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Among the many promises of Barack Obama's 2008 election campaign was a thorough reform of U.S. healthcare. The radical inefficiency of the existing system was obvious: although per-capita healthcare costs were about twice as high as in other industrialized countries, at least forty-six million people still lacked health insurance and forty-five thousand died each year as a result.¹

The 2010 Patient Protection and Affordable Care Act ("Obamacare") will not solve these problems. The reform does contain some positive elements, most notably its subsidies to low-income individuals, the extension of children's insurance to age twenty-six (assuming their parents are already insured), and the ban on insurance companies denying coverage based on pre-existing conditions. But these improvements are embedded in a structure that preserves and consolidates a fundamentally flawed system administered by private insurance corporations and populated by virtually unregulated for-profit providers.

The crux of the reform is the "individual mandate" requiring everyone to purchase insurance from private companies or pay a fine, a model that is far removed from a system of genuine universal healthcare in which progressive taxation funds a government-administered, single-payer insurance plan. This latter option, often called "Medicare for All," was never even considered by Congress or the administration, despite being far more efficient and humane than the alternatives.² Even a non-compulsory government-run insurance program (the "public option") was never seriously entertained in the Senate.

Here we analyze the healthcare reform as an illustration of the embeddedness of large corporations in U.S. policymaking. The affected industries were centrally involved in the process from the start, guaranteeing that their interests would receive priority, while public opinion and human rights considerations mattered little. The creation of Obamacare offers a lens through which to understand how and why the government embraces the class interests of the corporate elite.³ Yet the state is not just an instrument of domination; it is also a site of struggle. After reviewing the reform process, we offer some strategic propositions for the Medicare for All movement.

Public Opinion

Most press coverage of Obamacare has asserted a deep ambivalence among the U.S. public. Yet commentators have tended to ignore the *reasons* for the public's lack of enthusiasm. In a January 2010 CBS poll, for instance, 54 percent disapproved of Obama's "handling of health care reform," but large pluralities said the legislation did not go "far enough" in "covering Americans" (35 percent), "controlling costs" (39 percent), and "regulating health insurance companies" (43 percent). Far fewer (32, 24, and 27 percent, respectively) thought the reforms went "too far." Approval ratings for Congressional Republicans, who did not conceal their contempt for working people and the uninsured, were even lower than for Obama and the Democrats.⁴

Many people who were wary of Obama's legislation would have supported a single-payer, universal health insurance program, particularly if it were presented as "Medicare for All." In polls spanning decades, a majority of the U.S. public has consistently expressed a preference for this sort of program, with a *vast* majority agreeing that the government should guarantee access to healthcare for everyone in the country.⁵ In a poll just before the 2008 election, 77 percent of all people (and even 57 percent of those who planned to vote for Republican John McCain) agreed that the government "should be responsible for ensuring" that everyone's "basic need for healthcare" is met.⁶ In other words, most of the public was far more progressive than both the Republican Party and the mainstream of the Democratic Party.

While public opinion may have played some role in getting healthcare reform on the policy agenda, it was marginal to the policymaking process itself.

These figures refute the common assertion that the public will drive healthcare policy.⁷ While public opinion may have played some role in getting healthcare reform on the policy *agenda*, it was marginal to the policymaking process itself.⁸

The Shaping of the Reform

Several factors likely contributed to the Obama administration's decision to pursue healthcare reform in early 2009: the concern of business sectors over ever-rising healthcare costs, health insurers' apprehension about the broader financial crisis, the intense public concern about healthcare, and Obama's desire to deliver on a key campaign promise (and thus bolster his reelection chances and legacy).⁹ The exact weight of each of these factors in the administration's initial decision is not entirely clear.

