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COMPLUTENSE

The Affordable Care Act and the Transformation of US Health Care

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Resumen. El periodo neoliberal ha sido acompañado por una transformación trascendental en el seno del sistema de salud estadounidense. Como resultado de una serie de dinámicas políticas e históricas, la nueva ley de atención a la salud firmada por Barack Obama en el 2010 –La Ley de Cuidado de la Salud Asequible (ACA)- se basó menos en modelos universales de otros países que lo que se propuso en reformas conservadoras anteriores del sistema de salud. Esto fue en parte el resultado de la influencia de los intereses de poderosas empresas de salud. Esta ley expande la cobertura sanitaria, pero lo hace de forma incompleta y desigual, con disparidades aseguradoras y vacíos persistentes en el acceso al sistema según el estatus del seguro. Además, la ley incorpora un cambio total hacia un modelo consumista de cuidado caracterizado por costes elevados en el momento de su uso. Finalmente, la ley promociona una mayor consolidación del sector de cuidado de la salud, por ejemplo en unidades llamadas “Organizaciones de cuidado responsables” que se parece mucho a las organizaciones de cuidado de la salud promovidas por abogados de la atención médica administrada. El efecto total ha sido el mantenimiento de un sistema fragmentado que ni es equitativo ni es eficiente. Un sistema universal mediante contribuyente único hubiera podido, en cambio, ayudar a transformar la sanidad en un derecho social.

Palabras clave: La Ley de Cuidado de la Salud Asequible; modelos universales; el sistema sanitario estadounidense; modelo consumista de cuidados.

[es] La Ley de Cuidado de la Salud Asequible y la transformación del sistema de cuidado de la salud estadounidense

Abstract. The neoliberal period was accompanied by a momentous transformation within the US health care system. As the result of a number of political and historical dynamics, the healthcare law signed by President Barack Obama in 2010 -the Affordable Care Act (ACA)- drew less on universal models from abroad than it did on earlier conservative healthcare reform proposals. This was in part the result of the influence of powerful corporate healthcare interests. While the ACA expands

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healthcare coverage, it does so incompletely and unevenly, with persistent uninsurance and disparities in access based on insurance status. Additionally, the law accommodates an overall shift towards a consumerist model of care characterized by high cost sharing at time of use. Finally, the law encourages the further consolidation of the healthcare sector, for instance into units named “Accountable Care Organizations” that closely resemble the health maintenance organizations favored by managed care advocates. The overall effect has been to maintain a fragmented system that is neither equitable nor efficient. A single payer universal system would, in contrast, help transform healthcare into a social right.

Keywords: the Affordable Care Act; universal models; US health care system; consumerist model of care.

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1. Introduction

The “neoliberal era” – typically described as beginning sometime in the 1970s and continuing to the present – has witnessed great changes in the health systems of nations throughout the world. Some nations in Europe have seen efforts to rollback the universal scope, or privatize the delivery, of their universal public health systems, trends that may now be accelerating (Reeves, McKee, and Stuckler 2015, Pollock and Roderick 2015, Maarse 2006). The United States, in contrast, entered the twenty first century without a system of “universal health care,” with millions excluded from health care and many more with inadequate or second-tier care. The passage of the Affordable Care Act (ACA) in 2010 has been described by some as the long-deferred realization of the goal of a right to health care in the United States (Obama 2015). However, for reasons we will explore, this characterization is, unfortunately, inapt.

In this article, we will explore the transformation of the American health care system, with an emphasis on the recent reforms of the ACA. Our aim is to elucidate the major historical and structural features of the American health care system for an international audience, and we do so by taking the following course. First, we will succinctly summarize some of the important historical currents that explain how and why the United States entered the twenty-first century with a rising number of uninsured, despite our uniquely high health care expenditures. Second, we will describe the political and health policy origins of the ACA. Third, we will describe the factors leading to the passage of the ACA, with a particular emphasis on the role of key corporate health interests. Fourth, we will discuss the fundamentals of the ACA-model of “universal health coverage.” Fifth, we will assess the current landscape of US healthcare, emphasizing important quantitative trends, including the persistent problems of uninsurance and underinsurance. Sixth, we will examine how a process of corporate consolidation – in part through the emergence of “accountable care organizations” – is unfolding within the American health care landscape. We will conclude by briefly contrasting the ACA model of

reform with a potential alternative, namely a single payer national health insurance program.

Though these are US developments, they are highly relevant on the international level. The dynamics of health care in America have become increasingly important outside of the nation's boundaries as politicians and policy makers in other countries have, to varying extents, interpreted the ACA (or elements within it) as a possible model for health care reform (Pollock and Roderick 2015). By exploring the political processes that led to the ACA and highlighting the shortcomings of the law from the perspective of policy, we hope to demonstrate the pitfalls of a health system reform approach centered on the conciliation of corporate healthcare interests.

2. Historical Backdrop

During the twentieth century, the US diverged from most nations in Europe in its failure to create a system of universal health care. Understanding the US health care landscape today requires contextualizing it within the political history of health care reform. To do this, we can turn to a number of books which examine this history, and which highlight the key episodes within it (Numbers 1978, Poen 1979, Starr 1982, Hoffman 2001, Funigiello 2005, Gordon 2005, Quadagno 2005, Hoffman 2012, Starr 2013). The first episode occurred during the "Progressive Era," essentially during a short period around World War I. The second episode occurred during the "New Deal" of Franklin Delano Roosevelt, a time that otherwise saw a major successful expansion of the welfare state. The third episode occurred during the presidency of Harry S. Truman in the post-War II era, which corresponded to a crucial moment for welfare state expansion in Europe. The fourth episode is somewhat less well defined, but might be described as stretching from the successful passage of Medicaid and Medicare in 1965 to the failure of a national reform effort in the first half of the 1970s. A rightwing shift in national politics caused the next episode to be deferred for decades: health reform as a major national concern didn't again emerge until the Presidency of Bill Clinton in the 1990s. The final, fifth episode was that of the recent health reform struggle during the presidency of Barack Obama. Only two of these episodes resulted in major legislation: the passage of Medicare and Medicaid in 1965 (public health insurance programs for the elderly and the poor, respectively) and the ACA in 2010.

