Falling Short of the International Welfare State Standard:
Obama’s Health Reform Straddles Competing American Political Traditions

Paper Presented to the International Political Science Association
Panel RC39.02: Emerging Trends in Welfare Reforms
Poznan Poland, 27 July 2016

By
William P. Brandon, PhD, MPH, CPH
Emeritus MMF Distinguished Professor of Public Policy
Department of Political Science and Public Administration
University of North Carolina Charlotte
9201 University City Blvd,
Charlotte NC 28223
wilbrand@uncc.edu;

Draft: 6/24/2016
ABSTRACT
Falling Short of the International Welfare State Standard:
Obama’s Health Reform Straddles Competing American Political Traditions

By William P. Brandon, PhD, MPH, CPH
Emeritus MMF Distinguished Professor of Public Policy
Department of Political Science and Public Administration
University of North Carolina Charlotte
9201 University City Blvd, Charlotte NC 28223
wilbrand@uncc.edu

Research Question. The Affordable Care Act (ACA), which seeks to increase Americans’ financial access to health care, reduce cost increases and improve quality, has been under continuous attack since enactment in 2010. But this complex legislation falls short of the “international standard” of the social welfare state, the most advanced democratic polity yet developed. The research explains why U.S. health reform has fallen short of twentieth century international standards. The findings are directly relevant to the Congress’ themes of politics, inequality and welfare state policies.

Analysis. Victorian jurist A.V. Dicey’s typology for understanding law and public opinion helps explain why the ACA fails to reflect the ideals of the social welfare state. Dicey dissected the nineteenth century into three successive English legal regimes: “legislative quiescence,” Benthamite individualism or liberalism (in the original European sense), and collectivism. A brief review of employment-sponsored health insurance, health exchanges, and expanded Medicaid demonstrate the applicability of Dicey’s typology to each of these three ACA foci respectively. America has 3 competing strains of political thought corresponding to the 3 legal regimes described by Dicey. The first can be identified with the Robert Nozick of Anarchy, State, and Utopia and heroes of Ayn Rand novels; the second, with mainstream equal opportunity, anti-monopoly conservatives of the CATO Institute; and American “liberalism,” with genuine welfare state programs; each matches a focus of ACA reforms. The paper closes by suggesting that the effort to meld 3 competing approaches creates practical implementation problems and continued political conflict.
By enacting the Patient Protection and Affordable Care Act of 2010 (ACA, P.L. 111-148 and 111-152) to achieve greater access to health care, Congress and the President continued the country’s pattern of exceptionalism. The Act is a complex and peculiar piece of legislation that contrasts with the models followed by other wealthy democratic states that secure the basic necessities of modern life such as health care for their residents. The ACA’s efforts to advance universal financial coverage for health care while “bending” downward the inevitably rising cost curve and nudging the health care delivery system towards further integration are buttressed with provisions and rhetoric that appeal to the continuity of long-functioning institutions, such as employment-sponsored health insurance, Medicare, and Obama’s repeated pledge that “if you like your health insurance, you can keep it.” And yet other provisions of the health reform blueprint create new institutions, such as health insurance exchanges (AKA “health insurance marketplaces” or HIM), and profoundly change others (expanded Medicaid). The outcome of this mélange is a very complex piece of legislation that has been fraught with problems. Many of these problems, it should be observed, are due to boundary problems among its several moving parts or their interaction.

The strange concoction that is the ACA cries out for explanation. Naturally, the literature on the subject is burgeoning. Thus, almost every issue of The New England Journal of Medicine and Health Affairs contains papers in which health policy analysts dissect the successes and problems of the ACA’s implementation. Social scientists as well as journalists have done yeoman’s work in explaining how Congress happened to decide on the particular configuration and its legislative history. Shifting to a different level of analysis, Republican and Tea Party opponents have been full-throated in emphasizing the weaknesses that they discern in the legislation. And the conservatives’ widely-touted intellectuals at the Cato Institute collaborated on an E-book made up mainly of anti-ACA op-ed broadsides. On the left supporters of a single-payer health reform such as Bernie Sanders in his campaign for the
Democratic nomination in 2016 have not been shy in pointing out ACA weaknesses and the superiority of single-payer plans. Some even suggest that the evident weaknesses of the ACA will lead to the adoption of single-payer as the only remaining option that can maintain and expand the ACA’s advances in expanding coverage and controlling costs.