The subsequent process by which the reform was shaped is much clearer: the administration

invited the key corporate power holders into the policymaking process from the beginning. In the words of White House communications director Dan Pfeiffer, the Obama strategy was to "bring every stakeholder to the table."¹⁰ Journalist Ryan Lizza makes clear that "stakeholder" referred to capitalist interests and not the general public, noting, for example, that Obama "sent his toughest political operatives—like Rahm Emanuel and Jim Messina—to cut deals with the pharmaceutical industry and hospitals."¹¹

One major agreement that derived from this process of negotiation promised the health insurance industry tens of millions of new customers, who would be forced by the law to buy plans from private insurers. In exchange, the industry agreed to provide coverage to patients with pre-existing conditions.¹² In another major negotiation, administration operatives and Democratic Senator Max Baucus (Chair of the Senate Finance Committee) gained assent from the Pharmaceutical Research and Manufacturers of America (PhRMA) to the proposed law by renouncing the government's power to negotiate drug prices and import lower-cost drugs.¹³

The final product was generally deemed "a good deal" by industry insiders (the opinion of the senior vice president of PhRMA, which actually bought ads supporting the bill).¹⁴ Except for the five biggest private insurers (Aetna, Cigna, Humana, UnitedHealth, and WellPoint), most major players in the healthcare industry supported the reform or at least did not actively oppose it. This assent from the industry—a reversal of its decades of vigorous opposition—resulted from the shaping of the reform into a familiar form of corporate welfare: "a big injection of public subsidy to expand the overall size of the U.S. healthcare market," as the *Financial Times* noted.¹⁵

The corporate welfare aspect of the bill can be clearly seen in the negotiations with America's Health Insurance Plans (AHIP), the main health insurers' lobbying organization. Though AHIP never formally endorsed the bill, it agreed to the basic framework and did not mobilize its legislative weight against it. The law's central component—the individual mandate in exchange for "no pre-existing condition exclusions"—was precisely what AHIP and the right-wing Heritage Foundation had previously

proposed, and which had been enacted (with their consent) in Massachusetts under Republican Governor Mitt Romney.¹⁶ This provision, in tandem with government subsidies for low-income consumers, would assure a huge infusion of profits into the health insurance industry, especially since consumers were given no robust “public option.” To replace the public option, yet another government subsidy was added to the legislation: the creation of government-financed exchanges that directed consumers to private insurance, without the insurers paying for the service.¹⁷

The insurance industry also shaped many additional details of the legislation. Using their influence within the Senate Finance Committee, insurers substantially reduced the share of medical costs they would have been required to cover under earlier proposals.¹⁸ A final feature of Obamacare negotiated by AHIP was the virtual abandonment of government rate regulation, which is normally integral to government-subsidized services. The loose price regulations in the final legislation—cost containment will be essentially “voluntary”—were another result of the process of bringing “every [corporate] stakeholder to the table.”¹⁹

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With genuine cost containment forsaken, contention during the legislative process came to center around who was going to pay for the cost increases (which are largely *profit* increases for the healthcare industry). It was in this context that Obama administration political operatives sought to answer the demand of large corporate employers for control of health insurance costs. Two elements in the legislation were designed to transfer employer costs to their workers. First, the non-profit, multi-employer insurance plans that currently cover twenty million union workers (many of whom are temporary or seasonal) will be denied access to the

subsidies available to non-union employers on the new healthcare exchanges; Obamacare thereby creates an incentive for employers to withdraw from these non-profit plans and force their workers into for-profit plans run by private insurance companies, for which subsidies *are* available. The non-profit plans that might have been extended to cover the whole population are thus undermined by Obamacare.²⁰ Second, the law will levy a special tax on the higher-premium (and often higher-quality) insurance plans vilified as “Cadillac” plans by politicians. Starting in 2018, the increased tax will give employers an excuse “for cuts [in coverage] they wanted to implement anyway” as well as a strong incentive “to dump more costs onto workers by offering lower-premium, higher-deductible” (and higher co-pay) plans, writes Jenny Brown of *Labor Notes*.²¹ Obama personally intervened to preserve this tax in January 2010, viewing it as an alternative to increasing taxes on the rich.²²

Obamacare creates an incentive for employers to withdraw from non-profit plans and force their workers into for-profit plans.