The relative power of the constituencies favoring and opposing reform in each episode slowly shifted over time, reflecting larger changes in the US political economy. It's worth briefly mentioning the reasons for the failure of the first moment - the Progressive-era movement towards "compulsory health insurance" - because the dynamics of this first "failure" would play out again and again, in differing ways, in subsequent health care reform efforts up to the present. These dynamics thus help explain the current state of the American health care system.

Progressive-era "compulsory health insurance," as it was known, would have created systems at the state level roughly similar (with some differences) to Otto von Bismarck's 1883 Health Insurance law in Germany or Lloyd George's 1911

National Insurance Act in Britain (Lubove 1986, 67-68). Historians have identified a number of factors leading to the failure of this campaign, and the resultant historical divergence of the US from Europe with respect to health policy. One factor was a shift in opinion among physicians, who moved from a position of potential openness to reform to one of relentless hostility, the history of which is described by Ronald Numbers in his *Almost Persuaded* (Numbers 1978). A second important factor was the emergence of opposition from the insurance industry. Though health insurance was essentially nonexistent, the insurance industry presciently saw its interests threatened by the reform movement and joined the campaign against the bill (Gordon 2005, 212-213). A third factor was the relative isolation, and elitism, of the reform movement: health insurance never became linked to a broader popular movement (Hoffman 2001, 44, Gordon 2005, 262). Indeed, the cause of compulsory health insurance actually split organized labor, with the powerful mainstream American Federation of Labor opposed (Starr 1982, 249-251, Hoffman 2001, 4). Finally, US entry into World War I and the Bolshevik revolution provided a useful ideological weapon for those who opposed the campaign, insofar as health insurance could be characterized as both German and communist in inspiration (Hoffman 2001, 56, 163).

We outline the factors that resulted in the eventual destruction of the first effort at “compulsory” health insurance in the United States because they can be largely traced forward, albeit in changed form and circumstances, throughout the coming decades. The opposition of the conservative physicians’ lobby, for instance, would remain an important factor into the post-World War II era. The post-World War II Wagner-Murray-Dingell bill, which would have established a single payer type of national health insurance on more European-lines, was vigorously and successfully opposed by the powerful American Medical Association, as described by Monte Poen in *Harry S. Truman Versus the Medical Lobby* (Poen 1979). However, the relative power of physicians waned while the role of larger commercial and corporate health interests – hospitals, insurance companies, and the pharmaceutical industry – rose over the course of the twentieth century. The fate of future health care reform efforts, it might be reasonably argued, increasingly hinged less on the posture of physicians and more on the lobbying muscle of these corporate interests. The third factor we outlined – the fact that movements towards universal health care were frequently distanced or isolated from larger social movements – would continue to play a role in subsequent failures, but also in shaping the form of reform efforts themselves. For instance, the historian Alan Derickson, who has explored the role of organized labor in early health reform battles, notes that though labor supported the post-World War II campaign, this never developed into a grass-roots campaign. “As a result,” he writes, “no protest movement arose among the millions of uninsured and underinsured workers to counterbalance the AMA and its allies” (Derickson 1994, 1343). With the failure of post-World War II universal health care efforts, labor would increasingly embrace, earn, and expand upon *private* health benefits from their employers (Derickson 1994, 1354-1356). And finally, though the German roots of “compulsory” health insurance would quickly lose its propaganda value following the end of World War I, the “red-baiting” of the Progressive era fight for health care reform – i.e. the defaming of

reformists as dangerous, foreign, or even traitorous communists – would be carried forward into future fights for health care reform, to some extent to the present day.

These various factors – among others – help explain why, as the United States entered the twenty-first century, it continued to lack a system of universal health care. Different historians and scholars emphasize some of these factors over others as the “deciding” elements in this history, and arrive at different broad theses explaining the status quo. In Vicente Navarro’s Marxian interpretation, for example, class analysis is the overriding factor of importance. As he has written, the balance of power between the working class and corporate interests continued to favor the failure of reform over the decades. With respect to the failure of Bill Clinton’s health reform proposal of the early 1990s, for instance, Navarro emphasizes that, in the short-term, corporate interests might actually have favored universal health care reform, insofar as it would have relieved them of having to pay for an expensive employee benefit. However, given that the provision of these benefits actually bolstered employer control over employees, such interests preferred the perseverance of status quo (Navarro 1995, 458). More generally, he puts forth elsewhere, it was “the weakness of the U.S. working class,” in conjunction with the powerful “capitalist class,” a relatively weak labor movement, and the lack of a potent socialist party that “explain the absence of a comprehensive and universal health program in the United States” (Navarro 1989).

The larger story, however, is that over more than 100 years, despite the periodic recrudescence of reform movements, the US remained almost distinctive among high-income nations in its lack of some sort of system of comprehensive health care, for a combination of the reasons briefly outlined here: opposition of key groups (first physicians, later larger corporate interests), a divided and/or relatively weak labor movement, the ideological power of red-baiting, and the balance of power between classes.

However, within this narrative there is a second point that is of great importance in understanding the fundamentals of the Affordable Care Act, namely the rightward shift in the goals of mainstream health care reform advocates that occurred over the course of the century. This shift coincided with a larger transformation in the political economy of the country itself, and can be located back to that crucial “neoliberal” decade of the 1970s (Gaffney 2015). Following World War II, the proposals of mainstream health care reform advocates followed in the footsteps of European-inspired, universal programs. “The proponents of the Murray-Wagner-Dingell bills [e.g. during the Truman presidency],” as Theodore Marmor and James Morone have reflected, “took for granted the egalitarian argument ... that financial means should not determine the quality and quantity of medical care a citizen received” (Marmor and Morone 1977, 162). To some extent, Medicare – which universally provided health benefits to all seniors – was consistent with this heritage. Likewise, Senator Ted Kennedy’s 1970 Health Security Bill – which emerged after organized labor rekindled the fight for universal health care in the late 1960s (Quadagno 2005, 110) – would have created a universal system along such New Deal lines. Funigiello describes Kennedy’s bill thusly:

