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Health Care On a Budget: The Rise of Economic Dominance in Health Care Reform

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Health Care On a Budget

The Rise of Economic Dominance in Health Care
Reform

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Introduction: Setting the Stage

Liberty is to the collective body, what health is to every individual body. Without health no pleasure can be tasted by man; without liberty, no happiness can be enjoyed by society.” --
Thomas Jefferson

Today’s world has become completely saturated with the marketing and advertising of every product imaginable. Politics is no exception. When policy proposals are brought to the attention of the public they must be molded and portrayed in a way that will make people passionate about them and confident in policymakers’ ability to implement positive change. Important policy proposals often get large amounts of attention, which needs to be translated into a constructive process towards change. This requires careful consideration of how to strategically frame any reform. Major governmental changes are difficult in the United States, as we are a nation that generally prefers slow and incremental transformations as opposed to a massive overnight overhaul of a system. Proposals must, in their own way, be marketed and advertised just as any consumer good needs to be properly marketed to be successful.

Health care is an example of an issue that, especially in recent years, has received an exceptional amount of media attention and thus requires significant marketing skills on the part of political leaders to attempt to create a positive view of current reform principles aiming to correct deep-rooted problems within the system. The provision of health care is not a stagnant issue and attitudes as well as the policies that result are constantly changing. From the 19th century to the present, health care has been rapidly reforming. Since there have been many changes to health care in the United States, this means that it has also been brought to the public’s attention many times and survived. Though a positive public opinion does not necessarily equate to specific policy outcomes, pleasing the public is always a consideration of

politicians, whose main goal is generally to be reelected to office. Issue framing is a way of swaying public opinion in favor of an issue.

This thesis will argue that in order to pursue the social reform of health care, President Obama chose to frame the necessity of reform in an economic framework. The promise to use reform as a mechanism to reduce the federal deficit forced even the moral issues of expanding access to health care to be influenced by financial restraints. By combining the two approaches of viewing health care reform as both an economic and moral issue, the final law that was passed fails to fully fulfill the fundamental goals of either viewpoint.

There are numerous scholars who have devoted their life's work to studying health care reform and the financial implications. Paul Feldstein discusses the economics of health care and the influence this has on policy proposals. He lays out different possible methods of reforming the system in order to make the provision of health care more efficient and equitable. Thomas Rice also studies the economics of health care, but has a slightly alternative and more liberal approach that tends to be more negative towards market competition than most economists. Arnold Kling, Michael Cannon and Michael Tanner all have more conservative approaches to reforming health care. Though they discuss the many problems and solutions for the system, they clearly favor individual choice, market outcomes and less government intervention to improve the situation.

Various political theorists have contributed to analyzing the way that health care is viewed and public opinions. Thomas Nelson and Donald Kinder study how issues are framed and the influence that it has on the way the public views issues. William Saris and Paul Sniderman focus more specifically on health care and the public's views on various issues within

the subject. They are especially useful in understanding the public sentiment regarding how important reform is, but focus less on actual opinions of possible solutions.

Even though the passage of the Patient Protection and Affordable Care Act was fairly recent, there have already been many scholars to study the process of passing reform and the resulting law. Barbara Sinclair focuses on the unorthodox lawmaking process that Congress had to use to get the bill passed. Lawrence Jacobs and Theda Skocpol followed the push for health reform as it was occurring and the implications of the PPACA that passed. They are optimistic about Obamacare and the impact that it will have on expanding coverage and cost controls. The Congressional Budget Office publications and studies done by the Centers for Medicare and Medicaid Services are instrumental to determining the financial implications of passing the law. Informed reporters such as Robert Pear and Sheryl Gay Stolberg are essential for providing the most current information for the ongoing health care debate.

The Health Care Problem

Before health care reforms and the financial implications can be understood, the underlying problems with the health care system in the United States need to be clarified. As good health is essential to the success and prosperity of a nation, a flawed system draws numerous concerns. The US far surpasses any other nation in the world in terms of health expenditures. In 2010 almost \$2.6 trillion was spent on providing health care to Americans. In 1980, \$256 billion was spent (\$677 billion in 2010 dollars), meaning that in just 30 years expenditures multiplied by ten times. In 1960, expenditures were \$27.4 billion (\$201.85 billion in 2010 dollars). Though these numbers are exceptionally large, the extravagance depends upon the size of the population. Per capita expenditures, meaning the average amount spent per

person, increased from \$147 in 1960 (\$1,082.91 in 2010 dollars) to \$8,402 in 2010. These expenditures made up 17.9 percent of the nation's Gross Domestic Product (GDP) in 2010, and the number is continuously growing.¹ The increase as a portion of the GDP is especially alarming. If such a large segment of the American economy is dedicated to this one industry it may be threatening other segments of the economy. If people have to spend an ever increasing amount of their incomes on health care than there is an opportunity cost as they will not be able to buy as many other necessary or desirable goods.

The provision of health care has become the battlefield for the debate between public and private funding. The United States is unique in the way that it finances care. The debate over health care and how it should be funded is a long-standing issue among Americans. Once it was established that insurance was necessary for the affordability of health care, the decision between public and private, or a mixture of the two became important. Fifty five percent of US health care spending is comprised of private expenditures. This is the highest percent in the entire industrialized world. The welfare state in the United States is an intricate combination of the private and public provision of services.² Gaps in public programs as well as favorable policies encourage private involvement in providing welfare benefits. When considering health care or any welfare policy, it is simply impossible to ignore the private sector's role. This is especially true given the nature of the historical preference by American's for privatization. Because the private sector is so involved in providing what many consider to be public goods, they also have a large impact on policy outcomes.³ Another critical problem is that the system depends on insurance payments, but there is a significant portion of the population that is uninsured either

¹ Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, [National Health Care Expenditures Data](#), January 2012.

² Jacob S. Hacker, *The Divided Welfare State: the Battle over Public and Private Social Benefits in the United States*. (New York: Cambridge University Press. 2002), 6.

³ Hacker, 180-181.

voluntarily or involuntarily. In 2010 there were approximately 47.2 million people who were uninsured. This not only causes inadequate care and expensive bills for the uninsured, but it also raises the prices of coverage for everyone as the burden of supporting the uninsured falls on the rest of the population.

To better understand if the spending on health care is excessive and inefficient in the United States, it is useful to look at the situations abroad. Since the United States has the largest absolute GDP as well as the highest GDP per capita, one would expect our health care expenditures to be higher than that of other nations. While this is the case, according to the Organization for Economic Cooperation and Development, our spending is disproportionately excessive. In 2009, the United States spent \$7,960 on per capita health care expenditures. This is more than double what most other industrialized nations spent. For example, the United Kingdom spent only \$3,487 per capita and Canada spent \$4,363. The developed nation that comes closest to our spending is Norway, which spent \$5,352 in per capita health care expenditures.⁴ With such higher spending it would be assumed that the United States has better health outcomes, yet this is not the case. People in the United States are in fact worse off than other industrialized countries according to many health indicators. In other words, our spending is far less effective. For example, 34.3 percent of the American population is obese, while the United Kingdom comes in second with only 24 percent. The other nations that are included have obesity rates between 3.9 and 18 percent.⁵ According to the OECD health data, in 2007 the US infant mortality rate was 6.8 for every 1,000 births. In the United Kingdom the infant mortality rate was 4.8, 3.9 in Germany and 3.8 in France. These are indicators that show the relatively poor performance of the health care system in relation to other nations. There are clearly

⁴ Organization for Economic Cooperation and Development. (2011). *OECD Health Data 2011*.

⁵ Rexford E. Santerre, Stephen P. Neun. "Health Economics: Theory, Insights, and Industry Studies." 5th Edition (Mason, OH: South Western Cengage Learning, 2010).

problems with the provision of health care funding in the United States, thus creating the need for reforms.

There are other problems with health care that go beyond the high and growing costs, including the use of insurance. First, insurance does not provide complete coverage. There are often limits to the amount the insurer will pay over a person's life and patients still have to pay for a predetermined portion of their care. Insurance also creates the problem of moral hazard in the system. There is asymmetrical information, meaning that different actors in the health care system have different levels of information. Sick patients have the incentive to keep that information from their insurers and patients often do not know enough about medicine to know what treatments they truly need. A problem is also created because insurance is often tied to a person's job. If someone loses their job they will lose their coverage, or if they switch jobs the program will change. This is called job lock, which creates a less mobile workforce than would otherwise be optimal for the economy.⁶ In order to understand how health care finance turned out today it is necessary to know the history of how the current system developed.

A Brief History

Throughout the history of health care there have been fundamental disagreements that have framed the debate for reform. Health care access and the necessary reforms that ought to be made are frequently covered issues in scholarly literature. One important aspect that seems often to be overlooked is the question of how health care reform is framed to the public and the policy implications that this has. There was a fundamental shift in the way that the issue of reform was

⁶ David M. Cutler. "A Guide to Health Care Reform." *Journal of Economic Perspectives* 8, no. 3 (1994): 13-29.

presented from older and more socially based proposals to the most recent more economic approach laid out by President Obama.

The provision of both public and private health insurance is a fairly recent phenomenon in American history. The first federal health program to be established was the 1789 U.S. Marine Hospital Service. As it was not explicitly delegated as a federal power by the Constitution, it was assumed that health care was a state issue. At the start of the 20th century, health insurance was still virtually nonexistent. It was not until the collision of rising costs of health care and the Great Depression that significant changes began to be made in the provision of health care. Due to legislative failures, it was the private sector that first began increasing the availability of insurance in the United States. They benefited from favorable conditions and very little regulation. The first time that the idea of compulsory health care was seriously pursued was in the 1912 election when Theodore Roosevelt ran and lost with the Progressive Party.⁷ This policy has since been brought up and failed numerous times throughout the last century. Prior to the New Deal, any government assistance for health care was delegated at the state level. This represented a crucial turning point in health care finance in the United States.

The Great Depression led to the emergence of Blue Cross benefit plans for hospitals. The creation of these plans had multiple goals. They would ensure continuous incomes for the hospital during the hard times. It also helped families to pay incrementally for care instead of a lump sum when treatment was actually needed. Blue Shield was developed later as a payment system for physician services based on the same ideology.⁸ The New Deal created an enormous fundamental shift in the power structure of the government from the state level to the federal

⁷ Hacker, 191-200.

⁸ Diana M. DiNitto. *Social welfare: politics and public policy*. 7th ed. (Upper Saddle River, N.J.: Pearson Education, 2010), 277.
Hacker, 203.

government. The Social Security Act passed in 1935. At that point Franklin D. Roosevelt turned his attention to health care. However, by this time Congress had allowed so much reformation that they did not support increased government expansion through universal health care.⁹ The failure of universal health care to pass at the time enlarged the private sector insurance, which has played a dominant role ever since.¹⁰ As insurance policies provided by employers began to gain popularity, it became clear that there would be segments of the population that this system would be inadequate in covering or that would be excluded all together. Senators Wagner and Murray worked with Representative Dingell on legislation in 1943 that would add health insurance as a part of social security. The new legislation aimed to ensure the welfare of citizens beyond the original limited pool of beneficiaries of social security. This bill continued to be reintroduced even though it failed to gain the necessary support for victory. In his 1944 State of the Union Address, FDR proclaimed that the United States needed to add a second bill of rights, which he called the 'economic bill of rights.' Among other things this included the right to adequate medical care and good health.

The next major movement for health care reform did not come until the end of World War II. President Truman pursued a national health insurance proposal. Even though his election seemed to show widespread support for such reform, he faced fierce opposition. The fear of socialism and desegregation ended up blocking any proposals he attempted to introduce. In 1954 President Eisenhower proposed a federal reinsurance fund that would have allowed insurance companies to expand their coverage to more risky segments of the population, but this too failed. The Revenue Act of 1954 passed, which further promoted the private sector's involvement in health affairs. It exempted the contributions made by employers to the employee's health plans

⁹ "History of Health Reform Efforts in the U.S." *The Henry J. Kaiser Family Foundation*. Web. 22 Feb. 2012. < <http://healthreform.kff.org/flash/health-reform-new.html> >.

¹⁰ Hacker, 230-240.

from being taxable income¹¹. It acted as a subsidy to make private, employer sponsored insurance more affordable and thus enticed more companies to include health insurance as part of a benefit package.

The first major victory for federal welfare programs since the New Deal did not occur until President Johnson's Great Society movement in the 1960s. After the assassination of JFK, Johnson enjoyed unprecedented levels of public support. The expansion of private insurance coverage with premiums based on the risk different demographic groups posed left the elderly particularly exposed to rising health costs. In 1965 Medicare and Medicaid were added to the Social Security Act. Medicare focused on providing care for the elderly, with Part A paying for hospital insurance and limited home health care. Part B was optional and covered physician care. Medicaid helped provide assistance to states in order to provide health care for the poor and disabled. Up until 2010, this period marked the most sweeping health care reform that the country has made.

The period of the 1970s was marked with conflicting proposals between Democrats and Republicans. Senator Kennedy from Massachusetts was yet another Democrat who proposed national health insurance. This was competing against President Nixon's more conservative Comprehensive Health Insurance Plan (CHIP). Nixon's proposal would make three general changes. It would require employers and employees to contribute to an insurance plan to provide coverage for both the employee and their family. The federal government would finance a family insurance plan that would cover the poor and welfare families. The third part of the proposal was to encourage the development of health maintenance organizations (HMO) as a cost controlling mechanism. HMOs create contracts between insurance agencies, doctors and patients that set guidelines for doctors and restricts which health care providers people can go to

¹¹ "History of Health Reform Efforts in the U.S." *The Henry J. Kaiser Family Foundation*

without paying penalties. The main focus was that even though there would be changes to the provision of health care, it would still fundamentally be administered by private insurance companies.¹² The state of the economy in the 1970s and the implications of stagflation turned the focus from expanding health insurance to containing the costs when President Carter took office.

President Clinton was the next president to attempt significant changes to reform health care. It was one of his key goals throughout his time in office. His proposal called for what he termed managed competition. It included universal coverage, employer and individual mandates requiring insurance, increased competition between insurers, and government intervention to help control costs.¹³ Regional health alliances would be created to cover most people. Companies with over 5,000 people and Medicare recipients who do not work would remain in the current system. There would be new regulations on the insurance industry, such as charging community rates, accepting all people wishing to enroll in a program, forcing coverage of preexisting conditions, and accepting all renewals. Costs are controlled through encouraging the purchase of less expensive plans. The plan would also put a cap on the premiums that companies could charge in the alliances to help control inflating costs.¹⁴ Despite a tremendous effort by the Democrats to pass legislation and by the various opponents to kill it, Clinton was never able to even bring his proposal to a vote and it became another attempt in a long line of failures at achieving universal health care. As time has passed, the definition that is used for universal care seems to lose some of its meaning and proposals for universal care are becoming less comprehensive.