Throughout the shaping of the law, the Obama administration and Congressional leaders sought to construct legislation that answered the needs of the key “stakeholders,” meaning the corporate interests involved in or concerned with healthcare. Faced with considerable conflicts among health insurers, pharmaceuticals, hospitals, non-health industries, and other key players, the Obama administration sought to answer the pressing concerns of each, arriving, in the end, with legislation that served the collective interest of the capitalist class.

Implementation as Class Struggle

The implementation phase of policymaking is often just as important as the legislative phase. Choices by the Executive branch (and in some cases Congress) will determine the on-the-ground workings of the law and help decide who will pay the rising costs of healthcare.

Since 2010, the corporate world has been able to utilize its embeddedness within government to win most of these battles.²³ Consider, for example, the failure of lobbying from organized labor and other activists for temporary reprieve from Obamacare penalties, which contrasts sharply with the more accommodating posture toward the petitions of the corporate elite. Noteworthy examples of this class bias have included the granting of a one-year delay for major employers to insure all their workers—a concession worth \$10 billion to the affected corporations—and a two-year delay before the dialysis drug Sensipar is subject to Medicare price controls, which will transfer about \$500 million to biotechnology giant Amgen.²⁴

This pattern of accommodation highlights the importance of the implementation phase of policymaking as an arena of unending class struggle, with powerful “stakeholders” most frequently winning the battles over the application of the laws passed by Congress. Those stakeholders have usually been corporate elites, but ordinary people can become stakeholders, too—a point to which we return later.

Mechanisms of Corporate Influence

The example of healthcare reform challenges theories that stress the responsiveness of the U.S. state to its citizens²⁵ as well as arguments questioning corporate elites’ ability to work collectively to influence policy.²⁶ The process sheds light on the means by which powerful corporate actors shape state policy. Corporate influence derives from a host of mechanisms, many of which are familiar:

- *Campaign finance*: The key players in the crafting of Obamacare were largely dependent upon health industry corporations for election and re-election. Barack Obama received \$22.4 million in 2008, and the health sector was his third-most-important source of corporate donors (health industry donations alone were thirty-two times greater than *all* labor union contributions to Obama). The twenty-three members of the Senate

Finance Committee (SFC) received nearly \$16 million in 2008 and \$20 million in 2010. Since 2003, the Committee’s Chair, Max Baucus, had received \$3.4 million, or 23 percent of his total campaign donations; the minority leader, Republican Charles Grassley, had received \$2 million. Committee members’ opposition to a “public option” that would compete with private insurers tended to correlate with donations from the health industry over the previous two decades.²⁷ The structure of the electoral process thus guaranteed the presence of health industry loyalists in key Congressional offices.

- *Lobbying*: The healthcare industry spends more money on lobbying than any other, including nearly \$1 million a day on lobbying and campaign contributions during the 2009 debate.²⁸ Many elements of the legislation were written directly by lobbyists.

Many elements of Obamacare were written directly by healthcare industry lobbyists.

- *Politicians’ stock holdings*: According to a 2009 report, “Almost 30 key lawmakers” involved in drafting the legislation “have financial holdings in the industry, totaling nearly \$11 million worth of personal investments.” Then-SFC member John Kerry (D-MA) and his wife held “at least \$5.2 million in companies such as Merck and Eli Lilly.”²⁹ The personal interest of key policymakers thus lay in safeguarding and increasing the profits of healthcare corporations.
- *Personnel transfers*: The SFC, and Max Baucus’s office in particular, exemplified the personnel transfer or “revolving door” between government and industry (Table 1). The most blatant example was Elizabeth Fowler—who, as Senior Counsel to the Committee, was the key professional involved on the government side. Fowler was previously a vice president at WellPoint, one of the nation’s largest

Table I. The Revolving Door: Senator Max Baucus' (D-MT) Ties to Healthcare Industry (Partial List).

