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ObamaCare is Because Obama Cares!

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<p>Patient Protection and Affordable Care Act (PPACA) is a historical piece of legislation and the most significant domestic policy achievement of the Obama administration to date. In rare departure from the norm, those who oppose the law have kept up the fight years after it was passed by the Congress.</p> <p>The roots of the escalating health care debate in the United States of America go all the way back to the nineteenth century. The main purpose of this research is to offer a complete overview of the events in the past of the United States that shaped the US health care system. In order to achieve that, this bachelor paper provides a balanced way to understand health care reform-related decisions that are made in the United States now and outlines some meaningful conclusions that forecast the future of the PPACA in the upcoming years.</p> <p>The author mainly gathered relevant information required for the bachelor paper from the secondary research. Many sources gave partisan opinions due to the very politicized nature of the research topic. For this reason the author encourages readers to use critical thinking.</p>	
Keywords	The Patient Protection and Affordable Care Act, United States of America, Health Care Policy, Health Care Politics, ObamaCare, Health Care Reform.

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"Politics is how society manages conflicts about values and interests... And no issues trigger battles over values and interests more quickly and acutely than do the source and use of money in health reform proposals".

- Lawrence D. Brown



1 Introduction

On March 23d, 2010, the Patient Protection and Affordable Care Act (PPACA) became federal law. It initiated the most significant changes in the U.S. health care system since the passage of Medicare in 1965. (Kaiser Permanente, 2014) Some believe that implementation of key elements of the Affordable Care Act (ACA) is a historical piece of legislation and the most significant domestic policy achievement of the Obama administration to date. The Patient Protection and Affordable Care Act fundamentally changes the U.S. health care system because it requires that nearly all American citizens have health insurance by the end of 2014. (Burke & Kamarack, 2013)

Nevertheless, there is a strong opposition to the law that has kept up the fight for years since it was passed by the Congress. The most drastic tactic used by the opposition so far was tying a provision defunding the Affordable Care Act onto the continuing resolution in order to keep the government open and shutting down the government when the Senate refused to compromise. (ibid)

To many Americans, the shutdown of the government came out of nowhere. But interviews with a wide array of conservatives show that the confrontation that precipitated the crisis was the outgrowth of a long-running effort to undo the law since its passage in 2010 — waged by a galaxy of conservative groups with more money, organized tactics and interconnections (Stolberg, 2013).

Moreover, the Republican House of Representatives voted to repeal the law over fifty times, and there is an uncountable amount of tactics that have been used in order to prevent the implementation of the law. Some relevant examples are the proposal to delay the opening of the exchanges over privacy concerns, proposal to delay implementation of the entire bill etc. (Burke & Kamarack, 2013; ObamaCare Facts, 2014)

Therefore, the environment in which the PPACA takes effect is built on the divergence of political attitudes to ideological extremes. Polarized politics in the United States of America makes society see only what it wants to see without balanced understanding of the benefits or failures that the Affordable Care Act might bring in the upcoming years. (Burke & Kamarack, 2013) The main aim of this bachelor paper is to offer a complete overview of the events in the past of the United States of America that have shaped the health care system. The author attempts to provide a balanced way of un-



derstanding the decisions that take place now and, hopefully, to outline a number of meaningful conclusions that forecast the future of the ACA in the upcoming years. The main research question to be answered in this bachelor paper is the following:

"To what extent does the historical background of the United States of America affect decisions on the Patient Protection and Affordable Care Act?"

1.1 Structure

The thesis consists of seven chapters, each chapter is of significant importance to this research. Chapter two gives detailed summary of the Affordable Care Act where each title of the PPACA is discussed in detail in order to give the reader a complete overview of the bill. Third chapter goes deeper into the issue and discusses the politics of health care. It discusses two major topics: the health policy environment and the key health policy actors. Chapter four examines the evolution of the U.S. health care system, the author goes back in history to nineteenth century and discusses past reform efforts in the United States. Chapters five and six examine in detail two cases of health care reform proposals in the United States. Chapter five analyses failure of the health policy in the Clinton Era and identifies major mistakes and lessons learnt from it. Chapter six discusses success of the universal health care in Massachusetts that is taken as a role model for the Affordable Care Act. In the final chapter the author uses theoretical justifications from earlier chapters to evaluate the future of ObamaCare, provides brief summary of the lessons learnt from the past, and expresses her personal thoughts about the Patient Protection and Affordable Care Act future.

1.2 Methodology

The author mainly gathered the relevant information required for the bachelor paper from the secondary research meaning that research is based on already existing data. Scientific books, academic magazines, newspapers and published statistics were used in order to support this bachelor paper with empirical evidence. In particular, the focus was laid on the recently published academic papers and news articles from reliable sources. The main reason for the chosen sources is the nature of the topic – it affects everyone in the United States of America, i.e. government, society, businesses and individuals. The Patient Protection and Affordable Care Act is one of the most discussed topics of our time, hence new information on the topic is available on a daily



basis. Throughout the research it was essential to constantly check new sources of information, and one useful way to keep up with the news was Internet research. To conclude, the author would like to mention that the Affordable Care Act takes place in a very politicized environment, therefore many secondary sources provided partisan opinions. The author used critical thinking and compared different secondary sources without prejudices, which allowed her to create personal opinion on the topic.

1.3 Limitations

In order to define the scope of this bachelor paper, certain limitations should be mentioned. Firstly, there is a very broad variety of secondary sources available for this research but because of the time constrains the author used only what she thought was the most relevant in order to find answers for the research question. Furthermore, due to the politicized nature of the research topic it was very difficult to find sources with neutral perspective; therefore the author encourages readers to use critical thinking.

2 The Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (PPACA), known as the Affordable Care Act (ACA) or "ObamaCare" was passed by the Congress of the United States of America and then signed into law by the President, Barack Obama, on March 23, 2010. On June 28, 2012 the Supreme Court rendered a final decision to uphold the health care law. (U.S. Department of Health Human Services, 2014) PPACA is a very complex piece of legislation that aims to reform the healthcare system through providing more Americans with affordable quality health insurance and through restraining the growth in healthcare spending in the United States of America, which has been rising at an unsustainable rate for years. (Dog Media Solutions LLC, 2014)

2.1 Detailed Summary

From the perspective of the Democrats, PPACA will

...ensure that all Americans have access to quality, affordable health care and will create the transformation within the health care system necessary to contain costs. The Congressional Budget Office (CBO) has determined that the Patient Protection and Affordable Care Act is fully paid for, will provide coverage to more than 94% of Americans while staying under the \$900 billion limit that President Obama established, bending the health care cost curve, and reducing the deficit over the next ten years and beyond (Democratic Policy & Communications Center, 2014).

The PPACA addresses ten following main topics that aim to reform the U.S. health care system:

1. Quality, affordable health care for all Americans
 2. The role of public government
 3. Improving the quality and efficiency of health care
 4. Preventing chronic disease and improving public health
 5. Health care workforce
 6. Transparency and program integrity
 7. Improving access to innovative medical therapies
 8. Community living assistance services (repealed January 2013)
 9. Revenue provisions
 10. Reauthorization of the Indian Health Care Improvement Act
- (U.S. Government Printing Office, 2010)



Title I. Quality, affordable health care for all Americans

The PPACA aims to transform health insurance in the U.S. through shared responsibility, a highly essential concept that is necessary in order to achieve reform. Systemic insurance market reform will eliminate discriminatory practices such as pre-existing condition exclusions. To achieve these reforms without increasing health insurance premiums will mean that society must be part of the system and must have coverage. Tax credits for individuals and families will make sure that insurance is affordable to everyone. (Democratic Policy & Communications Center, 2014)

Title II. The role of public government

The PPACA expands eligibility for Medicaid and takes the federal responsibility for much of the cost of the expansion. It aims to improve quality of Medicaid for both patients and providers as well as to provide new options for long-term services and support. One of the aims is to provide oversight of health plans with regard to the new insurance market regulations and consumer protections. Moreover it provides federal support for Children's Health Insurance Program (CHIP) and simplifies Medicaid and CHIP enrollment. (ibid)

Title III. Improving the quality and efficiency of health care

The PPACA will improve quality of medical care services for everyone and especially for those, who are covered under Medicare and Medicaid. Payments for services will be linked to better quality outcomes. (ibid)

Title IV. Preventing chronic disease and improving public health

The PPACA aims to develop healthy communities, therefore the 21st century infrastructure will support this goal. New Prevention and Public Health Investment Fund will support interagency prevention council in order to better orient the nation's health care system toward health promotion and disease prevention. Bill aims to transit from a system focused primarily on treating the sick to one that helps keep people well throughout their lives. (ibid)



Title V. Health care workforce

The PPACA will encourage innovations in health workforce training, recruitment, and retention, and will establish a new workforce commission. The aim is to increase the supply of health care workers and support new workforce. (ibid)

Title VI. Transparency and program integrity

This Title creates new requirements to provide information to the public on the health system and promotes new set of requirements to prevent fraud and abuse in public and private programs. (ibid)

Title VII. Improving access to innovative medical therapies

The PPACA promotes innovation. It aims to end anti-competitive behavior coming from drug companies and to extend drug discounts to the hospitals and communities that serve low-income patients. Furthermore it aims to create generic versions of biological drugs, so that consumers have access to lower cost alternatives. (Dog Media Solutions LLC, 2014)

Title IX. Revenue provisions

The PPACA aims to raise taxes on high earners, large businesses, and the health care industry. Tax credits will help in reducing premium costs and purchasing new insurances. (ibid)

Title X. Reauthorization of the Indian Health Care Improvement Act

The PPACA reauthorizes the Indian Health Care Improvements and modernizes the Indian health care system. (ibid)

Overall the PPACA

...requires most U.S. citizens and legal residents to have health insurance. Create state-based American Health Benefit Exchanges through which individuals can purchase coverage, with premium and cost sharing credits available to individuals/families with income between 133-400% of the federal poverty level (the poverty level is \$19,530 for a family of three in 2013) and create separate Exchanges through which small businesses can purchase coverage. Require employers to pay penalties for employees who receive tax credits for health insurance through an Exchange, with exceptions for small employers. Impose new regulations on health plans in the Exchanges and in the individual and small group markets. Expand Medicaid to 133% of the federal poverty level (Kaiser Family Foundation , 2013).