Rather than revisiting the analysis of specific strengths and weaknesses of the Act and its implementation or the political story of enactment and subsequent rule-making, this paper steps back from the details to gain a broader perspective. It uses the resources of traditional political theory to provide a different sort of appraisal of the Obama administration’s health reform. By political theory, I mean normative political theory—the tradition that seeks to understand political structures and actions in their historical context, but without any assumptions about historicist inevitability. The reasoning is normative, but it does not seek any consequentialist ethical or moral justification to assign praise or blame to the ACA. Instead, the perspective is normative, because it uncovers specific values and traditions of thought informing different aspects of the ACA. More broadly, this paper does appraise the ACA against the mature polity which insures that residents under its jurisdiction have the necessities of life along with the personal freedom necessary to follow their individual self-directed “plan of life” (to adopt Rawls felicitous notion\(^5\)). But it seeks to understand where the Act, and through it the United States, stand in their political evolution rather than to engage in advocacy. Although I am describing a polity that is clearly an “ideal type,” this “international standard”\(^6\) is instantiated in the social welfare states that evolved in twentieth century in a number of different specific forms in the industrialized, democratic countries of Western Europe (and Japan as well as several members of the British Commonwealth). In light of the importance of the social welfare state for the argument in this paper, the analysis must begin by insuring that there is a common understanding of the concept. Clarity on the nature of the social welfare state cannot be assumed: In the 2012 presidential race American politics was overwhelmed with uninformed and self-contradictory charges that Obama is a socialist committed to transforming the U.S. into a European welfare state.\(^7\) Obviously the nature and role of the social welfare state is contested as well as misunderstood in America.
The Social Welfare State

Like other institutions, the state and the framework of practices and laws that provide the basis for legitimacy have changed dramatically over the last 500 years. At the dawn of what we now recognize as modernity in Western Europe, the chief focus of political institutions and their rulers was to monopolize force in order to suppress internal conflict (e.g., dynastic rivals, unruly barons, warlords and highwaymen) and defend its inhabitants from rapacious foreigners. Admittedly, there was little to restrain a ruler from seeking to augment his revenues and glory by using his monopoly on force to seize new territories. Over time the spread of aspirations for justice through the rule of law and ideas about consent of the governed laid the foundation of the modern state, which came no longer to be identified solely with the person of the ruler. Yet it was not until the twentieth century that this evolution produced institutional structures which could insure that residents of a state receive the necessary material and educational resources required for human flourishing, provided in a manner that preserves dignity. The ideal of polities concerned about human flourishing in an environment of freedom is perhaps best expressed in the “Universal Declaration of Human Rights” that was adopted by the UN General Assembly, 10 December 1948. Although the aspiration had existed for several centuries, its achievement in empirical political reality required the development of significant institutional infrastructure, such as uncorrupted civil service bureaucracies and near universal literacy.

The social welfare state must first of all be understood as the middle way emerging in late nineteenth and early twentieth century Europe as an alternative between unrestrained capitalism and “scientific” socialism, which developed in opposition to what it saw as capitalist appropriation of the value produced by labor. Socialism involves the state ownership and management of industry—or “the means of production” to use Marx’s rhetoric. The British National Health Service (NHS) is one of the few surviving examples of comprehensive national socialized medicine. Throughout the world it is common for states to control some industries; the specific mix of state-owned and private industries will change over time. Thus, railroads and telephone industries are or have commonly been government controlled in recent times. The immediate postwar labor government which established the NHS also nationalized the
steel industry, but that effort was not as successful as its reorganization of health services and was soon reversed. In the U.S., too, state management of services that are elsewhere in the private sector is common. In the U.S. government provision of water and sewer systems and garbage disposal is common but not universal. In Charlotte and New York, local governments own and run rail and bus systems and some local governments provide basic cable and internet services; the Tennessee Valley Authority, a federally-owned corporation, has galled private power interests since its founding in 1933. Thus, some ownership, even monopoly, of services is unobjectionable in the social welfare state. What distinguishes the welfare state from socialism is its recognition that private ownership must be the primary economic engine. Recognizing the role of capitalism goes much further than the democratic socialist’s respect for private property (which might always be nationalized if fair compensation is paid). The distinction between government’s often satisfactory record in providing public services through state-owned enterprises or government bureaucracies and success in the creation of new wealth should be noted. Socialist economies, such as those in communist Eastern Europe, failed to prosper. In addition to its shortcomings as a wealth generator, a completely socialist economy tends to discourage individual initiative by denying generous rewards for achievement. Thus, the range of diverse opportunities for individuals to make choices that they would find fulfilling is diminished.

In contrast, unrestrained or laissez-faire capitalism as approximated in the nineteenth century before government regulations began to be legislated can be characterized as “devil-take-the-hindermost” capitalism. It has no place for concern about the distribution of the products produced or wealth created, thereby eliciting the criticisms of violating norms of social justice. For most individuals the supposedly great freedom to make meaningful life choices was largely fabricated false consciousness, as socialist critics pointed out. Only individual acts of supererogatory charity by capitalism’s “winners,” that were often based as much on arbitrary whim as thoughtful study,\textsuperscript{12} moderated the harsh social effects of extreme capitalist competition. Even the great philanthropist Andrew Carnegie maintained in “Gospel of Wealth” that the only obligation of the businessman is to generate jobs, not to provide for the needs of others. Because no mechanism existed for redistributing the increasing wealth produced by
large-scale capitalistic enterprises, periodically demand would lag and overproduction plunged unregulated economies into depression. Therefore, laissez-faire capitalism was a failed political economy, not only because of its inability to serve the needs of social justice, but also because it could not create wealth without unnecessary periodic economic disruption. Thus, in the long run, it even failed to be efficient (the primary economic value).