Name	Position	Ties to health industry	Notes
Max Baucus	Chair of Senate Finance Committee (SFC)	Received \$253k in industry donations in 2007-2010, plus \$201k in donations from industry lobbyists in 2007-2009	Three of five top donors in 2007-2012 were healthcare or health insurance firms
Elizabeth Fowler	Top aide to Baucus, Senior Counsel to SFC, 2008-2010; previously Chief Health and Entitlements Counsel for SFC, 2001-2005	Vice president for Public Policy and External Affairs, WellPoint Insurance Co., 2006-2008	Helped write healthcare reform bill passed by Senate in March 2010; hired by Obama in July 2010 as Deputy Director of Office of Consumer Information and Oversight at HHS; later hired by Johnson & Johnson
Michelle Easton	Chief Health and Entitlements Counsel for SFC, 2005-2008	Former vice president at PhRMA; since 2008, lobbyist representing over a dozen health firms	
Jeff Forbes	Chief of Staff for Baucus, 1999-2002; Staff Director for SFC, 2002-2003	Lobbyist for HCR Manor Care PAC, 2007-2012, and for lobbying firm hired by PhRMA, Merck, HCR Manor Care, and other health industry firms, 2004-present	
Scott Parven	Chief International Trade Counsel for Baucus, 2003-2006	Director of Int'l Public Policy for Aetna insurance, 1998-2006; lobbyist for Pfizer, PhRMA, eHealth Inc., and other health industry firms	

Source. Center for Responsive Politics (www.opensecrets.org); Glenn Greenwald, "The Revolving Door Spins Faster on Healthcare Reform," *Salon.com*, July 15, 2010, available at www.salon.com/2010/07/15/fowler_4; Fraser, "The Affordable Care Attack," 98.

private health insurance corporations. After the reform became law, she was appointed by President Obama to oversee its implementation. The career of Fowler—and many other key players—involved moving back and forth between government service and the healthcare industry.

In addition to these familiar mechanisms of corporate influence, there is also a less-talked-about *structural* reason for the government's compliance with capitalist interests. Corporate influence does not always require direct colonization of the state or overt bribes like campaign contributions; capitalists also exercise power

by virtue of their structural control over the economy on which the state is dependent and through the structural constraints imposed by government institutions themselves, which have been shaped by past corporate influence in ways that limit the freedom of individual politicians. Comprising 18 percent of national gross domestic product (GDP), and linked to many other industries through interlocking boards of directors and other ties, health industry corporations contribute a substantial portion of the tax base on which the government relies for its revenues. They also employ large numbers of constituents and collect taxes from their workers on behalf of the government. In effect, then,

the state is dependent upon both the profit levels and the economic trajectory of the corporate world. Politicians must pursue policies that guarantee profits, even when such policies undermine the overall well-being of the population or the economy as a whole. U.S. healthcare firms thereby wield incredible power quite apart from the more visible mechanisms of influence identified above.³⁰

All these factors contributed to the accommodationist approach (to corporate interests) of the Obama administration and Congressional Democrats. Politicians do have individual and collective discretion, and it is often their personal interests and commitments that lead them to favor capitalist interests. Even when they are personally committed to progressive or anti-corporate policies, however, the political structure and process may preclude such initiatives. Having different politicians in Congress or having a more aggressive, more progressive president in the White House could have made some difference, but even a Ralph Nader would have been subject to many of the same constraints.

Medicare for All: What Will It Take?