¹² H. Barry Waldman. "Comments on the Nixon Plan for National Health Insurance: An Historic View." *Medical Care* 9, no. 6 (1971): 503-508. <http://www.jstor.org/stable/3762465>.

¹³ "History of Health Reform Efforts in the U.S." *The Henry J. Kaiser Family Foundation*

¹⁴ Cutler, 13-29.

President George W. Bush supported and signed the Medicare Drug, Improvement, and Modernization Act, also known as Medicare Part D, in 2003. This was a voluntary expansion to Medicare that would allow people to purchase subsidized plans that provided prescription drug coverage. In 2007 Senator Wyden and Bennett introduced the Healthy Americans Act, which would require individuals to purchase insurance through state health insurance purchasing pools.¹⁵ Throughout the 2008 presidential campaign, health reform remained a leading issue. The next major reform measure occurred when Obamacare was passed in 2010, which will later be discussed in depth.

Mechanisms for Reform

John Kingdon set a precedent in highlighting the importance of agenda setting in shaping public policy outcomes. His ideas have greatly impacted the field of political science. Though he is widely studied, his ideas have not been adequately applied to the case of the recent push for health care reform. Baumgartner and Jones also added to the agenda setting theory that is predominant today. A better understanding of agenda setting could be beneficial in studying, passing, and eventually implementing reforms, regardless of what the reform measures might be.

Although there are countless proposals and ideas on how to reform health care, there are two main approaches that they can be divided into. The first focuses on health care as a public good and the need for a universal health care system. Many, such as Anja Rudiger, support the ideal of a universal public health care system and demonstrate this in their writings. The other main approach focuses on market based approaches as a means to reform health care. Kling (2006) and Pauly (2008) along with numerous others emphasize the useful nature of market mechanisms and how they could be utilized in controlling the ever increasing costs of health

¹⁵ "History of Health Reform Efforts in the U.S." *The Henry J. Kaiser Family Foundation*

care. While scholars support many different methods of reform, little attention is paid to the political processes, agenda setting and issue framing that could most effectively lead to the implementation of such ideas. Even the best ideas are not useful unless they can survive the intense political process and remain intact.

Presidential words have been drawing issues to the forefront and bringing them to the attention of the public since the founding of our nation. How the issue is discussed can affect the way that the American people view it and whether they will enthusiastically support change. It all comes down to what can be said that will convince people that difficult changes are necessary and worthwhile. But in the case of health care, what will compel people to make the difficult decisions; is it morality or economics? These are two fundamentally different approaches to framing the issue of health care. Emphasizing the morality of the issue is making health care reform predominantly a social issue that aims to gain support through appealing to people's values and more generous side. An economic framework focuses on the financing and will appeal to the public through promising a fuller wallet as a result.

Bill Clinton gave an Address on Health Care Reform on September 22, 1993 in which he pleads "I ask you instead to look into the eyes of the sick child who needs care, to think of the face of the woman who's been told not only that her condition is malignant but not covered by her insurance, to look at the bottom lines of the businesses driven to bankruptcy by health care costs, to look at the "for sale" signs in front of the homes of families who have lost everything because of their health care costs."¹⁶ His main angle is to pull on the heart strings of the public to

¹⁶ Bill Clinton. "Address on Health Care Reform (September 22, 1993)—Miller Center." *Miller Center*. Web. 26 Apr. 2012. <<http://millercenter.org/president/speeches/detail/3926>>.

create the needed support for reform in order to cast the issue in a certain way. Reform of the way the nation provides health care is predominantly a moral issue.

President Obama gave a health care speech with similar goals, but the undertone of the reasoning for reform had fundamental differences. Obama emphasizes that, “Put simply, our health care problem is our deficit problem. Nothing else even comes close.”¹⁷ He is emphasizing that the bottom line for the need to reform is to help put the nation’s finances in order. The existing health care system created a burden on the economy that needed to be fixed in order to stimulate the economy and help end the economic downturn.

The choice comes down to what is more effective: the threat of an economic collapse or the sad eyes of a sick child whose parents cannot afford care. Though the morality of the issue cannot fully be ignored, Obama and his advisors decided that given the economic state of the nation at the time of the proposal, an economic framework would prove most effective. Instead of taking a more traditional Democratic approach, Obama realized that the economic situation of the nation and the tradition of failing reform proposals would require him to take a different approach to achieve success. He still kept some of the central moral arguments for reform, but he heavily marketed the added incentive of cost reductions and a more balanced budget. The question now lies in how this impacted the final policy outcomes.

The Nature of Health Care: Public or Private?

Health care is an especially controversial topic. The very nature of it as a good is frequently in question. Goods are generally divided into two categories, public and private. A

¹⁷ Barack Obama. "Transcript: Obama's Health Care Speech - CBS News." *Breaking News Headlines: Business, Entertainment & World News - CBS News*. N.p., 9 Sept. 2009. <http://www.cbsnews.com/2100-250_162-5299229.html?pageNum=2&tag=contentMain;contentBody>.

public good is something that can be consumed by everyone regardless of their ability to pay. There is not an issue of exclusion or rival consumption, meaning that everyone has access and one person's utilization of the good does not take away from that of another person. Public goods are often provided due to market failures that occur in the accessibility of the good. Some would argue that health care is a public good that should to be provided by the government. A private good has a price and people unwilling or unable to pay the price are unable to access that good through the exclusion principle. There is also rivalry in consumption in that one person enjoying the good takes away from another person.¹⁸ Take, for example, an ice cream cone. You can only eat the ice cream if you are willing to pay for it, and if one person eats the cone then another person cannot have it. Other, generally more conservative people believe that health care is like any other private good and that private provision is not only adequate but preferable. The competition that drives the success of capitalism should be the foundation of health insurance.

The problem is that health care does not adequately fit either definition, which leads much room for disagreements and interpretations. Health care does have some noticeable differences from the typical market good. The suppliers have much more information than the patients, or consumers. Insurance shields people from the costs of health care, so there are not the same incentives for consumers to pressure providers to keep prices at a reasonable level. Prices do not have as much of an impact on treatment decisions as perhaps they should.¹⁹ Most people view access to health care as a right that all citizens should be guaranteed. This is not a new idea, and it was even proposed to be included in a Second Bill of Rights but was never implemented by President Franklin D. Roosevelt. The question is less about whether people should have access to care, and more about what level of care should be guaranteed regardless of

¹⁸ Karsten, Siegfried G.. "Health Care: Private Good vs. Public Good." *American Journal of Economics and Sociology* 54, no. 2 (1995): 129-144. <http://www.jstor.org/stable/3487569>.

¹⁹ Hacker, 180-181.

ability to pay and where the funds should originate from.²⁰ These varying opinions need to be proposed in a way that will be best suited to ensuring their acceptance and implementation into public policy outcomes.

The Path Ahead

A long history of failed attempts at achieving universal health care and a recession caused President Obama to combine both a moral and economic framework to approach health care reform, resulting in a more conservative plan than he or previous Democrats expected or wanted. This thesis will begin with the necessary theoretical models in understanding liberalism and conservatism and their contributions to health care as well as competing theories of the nature of health care as a good. I will then discuss issue framing, the actors involved and the major impact that it has on public policy. This theoretical framework will then allow for the study of the movement from the social justice model to an economic model for explaining the need for reform. The Patient Protection and Affordable Care Act was built upon an economic framework for reform, so I will study how this impacted its content, process through the legislature and its implementation. Finally I will do an economic analysis of the PPACA to determine if the bill improves the country's financial situation as promised.

²⁰ Keith J. Mueller. *Health Care Policy in the United States*. (Lincoln: University of Nebraska Press, 1993).

Chapter 1: Political Theory and Health Care

One of the unique and wonderful things about America has always been our self-reliance, our rugged individualism, our fierce defense of freedom and our healthy skepticism of government. And figuring out the appropriate size and role of government has always been a source of rigorous and, yes, sometimes angry debate. That's our history.- Barack Obama

There are many competing visions in American political thought regarding the role of government and the policy areas that it should be involved in. This conflict is often brought to light through financing and economics, so it is especially important to study and understand these components. The United States has historically considered itself to be different and exceptional when compared to other nations in the moral, political and economic founding of the nation, thus creating different outcomes in response to problems that are common throughout the industrialized world. It is often useful to understand a policy through a philosophical lens. This can also be beneficial when framing reform to the public and making the reasons behind reform more transparent.

The United States is certainly unique in its provision of health care, but the exceptionalism of the system is in question. American health care has been evolving and a target of reform for policymakers since the inception of the nation. As with all major issues in American politics, there are various theories and models that are associated with the movement to reform health care. There are also basic liberal and conservative ideologies and principles that drive opinions on change.

Due to the varying ideas on what the role of government should be and the role of welfare in society, there is much variation about ideas on health care and how to reform the system. Health care is not a new issue in the United States, and it has been a widely debated subject. The question of the nature of health care as a good, conflicting ideologies, and the

sentiment of American exceptionalism all lead to very different ideas on how health care should be provided. Regardless of the policy in question, the issue has to be framed in a way that will elicit a favorable response from constituents, citizens, other politicians, as well as interest groups. Health care reform has been framed in either a social justice model or in an economic framework, and this has led to an enduring policy conflict.

Issue Framing and Public Opinion

Issue framing has gained particular importance in relation to the preliminary stages of creating policy preferences and bringing issues to the attention of the public and major actors. This process has the potential to have an enormous impact on public opinion. The way that party elites and the media portray an issue to the citizens shapes the way that people understand and perceive the situation and could bias the way they think about possible solutions. Opinions are often impacted by the way that individuals perceive different social groups that will be beneficiaries of different government programs. The idea that support for policies will differ depending on the group that benefits is called group-centrism. Since many American public policies are designed with certain demographics in mind, special advantages or disadvantages could occur depending on how their segment of the population is perceived. The framing of an issue is generally constructed by political party elites. It is then passed on to the public through speeches, television, newspapers, political talk shows, and debates, along with numerous other sources of information distribution.²¹ The reason that issue framing can have such a large impact

²¹ Thomas E. Nelson, and Donald R. Kinder. "Issue Frames and Group-Centrism in American Public Opinion." *The Journal of Politics* 58, no. 4 (1996): 1055-1078. <http://www.jstor.org/stable/2960149>.

on the public is based on studies that say that many citizens do not have definitive opinions on all issues, allowing for policy stances to change if there is a particularly convincing framework.²²

Framing can include all aspects of an issue throughout the political process. It begins by influencing how the fundamental problem itself is understood. In the case of health care this means seeing the issue as a problem of unaffordable costs or a problem of inadequate and inequitable access to health care. Framing then acts to impact the way that individuals should think about the issue and recommends possible solutions.²³ Leaders, however, are not free to frame an issue in any way that they desire. It must be consistent with their party message and goals. Individuals already have some ideas on how issues should be framed, so in order to change their minds the elites have to be convincing. Another important factor to keep in mind is that for every side of an issue, there will be people working vehemently in opposition to it. This means that citizens will be facing conflicting frameworks.

For changes in social welfare and health care reform there are two more general approaches that are used to appeal to the public. The first is a social and compassionate argument, saying that government has the responsibility to intervene to help citizens to be better off. The conflicting framework has an economic foundation and is focused on the costs of problems and potential reforms as well as individualism and personal responsibility. It appeals to the population's fears of redistribution in taking from the successful and hardworking people to give to those who enjoyed less success and may not necessarily be deserving.²⁴ The two frameworks, which are central to understanding the policy conflict over health reform, are expanded upon in the following section.

²² Willem E. Saris, and Paul M. Sniderman. *Studies in Public Opinion: Attitudes, Nonattitudes, Measurement Error, and Change*. (Princeton, N.J.: Princeton University Press, 2004), 135.

²³ Nelson and Kinder, 1058.

²⁴ Saris and Sniderman, 142.

Liberalism and the Social Justice Model

Since the founding of the nation, the United States has faced heated debates between strong and opposing ideologies, mainly those of liberals and conservatives. Liberalism tends to promote equal opportunities rather than equal circumstances. It has its foundations in the belief that society has a duty to help citizens who are in need and may not otherwise be able to provide for themselves. There is a more pragmatic and moderate approach to liberalism, which acknowledges that individuals are self interested and participate in a free market. This view emphasizes the need for some regulation in the free market to ensure equality of opportunity for all. The humanist approach to liberalism is more traditional and says that individuals think beyond themselves and are naturally interdependent, which can be better pursued through government intervention. Today liberals in government, typically Democrats, tend to favor policies that promote more government action to sponsor social policies. This requires higher government spending, increased taxes, and a government that is more involved in the daily lives of its citizens.²⁵ Recently many Democrats have viewed the provision of health care as a shared responsibility. There is an ethical duty to provide for fellow citizens that may not be in a position to provide for themselves. Individuals, employers and the government should work together in order to ensure that all Americans receive adequate care.²⁶

One of the major approaches taken to study the provision of health care is through the social justice model. This is a set of theories that has been developed through time by various philosophical and political thinkers. It emphasizes the connection between the individual and

²⁵ Eric Voegelin, Mary Algozin, and Keith Algozin. "Liberalism and Its History." *The Review of Politics* 36, no. 4 (1974): 504-520. <http://www.jstor.org/stable/pdfplus/1406338.pdf?acceptTC=true>.

²⁶ Rudiger, Anja. "From Market Competition to Solidarity? Assessing the Prospects of U.S. Health Care Reform Plans from a Human Rights Perspective." *Health and Human Rights: An International Journal* 10, no. 1 (2008), 126.

society and to what extent this relationship should exist. There are certain obligations between the two that need to be defined through the theory in order to determine what individuals owe to society and what society owes to them in return. Thus there is a type of contract that develops to promote the interests of both individuals and society.²⁷ There are a variety of approaches within this framework, the most prominent of which is attributed to John Rawls and his perception of justice.

The social justice model has been predominate throughout much of the history of American health care and has its foundations in ancient thought. Aristotle held the view that all people deserved to have the ability to achieve certain health goals, such as avoiding the threat of premature death. Health is viewed as a precondition for happiness.²⁸ The ideas of the ancient philosophers have endured through time and still have a significant influence on much of today's political thought, and the health care debate contains some of these same theoretical foundations. The social justice theory is deeply rooted and has pervaded through time as a traditional argument. Though a theory of social justice is often discussed, there are a few different approaches to the model.