Distinguishing the alternatives of socialism and laissez-faire capitalism has laid the groundwork for defining what makes a social welfare state. Unlike socialism, the social welfare state not only accepts but embraces capitalism, while rejecting its laissez-faire version. Capitalism in the social welfare state is, of course, regulated in the public interest including rules to forestall the development of monopolies. However, regulation, such as the factory acts starting in 1833 to protect British workers, anti-monopoly legislation and protection of consumers through oversight of food products and markets generally is not the defining characteristic of the social welfare state. In addition to controls requiring respect for the workers, consumers and the public, a welfare state levies modest but significant taxes on the fruits of capitalism and uses the revenues to assure that the basic needs of its residents are met. Typically the benefits are shared among all inhabitants; the true welfare state will largely avoid means-testing.\(^{13}\) Redistribution to the neediest (who pay little or nothing in taxes) is accomplished without means-testing in many welfare-states, because benefits— at least those involving financial transfers—are subject to progressive income taxes. Thus, some of what the state gives with its benefit hand it takes back with its tax hand. A wide tax base with greater rates on higher incomes allows taxes on the wealth produced by capitalism to avoid confiscatory rates. Social insurance programs are the signature form of social program in the welfare state program. They involve a tax whose revenues are used to pay qualifying benefits. Typical social welfare state benefits that are commonly organized as universally available social insurance are child allowances (e.g., Canada), free child care and pre-school programs, paid family leaves for family milestones, tax-supported pensions universally earned, and tax-supported universal health care systems. This ideal political economy is supported by the ethos of “solidarity,” an organizing concept that is not commonly discussed in the U.S.\(^{14}\) As Marmor, Mashaw and Harvey point out, the purpose may be less aimed at redistribution to the poor
than redistribution across the life course.\textsuperscript{15} Workers, presumably earning more than they can expect later in life, contribute to the program, but in turn they will receive pensions contributed by taxes on the earnings of future cohorts of workers. We have two excellent examples of such age-oriented social insurance programs in the U.S. in Social Security and Medicare, although Medicare has been eroded with the introduction of means-tested payments and benefits in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173).

Finally, it is important to emphasize that the full-fledged social welfare state requires the ability to manage the economy to insure economic stability and sustained government revenues. It was only with the Keynesian synthesis (including later versions, neo- post- and new Keynesian economics) allowing management of fiscal as well as monetary policy that sufficient control of the economic engine permitted the emergence of a sustained welfare state. A key to this economic breakthrough was the ability to manage consumer demand, a factor that Beveridge, writing the blueprint for postwar planning in the midst of the Britain’s existential struggle to survive, emphasized in \textit{Social Insurance and Allied Services}.

Of course, nothing guarantees that politicians and central bankers will adopt policies that accord with the best current knowledge, as Paul Krugman’s many columns in the \textit{New York Times} comparing the European Union’s continued commitment to economic austerity in the face of the manifest failure of Europe and especially Southern Europe to recover and the evidence of recovery by the U.S., which has pursued a modest stimulatory policies. And if further evidence of the failures of the alternative of planned socialist economies is required, one need only consider the creaky economies of the old Soviet Union and the socialist straitjacket from which India is still emerging.

This sketch of the social welfare state prepares us to understand how the ACA deviates from the pattern of social welfare state legislation that emerged in Europe and England in the late nineteenth and twentieth centuries. The analysis uncovers three, often competing, traditions of American political thought that are embodied in the ACA.

\textbf{Structure and Significance of the ACA}
The ACA creates 3 strata of coverage. The foundation is a public program, expanded Medicaid, which becomes a universal entitlement for low-income persons without other sources of insurance. I argued at length elsewhere that expanded Medicaid constitutes a fundamental transformation of what had previously been a categorical program into a universal entitlement with a simple qualification that is analogous to the age qualification for Social Security or Medicare in the U.S. Market-oriented opponents of the ACA suggest that government subsidies or vouchers could help such individuals purchase insurance on the private market. But the highly respected conservative economist Mark Pauley has demonstrated that the cost and likely take-up rates of a voucher program enabling this group to purchase insurance in a competitive market render that policy unfeasible. Although generally we Americans don’t like to admit it, many in this population suffer from functional illiteracy or behavioral problems that make the traditional model of consumer sovereignty a meaningless pipedream.