The legislation offered free universal health coverage, financed partly from increased taxes and partly from general revenues. It eliminated patient co-payments

and replaced all public and private health plans with a single, federally operated health coverage system. (Funigiello 2005, 173)

Yet this embrace of a single-payer national insurance plan was to prove to be short-lived. The neoliberal turn of the 1970s saw the essential abandonment of such a fully universal program. As Beatrix Hoffman has emphasized, an overriding concern for costs – over an embrace of universalism – came to dominate the health care reform proposals of both political parties. This turn coincided with a larger conservative political turn. As Hoffman puts it,

A consensus soon emerged that universal coverage would not be possible until health costs were brought under control ... The focus on cost control would lead to a new era in US health care history. Health care activists' vision of equality and universal coverage, which had been shared at least in part by Presidents Franklin D. Roosevelt, Truman, Kennedy, and Johnson, came to seem like a relic of a past era. All presidents since Carter, no matter their political persuasion, have placed cost control at the center of their reform efforts. (Hoffman, 164-166)

This continued focus on cost control (Hoffman, 206) – and the abandonment of the egalitarian, universalist spirit of post-World War II reform proposals – persisted into the twentieth-first century, and was reflected in the very name of the law which is the central concern of this chapter: The Affordable Care Act. Fundamental to this overall shift was the fact that mainstream reform advocates had come to see the accommodation of corporate health care interests – which had grown enormously in power and resources over the preceding century – as the price of any successful reform effort.

These, in brief, are some of the early historical dynamics underlying the political economy of American health care by the 1970s.

3. Roots of the Affordable Care Act

As a result of these dynamics, a more conservative health policy tradition emerged in the 1970s. The ACA would draw less on the universalist tradition, and more on this more conservative line. Indeed, to no small extent, the ACA brought to fruition a conservative model of health reform that can be traced back to Richard Nixon, as many have suggested. It's important to briefly review the lineage of this model of health reform. In 1971, to counter Kennedy's Health Security Bill, Nixon released a bill of his own, which would have expanded access to health coverage largely through private insurers and new "health maintenance organizations" (HMOs); this legislation would have included a mandate for employers to provide insurance to their workers, together with an expanded government program for the poor (Funigiello 2005, 176, Starr 2013, 54). While this would have expanded health care access, it would have also maintained a largely privatized system, one which would have fell well short of universalism, maintaining tiers of coverage based on class, and requiring out-of-pocket payments at the time of health care use (Starr 2013, 54).

Though it had little success in the 1970s, the idea of expanding access through "managed care" would come to play a fundamentally important role in health policy both in the United States and abroad. This "Health Maintenance Strategy," as the physician Paul Ellwood and colleagues described it in a 1971 paper, would

consist of a “series of government and private actions designed to promote a highly diversified, pluralistic, and competitive health industry ...” (Ellwood et al. 1971). Notably, it was explicitly conceived as a “market-oriented” alternative to a national health insurance system in which “the consumer would be able to purchase health maintenance services from a variety of competing organizations” (Ellwood et al. 1971). Nixon’s embrace of the HMO in the early 1970s was partly the result of Ellwood’s influence (Gray 2006, 318). In 1973 Nixon passed the HMO Act, a law that – as Gray notes – required some employers to offer an HMO plan to their employees (assuming one was available). The law would have little effect initially given various requirements that made HMOs unattractive for commercial insurers; over the course of the coming decades, however, with major modifications, it’s influence would be enormous (Gray 2006).

Another critical player in the elaboration of the modern managed care system was Alain Enthoven. While stationed at the US Department of Defense in the 1960s, Enthoven and his colleagues developed a “planning-programming-budgeting system,” an approach to maximizing the efficiency of military spending (Waitzkin 1994). Enthoven later went on to become a professor of health policy at Stanford, from where he would influentially advocate for a managed care-based model of health reform (Funigiello 2005, 192). As one of us (HW) has explored, several themes from Enthoven’s military work carried over into his articulation of a system of managed competition, including an emphasis on managerial over professional authority, cost analysis, and competitive choice (Waitzkin 1994).

Ellwood and Enthoven began collaborating in the 1970s, meeting in Ellwood’s home in Jackson Hole, Wyoming, together with an assortment of health policy academics, officials, and industry insiders (Ellwood, Enthoven, and Etheredge 1992). Drawing on the idea of the health maintenance strategy, Enthoven published his proposed “Consumer-Choice Health Plan” in 1978 in the *New England Journal of Medicine*. In this paper, he proposed a system that, like Nixon’s plan, emphasized coverage expansion through the private sector, with an emphasis on HMOs. However, his proposal went further in configuring an end to employment-based insurance, and its replacement with a system of health insurance plans – subsidized via tax credits – which would compete for consumers during an annual period of open enrollment. Medicaid would be voucherized, while those in Medicare could elect to enroll in a private plan instead (Enthoven 1978a). Enthoven counterpoised his “Consumer-Choice Health Plan” to the various other proposals circulating in the late 1970s during the Carter administration (Enthoven 1978b).

Little came of these proposals in the 1970s. Both Kennedy’s and Nixon’s national proposals, for instance, fell through. Yet Nixon’s 1973 HMO law, as mentioned, was passed. With some delay and significant later revisions, it would ultimately lead to the rise of powerful, large managed care corporations in the 1980s and 1990s (Gray 2006). Just as importantly, however, the intertwined health reform ideas of Ellwood, Nixon, Enthoven, and the Jackson Hole group would have a great impact on the health care policy proposals of both Democrats and Republicans in the decades to come (Waitzkin 1994). Clinton’s health care reform proposal would ultimately draw on aspects of this emergent conceptualization of

privatized universal health coverage: in a 1994 address, Clinton even acknowledged Nixon as the originator of the idea (Funigiello 2005, 186).

