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The American Health Care System, Health Care Reform, and the Effects of the Affordable Care Act

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The American Health Care System, Health Care Reform, and the Effects of the
Affordable Care Act

By

Adam Becker

Submitted in Partial Fulfillment
Of the requirements for
Honors in the Department of Political Science

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ABSTRACT

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ADVISOR: Professor Anthony Dell'Aera

Through the lens of access, quality, and cost I will present and outline the various historical approaches to health care reform, how they have contributed to the formation of our current system, and a preliminary evaluation of the Affordable Care Act. Specifically, I will be analyzing these major reforms in relation to, and their impact, on healthcare payers and providers. By understanding prior health care reform, it will provide the necessary foundation to properly investigate the prospects of success for the ACA.

In order to address these questions, I investigated the evolution of the medical professional and modern hospitals, the attempts at major health care reform during the 20th and 21st Century, as well as the design of the contemporary health care system. Furthermore, I outlined the problems that precipitated the call for the ACA, as well as analyzed the formation of reform and its provisions. Lastly, utilizing existing economic literature focused on the ACA, I attempt to discover preliminary trends to gain a better understanding of the ACA's effectiveness, its prospects for the future, and the ways in which it may require reform.

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Chapter One: Foundations of American Health Care

“America’s health care system is neither healthy, caring, nor a system.” —Walter Cronkite¹

To understand the formation of the current American healthcare system requires the fundamental analysis of the historical and social evolution of the actors that exist within the health care arena. The rise and sovereignty of the medical profession, the debate between proper public and private roles in the provision of health services, as well as the contemporary development of health care providers and insurers, combine to create the political discourse surrounding health care reform and its implementation. The prevailing theoretical approaches to addressing health care, which focus on the relationship between access, quality, and cost, provide a means of analysis to dissect and address the issues of equity, efficiency, and fiscal practicality. Throughout waves of political polarization and partisanship, this overarching political philosophy has guided the formation, implementation, and overall analysis of health care reform in America.

Academic research on health care reform has largely acknowledged these prevailing trends, drawing attention to the lack of successful political reform in combining all facets of this predominant health care ideology. Most recently, health care policy literature has focused on reforms for cost-containment, consumer-directed health care services, increased quality and efficiency, and outdated payment structures. Lastly, debate has centered on the enactment of the Affordable Care Act and its ability to reinvent the American health care system.

¹ Walter Cronkite, “http://www.brainyquote.com/quotes/authors/w/walter_cronkite.html.”

I. Political Theory

The political theory literature surrounding health care considers such questions as the right to health care, in addition to the proper government and private involvement in health care distribution. These political theories, which offer perspectives from both the right and the left, underlie the evolution of health care policy in the U.S. According to Norm Daniels, an American political philosopher and theorist at Harvard University, and in reference to his theory of justice outlined in his work, "Justice, Health, and Health Care," a social contract exists between society and its people, which involve certain positive rights. Daniels' belief in social liberalism, an extension of John Rawls' theory of justice, has roots in the conceptual ideas offered by Rawls' thought experiment, which discuss the ideas of nature in a "just" society and how those values contribute to the formation, organization, and implementation of health care systems.²

Rawls' theory of a just society requires putting oneself in the original position. In essence, if one were to assume they were not aware of their unique qualities or knew anything about their life, what would be the types of principles and policies they would want in place?³ Rawls concludes that a just society must assure people the basic liberties and equal value and opportunity for all: "The principle of [*fair equality of opportunity*] requires positive social measures that correct for the negative effects on opportunity."⁴ Rawls' understanding of a just

² Norm Daniels, *The American Journal of Bioethics*, Vol. 1, No. 2, Spring 2001: pg. 6.

³ Professor Dell'Aera, PSC-289R Class Lecture, Union College, May 21st, 2014.

⁴ Daniels pg. 2

society culminates with his conception of the “maximin principle:” a system, which is designed to maximize the position of the worst off members in society.⁵

Daniels’ extension of the maximin principle to the health care debate guides his theoretical discussion of three fundamental questions: What is the status of health care? What is its role? And why is it so special? According to Daniels, health care is essential because it enables people to achieve fair equality to opportunity.⁶ Using Rawls’ maximin principle as his foundation, Daniels outlines his theoretical concept of fairness: not equality, but a type of distribution in society. Daniels applies his theory of fairness to determine what constitutes a proper distributive mechanism in health care. More precisely, the distributive mechanism refers to the fair process for the allocation of health care resources.⁷ However, advocating for this particular theory of fairness raises an important question: If fairness, according to Daniels, is to maximize the utility of the least fortunate in society, how does that ideological approach reconcile with the allocation of finite resources? While Daniels argues in favor of government responsibility to oversee the distribution of health care resources, he fails to give an explicit answer of how, and in what ways, should finite resources should be allocated.⁸

Uwe Reinhardt, professor of political economy at Princeton University and health care economics scholar, discusses the relationship between efficiency and equity. Reinhardt, who defines efficiency in terms of the utilization of resources, attempts to address the role efficiency plays in health care policy: “It is widely taken

⁵ Daniels pg. 10

⁶ Daniels pg. 9

⁷ Daniels pg. 10 and 16

⁸ Daniels pg. 7

for granted that an *efficient* approach is *ipso facto* superior to an *inefficient* one.”⁹ Although the 1970s shift in health care policy towards greater “efficiency” helped to spur greater technological innovation and health care amenities, Reinhardt notes that this competition also priced many low-income Americans out of the market for health care services and insurance.¹⁰ Although from both an economic and market standpoint, Reinhardt understands how such reforms were seen as being efficient, he questions whether or not these claims of greater efficiency outweighed the loss of *equity*. To solve this dilemma, Reinhardt proposes welfare economic theories such as Pareto-efficiency.

In contrast to Daniels’ belief of health care as a basic right, Michael Cannon and Michael Tanner, authors of *Healthy Competition*, interpret health care as a commodity and dispute the claim of health care as an individual right. Both Cannon and Tanner find inconsistencies and flaws with Daniels’ inability to outline how a distributive mechanism would function in a system of a universal right to health care. From the author’s perspectives, the crux of the debate concerning a right to health care can also be simplified into three questions: who defines that right, what does that right entail, and who pays?¹¹

The debate that surrounds the distributive allocation of finite health resources inevitably generates questioning surrounding what types of services will be offered, which include discussions on whether or not certain treatment options,

⁹ Uwe Reinhardt. "Reflections on the Meaning of Efficiency: Can Efficiency Be Separated from Equity?" *Yale Law & Policy Review* 10, no. 2 (1992): pg. 302.

¹⁰ Reinhardt pg. 305

¹¹ Michael F. Cannon and Michael D. Tanner. *Healthy Competition: What's Holding Back Health Care and How to Free It*. 2nd ed. Washington, D.C.: Cato Institute, 2007. pg. 33-35.

procedures, or preventative care measures will be included. Furthermore, in reference to the potential consequences of a large-scale distributive mechanism, how does government balance the right to health care services, while simultaneously limiting the fiscal burden on taxpayers? Cannon and Tanner argue that a universal system lacks a key disincentive mechanism to the engagement in the overconsumption of health care goods, which could lead to a substantial drain in societal resources.¹²

Despite in all likelihood the good intentions of government, Cannon and Tanner believe that the overutilization of available resources, combined with extensive welfare programs, promote wasteful spending when health care is viewed as a basic right. According to their perspective, the introduction of a market-oriented system would improve consumer choice, which will promote lower prices and higher quality in competitive markets. Theoretically speaking, by increasing the pool of health care providers, not only will the competition foster greater innovation, but also the range of options could promote more conscientious consumers.¹³ As supported by Cannon and Tanner, limiting government involvement in health care will increase the autonomy given to both patients and physicians by providing both parties with a broader range of choices to direct the care they are receiving and providing.¹⁴

Arnold Kling, economist and adjunct scholar with the Cato Institute, also discusses the importance of consumer-directed services and market-based

¹² Cannon and Tanner pg. 33-34

¹³ Professor Dell'Aera, PSC-289R Class Lecture, Union College, May 25th, 2014.

¹⁴ Cannon and Tanner pg. 30 and 151

management as a model for the delivery of health care. In terms of the former, Kling suggests that allowing consumers to control the sources of funding will help to improve the quality of care they receive: "The quality of the market will depend on the emergence of a good set of consumer information and rating services...corporations would then be under pressure to deliver good value for the consumer's money."¹⁵ Kling's theory promotes a realignment of incentives that favors consumers. The integration of corporate models into the health care arena encourages firms to provide high quality health services, as a result of the theoretical increase in consumer market power. Just as superior firms in traditional markets push out inferior firms, health care providers and companies should not be immune to these general market principles.