3 The Politics of Health Care

In order to understand the roots of the escalating health care debate in the United States of America, it is essential to provide a detailed analysis of the health policy environment that shapes health care policymaking and to examine the roles key actors play in the healthcare field.

According to Rosenbaum (2010), the health policy environment can be thought of as a total matrix of factors that influence and shape the health policy cycle. These factors include constitutional or legal requirements, institutional settings, shared understanding about the rules of the game, cultural values of a society, political ideology, economic resources, and technological innovations and their impact on the cost and delivery of health care services. Therefore, on one hand policy environment can help facilitate policymaking but, on the other hand, can also hinder policy development because of a number of constraints it imposes on policymakers. The constraints imposed by the policy environment make it very difficult for the government to resolve issues and to be creative in problem solving. (Patel & Rushefsky, 1995: 1-2)

In the United States of America health care is the largest single industry. It involves very complicated processes of decisions made by various institutions and political actors across a broad spectrum of the public and private sectors. In the public sector these actors and institutions include federal, state and local governments. While in private sector they include health care providers such as hospitals and nursing homes, health care professionals, and health care purchasers such as insurance companies, industries and consumers. Furthermore, a wide variety of interest groups influence health care policymaking. (ibid)

These actors and institutions are involved in the policy cycle. The policy cycle includes wide variety of activities such as getting problems to the government and agenda setting; policy formulation and legitimation; implementation, evaluation, and decisions about policy continuation; modifications and/or terminations. (Anderson, 2011; Jones, 1984) According to L.D. Brown (1978), these institutions and actors interact at every stage of policy cycle, and no one institution or actor dominates any one stage of policy development. Therefore it does not come as a surprise that each party contributes to



the process by providing input that is often designed to promote institution's own interests and goals.

The wide diversity of institutions and actors in health policymaking creates various problems in decision-making process in health system. Any plan to regulate the health care system ends up in immediate and heated response from the public and afterwards produces pressure from opponents of regulation who favor market-oriented approaches to delivery of health care. Government regulations very often have been opposed by those being regulated as well as by actors in the system who are against a strong government role. (Brown J. , 1997)

Health care policy in the United States is in a constant state of fluidity, lacks consistency, and often encompasses a mishmash of programs involving conflicting values. One of the main reason for that is short-term basis approach of the Congress that deals with most pressing problems one at a time and not in a framework of overall health care policy in order to receive better results in reelection. (Patel & Rushefsky, 1995: 3)

3.1 The Health Policy Environment

3.1.1 Constitutional Environment

Founding Fathers of the United States of America established a constitutional system of government that had two main purposes. First of all, it established a government with power to act, and, secondly, it attempted to prevent tyranny of majority. Therefore, the main goal was to have a decentralized structure in the government. (ibid)

The Constitution created a system where the powers of the national government are divided among the legislative, executive, and judicial branches of government. Three of these branches are coequally important in power. The major feature behind sharing of powers was that it would lead to checks and balances, i.e. an attempt by one branch of government to assume too much power or abuse its powers would be checked by other branches. (ibid)

What the Founding Fathers did not think about is constant competition between these branches for preeminence in various policy areas. This system makes it extremely diffi-



cult to negotiate and a fortiori formulate a comprehensive set of policies. In most of the cases the result is inaction. (ibid)

On the top of divided powers of national government the Constitution also created a federal system of government in which governmental authority is dispersed and divided between the national and state governments. Moreover, both national and state governments in many cases have delegated important functions to thousands of units of local government. Therefore when question of health care reform arises authority over health care policy remains divided and shared between the national, state and local governments. (ibid)

An important conclusion here is that no single institution representing the nation as a whole defines the public interest and serves the public good. The result is a health care system made up of multiple "little governments" and "little empires" that try to achieve their own goals and act mostly in their own interests. (Altenstetter, 1975)

3.1.2 Institutional Environment

The institutional environment provides major rules, structures and settings within which major institutions involved in policymaking operate. For example Congress is the primary policymaking institution while the executive is responsible for implementing policies and the judiciary resolves constitutional and legal conflicts. In the end all three institutions share the responsibility in policymaking and implementation. (Patel & Rushefsky, 1995: 5)

3.1.3 Political Environment

The political environment includes a shared understanding among the policymakers about how policy decisions should be made. In case of the United States the public philosophy of interest-group liberalism combined with constitutionally guaranteed freedom of speech, association, and petition allow each interest group to promote their own motives using a rhetoric of the common good. Moreover each interest group can successfully defeat proposed policies if they seem to be harmful to their own interests. It is not surprising that within such a diffused and fragmented system it is almost impossible to establish a comprehensive national health care policy. (ibid)



3.1.4 Economic Environment

The economic environment is extremely important in health policy decision-making process. When economy is growing at healthy rate policymakers find it easier to access resources needed to improve health care system. While in constrained economic environment health policymakers need to make hard choices. Therefore limited choices in hard economic times accelerate health care debate over efficiency, access and equality. (ibid)

3.1.5 Technological Environment

In the last decades the United States experienced high volumes of new health care technologies that changed health care dramatically but on the other hand they have been linked to increase in the cost of health care. Because health care costs make up an increasing part of the government budget, the role of the government becomes crucial in allocation of resources. Therefore debate on the government responsibilities continues to escalate. (ibid)

3.2 Key Health Policy Actors

3.2.1 Health Care Purchasers

In the year 2013 an estimated figure of federal, state and local governments combined spending on health care services was about \$1 186 billion. (Chantrill, 2014) Since health expenditures are very high and constantly increasing, the role of all three levels of government in health care is extremely important.

Separation of powers within the national government creates three major branches that play a crucial role in healthcare policymaking. The primary policymaking responsibility lies with the Congress, while major actors in the implementation stage are the President and bureaucracy. In the recent past, federal courts have obtained a significant role in the health policy cycle due to high volumes of conflicting interests that must be settled down. (Patel & Rushefsky, 1995: 7)



As it was discussed before, federal system of government creates state and local governments that are significant actors in the health care field too. Their main areas of concern are personal health, environmental health, health resources and laboratory services. Furthermore they perform general administrative and service functions. (ibid) In the United States most of the companies provide health insurance coverage for their employees. Therefore, it makes large corporations the third group of health care purchasers. Total health care spending in the United States is expected to reach \$4.8 trillion in 2021, up from \$2.6 trillion in 2010 and \$75 billion in 1970. This means that health care spending will be accounted for almost 20% of gross domestic product (GDP) or one-fifth of the U.S. economy in 2021. (Aetna Inc., 2014) As healthcare costs have been increasing tremendously in past years companies are more cautious nowadays. Each company tries to use different techniques in order to cut their health care costs, for example managed care, cost sharing, cost shifting etc. (Patel & Rushefsky, 1995: 7)

3.2.2 Health Care Providers

While discussing health care providers in the United States, it is important to keep the major feature of the American health care system in mind – its entrepreneurial nature. The prices that health care providers charge in the U.S. are much higher than in Europe and it does not necessarily mean that quality is better. (Aetna Inc., 2014) The major health care providers include health care institutions and health care professionals. Both parties are very important to consider because they not only deliver health care services but also influence the way in which services are delivered and the type of services that are delivered. (Patel & Rushefsky, 1995: 8) Consequently when discussing the recent debate about PPACA let's keep in mind that in the U.S. most of the pharmacies and manufacturers of pharmaceutical and medical equipment and suppliers are private, profit-making enterprises. Similarly, most of the physicians are private practitioners who act in their own interests. (Heineman & Froemke, 2012)

3.2.3 Third-Party Payers

A third-party-payer system dates back to 1929 with the establishment of the Blue Cross plans for hospital insurance. The main idea is that consumer needs to pay predetermined monthly premiums to an insurance company while in return the insurance



company agrees to pay the health care provider for a specific range of health services received by the consumer. (Patel & Rushefsky, 1995: 8) Insurance business grew tremendously over the years and the costs rose too. Cost increases pressure insurance companies and therefore premiums grow higher and higher leaving poorer part of the society no choice but to stay uninsured. Many people do not have access to coverage through a job, and gaps in eligibility for public coverage leave many without an option. Over 47 million nonelderly Americans were uninsured in 2012. (Kaiser Family Foundation, 2013)