Similarly, the principles of the Nixon reform proposal were incorporated in the state-level health care reform signed into law in the state of Massachusetts in 2006 by governor Mitt Romney (and later into the Affordable Care Act).³ Like the Nixon plan, Romney's reform expanded the health system for the poor (in the case of Romneycare, via the state Medicaid program for children as well as a new subsidized insurance exchange) and also incentivized employers to provide insurance to workers (Starr 2013, 171-172). The plan additionally incorporated a feature not found in the Nixon plan: an "individual mandate," requiring those who didn't get insurance through their employer or through the state to buy a private plan, an idea sometimes traced back to a 1989 report from the conservative think-tank the "Heritage Foundation" (Brill 2015, 30).

The Obama administration's Affordable Care Act would, to no small extent, be modeled on this "Romneycare" model, which itself drew upon the Nixon plan coupled to an "individual mandate." Despite this history and intellectual lineage, however, those who argue that the Affordable Care Act is nonetheless still not a Republican Party idea are basically correct (Lemieux 2014). The Democratic Party proposal for healthcare reform drifted, over decades, away from an emphasis on universalism, and towards an acceptance of the principles of the Nixon plan of the early 1970s. Thus, by the time Romneycare was passed, this model *was*, to some extent, a Democratic party plan.

In other words, over the decades of the neoliberal era, the meaning of health care reform shifted: the party of the center Left came to embrace what was once the vision of the Right.

4. Passage of the ACA

The politics and the detailed legislative history of the passage of the Affordable Care Act is explored in three recent and useful books, including those of a sociologist (Starr 2013), a legislative insider (McDonough 2011), and a journalist (Brill 2015). Rather than review the chronological history of the ACA here, we instead explore a few critical points about the law's passage that help us understand what it accomplished, and what it did not.

First, it is important to emphasize at the outset that one underlying impetus for the law was, to no small extent, strong public support for health care reform. "Health care ranks as the top domestic issue in opinion polls," as Jonathan Oberlander wrote in the pages of the *New England Journal of Medicine* in late 2007, "and talk of major reform is back in vogue as the 2008 election approaches" (Oberlander 2007). Indeed, in the lead-up to the 2008 election, Kaiser Family Foundation health tracking polls found that health care was a leading concern

³ Many have made this point. One columnist expressed this succinctly as: "RomneyCare=ObamaCare=NixonCare=DoleCare." Robert Dole was a Republican Senator in the 1990s. Of course, there are also important differences (Budowsky 2012).

among voters (Henry J. Kaiser Family Foundation 2007a, b, c, Starr 2013, 182). This concern likely reflects a number of serious deficiencies of the American health care system, such as uninsurance, underinsurance, and high costs. Yet, the translation of this widespread public desire for a better health care system into actual legislation, as we'll see, was powerfully molded by a number of key corporate interests and political factors.

Second, there was a consensus among the major Democratic candidates in the 2008 election that any health care reform would be not overly disrupt the health care landscape (Starr 2013, 195). Although some minor differences arose among the candidates, the common ground was clear. "At its core, theirs [the Democratic candidates'] was a plan," as Brill puts it, "any Republican or chamber of commerce lobbyist would likely love: The government would create tens of millions of new customers for all those profiting from the current system..." (Brill 2015, 18). The Republicans, meanwhile, largely abandoned the Nixon-Heritage-Romney reform structure in the 2008 election, and instead embraced a variety of "market-oriented reforms" based on such ideas as health savings accounts (Oberlander 2007).

The third point worth underscoring is that the law's passage was based on the accommodation of key corporate health interests. One strategy for health care reform (whether it could have been successful is of course unclear – no doubt the barriers would have been formidable) would have been to challenge these interests more directly, relying for support on a broad-based popular mobilization. A second strategy – and the one employed by the Obama administration – was to avoid confronting these interests by accommodating them (Waitzkin 2010, 2011, 182-186). This is how McDonough, an insider in the process, describes the process of deal-making:

Finance Committee staffers – sometimes with White House participation and sometimes without – began meetings with drug companies, insurers, hospitals, device makers, home health companies, hospices, and others to hammer out detailed concessions from each industry to pay for as much of the health reform tab as possible. All participants rejected the word *deal* to describe their deals" (McDonough 2011, 76).

While McDonough describes the "concessions" of these industries, each industry also actually had a great deal potentially to *gain* from the ACA. However, each also had the potential for *loss* that could result from a more sweeping reform. Or, as Brill puts it,

They each came offering deals – changes they would agree to that would help finance reform or otherwise further the goal of getting a reform bill passed. It was implicit, and it would gradually become explicit, that what they wanted in return was to avoid more radical reforms that would attack their bottom lines (Brill 2015, 96).

The "deals," some of which were explicit and some of which were more implicit, are well described by Brill, and can be briefly summarized. First, the essential "deal" between the administration and the health insurance industry had been agreed upon early. The industry lobby group – America's Health Insurance Plans (AHIP) – agreed that in exchange for an "individual mandate" requiring everybody to buy health insurance, it would agree and/or support a law that precluded discrimination against those who were sick (i.e. no denying coverage based on "pre-existing conditions") (Brill 2015, 52, 107-109, 186-187). The devil

was in the details – for complex reasons, the AHIP would later, in somewhat Machiavellian fashion, fund advertising against the ACA (McDonough 2011, 78-79) – but it was this basic framework that ultimately became law. A more explicit deal was reached with the drug companies (Brill 2015, 125-126), which had both much to gain and much potentially to lose from a national health reform bill. The fear was that serious reforms – i.e. allowing the government to negotiate with drug companies over pharmaceutical prices (a common practice in other countries) – would provoke the pharmaceutical industry into an unrestrained public relations assault on the bill (Starr 2013, 204-205). Ultimately, any such deep reforms were entirely avoided, and in exchange the industry actually funded \$150 million in advertising to support the passage of the law (McDonough 2011, 76). Conversely, the primary demand of progressives – a so-called “public option” insurance plan that would compete with the private insurers – was discarded (Brill 2015, 176).