The second stratum is composed of the near-poor and working-class families who lack employer sponsored insurance: they will be served by the health insurance exchanges. Because an effort to allow those 55-64 to buy into Medicare was defeated in congressional consideration of the ACA, the possibility of purchasing affordable coverage on the exchanges to bridge to Medicare eligibility at 65 can also be a godsend for early retirees without retiree coverage by former employers. Moreover, many older middle-class workers who became unemployed in the Great Recession and are unlikely ever to work again need this access to affordable coverage and the federal subsidies it brings. Unlike many of those near or below the federal poverty level, the consumer model can work for this large group of Americans, if adequate government subsidies make insurance affordable and if the choices are structured in a meaningful way.

The third stratum is constituted by the long-established programs of employment-sponsored health insurance, aptly described as "private social security" by Paul Starr, and Medicare, America’s only full-fledged social health insurance program. Medicare has filled the gap that private efforts could not adequately address since 1965. Both employment-sponsored insurance and Medicare are tweaked by the ACA, but do not become a major focus
of the new legislation. The ACA does manifest concern about maintaining the institution of employment-sponsored insurance by establishing potential penalties for employers (defined as 51 or more employees) that do not offer coverage. But generous exemptions for existing plans from new standards and the unchallenged persistence of experience rating of large-employer plans (101 or more employees) demonstrate the desire not to disrupt current arrangements. Perhaps most striking, if not so widely known, is that employers are not mandated to meet the requirements of the essential benefit package that is required for individual health insurance plans purchased inside and outside HIM.\textsuperscript{19} Employers are subject to regulation requiring the provision of certain preventive benefits and coverage of children up to 26 on family plans.

Here a comparison of the ACA and Clinton’s “managed competition” proposal for health reform in September 1993 is instructive. The Clinton plan would have constituted a major legislative takeover of the heretofore private workforce coverage arrangements of larger employers. Clinton proposed a form of health insurance exchanges named Health Insurance Purchasing Cooperatives (HIPCs) and also Regional Health Alliances that would generate most of the increase in coverage. The Alliances and HIPCs played a central role in defining coverage: employers paid into them and workers received insurance from plans regulated by the HIPCs or Alliances. Indeed, it was the HIPCs that contracted with the insurer on behalf of the insured, not the employer. Employers with 75 or more employees had a straightforward mandate to fund health insurance purchases by employees or pay into a fund that would subsidize the purchase by individuals through the same exchanges. Insurance through the exchanges would be community rated, thereby equalizing the cost among high- and low-risk employer groups. Unlike the low threshold of 100 employees established by the ACA, only firms with more than 5000 employees could by-pass the public exchanges to seek the better rates attainable through experience rating.\textsuperscript{20} Thus, Clinton’s proposed exchanges would have been the source of insurance for many more individuals and firms than will buy insurance from the HIMs. Clinton’s health reforms did not call for a great expansion of Medicaid. Indeed, his health reform efforts preceded the expansion of health poverty programs in his second administration, viz., the State Children’s Health Insurance Program (SCHIP, which was part of the Balanced Budget Act of 1997, P.L. 105-33).
Clinton, following the policy proposals of an influential group of market-reform oriented economists, focused on reforming employment-sponsored insurance to leverage near universal coverage with an employer mandate to provide coverage or pay into a common pool to cover unpaid workers. In contrast, the Obama administration’s primary focus is on the individual mandate. Both exemptions in the ACA (e.g., “grandfathering in” of employer insurance already in place from provisions of the law and exclusion of employers’ coverage from the minimum benefit) and generous waivers granted in the implementation process demonstrate that twenty-first century health reform is willing to go to great lengths to maintain the existing structure of employment-sponsored health coverage. The contrast between the two most recent health reform efforts highlights the fact that the ACA represents the wholesale adoption by the pragmatic wing of the Democratic Party of formerly conservative Republican market-oriented ideas. The initiative for an individual mandate to become the basis of near-universal health insurance was generated by the very conservative Heritage Foundation to oppose the Clinton reform; it then became the basis of a bill offered in 1993 by Senator John Chafee (R-RI) that Paul Starr characterizes as “the main Republican moderate alternative.”

The two quite different approaches to incorporating employer-sponsored health coverage into health reform do share one similarity. Both Clinton’s employer mandate and Obama’s individual mandate elicited outrage from the political right about the threat to freedom. Similar widespread and well-orchestrated objections were used by small business to galvanize opposition against the employer mandate of Clinton and the ACA’s individual mandate. In fact, the National Federation of Independent Business, the lead plaintiff in the suit to declare the ACA and its individual mandate unconstitutional, led the opposition objecting to the employer mandate in the Clinton plan.

Ontogeny Recapitulates Phylogeny in a Welfare State?