One significant theory regarding social justice was developed by utilitarian intellectuals. John Stuart Mill and Jeremy Bentham are two prominent philosophers on the subject. In the classic form, utilitarians believe that society has its foundations in contracts that individuals voluntarily enter in an attempt to better their lives.²⁹ Aristotle's preliminary ideas on the subject influence this type of thought through his insistence on a just distribution of goods. Though his ideas influenced utilitarians, he did not fall into this overall category as he did not agree in what

²⁷ Rawls, John. *A Theory of Justice*. (Cambridge, MA: Belknap Press of Harvard University Press, 1971), 1-10

²⁸ Aristotle. *Nicomachean Ethics*. Oxford: Clarendon Press ;, 1998.

²⁹ John Stuart Mills, and Dorothy Fosdick. *On social freedom*, (New York: Columbia University Press, 1941).

the just manner of distribution of goods would be. The philosophy says that the social welfare is equal to the sum of the welfare of all the individuals in society. The goal is to maximize the situation of as many people in society as possible. This, however, can lead to the exclusion of the very wealthy and very poor individuals, as long as the overall benefits to society are maximized. All decisions, contracts and rules are meant to be promoting the common good rather than an individual's personal interests. The citizens also have a duty to assess the government to ensure that it is in fact pursuing the common good. This theoretical framework could cause problems as maximizing the overall public good could be exclusionary to some groups of the population, some of which may be the most vulnerable in the first place.³⁰ By focusing on solely the aggregate of a group of individuals this philosophy does not take into account what is right or fair. Social choices made by individuals are what impact the distribution of resources, not a system of social justice.³¹ The utilitarian claim for universal health care would be that it is acceptable to limit the rights of some as long as the net benefit to society is positive. The wealthy assisting in providing health care to the poor is acceptable because it will create an overall benefit for society

A controversial yet widely studied theory of social justice developed through the Marxist school of thought. The focus is on social systems that will work to maximize production. People will contribute differently depending on their abilities, but they will receive based upon their level of need. In return people have the right to rebel against governments that do not properly promote the liberty of citizens, discourage inequalities and preserve basic rights. Though there are varying approaches to Marxism, one is the combination of the typical socialist ideals with the

³⁰ Gunnar Robert Almgren. *Health Care Politics, Policy, and Services: A Social Justice Analysis*. (New York: Springer Pub., 2007).

³¹ Thomas Rice and Lynn Unruh, *The Economics of Health Reconsidered*. 3rd ed. Chicago: Health Administration Press, 2009, 292-294.

politics of a democratic state. This combination leads to four core principles of social justice. Security is a right, there is a minimum list of requirements for basic liberties such as free speech and property rights, individuals have the right to partake in decision making, and there are only very limited circumstances when inequalities are justifiable. In this view it is seen as a right that people be provided with a certain level of necessary goods.³² According to this ideology, there is an enormous under provision of subsistence goods by the government to the needy members of society. This ideology would justify a health care system that forced equality, meaning that everyone would be treated in the same way regardless of their ability to pay.

John Rawls is one of the most prominent scholars who derived a theory of justice. He is considered to have a more classical liberal theory and thus it is more widely accepted. His theories are based upon the idea that all individuals within a community agree upon a definition of justice and that the institutions of society are implemented in the pursuit of principles that make up this agreed upon version of justice. There will be conflict upon exactly what justice should entail, but there is likely to be widespread agreement on its' necessity. This is resolved through entering into a form of contract, as many of the other models agree upon. Rawls believes that justice is fundamentally based on the idea of fairness.³³ Justice should be determined when everyone is at the same basic level and does not know their own level of wealth and power. In this environment individuals will be more enticed to help the less fortunate. His approach is realistic in that he understands that society is pluralistic and that a democracy will not lead to equal distribution of all goods. If the definition of social justice is dependent upon the views of the population, then it would seem that as a function of American exceptionalism the

³² R. G. Peffer. *Marxism, Morality, and Social Justice*. (Princeton, N.J.: Princeton University Press, 1990). Almgreen

³³ Rawls, 10-30.

understanding of Americans could vary greatly from that of their foreign counterparts. Rawls theory suggests that there should be far more redistribution within society than there currently is. Though he did not reference health care as one of the primary goods in his work, his theory of justice would support a more equitable health care system.³⁴

Each of the mentioned theories of social justice differs slightly, but they can all be applicable to justifying different types of health care reform. Though it is more characteristic of today's Democrats to use theories of social justice as a framework for their proposals for reform, this is not always the case and it can be attributed to Republican ideals for reform as well. An example is a theoretical view on social justice through the perspective of libertarians. Libertarians uphold individualism as the central virtue and belief that governments should do little more than provide basic protections to its citizens. Robert Nozick was a prominent libertarian theorist. He developed the entitlement theory, in which he claims that the distribution of wealth is just if the original assessment of wealth is agreed at fairly and the existing distribution of wealth occurs due to voluntary interactions.³⁵ "Individuals have rights, and there are things no person or group may do to them (without violating their rights). So strong and far-reaching are these rights that they raise the question of what, if anything, the state and its officials may do."³⁶ They believe that society is made up of autonomous individuals that need to be governed in a way that preserves an agreed upon set of rights for all. Governments should only intervene minimally and for the purpose of extending individual freedoms, not to suppress them. Defense should be the main goal of government, along with the enforcement laws, and anything beyond this could be construed as infringement upon rights. The responsibility lies on

³⁴ Thomas Rice and Lynn Unruh "The Economics of Health Reconsidered." P.295-296.

³⁵ Thomas Rice and Lynn Unruh "The Economics of Health Reconsidered." P.298-299

³⁶ Robert Nozick. *Anarchy, State, and Utopia*. (New York: Basic Books, 1974).

the individual to protect themselves against negative occurrences in society such as illness and unemployment. Some examples of protections are engaging in insurance and savings, pooling family resources when the need arises, and becoming involved in charitable organizations. In return for these core protections of individual rights provided by the government, the individual has certain obligations to society. These obligations, however, completely rely on the consent of the individual as personal freedoms are of utmost importance to society. As a result individuals must bear the full burden of any consequences of their actions. The main idea is that people should be left alone as long as their actions do not impose on the rights of others.³⁷ Due to the limited role of government, health care is not considered a public good that will inevitably be provided by the government to all citizens. The impact of this ideology can still be seen today through the difficulties that arise in trying to implement widespread health reform.

Conservatism and an Economic Framework

Conservatism also has deep roots in American ideology, but it promotes very different means to arrive at policy outcomes. Conservatives generally prefer less government intervention in daily lives, promote lower taxes, and discourage reliance on the state for necessities by individuals. Social conservatism is based upon a negative view of human nature that assumes people are naturally untrustworthy. This means that members of the government also have these unfavorable characteristics which are inherent to human nature. Society is always going to have some dimension of income inequality, and it is not the role of the government to intervene and provide for the citizens who are less well off. Traditional welfare is discouraged and is considered to promote bad behaviors and create a dependence on the system. Morality and religious behavior are to be encouraged, promoting private charity over public support. Laissez-

³⁷ Nozick. *Anarchy, State, and Utopia*.

Faire conservatism, which is similar to Libertarianism, has also evolved throughout American history. The belief is that individuals should have the freedom to pursue anything that they desire as long as it does not harm another member of society or keep others from having full freedom to pursue their interests. This leaves room for only a very minimal government that protects property, provides defense and upholds laws which are intended to promote liberty. Individuals are thus responsible for their own actions and failures, so there is no social safety net.³⁸ In terms of health care, Republicans emphasize personal responsibility and private markets, which have long been core values influencing American politics.³⁹

While health care is often portrayed as a moral and social issue facing society, the great expense of providing health care also creates the ability to portray the necessity for reform as an economic issue. Republican reforms are often based on market mechanisms, so they tend to draw on economics to support their proposals. Especially in times of a recession or economic hardship, the public is responsive to initiatives that are proven to reduce government costs and therefore the burden on taxpayers. Health care makes up a significant portion of the current Gross Domestic Product. In 2008, the percentage of GDP spent on health care in the United States was 16 percent. Compared to other countries, this is a significant portion of GDP and is increasing rapidly.⁴⁰ When the ability of the country to even pay off its debts is in question, spending cutbacks by the government are extremely palatable to the citizens. An economic framework will focus on the costs of reform and the potential savings to both individuals and the government

³⁸ Wickwar, W. Hardy. "Foundations of American Conservatism." *The American Political Science Review* 41, no. 6 (1947): 1105-1117. <http://www.jstor.org/stable/pdfplus/1950581.pdf>.

³⁹ Rudiger, 127.

⁴⁰ Paul Feldstein. "How Much Should Spend on Medical Care". (Chapter 2). *Health Policy Issues: An Economic Perspective*, 4th edition, (Chicago: Health Administration Press, 2007),

that could be gained due to the measures. Economic influences on framing health care reform will be further discussed in chapter three.

The Influence of American Exceptionalism

Since its founding there have been assertions that the United States is different than any other nation that has existed and that this leads to very different outcomes socially, economically and politically. The term American exceptionalism is an idea first discussed by Alexis de Tocqueville in 1831. The point of the argument of American exceptionalism is that the United States has many qualitative differences from the other developed nations of the world that makes it inherently different and unique. Historical and geographical differences led it to develop very differently than other nations, thus creating a unique culture and institutions. Tocqueville was writing about his observations of the New World to report back to France in making this discovery. In analyzing Tocqueville's work, Lipset defined the American Creed, which characterizes five crucial concepts for the success of American society. These ideas together are distinctive to the United States because they developed due to the lack of a set hierarchy and a history unlike that of any other nation. The concepts are liberty, egalitarianism, individualism, populism, and laissez-faire.⁴¹ American exceptionalism has many positive attributes, but according to Lipset, it can also be viewed as a double edged sword. There is both a good side and a darker side to the unique qualities of the United States. The good side is that America promotes the equality of opportunity and egalitarianism. The intent is that anyone within the society has the opportunity to be successful regardless of their background, with the only limit being an individual's own ambition. The darker side of American Exceptionalism stems from the very same ideals that are attributed to making America so great. Some of the core values of society

⁴¹ Lipset, Seymour Martin. *American Exceptionalism: A Double-Edged Sword*. (New York: W.W. Norton, 1996).

are challenged through the pursuit of individualism and self reliance. This has created many of society's greatest problems, such as violence, high crime rates, divorce, teen pregnancy, the polarization of wealth, and low voter turnout. Even some of the best principles that uphold society can have unintended negative consequences.⁴²

This leads to the question of whether public policy in America is exceptional as a result of its exceptional qualities. If the problems facing society can be linked to the dark side of American exceptionalism, then it is logical that the policy responses are related as well. Many of the major problems facing government today, however, are common problems facing all developed nations.⁴³ The need to provide access to health care is an example of one such problem. It is the way that we view and handle such problems that extends American exceptionalism through to today.

This double edged sword can help to explain some of the inadequacies in the health care system of the United States. There are many good intentions at play in pursuing health care. The qualities that Tocqueville saw as the best parts of American society led to the system that focuses more on the responsibility of the individual to obtain health care, but it has also left many of the vulnerable sections of society to fend for themselves.

The concept of American Exceptionalism has been longstanding and is constantly referred to in politics to this day. As proposed by John Winthrop, America stands as a "city upon a hill," which provides an example of a society that is immune to many of the problems facing other societies. Though the meaning has transitioned over time, it is still a concept that is often

⁴² Tocqueville, Alexis de, Henry Reeve, and John C. Spencer. *Democracy in America*. 3rd American ed. (New York: G. Adlard, 1839).

Lipset
⁴³ Byron E. Shafer, *Is America Different? A New Look at American Exceptionalism*. (New York: Clarendon Press, 1991).

referred to in political discussion in order to evoke nationalism and support for various causes. John F. Kennedy found inspiration in the idyllic city upon a hill in an address to the people of Massachusetts in 1961. Ronald Reagan discussed his vision of America as a ‘shining city upon a hill’ first in his 1984 acceptance speech at the Republican National Convention and more profoundly in his 1988 Farewell Address to the nation at the end of his presidency.⁴⁴ The idea of American exceptionalism has been invoked many times as it transcends party lines and has the ability to unite the nation which is so often divided. It can thus be a useful tool to be used when eliciting public support for monumental changes.

Conclusion

American exceptionalism may help to explain why the United States lacks a national health care system when most of the rest of the industrialized world has had such a system for years. It is part of the American culture to praise individuals for their success and condemn them for their failures. Individuals are responsible for their own well being. Public services are seen to create dependency instead of as confirming positive rights. Thus the citizens of the United States are not linked by rights and universal public provision of goods but rather by a sense of community of similar people or a shared religion and a vivid nationalistic sentiment. Though nationalism is strong in America, it does not lead to the idea that health care is a right.⁴⁵ Such fundamental disagreements in discussing health care policy leads to a great importance of politics and how the issues are portrayed in order to pass positive legislation that could potentially help to solve some of great problems with the provision of health care in the United States.

⁴⁴ Ronald Reagan. "Presidential Speech Archive." Miller Center." Miller Center.
<http://millercenter.org/president/speeches>

⁴⁵ Rudiger.

Chapter 2: Political Analysis of the Patient Protection and Affordable Care Act

I am not the first President to take up this cause, but I am determined to be the last. It has now been nearly a century since Theodore Roosevelt first called for health care reform. And ever since, nearly every President and Congress, whether Democrat or Republican, has attempted to meet this challenge in some way. – Barack Obama

The timing of the reform was nearly ideal for extensive changes to occur. Obama had just swept up the nation in a revolution which demanded change through his presidential campaign. The primary battle against Hillary Clinton had captivated the country with its historic significance. Upon entering the Oval Office, President Obama had soaring approval ratings and the public was eager to see what he could accomplish. Democrats held the majority in both the House and the Senate and were ready for action. There were 261 Democrats and 180 Republicans in the House of Representatives. In the Senate there were 58 Democrats, two independents who caucused with the Democrats, and 40 Republicans.⁴⁶ Obama was even able to use the recession to his advantage in a push for health care reform to avoid unaffordable costs.

Putting Health Care on the National Agenda: The Presidential Election and Public Opinion

Ever since 1988, a combination of health care and/or Medicare has been among the top five most important issues influencing American voters. It was consistently a higher priority for Democrats than Republicans, as is to be expected based on their ideologies. For the 2008 election period, health care was the second most important issue to Democrats, only falling behind the economy. Though there was a large sentiment that changes needed to be made to the

⁴⁶ Jenniver E. Manning. Congressional Research Service. *Membership of the 111th Congress: A Profile*.

health care system, there was very little consensus regarding what the key problems actually were, let alone how to solve them.⁴⁷

There were two major reasons that the timing was beneficial for health care reform. The first was the recession that was crippling the economy and putting a large strain on the budgets of American families. While the economy created a competing priority for policymakers it also acted as a compelling reason for immediate health care reform. Americans could not afford the continuously increasing health care costs. The other development that put health care on the Congressional agenda was the important role that it played in the 2008 primary elections. The Democrats put a large emphasis on the importance of health care reform and put it on the public's agenda as well as the congressional one.⁴⁸

When Democrats reclaimed control of Congress in the 2006 midterm elections, it was clear that the public was looking for change. After eight years of President George W. Bush in office, the country was clearly open to Democratic candidates in 2008. The major players in the Democratic primary were Hillary Clinton, John Edwards and Barak Obama. Obama was initially the weakest and least specific of the three on the issue of health reform, but all along it was an important issue that was often brought up among the candidates. It was even the first specific issue to be showcased in a Democratic presidential forum.⁴⁹ Though he was not especially impressive compared to the other candidates on health care, Obama did make the promise that “I

⁴⁷ Robert J. Blendon. *American Public Opinion and Health Care*. (Washington, D.C.: CQ Press, 2011), 47-48.