The final bill required a great deal more wrangling and revisions, in part as the result of the peculiarities of the U.S. political system (McDonough 2011, 82-97). Nonetheless – and though many thought it might not actually happen – the ACA was ultimately signed into law by President Obama on March 23, 2010. It has subsequently survived two major challenges in the Supreme Court. Republican presidential candidates continue today to call for its repeal, though this seems unlikely for the time being. The majority of its provisions are now in effect. The ACA – a law with its roots in a reform tradition that can in large part be traced back to Republican Party proposals – is now, as its frequently put, the “law of the land.”

But what does it do? Is it – as many have hoped – tantamount to an achievement of long-sought “universal health care”? Unfortunately, the inclusion of a fundamental role for private health insurance in the law meant that it would, invariably, fall well short of that goal.

5. The ACA and the “Three-Legged Stool”

Rather than a provision-by-provision breakdown of the ACA, in this section of the article, we’ll briefly describe how the ACA brings the US towards what is often referred to as “universal health coverage.” Two points are worth making at the outset. First, though the ACA moves the United States in the direction of universal health “coverage,” many will still be left uncovered. But second, even if ACA-type coverage indeed became available to all US residents, the resulting system would still not be true “universal health care” (at least according to our interpretation of the term). This is because, apart from the problem of uninsurance, a variety of inequities and barriers to care are inherent in the current US system, and will persist. We argue that it would still therefore fall short of health care universalism.

Health insurance coverage in the United States, both before and after the ACA, is a private-public patchwork. Most U.S. citizens are covered by employer-provided health insurance plans, a system which has its origins in the vagaries of World War II-era wage controls and tax policies (Quadagno 2005, 49-52). A minority purchase private, “non-group” insurance plans on the individual or family

level. Additionally, Medicaid and Medicare legislation, passed in 1965, provide coverage for two large groups, certain individuals of low income and adults aged 65 and older, respectively. A variety of other programs cover smaller segments of the population. Together, however, this combination of private and public health insurance programs nonetheless leaves a substantial fraction of the nation uninsured: in 2013, before the main coverage expansion of the ACA had gone into effect, 16.7% were uninsured, up from 12.9% in 2000 (Kaiser Commission on Medicaid and the Uninsured 2015).

One way to cover these individuals would have been to enact a universal public program that covered everyone; as we have seen, this was not the road taken. Instead, the ACA increased health insurance coverage by two primary mechanisms (Kaiser Commission on Medicaid and the Uninsured 2015). First, it expanded Medicaid, a means-tested health insurance program for the poor, to a much larger number of citizens. The impact of this measure should not be understated. From 2014 onward, the Medicaid program was extended to people making 138% of the federal poverty level or less (Crowley and Golden 2014). However, the Supreme Court decided in *National Federation of Independent Business v. Sebelius* that requiring states to participate in the Medicaid expansion was unconstitutional, and so the expansion became optional at the state level (Henry J. Kaiser Family Foundation 2012). As a result, many states – 19 at the time that this was written (Henry J. Kaiser Family Foundation 2015b) – have elected not to implement the expansion, leaving many of their low income citizens without access to health care. However, Medicaid – similar to means-tested public programs in other nations – also contains several weaknesses as a lower “tier” system, as we’ll shortly discuss.

Apart from the Medicaid expansion, the Affordable Care Act sought to reduce uninsurance through the “Romneycare” private-sector mechanism discussed earlier. Essentially, everyone not covered by either their employer or by a government program would be required to purchase private health insurance. The underlying structure is frequently described by the metaphor of a “three-legged stool,” which is meant to emphasize the interdependence of the law’s three “legs”: if any single leg were to be removed, as Jonathan Gruber has argued, the law would largely cease to function. The three-legged stool, to some extent, can be thought of as a mechanism to circumvent the inherently unstable private health insurance market. Selling insurance plans as if they were any other commodity runs up against three substantial problems. First, those who need health insurance the most – the sick – are poor investments for insurers, who will either deny them policies or charge them prohibitively high premiums. Second, those who are well have an incentive, as Gruber notes, to not purchase health insurance until they become sick; this destroys the actuarial framework necessary for an insurance system. Third, many of the uninsured can simply not afford to purchase insurance at market prices, even if insurers charge the same to all, whether sick or well (Gruber 2010).

Each of these pitfalls is met by the one of the three “legs” of the ACA (Gruber 2010). The first pitfall is met by the ACA requirement that insurers not discriminate on the basis of medical condition in the sale of insurance plans. Insurers can neither decline to sell a plan to an individual with a “medical condition” nor charge him or her a higher premium because of it. The second

pitfall is met by the “individual mandate,” which, as discussed, has its roots in a conservative health care proposal. By forcing everyone to buy health insurance, the law prevents individuals from waiting until they are sick to buy insurance. The third pitfall is met by public subsidies that allow individuals of low income to purchase private health insurance. These subsidies are graded by an individual’s income; the lower the income, the higher subsidy, thereby making the purchase of private insurance plans affordable to those for whom insurance would otherwise be out of reach.⁴ Overall, the three-legged stool breathes new life into the private health insurance industry: it attempts to address the intrinsic difficulty in simultaneously treating health insurance as a market commodity while aiming to make it universal.

Other aspects of the ACA further solidify this system (Henry J. Kaiser Family Foundation 2013). For instance, the law has certain requirements for the benefit packages offered by these plans. It additionally creates online “exchanges” for individuals to shop for health insurance plans. The law also contains, like the Nixon plan, an “employer mandate.” The employer mandate, once in full effect, will require that businesses with greater than 50 workers pay a penalty if they do not provide sufficient insurance for their workers, *and* if one of their workers goes to purchase health insurance on the exchanges (Kaiser Commission on Medicaid and the Uninsured 2015). We’ll further explore some additional aspects of the law in the sections ahead, but for now will turn to the question of how this combination of provisions affects health care access in the U.S.