This playful reference to Ernst Haeckel’s “law” is intended both to set the tone for a foray back to the nineteenth century, which countenanced bold generalizations to a greater extent than is the current fashion, and to intimate that perhaps the U.S. has maintained arrangements that have entirely disappeared elsewhere. In exploring this possibility, we seek
to rehabilitate—or at least translate into twenty-first century terms—a somewhat breathtaking conceptual framework proposed in series of lectures reflecting on legal evolution in Britain during the nineteenth.

**Three Legal Regimes.** In *Lectures on the Relation between Law and Public Opinion in England During the Nineteenth Century* delivered at Harvard Law School in 1898, A.V. Dicey suggested that legal regimes (my characterization) need to be understood in terms of the public opinion that underlies them. Although individual laws such as parliamentary reform or the repeal of the corn laws may initiate or set the tone, what I’m calling the “legal regime” is more coherent than a series of similar laws. Perhaps borrowing a late nineteenth century coinage we can think of Dicey’s view of law as the politico-legal gestalt appropriate for a specific era. It goes without saying that by “public opinion” Dicey was not thinking of the findings of survey research. He suggests that public opinion underlying a legal regime are the “beliefs or sentiments” constituted by “the wishes and ideas as to legislation held by the people of England or [more precisely]...by the majority of those citizens who have at a given moment taken an effective part in public life.” In short, “the assertion that public opinion governs legislation in a particular country, means that laws are there maintained or repealed in accordance with the opinion or wishes of its inhabitants.”

In his view in England law was fully consonant with public opinion, but this was not the case in many other countries (although at some fundamental level all governors require at least the sufferance of the governed). In the *Lectures* Dicey set himself the task in the lectures of understanding what he regarded as the remarkable changes of British public opinion and their manifestation in successive legal regimes in nineteenth century England. The changes were not due to the growth of democracy as the franchise was extended, because he saw much slower change in supposedly revolutionary France and in the U.S. (“the government of a pure democracy...[where] in no country is the expression of opinion more free”).

Dicey divides the nineteenth century into 3 distinct legal regimes. During the first 30 years of the century the legal regime was one of “legislative quiescence” in which Parliament passed few new laws and existing laws, including protectionism, were left in place. Change in the law was largely due to the work of judges building on Blackstone. His prime example was Lord
Eldon whose “strenuous and almost reactionary toryism” stayed needed changes in reaction to the events in France from 1789 to 1815. He does, however, give Eldon credit for “cautious elaboration of the doctrines of equity,” while obstructing other changes and improvements in the law.  

That legal regime fell in the 1830s to the legal critiques of Jeremy Bentham and the more encompassing changes in public opinion that he characterized as Benthamite individualism or liberalism. The dominant public opinion in the middle third of the century saw the realization of laissez faire and Adam Smith’s economics. Dicey, whose ideas were developed at Oxford in mid-century, remained devoted throughout his life to the complex of ideas constituting classical liberalism. He believed that they represented the apogee of individual liberty. Above all, liberalism affected all parts of English law and led to “constant activity” by “Parliament,...sweep[ing] away restraints on individual energy,...and exhibit[ing] a deliberate hostility to every historical anomaly or survival, which appeared to involve practical inconvenience, or in any way to place a check on individual freedom.”

Dicey uses the generic term “collectivism” for third wave, whose sway he dates from roughly 1865 to 1900. Collectivism includes socialism, but Dicey used the term to cover—and denigrate—regulation that in the twenty-first century is assumed to be the settled work of any government without regard to ideology: “laws...to regulate the conduct of trade and business in the interest of the working classes, and, as collectivists believe, for the benefit of the nation.” Unlike Bentham’s clear (if unreflective) presentation of legal reforms, he regarded collectivism as more a sentiment that “favors the intervention of the state, even at some sacrifice of individual freedom for the purpose of conferring benefit upon the mass of people.” Dicey was aware that Bentham’s utilitarian principles can start by endorsing actions that enhance individual freedom but evolve into the collectivist sentiment. He illustrated this subtle change with labor laws that in the liberal era strove to reform law in order to give the worker the same rights to compensation for a tort caused by the employer that a stranger could insist upon. But in Dicey’s view that effort became perverted into a collectivist cause in the Workmen’s Compensation Acts of 1897 and 1900, which required the employer to be responsible for any job-related damage suffered by the worker.
Dicey’s concept of collectivism is sufficiently broad to encompass the welfare state as it has developed in the twentieth century. Bismarck’s authoritarian welfare state, of course, was being developed precisely within the period when Dicey saw the rise of collectivism in Britain, although Dicey does not deal with developments on the continent. In the matter of workman’s compensation laws, for example, Hennock notes the occurrence of a common pattern: the British expansion from 1893-7 was an answer to pressure from organized labor, whereas government officials initiated the social reform in Germany 1884-1887. If the desire of autocrats for greater social stability led to the welfare state in Germany, similar results were generated by different political forces elsewhere in Europe. Increasingly assertive democratic movements in Great Britain and Scandinavia led to the acceptance of capitalist appropriation with the understanding that the state would receive an adequate share of resources to allow it to assume the social and financial risks that in Dicey’s world had resided entirely with individuals and their families. It was not until the Great Depression and the development of Keynesian theory that economics was fully joined with the assumption by the state of social and health risks.

