HUMANITARIAN & DEVELOPMENT PROGRAMME

BETWEEN THE HAMMER AND THE ANVIL: Health Issues and Electoral Behaviours in the United States

By Roger PERSICHINO
AUTHOR OF "THE PRESIDENTIAL ELECTIONS IN THE UNITED STATES" / GALLIMARD 2008

NOVEMBER 2016

« GLOBAL HEALTH » THINK TANK

IRIS
INSTITUT DE RELATIONS INTERNATIONALES ET STRATÉGIQUES

The presidential election on the 8th of November in the United States draws great attention. The debates have largely focused on Mr Trump's personality and, to a lesser extent, that of Mrs Clinton's - the two main candidates - to the detriment issues that have been prominent in American news in recent years. This is particularly the case for healthcare, a matter that 95% of potential voters consider important or very important, at the same level as national security, and far head of all other themes of the campaign (1).

On signing his pioneering law on the healthcare reform - called Obamacare – President Obama aimed to increase the country's health coverage to 100%. From this stance, the healthcare reform has been a success, having reached at least 13 million more people (2). Nevertheless, the reform was vigorously contested, having twice been the subject of a (favourable) constitutional judgement in the Supreme Court. The Republicans have campaigned for an absolute abrogation of the law for three electoral cycles. In spite of this, the matter was hardly mentioned during the debates between Mrs Clinton and Mr Trump. It remains, however, a hot topic: the 1st of November saw the start of enrolment for insurance policies in 2017 on the state's stock market. The withdrawal of some insurers involved in individual coverage and the average increase in the number of policies by about 25% are seen by some as a predictable failure (3) and likely to influence the behaviour of certain voters during the presidential election.

It is worth noting that in the United States, most health protection is either provided by employers (49%) or by the federal state (36% via the Medicare or Medicaid programmes, or others)(4). Whilst the scope of the reform is too broad to be discussed here, it has had a significant impact on the coverage provided by these biases, notably through stronger regulation of insurance. The primary objective of Obamacare - reaching a universal coverage of 100% of the population - rested on three pillars: an obligation for all to take out a policy or face a fine; a system aiming to reduce the costs of policies by creating individual markets in each state (administered by the state or by the federal government); and a subsidies scheme either through being included in the existing Medicaid programme or by direct grants.

THE POLITICAL ECONOMY OF MEDICAL CHOICES

In terms of overall balance, Obamacare is far from being the disaster against which the Republicans fought hard. However, the individual market system is under considerable pressure and forces a significant portion of the population to make difficult choices, which

may, in part, explain certain political attitudes. In a book written on the White Working Class in Great Britain and the United States, politician Justin Gest heard the following testimony from a Youngstown family in the swing state of Ohio: "We are between the hammer and the anvil," said Gillian. “If we get a job, we lose our medical coverage [currently provided by Medicaid], but if I don’t have a job, then we really don’t have enough. Every month, we try to strike the right balance [for income]: high enough to pay the bills, and low enough to keep our medical coverage and dietary needs." (5)

With an average $2500 in monthly income for four people, Gillian’s family barely sit below the eligibility criteria for Medicaid, the federal medical assistance program for low-income households. Thanks to Obamacare, the threshold was raised to cover families earning 133% or less of the federal poverty level (FPL), which is about $2700 for a family like Gillian’s in Ohio (6). She and her husband lost their jobs in 2010, and have since lived off flea markets, with unstable income, which explains the aforementioned remarks: her household may sometimes prefer to refuse sales that would temporarily provide them with more income, but this would then put them at the 133% limit given by FPL that determines its medical coverage. What happens then?

Gillian would then have two options. The first would be not to take out a policy for medical insurance. But Obamacare would then impose a penalty. This penalty, a monthly maximum of around $285 in 2014, now reaches $2085 and is set to increase in 2017(7). The figure is adjusted for income and household size, but it is almost certain that this would wipe clean the marginal earnings made, making Gillian's family vulnerable to the risks associated with lack of health insurance in the United States, the leading cause of personal bankruptcy.

The second option would be to buy available insurance on the Ohio Stock Exchange. In 2016, the average price for a standard individual policy (excluding smokers) in 10 states (excluding Ohio) was $288 per month (8). In 2017, an average price increase of 13% for these policies will affect those available in Ohio, with an increase between 0.85% and 39%(9), which will vary according to the insurers. These two factors, the increase in premiums and the variability in the number of insurers (and hence the effective increases) must be put into perspective. Gillian is lucky enough to be in Ohio. The average increase expected for the country as a whole in 2017 is estimated at about 25%, reaching 76% in states such as Oklahoma (10). And the number of insurers available per county is expected to decline substantially, mainly due to the withdrawal of Aetna, one of the key players in the individual health insurance market.

ARBITRATION AND THE AMERICAN DREAM

The Kaiser Family Foundation, an independent body, estimates that by 2017, "four more states will only have one insurer per county: Alabama, Alaska, Oklahoma and South Carolina, to make a total of five (including Wyoming, which already has only one insurer in the state). Other states with a significantly increased number of single-insurer counties will likely include Arizona (87% of counties in 2017, 0 in 2016), Mississippi (80% vs. 0), Missouri (85% vs. 2%), Florida (73% versus 0%), North Carolina (90% versus 23%), and Tennessee (60% vs. 0%)(11). "–In the Oklahoman counties, policy-holders will be unable to avoid rising costs from the local insurer alone, with devastating consequences for household finances.