Furthermore, Kling believes that corporate management can provide more efficient and coordinated care for health care providers and companies. As Kling writes,

Corporate compensation schemes are far from perfect. However, under the pressure of market competition, the private sector is more likely than government to continuously adapt payment structures in order to achieve better alignment between doctor compensation and patient interest."¹⁶

Extending Kling's belief to the access, quality, and cost debate, corporate-style management can more effectively set standards of care and integrate project management leadership to improve the coordination of complex care for patients.¹⁷

¹⁵ Arnold Kling and Michael F. Cannon. "Does the Doctor Need a Boss?" *Cato Institute Briefing Papers*, no. 111 (2009): pg.7.

¹⁶ Arnold Kling. "How to Fix Healthcare Delivery." Cato Institute. June 17, 2007.

¹⁷ Kling and Cannon pg. 5

Similar to the perspectives offered by Kling, John C. Goodman, a libertarian economist and founder of the National Center for Policy Analysis, argues in favor of consumer-directed health care. According to Goodman, "The value of most health care is experienced subjectively. The current system not only systematically denies patients the opportunity to make such choices, it distorts the incentives of providers in the process."¹⁸ From a theoretical standpoint, Goodman contends that consumers should be allowed to control their health care services, which enables them to maximize their benefits, but also holds them accountable to bear the costs. Theoretically, as consumers hold a larger financial stake in their health care responsibilities, Goodman claims consumers will limit their utilization of health care resources.

Furthermore, Goodman argues against government-run health care, specifically single-payer systems. Goodman disputes the predisposed notion of equity inherent to these systems and sheds on light on their lack of access to high-quality procedures, modern technology, and medications.¹⁹ In order to address the deficiencies of government activity in health care, Goodman claims, "The best remedy for all countries' health care crises is not increasing government power, but increasing patient power instead."²⁰ Goodman believes in the ability of free markets and the power of consumer choice to address the problems facing the health care system.

¹⁸ John C. Goodman "What Is Consumer-Directed Health Care." *Health Affairs*, 2006, pg. 540.

¹⁹ John C. Goodman. "Health Care in a Free Society Rebutting the Myths of National Health Insurance." *Cato Institute* 532 (2005): pg. 1.

²⁰ John C. Goodman. "Health Care in a Free Society Rebutting the Myths of National Health Insurance." *Cato Institute* 532 (2005): pg. 1.

Richard A. Epstein, the Laurence A. Tisch Professor of Law at New York University School of Law and adjunct scholar at the Cato Institute, contributes to the perspectives of health care as a commodity. In accord with the philosophies of Cannon, Tanner, and Kling, Epstein argues for the elimination of the belief that government can provide both universal access to welfare services, while also being fiscally responsible: “We can no longer start our public debate with the false but comforting assumption that our social abundance can support social safety nets and minimum entitlements to everyone in society.”²¹ Striking down Rawl’s maximin theory, Epstein argues against the need to ensure individual welfare rights due to both the scarcity of resources available and also the unfairness of the societal burden of paying for services that are not used equally.²² The use of private markets, which Epstein promotes, can establish fair prices, foster competition and innovation, and also deter the monopolization of health care services, which inevitably lead to higher consumer costs.²³

The left-wing’s underlying theory of social welfare promotions, which center on the on the opportunities provided by various distributive mechanisms, and the contrasting marketplace initiatives supported by the right, represent the basic dichotomy that exists when conceptualizing the proper design of a national health care system. While there may never be a consensus on the proper application of these competing principles, to act that one cannot exist without the other would be to greatly undermine the legitimate claims of both the public and private sector to

²¹ Richard A. Epstein. *Mortal Peril: Our Inalienable Right to Health Care?* United States of America: Addison-Wesley Publishing Company, 1997, pg. 4.

²² Epstein pg.44-45

²³ Epstein pg. 17-18

provide a delivery of health care services. The task that has historically, and arguably will always, confront health care reformers is to find a successful balance between the public and private roles in addressing access, quality, and cost in their relationship to providing health care.

II. Health Care History

Scholars who have contributed to the literature of the historical evolution of health care in America have remained consistent in their history that has been told. The literature provides an emphasis on the importance of understanding the historical developments of the medical profession, health care payers, and health care providers as a way to properly assess current health care policies and for an ability to craft insightful approaches for potential reform. The rhetoric within the literature also serves as an opportunity for constructive criticisms in relation to the arguments of a haphazard design of certain American health care policies.

According to Paul Starr, author of *The Social Transformation of American Medicine*, the 1984 Pulitzer Prize winner for General Non-Fiction, the transformation of the medical profession, which increased its cultural authority over time, directly impacted the ways in which health care is provided today: “Social structure is the outcome of historical processes. To understand a given structural arrangement one has to identify the ways in which people acted, pursuing their interests and ideals under definite conditions, to bring that structure into

existence.”²⁴ In other words, Starr argues that the rise of the medical profession, which achieved its legitimacy both from a societal increase on the reliance of professional specialization, and also as a result of institutional developments, served as the key foundation for the creation of a vast health care industry.

More specifically, Starr argues that the beginning of professional authority and legitimacy within the medical profession coincided with the industrialization of American society. The beginnings of medical authority can be traced back to both the growing acceptance and reliance on specialized labor, as well as the institutional advancements within the medical profession.²⁵ From an institutional standpoint, the medical profession acquired its legitimacy through the implementation of medical education and licensing practices. On the other hand, the social aspects of the doctor-patient relationship led to significant forces of dependency within the health care environment. Starr comments on the institutional and social forces that helped to solidify the legitimacy and authority of the medical profession: “In their combined effect, the mechanisms of legitimation and the mechanisms of dependency have given a definite structure to the relations of doctors and patients that transcends personalities and attitudes.”²⁶ The social and institutional forces ushered in a new wave of professional sovereignty, which translated into essential political clout and economic power for the medical profession and the health care industry.

Ezekiel Emanuel, Chief of the Department of Bioethics at the Clinical Center of the U.S. National Institutes of Health, and author of *Reinventing American*

²⁴ Paul Starr. *The Social Transformation of American Medicine*. New York: Basic Books, 1982. pg. 7.

²⁵ Starr pg. 18

²⁶ Starr pg. 20-21

Health Care, also believes in obtaining a understanding of the historical evolution of health care as a necessary prerequisite to addressing the health care challenges of today. When asking the question “How Did We get Here?” Emanuel provides a basic explanation through a theory of path dependence: “The institutions and arrangements created before—often created haphazardly or as an expedient—now constrain and shape the changes that are possible today.”²⁷ Emanuel believes that understanding how health care went from point ‘a’ to point ‘b’, in order to create a future point ‘c’, requires an analysis of the history of health care.

Emanuel’s historical evaluation of hospitals and physicians mirrors the narrative offered by Starr. From an institutional standpoint, the hospitals initially served as a charitable function, providing only the most basic and limited forms of treatment to the poorest in society.²⁸ Emanuel traces the development of hospitals to their current status today, as prominent facilities and institutions of substantial profitability. Similar to the growth of hospitals, Emanuel credits the rise of physicians to their ability to establish professional standards and licensing procedures, as well as an increase in the specialization of services provided. Emanuel’s literature provides a thorough analysis of the foundations of the American health care system, the payment mechanisms for both physicians and hospitals, and how particular historical designs influence the proposals within the Affordable Care Act, which seek to reconcile many of these underlying issues.

²⁷ Ezekiel J. Emanuel. *Reinventing American Health Care: How the Affordable Care Act Will Improve Our Terribly Complex, Blatantly Unjust, Outrageously Expensive, Grossly Inefficient, Error Prone System*. New York: Public Affairs, 2014. pg. 18.

²⁸ Emanuel pg. 18

While both Starr and Emanuel address the historical developments of health care as a progression of social transformations and institutional growth, Arnold Kling criticizes the haphazard construct of health care in America. More specifically, Kling discusses the lack of design of health insurance following World War II compared to other industrialized nations.²⁹ Kling's arguments focus on the provisions surrounding health insurance in America, as well as the long-term consequences of the flawed system: "The U.S. health care system evolved with no central planning [and] emerged haphazardly, rather than by design. The lack of design also means that there is no mechanism in our system for controlling costs or ensuring rational use of medical procedures."³⁰ Kling largely attributes the deficiencies of the current health care model to the lack of careful design that occurred during its development in America.

Shannon Brownlee, author of the book *Overtreated*, contributes to the literature that criticizes the historical path of American health care and the perverse incentives that have been a consequence. Brownlee focuses most of her research on health care providers and how historically they have not acted in accordance with general market principles. She characterizes the market as supply-driven, which has distorted the incentives for physicians and providers: "We can't achieve efficiency through market forces when normal economic rules don't apply, when the supply of many resources is dictating what kind of care patients receive, and how much of it,

²⁹ Arnold Kling. "American Health Care Policy Issues." *Für Die Freiheit* 1, no. 92 (2010): pg. 9.