As explained above, there is now almost universal acknowledgement that government of modern industrialized states is responsible for fostering the “general welfare,” which includes a positive role in insuring a thriving economy, assurance of the basics required for human flourishing, and a commitment to foster individual freedom and dignity. Such a democratic social welfare state is manifestly superior to the liberalism that constituted Dicey’s ideal polity. Under the social welfare state individuals who were not part of the privileged elite in mid-nineteenth century England can enjoy a wide range of opportunities for pursuit of self-chosen life plans. Since the French Revolution the social consequences of great economic and status inequality have repeatedly led to social and civil disruption.

**Dicey and the ACA.** It is natural to ask how understanding of the ACA can be aided by reference to the retrograde ideas of a long-dead British jurist that were published almost on the eve of the destruction of British social, economic and political structures by the previously unknown phenomena of world war and global depression. Little seems to be gained by labeling as “collectivist” the full-fledged welfare state found in Europe, even if Dicey had known the
English term. But one should be ambivalent about declaring the ACA an ordinary, if important, piece of welfare-state legislation. It is such peculiar legislation, as measured by the European model, that the conceptual framework provided by Dicey is useful precisely because it is so anachronistic.

As bizarre as it may seem, each of the parts of the ACA can be parsed in terms on one of the eras delineated by Dicey. Moreover, the animus towards the legislation expressed by a range of ACA opponents from ordinary Americans to highly educated right-wing pundits resonates with liberalism’s sentiments and uses much of the language that we find in Law and Public Opinion. The attacks on the mandate to purchase insurance, in particular, were expressed in terms of the fundamental rights of Americans.

After the implementation of the ACA four sources—Medicare, employment-sponsored health insurance, individual and small employer HIM-purchased coverage, and Medicaid—provide coverage for the general U.S. public. Two of these programs obviously qualify as collectivist in Dicey’s taxonomy: Medicare is a social insurance program and Medicaid is fundamentally transformed by the ACA if states choose to make it a universal entitlement. As such, it transcends its origins as a particularistic and often arbitrary charitable program.

It does not take much imagination to see the appeal of health insurance exchanges as stemming from a desire to preserve market competition and consumer sovereignty. Of course, this is the classic liberal ideal that so informed Dicey. Yet there is some irony in the fact that latter-day “neo”-liberals must use government to carefully tend the fragile plant of insurance competition in the greenhouse of a highly regulated, government-initiated health insurance exchange. Of course, the larger purpose of the exchange is to accomplish the important societal goal of securing access to health care for everyone. Vouchers have long appealed to Republicans and social conservatives, because they are believed to foster support of self-reliance and individual initiative. These same sentiments informed the “scientific philanthropy” practiced by such organizations as The London Charity Organization (founded in 1869).

If Medicare and expanded Medicaid are forms of collectivism and the health insurance exchanges reflect the spirit of Dicey’s liberalism, employment-sponsored insurance fits into Dicey’s typology as a latter-day example of legislative quiescence. A brief review of the
development of employment-sponsored health insurance supports this interpretation. It originated and grew in the absence of any government requirement to cover health care for workers and their families. Employment-based health coverage began in a small way in the 1930s as a leftish consumer movement that encouraged some progressive employers to make payroll deductions to cover hospitalization; commercial insurers did not sell health insurance, because they did not perceive that it could be profitable. During World War II wages and salaries were frozen to restrain inflation, but fringe benefits up to 5% of wages could be increased. Therefore, many wartime industries competed for labor by increasing fringe benefits, including coverage of health care. These benefits were not subject to the income tax. After the war and the defeat of universal national health insurance in the 1940s, labor unions decided to make health benefits a major issue in collective bargaining with employers. A Supreme Court case (Inland Steel) confirmed that under the statute health insurance fell within “conditions of employment” that were legitimate issues for collective bargaining between employers and labor unions.38