3.2.4 Consumers

The general public plays a powerful role in health care policymaking. On one hand, general public can be seen as an important actor in health care field because of high purchasing power. But, on the other hand, general public got substantial affect because of the values, perceptions and attitudes they bring to the health care as consumers. (Patel & Rushefsky, 1995: 10) Study made on behalf of The Commonwealth Fund Commission on a High Performance Health System discovered that eight out of ten U.S. citizens agreed that the health system needs either fundamental change or complete rebuilding. Moreover the majority of adults said that is essential for the 2008 presidential candidates to seek reforms to address health care quality, access, and cost. (How;Lau;Schoen;& Shih, 2008) In general society is dissatisfied with the health care but they are also very divided about the options that would change the system. Majority of Americans believe that universal health care system would be better for the country but other part believes that government-run system would affect their freedom of choice and lower quality of health care and therefore would be unconstitutional. Another interesting point is public opinion about cost. Costs for health care have been rising for years but public still believes that there should be more spending for health care. However they want the government cover the cost for the health care and no one is interested to pay out of their own pocket. (Patel & Rushefsky, 1995: 10) Such controversial points of view create many conflicts of interest and raise dilemmas that policymakers in U.S. could not resolve for years.



3.2.5 Interest Groups

Interest groups in the United States play one of the major roles in the healthcare field. They became important political brokers in American politics. Good examples of such organizations are American Medical Association (AMA), American Hospital Association, Health Insurance Association of America, and American Health Care Association etc. There are two main types of interest groups: public interest groups which go for the public interest and common good and private interest groups that work for the benefit of their members. Due to the fact that health care affects everyone in society there are thousand of interest groups involved in health care politics and policymaking. Many believe that interest groups open the door for citizen participation in political process while others have argued that specific interests of these groups are stealing America and destroying democracy. Once again views are very disputable. But it is important to notice one very interesting fact, one of the major ways in which these groups try to influence the political process is through their political action committees (PACs). PACs provide very generous contributions to the election cycles and therefore affects future policymaking. (ibid)



4 The Evolution of the U.S. Healthcare System

Healthcare reform is not a new topic for the United States of America — it has been debated since the nineteenth century. Therefore, in order to find rational reasons behind the debate there is a need to examine historical development of health care policies in the United States.

Between the years 1750 and 2000, healthcare in the United States changed tremendously. From a simple system of home remedies and itinerant doctors with little training, health care evolved into a complex, technological and bureaucratic system that is nowadays called the “medical industrial complex”. The complex is based on medical science and the authority of medical professionals. (Fillmore, 2009)

Before going deeper into historical facts it is important to identify the health care model of the United States. The United States remains the only major Western industrialized nation without a national health insurance system or universal health care. The United States is an example of a mostly private health care system, where majority of workers are covered through private insurance that is provided by employer. Private hospitals and doctors deliver health care services and government provides public insurance for those who are not covered by private insurance but there are still many exceptions, for example pre-conditions. (Patel & Rushefsky, 1995: 15) The PPACA promised to ensure that all Americans will have access to affordable health care in the near future but there is still a very long path to go in order to see the real results.

Interestingly enough the United States has the highest health spending in the world – equivalent to 17,9% of its GDP, or \$8,362 per person in 2012. While Germany’s health spending is 12% of GDP. (Rogers, 2012) Despite the fact that USA’s health spending is higher, health indicators do not show very good results. For example life expectancy at birth in USA is 76 years while in Germany that spends less on health care life expectancy is 78 years for 2012. (World Health Organization, 2012)

For years majority of Americans have been frustrated with mismatch between constantly increasing costs of health care and decreasing quality of treatment. Many tried and still trying to understand how the U.S. health care system got so sick. Therefore



following chapters address historical development of health care in the U.S. and discuss major initiatives over the years that shaped health care policy.

4.1 How did it get this way?

The progress of medicine, or the “healing arts”, was very slow in the 1700’s and 1800’s in the United States. It was a matter of “family affair” meaning that women were expected to take care of illnesses in families and only in very serious occasions doctors were invited. In general the biological sciences were not very popular with the general public therefore doctors did not have credentials they must now have. (Fillmore, 2009; Patel & Rushefsky, 1995: 17)

Physicians with medical degrees and scientific training began to appear in the U.S. in the late colonial period. The University of Pennsylvania opened the first medical college in 1765 and the Massachusetts Medical Society incorporated in 1781 attempting to license physicians. While the origin of a hospital system is associated with the establishment of the first Marine Hospital in 1799. Though only in 1870 Congress reviewed the Marine Hospital System and passed the first Recognition Act. On one hand with scientific training doctors became more authoritative and practiced medicine as entrepreneurs, charging fees for services but on the other hand physicians began to admit patients to hospitals where patients paid fees and in return hospitals provided physicians with their facilities to provide free care for poor. This system did not work for long, already in the mid 1800’s hospitals, first built to treat poor began treating privately and charged higher fees. Thus, private practice and fees for medical services were established in the early years of American health care system. (ibid)

One important event that continues to influence politics and practice of medicine in the United States was an establishment of the American Medical Association (AMA) in 1846. During the first decade of the twentieth century reform of medical schools was the top priority of the AMA. But organization was lacking the authority and feared that legislatures that chartered them would restrict their power or tax them out of existence. Nevertheless, AMA invited an outside party, the Carnegie Foundation for the Advancement of Teaching, to investigate medical schools. The representative of the Carnegie Foundation, Abraham Flexner, completed an investigation and produced



Flexner Report in 1910, where he suggested adopting German model of medicine. Following this report, the process of consolidation of medical education proceeded at a rapid pace. The AMA became a national accrediting agency for medical schools and established itself as a powerful force in American medicine. (ibid)

Another significant development during this period was the establishment of pre-payment plans also known as the Blue Cross plans. During the years of the Great Depression of the 1930's, the income of the hospitals and physicians declined. Society could not afford to pay for medical services therefore hospitals realized that they would operate better with a steady income. The same plans were invented for physicians' services, they became known as Blue Shield plans. Both plans were highly successful and federal government encouraged the development of private insurance during 1940's. The high volumes of the third-party payers resulted in a "moral hazard", consumers got isolated from the real health care costs leading to overconsumption. Both hospitals and physicians prospered without realizing the continuing rise in healthcare costs. This change in healthcare financing led to employer-based health insurance programs. (ibid)

4.2 History of reform efforts in the United States

The United States of America has been on the verge of national health care reform many times before the Patient Protection and Affordable Health Care Act got signed into a law in 2010. History of the small proposals for the improvement in health care dates all the way back to early 1900's. By briefly analyzing the major national health reform efforts in the United States health care history, important lessons about current debate can be learned. (Hoffman, 2009)

During the Great Depression years (1929-1939) there was an increased demand for social insurance all over the world. Most Western countries decided to move to the direction of providing free medical care or reimbursement of its costs, while United States of America attempted to supply more general social security benefits such as unemployment insurance and old-age pensions. President Roosevelt administration did not want to jeopardize the enactment of the Social Security Bill because of strong opposition from the medical professionals and AMA therefore the final Social Security Act



of 1935 left out the national health insurance. President Roosevelt wanted to make health national insurance an issue in future election but unfortunately failed both times in 1938 and 1940. The medical profession has succeeded in defeating national insurance proposals. (Hoffman, 2009; Patel & Rushefsky, 1995: 18)

Three months after the World War II, President Truman once again called upon Congress to pass a national program to ensure the right to medical care. Plan proposed a single insurance system that would cover all Americans with public subsidies to pay for the poor. One of the major problems was that no new hospitals construction took place during the Great Depression or World War II therefore in 1946 Congress passed the Hill-Burton Act, also known as National Hospital Survey and Construction Act. It was very tough times for Truman's administration, transition from a war-time economy led down public confidence. Nevertheless, Truman did win the election and achieved Democratic majority in the Congress. In the end it still did not help and opponents successfully scared society with fear of the government control and "socialized medicine". The AMA highly opposed Truman plan and made public support for national health insurance drop dramatically. (Hoffman, 2009)

From the above examples it is clear that in early years of American health care efforts at establishing national health care system consistently failed because of high volumes of propaganda that such plans would constitute "socialized medicine". As it was discussed in the beginning of the bachelor paper the concept of socialized medicine went absolutely against the general public philosophy of classical liberalism, which promoted limited government involvement, and also specific philosophy of interest group liberalism, where different interest groups, such as AMA, exercise veto power over governmental policy decisions that do not suit their private interests. (Patel & Rushefsky, 1995: 34)

4.2.1 Increasing access to health care

The failure of universal health insurance advocated policymakers to change their strategy and objectives. In late 1950s they began to advocate the increasing health care for specific needy groups such as the elderly. It was a perfect target group for providing



health care because of their greater medical need. (Hoffman, 2009; Patel & Rushefsky, 1995: 35)