³⁰ Arnold Kling. "American Health Care Policy Issues." *Für Die Freiheit* 1, no. 92 (2010): pg. 11-12.

rather than what's best for them."³¹ Brownlee's integration of historical and economic principles allow for a more insightful approach to generating analysis for future health care reform.

Guy L. Clifton, M.D., Chair of the Department of Neurosurgery at the University of Texas Medical School at Houston, adds to the literature of Brownlee by outlining three historical pathways to hospital profitability: gain monopoly power in the community, avoid the uninsured, and promote surgery.³² Dr. Clifton offers a medical perspective to the health care debate by providing examples of how the evolution of hospitals created incentives that propped up unhealthy payment structures such as the traditional fee-for-service method for physicians, as well as the Medicare reimbursement rates for hospitals.³³

III. Health Care Policy

Historically, the impetus for health care reform has been to address the theoretical concepts of access, quality, and cost. Although political discourse has generally shown a willingness to address these foundational pillars, uniting these three objectives into large-scale policy efforts has been a significant challenge evading reformers. Academic research on health care reform has largely acknowledged these prevailing trends, drawing attention to the lack of successful political reform in combining all facets of this predominant health care ideology.

³¹ Shannon Brownlee. *Overtreated: Why Too Much Medicine Is Making Us Sicker and Poorer*. New York, New York: Bloomsbury USA, 2007. pg. 116.

³² Guy L. Clifton, M.D., *Flatlined: Resuscitating American Medicine*. New Brunswick, New Jersey, and London: Rutgers University Press, 2009. pg. 145.

³³ Clifton pg. 251 and 254

Most recently, health care policy literature has focused on reforms for cost-containment, consumer-directed health care services, increased quality and efficiency, and outdated payment structures. Lastly, debate has centered on the enactment of the Affordable Care Act and its ability to reinvent the American health care system.

According to Paul Starr, initial attempts to address access and cost in the health care arena began with a push by the American Association for Labor Legislation (AALL). The AALL's ideas, rooted in both capitalism and social welfare, argued that it would "reduce the total costs of illness and insurance to society,"³⁴ while also providing poverty relief. However, Starr notes that the opposition from the medical profession, labor leadership, and businesses would lead to this initial health care defeat.³⁵ Starr argues that the failure to develop health insurance during this time period had tremendous consequences during the Depression Era, which saw the introduction of welfare medicine as a necessity to respond to widespread poverty and to aid the cost of access for medical treatment.³⁶

Despite omitting health care reform from the New Deal legislation, Starr discusses the next wave of health care policy during the 1940s, which again focused on providing more access to health care services. Led by President Truman, the push for national health insurance focused on improving access for *all* Americans: "It aimed to expand access to medical care by augmenting the nation's medical resources and reducing financial barriers to their use, and it promised doctors

³⁴ Starr pg. 244

³⁵ Starr pg. 255

³⁶ Starr pg. 270

higher incomes and no organizational reform.”³⁷ However, even with President Truman’s concessions to the medical field, the opposition by the American Medical Association proved to be insurmountable as they succeeded in their blockage of national health insurance. This seminal moment in the policy process led to private health insurance for the well-off and welfare services for the poor.³⁸

Further policy efforts aimed at addressing access and cost culminated with the redistributive programs of Medicare and Medicaid. From an access standpoint, Starr discusses the compulsory insurance program under Medicare Part A, in addition to the cost aspects, which utilizes government funding to pay physician costs. Additionally, Medicare Part C, otherwise known as Medicaid, provided access and funding to medical services for the poor. President Lyndon Johnson’s ability to maneuver the political landscape, by combining aspects of both Democratic and Republican ideas, helped to ensure the enactment of health care reform of this magnitude.³⁹

The health care policies of the 1970s, which centered on addressing the cost of health care services, provided an infusion of market-based principles by promoting corporate management and bureaucratized regulation within the health care industry. Starr discusses the motivation for this trend by focusing on President Nixon’s actions during this time period and his introduction of Health Maintenance Organizations as a “new national health strategy.”⁴⁰ In addition to the idea of prepaid group practices, Nixon’s National Health Insurance Standards Act also

³⁷ Starr pg. 281

³⁸ Starr pg. 286

³⁹ Starr pg. 369

⁴⁰ Starr pg. 396

encouraged access to health care services, which would have required employers to provide minimum health benefits.⁴¹ Furthermore, Starr outlines the introduction of regulatory bodies such as Professional Standards Review Organizations (PSROs) and other health planning agencies to help control costs.⁴²

Although the 1960s emphasized health care policy in relation to the access of health care services, the impetus for health care reform of the 1970s focused on containing the costs of these various distributive programs. As Starr notes, “In the early 1970s, rising costs made public efforts to improve access to medical care seem all the more urgent; now they made such efforts seem all the more risky.”⁴³ Both the political economy and public opinion during the end of the 1970s influenced the direction of health care policy and the reforms pursued. While the late 1960s and early 1970s saw an overwhelming push for access, the conservative movement at the end of the decade shifted the policy process on health care towards greater efficiency in the name of reducing health care costs.

According to Ezekiel Emanuel, analysis of prior health care reform is of great necessity: “A major reason to focus on [health care] history is that the last battle shapes the future war. Previous failed reform efforts have shaped subsequent efforts. When it comes to health care reform, the past is truly prologue.”⁴⁴ Emanuel’s historical timeline of health care reform in the United States outlines the key players involved in the policy process, which includes various labor organizations, presidential figures, and influential politicians. Emanuel’s research of health care

⁴¹ Starr pg. 397

⁴² Starr pg. 404

⁴³ Starr pg. 406

⁴⁴ Emanuel pg. 127

policy outlines six principles specific to legislating for health care reform: understand it will be a fight, political unity is a necessity, recognize the “power and fragility of Washington egos,” maintain speed in the policy process, build on prior reform successes, and defend against antigovernment rhetoric.⁴⁵

Consistent with Paul Starr, Emanuel traces the beginning of access-based health care reform to the Progressive Era. Although the AALL developed a compulsory health care proposal during this time, the power of the AMA halted any prospect for reform.⁴⁶ Furthermore, Emanuel emphasizes the push for compulsory health care reform under President Truman. Unfortunately for President Truman and the democrats of this era, they failed to defend against the antigovernment rhetoric during the policy process: “The [AMA] effectively deployed the charge of “socialized medicine” against Truman’s plan. This charge also resonated with the nation’s growing anticommunism.”⁴⁷ Opposition to President Truman’s comprehensive medical plan halted initial attempts to provide widespread access for health care services for many Americans.

Not until the 1960s did Congress enact health care legislation that provided access to comprehensive health care services. As noted by Emanuel, due to the growing costs of hospital care, and in response to the frustrations of employer-based health coverage, democrats again began their push for health care reform focused on access. President Kennedy, who was vocal in his support for Aime

⁴⁵ Emanuel pg. 156-158

⁴⁶ Emanuel pg. 129-130

⁴⁷ Emanuel pg. 136

Forland's (D-Rhode Island) sponsorship of the initial Medicare proposal, fought against the backlash of the AMA in the hopes of securing health care reform.

Emanuel notes two critical aspects that led to the successful passage of reform and the introduction of Medicare and Medicaid services. For one, the ability of the reformers to craft policy based on prior successes and existing institutional structures, which Emanuel considers important steps in the policy process, helped contribute to the enactment of this major health care reform: "It utilized the existing insurance-provider relationships and ensured Medicare was amalgamated to the existing health-financing infrastructure."⁴⁸ Second, in order to secure momentum for reform, as well as to maintain political unity throughout the policy process, Emanuel discusses the government concessions from a cost standpoint. Although government agreed to incentivize the expansion of hospital facilities, which were considered essential for political support, the expedience and necessity for cooperation during the policy process had long-term consequences: "[The reform] ended up encouraging perverse incentives, such as emphasis on hospital expansion, hospital-based care, and fragmentation of the delivery of care."⁴⁹ While the reforms succeeded in their ability to provide access to health care services, both the ultimate cost of these policies and the requirements of the political process, contribute to the issues facing health care today.

Future reforms of the 1970s centered on cost-control measures and the development of health maintenance organizations. Emanuel discusses Senator Edward Kennedy's Health Security Act, as well as President Nixon's National Health

⁴⁸ Emanuel pg. 141

⁴⁹ Emanuel pg. 141-142

Insurance Act. Additionally, Emanuel highlights the missed opportunities for national health insurance through Nixon's Comprehensive Health Insurance Plan, as well as Kennedy and Mills' plan, which could have provided national health insurance.⁵⁰ Although this era predominately encouraged reform based on cost-control measures, simultaneously the underlying themes also attempted to provide economically efficient ways to provide access to health care.