⁴⁸ Blendon, 499.

⁴⁹ Lawrence R. Jacobs and Theda Skocpol. *Health Care Reform and American Politics: What Everyone Needs to Know*. (New York: Oxford University Press, 2010), 30-34.

will judge my first term as president based on...whether we have delivered the kind of health care that every American deserves and that our system can afford.”⁵⁰

When Obama won the nomination after a tight race and turned his attention to defeating John McCain in the general election, he maintained health care reform as one of his key issues, but shifted the framing to an economic issue. In order to entice the former Clinton supporters who were more generally moderate blue collar workers, Obama combined his theme of the necessity of affordable health care with the goal of universal coverage. He still remained relatively vague in his actual proposals as he wanted to continue to appeal to as many voters as possible. It was clearly a time for change, as the election ended with a 365 to 173 Electoral College victory for Obama and a net gain for Democrats in Congress of 19 seats.⁵¹ The House ended up with a 257 to 178 seats Democratic majority. In the Senate the Democrats now held 58 seats and there were two independents that caucused with the Democrats. This victory gave Obama the momentum that he would need to begin making major changes when he was sworn into office.

Actors Involved

It was clear from the campaign that the President elected in 2008 would take on the large challenge of health care reform. As with all legislation that has the potential to make such an enormous impact, there were numerous actors who immediately wanted to become involved. From the early phases there was significantly more media attention for the legislative process than usual, making the actors prominent public figures.⁵² These actors came from a wide range of backgrounds and sources. There were, of course, many political actors from both the

⁵⁰Jacobs and Skocpol, 34.

⁵¹ Brian Naylor. "Democrats Make Major Gains In Congress : NPR." *NPR : National Public Radio : News & Analysis*. 5 Nov. 2008. Web. <http://www.npr.org/templates/story/story.php?storyId=96670543>.

⁵² Jacobs and Skocpol, 50-99.

legislative and executive branches. In March 2012 the Judicial Branch also became involved as the Supreme Court took on the case of the constitutionality of the reform. There were also actors who were not directly involved in the policy making process but that wanted to impact the politicians. These people included lobbyists for various industries such as insurance, big businesses and unions.

As Congress is the branch that actually creates legislation, it had a large number of actors that were extremely involved in the process of creating health care reform. Each house of Congress has a rigid leadership structure. The Vice President of the United States is officially the President of the Senate, but in practice the majority leader is in charge of running the Senate through scheduling, working with committee chairs and directing strategy. The minority leader also plays an important role as they direct strategy and positions for the minority party. The House of Representatives is run by the elected Speaker of the House. There is also a majority and minority leader as well as party whips who play important roles.⁵³ The majority leader of the Senate was Harry Reid during the 111th Congress, and the minority Republican leader was Mitch McConnell. The Speaker of the House was Democrat Nancy Pelosi, the majority leader was Steny Hoyer, and the minority leader was John Boehner.

Congressmen in leadership roles on major committees also became major actors in the health care reform process. Under the guidance of Senators Ted Kennedy and Chris Dodd, the Senate Health, Education, Labor and Pensions Committee was working on a health care proposal bill. Senator Kennedy from Massachusetts devoted much of his career to the health care debate, and after being diagnosed with terminal brain cancer the issue became especially important to

⁵³ Carol S. Weissert and William G. Weissert. *Governing health: the politics of health policy*. (Baltimore, MD: Johns Hopkins University Press, 1996).

him. He was determined to help with the bill even in his final months of life. He, with much help from his staff, produced a draft of a proposal for the committee.⁵⁴ The Senate Finance Committee was led by Chairman Max Baucus, a Democrat from Montana. He was determined to facilitate communication with the Republicans in order to produce a bipartisan bill.

There were other, unanticipated members of Congress that ended up playing a large role in the process. Olympia Snowe was a moderate Republican Senator from Maine. She was given many opportunities to work with Democrats in order to turn possible legislation into something that she could support. In the end the efforts were futile as she eventually stopped working with them, but she still became at least temporarily a common figure in the health care debate.⁵⁵

Senator Ted Kennedy, a longstanding Democrat from Massachusetts, passed away in the middle of the reform process. Republican Scott Brown was elected to take over his seat. This was a possible signal from an extremely liberal state that they were not pleased with the direction that reform was headed. This made many people pushing for reform nervous as some alleged that the health care battle would now come to an unsuccessful end. A new and colossal problem was created for Democrats in the senate as they no longer had a filibuster resistant majority.⁵⁶

Though they were not members of Congress, there are many often conflicting interests looking to be represented in the battle for reform. From the beginning, the administration sought out the opinions of the public. Since the fall of 2008, Democrats from the Senate met with lobbyists for insurance, doctors, and pharmaceutical companies. The hope was that by allowing them to have a voice in the discussions, Congress would have their support. Senator Kennedy

⁵⁴ Robert Pear, "Sweeping Health Plan is Drafted by Kennedy." *New York Times*, June 6, 2009. <http://www.nytimes.com/2009/06/06/us/health/policy/06health.html>

⁵⁵ Jacobs and Skocpol. 83-84.

⁵⁶ Jacobs and Skocpol. 103-105.

called these meetings a “workhorse group.”⁵⁷ The Tea Party conservative movement also arose as a result of the threat of a government takeover of the health care system. Members of the movement vehemently opposed government expansion in the health care industry and disapproved of Obama’s handling of the issue. Republicans such as Congressman Ron Paul also supported a movement towards a smaller and less invasive government.⁵⁸

As the health care legislation progressed, competing interests became more outspoken. Supporters of reform, such as the coalition Business Forward, ran radio ads suggesting that business executives should work with Obama and Congress in the reform process. Opposition groups went as far as to produce a thirty minute video showing the inadequacies of care in Great Britain and Canada, both of which have universal health care systems. Millions of dollars were spent on the media in order to influence public opinion in favor of certain interests.⁵⁹ One such ad was meant to raise fear about losing the ability to control one’s own health decisions. An elderly couple is discussing a surgery that would not be covered that the husband needed to survive, yet their tax dollars would be going towards elective abortions. The advertisement closes with: “Our greatest generation denied care, our future generation denied life.” This was paid for by the Family Research Council Action, but there were countless other organizations that funded both positive and negative advertisements.

Obama’s Role in the Legislative Process

President Obama has played an enormous role in helping to pass the health care bill. Robert Spitzer argues that over time the President has become the chief legislator in the

⁵⁷ Robert Pear. "Democrats Agree on Health Plan; Now Comes the Hard Part." *New York Times*, March 31, 2009. <http://www.nytimes.com/2009/04/01/us/politics/01health.html>.

⁵⁸ Jacobs and Skocpol, 76-78.

⁵⁹ Robert Pear, "Warring Sides on Health Care Carry Their Fight to TV and Radio Ads." *New York Times*, May 28, 2009. <http://www.nytimes.com/2009/05/28/health/policy/28health.html>.

government even though this is not an official role. The Office of the President generally decides what issues should be on the agenda and produces a budget. The presidency has lobbyists who work with Congress and generally try to determine who will be supporting legislation that the President deems to be of high significance. One of the most powerful tools that the President possesses is the ability to go public with an issue to rally support.⁶⁰ Obama has utilized many of these various tools in pushing for health reform. He continuously claimed that he was going to leave the details up to Congress, but over time Obama became increasingly vocal about what he wanted the bill to accomplish and entail. A public relations campaign began with radio addresses and grassroots lobbying across the states promoting the legislation in an attempt to raise public awareness and approval.⁶¹

The pinnacle of Obama's efforts occurred when he went before a rare joint session of Congress on Wednesday September 9, 2009. He spoke for forty-seven minutes, addressing Congress as well as much of the nation. He demanded forward progress from the legislators, saying "The time for bickering is over. The time for games has passed. Now is the season for action."⁶² Obama wanted to make it clear that although they were still open to ideas, they would not put up with tactics meant to stall the legislation. For the first time he stated specifics of what he was looking for in the bill. Even more importantly, he was appealing to the people who were already satisfied with their existing coverage and were extremely skeptical of the impact this plan would have. The morality of the issue was pointed out in the reading of a letter Senator Kennedy had written prior to his death with instructions to the President and emphasized the

⁶⁰ Robert Spitzer, *President and Congress: Executive Hegemony at the Crossroads of American Government*. (Philadelphia: Temple University Press, 1993).

⁶¹ Sheryl Gay Stolberg, "Obama to Forge a Greater Role on Health Care." *New York Times*, June 7, 2009. www.newyorktimes.com.

⁶² Sheryl Gay Stolberg. "Obama, Armed with Details, Says Health Plan is Necessary." *New York Times*, September 9, 2009. <http://www.nytimes.com/2009/09/10/us/politics/10obama.html?pagewanted=all>

importance of the legislation for social equality. The speech was able to help gain some momentum and increase party unity, which proved to be imperative to the passage of the bill.⁶³ Obama has been the driving force behind healthcare reform and was forced to utilize all of the tools available to him to rally the necessary support for passage.

The Unorthodox Legislative Process

As legislation is changing and becoming more complex, so are the systems necessary for new laws to be passed. The textbook version diagramming how a bill becomes a law is no longer accurate in most cases, especially with major legislation. Barbara Sinclair outlines the many changes that have occurred in policymaking, many of which had to be utilized in the attempt to pass the health care legislation.⁶⁴ Referral to multiple committees is a fairly new occurrence, but it makes sense to have many points of view for important reforms such as health care. Five different Congressional committees proposed a version of possible legislation and had a large influence over what the final bill would look like. Sinclair says that the shift towards unorthodox methods occurred before Congress became increasingly polarized, but it seems that in this case, party politics is a major factor contributing to the need for alternative methods to pass the bill. The budget process is protected from intense polarity in Congress as reconciliation bills and budget resolutions are protected from filibusters in the Senate.⁶⁵ This provided Senate majority leaders with a possible tool for passage if they could not get the necessary sixty votes for cloture.

From early on in the process, the White House pressured Senate leaders to take some precautions to make sure that the Republicans would not be able to stop the passage of this top priority legislation. They planned to use special Senate rules to avoid the threat of a filibuster.

⁶³ Stolberg, "Obama, Armed with Details, Says Health Plan is Necessary."

⁶⁴ Barbara Sinclair, *Unorthodox Lawmaking: New Legislative Processes in the U.S. Congress*. 4th ed. (Los Angeles: SAGE, 2012), 108-110.

⁶⁵ Sinclair, 129.

Under the process of reconciliation, Democratic leaders determined that health legislation that met targets established in the budget could be passed by a simple majority. They claim that this is simply a protection, only to be used as a last resort. Republicans vehemently opposed the idea, saying that health care is far too important of an issue to exempt it from normal Senate rules.⁶⁶ The Democrats were able to get all 58 Democrats and two Independents to vote in favor of the Senate bill, avoiding the need for reconciliation. In order to protect the caucus from an unpopular vote, Speaker of the House Nancy Pelosi considered using a “deem and pass procedure” to move the bill on to be signed by the President. This is also called the “self executing rule.” This would allow the House to vote on a bill of changes to the Senate bill, which would have a provision stating that by passing these changes, they would deem that the Senate bill was passed. This would protect Representatives from having an outright vote for the Senate bill that still had some unpopular portions that needed adjusting.⁶⁷ Even with a democratic President and a majority in both houses, various legislative maneuvers were considered and utilized, but the Democrats were not the only ones scheming throughout the healthcare process.

Having a considerable minority, the Republicans had a clear disadvantage in the 111th Congress, but this created more of an incentive for them to use various strategies to have their ideas heard and to slow what they considered to be a disastrous reform bill. The Senate minority leader, Mitch McConnell, had an especially extensive knowledge of procedure, and planned to use this to keep the Republican Party unified and to allow them to have a say in policymaking. He was very similar to Senator Reid, the majority leader, who also had put to use his extensive knowledge of Senate procedure. McConnell embraced unorthodox lawmaking as the Democrats

⁶⁶Sinclair, 187.

Carl Hulse. "Obama Tactic Shields Health Care Bill from a Filibuster." *New York Times*, April 25, 2009. www.newyorktimes.com

⁶⁷ Lori Montgomery and Paul Kane, "House May Tru To Pass Senate Health-Care Bill Without Voting On It." *Washington Post (Washington D.C.)*, March 16, 2009. www.washingtonpost.com

did, but as the minority the Republicans used the strategies to stop or stall the passage of legislation. Throughout the entire process they threatened filibusters and added numerous and often irrelevant amendments. Senator McConnell played a fundamental role in keeping the minority unified. He was determined to keep even a single Republican from voting for the health care bill, as this would have allowed Democrats to claim it was a bipartisan bill. The public generally assumes bipartisan must mean that it is good, and this bill had major flaws. It was not that the Republicans were completely against any reform, they just wanted to have a say in the process. While the obstructionist method slowed down the health care bill, it led many to criticize the Republicans as only trying to impede legislation, claiming they did not have any ideas of their own. By keeping the party unified in opposition of the bill, McConnell forced the Democrats to use legislative maneuvers that tainted the public's opinion of Democrats and their ability enact policy changes.⁶⁸ Both parties used unorthodox practices in the health care reform process, but the Democrats have received more public scrutiny.

The Legislative Outcome: Obamacare

On March 23, 2010 when President Obama signed the long anticipated Patient Protection and Affordable Care Act into law, Americans were split on their support and uncertain about what the document, which contained thousands of pages of political and legal jargon, actually meant. Within the enormous document lies fundamental changes to the way health care is provided and funded that will impact the lives of all citizens and businesses, whether they like it or not. This section will outline the basic changes that will be implemented.

⁶⁸ Carl Hulse and Adam Nagourney. "Senate G.O.P. Leader Finds Weapon in Unity." *New York Times*, March 16, 2010. www.newyorktimes.com.

The PPACA set out a blueprint of changes that would be put into action over the course of the decade following the passage of the bill. The goal of the bill is to benefit the large majority of Americans and to protect the interests of the citizens. The law is broken down into ten titles, each focusing on a different aspect of reform. This was followed with the passage of the Health Care and Education Reconciliation Act of 2010, which made changes to the PPACA to ensure that it satisfied both houses of Congress.