The first result of the proposal was the passage of the Kerr-Mills Act by Congress in 1960. But it proved to be ineffective when by 1963, only 28 states chose to participate and an investigation by the Senate Subcommittee on the Health of the Elderly revealed that only one percent of the nation's elderly received help under the program. (Fein, 1986: 60-61 as cited in Patel & Rushefsky, 1995: 35)

The issue of financing health care for the elderly remained on political agenda and on 21 February 1963, President Kennedy delivered his "Special Message on Aiding Our Senior Citizens". The key proposal was Medicare that had two main objectives: protection against the cost of serious illness and insurance protection on which supplementary private programs could be added. (Sheri, 1985: 90 as cited in Patel & Rushefsky, 1995: 35) The assassination of Kennedy left the task to fight for Medicare to his successor, Lyndon Johnson. He incorporated the proposed health care legislation into the Great Society's War on Poverty program. Health insurance was at the top of the legislative agenda in 1965 and caused enormous debate. Once again AMA and insurance companies were at the top of the opposition suggesting that the plan was compulsory, it represented socialized medicine, it would reduce the quality of health care and it was "un-American". Although this time there were many proponents who strongly defended the plan as designed to help the needy by providing them with access to medical care and thus respect American ideals of equity and equality. (Skidmore, 1970 as cited in Patel & Rushefsky, 1995: 36) Nevertheless, this time in 1965 Congress successfully passed the Medicare program for the elderly and Medicaid program for the poor as amendments to the Social Security Act of 1935. The final product was a classic compromise between opposing interests. It included a compulsory health insurance program for the elderly, financed through taxes (the Johnson proposal), a voluntary insurance program for physicians' services subsidized through general revenues (the Republican proposal) and an expanded means-tested program administered by the states (the AMA proposal). (Patel & Rushefsky, 1995: 36) Results of the Medicare and Medicaid programs were very successful. Both programs dramatically increased equal access to health care for the elderly and poor. (Darling, 1986: 286 as cited in Patel & Rushefsky, 1995: 37)



This is a great example that shows how health policy environment and high numbers of health policy actors that have been discussed earlier create constant barriers for policymakers. Each piece of legislation ends up in constant bargaining and compromises among major institutions and key actors in the health policy field. Therefore the result is contradictory policies that often contain conflicting interests. (Patel & Rushefsky, 1995: 7)

4.2.2 Health Care Cost Containment

The 1970s represented a decade of change in the American health care system. Before federal healthcare policy was shaped by three major assumptions. One of the major assumptions was that the health care system suffered from too few health care facilities and services, therefore as was discussed before Congress passed the Hill-Burton Act in 1946, also known as National Hospital Survey and Construction Act. Another assumption was that there is a limited financial access to health care among disadvantaged people hence Medicare and Medicaid were established. Last but not least there was a belief that competitive markets and regulatory strategies do not work in the health care field. (Brown L. D.: 572 as cited in Patel & Rushefsky, 1995: 37)

By the 1970s the economy continued to grow but inflation was becoming a serious concern and rising costs of the health care started to change previous perspectives. Policymakers started to realize that the health care system was too large comparing to opposite views of 1960s. According to Patel & Rushefsky (1995: 37) "...the one of the reasons for increased health care costs was unconstrained diffusion of biomedical technology and an excess supply of hospitals and physicians, which encouraged excessive tests and treatments". In order to realize the cost increase it is important to look at the numbers. Total national health care expenditure increased from \$27,1 billion in 1960 to \$74,3 billion in 1970. (Levit, 1993: 285 as cited in Patel & Rushefsky, 1995: 37)

Policymakers perspective changed, in 1970s instead of providing access and quality health care it was decided to began cost containment in order to stop rising health



care costs. During the 1970s and 1980s government took several market-oriented policies in an effort to contain costs. (Patel & Rushefsky, 1995: 39)

First concern of the policymakers was one of the factors that often cited as responsible for increased health care cost – overutilization of health resources. Congress created the Professional Standard Review Organizations (PSRO) that reviewed and monitor care provided to Medicare and Medicaid patients by hospitals. These organizations were given an authority to deny approval of payment to physicians who provided services to patients under Medicare or Medicaid. (Patel & Rushefsky, 1995: 40)

Another important attempt to contain health care cost was Nixon's proposal to provide federal funds for the development of health maintenance organizations (HMOs). HMOs are a system in which enrollees pay a fixed price in advance and in return they receive a comprehensive set of health services. The idea behind HMOs was to create a competition for traditional care delivery services and encourage patients to use less costly services such as doctors' offices. Nixon was not interested in starting any debate about universal health care, his main goal was to create a piece of legislation to control health care cost that would be uniquely Republican. And almost after three years Nixon sent his proposal to Congress, in 1973 it was approved. (Patel & Rushefsky, 1995: 41)

Also in 1974 Congress passed the National Health Planning and Resource Development act that required all states to adopt certificate-of-need laws. These laws required hospitals to document community need to obtain approval for major capital expenditure for facilities or services. (Patel & Rushefsky, 1995: 42)

In 1977 Jimmy Carter proposed a series of all-payer revenue controls on hospitals, known as hospital cost-containment proposal. Plan had high potential, it would control hospital costs that was necessary because traditional market forces could not keep those costs down. But as it happened before there was a very strong opposition that defeated the proposal in favor of a promised voluntary effort by hospitals to contain costs. (Patel & Rushefsky, 1995: 43)

In the mid-1980s Reagan administration started to realize that Medicare program was unable to meet the health expenses of its beneficiaries. Moreover Medicare did not



provide coverage for some of the basic services such as outpatient prescription drugs, custodial care, and most of the cost of nursing homes. Therefore Reagan proposed to expand Medicare and passed the proposal to Congress in 1988 as the Medicare Catastrophic Coverage Act. It was a brilliant solution to many problems but it had one unusual point for American society, all the new benefits were to be financed entirely by the beneficiaries themselves through supplementary premiums. Once again significant protests defeated the Medicare Catastrophic Coverage Act and forced Congress to repeal it in 1989. (Hoffman, 2009; Patel & Rushefsky, 1995: 45)



5 Health Policy in the Clinton Era

It is not the first time in history of the America that the moment for the health care reform arrived and there is a strong belief that society stands on the verge of a historic change. Predecessor of the PPACA was the Health Security Act (HSA) proposed by Clinton Administration in 1993. In order to identify potential outcomes of the PPACA it is important to analyze what went wrong previous time when reformers tried to achieve change in the American health care system.

5.1 Background

In the early 1990s reformers had a strong belief that the worsening conditions in the health care system developed to the point when change was a must. Health care costs were rising at a rapid rate for over a decade, the number of uninsured was steadily increasing, employers were shifting costs of insurance to their employees and employees were afraid to change their job for fear of losing their health insurance. This combination of negative factors led to a crisis mentality in the U.S. health care system. Public opinion polls showed that health care was ranked third on the list of the voters concerns in the 1992 election, behind the federal budget deficit and economy. Therefore when President Bill Clinton took office in 1993 there was major expectation for the health care reform. (Gruber & Cutler, 2001)

On the September 23, 1993 President Bill Clinton introduced one of the major initiative of the new Administration – the Health Security Act, 1 342-page bill to reform health care. (Gruber & Cutler, 2001; Porter & Teisberg, 2006: 79) The Clinton plan aimed to transform public-private system of health care in the United States. It called for universal coverage, with all employers required to contribute to the costs of insurance premiums for the employees. It was expected that the market would shift toward managed care and all American citizens could choose from multiple private insurance plans that would compete for their enrollment. The government planned to regulate insurance practices through regional purchasing pools and to impose limits on the growth of insurance premiums in order to ensure cost control. (Oberlander, Learning from Failure in Health Care Reform, 2007)



The architects of the Health Security Act had a strong belief that they embodied a winning political formula. Plan was perceived as a synthesis of liberal ends due to universal coverage and conservative means due to managed competition among private insurers. (Zelman, 1994 as cited in Oberlander, 2007) Moreover plan was built on the familiar to the society system of employer-sponsored insurance, avoided new broad taxes, left Medicare intact and most importantly promised Americans health security and choice. (Hacker, 1997 as cited in Oberlander, 2007)

The Health Security Act was a very impressive and ambitious proposal, at first it seemed that Clinton would move the country. Commentators believed that no matter how the battle over details might work out, the president had established the right principles and challenged Americans to a great, historic mission. But they were all wrong. A year later, Senate Majority Leader George Mitchell pronounced health care reform dead. The opposition turned public against the legislation by focusing attention on what those with good health care might lose and commentators turned on the president suggesting that he "led the country into a blind alley with his grandiose reform plan". (Starr, 1995)

5.2 Major Mistakes

It is believed that one of the major mistakes of the Clinton administration was excessive ambition. (Brown L., 1994 as cited in Oberlander, 2007) The bill attempted to solve too many problems simultaneously: secure universal coverage, change health care financing through an employer mandate, regulate the private insurance market, control costs and transform the delivery system through managed care. Any goal alone would be extremely hard to achieve and by combining them together makes it almost impossible. (Oberlander, Learning from Failure in Health Care Reform, 2007)

