for a brief few months in the fall of 2009.

Despite the Great Recession, Obama put health insurance reform at the top of his agenda, right after passage of an emergency economic stimulus, but before the Democrats began a push for much needed regulation and reform of the banking industry. The stimulus passed quickly, in February 2009, which left the field clear for healthcare. In contrast, Bill Clinton had allowed a divisive debate over the North American Free Trade Agreement to precede a big push for health insurance reform, thereby sapping the energy and unity congressional Democrats would need to pass healthcare legislation.

And Obama let Congress do it. The key congressional committee was Senate Finance, where Obama and Chairman Max Baucus hoped to get some Republicans on board, in particular, Iowa’s Charles Grassley who was on record favoring the individual mandate as a healthcare analogue to compulsory auto insurance. This extended the negotiations for several

additional months and ended in partisan failure, but the orientation toward Congress and the Republican demonstration of intransigence probably served to keep conservative and maverick Democrats like Joe Lieberman and Jim Webb on board, even if the price was elimination of a government funded “public option” among the health insurance plans from which the uninsured might choose.

Obama proved a more skillful deal-maker than the Clintons fifteen years before. His team managed to avoid the conflicts and betrayals that bedeviled Clinton when business and insurance support for “Hillarycare” collapsed. Obama would offer potential opponents millions of new clients and billions in new revenue, making them stakeholders while a new framework for health insurance was put in place.

This kind of corporatist deal-making had a double-edged character with immediate consequences for the current GOP effort to repeal the law. On the one hand, Obama created a set of interests with a big financial stake in his health reform plan. Hospitals and drug companies would make a lot of money with all those new customers. But the bargains his team struck were also both economically fragile and politically unseemly. Pull out one regulation or revenue source and the whole edifice might well collapse, which is precisely what contemporary GOP repeal efforts are designed to do.

The most important bargain struck by Obama was a quid pro quo with the insurance industry. In exchange for guaranteed issue—no insurance company could henceforth deny a policy to an individual because of a pre-existing condition—the government would mandate, under an escalating financial penalty, that all individuals, including the young and healthy, purchase medical insurance if they did not already have it through a government program or through their employer. They would buy it through a set of insurance exchanges designed to be run by the states, or if these jurisdictions declined, by the federal government. The purchase of such insurance policies would be subsidized by the federal government, sometimes at a ratio of as much as eight or nine federal dollars for every dollar paid by an enrollee.

The individual mandate had once been a Republican idea, put forward by some individuals associated with the Heritage Foundation in the early 1990s and then championed by GOP moderates like John Chafee of Rhode Island. Its advocacy by elements of the Republican hard right was almost certainly a cynical ploy to subvert the Clinton health insurance plan. But Obama and the Democrats thought that they could make it work with enough carrots—government-financed insurance subsidies for moderate-income people—and sufficient sticks, which in this instance entailed the threat to slash tax refunds for all those who failed to purchase health insurance. Combined with such a penalty, the individual mandate had worked in Massachusetts. There, Mitt Romney, then a moderate Republican governor, had proudly worked with a Democratic legislature to create a state-level

insurance exchange that had boosted insurance coverage to the highest in the nation, and without much backlash against this mildly coercive government mandate.

Although the insurance industry would make billions from the 20 million new policies they were expected to issue under the ACA, they were ambivalent about the overall scheme. They were not sure that in exchange for “guaranteed issue,” a major concession on their part, enough healthy young customers would sign up through the exchanges. Indeed, it is telling that what ultimately prompted insurers to move into formal opposition to Obama and the bills developing in Congress was the September 2009 decision of the Senate Finance Committee—under pressure from Republicans—to weaken the planned penalties for Americans who, after 2014, did not obtain insurance. This worried private insurers who now feared that millions of young, healthy, and/or low-income people would pay the penalty and skip coverage. They wanted more government regulation, and a stronger mandate, not less.

And by 2016 the industry was proven largely correct, with at least 5 million fewer people signing up for the insurance exchanges than expected. To the federal government, this actually reduced the overall cost of Obamacare, but in rural areas of many states, insurers hiked rates or pulled out of the exchanges. To the extent that Trump Republicans fail to enforce the mandate and slash subsidies, insurers will flee the exchanges even in those blue states most supportive of the program.

But back in 2010 the ACA did something quite extraordinary. To pay for the exchange subsidies and Medicaid expansion, the new law imposed a set of progressive taxes that represented the most consequential redistribution of income, from the top to the bottom, that Americans had seen since the imposition of Second World War-era hyper-taxes on the very rich. Unlike the regressive payroll taxes used to pay for Social Security, Obamacare added a .9 percent additional Medicare tax on wages above \$250,000 per family and a 3.8 percent tax on investment income as well, including capital gains from stocks and real estate, which have powered so many fortunes of the super rich. Both of these taxes generated an additional \$230 billion to pay for the healthcare reform, about a quarter of all new revenue over a ten-year span. In all, the rich paid an additional 4.7 percent tax to fund medical care for the poor and the lower middle class. The Congressional Budget Office estimated that another \$106 billion would come from employers who failed to offer adequate insurance for their own workers.