The recurring themes of cost control and access were also supported during President Clinton's attempt at health care reform during the 1990s. Clinton's Health Security Act Bill, which required employer mandated health coverage, as well as government subsidies to control costs, offered another opportunity to expand widespread access to health care coverage at a proposed affordable cost to employers. However, despite support from the business community, Emanuel outlines several failures to the Clinton plan, which ultimately sunk any opportunity for successful reform.⁵¹

In the most recent decade, the areas of access, quality, and cost have continued to dominate the health care agenda. President Obama's quest for health care reform, a major component of his 2008 presidential election campaign, revolutionized the health care landscape, as it was known. Unlike his predecessors, the introduction of the Affordable Care Act, which would later be referred to as "Obamacare," became the first legitimate attempt to address each health care component within a single piece of legislation. According to Ezekiel Emanuel, three preconditions necessitated the enactment of this comprehensive reform. From an

⁵⁰ Emanuel pg. 142-145

⁵¹ Emanuel pg. 149-154

access standpoint, the American public could no longer tolerate the inequities associated with private health insurance coverage. Emanuel notes, “About 15% of the population at any given time were uninsured, representing just under 50 million Americans.”⁵² Crafting legislation to address the millions of uninsured Americans would serve as a foundational pillar for Obamacare.

Furthermore, and arguably the most concerning problem that faced the health care agenda, Emanuel discusses the rising costs of health care spending. In comparison to other nations, the United States spent 40% more per person on health care spending.⁵³ Additionally, Emanuel’s examination of the economic trends prior to the implementation of the ACA forecasted an unsustainable financial outlook: “If health care inflation continued at its historical growth rate of GDP+2% then health care would consume about half of the federal budget by 2035.”⁵⁴ With these economic challenges in mind, Obamacare contained several strategies specific to addressing cost containment.

However, the irony of such excessive spending on American health care was, and still remains, the average, and at times, low-quality treatment given to patients. Emanuel’s scrutiny of the variation within the quality of care received, offers insight on the necessity for a change in acceptable care standards. For example, Emanuel discussed both the economic and health costs associated with poor quality treatment: “High-quality care? Roughly 1 of every 20 people hospitalized suffers a

⁵² Emanuel pg. 49

⁵³ Emanuel pg. 100

⁵⁴ Emanuel pg. 107

hospital-acquired infection, causing nearly 100,000 deaths per year.”⁵⁵ The importance of a realignment of policies based on treatment *outcomes*, rooted in efficient care models, would serve as the foundational rhetoric for new quality metrics under Obamacare.

IV. Moving Forward

The second chapter of the thesis will provide a more in-depth overview of the history of the medical profession and hospitals by tracing the development of their particular autonomy and sovereignty within the health care landscape. Within this analysis, the various institutions and actors involved, which range from political, bureaucratic, private, and professional leaders will be examined. Using this chapter as a building block, the third chapter will discuss the history of health care reform, how it traveled through the policy process, as well as highlight particular health care policy successes and failures.

With the third chapter as a foundation, the fourth chapter will discuss the contemporary health care structure, the extent of contemporary health care problems between health care payers and providers, as well as what precipitated the call for the Affordable Care Act. Furthermore, the fifth chapter will be devoted to analyzing the impetus for reform, how it traveled through the political process, the final blueprint of the Affordable Care Act, and the ways in which the legislation attempts to address the failures and limitations of prior health care reform efforts. The research will also intend to pose the question of whether or not the Affordable

⁵⁵ Emanuel pg. 111

Care has been able to successfully address access, quality, and cost within a single reform, which has historically evaded reformers.

Lastly, the sixth chapter will concentrate on the preliminary effects of the Affordable Care Act, as well as discuss the initial impediments that attempted to derail its implementation. As a reminder, in order to address all three aspects of access, quality, and cost, the Affordable Care Act has certain requirements and regulations that affect the practice of medicine in many ways. This chapter will be devoted to assessing the effectiveness of these reforms and their potential for achieving the goals stated within the legislation.

Chapter Two: Rise of the Medical Profession and Hospitals

"You cannot explain the present by the present."—Professor Stephen Berk

In combination with evolving social norms and scientific advancement, the actors of the medical community, together with the institutional progression of the hospital facility, established a prevailing cultural authority and legitimacy within society. A requisite understanding of the historical transformation of health care in America requires the examination of these authoritative origins and their representation as foundational health care pillars. Ranging from the obtainment of professional sovereignty, to the conflicts between the proper function and value of hospital care, these internal struggles and triumphs influenced the early conceptualizations of the American health care model. Furthermore, the various thematic ideas of democratization, organizational hierarchy, and the role of private versus public control play a role in this critical historical process.

With that being said, as contemporary scholars continue to criticize the construct of the American health care model, namely by referring to the stratification of care between the rich and the poor, they do so by highlighting the consequences of the haphazard process of development.⁵⁶ If the historical examination holds these criticisms to be true, the more important question pertaining to this analysis must focus on if, and how, this particular process introduced and impacted the theories of access, quality, and cost. Through this analysis, it will better enable the critiquing of health care reform movements by

⁵⁶ Arnold Kling. "American Health Care Policy Issues." *Für Die Freiheit* 1, no. 92 (2010): pg. 9.

understanding the foundations of power in health care and how the distinct actors and institutions spawned the vast industry of health care known today.

I. The Medical Profession

Throughout the development of the health care industry, the value of the physician to society has been a force. Although early on the medical profession was generally viewed as serving a humble and charitable function, its growing cultural authority and indispensability to society elevated the profession to a prominent status. As Paul Starr notes, these particular characterizations of authority and dependence not only help to explain the development of the medical field's professional sovereignty, but even more so, how those specific qualities would help to influence the shape of future health care framework and policy.⁵⁷

Prior to examining the ways in which its cultural authority and indispensability to society elevated the formation of contemporary health care, it is necessary to discuss the origins of these unique power structures, which provide important historical context. Despite today's commonly accepted notion of health care as a source of tremendous value and importance, concerns about its legitimacy and purpose were widespread among early 18th century Americans. The dominance of domestic medicine within this time period called into question the effectiveness of professional medicine and its overall practicality for treating the sick: "[Many] upheld the view that professional knowledge and training were unneeded in treating most diseases [and maintained] the belief that ordinary people

⁵⁷ Starr pg. 8

were fully competent to treat illness.”⁵⁸ As the common use of simple home remedies dominated this era, many questioned the safety of introducing a new range of medical practices to society and accepting the legitimacy of newfound medical knowledge.⁵⁹

However, the gap between domestic medicine and professional medicine would start to close as physicians began to take their first steps in bringing authority and respectability to the profession. Starr begins his outline of these transformations by discussing the European influences on the development of the professionalization of medical care in America. While the American model did not mirror the European system precisely, the importance of creating medical institutions and societies, protective medical legislation, and the use of apprenticeships for learning were all adopted from European models, the British in particular.⁶⁰ As the American medical profession began to establish legitimate medical institutions, physicians attempted to elevate the prestige and integrity of the profession in order to achieve the same level of respect as their medical counterparts in Europe.⁶¹

Yet, the process towards developing and maintaining a profession of legitimacy did not come to fruition overnight. Despite efforts to organize and create a system of corporate structure, these early physicians faced road blocks along the way: “Physicians tried to raise their standards, dignity and privileges through medical schools, societies, and licensing, but the openness of the society and the

⁵⁸ Starr pg. 34

⁵⁹ Starr pg. 34

⁶⁰ Starr pg. 40

⁶¹ Starr pg. 40

ambitions of their fellows subverted their efforts.”⁶² The proliferation of medical schools, societies, and licensing standards began to form an initial framework of legitimacy, but the lack of defined regulations inhibited many to discern between qualified and non-qualified physicians.⁶³ Although the democratization of this era helped to spur expansion within the medical field, these same democratic principles stood in contrast to the societal expectation that medicine, like anything else, could be open to all. These conflicting notions hindered the medical field from achieving the exclusivity and cultural legitimacy they sought for the profession.⁶⁴

However, with the advancements in research and scientific knowledge, the medical community found the backbone it needed to enhance its legitimacy and status relative to other professions: “Science shares with the democratic temper an antagonism to all that is obscure, vague, occult, and inaccessible, but it also gives rise to the complexity and specialization, which then remove knowledge from the reach of lay understanding.” For the profession, acceptance by society of the complexity of science rendered the authoritative status and respectability they had been desperately seeking. At this moment, the value of medical care had been established, and simultaneously, the theory of access within the health care arena was introduced: “Every man, it became clear, could not be his own physician.”⁶⁵ The prevailing confidence in domestic medicine had been relinquished and a new ethos born.