6. The Uninsured and the ACA

At the dawn of the ACA era, uninsurance was a severe problem. A report from the Kaiser Family Foundation gives a picture of this scene (Kaiser Commission on Medicaid and the Uninsured 2015). The first decade of the twentieth-century saw a decline in rates of insurance provided by employers, which was further exacerbated by the Great Recession of 2008. By 2013, more than 41 million US residents less than age 65 lacked health insurance. These individuals were mostly members of working families, predominantly of either low or moderate income. Levels of uninsurance varied with type of occupation, with “blue collar” workers having higher levels of uninsurance than “white collar” workers. A substantial proportion of the uninsured were living in poverty. They were disproportionately racial minorities, either black or Hispanic. However, even though those without US citizenship were much more likely to be uninsured, most of the uninsured – 80% – were in fact citizens. Finally, it is worth noting that rates of uninsurance differed substantially from state to state. Some 15 states had uninsurance rates among the nonelderly of less than 12%, whereas 16 states – concentrated in the southeast and southwest but also including California – had uninsurance rates exceeding 16%.⁵

⁴ The discussion of the “three-legged stool” in this and the paragraph draws on the article of Gruber, as cited.

⁵ We rely throughout this paragraph on the 2015 Kaiser report cited at the beginning of the paragraph. These are 2013 numbers.

A substantial portion of the United States thereby lacked access to health insurance in the early twentieth-century. Much research documents the detrimental consequences of uninsurance for individuals and families, from the perspectives of health care access and household finances (Kaiser Commission on Medicaid and the Uninsured 2015). Among those with chronic illnesses, for instance, lack of insurance translates into a lower likelihood of seeing a doctor (Wilper et al. 2008). Lack of health insurance has also been associated with increased mortality in the general population (Wilper et al. 2009). Many have placed great hope in the potential of the ACA to address this deadly problem.

However, the amelioration provided by the ACA will be partial only. Before describing some estimates, it's worth noting that there is still significant uncertainty about the ultimate effect of the ACA. As Blumenthal and Collins wrote in a description of the ACA's effects on coverage in 2014, the effect of the law cannot be reduced to a single number:

Ultimately, the success of the coverage expansions of the law will be judged by their effect on a set of variables: the numbers of uninsured Americans, the adequacy of insurance (which will perhaps best be judged by the number of people who remain underinsured), and the affordability of private coverage. It may take years, however, before we can render a considered judgment on these critical outcomes (Blumenthal and Collins 2014).

With that caveat in mind, it's worth having a glance at the estimates of the Congressional Budget Office (CBO) on the ACA's health coverage impact (Congressional Budget Office 2015). As we have described, the ACA expands health insurance through two main approaches: the expansion of Medicaid to those earning <138% of the federal poverty level, and the provision of government credits for individuals to purchase health insurance on "exchanges." By 2025, the CBO estimates that an *additional* 14 million Americans will be receiving coverage from Medicaid. It estimates that in that same year, some 22 million will purchase private health insurance plans on the "exchanges," 16 million of whom will do so using government credits. Accounting for an estimated decline in private insurance outside the exchanges, the CBO estimates that the ACA will result in a net reduction in the number of uninsured by 25 million in 2025. Thus, whereas an estimated 52 million would have been uninsured in that year *without* the ACA, it estimates that 27 million will be uninsured by that time *with* the ACA, which translates to a 10% overall uninsurance rate (excluding undocumented immigrants, that number becomes 7%). In summary, though it is tantamount to the largest expansion in health care coverage since the passage of Medicaid and Medicare in 1965, the ACA will still not achieve even the limited goal of "universal coverage."

Furthermore, it is important to emphasize that the goal of "universal coverage" is itself a limited one. The ACA expands coverage along multiple tiers, in which benefits, coverage, and access are unequal. Medicaid, which again is the means-tested system of health care for the poor, is – as the headline of one article puts it – a "[f]lawed but [b]eneficial" program (Frakt et al. 2011). There is little doubt that the program helps many. As Frakt et al. argue, the notion that Medicaid is somehow inferior to no coverage at all – as some have argued on the basis of a limited number of studies – lacks any clear scientific rationale and is belied by other studies (Frakt et al. 2011, Frakt and Carroll 2013). For instance, one notable

study found that pre-ACA Medicaid expansions in three states were associated with significantly reduced all-cause mortality (Sommers, Baicker, and Epstein 2012).

That being said, health systems specifically designated for the poor may be at increased risk of cutbacks and limitations in access, even when benefits are broad. For instance, in comparison with Medicare – a universal system relied upon by the great majority of older Americans – Medicaid reimburses providers at lower rates, a fact which likely contributes to reduced access to providers by Medicaid beneficiaries, a fact which likely explains evidence pointing to relatively inferior access to specialty care for those with Medicaid (Skinner and Mayer 2007). Other evidence similarly points to disparities in access to care based on insurance. For instance, the Medicaid programs of many states have erected barriers to access to an important new hepatitis C drug (Barua et al. 2015). Such inequalities demonstrate how universal *coverage* is by no means tantamount to the elimination of inequalities in health *care*.

7. The ACA and the Rise of Consumerist Health Care

Thus, the health care system of the United States – even with the full implementation of the ACA – is still notable for its lack of universal coverage. However, it is equally important to emphasize how the US health care system – again both before and after the ACA – impedes access in a separate way: through high cost sharing at the time of health care use, a phenomenon crassly described as giving patients “skin in the game.” The idea here is that individuals who are financially exposed to the costs of their medical care at the time of use (i.e. have “skin in the game”) will use health care more judiciously, whereas those who are fully covered (either by private insurance or the government) will be less concerned through the benefits or costs of care (Bach 2008).

First, it is important to recognize that giving patients more “skin in the game” has long been a goal of some US health care economists and policy thinkers. Timothy Jost, for instance, has described and critiqued the emergence of a “consumer-driven” health care movement in American medicine that sought to impose greater patient contribution to health care costs (Jost 2007). Exposing health care consumers to the costs of their health care, some have longed argued, helps to prevent against the utilization of unnecessary services that results from the “moral hazard” of health care that is free at time of use (Geyman 2007). This shift to an embrace of skin in the game ideology – in contradistinction to the early health care proposals of Ted Kennedy, or the health care systems of Canada, Britain, and elsewhere – might fairly be described as a “neoliberal” shift in health care thought (Gaffney 2015).