As the key Senate staffer and Edward Kennedy aide, John McDonough, put it in his 2011 account of how the ACA was muscled through despite near unanimous GOP opposition: “For progressives, this is an enormous and positive breakthrough in tax policy heretofore considered untouchable; to conservatives the policy is anathema.”

In truth, a lot of liberals were but dimly aware of the radically progressive

character of these Obamacare taxes, but Republicans knew the score. Under virtually any version of GOP “repeal” legislation, these taxes will be the first to go. Once they are gone, any Democratic filibuster that blocks conservative efforts to dismantle other provisions in the law will constitute a pyrrhic victory.

The revenue raised by those taxes helped pay for a dramatic expansion and improvement of Medicaid, transforming it from a poorly financed “welfare” program by planting it firmly within a national system of health provision. No longer would eligibility be limited to mothers with small children or the disabled. Instead, anyone with an income less than 138 percent of the poverty line (in 2016, \$16,242 for an individual, not far below many full-time Walmart clerks) could enroll. Payment schedules were improved for physicians and health services dramatically expanded in poor and rural regions of the country.

With enrollments 50 percent greater than those projected by the Congressional Budget Office in 2010, Medicaid’s transformation demonstrated the virtues of what was in effect a single-payer, Canadian-style system for the bottom half of the working class. Nearly 15 million new people were covered by Medicaid and the closely linked Children’s Health Insurance Plan, and another 4 to 4.5 million would almost certainly be enrolled if the Supreme Court in 2012 had not allowed states to reject Medicaid money and the new eligibility standards put forward under the ACA. Thus in Texas and Florida alone, where Republican governors and legislatures turned down ACA Medicaid expansion, almost 1.9 million lower-income people have no access to the new program.

But when a Southern state did expand Medicaid, the results were truly dramatic. In Kentucky, where a Democratic governor was an ACA partisan, Medicaid and CHIP enrollment leaped more than 101 percent in less than three years, with more than 400,000 new people covered in 2016. Almost a third of all residents are in the program, thus dropping the state’s uninsured rate to 7.5 percent today from 20 percent in 2013. In some former mining counties 60 percent of all residents are covered by Medicaid.

But none of this made Obamacare a popular program in most of those red, rural, and white counties where the program had such a large impact. While Donald Trump’s victory in Appalachia and the Rust Belt might seem to exemplify this phenomenon, it was even more clearly evident in the 2015 gubernatorial victory of GOP conservative Matt Bevin, who promised to dismantle Kentucky’s insurance exchange and roll back much of the Medicaid expansion that had benefited so many in his state. Indeed, Bevin’s success was most notable in the very eastern Kentucky counties where Medicaid expansion had the most impact. In desperately poor Clay County, where 60 percent of the 21,000 residents are covered by Medicaid, Trump won 86 percent of the vote in 2016 while Bevin took 71 percent the year before.

The same proved true throughout the nation. While majorities did like

“guaranteed issue” and the enrollment of children up to age twenty-six on their parents’ health insurance policy, Obamacare’s popularity never rose much above the 45 percent approval it achieved when first introduced to the American public in 2009.

Although popular support for the ACA has become more visible since Trump’s election, Congressional Democrats remain firmly supportive of the law and Republicans appear divided over what precisely “repeal and replace” actually means, a debilitating degradation of Obama’s signature policy seems almost inevitable. Some parts of the ACA will remain intact, protected by a Democratic minority in the Senate ready and willing to use the filibuster to veto Republican efforts to simply abolish the exchanges, guaranteed issue, or the Medicaid expansion. But none of that protects the law from the kind of maladministration, amounting to outright sabotage, already put in effect by Trump’s executive orders, or the elimination of taxes levied against the very rich, which a GOP-controlled Congress can easily pass because such budget issues are not subject to the sixty-vote filibuster rule in the Senate. Thus the Trump administration has given both the IRS and those directly administering the law a green light to halt enforcement of the individual mandate, while also tightening standards and enrollment times for those seeking to purchase insurance policies on the exchanges. All this will reduce the likelihood that the young and healthy will sign up, thus engendering, in actual fact, the pool of sicker enrollees, higher premium costs, and insurance industry “death spiral” that the GOP has long forecast as leading to the collapse of the ACA.

Meanwhile, in their American Health Care Act, the “repeal and replace” legislation House Speaker Paul Ryan introduced in early March, the GOP has made clear that above all “repeal” means elimination of all the progressive taxes that have funded Medicaid expansion and insurance exchange subsidies. Even if Republicans are nervous about how repeal will play in their districts, they can all nevertheless agree upon the need to cut those taxes that fall heavily upon higher incomes. In turn, such a radical defunding of the ACA makes other efforts to cut costs, like the new limits imposed on Medicaid funds to the states or a recalculation and reduction of insurance subsidies for those on modest incomes, a fiscal necessity if deficits are not to explode. In the end, something called national health insurance will stay on the books, but it seems certain to share the fate of so many other efforts to expand the welfare state in the United States: to remain underfunded, awkwardly administered, and ideologically abused. What’s left of the ACA will linger on as an abject lesson to which conservatives can point when fighting against those who would once again seek progressive and universal health insurance reform.

Nelson Lichtenstein is Distinguished Professor of History and Director of the Center for the Study of Work, Labor, and Democracy at the University of California, Santa Barbara.