⁶² Starr pg. 54

⁶³ Starr pg. 54

⁶⁴ Starr pg. 58-59

⁶⁵ Starr pg. 59

From the era between 1870 to the early 1900s the medical community began to expand on its foundation of legitimacy, with a particular focus on its authority, otherwise known as the wealth and status of the profession.⁶⁶ According to Paul Starr, successful attainment of authority and professional mobility centers around the principles of consensus and legitimacy: “Consensus facilitates the articulation of common interests and the mobilization of group effort, while respect and deference, especially from the more powerful classes, open the way to resources and legally sanctioned privileges.”⁶⁷ Addressing the variability of standards and training within the profession were causes of concern and affected the perception of the medical community by society and patients. Creating a more cohesive unit, with unified regulations, would serve to provide more authority and credibility to the profession.

The American Medical Association, which formed in the mid-1800s decided to take on the call of encouraging a more collective medical community. During this era many physicians relied on their own social status within society to obtain patients, which created a strong sense of competition within the profession: “The orientation of the profession in short, was *competitive* rather than *corporate*.”⁶⁸ Although the AMA initially struggled to generate support among the medical community, it took important strides to lift up the status of the profession. The efforts to decrease the competitiveness within the profession led the AMA to address three main areas during this time period: licensing, organizational structure, and medical education. While the success the AMA desired would still be

⁶⁶ Starr pg. 79

⁶⁷ Starr pg. 80

⁶⁸ Starr pg. 92

years away, the early actions taken cannot be understated. The shift towards a more collective unit, not only would help to provide the medical community with more power in society, but also tremendous political and economic clout in relation to the access and cost of medical services.

The first order of business for the AMA was to improve the licensing procedures for physicians in order to strengthen the barriers to entry for the profession and to contain the competition for patients to those who were qualified.⁶⁹ Furthermore, the licensing regulations of the AMA also contributed to an increase in the organizational structure of the medical community: “The [new] organizational structure forced all physicians who wanted to belong to their county medical society or to the national AMA to become dues-paying members of their state association.”⁷⁰ By joining forces as physicians, the profession became more centralized and shifted the power away from the individual and more so to the group.

Although the licensing improvements undertaken by the AMA helped to provide a greater sense of trust in the physician, licensing did not ultimately succeed in reducing the number of unqualified physicians, which threatened the business of many individual physicians.⁷¹ In order to continue the process of consolidating the profession to an elite level, the AMA and others again took an introspective approach by reforming and strengthening the medical colleges. With the help of the Association of American Medical Colleges and the reputations of the prestigious

⁶⁹ Starr pg. 102

⁷⁰ Starr pg. 109

⁷¹ Starr pg. 112

universities themselves, medical schools went through a transformation of qualifications, standards, and regulations.

Leading the institutional charge, Johns Hopkins University was one of the first medical colleges to implement a four-year training program and “the unprecedented requirement that all entering students come with college degrees.”⁷² Furthermore, the medical education at Johns Hopkins emphasized both “scientific research and clinical instruction,” which contributed to the foundation of today’s medical education. Institutions such as Johns Hopkins, the University of Pennsylvania, Harvard, and others, elevated the quality of physicians entering the workforce.

It is important to note that the reforms of the medical colleges did not exist solely on their own merit. The AMA, which began to focus its efforts on improving the quality of medical education, established a Council on Medical Education, which started the process of grading the standards and quality of the various medical institutions.⁷³ As the AMA implemented and established the new standards many medical colleges folded, which further decreased the supply of physicians by creating stricter admissions standards, training regulations, and rising costs. Additionally, the AMA’s growing reputability among the medical community forced the medical colleges to either comply with the new policies or face the prospect of license denial.⁷⁴

⁷² Starr pg. 115

⁷³ Starr pg. 117

⁷⁴ Starr pg. 119

Lastly, to examine the status of medical colleges and whether or not they were adhering to the new standards, the AMA hired Abraham Flexner to visit each medical school across the country. This evaluation, which would later become known as the Flexner Report, encouraged the medical colleges to follow the standards or “[make] themselves more vulnerable to public exposure [for their flaws] and embarrassment.”⁷⁵ Within the report, Flexner recommended that medical schools follow the Johns Hopkins model for education and also to consolidate the number of medical colleges producing poorly trained physicians: “His report successfully legitimated the profession’s interest in limiting the number of medical schools and the supply of physicians.”⁷⁶ The significance of the Flexner report extends to this day; it provided legitimacy to a medical degree, increased the standards of the profession, and dictated the medical curriculum taught today.

Before reflecting on the legacy of these initial developments, understanding how the quest for legitimacy and authority affected the medical landscape is of importance. As the AMA President at the time, William Allen Pusey, wrote, “As you increase the cost of the license to practice medicine you increase the price at which medical service must be sold and you correspondingly decrease the number of people who can afford to buy this medical service.”⁷⁷ The profession’s focus on reaching the elite status did not come without consequence. By developing their own professional sovereignty and raising the standards of requirement, their collective strength would determine the direction of future policies and the way

⁷⁵ Starr pg. 120

⁷⁶ Starr pg. 120

⁷⁷ Starr pg. 126

medical care would be provided. In doing so, these early reforms shaped the medical community in a way that still affects the health care landscape today.

Yet, the impact of these early struggles and triumphs stretched beyond the growing collectiveness of the medical community. By the early 20th century the medical profession had essentially reached the prestige and level of income those in the community had desired.⁷⁸ The profession's flexibility and willingness to adjust to the times, as well as their ability to take the necessary steps to reform, guided the profession to new heights of authority and legitimacy that could not have been achieved solely by a selective few. "The basis of [the profession's] high income and status is its authority, which arises from lay deference and institutionalized forms of dependence."⁷⁹ The rise of the medical profession cannot be explained by one singular element. The combination of scientific advancement, skill acquisition, and most importantly the cooperative elements, legitimized the profession, and enabled those in the medical community to wield their authority for decisions regarding the future formation of health care in America.

II. The Formation of American Hospitals

As medicine continued to evolve throughout the 20th century, the development and expansion of the hospital entrenched itself as another force expanding the reach of the health care landscape. Analogous to the authoritative growth of physicians, hospitals gained legitimacy and authority throughout the course of three historical phases. The first phase centers on the initial function and

⁷⁸ Starr pg. 143

⁷⁹ Starr pg. 144

services of the hospital, which can be described as providing minimal and charitable treatment to the poor. Phase two examines the impact that new scientific advancements and techniques had on allowing for improvements and successes in care, which expanded the services of the hospital to the middle and upper classes. Lastly, phase three sheds light on the hospital as a dominant area of the health care field, and its expansion to becoming tremendous facilities of research, innovation, and surgical care.⁸⁰

The haphazard development of hospital care in America stems from its unique institutional design as a primary source of religious and charitable care:

The hospital is perhaps distinctive among social organizations in having first been built primarily for the poor and only later entered in significant numbers and an entirely different state of mind by the more respectable classes.⁸¹

Contrary to their medical counterparts in Europe, mid-19th Century American physicians were not concerned with using the hospital facility. As Benjamin Rush, a Founding Father and civic leader, once stated in reference to the hospitals at the time: “[they are] the sinks of human life.”⁸² Furthermore, because the hospitals during this era were rooted in a moralistic service, the major leaders in the community took it upon themselves as a civic duty to support those in need and served as the primary funders of the hospital. Lastly, the lack of surgical care, treatment options, and high risk of infection were all common traits of early hospitals.⁸³

⁸⁰ Emanuel pg. 18-23

⁸¹ Starr pg. 145

⁸² Emanuel pg. 18

⁸³ Emanuel pg. 18

Although the majority of physicians did not utilize the hospital facility at the beginning of phase one, by its end, the medical community began to see the potential opportunities the hospital could offer. As the desire to improve their medical and clinical skills grew across the profession, many physicians believed the treatment of these poor patients could provide excellent learning experiences and prospects for new developments: “These facilities mainly provided an educational function—doctors could learn by treating poor patients—and a way to enhance prestige. So valuable were these functions that physicians volunteered their services.”⁸⁴ Essentially acting as physician “workshops,”⁸⁵ these early interactions between the medical profession and the hospital created the openings for future inroads of interaction.