Also it is important to consider battle of the budget that Clinton faced in 1993, it threatened his presidency and made him to leave health care on the background. This loss of time on health care allowed ideological and interest group opponents of reform to change the focus of debate from health care to the government. In 1994 the Chamber of Commerce reversed its support, AMA excluded most of the private doctors and Republicans were already anticipating big midterm election. It is fair to believe that



overall mood changed and Americans were not worried about their jobs and health coverage due to better economic conditions. (Oberlander, Learning from Failure in Health Care Reform, 2007) "It is ironic feature that the Administration's successful effort to promote macroeconomic growth helped to kill one of its signature social insurance programs". (Gruber & Cutler, 2001)

Another explanation of the HSA failure is politics. Far right Republican leaders were asserting their power over the Republican Party and saw the defeat of HSA as the way to achieve their goal. (Gruber & Cutler, 2001) Moreover each part of the Clinton plan made opposition take immediate action and lobby almost every aspect of HSA. The Health Insurance Association of America fought against federally imposed cost controls, the National Federation of Independent Business highly opposed employer mandate, while Congressional Republicans denounced the entire plan. (Oberlander, Learning from Failure in Health Care Reform, 2007)

Decline in the middle class support had a big effect on the Clinton Plan too. The HSA involved significant redistribution from the middle class to the poor and history shows that it is very hard to achieve. As it was discussed before the Medicare Catastrophic Care Act attempted to raise the premium on higher income elderly to improve the benefits package for lower income elderly and received very low support from the public. The Clinton Plan was not an exception, middle class people turned off from it because they wanted the focus to be on their personal health care problems such as insurance security, not on the health care system in general. (Gruber & Cutler, 2001)

Starr (1995), who has been one of about ten people on the health policy team in the White House, believes that the Clinton Administration ignored the first rule of the political cooperation: "In on the takeoff, in on the landing". The HSA was developed "behind the closed doors" and those who felt shut out responded predictably in the mid-term elections. His personal opinion on the issue summed up in this sentence "we had a historic opportunity, and we blew it".



5.3 Central Lessons

The Clinton administration's failure to adopt health care plan into the law carries several lessons about the politics of health care reform that were discussed earlier in theoretical terms and now can be seen in practice.

Oberlander (2007), who is an associate professor of social medicine and of health policy and administration at the University of North Carolina-Chapel Hill, believes that the status quo is deeply entrenched in the U.S. health policy. And despite all its weaknesses and failings, the health system is noticeably resistant to change. The reason behind it is high amount of interest groups who aim to profit from it, the national reality is that health care spending of the government and citizens represent profit to health care industry stakeholders, whose main desire is high income. Therefore the first lesson learnt from the Clinton Era is that the American health care goes through the vicious circle that is extremely hard to break.

As was discussed before the Founding Fathers of the United States opted for a decentralized structure of the government. There were historical reasons for that, mainly the repressive measures of the concentrated power under British rule. Nowadays the ideas of the Founding Fathers represent major features of the American system of government. (Patel & Rushefsky, 1995: 2) Consequently, expanding government power over the health care system in a country that is very public power driven is an extremely hard task. Oberlander (2007) sums up the second central lesson in one sentence: "...no universal coverage plan, no matter how clever, can evade that ideological debate".

Another feature of the American government is complicated institutional environment. All three main institutions (Congress, the executive and the judiciary) share the responsibility in policymaking and implementation. (Patel & Rushefsky, 1995: 6) These political institutions limit presidential power, provoke divisions in Congress and create opportunities for those with interest in the block change. Thus the third lesson learnt is that the complicated institutional environment makes it very difficult to adopt any health care reform. (Oberlander, Learning from Failure in Health Care Reform, 2007)



Last but not least is the unanswered question that turns up during each health reform proposal: "who pays for the health care reform?" The Clinton plan collapsed because there was no support for the employer mandate but there was no other choice. There are different options, for example taxation but there is a persistent antitax politics in the United States. Furthermore, federal deficits continuously constrained payment options. Ultimately, to make a comprehensive health care reform in the United States is extraordinarily hard. (ibid)

5.4 Incremental Insurance Expansion

Even though President Clinton failed to legislate the Health Security Act, his administration accomplished an enormous amount of tasks in health care policy during his time in the office. After the dramatic defeat the Clinton administration chose to pursue bite-sized, less controversial issues with limited scope for legislative failure – so called incremental approach to expand health insurance coverage. (Gruber & Cutler, 2001)

One of the first "small" victories accomplished by Clinton administration was successful stand against the Republican's proposal to block grant the Medicaid program, giving states almost total control of what has been traditionally a very centralized federal program. The battle led to the government shut down in the winter of 1995 but ended successfully with administration winning and Republicans compromising. (ibid)

Further accomplishment of the Clinton administration is the adoption of the Children's Health Insurance Program (CHIP). As Clinton entered its second term, the particular concern was the rising number of uninsured children. In May, 1997, the Administration and the Republican Congressional leadership reached an agreement: states were given the choice of either expanding their Medicaid programs or introducing an entirely new insurance program CHIP. According to statistics in 1990s the number of uninsured kids declined the first time in a decade, consequently CHIP program proved to be successful. (ibid)

Another important concern of the Clinton administration was the tobacco industry. Administration failed to legislate its proposals but the efforts had an enormous impact on tobacco policy. First of all, the 15-cent rise in the tobacco excise tax was the first major increase in federal tobacco taxation in 15 years. However, the biggest result that Clin-



ton achieved was that the tobacco industry was not invincible anymore. It made public turn against it leading to price increases consequently bringing the tobacco producers down. (ibid)

The important conclusion that can be made from the health policy in the Clinton Era is "out of the ashes of failure came significant success". Despite the spectacular failure of the Health Security Act, Clinton administration accomplished long list of the successful health care policies, to name a few: coverage expansion for children, changes in long-term care and care for disabled and dramatic change in the public's view of cigarettes. (ibid)

6 Universal Health Care in Massachusetts

"I give a lot of talks to groups from outside the state," says Andrew Dreyfus, CEO of Blue Cross Blue Shield of Massachusetts, "and I often begin, 'Hi, my name is Andrew Dreyfus, and I am from the future.' " In order to get some ideas about the future of the PPACA as well as to find out the reasons for strong Republican opposition there is no better place to look at than Massachusetts. (Gengler, 2013)

6.1 The "Act"

On April 12, 2006, Governor Mitt Romney, of Massachusetts, signed one of the most significant bills of his career: a law requiring every citizen in his state to buy health insurance – landmark legislation entitled, An Act Providing Access to Affordable, Quality, Accountable Health Care (the "Act"). (Chirba, 2008; Lizza, 2011) Consequently for the first time in the American history successfully introducing universal health care on a state level. Many believe that Mitt Romney was the one who laid the groundwork for Barack Obama's health care reform.

6.1.1 Composition of the health care reform

Once Mitt Romney was elected to be a governor of Massachusetts his first concern was the health care reform, it consumed thirty percent of the state budget and costs were continuously increasing. Romney administration hired three main advisers who worked on the health care plan: Mike Murphy – pro-government Republican, Jonathan Gruber – the liberal academic and Amy Lischko – the state employee who for years has been studying the composition of the uninsured in Massachusetts. (Lizza, 2011)

The three Romney advisers came up with the universal health care coverage for all residents of Massachusetts. "Its key provisions mandate coverage, emphasize personal responsibility, and create incentives for employers, particularly small businesses, to provide insurance. It also reorganizes the insurance market to foster competition and choice, and expands subsidized assistance without raising taxes". (Chirba, 2008)

First idea for the health care plan came after Lischko presented statistics of Massachusetts's uninsured. It was concluded that instead of paying about one billion a year



compensating hospitals for treating uninsured patients who did not pay for their medical services it is better to use that money to subsidize the poor in buying insurance plans on the private market. (ibid)

Another area of concern was overregulated insurance market. Murphy figured out that there should be an easier way for individuals to buy insurance. The result was an idea of an exchange to help people buy the insurance. Advisors of the health care reform assumed that exchange could bring together willing providers and consumers into one centralized marketplace to facilitate consumer driven competition. Moreover it could help to accomplish another conservative policy goal: transforming health insurance from a responsibility for employers to a responsibility for individuals. (Chirba, 2008; Lizza, 2011) In theory it could expand consumer choice and increase consumer bargaining power while helping to reduce individual premiums by estimated 24%. (Chirba, 2008)

But the most interesting part of Romney's health care plan is how it was funded. Starting in 1997, Massachusetts received a waiver that allowed it some flexibility in how it administrated the Medicaid program. Furthermore, Massachusetts received special amount of money for the politically powerful Cambridge Health Alliance and Boston Medical Center. But after some years Bush Administration warned Mitt Romney that the waiver for Medicaid can be extended only for another 3 years and all the extra money would be cut off in 2005. Mitt Romney came to the conclusion that he will present his health care ideas to the Bush Administration and kill two birds with one stone. First of all Massachusetts could continue to receive extra money and Romney would be able to achieve universal health care reform in his state. Furthermore if the strategy would work both he and Bush Administration could receive credit for reforming health care by using market-based ideas without raising taxes. (Lizza, 2011)