One of the main attributes of the law is to enforce restrictions on health insurance providers in order to protect citizens who are enrolled in their programs. The Title I Subtitle A “Immediate Improvements in Health Care Coverage for All Americans” lays out some of these new protections. It places restrictions on creating limits for lifetime benefits as well as makes it illegal to rescind coverage of individuals. Some preventative procedures are required to be covered with no cost or premium to be paid by the insured. Children can be covered under their parent’s insurance plans until they are 26 years old. These requirements were implemented within six months of the signing of the bill into law.⁶⁹

New reporting regulations are imposed on insurance providers as well as hospitals and health care professionals. The newly appointed Secretary of Health and Human Services develops standards for health plans and reporting requirements. Health plans are required to submit information on loss ratios in order to determine possible rebates for enrollees. All hospitals have to start providing a public list of the services they provide and what the charges are to help increase competition and to educate consumers on prices. New regulations are also imposed that restrict the allowed increase on premiums each year. Cost increases are especially

⁶⁹ U.S. Congress *Patient Protection and Affordable Care Act*. Public Law 111-148. 111th Cong., (Washington, DC: GPO, 2010). Sect. 1001-1004.

restricted for Medicaid.⁷⁰ The sharing of information with the public was also to be improved. A website was created by the Secretary to spread information on affordable health insurance options in each state.

Pre-existing conditions have always created a problem for insurance companies. Insurance premiums are based on risk, but someone with a pre-existing condition does not just have the risk of falling ill, they already are. This means that insurance companies would not want to charge less than the amount they know they will have to spend on this sick person. It conflicts with the very nature of insurance, so people with preexisting conditions often found it impossible to find coverage. Section 1101 immediately creates a high risk health insurance pool that will provide coverage to individuals with preexisting conditions until 2014, when it becomes illegal to exclude individuals based on these conditions.

One of the main goals of health care reform was to expand coverage and lessen the number of uninsured individuals. About 32 million people who did not have insurance in the past will have insurance as a direct result of the new legislation. This increases the percentage of insured people to 94% of Americans.⁷¹ Part of this increase is due to a new provision that forces insurance plans to accept every employer or individual who applies for coverage and to renew already existing customers. Eligibility rules are not allowed to be based on uncontrollable factors such as medical history, genetic information, or medical conditions.⁷² The largest increase in coverage will be due to the expansion of Medicaid to more individuals and families.

Coverage will be provided in a new way with restrictions on the premiums that may be charged. Through the use of benefit exchanges, individuals and families that are not eligible for

⁷⁰ U.S. Congress *Patient Protection and Affordable Care Act*, Sect 1103.

⁷¹ Jacobs and Skocpol, 122

⁷² U.S. Congress *Patient Protection and Affordable Care Act*, Sec. 1103.

large employer based insurance plans can partake in a marketplace with competing policies. Coverage is separated into four different levels. A Platinum plan covers 90% of costs, Gold covers 80%, Silver is 70%, and Bronze is 60%. There is also a cheaper catastrophic coverage option for healthy individuals under 30 years old who do not need or want to pay for more extensive coverage. New cost-sharing-limits are also imposed. No individual plan in the small group market can cost more than \$2,000, or \$4,000 for a family.⁷³

The new regulations of the private sector created by the Patient Protection and Affordable Care Act were combined with changes to the public programs that were already in existence. Medicaid coverage will be expanded to low income people and the expansion will be funded mainly by the federal government. All people with family incomes of up to 133 percent of the poverty level will be eligible for Medicaid in 2014. The Children's Health Insurance Program (CHIP) will receive a significant increase in federal funding. Not only will the number of people covered expand, it will become easier to enroll through the use of state run websites. A new Health Care Office was to be opened by March 1, 2010 in order to coordinate dual eligibilities and payments for the Medicare and Medicaid programs. This office is also meant to improve communication between the state and federal levels in the provision of these programs.⁷⁴

The next impact of the PPACA was to focus on the quality and efficiency of the health care system. One way that the law hopes to improve both of these is through linking the payments for medical services to the quality of the outcomes produced. The focus will be on high cost conditions that are especially common, such as cardiac surgery or care for pneumonia. Another intention is for consumers, or patients, to become more knowledgeable about their

⁷³ U.S. Congress *Patient Protection and Affordable Care Act*, Sec. 1201,1302

⁷⁴ U.S. Congress *Patient Protection and Affordable Care Act*, Sec. 2001, 2101, 2201.

treatment options and costs so that they can make more informed decisions. New patient care models are to be developed with the help of a new Center for Medicare & Medicaid Innovation. Protections will be added to rural areas to help defray their costs. Part C Medicare Advantage plans will have payments based on the average of bids that are submitted by insurance plans in each market. There will also be changes to the Medicare Part D prescription drug benefit that will help to further solve the problems created by having a gap in coverage that exposes the elderly to unaffordable prescription drug costs. For drugs to be included in this coverage, the manufacturers have to give a 50 percent discount. A Medicare Advisory Board of fifteen experts is to be created to present ideas to Congress on how to continue to reduce costs while increasing quality of care.⁷⁵

The next section of the reform law focuses on preventing chronic disease and improving public health. Yet another council will be created, with the purpose of promoting healthy policies through a national strategy. There will be a new focus on preventative care through various new programs. Some examples are the use of school based health clinics, a dental health education campaign, full Medicare coverage for annual physicals and providing grants to states that give incentives for healthy lifestyles to Medicaid beneficiaries. The goal of these programs is to lower total costs through increasing preventative care that can help avoid large costs later.⁷⁶

Having a strong and well educated medical care workforce is essential to the supply side factors of improving health care while reducing costs. Title V focuses on the delivery and access of health care to all individuals.⁷⁷ The healthcare workforce will be studied in order to better align the supply and demand requirements. In order to increase the absolute number of

⁷⁵ U.S. Congress *Patient Protection and Affordable Care Act*, Sec. 3001, 3021.

⁷⁶ U.S. Congress *Patient Protection and Affordable Care Act*, Sec. 4001

⁷⁷ U.S. Congress *Patient Protection and Affordable Care Act*, Sec. 5001.

individuals working in health care, the federal student loan programs will be modified in order to make them more enticing. People who specialize in medical areas where there is a shortage of workers, who work in underserved areas or with underserved populations will receive special incentives. Better training systems will be developed in areas such as family medicine, internal medicine, long term care, dentistry, nursing, and some others. It is impossible to have an effective health care system without having exceptional medical workers across the country.⁷⁸

To help ensure credibility to the federal health programs, there will be new transparency requirements as well as increased tactics to prevent cases of fraud. Medical supply manufacturers have to start reporting any gifts or transfers that they make to physicians or teaching hospitals. Increased information needs to be provided from nursing home facilities serving Medicare and Medicaid patients. More opportunities to submit complaints must also become available. Incentives will be provided to facilities that will self report problems and work to correct them on their own. Providers and suppliers working with Medicare, Medicaid or CHIP will begin to face stricter screening and requirements. Severe penalties will be imposed on anyone who knowingly makes false statements on applications or does not return overpayments. These fines can be up to \$50,000 per offense. Funding to the Health Care Fraud and Abuse Control will be increased by \$10 million each year from 2011 to 2020. The elderly represents a group that often faces abuses. The Elder Justice Act is implemented to prevent abuse, neglect and exploitation to the elderly. Though no policy suggestions are implemented, there is also encouragement to reform the way that issues of malpractice are addressed.⁷⁹

⁷⁸ U.S. Congress *Patient Protection and Affordable Care Act*, Sec. 5201-5209.

⁷⁹ U.S. Congress *Patient Protection and Affordable Care Act*, Sec. 6401-6408

There have been many changes enacted due to the Patient Protection and Affordable Care Act and many that are still to come, but with these changes comes a price. Though there are claims to eventually create cost savings, there is an upfront cost to reforms that needs to be discussed. This is where the financing and economic framework becomes especially important.

Sources of Revenue to Fund Reform

Title IX of the Patient Protection and Affordable Care Act discusses the revenue provisions of the law. A new excise tax will be imposed of 40 percent on any health care plan that has an annual premium of above \$8,500 for individuals or \$23,000 for families that is sold as a self-insured plan or in the group market. This is meant to discourage plans with excessive coverage and abuse of the tax incentives of employer based care. Workers W-2 forms will have to disclose the amount of health benefits provided by the employer to the employee. There will be additional taxes for health savings account withdrawals before the age of 65 and for Archer MSA withdrawals. Contributions to tax favored health flexible spending accounts cannot exceed \$2,500 per year. A new annual flat fee of \$2.3 billion is imposed on the pharmaceutical market and will be paid according to market share. Medical device manufacturers will also have an annual fee, though theirs will be \$2 billion. Health insurance providers will face the largest flat fee of \$6.7 billion annually to be divided across the industry by market share. Another cost cutting measure is to eliminate the deduction for the employer subsidy for maintaining prescription drug plans for retired employees who are eligible for Medicare Part D. The gross income threshold for being able to claim medical expense deductions will increase from 7.5 percent to 10 percent. A new excise tax of 5 percent was imposed beginning January 1, 2010 on all elective cosmetic procedures performed by a medical professional. New limitations on executive compensation limit deductions to \$500,000. The hospital insurance tax rate will

increase by 0.5 percent for individuals earning over \$200,000 and couples earning over \$250,000. The non-profit Blue Cross Blue Shield program can have access to special deductibles, but only if their medical loss ratio is 85 percent or higher.⁸⁰

It is significant to note that there is not a public option included in the Act, but this is certainly not due to lack of trying. This was central to many of the Democratic plans, but it simply could not get the necessary support within Congress to pass. A public option could create a health insurance plan that was publically run that would compete with the private market insurance companies.⁸¹ It was meant to be the keystone of the reform movement, but as public support fell, it was clear that bipartisan support was impossible, and there was not overwhelming support from all democrats, the public option was dropped from the legislation.

⁸⁰ U.S. Congress *Patient Protection and Affordable Care Act*, Sec. 9001-9022.

⁸¹ Jacobs and Skocpol, 78

Chapter 3: The Economics of Health Care

It is not government's job to mandate responsibility on our behalf. We have the intelligence and good sense to make wise consumption choices for ourselves and our children. It is up to us to do what is best for our health and our children's health. -Senator Michael Crapo

The United States has a long and complicated history of political and economic thought. The battle for health care reform brought this to the forefront as a compromise needed to be found in an attempt to better the nation. President Obama placed great importance on the economics and financing of this reform, so the economics of health and healthcare were raised to a new level of prominence. There is no such thing as the perfect health care system. There will always be concessions that have to be made. It would be impossible to have a system that is completely accessible for all, insulates individuals from the costs as well as is affordable for society overall. It is possible, however, to create the optimal system based on the importance that society places on each of these three factors.⁸² Economics is all about the allocation of scarce resources. The best health care system will find a way to provide efficient and equitable care.

Supply and Demand

In a market environment, supply and demand will dictate the equilibrium that occurs. In economics, equilibrium determines the optimal level output and the price for a certain good. In terms of health care, the supply refers to medical care professionals, technologies, hospitals, physicians, medications and other goods and services that help to promote good health. The demand is for good health, and thus consuming these goods will lead to increased levels of

⁸² Arnold S. Kling. *Crisis of Abundance: Rethinking How We Pay for Health Care*. (Washington, D.C.: Cato Institute, 2006), 45.

health and higher utility. The demand for medical care is influenced by factors such as price, the price of substitutes and compliments, income, health status as well as tastes and preferences.

Due to the high costs of health care, there is a demand for medical insurance. Most people are risk adverse, meaning that they are better off with a definite outcome than when there is a risk of a positive or negative outcome. Insurance helps to provide individuals with a higher level of utility for the same quantity of consumption. Though logically this makes sense, the health care market operates differently. When health care costs and premiums increase, empirical evidence shows that people do not act as expected. Instead of buying more insurance to be protected from the high costs, individuals tend to buy less insurance as they cannot afford it.⁸³ As health care costs have been rising at much higher rates than inflation, this causes enormous problems. For people that do have access to health insurance, it creates problems for the demand and distorts the market equilibrium.

One of the major economic problems with the United States health care system is that customers pay a very small percentage of the services that they consume. Individuals are insulated from the costs of health care. Only about 14% of health care costs are paid out of pocket.⁸⁴ Insurance is generally considered to be protection for individuals or businesses against risk. Health insurance in the United States is more comprehensive, meaning that procedures and services are covered beyond catastrophic risks. Preventative measures, vaccines and routine doctors visits are generally covered, but these are not a risk with a slight probability of occurring. These are almost guaranteed to occur. Risk adversity makes it logical to have insurance against large and infrequent expenses. Many of the services that health insurance currently cover do not

⁸³ Thomas H. Rice, and Lynn Unruh. *The Economics of Health Reconsidered*. 3rd ed. (Chicago: Health Administration Press, 2009), 74-79.

⁸⁴ Kling, 51.

fall into this category.⁸⁵ This goes beyond insurance as it insulates individuals from their health expenses. Consider homeowners insurance, for example. Insurance does not cover slight fixes or preventative renovations such as painting or window replacements, but if a fire were to destroy the house insurance would protect the owner from this large and unlikely risk. Insurance creates a moral hazard which entices individuals to over consume health care. This causes a shift in the market equilibrium which results in higher prices. The burden of these prices, however, is not put on the consumers but rather on the insurance companies and the government, both of which are third party payers. Estimates say that for some procedures, as many as 30 percent of the procedures undertaken could be unnecessary.⁸⁶

Supply also plays an instrumental role in determining the market equilibrium. The amount that firms want to sell at a given price determines the supply. In a competitive market, the suppliers are relatively passive and act in response to changes in demand with their willingness to produce based solely on price. For health care, however this is not the case. The physician plays a large role in determining what the demands of the consumers will be based on their recommendations. In some situations, such as in hospitals, the suppliers may actually influence the price. Health care has many social implications, so the suppliers may base their production on factors other than price. They take into account the needs of the community and the quality of the care provided. There are current shortages in the supply of different medical care professionals. Normally this would lead to higher wages in these fields and thus solve the shortage. The fact that these shortages still exists shows that there are flaws in applying the theory of a perfectly competitive market to health care.⁸⁷

⁸⁵ Kling, 51.

⁸⁶ Rice and Unruh, 103.

⁸⁷ Rice and Unruh, 161-170.