Even more importantly, the authority that physicians had developed over the prior century allowed them to invoke their autonomy within the hospital, which established a precedent of power still felt today: “Once the hospital became an integral and necessary part of medical practice, control over access to its facilities became a strategic basis of power within the medical community.”⁸⁶ As a result, hospitals were soon dominated by various networks of physicians, despite never becoming salaried employees of the facilities. The physician’s authority over the facilities began the process of following their patients into the hospital facilities to

⁸⁴ Emanuel pg. 18

⁸⁵ Starr pg. 146

⁸⁶ Starr pg. 146

continue their treatment, rather than transferring the patient to an employee of the hospital.⁸⁷

The American divergence from the European model, which based itself on public control and management of hospitals, while also providing a separate hospital staff, developed along the lines of private physician control.⁸⁸ Recognizing the differences between the foundation of public and private control in hospitals provides clarity to the mismanaged care and lack of structural hierarchy that are often criticisms of the American system: “Both internally and as a system, American hospitals have had a relatively loose structure because of the autonomy of physicians from hospitals and of most hospitals from the government.”⁸⁹ On the one hand, the benefits of this institutional design allowed for a more intimate relationship between physicians and patients. Yet, the consequences of this particular design did so at the cost of organizational management, which may not have been, and still in question today, the most effective way from a financial or quality standpoint to provide health care services.⁹⁰

Coinciding with the rise of the industrial revolution, the advancements in scientific innovation helped to spur the second phase of hospital development from 1890-1920. The growth of cities, high concentration of people, and increases in the workforce meant a societal change in common familial roles: “Urbanization meant that many people lacked families to provide nursing and other care for them at

⁸⁷ Starr pg. 146-147

⁸⁸ Starr pg. 147

⁸⁹ Starr pg. 147

⁹⁰ Starr pg. 147

home when they were sick.”⁹¹ The demand for hospital care had reached new heights. Additionally, the developments by men such as Joseph Lister, John C. Warner, Robert Koch and Louis Pasteur, led to advancements in surgical procedures, sterilization, anesthesia, antiseptic, diagnostic tests, X-rays, and other techniques, which increased the effectiveness of various treatments options and procedures.⁹² The advent of these new safety controls allowed physicians to explore the human body in ways never done before.

Furthermore, the establishment of trained nurses into the hospital setting created the necessary actors to carry out the hygienic concepts introduced to the facilities during this phase.⁹³ As the hospital gained credibility for being able to successfully perform procedures, while also attempting to limit the rates of infection, society began to feel more comfortable using the hospital facilities. These prerequisite steps allowed the physicians and hospitals to further their legitimacy and future goals: “Growth in the volume of surgical work provided the basis for expansion and profit in hospital care.”⁹⁴ The transition from charitable care to surgical treatment represented a major shift in the purpose of hospitals moving forward.

However, as hospitals began to focus their efforts on surgical and acute care, the organizational power structure within the hospital would be reformed. Due to the rise in the legitimacy of hospitals, as well as their expansion of available resources, holding privileges in the hospitals became essential for physician income

⁹¹ Emanuel pg. 19

⁹² Emanuel pg. 19

⁹³ Starr pg. 155

⁹⁴ Starr pg. 157

and success. The economic implications of hospital privileges were important for both parties involved. For the hospitals, expanding the use of their facilities to more physicians created a “feeder” system to fill the beds, which provided the income necessary to keep the doors open. On the other side of the coin, the opportunity for physicians to continue the care of their patients became an important source of their economic well-being.⁹⁵

While phase three of hospital development will be explored more in depth in future chapters, the precursors to the technological successes during the second half of the 20th century grew on the coattails of the second phase’s expansion. Although up to this point hospital expansion and funding had been fully operated by the private sector, the addition of government aid allowed hospitals to reach phase three. What would later be considered one of the most influential political reforms of health care history, the Hill-Burton Act of 1946 provided the impetus for hospital expansion and growth nationwide: “Over the next 25 years Hill-Burton contributed funds to approximately a third of all hospital construction programs.”⁹⁶ The availability in funding generated new hospitals both in affluent and poorer communities, while also keeping afloat those that needed increased funding. As hospitals grew in their ability to function as facilities on the forefront of technological advancement and offering high quality care, they elevated their prestige and importance to those they served.

As hospitals developed across America during the 20th Century, their particular focus and range of care mirrored the populations they served. The range

⁹⁵ Starr pg. 166

⁹⁶ Emanuel pg. 21-22

of hospitals, which included elite voluntary hospitals, municipal and county hospitals, and profit-making hospitals, all varied in the types of services offered, sources of funding, and patients treated. The elite voluntary hospitals, which maintained close ties with the medical schools and benefited from large private endowments, focused much of their efforts on acute care, while also serving the upper classes. Second, the municipal and county hospitals covered a wider range of illnesses, were often funded through government aid, and dealt with the poor and patients with chronic conditions. Lastly, profit-making hospitals remained centered on surgical care, which meant that their funding sources were entirely fee-based. As a result, these hospitals were generally used by the middle and upper classes due to the cost of care.⁹⁷

However, the result of an undefined central mechanism to guide the construction of early hospital care meant that the hospitals would inevitably be influenced by prevailing social structures: “The hospital system had no design since it was never planned, but it had a pattern because it reflected a definite system of class relations.”⁹⁸ The elements of inequities of care, access, and the impact of the cost of treatment are a consequence of the absent methods of planning. As the privately owned facilities naturally developed into more enviable treatment centers, the publicly run hospitals often faced much more difficult cases and issues of overcrowding. This is not to say that poorer patients were never admitted to the top facilities, but in general, hospital care developed along class lines.⁹⁹

⁹⁷ Starr pg. 171

⁹⁸ Starr pg. 171

⁹⁹ Starr pg. 173

As hospital care developed by favoring the upper class, surgical care, and profit, the access to care, the cost of care, and quality of care, were virtually unobtainable for the poorer classes of society during this era. The rhetoric of this time period set a precedent for the type of care that Americans would allow, which influenced and impacted the construct of future health care policies: “This pattern became a standard feature of American medicine—a highly developed private sector for acute treatment and an underdeveloped public sector for chronic care.”¹⁰⁰ As history will continue to show, the inadequacies of early hospital development created a system of care that would favor the few over the many.

Lastly, the final legacy of 20th Century hospital growth deals with the inadequate management structures, which reflected both a divide in priorities and the grand vision of hospital care among the parties involved. As hospitals began to grow in their size and services offered, the necessity for management led to the introduction of hospital administrators. Again in contrast to the European model, the absence of a static hospital staff and the circulation of attending physicians within the hospital, led American hospitals to require more leadership to coordinate all of the various tasks within the facility:

Each hospital had to raise its own funds for capital expenditures, set its own fees, do its own purchasing, recruit staff, determine patients’ ability to pay, collect bills, and conduct public relations efforts. All these activities required staff, money, and space.¹⁰¹

As hospital administrators began to take on a larger role, the power and authority of the physician would be confronted.

¹⁰⁰ Starr pg. 173

¹⁰¹ Starr pg. 177

Yet, despite the fact that hospital administrators would serve a critical role, their growing authority and view on the purpose of the hospital did not necessarily align with that of the physicians: “Private physicians continued to regard hospitals as “doctors” workshops, while the administrators tended to see them as “medical centers” serving the community.”¹⁰² From a historical perspective, the trends in leadership changes are important to note. In the beginning, hospitals devolved their authority to the trustees, due to their investments in capital and ability to fund the facility. Second, physicians secured power from the trustees, as a result of their medical expertise and skillset. Lastly, as hospitals demanded a more formal management structure, hospital administrators came onto the scene as essential figureheads in charge of the decision-making processes.¹⁰³

III. Sovereignty and Authority

The authoritative trends over time have presented complexities from a management and coordination perspective. The consequences of a deficient and unclear bureaucratic structure has often resulted in a power struggle between three groups—trustees, physicians, and administrators—seeking to influence hospital management with their own desired values and goals: “Hospitals [remain] incompletely integrated, both as organizations and as a system of organizations—a case of blocked institutional development.”¹⁰⁴ The origin of the inefficient model of care concept, which has been a longstanding criticism of the current hospital

¹⁰² Starr pg. 178

¹⁰³ Starr pg. 178-179

¹⁰⁴ Starr pg. 179

structure, was established through the haphazard development of hospitals during this era.

Indeed, the foundation of poor governance, rooted within the institutionalization of the hospital structure, inhibits the quality and coordination of care today. Due to the inability to retain a succinct, hierarchical leadership within the hospital, not only do the patients suffer in terms of the care they receive, but the inefficiencies also affect the overall cost of medical services. Understanding the internal growth of the hospital structure, both from a social and authoritative perspective, provides the requisite lens for dissecting the issues facing health care providers today.

The ascension of the medical profession, and the subsequent rise of the hospital, paved the way for the dominance of the health care industry within society. As each discovered their own legitimacy and authority, both areas did so through the pathways of trial and error, cultural phenomena, scientific advancement, and the establishment of sovereignty. The initial growth and expansion of the structure and institutional design of American medicine paved the way for the types of reforms that would follow and the rhetoric and actors that would have a voice.