But before going to submit his proposal, Romney needed to decide should he or should not establish an individual mandate in order to require citizens to buy insurance. It was very philosophical question because on one hand it's about personal responsibility but on other hand there is a libertarian view that suggests that the government had no business requiring people to buy something. This was the question Republicans had been discussing since 1990s suggesting that health care plan should be "a two-way



commitment between government and citizen". In the end Romney's adviser, Mr. Murphy stated: "This is not Calcutta. We don't let people go and die in the street. And then the question is, who bears that cost? Those costs get paid by increased premiums for the people who do buy insurance, or they get paid for through socialized costs and claim our tax revenues and come at the expense of other things that people might want to do, like building roads and bridges. And in the Republican Party that I grew up in – go back to the welfare debate, it's about personal responsibility – that seems pretty reasonable". Mitt Romney sympathized with the personal-responsibility argument and submitted his proposal to the Bush Administration. The Department of Health and Human Services agreed to a deal on specified conditions, if Massachusetts passed the plan, the federal government would keep the money flowing to the state but it would go to subsidize people buying insurance and not politically powerful hospitals as it was before. (ibid)

It took months to achieve a consensus between different ideological groups. It was decided that there should be an individual mandate but there was a stalemate around employer mandate. The House and liberal health-care advocacy favored it and the Senate and Romney thought about it as a tax increase that would strangle his Presidential ambitions, opposed it. This was the point when Romney came up with his strategic plan. In Massachusetts, the governor can exercise a line-item veto, but only for spending bills. Therefore Romney decided that if he establishes a veto it would be overturned anyway and he could finally sign the bill. This plan worked out perfectly: Democrats agreed to compromise on employer mandate and then rolled the whole health care plan into a spending bill. The law was passed and many suggested it could have a major impact on passing universal health care nationally. Romney himself stated: "I am proud of what we've done. If Massachusetts succeeds in implementing it, then that will be a model for the nation". (ibid)

6.2 Turning point

Initially Mitt Romney thought that health care plan could help him politically. George Bush, who fought the libertarian wing, seemed to offer a very stable platform for other Republican governors and Romney's choices were very consistent with the ideology of his party. He successfully refused to raise taxes and focused on personal responsibility



rather than personal liberty, his health care reform made Massachusetts the most insured state in America. But circumstances turned against Republicans, financial crisis changed the turn of events and Barack Obama won the Presidency. This was the turning point for the Republican Party, it came back to the libertarianism and gave up the debate on the health care mandate. While Mitt Romney maintained support for his achievement – the universal health care in Massachusetts, he suggested that it bears no resemblance to Obama’s national program whatsoever. He described ObamaCare as “a government takeover of health care” and made it clear that “one-size-fits-all plan across the nation” will not work. Ironically these statements go in absolute contradictory with the views expressed on health care before President Obama won the election. (Lizza, 2011)

Overall health care reform in Massachusetts is very familiar to the Affordable Care Act and follows similar architecture. It differs in two main ways. First of all Romney was able to finance his reform mostly with the revenue from the federal government, while Obama used mixture of taxes and savings from Medicare. Another major difference is that Obama aims to include health care cost containment features that were not part of Romney’s reform. (ibid)

This chapter is of extreme importance to this bachelor paper. It shows that the political and procedural path to passing a universal health care bill in the United States was developed by a Republican Governor. But a Democratic President passed the law and Republicans have seized on the individual mandate as the most anti-American feature of the ObamaCare. This conflict between two parties caused the government shut-down. But ironically a Republican Governor developed the concept of the individual mandate. This controversy brings us to the last chapter of the bachelor paper where the finding can be analyzed. (ibid)

7 Conclusion

In the course of this bachelor paper, the author aimed to offer a complete overview of the events in the past of the United States of America that shaped the health care system and attempted to provide a balanced way to understand the decisions that take place now. In the end of the research, the author wishes to outline some meaningful conclusions establishing failure or success of the PPACA in the upcoming years and provide brief summary of the lessons learnt from the past.

7.1 The Future of the ObamaCare

Since 2010, the fate of the ObamaCare has been very uncertain. Law passed the Congress without a single Republican vote and opposition kept up the fight years after. (Oberlander, *The Future of Obamacare*, 2012) Opposition has continued to try preventing its implementation through a wide variety of tactics. One of the most dramatic was shutting down the government in October 2013. (Burke & Kamarack, 2013) In March 2014, the Republican-led House of Representatives marked the 50th time it tried to repeal the Affordable Care Act. (ObamaCare Facts, 2014) This is not the first time Republicans shut down the government, as was discussed before in winter 1995, Clinton administration faced very familiar situation but each time these actions were referred as nothing more than a blackmailing. (Weisman, 2013) In the aftermath of the 2012 elections, with President Obama reelected and Democrats maintaining majority control of the Senate, Republicans lack an opportunity to overturn the law. The next time there might be a Republican in the White House is 2017 therefore the PPACA provisions will be in effect already for three years. Consequently Republicans tactics cannot stop the PPACA from moving forward in the coming years. (Oberlander, *The Future of Obamacare*, 2012) Nevertheless, it is important not to forget about midterm elections that will take place in November 2014 where the struggle over national health reform will once again take place.

In any case the highly politicized environment in which PPACA is implemented means that in the short-term people will see only what they wish to see. The constant criticism of the bill divided public to those who oppose the bill and those who support it. For the last few years the PPACA has been opposed by half or more than half of all



those polled. (Burke & Kamarack, 2013) Figure 1 gives an overview of overall public opinion of the law from 2010.

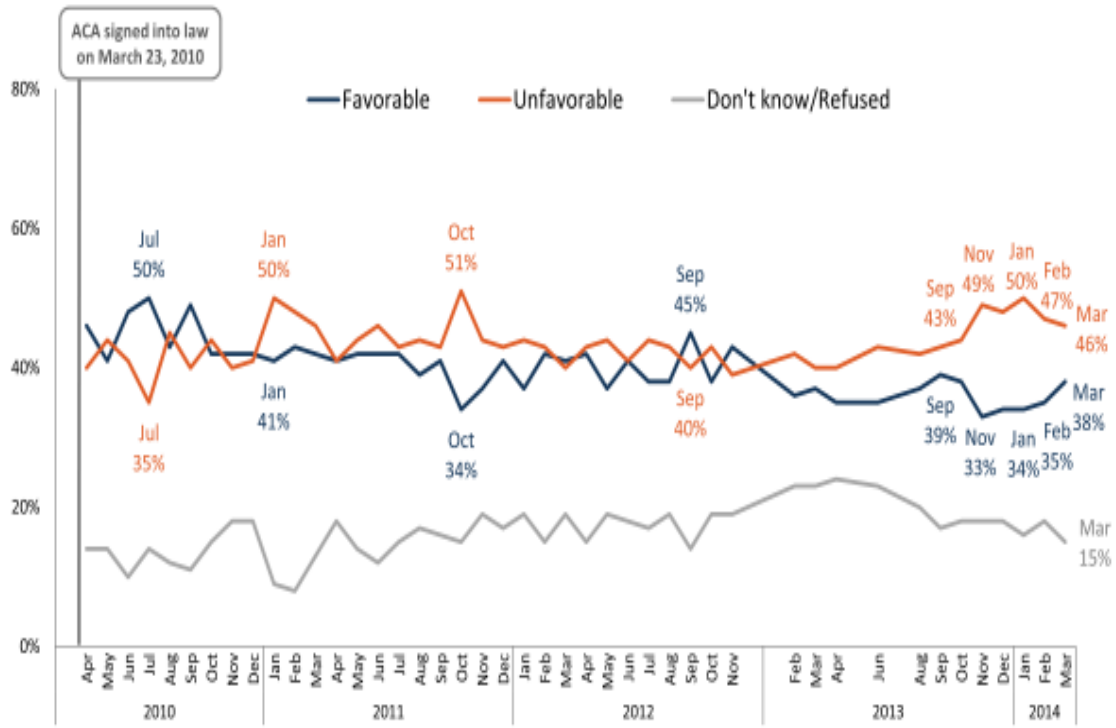


Figure 1 - Affordable Care Act Opinion

Source: Modified after Kaiser Family Foundation, 2014

Good news is that overall public opinion on the law shifted in a more positive direction in March 2014. Nevertheless unfavorable views still outnumber favorable ones. In March 2014, 46 percent say they have an unfavorable view of the law while 38 percent say they have a favorable view. The gap between unfavorable and favorable views is now eight percentage points, down from 16 points in November and January. (Kaiser Family Foundation, 2014)

Taking into account very volatile opinions of the public and constant opposition there are many challenges that lay ahead on the road of implementation of the PPACA, this chapter evaluates the long-term versus short-term success or failure of the law.