Having high exposure to out-of-pocket medical costs despite having insurance has been called “underinsurance” (Banthin and Bernard 2006, Schoen et al. 2008), and understanding this phenomenon is crucial to understanding the US health care system, and the limitations of the ACA. Preceding the ACA, the twentieth-first century saw a rise in “skin in the game” for patients. Between 1996 and 2003, for instance, Banthin and Bernard described a significant rise in the out-of-pocket

health care burden of Americans: a total of 17.1 million nonelderly individuals with insurance were underinsured in 2003, which they defined as having a “health care services burden” (not including insurance premiums) of more than 10% of disposable family income. More vulnerable groups were more likely to have high out-of-pocket financial burden to health care, including those with physical limitations and a variety of chronic medical conditions (Banthin and Bernard 2006). Another study, which used a broader definition of underinsurance, found a 60% increase in rates of underinsurance among nonelderly adults between 2003 and 2007. The consequences of underinsurance in this study included forgoing health care and having “high rates of financial stress related to medical bills” (Schoen et al. 2008). By 2010, the percent of underinsured nonelderly adults was almost double what it was in 2003 (22% vs. 12.3%) (Schoen et al. 2011). The financial impact of underinsurance, especially for poor, working class, and middle class families, can be profound. A frequently cited study, for instance, described the growing problem of “medical bankruptcy.” A majority of bankruptcies, it demonstrated, have medical causes, yet at the same time a majority of those going bankrupt are actually insured (Himmelstein et al. 2009). In addition to the financial consequences, however, high cost sharing may have deleterious health consequences, especially for the poor and chronically ill (Brook et al. 1983, Geyman 2007).

There was some hope that the ACA would reverse the trend towards rising underinsurance, with one group estimating a possible 70% reduction in underinsurance with full implementation of the law (Schoen et al. 2011). This would primarily be made possible through the subsidies provided under the ACA for private insurance premiums and cost sharing – the third “leg” of the three-legged stool discussed earlier. Such an optimistic prediction, however, seems rather unlikely, for several reasons.

First, the law does nothing to accommodate rising cost sharing – or “skin in the game” – for employer-provided health insurance, which is still the form of insurance relied upon by the majority of non-elderly Americans. This is a problem because – over the last decade – insurance plans for insured workers have increasingly included additional payments beyond annual premiums, even while workers’ proportionate contribution to insurance premiums has risen (Henry J. Kaiser Family Foundation 2015a). The ACA’s so-called Cadillac tax – an excise tax on expensive but by no means luxurious health care plans which goes into effect in 2018 – may already be encouraging employers to increase the amount of cost sharing in the insurance plans they provide to their employees (Health Policy Brief 2013).

Second, the health insurance plans offered for purchase on the exchanges were structured under the ACA to have relatively high levels of cost sharing. Such cost sharing takes a number of forms in US health care plans, including include copayments, deductibles, and coinsurance. Copayments are fixed out-of-pocket payments – paid at the time of use – for health care services like physicians visits or for prescription drugs. A deductible is the amount a patient must pay out-of-pocket for health care services over the course of a year *before* the insurer begins paying. Co-insurance is a percent of the price of a health care service that the insured must pay out-of-pocket: 30% co-insurance for a drug requires that patients

pay 30% of the price of the drug while the insurer pays the other 70%. Plans offered on the ACA exchanges frequently incorporate all three types of cost sharing (Claxton, Cox, and Rae 2015).

These exchange plans come in four main “metallic” tiers: bronze, silver, gold, and platinum. The “value” of each tier, however, is based entirely on actuarial calculations. The four tiers have 60%, 70%, 80%, and 90% actuarial values, respectively (for those with low-income, cost-sharing subsidies are available that increase these values). It’s important to emphasize, however, that these figures represent the proportion of *average* health care costs covered by insurer, based on actuarial estimations, over the course of a year for all members within a given metallic tier. Thus, for a particular individual or a family with (for example) a bronze plan, out-of-pocket payments can be higher than 40% of overall health care costs. Importantly, these actuarial values apply only to in-network benefits: families that obtain care outside of the insurance network of provider are largely unprotected (Claxton, Cox, and Rae 2015).

There are also, it’s important to point out, out-of-pocket maximums. However, these can be as high as \$6,600 for those with individual plans and \$13,200 for family plans (Claxton, Cox, and Rae 2015). (There are lower caps for those with lower incomes). Still, this leaves the potential for very high residual out-of-pocket health care costs for many. For instance, the average deductible for 2016 for a family silver plan is \$6,480, while in 2015 the average specialist copayment for those with a silver plan was \$57 (HealthPocket 2015b, a) In a sense, the structure of these plans represents a sort of triumph for so-called “consumer-directed” health care, even if they do not go explicitly by that name. Though more time is needed to accurately understand the precise effects of the ACA on underinsurance, a survey conducted in the second half of 2014 demonstrated no substantial change in underinsurance from earlier in the decade, while the percent of those with a high deductible continued to rise (Collins et al. 2015).

Underinsurance, it’s worth emphasizing, is – in the views of many – essentially an *intentional* goal. As opposed to systems where most health care services are free at point of use – as in Canadian Medicare or the British National Health Service – the United States has come to accept a “consumer-driven” model in which out-of-pocket payments, often substantial, are the norm among the insured. This reflects an embrace of a commodified vision of health care, and a rejection of an approach that treats it as a social good or human right.

8. An Age of Consolidation?

The story of health care in the ACA era would not be complete, however, without a discussion of the process of corporate consolidation that is unfolding in parallel with the changes thus far described. Consolidation is happening on several levels: “horizontally,” or between hospitals, and “vertically,” between hospitals and other types of health care facilities like physicians groups or nursing homes (Cutler and Scott Morton 2013). The result is larger, sometimes oligopolistic health care systems. Additionally, there have also been reports of moves towards consolidation in the insurance and pharmaceutical industry (Abelson 2015).