Chapter Three: The Winding Road of Reform

“I would not be sorry if these analyses of roads not taken served as a reminder that the past had other possibilities, and so do we today.”¹⁰⁵—Paul Starr

The origin and evolution of the American health care system developed in combination with various actors, institutions, and political climates. Commencing with the medical profession, which successfully achieved sovereignty from a distinct power structure and pervading cultural authority, and in combination with the rise of hospital facilities, each contributed to the early foundation of American health care. The current framework, in large measure, is a result of the interactions between those groups: the opportunities taken, the choices made, and the chances missed. However, as health care has traveled from its rudimentary beginnings to the path of vast industry, it has done so, often times, despite the lack of a unifying force, and without a central mechanism to guide its systematic construct. The consequence of this patchwork progression has, for the most part, engineered the complexities and recent problems confronting health care reformers today.

While certainly not all of the institutions and policies enacted are failures, or should be considered so, their periodic inability to address the components of access, quality, and cost, has led to an underperforming and inefficient model of care. Examining the historical transformation of American health care will help to generate answers to the questions of how did we get here, why were these specific paths chosen, and what prompted the impetus for sweeping reform. The breadth of such a perspective will further enable a more precise assessment of contemporary

¹⁰⁵ Starr pg. xi

health care issues and a more helpful tool when introducing, enacting, and implementing future health care reform.

I. Principles to Legislating for Health Care Reform

Historically, American political ideology has been characterized by a tradition of maintaining the status quo. The recurring theme of the general disdain for government intervention contributes directly to the fragmentation that exists within American institutions and the overall political process. While the preventative intentions of the public policy process exist to halt major change, its ability to facilitate an effective answer to a problem in need of attention remains in question. The extension of this foundational political belief to the consensual model of policymaking, attempts to combine varying interests in order to create effective policy. However, the decentralization of political leadership in Congress and the disparities within the legislative agenda, combine to substantially affect public policy outcomes.¹⁰⁶

The repercussions of the current institutional roadblocks have resulted in the susceptibility of the political process to various outside interests and actors, which impact both the formation and implementation of public policy. Prior to examining the historical progression of health care policy in America, attention must be given to the political process specific to health care. The purpose of analyzing health care policy, in relation to the larger concepts of public policy, helps to generate a proper roadmap to navigate the intricacies of the health care

¹⁰⁶ Adam Becker, "Obesity and Food: A Reconsideration of American Agricultural Policies." June 11th, 2014, pg. 1.

landscape. The emerging discussion encourages the development of an essential range of critiques and reflections useful for addressing future attempts at reform. Furthermore, constructing answers to the questions of who and or what governs the health care policy arena, as well as why certain reforms succeed and others do not, represents a vital tool for tackling the issues inherent in the policy process.

Borrowing from the legislative principles of former President Lyndon Johnson, Ezekiel Emanuel adheres to the belief that six specific principles exist within the health care policy process. According to Emanuel's research of health care policy, his outline of the specific principles to legislate for health care reform include: understanding it will be a fight, political unity is a necessity, recognizing the "power and fragility of Washington egos," maintaining speed in the policy process, building on prior reform successes, and defending against antigovernment rhetoric.¹⁰⁷ While these beliefs, in and of themselves, are not mutually exclusive, their appearance historically within health care reform efforts suggests their significance and value to enacting successful reform.

First and foremost, recognition of the characteristics central to the policy process remains a prerequisite for any reform effort: the political process remains tumultuous, which includes many roadblocks intended to impede reform. As the study will reveal, guiding reform from concept to outcome has eluded even the most skilled politicians and presidential figures: "Since 1912 the United States has resisted any universal coverage or national health insurance coverage."¹⁰⁸ American political ideology and the political process are not welcoming to change;

¹⁰⁷ Emanuel pg. 156-158

¹⁰⁸ Emanuel pg. 156

understanding this foundational attitude and maintaining a willingness to move forward separates those political actors and leaders that have succeeded versus those who have succumbed to the political pressures.

Second, reformers must not underestimate the power of political unity and its importance towards facilitating the policy process. Not only does unity provide the glue required to overcome various roadblocks, but it also serves as a tremendous function in helping to stand firm against political opposition: “Lack of agreement dissipates those in support, thereby allowing a smaller but focused group of opponents to be more effective.”¹⁰⁹ Rallying around a united cause inevitably leads to a stronger base of support and a greater likelihood of success. Third, people, their egos, and their personalities are important. In order to ensure that members of the political unit are given their fair share of respect and responsibility, utilizing the themes from the second concept helps to limit animosity and ill-will throughout the policy process.¹¹⁰

Additionally, in combination with maintaining a cohesive unit, as well as managing various “Washington egos,” speed is essential during the introductory stages of potential reform efforts. According to President Johnson, his mentor Sam Rayburn (D-Texas), former Congressman and the longest tenured Speaker of the House in U.S. history, once commented to the President on the importance of swift reform:

For God sakes, don't let dead cats stand on your porch, Mr. Rayburn used to say, “They stunk and they stunk and they stunk.” When you get one [of your

¹⁰⁹ Emanuel pg. 156

¹¹⁰ Emanuel pg. 156

bills] out of that committee, you call that son of a bitch up before they [the opposition] can get their letters written.¹¹¹

Generating speed as a mechanism to suppress an opposition faction from developing increases the prospects for political success and a decrease in the chances that blockages will form. To further reiterate the significance of moving quickly throughout the policy process, it took merely seven months for the passage of both Medicare and Medicaid under President Johnson.¹¹²

Yet, when analyzing this strategy from a larger perspective, and with public concern in mind, the principle of speed acts as a double-edged sword. While speed may be required for securing and succeeding with extensive reform, it consequently limits opportunities for discussion and to properly fine-tune aspects of the bill. Although ironing out the smaller details of reform can certainly occur following its passage, and during implementation, the aggressive nature of such an approach nonetheless may result in unforeseen and unwarranted outcomes.

As noted above, American political ideology is rooted within a sense of maintaining a level of political consistency, and as such, an aversion and apprehension to new political changes. The result of this political climate encourages policy development based on prior political templates and ideas: “Representatives and senators instinctively oppose the new and are comfortable with what they have already enacted. [Simply put], Congress does not like new things.”¹¹³ From the onset, formulating new and acceptable policy reform presents a significant challenge for policymakers. As such, it is essential for any political actor

¹¹¹ Emanuel pg. 157

¹¹² Emanuel pg. 157

¹¹³ Emanuel pg. 157

to utilize what other reformers have successfully put forth in order to increase the level of support for reform.

Furthermore, due to the influence of speed discussed earlier, adhering to this line of reasoning does not create the easiest of conditions to produce an entirely authentic piece of legislation: “No one can write a new 1,400 page bill; they have to borrow heavily from what already exists.”¹¹⁴ Ranging from detailed aspects of Medicare to the Clinton health care plan, the health care reform landscape is littered with examples of political actors using past reform efforts and promptly amending them to achieve passage.

Lastly, and in relation to principle number one, policymakers must defend against anti-government rhetoric and overall, the opposition. With any attempt at health care reform, notions of excessive government interference are common themes used as propaganda by the opposition: “[The Opposition’s] line of attack is tried and true—it taps into the traditional American suspicion of government.”¹¹⁵ The slogan of “socialized” medicine, which is routinely used as a mechanism to castigate reform efforts, most recently gained exposure in opposition to the Affordable Care Act. Additionally, efforts by physicians, insurers, and businesses, and specifically groups such as the AMA, have often stood as tremendous opposing forces to government interference and new legislation.¹¹⁶

In the ensuing historical assessment, various political actors have attempted to wield components of these foundational political guidelines. For some, successful

¹¹⁴ Emanuel pg. 157

¹¹⁵ Emanuel pg. 158

¹¹⁶ Emanuel pg. 158

passage of reform has meant the utilization of a multitude of legislative principles. However, for others, failure to incorporate a certain principle has led to severe blunders, which has more often than not, derailed the political process entirely. While each tool makes an impact on its own, the ability of policymakers to use each aspect in combination elevates their overall effectiveness in overcoming a system of beliefs designed to limit the amount of paradigmatic change. The following historical outline over the previous century will depict the use of these tools and how political actors have sought to enable them as they address access, quality, and cost within health care policy.

II. Antecedents to Major Health Care Reform

At the turn of the 20th Century, a collective sense of social activism and political reform infused the American political climate. This movement, otherwise known as the Progressive era, introduced a range of new attitudes and theories on the proper role of both society and government in providing assistance for their fellow Americans. As the value of health care continued to grow in its effectiveness and overall legitimacy, the concepts of a social right to health care became a main focus of the Progressive movement.¹¹⁷ During this era of the mid-1910s, America would receive its first opportunity to expand health coverage, which thereby would provide access to health care services for all Americans.