7.1.1 Short-term focus

In the short-term, the attention is on the states. The PPACA includes a number of very important decisions that were left up to states. First of all is the decision whether or not to create an insurance exchange. Another decision is whether to expand Medicaid coverage or not. (Burke & Kamarack, 2013)

Given the highly polarized nature of the health care debate, it is not surprising to learn that decision to create or not create an insurance exchange depended on the political ideology of the state. Figure 2 shows the decisions of Republican governors while Figure 3 describes the decisions of Democratic governors. (ibid)

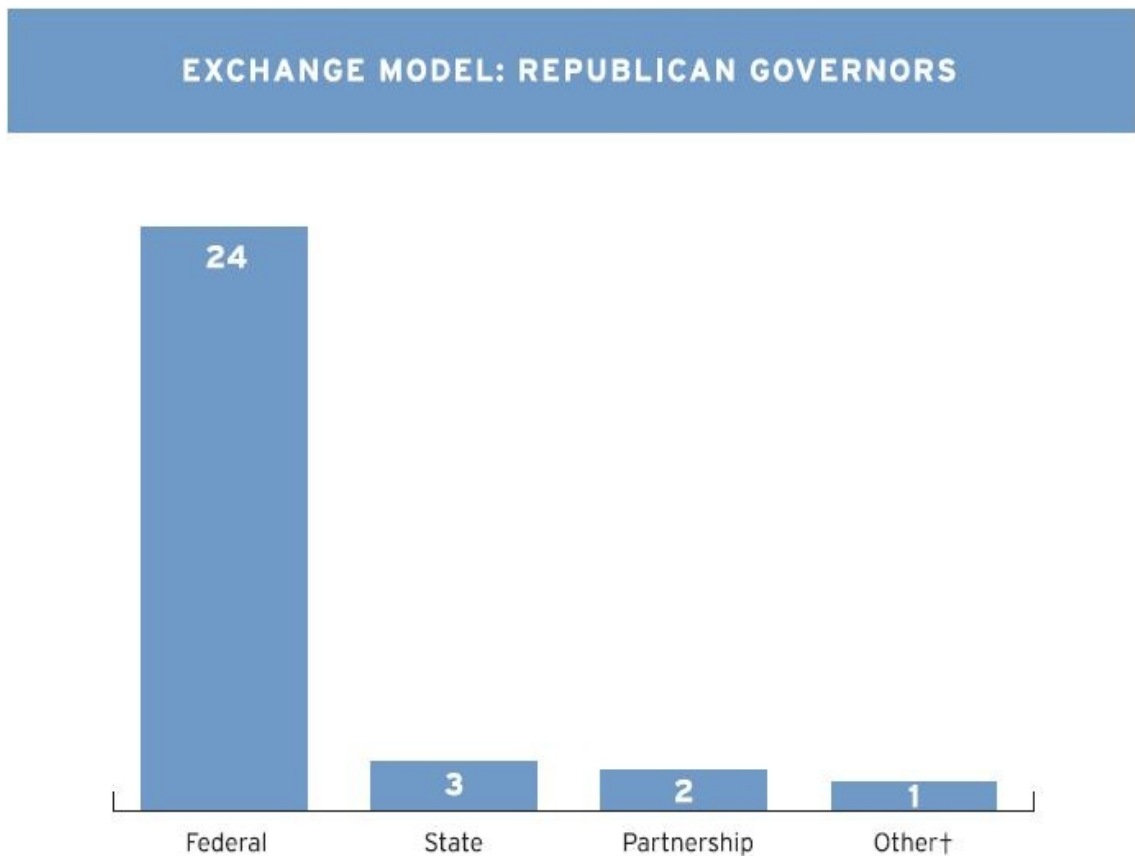


Figure 2 - Exchange Model: Republican Governors

Source: Kaiser Family Foundation, 2014

EXCHANGE MODEL: DEMOCRATIC GOVERNORS

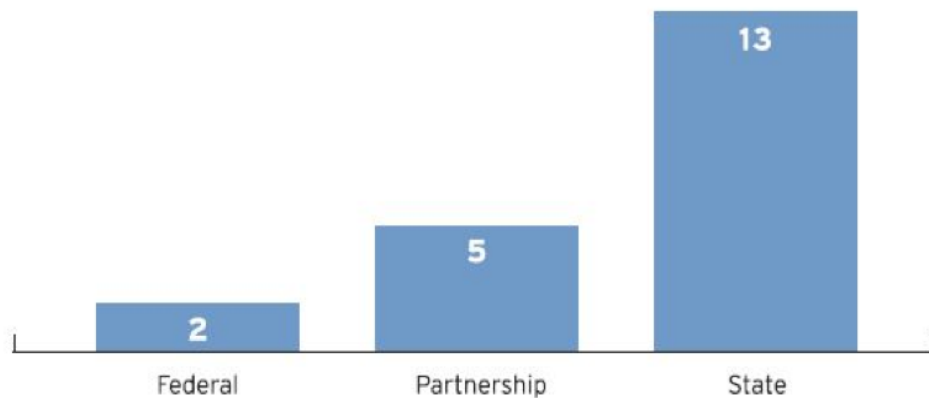


Figure 3 - Exchange Model: Democratic Governors

Source: Kaiser Family Foundation, 2014

Almost all of the Republican governors chose to leave the responsibility of the insurance exchanges to the federal government. There were few exceptions, first one is state of Utah that decided to set up small business exchange and leave individual exchange for the federal government (listed as "other" on the Figure 1). And Iowa and Michigan governors opted for a partnership with the federal government. Only three states decided to create a state-run insurance exchange: Nevada, Idaho and New Mexico. On the other hand, Democratic states show complete opposite results. Most of the governors chose to create state-run exchanges. Only two states declined this choice and asked for federal exchanges: Missouri and Montana. Everyone else opted for some kind of partnership with the federal government. (Burke & Kamarack, 2013)

Another important choice of the states was the decision to expand or not to expand Medicaid program. Figure 4 shows the current status of states Medicaid expansion decisions.

Current Status of State Medicaid Expansion Decisions, 2014

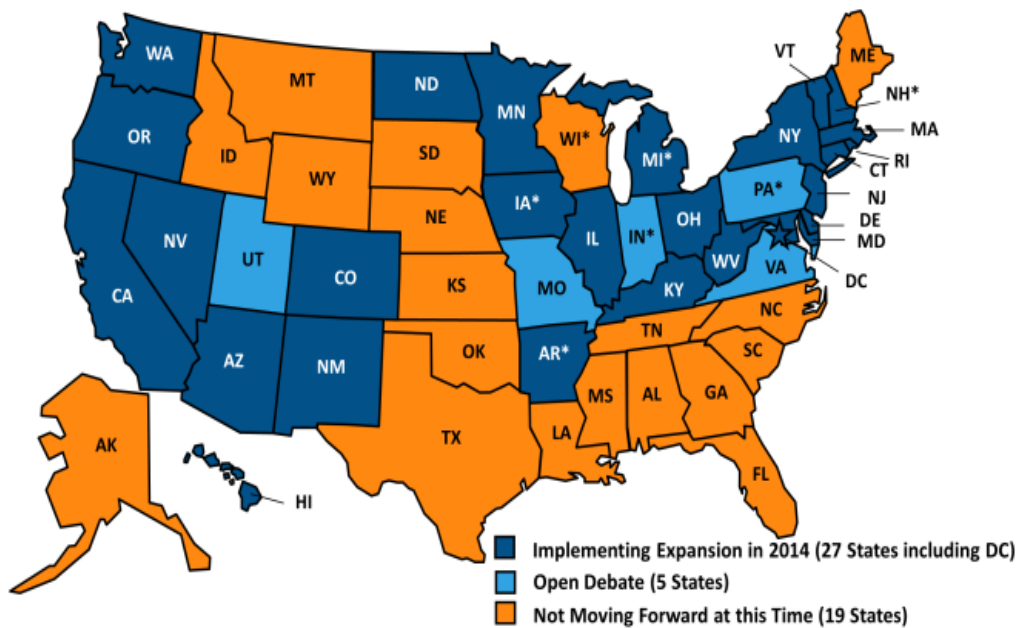


Figure 4 - Current Status of State Medicaid Expansion Decisions, 2014

Source: Kaiser Family Foundation, 2014

States followed the same path as in the previous decision – with the majority of Democratic states expanding Medicaid and the majority of Republican governors choosing not to. (ibid) It is important to notice that in the states without Medicaid expansion, most of the low-income, uninsured residents will be ineligible for subsidies in the exchanges therefore remaining without coverage. This is one of the major weaknesses the PPACA faces comparing to the health care reform that was implemented in Massachusetts. PPACA does not enjoy the bipartisan support, it is more complex piece of legislation that cannot change every state's political environment. (Oberlander, *The Future of Obamacare*, 2012)

There remain many political challenges to getting more supporters behind the PPACA. The public is still very divided over ObamaCare, complexity of the bill and no Republican support predict many more steps taken against the PPACA in the following years. But good news is that not many of them will matter because even in states that are hostile to the PPACA implementation, the implementation will be in the hands of the federal government that would do its job according to the legislation. Nevertheless, it is worth following Democratic states that opted for state exchanges and for the expansion of Medicaid in coming years, because they will prove to be the purest test of the thinking behind the ACA since they will accomplish two of the most critical things to predict increase coverage. (Burke & Kamarack, 2013; Oberlander, *The Future of Obamacare*, 2012)

7.1.2 Long-term focus

On the other hand there are several fundamental issues that are engraved in the architecture of the PPACA and cannot be fixed by federal or state coordination. These are the main features that can predict the future failure or success of the bill. This subchapter describes in detail each of these issues.