The extent of corporate embeddedness in the policymaking process has important implications for movement strategy. Since politicians are not actually the main authors of policy, targeting politicians may not be the most effective way to change state policy. We instead propose that, given the political power of corporations, the most effective strategy for influencing state policy is to threaten those corporations directly. Doing so can mitigate their opposition to reform, or even—if the threat is great enough—compel them to support it.³¹

The dismal results of healthcare reform show that the entire process of legislation and implementation needs dramatic, revolutionary overhaul. But in the absence of such structural change, substantial segments of the corporate leadership will have to come around to the idea of single payer before it can happen. In the current U.S. context, any progressive reform that stands to negatively affect key business stakeholders will fail unless its advocates can find a way to compel

support for the reform among major segments of the corporate elite, either in the affected industries or elsewhere. In our view, movement energies are thus best spent targeting not politicians but rather the real power holders in the political process: the corporate elite, or—more broadly—the capitalist class. The goal of the single-payer movement should be to increase the financial pressure on corporations to the point that they go to the politicians and *demand* single payer.

Movement energies are best spent targeting not politicians but rather the real power holders in the political process: the corporate elite.

This indirect path to government policy change has been essential to some of the most important reform struggles in U.S. history. The 1935 Wagner Act guaranteeing private-sector workers the right to unionize was only implemented after workers' agitation threatened employers to the point that they embraced union representation as a "lesser evil" compared to workplace disruption. Similarly, the economic damage that black activists inflicted on segregated businesses was arguably a prerequisite for the enactment and implementation of civil rights reforms in the 1960s. In both cases, activists changed state policy not so much by targeting politicians but by targeting economic power holders, who reluctantly accepted the changes desired by the activists as a lesser evil option, and then instructed their political representatives to do the same.³²

With regard to healthcare, we have no magic-bullet strategy to offer but would propose that the single-payer movement focus on building labor-community alliances that can force corporations to absorb more of the costs of healthcare. If they are forced to bear these costs, employers outside the healthcare industry may decide to use their political influence on behalf of single payer. There are any number of reasons why non-health-industry CEOs have not already embraced single payer: their ties to the healthcare industry, the desire to maintain a powerful bargaining chip vis-à-vis their workers, the desire for leverage over the unemployed, and perhaps in some cases ignorance or lack of

long-term vision. But at some point employers—if their healthcare costs continue to spiral upward—could decide that the benefits of single payer outweigh the costs. Employers today are increasingly worried about healthcare prices, meaning that an obstreperous movement that forces them to bear more of those costs could help tip their cost-benefit scales toward the single-payer option.³³ Workers inside the healthcare industry—which still has relatively high unionization rates—could also play an important role. By shifting more costs onto their employers (hospitals, clinics, nursing homes, etc.), they may be able to turn these sectors of the industry against the health insurers.

Historically, there is a strong positive correlation between the strength of labor in a given country and that country's establishment of national health insurance and other social welfare measures.³⁴ Though weaker than in most industrialized countries, U.S. labor unions have been a major force advancing the interests of the entire working class, not just their members. Sometimes they help the broader working class even without trying, by increasing wages and benefits across the economy and impelling employers to embrace government social programs. They have been most effective, however, when they have deliberately fought on behalf of the broader working class and other oppressed populations.³⁵

Hundreds of U.S. union locals, twenty-two internationals, and even the AFL-CIO have endorsed single payer. However, the level of commitment to the cause varies widely among them, and many of those same unions were also enthusiastic promoters of the Obamacare legislation.³⁶ This disjunction reflects an insularity of vision, reinforced no doubt by many unions' accustomedness to their own employer-based health plans. It also reflects most unions' continued attachment to a strategy of building relationships with Democratic politicians and avoiding confrontation with employers. But unions can change, both through internal revitalization and through the healthy influence of other mass movements.³⁷ Non-union, community-based organizations can play a key role in this struggle by organizing non-unionized workers and articulating a bold, progressive agenda

that pulls unions to the left. Vibrant grassroots groups like the Vermont Workers' Center and Healthcare-NOW! have been leaders in this regard, most notably in Vermont but in many other states as well.