The Free Market Economy

The free market economy is one of the fundamental institutions supported by American economic thought. Most consider the market to be the best way to efficiently allocate goods and to ensure economic growth. It provides incentives and rewards for hard work and innovative ideas. Though government intervention is occasionally necessary to avoid market failures, the theory behind the free market is that it is most effective when left alone. Non economists may view the market as wasteful and unfair and believe that industries could be better served through government intervention, but these criticisms can be disputed. State run industries are often extremely inefficient and do not effectively allocate resources. The opportunity for profits gives companies the incentive to be innovative and develop new products even though the process is costly. The duplication that is created by competition within industries has its disadvantages outweighed by the benefits provided by competition. Duplication in itself can be beneficial as it allows for more trial and error and a more diverse array of ideas and possible solutions.

Competition in the Market

Competition lays the foundation for a free market economy. Producers in the free market have to compete with one another to serve the customer's needs at the lowest cost. Efficiency is rewarded and inefficient producers are forced out of the market.⁸⁸ There are certain prerequisites that must be present in order for competition to occur and be successful. A free market requires a large amount of competitors. Within this group there needs to be entrepreneurs who will develop new and innovative ideas. There needs to be low barriers to entry in order to entice many competitors to participate. Within the industry there needs to be some flexibility so that

⁸⁸ Michael F.Cannon, and Michael Tanner. *Healthy Competition: What's Holding Back Health Care and How to Free It*. (Washington, D.C.: Cato Institute, 2005), 51.

entrepreneurs can experiment with new ideas and adjust to changing circumstances. Finally, competition requires there to be various mechanisms in place to evaluate the different ideas of producers. The best means of evaluating the health care industry is through the feedback of patients. In a market economy this feedback becomes clear through the individual consumption choices that are made.⁸⁹

Competition does not only have to be solely within the health care industry in the United States. A way to ensure that the health care market is functioning properly can be through an international comparison of prices. Many of the countries that have government run health care systems are faced with long waiting periods before medical services are available. This has created a new international market of hospitals who want to treat these patients outside their home country to avoid the wait. This market also attracts patients who face expensive surgeries that they cannot afford in the United States but can receive treatment for a fraction of the cost somewhere else in the world. In 2003, India treated 150,000 international patients who traveled there for care that they could not receive or afford elsewhere. The savings end up being considerable. For example, a man in North Carolina with no health insurance needed open heart surgery. He was told that the procedure would cost him \$200,000. Due to the extraordinary cost he decided to fly to New Delhi and had the very same procedure done for less than \$10,000. The surgeon in India was not a substandard doctor but a former professor at the New York University Medical School. Costs are often one-fifth to one-quarter the price that would be charged in the United States.⁹⁰ This international competition has created new and innovative solutions to high costs and long waits, demonstrating the positive impact that competition can have.

⁸⁹ Cannon and Tanner, 4.

⁹⁰ Cannon and Tanner, 8-9.

Competition has demonstrated its power internationally, but there are some segments of the United States health care industry that show the beneficial nature of competition. Cosmetic surgery is a specialty that provides high quality procedures with relatively low costs. These procedures are usually elective and therefore are paid for out of pocket. Unlike other sectors of the health care industry, this forces individuals to weigh the costs and benefits of the services before making a decision on care. This has caused the inflation adjusted prices of cosmetic surgery to fall since it was gaining prevalence in the 1990s. Laser eye surgery provides another example of effective competition. Prices fell from \$2,100 per eye in 1999 to less than \$1,600 per eye in 2001. Over the counter medications tend to have low prices because there are many competing brands selling the same or very similar products. When a new medication is developed and under patent it tends to be extremely expensive, but once competitors are allowed to produce similar products the price diminishes significantly.⁹¹

While competition propels the rest of the American economy, it is noticeably lacking in the health care sector. Government intervention deserves much of the blame for disabling competition in the sector. It is common knowledge that regulation hinders competition, and there is significant government involvement in the provision of health care. While the government has the good intentions of trying to protect consumers and lower costs of care, intervention can often have the opposite effect of that which was intended. In the efforts to protect the health of citizens the government ends up promoting excessive levels of health care consumption. The system of having much of health care financing come from a third party payer also stifles competition. Patients do not have the incentive to search for the best value, so physicians do not have the incentive to do high quality work at competitive prices. Employer based health insurance

⁹¹ Cannon and Tanner, 7-8.

discourages competition on an individual level. Most companies provide very few options, if any, to their employees regarding what type of insurance they want. Approximately 53% of workers have, at most, two options given by their employer.⁹² A free market solution to the health care problem is not possible until true competition can be reintroduced into the industry.

The Role of Government in Economics

The role that government should play and the extent of government influence on society are widely debated topics. Even supporters of free markets must admit that there are times where government intervention is necessary. A widely agreed upon purpose of government is to provide public goods. These will be underprovided in the market, so it is necessary for the government to ensure that the citizens have access to them. The problem is that many important goods are not completely public or private. Disagreements on these goods, such as health care, complicate the debate on how active the government should be.

Health care is an especially sensitive issue, as it often responds to life and death situations. Economists tend to focus on efficiency, but when considering medical services many people think first about fairness in the system. The government intervenes to help prevent market failures. Medicare and Medicaid were created to ensure that the most vulnerable portions of the populations, the poor and the elderly, would have access to adequate care. There are two main objectives of the government in the area of providing health care: to redistribute medical resources to the poor and to improve efficiency.⁹³ Though the intentions may be good, economists often see government through a much more negative light.

⁹² Cannon and Tanner, 51-65.

⁹³ Paul J. Feldstein, *Health Policy Issues: An Economic Perspective*. 5th ed. (Chicago: Health Administration Press ;, 2011), 436.

Just as markets have the potential to fail, so do governments. Sometimes governments do not just correct market failures, they stifle the competition that would be created in a free market. Competition is seen as driven by individuals and consumer choices, and government has the potential to take this away.⁹⁴ The government is monopolistic in nature. This means that it does not have to be as concerned with the bottom line losses and profits that firms operating in the market have to consider.⁹⁵ The government can be a threat to innovation. Bureaucracies tend to be slow in reacting to new situations and even slower at implementing solutions. While some market failures have the potential to be solved through innovation and entrepreneurship, government errors are likely to get worse and remain unsolved.⁹⁶

Government creates many of the same third party payer problems that insurance creates. When the government pays for the coverage of segments of the population, a moral hazard is created. They have the incentive to consume more health services than are actually necessary. Government subsidies effectively lower the costs of care for individuals, but this increases the demand. The increase in demand causes prices to rise even higher, but because individuals do not pay the bill they do not feel the negative effects that could otherwise alter their consumption. The government alters the equilibrium position of health care consumption and price to a level that exceeds what is necessary to promote a healthy society.⁹⁷

The government uses price controls as an attempt to keep costs from exponentially increasing. This creates problems too, because if the controls are set too high or too low the system is inefficient. It would be extremely difficult for a bureaucracy to keep up with what adequate pricing for services should be when the market is constantly changing and new

⁹⁴ Cannon and Tanner, 11

⁹⁵ Rice and Unruh, 49.

⁹⁶ Kling, 79-81.

⁹⁷ Kling, 78-79.

technologies are being invented. Set payment rates create additional waste in the system through their inefficiency and create unnecessary obstacles to competition.⁹⁸

Tax policy is often used to influence various sectors of the economy. The government has historically had favorable tax policies for the insurance market. The money that employers use to pay for health insurance for their employees is exempt from taxes. This lowers the cost of employer based health insurance relative to other goods in the market or other types of insurance policies. These tax incentives have played a major role in making employer based health insurance the most common type of coverage for Americans to have. It generally covers both catastrophic and routine medical expenses. The coverage has expanded beyond paying for unlikely large expenses because the tax incentive makes it less expensive to pay for routine care with tax free earnings than without tax benefits out of pocket. A reliance on employer based health insurance has numerous negative consequences. Just as with government control, the tax incentives take away consumer choice, discourage savings, lower wages, and create discrimination against individuals who are not able to have access to employer based health insurance. This system is also partially responsible for the high number of uninsured people in the United States as people lose their coverage when they change jobs or face periods of unemployment.⁹⁹

Numerous government regulations of the health care sector distort the market and are a factor in keeping it from operating in a competitive environment. Christopher Conover of Duke University conducted a cost-benefit analysis of health care regulation to test its effectiveness. His findings demonstrated that costs outweigh the benefits at a two to one ratio. The costs of health

⁹⁸ Cannon and Tanner, 81-82.

⁹⁹ Cannon and Tanner, 67-68.

care regulation were estimated to be more than Americans spend on oil and gasoline and twice as expensive as annual expenditures were for the war in Iraq. Regulation costs make up approximately 10 percent of total US health expenditures without even considering many government activities. Some regulations are important for protecting consumers, but others create unwanted costs for protections that all consumers may not see as necessary.¹⁰⁰

One area that the problems with government regulation are especially evident is in the pharmaceutical industry. New drugs are imperative for curing and preventing diseases. Innovation is essential to success and the ability to access profits is what drives the immense amount of capital that has to be invested into the research and design departments. The Food and Drug Administration (FDA) is faced with the daunting task of testing all of the drugs that companies want to sell in the market. The testing and approval process is extremely long as it increased from averaging 8.1 years in the 1960s to 15.2 years in the 1990s. Often the FDA ends up inadvertently keeping lifesaving treatments off the market which causes unnecessary deaths. The FDA has a monopoly over the approval process which means that there is less pressure to reform the flaws that clearly exist in the administration.¹⁰¹

It is staggering how much is actually spent on US health care when taking into consideration all of the different ways that government is involved in and contributes to the health care sector. Direct government payments, public employees benefit costs, and tax subsidies added up to about \$723.8 billion in 1999, which was \$2,604 per capita and 59.8% of total health spending. According to a study by Woolhandler and Himmelstein, the amount that the United States government spends on health care per capita is enough to pay for universal

¹⁰⁰ Cannon and Tanner 115-116.

¹⁰¹ Cannon and Tanner 121-128.

health care system based on the figures of other nations. Basically, the US pays for universal health insurance without actually having it.¹⁰² Americans viciously object to the idea of raising taxes, but taxes already fund a much larger portion of health care than many realize.

Conclusion

The free market and the role of competition in creating an efficient equilibrium price and quantity of medical services provided are central to the discussion of the economics of health care. By promising that health care reform would be beneficial to the budget deficit, Obama made a commitment to taking the economic theories and cost-benefit analysis into consideration in trying to fulfill social justice. It is important to understand the theoretical framework behind the economics of health care in order to understand the impacts that the Patient Protection and Affordable Care Act actually have on society and budgets.

¹⁰² Steffie Woolhandler and David U. Himmelstein. "Paying For National Health Insurance- And Not Getting It." *Health Affairs* 21, no. 4 (2002). <http://www.pnhp.org/publications/payingnotgetting.pdf>

Chapter 4: Economics and Obamacare

There's a need for accepting responsibility - for a person's life and making choices that are not just ones for immediate short-term comfort. You need to make an investment, and the investment is in health and education. - Buzz Aldrin

Though Obamacare did not implement universal health insurance, it contained policies that would move the country in that direction. Access to insurance was greatly expanded through the passage of the PPACA in 2010. Coverage is to be expanded to 95% of all legal Americans. This is done through a combination of expanding eligibility to Medicaid, individual and employer mandates, and credits for private insurance.¹⁰³ The overall cost of the new law will be \$938 billion over 10 years. Some projections say that it will reduce the budget deficit by \$143 billion in the first decade and by \$1.2 trillion in the second decade after the implementation.¹⁰⁴

In order to achieve the goal of expanded coverage, Obamacare utilizes both individual and employer mandates. An employer mandate states that large employers with more than 50 full time employees need to provide health insurance that satisfies minimum requirements for their workers or pay a penalty to the government. In the PPACA the penalty is \$2,000 per full time employee that would receive a premium credit or cost-sharing subsidy. The first 30 employees are not included in the calculation of the penalty payment.¹⁰⁵ The idea supporting an employer

¹⁰³ Feldstein, Paul J.. *Health Policy Issues: An Economic Perspective*. 5th ed. (Chicago: Health Administration Press ;, 2011).

¹⁰⁴ Elenora E. Connors and Lawrence O. Gostin. "Health Care Reform- A Historic Moment in US Social Policy." *Journal of the American Medical Association* 303, no. 24 (2010). <http://jama.ama-assn.org/content/303/24/2521.full.pdf+html>, 2522.

¹⁰⁵ U.S. Congress *Patient Protection and Affordable Care Act*. §§ 1513, 1514 and 10106 adding §§ 4980H and 6056 to the Internal Revenue Code (IRC); § 1003 of Reconciliation Bill).

mandate is that the employer will help to pay the costs of providing insurance, but in reality this system pushes the costs of insurance onto the employee through lower wages.¹⁰⁶

The individual mandate is one of the most fundamental changes that the PPACA makes to the health care system. It requires that all individuals maintain at least a certain level of health coverage throughout the year or pay a penalty. All of the government sponsored plans fulfill the mandate, as well as employer sponsored plans and individual market plans that fulfill the minimal requirements. The penalty is the higher amount of either a fee for each individual or a percentage of the individual's taxable income. The flat fee will increase from \$95 in 2014 to \$325 in 2015 and to \$695 in 2016. After this point the amount would be tied to inflation and is not to exceed 300% of the flat dollar amount. The rates for charging a fee as a portion of an individual's income that is above a certain threshold will also be phased in starting in 2014 at one percent. In 2015 it will rise to two percent and finally 2.5% in 2016.¹⁰⁷ The purpose of the individual mandate is to insure that all individuals who can afford coverage buy at least catastrophic coverage so that they do not become a burden to society in the event of an expensive illness or procedure. For people who cannot afford to fulfill the requirements of the mandate, premium credits and subsidies will be provided. By adding so many additional people to the insurance pool it would increase competition between insurance companies as they try to attract new business. This would hopefully raise quality while lowering costs through market mechanisms.¹⁰⁸

In an attempt to contain rising costs, the PPACA uses government regulations in many of the cost containment mechanisms. The goal is to entice insurers to lower prices and gain

¹⁰⁶ Feldstein, 460-461.

¹⁰⁷ U.S. Congress *Patient Protection and Affordable Care Act* §§ 1501, 1502, 1002 of Reconciliation Bill

¹⁰⁸ Feldstein, 461-462.

efficiency by competing to have the best quality rather than avoiding the sick. Implementing new regulations has a cost as well, so determining the impact will require a study of the costs and benefits of the new law.

Did Obama's Economic Framework Help to Create a Bill that Aids the Economy?