In part, these dynamics can be seen as a response to the ACA. The law, as one observer has described, “unleashed a merger frenzy, with hospitals scrambling to shore up their market positions, improve operational efficiency, and create organizations capable of managing population health” (Dafny 2014). Greater organizational size gives health systems pricing power when they come to the bargaining table with insurers. Simultaneously, however, the ACA included provisions specifically promoting the formation of “Accountable Care Organizations” (ACOs) under Medicare (Berenson and Burton 2011). ACOs are now seeing rapid growth and are quickly becoming critical – and at some point, possibly dominant – elements of the American health care landscape.

The ACO is best understood in relation to the HMO/managed care strategy, as we earlier saw advocated by Ellwood, Nixon, and Enthoven. ACOs, like the HMOs of the 1980s and 1990s, are seen as a way to lower health care costs by inducing a change in financial incentives away from a fee-for-service model that rewards the provision of *more* care towards – in theory – the provision of less expensive but still high quality care (Berenson and Burton 2011). The great unpopularity of HMOs – among both providers and patients – contributed to their retreat in the late 1990s and early 2000s. The ACO can thus be interpreted as an effort to embrace key elements of the HMO, while avoiding the shortcomings that led to its unpopularity. Berenson and Burton succinctly describe the key features of the ACO, as well as its key differences with HMOs:

ACOs consist of networks of providers that are rewarded financially if they can slow the growth in their patients’ health care spending while maintaining or improving the quality of the care they deliver. An important difference between HMOs and ACOs is that providers themselves, rather than an often distant insurance company, control the diagnosis and treatment decisions, but exercise this control under new payment incentives that encourage greater prudence in the use of health services. Furthermore ... patients retain the freedom to seek additional services from any clinician or facility at any time. And to prevent providers from inappropriately limiting patients’ access to services in order to save money, the ACO is monitored through its performance on a suite of quality measures... (Berenson and Burton 2011).

There is more than a passing similarity here to Enthoven’s, or Ellwood’s, managed care organizations; indeed, as some have argued, the points of similarity between the HMO and the ACO – and not the differences – are the more relevant fact (Himmelstein and Woolhandler 2014). Quality monitoring – an essential safeguard against the abuses of the HMO era – is, as Himmelstein and Woolhandler note, highly susceptible to gaming. Capitation, they argue, invariably leaves open the door to further skimping of care. Additionally, they note that the current dynamic towards a small number of large, powerful ACOs that are able to dominate particular regional markets is itself a problematic development. “... [A] system dominated by profit-maximizing oligopolies,” as they put it, “is a perilous route to savings.” Nonetheless, the stage is currently set for the continued growth of ACOs. Medicare legislation passed in 2015, for instance, will strongly incentivize physicians to be paid through ACOs or another “alternative payment model,” as opposed to the traditional fee-for-service model (Oberlander and Laugesen 2015, Pham et al. 2015). The private sector is likely to follow. Thus, if

current dynamics continue, it is possible that we will see a health care landscape increasingly centered on large, consolidated health care systems – either operating in parallel to large insurance companies, or maybe combining with them.

From a broader, longer-term perspective, these changes can be seen as the most recent chapter in a process of health industry consolidation and commercialization, stretching back decades. This dynamic also clearly has international reach. For instance, some have likened the NHS's Clinical Commissioning Groups (CCGs) – created by the Health and Social Care Act of 2012 – to American HMOs and ACOs (Pollock and Roderick 2015). Indeed, the British health secretary himself made the ACO comparison (Pollock and Roderick 2015). This embrace of market-based American solutions will likely have detrimental effects for nations that had previously embraced a universalist-model of health care, premised on the notion of social rights.

9. Conclusions

In this article, we have sought to place the ACA in historical and political context. As we have seen, many of the dynamics of the previous century of health care reform efforts were still at play in the early twenty-first century. The accommodation of powerful health care interests led to a health care reform in which the private health insurance industry retained a predominant position. The intrinsic contradiction of attaining a state of universal, or even near-universal coverage, through for-profit private health insurance on its own necessitated the large-scale transfer of public resources to the private sector, so as to permit the subsidized purchase of insurance plans. At the same time, the approach still required that the patients who represent the poorest investment (from the commercial perspective) be covered by the public sector – e.g. the poor by Medicaid and the elderly by Medicare. The resultant patchwork – expanded, but overall maintained, by the ACA – is nonetheless neither equitable nor efficient. As we have examined, uninsurance will continue under the ACA, while underinsurance has essentially become enshrined by the law. Still, the ACA did help millions gain access to health coverage (albeit often inadequate), reducing the overall rate of uninsurance.

A number of lessons might be drawn from the US experience for those endeavoring towards health system change (or preservation) in other nations. First, there is much to be learned from the political history of US health care reform. As we saw, the fact that a system of universal health care was never created in the US in the twentieth century reflected (in part) an adverse balance of power between constituencies that would have gained from reform and those who would have lost. The power of health care interests—first physicians, later corporate entities—outweighed that of those who supported it, like organized labor. As the balance of power between such groups evolves in other nations, attempts to roll back the scope and potency of universal health care systems should be anticipated. Second, however, we believe that the example of the ACA demonstrates the policy shortcomings of health care reform that give precedence to the prerogatives of corporate health care interests. Other nations seeking to move towards “universal

health coverage” through the subsidized provision of private health insurance plans to all (or almost all) will likely have many of the same shortcomings as the US system, including its inefficiencies, inadequacies, and injustices.

It should be noted that the ACA is by no means the only path for the US. An alternate single-payer approach to health care reform – in which the entire nation is covered under one public plan, without cost-sharing and without the for-profit provision of care – was, and is, possible (Woolhandler et al. 2003, Gaffney et al. 2016). From the health policy perspective, there is much to recommend such single-payer health care reform – administrative simplicity, substantial savings on pharmaceuticals, and the end of both uninsurance and underinsurance. The barriers to such an approach – both in the present and in the past – are, of course, political.

Moving towards such an alternative approach to health care – that is to say, transforming health care into a social right – will therefore invariably necessitate social mobilization and political change.

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