In addition to increasing the financial pressure on employers, a revitalized labor movement could simultaneously help to mobilize the broader public around the single-payer agenda. Unions like National Nurses United and professional organizations like Physicians for a National Health Program have been at the forefront of the single-payer movement, helping to educate union and non-union workers alike about the benefits of single payer. A coherent progressive counter-narrative and labor-community solidarity are both crucial, for the elite targets of agitation will inevitably respond to increased financial pressure by blaming workers and the poor and seeking to pit the non-unionized against the unionized.

A successful strategy in this case depends upon building grassroots power while exploiting the vulnerabilities and inner divisions of the corporate elite. A confrontational movement structured around labor-community alliances and oriented toward the needs of the entire working class (nationally and globally) could greatly accelerate the tipping of corporate leaders' cost-benefit scales and, by extension, the achievement of a civilized healthcare system.

Notes

1. Andrew P. Wilper, Steffie Woolhandler, Karen E. Lasser, Danny McCormick, David H. Bohr, and David U. Himmelstein, "Health Insurance and Mortality in U.S. Adults," *American Journal of Public Health* 99, no. 12 (2009): 2289-95. On costs see the Center for Economic and Policy Research, "Health Care Budget

- Deficit Calculator,” available at www.cepr.net/calculators/hc/hc-calculator.html.
2. Steffie Woolhandler, Terry Campbell, and David U. Himmelstein, “Costs of Health Care Administration in the United States and Canada,” *New England Journal of Medicine* 349, no. 8 (2003): 768-75.
 3. State policy is also influenced by other logics of domination (racism, heterosexism, etc.), as the history of U.S. social policy makes very clear. Our focus here is on capitalist class influence, but a full analysis of Obamacare would have to assess the ways that these other, overlapping logics also help determine the policy and the effects on the population. On the historic importance of race and gender in shaping U.S. health policy and debates, see Colin Gordon, *Dead on Arrival: The Politics of Health Care in Twentieth-Century America* (Princeton: Princeton University Press, 2003), 78-82, 153-57, 172-209.
 4. CBS News, “The President, Health Care and Terrorism,” January 11, 2010, available at http://www.cbsnews.com/htdocs/pdf/poll_obama_011110.pdf?tag=contentMain;contentBody.
 5. See Western PA Coalition for Single-Payer Healthcare, “Poll Results on Single-Payer,” updated 2013, available at <http://wpsinglepayer.org/learn-about-single-payer/poll-results-on-single-payer>; Benjamin I. Page and Lawrence R. Jacobs, *Class War? What Americans Really Think about Economic Inequality* (Chicago: University of Chicago Press, 2009), 65-67, 83.
 6. WorldPublicOpinion.org, “Obama, McCain Supporters Agree Government Responsible for Ensuring Basic Healthcare, Food, and Education Needs,” October 13, 2008, available at <http://www.worldpublicopinion.org/pipa/articles/brunitedstatescanadara/553.php?lb=brusc&pnt=553&nid=&id=>.