Thus, private nonprofits such as charitable hospitals, unions, and nonprofit Blue Cross pioneered in developing insurance. During and after the war regulatory and legal interpretations reinforced it. Even the labor legislation (the National Labor Relations Act of 1935, aka The Wagner Act, and the Taft-Hartley Labor Act of 1947) never mentioned health: the vague phrase “wages and conditions of employment” was left to lawyers and judges to define. Although Congress has generated a great deal of legislation in other areas, in controlling employment-sponsored health insurance federal law-making has been inactive. Prior to penalties imposed by the ACA no statute required employers to provide health insurance. What binds most large employers, however, is labor contracts freely arrived at—according to the liberal theory—between worker and employer. The principal federal statute bearing on health insurance, the Employee Retirement Income Security Act of 1974 (ERISA, P.L. 93-406), preempts state regulation of employers’ fringe benefits relating to health. But unlike provisions reforming employer pensions, Congress had not introduced any systematic legislation relating to employment provision of health coverage as a fringe benefit prior to the ACA. Indeed, ERISA’s chief effect on health care coverage has been to prohibit states from
regulating employers’ fringe benefits. These brief observations should be sufficient to justify considering the ACA provisions that reinforce employment-sponsored coverage as accommodating developments taking place independently of non-judicial policy-making.

Informing the three approaches to health coverage combined in the ACA lie three competing streams of political thought. The private contracts and legal disputes that largely govern employment-sponsored coverage is the approach taken by proponents of the minimalist state such as Robert Nozick or the characters in Ayn Rand novels. This constricted view of government regards health care and other social services as beyond the proper role of any legitimate government, because government provision is destructive of self-reliance and excessively consumptive of tax revenue and therefore confiscatory. The classical liberal ideal is embodied in the HIM where individuals making choices among insurers is supposed to reward high quality providers and competition among many purveyors of insurance controls prices. The conservative idea of using vouchers or tax credits to enable beneficiaries to choose, the chief innovation in the ACA, has long been a Republican solution for health care access and other social and educational programs until Democrats adopted it in the ACA. (Vouchers are regarded as a way to realize greater equality of opportunity without disrupting markets or interfering with regulations.) Finally, social insurance, the principal mechanism of the social welfare state, is represented in the ACA by expanded Medicaid. That component of the ACA transformed the categorical charity program into a universal entitlement (in those states choosing to expand Medicaid) where it joins the other U.S. social welfare programs, Social Security and Medicare.

The broad conclusion is that the ACA is very peculiar legislation that combines quite different elements. Each of these components is designed to play an important functional role in expanding health care coverage among legal U.S. residents; these are not vestigial remnants of an earlier time, to return to the biological trope. The imperatives of practical politics may have led the administration and congressional leaders to pull together components that seemed most pleasing—or, more likely, least displeasing—to one or another of the political decision-makers. However, the practical cost of combining disparate approaches to coverage, each imbued with the spirit of a different political tradition, is that the different “moving parts”
of the ACA chafe against each other. For example, boundary problems have already been created by prohibiting individuals (with the ironic exception of legal aliens) below the poverty level in non-Medicaid expansion states from purchasing coverage in HIM and restrictions denying subsidies for the purchase of HIM insurance by low income dependents of workers whose employer offers family coverage but does not pay for dependents.

Although arguably a political necessity, the complex mixture that is the ACA hardly inspires anyone. Well, to be accurate, it has clearly incensed many opponents. Perhaps proving the superiority of programs based on single coherent political perspectives is best demonstrated by the career of Social Security. When legislated in 1935, it was extremely controversial and the rhetoric of its many opponents was quite as heated as that generated by the ACA. However, within only a few years it had become such a generally accepted part of the American polity that no serious politician could question it. Clearly, the ACA proponents have been counting on such an outcome. In fairness, it must be admitted that Obama and the Democratic congressional leadership finally accomplished a legislative goal that legions of others over a century have attempted but failed to achieve.

Conclusion

Perhaps the ACA does constitute a social welfare-state achievement of a peculiarly American and flawed form. Perhaps it falls so far short of the ideal that it is misleading to regard it as social welfare state legislation. What this analysis shows is that the mismatched parts of this jerrybuilt health reform are inspired with different political theories and are likely to continue coming into conflict in what I have called “boundary problems.” Structure, whether in architecture or the social sciences, is important. It would be unfortunate if the authors and proponents of this legislation, having prevailed after a century of failure, should have achieved a structure which is so full of internal contradictions and challenges that it cannot be sustained.

The differences between the “international standard” of the most advanced welfare states and the ACA does make one ask why does America continuously attempt to achieve social and political ends in ways that differ from other advanced industrial countries. The specific issues of health policy, then, point to the larger general problem of American exceptionalism.
Endnotes

1 Another example of innovation in the ACA is that it established America’s first general, publically supported long-term care program. Title XXXII, The Community Living Assistance Services and Support Act (CLASS) was abandoned as unfeasible by the administration and subsequently repealed by Congress.