President Obama claimed that health reform was necessary in order to help turn the economy around after the recession, but opinions are divided on just what the impact will be. The Congressional Budget Office estimates that there will be a net reduction in federal deficits of \$124 billion over the period from 2010 to 2019. Most of these net reductions will come from health care and revenue provisions and the rest of the reductions come from the education provisions of the Reconciliation Act. The number of uninsured people is estimated to decrease by 32 million, to 23 million uninsured. Of this number, however, about one third of the individuals are illegal aliens who do not qualify to partake in the benefits of the PPACA.¹⁰⁹

Costs of Reform

The Centers for Medicare and Medicaid Services completed a detailed study on the implications of the Patient Protection and Affordable Care Act. They calculated the costs of various provisions from the law over the period from 2010 to 2019. Coverage expansion through Medicaid and additional funding for CHIP will cost \$828.2 billion dollars over the period. Other Medicaid and CHIP provisions will cost \$28.3 billion. Immediate reform measures cost \$10 billion, but these are only over the period of 2010 to 2012. Some of the provisions are in fact estimated to bring overall cross savings. Medicare will end up saving \$575.1 billion over nine

¹⁰⁹ Congressional Budget Office. U.S. Congress. *Final Cost Estimate*. By Douglas W. Elmendorf. March 20, 2010. (Washington, D.C.: United States Government Printing Office, 2010).

years. Reforms aimed at limiting the trend of rapidly increasing costs will save \$2.3 billion from 2010-2019. The Community Living Assistance Services and Supports (CLASS) program will bring \$37.8 billion in savings. This program is a voluntary Federal insurance program for people with cognitive impairments or who cannot conduct normal daily activities. It is financed entirely through participant premiums with no opportunities for Federal subsidies. The savings, however, are misleading as they are due mainly to the initial 5 year period where no benefits would be paid. In the long term benefits are likely to exceed premiums and the system could become unsustainable without further reforms.¹¹⁰ There is a net cost of \$251.3 billion over the first decade. There are revenue provisions that are not included in this cost analysis that are expected to help pay for the costs of the PPACA. The Congressional Budget Office has estimated that with the Medicare savings, additional taxes, and other revenues, the revenues and reductions are more than the costs and lead to a net deficit reduction.¹¹¹ At least for the first nine years following the implementation of the PPACA, health care costs will continue to rise because the increase in coverage will exceed the measures that are meant to reduce costs.

Tax credits to help people pay for premiums and subsidies to make out of pocket costs for medical services more affordable create more costs for the PPACA. Tax credits help people with incomes up to 400 percent of the Federal Poverty Level to pay their premiums. These individuals would only have to pay premiums in a range from 2 to 9.5 percent of their income. Estimates show that about three-quarters of the 25 million people enrolled in the Exchange would benefit from these subsidies. These subsidies will cost the government approximately \$451 billion

¹¹⁰ U.S. Congress *Patient Protection and Affordable Care Act*, Sec. 8001, 8002.
U.S. Department of Health & Human Services. Centers for Medicare & Medicaid Services. *Estimated Financial Effects of the "Patient Protection and Affordable Care Act, as Amended*, by Richard S. Foster, April 22, 2010, (Baltimore, MD, 2010), 21.

¹¹¹U.S. Department of Health & Human Services. *Estimated Financial Effects of the "Patient Protection and Affordable Care Act, as Amended*, 1-3.

through 2019. Cost sharing credits would also apply to individuals and families with incomes up to 400 percent of the Federal Poverty Line (FPL). This will cost \$55 billion through 2019 to help people pay for out of pocket health services.¹¹²

Sources of Revenue

One way that the rising costs of health care will be offset is through penalties imposed on individuals and employers who do not comply with their new mandates. These penalties are expected to add up to \$120 billion through 2019. The individual penalties are expected to add up to \$33 billion and the employer penalties would produce \$87 billion in new revenues. This amount is fairly small due to the low penalty payments.¹¹³

Effects on Insurance and Coverage

One of the major goals and cost cutting techniques that the legislators wanted to achieve was to increase the percentage of the population that was covered by various forms of health insurance. An additional 34 million people will have access to coverage as a direct result of the PPACA by 2019. The number of Medicare beneficiaries will not change and the number of individuals covered under employer sponsored plans will decrease from 165.9 million to 164.5 million from 2010 to 2019. About 18 million additional people would be covered by Medicaid due to less restrictive eligibility requirements that allow adults that are under 133 percent of the Federal Poverty Line to be Medicaid beneficiaries. Sixteen million people, most of whom were previously uninsured, will get coverage through the American Health Benefit Exchanges. Many

¹¹² U.S. Department of Health & Human Services. *Estimated Financial Effects of the “Patient Protection and Affordable Care Act, as Amended*, 5.

¹¹³ U.S. Department of Health & Human Services. *Estimated Financial Effects of the “Patient Protection and Affordable Care Act, as Amended*, 5.

people who purchase individual coverage through the exchanges will be eligible to receive Federal premium or cost sharing subsidies.

The American Health Benefit Exchanges are meant to make it easier for consumers to understand different health insurance plans and to create a market to purchase different options. It is estimated that of the people eligible to purchase insurance in the exchange, about 63% will actually do so. The penalties on individuals who do not purchase health insurance are low, so they do not end up making a big difference in encouraging people to become insured. Individuals and families are also exempt from the penalties if purchasing the ‘bronze’ premium level would be more than eight percent of their income. This is estimated to include people with incomes between 400 and 542 percent of the FPL.¹¹⁴

For better or worse, employer sponsored health insurance has been the largest provider of health insurance and it will continue to be with the enactment of Obamacare. Though it will remain the most popular way for people to have access to health care, there will be changes to the system. By 2019, an estimated 13 million new workers and families will be covered by their employers due to more employers offering insurance, dependents being covered until age 26 and more employees taking advantage of their employer’s plans. Some smaller companies and employers who pay low wages would stop offering insurance as they and their employees would be better off covered by Medicare or on the Exchange with the government subsidies and tax credits. The penalties for not providing coverage from employees is not very high compared to

¹¹⁴ U.S. Department of Health & Human Services. *Estimated Financial Effects of the “Patient Protection and Affordable Care Act, as Amended*, 7.

the costs of providing health insurance, so it is not likely to deter many companies from dropping coverage if other options would be better.¹¹⁵

Even though the PPACA greatly increases the number of Americans with health insurance, there are still people in the country who will remain without insurance. About 5 million of the 23 million uninsured people are illegal aliens who are not eligible to partake in Medicaid or the Exchange subsidies. The other 18 million people would choose to be uninsured and pay the penalty that goes along with this decision, assuming that their income is above the threshold. Individuals who choose not to become insured will generally either be the healthy whose health care costs, even with the penalty, are expected to be lower than the cost of purchasing insurance or people who irrationally do not purchase coverage even though it is in their best interest financially.¹¹⁶

The Financial Impact on Medicare and Medicaid

Medicare will provide a net savings of \$575 billion from 2010-2019. This savings will come from a variety of sources. Some of the cost savings will come through lowering Part A and Part B payments for services and through the adjusted lower future payments due to increased productivity in the health care sector. This will amount to approximately \$233 billion over the period.¹¹⁷ Eliminating the Medicare Improvement Fund will save the government \$27 billion. This, however, is just ‘revenue’ that is created by closing an existing account, not by substantial reform.¹¹⁸ Disproportionate share hospital payments will be reduced by \$50 billion

¹¹⁵ U.S. Department of Health & Human Services. *Estimated Financial Effects of the “Patient Protection and Affordable Care Act, as Amended*, 6-7.

¹¹⁶ *Ibid*, 8.

¹¹⁷ *Ibid*, 8.

¹¹⁸ U.S. Congress *Patient Protection and Affordable Care Act*, Sec. 3112.

through 2019.¹¹⁹ Reducing Medicare Advantage payment benchmarks will save \$145 billion, and an additional \$8 billion will come from freezing the income thresholds for Part B income related premiums for nine years. A new Independent Payment Advisory Board will be created, and this along with cost growth rate targets will save \$24 billion. To go along with the trend of the wealthy paying the bill of the legislation, \$63 billion of the Medicare savings will come from a 0.9 percentage point increase on the payroll tax for individuals earning over \$200,000 and families over \$250,000.¹²⁰ It is expected that with the savings for Medicare Part A, the Hospital Insurance fund will not run out in 2017 as it would have under the previous system, but will last an additional 12 years until 2029.

Though there is a net savings associated with the changes to Medicare, there are some additional costs that need to be taken into consideration. It will cost \$12 billion to close the Medicare Part D coverage gap to help make prescription drugs more accessible and affordable. To further ensure that prescription drugs are attainable, the growth of the out of pocket expense threshold will be reduced. Other costs are associated with extending some special payment provisions that would otherwise expire and through improving the quality and access to primary and preventative care.¹²¹

The estimated savings for Medicare will probably not actually be as high as they were estimated to be. Some of the savings come from lessening payments for medical services due to increased production efficiency. These payment reductions do provide incentives to lower costs and increase efficiency, but more likely they will cause costs to rise faster than payments and create incentives for producers to stop accepting Medicare patients. Providers whose patients are

¹¹⁹ U.S. Congress *Patient Protection and Affordable Care Act*, Sec. 2551.

¹²⁰ U.S. Department of Health & Human Services. *Estimated Financial Effects of the "Patient Protection and Affordable Care Act, as Amended*, 8.

¹²¹ *Ibid*, 8.

mostly from the pool of Medicare beneficiaries could cease to be profitable. About 15 percent of Part A providers could become unprofitable in just ten years due to the productivity adjustments.¹²²To avoid this situation more regulations will become necessary, further hampering free market competition.

While Medicare will remain relatively stable in the number of beneficiaries, Medicaid and CHIP will begin to cover many new beneficiaries, either from the pool of the uninsured or people who were part of other plans that become newly eligible. Medicaid notoriously has low reimbursement rates, so there could be a shortage in the supply of health care workers willing to treat these newly included beneficiaries. The reimbursement rates rise temporarily for 2013 and 2014, but services could still be limited for beneficiaries. This means that the expansion of access to insurance through Medicaid is not likely to be as large as projected.¹²³ The PPACA does have some cost cutting mechanisms associated with these programs. Medicaid will increase its access to prescription drug rebates, creating savings of \$24 billion. Decreasing Medicaid DSH expenditures will save \$14 billion. The cost increases for Medicaid and CHIP occur due to the \$29 billion price of Community First Choice Option and programs that encourage home and community based services. Other increased costs are due to increased state matching programs, increased payments to primary care physicians, and increased funding for the territories.¹²⁴

¹²² U.S. Department of Health & Human Services. *Estimated Financial Effects of the “Patient Protection and Affordable Care Act, as Amended*, 10.

¹²³ Connors and Gostin, 2521.

¹²⁴ U.S. Department of Health & Human Services. *Estimated Financial Effects of the “Patient Protection and Affordable Care Act, as Amended*, 12.

U.S. Congress *Patient Protection and Affordable Care Act*, Sec 2401-2406, 2501.

Taxing the Wealthy

In an attempt to make health care more equitable and to ensure that the poor have access to care, the PPACA requires significant funding from the wealthiest portion of the population. The Reconciliation Act includes a 3.8% tax on unearned income such as interest, annuities and dividends, on wealthy families and individuals. This is called the unearned income Medicare contribution, but the funds do not actually contribute to the Medicare trust funds.¹²⁵ The excise tax on high cost employer sponsored health insurance will cut costs of the law by imposing another charge on the wealthy. When this tax takes effect in 2018, employers will have an incentive to reduce the coverage of their health care plans.

National Health Expenditures

The national health expenditures (NHE) will increase by \$311 billion from 2010-2019. This is due mainly to the increases in coverage due to the PPACA. People with insurance tend to use more medical services than people without access to a third payer, so consumption is likely to increase. By 2019 NHE are estimated to be 21 percent as opposed to the estimate of 20.8 percent prior to the enactment of the new law.¹²⁶

Though the impact of the PPACA on NHE is not especially encouraging, it is expected to significantly lower overall out of pocket spending. This is due to coverage expansion, cost sharing subsidies for the low and middle class, limits on out of pocket spending and increased workers cost sharing. This means that many Americans will be paying less for their medical

¹²⁵ U.S. Department of Health & Human Services. *Estimated Financial Effects of the "Patient Protection and Affordable Care Act, as Amended*, 9.

U.S. Congress *Health Care and Education Reconciliation Act*. Public Law 111-152. 111th Cong., (Washington, DC: GPO, 2010), 1402.

¹²⁶ U.S. Department of Health & Human Services. *Estimated Financial Effects of the "Patient Protection and Affordable Care Act, as Amended* ,15-17.

care.¹²⁷ Lower payments may sound enticing to the low and middle income Americans who would benefit, but economists realize the negative implications that this could have. Lower prices lead to increased consumption. The United States already has an enormous problem with over consumption due to the third party payer system, and this is likely to exaggerate the problem.

Conclusion

Some of the major cost cutting mechanisms were related to Medicare, but as discussed above these may not be as effective as they are promised to be. The PPACA minimally increases the NHE over the next decade. Personal expenditures on health care will decrease, but government spending will increase. This contradicts suggestions by many economists to put the burden of the cost back on consumers so that they will have incentives to pursue lower prices and will decrease consumption. Perhaps there are other solutions that could better serve the health care system.

¹²⁷ U.S. Department of Health & Human Services. *Estimated Financial Effects of the "Patient Protection and Affordable Care Act, as Amended*, 17-18.

Chapter 5: Additional Options for Reform

The recognition by government, employers, MCOs and individuals that resources are scarce and that their objective is improved health rather than provision of additional medical services will lead to new approaches to improve health. – Paul Feldstein

Health care has many complex problems, so there are numerous suggested reform mechanisms that impact various aspects of the industry. Generally the possible solutions will try to increase both efficiency and equity, but each proposal has a different approach to achieving these goals. Possible alternate solutions to Obamacare range from a much more liberal government takeover of the industry to a more conservative exclusion of government and its regulations from the sector in favor of true market competition.