 7. One journalist inexplicably asserts that “the obligation to the uninsured and uninsurable didn’t poll well”—but “it weighed on Obama” (Jonathan Alter, *The Promise: President Obama, Year One* [New York: Simon & Schuster, 2010], 247). See also Paul Starr, *Remedy and Reaction: The Peculiar American Struggle over Health Care Reform* (New Haven: Yale University Press, 2011), 1-24, 177, 180-81, 220.
 8. Polls were significant mainly in that they helped politicians sell their chosen policies to their constituencies. Obama’s chief pollster Joel Benenson hinted as much in a 2009 comment on the health care debate, saying that “the more we know about [the] underlying values and attitudes” of the public, “the more we can fine-tune a message” (quoted in Michael D. Shear, “Polling Helps Obama Frame Message in Health-Care Debate,” *The Washington Post*, July 31, 2009, A10). See also Lawrence R. Jacobs and Robert Y. Shapiro, *Politicians Don’t Pander: Political Manipulation and the Loss of Democratic Responsiveness* (Chicago: University of Chicago Press, 2000).
 9. Obama reportedly defied some advisers in pursuing health care reform this early in his administration (Starr, *Remedy and Reaction*, 196-201).
 10. Quoted in Peter Baker, “Obama Pushed by Drug Lobby, E-mails Suggest,” *The New York Times*, June 9, 2012, A1.
 11. “As the World Burns,” *The New Yorker*, October 11, 2010, 76. See also Starr, *Remedy and Reaction*, 174-238.
 12. As we note below, this latter provision, one of the positive elements in Obamacare, was not forced upon the insurers; they themselves had proposed it. If they had not agreed to accept patients with pre-existing conditions, the law would have had to include a “public option” to guarantee that such patients could access health insurance, thus creating public competition that would give at least some consumers a non-private insurance option. Whether a public option would have constituted a meaningful alternative that competed with private companies would have depended partly on the details of its design; it is certainly possible that it would have served as a place for private insurers to dump sick customers, making it expensive and unsustainable (especially if the already-insured were not given the public option, as seems likely). In any case, it would inevitably have been inferior to a single-payer system. See Physicians for a National Health Program, “The ‘Public Plan Option’; Myths and Facts,” available at www.pnhp.org/change/Public_Option_Myths_and_Facts.pdf.
 13. Edward Luce, “Gloves Off in Health Reform Battle,” *Financial Times*, October 13, 2009, 7; Starr, *Remedy and Reaction*, 14, 187, 204-205, 218-19.
 14. Quoted in Baker, “Obama Pushed by Drug Lobby”; See also “PhRMA Statement on Health Care Reform,” March 25, 2010, available at www.phrma.org/media/releases/phrma-statement-health-care-reform-1.
 15. Luce, “Gloves Off in Health Reform Battle”; For a historical account of the health care industry’s role in blocking national health insurance see Gordon, *Dead on Arrival*.
 16. AHIP Board of Directors, “Now Is the Time for Health Care Reform: A Proposal to Achieve