The aforementioned figures are only estimates. It is as of the 1st of November that the markets will open either for new policy sales or for the renewal of existing policies. It is for this reason that the deadline is important: what will be the reaction of voters when discovering the huge increase in prices planned for next year, just one week before the election? In most of the states mentioned above, this should have little impact as they already seem promised to one candidate or another. On the other hand, in states where candidates are neck and neck (12), such as Florida, Arizona or North Carolina, the question remains the same as in Ohio where Gillian is confronted with these Cornelian choices.

If family income were to increase, it would remain below the 400% ceiling of the FPL, which would allow Gillian to apply for grants in the form of tax credits. The mechanism for these grants is quite complex, but it ensures that any individual with an income between 133% and 400% of the FPL spends no more than 9.5% of their income on enrolling onto a policy. Gillian would approximately need an additional $200 per month to take part in this new package, a figure that would roughly match what she would have to pay for her insurance anyway, once federal subsidies are deducted and taking into account the entire household. Her insurance would further be much more precarious than the Medicaid she currently has. Her situation is effectively that of non-choice, with no real options for improving her income. She is forced to accept Medicaid's support and the stigma attached to poverty - or her perception - and so concludes her testimony: "The American dream is working for some. Others just live day by day. If you have a dream, this city will find a way to destroy it." (3)

THE IMPACT ON POLITICAL ATTITUDES

What are the political consequences? Although she is living in a largely Democratic county, Gillian is one of the voters who might be sensitive to Donald Trump's description of a down-graded America and his promise to "Make America Great Again." This sensitivity is not straightforward and must be read in the broader context of Mahoning County. Located in northeastern Ohio, 63% of voters in this county voted for Obama compared with 35% for Mitt Romney in 2012 and John McCain in 2008. More broadly, the local Democratic Party machinery has always controlled Mahoning County. Voting Republican is simply not part of the county's political culture.

Yet the issues Gillian is facing partially explain why analysts expect Clinton to lose many votes over Obama in this region (Mahoning and the two counties to the north) (14): during the Republican primaries, Mahoning was Trump's second best county among the 88 counties of the State. Obama had gained a vote difference of about 66,000 in the region in 2012, more than a third of his final win in Ohio. Hillary Clinton can hope to compensate for these predictable losses in growing metropolitan areas around Columbus, for example, and also take advantage of Trump's sexist remarks. But Mahoning has always remained close to its opponent in the polls (15), unlike other states where we observed a hard stall for Trump after the first televised debate.

Other factors are at play in Mahoning County that explain the attraction to Trump. The loss of industrial jobs since the 1970s led to a rather strong urban exodus. Youngstown has lost more than 100,000 residents in 50 years, and income from local taxes, with drastic consequences on funding for local schools and the police force. The demographic decline is predominantly concerned the white population. Although African-Americans account for only 15% of the county, they constitute more than 50% of the population of Youngstown, almost double the amount observed in 1970. This phenomenon has taken place alongside the decline of the organised crime that has decentralised the drug market (heroin, crack, marijuana). Whilst a 'godfather' previously controlled the market, it is now in the hands of 40 gangs who occupy each of the smaller territories but with much greater visibility (16). For the white population of Youngstown, Donald Trump's 'declinist' discourse resonates convincingly.

Gillian and her family are not lone cases: their average annual income is somewhat above the average household in Youngstown, which was $24361 between 2010 and 2014(17). Thanks to Obamacare, Gillian was able to benefit from federal assistance provided by Medicaid after the expansion of the programme. Conversely, Obamacare has significantly frozen its options due to the threshold effects that may make it switch to stock exchanges.

One of the paradoxes and failings of the reform is that it has ossified the disestablishment of certain populations. One solution would be to increase coverage of Medicaid and offer a public insurance programme in each county. This is what the President proposed as a legislative agenda for 2017, which the Republican majority in Congress promptly refused on the 20th October (18).

Health is not the only explanation for Trump's resilience in the polls despite remarks that would have disqualified any other candidate. The subject, however, gives an insight on political behaviours that are, at best, misunderstood and often the subject of criticism. And in all likelihood, the results on the 8th November will not provide the next President with a legislative majority large enough to hope to reform Obamacare in one way or another. The possible choices for families such as Gillian's show the difficulty in the support for or against Obamacare. This tension accurately represents the polarisation in Congress.

The political structure of the country, moreover, suggests the ways in which the situation could evolve: 11 of the 146 referenda submitted to the vote concern public health measures in 8 states (19). In other words, state autonomy allows a large number of local health policy initiatives that could counterbalance federal inertia. Without governmental functions, Washington remains powerless in proposing a national solution to the gaps within the country, but arrangements can be envisioned at the state level, especially if the 19 states that have not yet agreed to participate in the Medicaid expansion finally have to accept it (20). ■

BETWEEN THE HAMMER AND THE ANVIL: Health Issues and Electoral Behaviours in the United States

By

Roger PERSICHINO

Author of "The Presidential Elections in the United States" (Gallimard 2008), and many articles on American politics.

November 2016

« GLOBAL HEALTH » THINK TANK
Directed by Nathalie ERNOULT and Dr. Anne SÉNÉQUIER
ernoult@iris-france.org – senequier@iris-france.org

A Think Tank under the
HUMANITARIAN & DEVELOPMENT PROGRAMME
Directed by Michel MAIETTA, Senior Fellow, IRIS
maietta@iris-france.org

INSTITUT DE RELATIONS INTERNATIONALES ET STRATÉGIQUES
2 bis rue Mercoeur
75011 PARIS / France

T. + 33 (0) 1 53 27 60 60
contact@iris-france.org
@InstitutIRIS

www.iris-france.org