National Health Insurance

An approach to reform that has been tried and failed throughout the last century is to provide national health insurance. While the current system in the United States is a complicated mixture of public and private funding, a national health insurance plan would simplify the system through focusing on one source of funding and delivery. This reform is often associated with a government single payer system such as the one that is established in Canada, but in reality national health insurance can occur in a variety of forms. The goals of national health insurance, as with most reforms of the health care system, are to improve production efficiency, efficiency in consumption, and to allow for an equitable redistribution.¹²⁸

A single payer national health insurance system would cover the entire population with no out of pocket costs and equal benefits for all. Private insurance is not allowed as everyone is forced to participate in the national health insurance policy. This type of universal coverage is generally funded

¹²⁸ Paul J. Feldstein. *Health Policy Issues: An Economic Perspective*. 5th ed. Chicago: Health Administration Press ;, 2011.

through income taxes, various other taxes such as taxes on alcohol and tobacco, and Medicare and Medicaid payments. Contributions to the system would be made according to ability to pay, but benefits would be uniform throughout the population. As with all reforms, this method has both its advantages and disadvantages. A single payer system is more simplistic than the convoluted current system, which could help to reduce costs and administrative tasks. The coverage is truly universal, so there are not the high emergency costs that arise from uninsured people needing services due to lack of preventative care. There are significant disadvantages that conflict with some of the ideals that Americans deem to be most important. To keep costs low the government or other payment source puts a cap on the amount that will be spent on medical services. This means that there may be less access to new technologies and could cause longer waits for treatment.¹²⁹ There is less consumer choice and individuals have less control over their medical care, which contradicts the sentiment favoring rugged individualism that has been present in the American population since its founding. Alterations would have to be made for a system such as a single payer system to be acceptable and assimilate with the American ideology. Some experts see expanding current programs as a way to incrementally move towards a single payer system in the United States. Through covering more poor people under Medicaid and children under SCHIP by altering eligibility levels as Obamacare did, the number of people insured by the government expands. Individuals with private insurance could eventually come to favor these government policies if they could prove to be more efficient and less costly than their private policies.¹³⁰

Demand Side Solutions

Some of the reforms will impact the demand side of the market. This means that they cause movement along the demand curve or even cause it to shift. Excess demand is attributed to consumers' insulation from costs. Making patients responsible for more of their treatment costs should improve this situation dramatically.

¹²⁹ Feldstein, 459.

¹³⁰ Feldstein, 459-460.

One suggestion to help solve some problems created by third party payers would be to better match the systems of funding to the needs of the population. The extremely poor and very sick people in a population will inevitably need help paying for their health care, either through insurance, charity or government assistance. The rest of the population does not need help paying for medical care, and thus would pay out of pocket for the services that they consume. Insurance coverage under this type of system would shift from providing comprehensive coverage to providing catastrophic coverage against major expenses. This catastrophic health coverage would cover the expenses for the very sick people. The government or a charitable organization would help to pay for medical expenses for the poor people, generally defined as those below the poverty level. This plan would have some major advantages. Government would no longer face the same financial strain in paying for extensive government health programs. Employer based health insurance and all of the problems it creates would no longer be needed. A much larger portion of health care expenses would be paid out of pocket, so consumers would have more incentives to take costs into consideration. People would begin to increase their savings in preparation of old age instead of relying on the government for elderly care. The poor would also pay less out of pocket for care and would therefore receive the necessary care. Unfortunately, this could lead the poor to over consume care and lead to a dependence on the government.¹³¹ This type of system would make individuals more responsible for their care and thus reduce demand and expenses. However, like all plans that have been considered, this has its issues and would face significant opposition from various actors.

The creation of health savings accounts (HSAs) would ensure that consumers were helping pay for their care. HSAs help to provide health insurance and encourage savings for health care through favorable tax policies. These accounts can be opened by people who buy insurance with high deductibles. There are protections for consumers to ensure that the plans provide enough coverage through setting limits on what consumers can pay out of pocket not including their deductible. Individuals can contribute

¹³¹ Kling, 63-75

up to \$2,900 and families \$5,800 to these savings accounts. The money can only be used towards medical expenses. It can be used that year or saved for future medical expenses. The idea behind these accounts is that people will be more conscious of their health care spending and with therefore be more selective about the care that they pursue.¹³²

Supply Side Solutions

The most effective supply side reforms will entice medical professionals to avoid providing unnecessary services. Traditional insurance embraces a fee-for-service system where the medical staff is paid for every service that they provide. This creates the incentive to produce more medical care than is necessary or efficient. Reforms to the way doctors are compensated could eliminate these negative incentives. For example, annual salaries would not allow for increased payments based on overuse. Contracts could also be created paying a certain amount per patient that will cover certain care. This would create an incentive to provide more efficient care as the doctors could achieve higher monetary gains by providing fewer services. Bonuses could also be paid to medical professionals who limit the provision of unnecessary services. A popular reform suggestion is to pay for performance. This will encourage quality of care over excessive treatment. Each doctor would be measured based on their quality and efficiency. Their compensation would be based on their assessment in these categories. This system of payment has already gained some popularity. By 2006 almost half of all HMOs based their payments on performance.¹³³

Other supply side reforms focus on the way that care is provided rather than the payment mechanisms. Guidelines can be established that offer suggestions on the proper treatment of various illnesses. They would suggest the optimal way to diagnose and treat patients based on different symptoms that patient's exhibit. Specialist care is extremely expensive, so to help reduce overuse of specialized care referrals from primary care doctors can be required. Hospital stay costs can be reduced by preauthorizing

¹³² Rice and Unruh, 111

¹³³ Rice and Unruh, 170-171.

the hospital visit or expensive treatments. Managed Care Organizations (MCOs) implement some of these reforms and have the possibility of helping to contain rising health care costs. Networks of providers are selected and patients must stay within the network when they receive care. HMOs and PPOs are the main forms of MCOs.¹³⁴ While some of these supply side reforms have proven to be effective, they often are strongly opposed by the public. Consumers tend to prefer the least restrictive health care plans, which would explain the predominance of PPOs. Reforms that are expected to be widely unpopular with the public are much less likely to be brought up in Congress.

The medical services workforce faces problems of shortages in certain geographical areas and specialties. There are various characteristics of the health care labor market that make it difficult for these problems to self correct. Educational requirements and the need for certifications create a significant barrier to entry into the industry. Wages and salaries in the health care sector tend to be ‘sticky,’ meaning that they do not react as quickly to changes in supply and demand as wages would in a competitive market. There is a discrepancy between the number of primary care doctors and specialists. There is also a much higher concentration of urban doctors compared to rural areas. Both the Association of American Medical Colleges (AAMC) and the Council on Graduate Medical Education (COGME) suggest that the medical professional workforce needs to increase, with COGME saying it should increase by three percent by 2020. There are several policy proposals that could help to correct this maldistribution. The medical school curriculums could shift their focus towards primary care and care in rural areas. Different funding techniques could be used to create incentives to focus on underserved populations, such as loan repayments or increased compensation for primary care doctors. Funding incentives could also be given to medical schools that attract more primary care doctors and people willing to work in rural areas. This would encourage these factors to be taken into consideration in the admissions selection process.¹³⁵ While regulation has the possibility of bettering the situation, it is regulation through barriers to entry that caused these problems in the first place, so another approach would be deregulation.

¹³⁴ Rice and Unruh, 172-173.

¹³⁵ Rice and Unruh, 280-283.

Reforming Medicare and Medicaid

As previously discussed, Medicare and Medicaid have significant problems that need to be reformed in order to improve the American health care system. The PPACA expands access to Medicaid and enforces cost cutting techniques for Medicare, but many criticize the programs saying they need significant reforms or even to be eliminated all together. The tax burden on society is increasing and even with the recent reform the programs are unsustainable in the long run.

Benefits promised from Medicare exceed the revenues for the program. A possible solution would be to make Medicare a prefunded program. This would also eliminate the problems associated with making intergenerational payments. Currently each generation demands more benefits than those that they actually paid for, leaving the burden of payments on their children and grandchildren. Prefunding could be achieved through encouraging health savings accounts combined with catastrophic coverage. Seniors would have more freedom of choice and the demand would be more influenced by prices, but they would still be protected from the high costs that are associated with the final years of life.¹³⁶ To begin the switch to this and encourage individual control, the age of eligibility could slowly be raised and more health savings accounts could be established.

A mechanism to reform both Medicare and Medicaid would be to give the assistance directly to the beneficiaries through vouchers. This would encourage the poor and senior members of society to choose the optimal coverage for their needs. Many more conservative critics believe that Medicaid creates a reliance on the government and that cash assistance should be minimized to create more incentives for the impoverished to work hard to better their circumstances. More liberal critics argue that the government systems should be expanded to include all citizens.

¹³⁶ Cannon and Tanner, 90-95.

Conclusion

The suggestions for reform and even the PPACA itself are filled with examples of the arguments that have been central to the nation's ideologies since the founding. The way that people perceive the issue of health care will impact the reforms that they see as necessary. It is easy to offer numerous suggestions on how the system could be reformed, but to determine what is best for a nation of almost 312 million people is much more difficult, and there is no perfect solution that can satisfy each individual's beliefs and needs.

Conclusion: Reform and the Future

America has the best doctors, the best nurses, the best hospitals, the best medical technology, the best medical breakthrough medicines in the world. There is absolutely no reason we should not have in this country the best health care in the world. - Bill Frist

When considering the various political and economic influences that had an impact on the Patient Protection and Affordable Care Act and the legislative process that led up to it, its evolution becomes easier to understand. There are many conflicting interests and ideas present in any society. As James Madison stated in the Federalist Papers, “liberty is to faction as air is to fire.”¹³⁷ There will always be factions in society, but this does not have to inhibit forward progress. Varying opinions leads to more ideas and the possibility of better outcomes through challenging ideas to determine what is best.

The framing of an issue can act as a unifying force across different groups in support of an idea that can be beneficial to society. Congress has become much more polarized in recent decades, which has made it more difficult to rally sufficient support to make major changes. President Obama was able to work with Congress to pass legislation representing significant social change, but this was certainly not without hard work and efforts to draw in many individuals and groups with conflicting interests. This is what made the framing of the legislation so important. Given the modern trend towards unorthodox lawmaking procedures, it was essential to get as much support as possible.

By combining health care into both a moral and economic issue, Obama was able to gain support as well as justify sweeping and initially expensive reform in a highly politicized

¹³⁷ Madison, James. Federalist No. 10: "The Same Subject Continued: The Union as a Safeguard Against Domestic Faction and Insurrection." *New York Daily Advertiser*, November 22, 1787.

environment. By promising a budget conscious reform, however, legislators had to be especially careful with the funding mechanisms and spending levels, making progress even more difficult. The Patient Protection and Affordable Care Act that was eventually signed into law displayed the conflict and interaction between needing to satisfy reform in both a moral and economic sense. Though coverage is expanded to a larger portion of citizens and there are new cost cutting techniques to be implemented, the political process and economic restraints kept reform from being as sweeping as the Democrats had hoped.

The PPACA is generally funded through redistributive economics, as the increased provision of health care to the poor is financed through taxes and charges that disproportionately impact the wealthy individuals and families. Though expanding the market of people seeking insurance coverage has the possibility of increasing competition and allowing market forces to seek lower prices, the significant increase in government regulation could have the ability to cancel out these benefits.

The economics that Obama and Congress used for the financing of the law fits with some of the moral aspects of the social justice model that is often advocated by Democrats. Rawls viewed the redistribution of assets to benefit the needy as just and necessary. The individual mandate requires the healthy and people who can afford it to buy health insurance. Those who are too poor will receive government assistance provided by increased taxes and fees for wealthy individuals and families. This generally satisfies the Rawlsian view of social justice. The PPACA also has some utilitarian aspects to it. Utilitarians believe that the aggregate impact is what is important. As long as the majority of the population is better off, even at the expense of the few, then the act is just. The various government protections and the increase in eligibility for

Medicaid mean that there are potential benefits to the majority of Americans, but this certainly does not come without a significant cost.

Both the Marxist and Libertarian philosophical views would vehemently oppose the PPACA, but for very different reasons. Marxists would agree that expanding coverage was a step in the right direction, but it does not go far enough in promoting true equality. They would be more likely to favor more universal coverage through the form of a single payer system. The libertarians, such as Nozick, would also oppose the new law, and especially the individual mandate. This violates the core ideology that individualism is the central virtue and that government has no right to infringe upon individual choice.

Given that modern Democrats ideas of social justice tend to align more closely with the Rawlsian ideas than those of Marxism and Libertarianism, it makes sense that the financial decisions that were made are more agreeable with that viewpoint. Obamacare is a logical culmination of trying to mix a more liberal view of economics with the social justice theory of Rawls. However, this combination ignores many of the concepts that are most vital to economic discussions of efficiency. The combination of economics and ethics is basically trying to find a perfect combination of efficiency and equity, while each framework on its own neglects one of the two.

The final law is uniquely American in its continued mixture of public and private coverage and payments. American exceptionalism and pride would never have allowed the United States to model its health care reform on another country's success. This would have been to acknowledge inferiority and that would not have been acceptable. Many of the outcomes due to the new law are difficult to predict as many of the provisions have not previously been tested

on a large scale. This means that the success or failure of the Patient Protection and Affordable Care Act is yet to be determined.

March 23, 2010 marked the day that the PPACA was signed into law, but it certainly did not mark the end of the debate. Immediately states began to question the constitutionality of the individual mandate that forces people to purchase insurance whether they want it or not. In March of 2012, the Supreme Court took on the case of the constitutionality of the PPACA and had three days of intense oral arguments on the subject. The law was vehemently challenged by 26 states, the national Federation of Independent Business and a group of individuals. The first day of the hearings was focused on determining if they could even rule on the case at the time or if the justices would have to wait until the first penalties were due in 2015. Lawyers from both sides argued that they should continue the proceedings, and the justices agreed. The second day focused on the core of the issue as justices questioned whether the federal government could force individuals to buy insurance. The final day focused on what the ramifications would be if they ruled the central premise of the law unconstitutional. Based on the questions asked by the justices, this is a real possibility. Four of the more liberal judges have made it evident that they will support the mandate, but for the law to be upheld one of the other five decidedly more conservative justices will have to support it as well. The decision will not be made until June of 2012, so the waiting and speculation will continue. At this point it is still unclear what the outcome will be.¹³⁸

The premise of Obamacare is that it hopes to expand coverage and benefits for all Americans, with the majority of the costs being paid by the wealthy and big businesses. The

¹³⁸Liptak, Adam. "Health Care Reform and the Supreme Court." *New York Times*, March 28, 2012. http://topics.nytimes.com/top/reference/timestopics/organizations/s/supreme_court/affordable_care_act/index.html.

provisions of the bill that protect consumers of health care against the insurance companies are popular and unlikely to be eliminated. The new system will put a much larger burden on the wealthy in support of less fortunate individuals. Though America puts a high importance on charity, it puts an even larger emphasis on individualism. Continuing to take away the benefits of hard work and innovation could eventually threaten the ingenuity of the citizens that has made America so great.

Regardless of what happens with the Supreme Court decision, the passage of the Patient Protection and Affordable Care Act has already made an enormous impact on the legislative process and on the country as a whole. The process has brought American's concerns about the role of government and the fear of its intervention in the lives of citizens to the forefront. It also exposed the very ugly side of politics in a very public way. The polarization of Congress and the rigid divide between parties made it clear to the public that the system had become disjointed and that forward progress was difficult.

With the excitement of an election year looming and the uncertainty of what the Supreme Court ruling will be in June, it is certain that health care will remain a popular and controversial topic. It will be interesting to see the impact of the Supreme Court decision on the presidential campaign. Obama's technique to frame the issue as both economic and moral had a great impact on the outcome of the legislation. In order to keep it intact the marketing that was fundamental to the legislative process will have to continue.

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