- Universal Coverage, Affordability, Quality Improvement, and Market Reform,” available at www.ahip.org/nowisthetime-hcr.
17. The exchanges were also a feature of prior Republican proposals, originally conceived as a business-friendly alternative to single-payer “Medicare for All.” See Starr, *Remedy and Reaction*, 202-203.
 18. Chad Terhune and Keith Epstein, “Why Health Insurers Are Winning,” *Businessweek*, August 17, 2009, 39.
 19. Robert Pear, “Health Care Industry Is Said to Promise to Hold Down Costs Voluntarily,” *The New York Times*, May 11, 2009, A12; Baker, “Obama Pushed by Drug Lobby.” The adoption of this last AHIP proposal guaranteed continued cost increases in the health care sector far above the overall inflation rate, reflecting the abandonment of the goal of cost containment that had supposedly been a major motivation behind the reform. It also signified the further entrenchment of the insurance industry in the administrative and regulatory apparatus of U.S. health care. In effect, insurance companies *are* the regulators, for they retain the power to negotiate with care providers and, despite some minor new constraints, the power to determine prices.
 20. Max Fraser, “The Affordable Care Attack,” *New Labor Forum* 23, no. 1 (2014): 96-98; James McGee, “Union Health Plans Will Suffer under Obamacare,” *Labor Notes*, March 18, 2013, 14-15.
 21. Jenny Brown, “Obamacare Opens for Business, Shuts Out Labor,” *Labor Notes*, August 1, 2013, 3-4; Reed Abelson, “High-End Health Plans Scale Back to Avoid ‘Cadillac Tax,’” *The New York Times*, May 27, 2013, B1.
 22. David M. Herszenhorn, “Obama Urges Excise Tax on High-Cost Insurance,” *The New York Times*, January 6, 2010, A21; Starr, *Remedy and Reaction*, 223.
 23. A similar pattern has characterized the implementation of the Dodd-Frank financial reform so far; see Robert Pollin, “Fighting for Wall Street Regulation: Who Said It Was Easy?” *New Labor Forum* 22, no. 2 (2013): 88-91.
 24. Brown, “Obamacare Opens for Business,” 1; Eric Lipton and Kevin Sack, “Fiscal Footnote: Big Senate Gift to Drug Maker,” *The New York Times*, January 20, 2013, A1.
 25. For instance, Clem Brooks and Jeff Manza, “Social Policy Responsiveness in Developed Democracies,” *American Sociological Review* 71, no. 3 (June 2006): 474-94.
 26. E.g., Fred Block, “The Ruling Class Does Not Rule: Notes on the Marxist Theory of the State,” *Socialist Revolution* 33 (May-June 1977): 6-28; Mark S. Mizruchi, *The Fracturing of the American Corporate Elite* (Cambridge, MA: Harvard University Press, 2013). Mizruchi does recognize greater collective ability to *thwart* reforms, though, as opposed to advancing their own.
 27. Center for Responsive Politics, database, “Politicians and Elections,” updated 2014, available at www.opensecrets.org; Daniel Ward, “The Money Taboo in Health Reform Coverage,” *Extra!* November 1, 2009, 7-8.
 28. Ward, “The Money Taboo,” 7.
 29. Paul Kane, “Lawmakers Reveal Health-Care Investments: Key Players Have Stakes in Industry,” *The Washington Post*, June 13, 2009, A1.
 30. Block, “The Ruling Class Does Not Rule”; Michael Schwartz, ed., *The Structure of Power in America: The Corporate Elite as a Ruling Class* (New York: Holmes & Meier, 1987).
 31. We develop this theoretical argument in Kevin Young and Michael Schwartz, “A Neglected Mechanism of Social Movement Political Influence: The Role of Anticorporate and Anti-Institutional Protest in Changing Government Policy,” *Mobilization* (forthcoming, 2014).
 32. For more detailed discussion of these two examples, see Young and Schwartz, “A Neglected Mechanism.”
 33. Our strategy has been attempted before, most notably after World War II when the United Auto Workers (UAW) pushed for employer-based health care, thinking the auto industry would respond to rising costs by pushing for single payer. The strategy failed then, and the union’s own commitment to single payer and other national welfare measures thereafter “began to flag” (Nelson Lichtenstein, *The Most Dangerous Man in Detroit: Walter Reuther and the Fate of American Labor* [New York: Basic Books, 1995], 297). But the era of skyrocketing health care costs and increased global competition had not yet begun, meaning that companies could more easily pass costs onto consumers. The corporate calculus would likely be different today.
 34. Vicente Navarro, *The Politics of Health Policy: The US Reforms, 1980-1994* (Oxford: Blackwell, 1994), 135-93.
 35. Leftist-led unions have tended to win the best contracts while also being the most inclusive and democratic. See Judith Stepan-Norris and

Maurice Zeitlin, *Left Out: Reds and America's Industrial Unions* (Cambridge, UK: Cambridge University Press, 2003).

36. For endorsements, see the websites of the Labor Campaign for Single Payer (www.laborforsinglepayer.org) and Unions for Single Payer Health Care (<http://unionsforsinglepayer.org>). Alan Derickson notes that in the postwar era U.S. union support for single payer has been fairly widespread but often quite shallow; by 1950 most unions “gave national health insurance only lip service” (Alan Derickson, “Health Security for All? Social Unionism and Universal Health Insurance, 1935-1958,” *Journal of American History* 80, no. 4 [1994], 1351).
37. [Kim Voss and Rachel Sherman, “Breaking the Iron Law of Oligarchy: Union Revitalization in the American Labor Movement,” *American Journal of Sociology* 106, no. 2 \(September 2000\): 303-49](#); [Larry Isaac and Lars Christiansen, “How the Civil Rights Movement Revitalized](#)

[Labor Militancy,” *American Sociological Review* 67, no. 5 \(October 2002\): 722-46.](#)