One of the major goals of the PPACA is to decrease the amount of the uninsured in the United States. The number of uninsured will be effected by three major factors: the number of people who buy insurance on the exchange, the number of people who get covered by Medicaid and the number of people who continue to have insurance from the employer. Consequently, the more effort state puts into the promotion of the PPACA and the more assistance it provides to its citizens the more successful results can be achieved in the long run. (Burke & Kamarack, 2013) From the previous discussion about highly partisan decisions within states, the author can make a conclusion that in Democratic states the level of uninsured will drop faster than in Republican states.

Furthermore as the author discussed earlier the extent of the conflicts between federal and state government will shape the PPACA in the future years. Already now there are clashes between Republican states and Democratic administration. If existing conflicts



will not diminish over time, they might result in highly complicated court cases where the bill itself will be the one to blame. (ibid)

It is worth mentioning that insurance companies might decide that the risk of participation in exchanges is not worth it. Many insurance companies might drop out in the long term. However, there is another view on this topic. It can be the case that insurance companies might see new business possibilities in the PPACA and participate because of subsidies. After all by following the number of plans in the exchanges individual can figure out the level of success of the PPACA provisions. (ibid)

Another measure to follow is the "individual shared responsibility provision". Every individual or family member who does not have "minimum essential coverage" must pay a fine. But main problem here is that it might turn out to be cheaper for individual to pay a fine than to buy an insurance coverage. Therefore, if number of those paying penalty will increase over time, there is another weakness in the PPACA. Same logic can be applied to the employer-mandate, that obliges employers with 50 or more workers who do not offer health insurance to pay a penalty. Employers might decide that it makes economic sense to pay a penalty but this can cause big troubles for the PPACA such as higher costs of the program to the government. Employer mandate is a bit tricky because it requires providing health insurance or facing a fine only for the full-time workers (defined as 30 hours per week). Therefore opponents of the bill argue that employers will pull back the hours in order to save the health care costs. (ibid) And this is very sensitive issue, citizens still did not recover after the financial crisis and any changes in job market can cause a lot of critiques against the PPACA.

But one of the most difficult challenges for the PPACA in the long-term is the cost control. There is an escalating debate that new requirements on the plans sold to individual and small businesses might cause "adverse selection". Adverse selection refers to the possibility that sick people will sign up for insurance on the new exchanges while healthy people will choose to pay the relatively small penalty versus paying what may be a higher cost premium. If this will be the case, overall costs to insurance companies and to the insured will rise tremendously. This issue in particular plays into the hand of opponents of the bill. (ibid)



7.2 What the past teaches us?

In these final pages, the author would like to summarize the discussions of the bachelor paper, focusing on the past events in the history of the health care policy in the United States that shaped the system and consequently effecting decisions that take place now on the Patient Protection and Affordable Care Act.

The author has begun the bachelor paper by analyzing politics of health care. Two main features were examined in detail: the health policy environment and key health policy actors. One of the main lessons was that in the United States the constitutional structure of government creates bias against any major changes. The system of checks and balances creates separate institutions that constantly compete for the power. Furthermore, federalism divides powers between federal, state and local governments. Consequently, complicated structure of government results in a series of health care programs and policies that often reflect conflicting values of access, equality, quality of care, and efficiency. (Patel & Rushefsky, 1995) It does not mean that change is impossible, there were many attempts to reform the health care system but most of them ended up in incremental expansions because of constant need for consensus.

Another important lesson is crucial role of interest groups. The public philosophy of interest-group liberalism allows them to promote interests of private groups and defeat major governmental health care proposals. This takes us to the next point. Since nineteenth century there were numerous attempts by federal government to establish some form of the national health care policy. Almost every single time each proposal follows the same scenario and in the end gets defeated by powerful interest groups such as AMA and insurance companies. But what is important to realize is that behind each insurance company there are shareholders who must be satisfied with good profits therefore these interest groups hide their real selfish interest behind statements that they want to protect the public interest by appealing to the value of freedom and by raising the fear of "socialized medicine". (Heineman & Froemke, 2012 ; Patel & Rushefsky, 1995)

There were numerous health care plans that were defeated by interest groups and strong opposition. Interest groups got status quo that they want to protect and in any



circumstances they are ready to fight for it. The fundamental fact is that national health care spending is someone else income and groups who profit always want more. Also various political institutions in the United States restrict presidential power. Combination of these facts leaves policymakers with no choice except regular compromises. Good example is President Clinton attempt to introduce universal health care in 1993. Many commentators stated "the President had established the right principles and challenged Americans to a great, historic mission". But after one year, health care reform was dead, there were many factors that affected the path of the reform but for years it was remembered as one of the greatest political opportunities in American history that was lost. Ironically the demise of the Clinton plan says less about the administration's mistakes than it does about the extraordinary difficulty of adopting comprehensive health care reform in the United States. (Oberlander, 2007; Patel & Rushefsky, 1995; Starr, 1995)

Nevertheless, there is a state in the United States that successfully adopted universal health care plan in 2006 – Massachusetts. It was Republican Governor, Mitt Romney, who accomplished a longstanding Democratic goal by combining conservative policies. Mitt Romney proudly stated that Massachusetts's health care reform could be "a model for the nation". But in 2009 Barack Obama won the presidency and he was the one who introduced health care reform on the national level not Mitt Romney. This was the starting point for the strong opposition from the Republican Party. After four years after the Congress passed the Affordable Care Act, Republican opposition is still there, year after year it tries to use different techniques to undo the law. It is for the reader to decide whether opposition takes place because the ACA provisions promote socialism or it is there because the Democratic president introduced the law. In any case Mitt Romney was the one who unintentionally laid the groundwork for the President Obama's national health care reform. (Lizza, 2011)

The latest news on ObamaCare is that it is working. According to the White House (2014) 8 million people signed up for the private insurance in the Health Insurance Marketplace, 35 percent of those signed up are under 35 years old and 28 percent are between 18 and 34 years old. Over 3 million young adults gained coverage and the same amount was enrolled in Medicaid and CHIP programs. But the most important is that the health care cost growth is the lowest in decades as Figure 5 indicates.



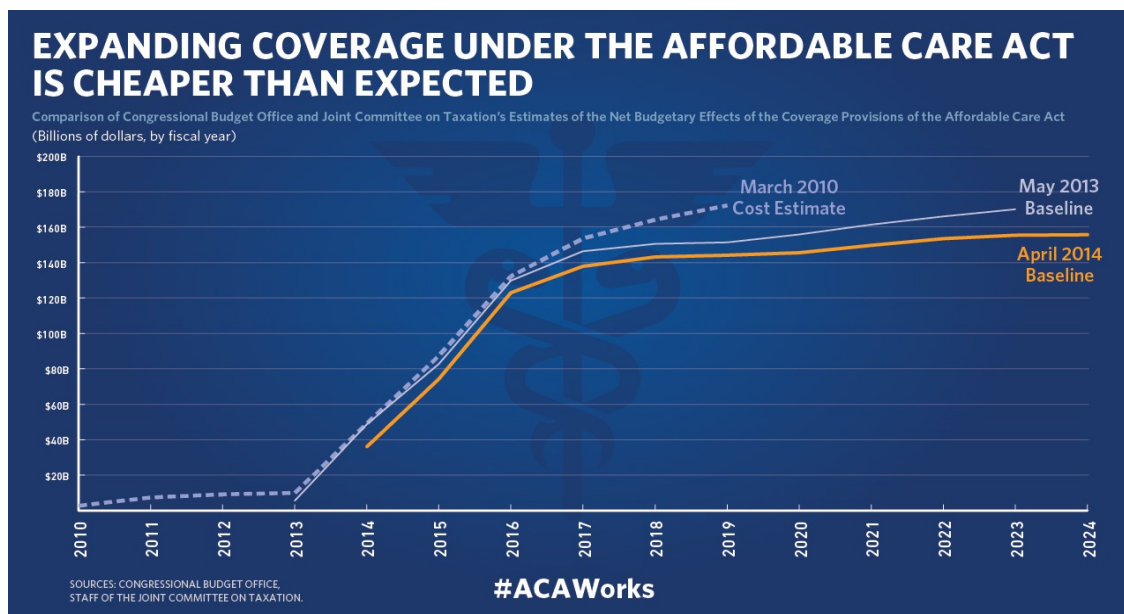


Figure 5 - Health Care Cost Growth

Source: The White House, 2014

Health care spending is historically low and it is predicted to go further down, accomplishing one of the most important goals of the PPACA.

Without a doubt, the Affordable Care Act is a historic piece of legislation for the United States of America. Not only it transforms the health care system but it also changes mindset and allows public to see the advantages of the "socialized medicine" that so dreadfully defeated numerous amount of health care reform proposals before. In the United States there are various socialized systems, for example schools where kids are allowed to go for free or libraries. Another example is firefighters who do not take a fee after put down the fire. Therefore, it is ignorant to believe that government involvement can bring only negative aspects to health care system because it is no different from any other already socialized systems in the country.

In 2014 ObamaCare brings a change to the health care market in the United States, while change brings an opportunity. It is thus tempting to believe that the moment has finally arrived and it is just a beginning.



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