6 I have borrowed the term from Joseph White.


8 Although “welfare state” is the common term in the discourse of social scientists, I add the prefix “social” in an effort to overcome the ambiguity created by the fact that welfare in the U.S. is a poorly funded means-tested income maintenance program for those among the poor who can show that they have some sympathetic characteristic (such as children in the home, blindness, or old age) that makes them deserving. Negative perceptions of this program infuse the word “welfare” with pejorative overtones for most Americans. By employing “social” before welfare state, I hope to soften this potential negative response and draw upon American’s positive experience with social insurance in the Social Security and Medicare programs. Social insurance, as will be pointed out in the next section, is the signature type of program of the social welfare state.

9 Machiavelli’s Prince is, of course, the textbook for those who aspired to rule such primitive, almost pre-modern states.


11 “Scientific” is the turn used by Marxists to distinguish their understanding of the necessity of class struggle in industrialized societies from the “utopian socialists” of the early nineteenth century who fail to see the role of class struggle. See, for example, Karl Marx and Friedrich Engels, “Manefesto of the Communist Party,” Marx and Engels: Basic Writings on Politics and Philosophy edited by Lewis S. Feuer (Garden City NY: Anchor Books, 1959), pp.1-41.

12 Significantly, John D. Rockefeller, who was unsystematic in his giving in his early years, found the results unsatisfying and the importing of those seeking help bothersome. His solution was to hire Fredrick Taylor Gates, a successful Protestant pastor and educator in Minnesota, as his philanthropic advisor. Gates, a systematic thinker and organizer, devoted the rest of his life to the Rockefeller philanthropic efforts. He was responsible for much of the success of Rockefeller’s philanthropic agenda. Frederick Taylor Gates, Chapters in My Life (New York NY: Free Press, 1977).
13 The most famous blueprint of the welfare state is contained in the wartime study by Sir William Beveridge, Social Insurance and Allied Services (New York NY: Macmillan, 1942). It is explicit in recognizing the need for what we would now call categorical programs and for means-testing for individuals and families for whom the benefits of social insurance are not sufficient. However, his emphasis is on programs of social insurance.

14 Perhaps its greatest prominence in America is in songs from the first half of the last century that celebrated union organizing.


16 Brandon, “Medicaid Transformed.”


19 Patient Protections and Affordable Care Act (P.L. 111-148), sec.2076 (see also sections 1301 and 1302(b)(1)(A)). See also N.C. Institute of Medicine President and CEO Pam Silberman, JD, DrPH, “The Impact of the Affordable Care Act on North Carolina,” Address to Medlink Access to Care, Charlotte NC, 26 February 2013, PowerPoint Slide 26.

20 Brandon and Carnes, “Health Insurance Marketplaces.”

21 The proposals and role of economist Alain Enthoven, Paul Ellwood, MD, who popularized the “health maintenance organization” and others associated with the Jackson Hole (Wyoming) group is discussed by Starr, Remedy and Reaction, Chap. 3 and 4.


24 A. V. Dicey, Lectures on the Relation between Law and Public Opinion in England During the Nineteenth Century, 2d edition (London: Macmillan, 1914) reprinted by AMS Press (New York: 1978). Although the lectures were delivered in 1898, the first edition was published by Macmillan in 1905. “Legal regime” is my term to try to capture the idea of set or complex of laws in a way that differs from our normal use of jurisprudential schools or legal theories. It would be tempting to call Dicey’s use of “law” the “spirit” of the laws, except Montesquieu has preempted that phrase for quite different purposes.


26 Ibid., p. 7.


28 Dicey, Law and Public Opinion, pp. 63, 8.

29 Cosgrove, The Rule of Law.

30 Dicey, Law and Public Opinion, pp. 63-64, see also Lecture VI, pp. 126-210. Much of this rhetoric will sound quite modern to American readers of material generated by the Cato Institute. Some of these modern libertarians even concur in the attack on evils embedded in the law from previous ages. For example, some of
their issue briefs attack laws prohibiting recreational drug use and restricting marriage to heterosexual relationships.

31 Ibid., pp. 64-68.
32 Ibid., pp. 65-69. Dicey has been criticized for overlooking the way that Benthamite principles support collectivism, but this example demonstrates his awareness of their possible extension or reinterpretation. In Rule of Law Cosgrove claims that this criticism of Dicey is unfair. Interestingly, Sabine recognizes the individualism of Bentham as a cornerstone of liberalism, but also finds the evolution of communitarian implications within utilitarian principles. He regards John Stuart Mill, who had a foot in both camps, to be the turning point to this second phase. George H. Sabine, A History of Political Theory, 3d edition (New York: Holt, Rinehart and Winston, 1961), pp.673-674.


35 Before the Supreme Court spoke, the civic discourse (if that’s what it was) almost seemed to assume that our right not to buy insurance was a fundamental right equivalent to that of our inalienable right to buy as many guns and accompanying ammo as our credit cards allow.

36 Brandon, “Medicaid Transformed.”


38 Starr, Social Transformation of American Medicine.