Drawing on European precedents, the American Association for Labor Legislation (AALL) introduced prospective access-based reform by combining

¹¹⁷ Starr pg. 238

elements of compulsory insurance, while also promoting American capitalist influences:

On the one hand, in emphasizing the relief of poverty, they made an appeal to moral compassion; on the other, in emphasizing prevention and increased national efficiency, they made an appeal to economic rationality.¹¹⁸

The combination of access to health care services, with its underlying social cost-saving components, initially succeeded in unifying the medical community: “[T]he AMA and the AALL formed a united front on behalf of health insurance.”¹¹⁹ Latching onto the zeitgeist of the times, it seemed Americans would succeed in delivering a broad-range of health care services not only to the rich, but also to the underclasses of society.

Yet, as would become the tale of health care reform throughout the century, preliminary support does not always translate into political action. The demise of access-based reform during the Progressive era, which would have secured compulsory health care coverage for Americans, succumbed to the pressures of cost containment and the AMA itself. From a cost standpoint, the Committee on the Costs of Medical Care (CCMC), a private committee organized by the AMA, argued that health care coverage would lead to an excessive economic burden and the intrusion of government intervention: “Instead [of compulsory health insurance], the CCMC endorsed voluntary insurance that would promote group practice organizations and prepayment.”¹²⁰ Moreover, the CCMC recommendations also corresponded with the AMA’s desire to maintain physician payments based on a per visit basis, rather than

¹¹⁸ Starr pg. 244

¹¹⁹ Emanuel pg. 129

¹²⁰ Emanuel pg. 130

the reformer's support for capitation payments.¹²¹ The inability of reformers to shift the position of the AMA set the table for physician control of payment structures, which remains the focus of much debate among contemporary health care reformers.

Furthermore, the ethos of welfare assistance continued to influence the political agenda during the Great Depression, which again set the stage for prospective access-based health care reform. As Americans faced unprecedented levels of unemployment, while also still in need of health care services, the platform for compulsory health care coverage seemed ripe for the taking.¹²² Furthermore, the Depression directly impacted the level of physician incomes and many looked to government support in order to help offset their loss of service volume and payments: "Not only were patients seeing doctors less often; they were paying their doctors' bills last. For the first time [physicians] asked welfare departments to pay for the treatment."¹²³ The significance of government intervention within the health care arena must be noted, both as a point of foreshadowing and as an establishment of precedence. Prior to this era, defraying health care costs were generally not extended to welfare policies. What initially had been characterized as a "temporary expedient,"¹²⁴ state and federal reimbursements for medical care services would become the norm in health care funding.

Yet, despite support from large numbers of physicians who would benefit from government involvement in the health care setting, the AMA threatened again

¹²¹ Starr pg. 248

¹²² Starr pg. 266

¹²³ Starr pg. 270

¹²⁴ Starr pg. 271

to stand as a roadblock to reform. According to leadership within the association, government involvement within the profession threatened the fraternal bonds of the medical community and the very relationship between doctors and patients: “[Welfare] must be considered as a temporary expedient only, and must be discontinued as rapidly as the stress on the profession is relieved.”¹²⁵ Even with the private support of President Roosevelt, the strength of the AMA and wealthy physicians ultimately succeeded in denying compulsory health care reform within the New Deal and specifically under the introduction of the Social Security Act.¹²⁶

The failure to adopt comprehensive coverage during the Roosevelt administration can be characterized by the inability to address the legislative principles of strong initial support by key political actors, as well as to defeat the multitude of groups in opposition to reform. From a leadership standpoint, President Roosevelt’s interest in health care reform on purely a private level reflected his lack of desire to address health care reform head on. His decision not to voice his recommendations, publicly, reaffirmed that this was not his fight to face.¹²⁷ Second, and even more importantly, the strong opposition by the AMA and the CCMC successfully derailed health care reform through a collaborative opposition, rooted within anti-government rhetoric.

In contrast to the Roosevelt presidency, the Truman administration led a more forthcoming effort for proposing a national health insurance program, which attempted to encompass increases in the access of services, while also addressing

¹²⁵ Starr pg. 271

¹²⁶ Emanuel pg. 131

¹²⁷ Emanuel pg. 132

the affordability of health care costs. In conjunction with the Wagner-Murray-Dingell bill, which sought to augment the Social Security bill through the addition of health care coverage, Truman's plan aimed to expand access to health care within a single national health insurance system: "This was the first time in American history that an administration had introduced national health insurance legislation."¹²⁸ This proposal, known as the National Health Insurance plan, represented a key juncture in American health care history and the strongest display of presidential activism for comprehensive health care coverage.

Yet, even with strong political activism from the start, as well as building on prior health care reform templates for greater support among Congress, President Truman also fell victim to legislative principle number six: defend against the opposition. Analogous to the AMA's successful defense against reform during the Roosevelt era, the group again employed antigovernment charges as a strategy to spoil the advent of potential reform. In order to hold the line in opposition to health care reform, the AMA employed the services of Whitaker and Baxter, a political consulting firm, which agreed to undertake one of largest public relation campaigns of that time.

The savvy lobbyist efforts of Whitaker and Baxter resonated with President Truman's health care policy as a form of socialized medicine. A number of pamphlets released by the firm asked, "Would socialized medicine lead to [the] socialization of other phases of American life?" While also employing common scare-tactics, which claimed, "socialized medicine is the keystone to the arch of the

¹²⁸ Emanuel pg. 134

Socialist State.”¹²⁹ Furthermore, the large sources of funding provided by the AMA, which amounted to nearly \$5 million, increased the efficacy of the campaign and the firm’s success in “[collecting] key endorsements from the American Association, American Dental Association, and American Legion.”¹³⁰

Simply put, the question of whether or not President Truman’s National Health Insurance plan was by definition alone, socialist, fails to grasp the larger concept of public perception at hand. What the AMA carefully understood, and critically identified, is the notion that perception, above all else, is reality. While the Truman plan may have never contained socialist provisions to begin with, the AMA, along with Whitaker and Baxter, identified a potential ally in the American public. Truman’s consequential failure in defending his policy from the swarms of socialist rhetoric led to a “[drop] in [support among] public opinion polls from 58 to 36 percent,”¹³¹ which thereby secured the AMA’s victory against compulsory health care coverage.

III. Historical Development of American Health Coverage

For the American public, the decision to choose private insurance, rather than embark on the path of universal health coverage, represents a watershed moment in the discussion of health care policy, and arguably, the American way of life. Eluding the American public of the time, this opportunity to secure access-based health care reform would have sufficiently addressed the issue of access to health

¹²⁹ Starr pg. 285

¹³⁰ Emanuel pg. 136

¹³¹ Starr pg. 285

care coverage: “Instead of [Truman’s] universal system, American society provided insurance against medical expenses primarily to the well off and the well organized.”¹³² The significance of this seminal moment in American history not only introduced the rise of the health insurance industry, but also more importantly developed the beginnings of the disparities in care between the rich and the poor.

The monumental shift towards a predominately private-insurer based health care system influenced to an even greater extent the cost of financing health care services. For many, movement in favor of the path of private responsibility of health care services aligned with the traditional themes of American individualism, in addition to those who supported the theoretical concepts of health care as a commodity: “Rights do not exist in a vacuum. To create a right on A is to impose a correlative duty on some other person, [B].”¹³³ At this juncture in history, Americans, and political leadership for that matter, did not concern themselves with constructing a system of welfare rights based in large measure on government funding. The importance of cost containment of health care deflated the impetus for providing a social safety net and the overall access to universal health care services.¹³⁴

Prior to dissecting the various forms of private insurance that developed out of the mid-20th Century era, it is essential to discuss the two main issues associated with health insurance: moral hazard and adverse selection. The former, based on the belief that universal access will lead to the overconsumption of health care

¹³² Starr pg. 289

¹³³ Epstein pg. 5

¹³⁴ Epstein pg. 3-4

services, can be explained through the theory of positive rights: a social entitlement or collective duty. In terms of this moral hazard, various concerns have focused on addressing the inherent dilemma within the demand for health care services, which may or may not always be warranted: “Legal entitlements must be geared for a world of scarcity, for a world where some legitimate wants have to remain unsatisfied.”¹³⁵ Theoretically speaking, in order to contain costs health care demands cannot entirely be provided so long as a scarce amount of resources exists.

With this principle in mind, private insurers have implemented various components to limit “wasteful health care expenditures.”¹³⁶ Through the addition of deductibles and co-payments to insurance plans, which increase the level of financial responsibility for patients, private insurers have attempted to reduce the demand for the overutilization of health care services.¹³⁷ The fundamental concerns associated with moral hazard negate the prospects for success of the economic feasibility to a universal system of health care: “It is a feat of blind optimism to assume that any political process is capable of translating the idea of minimum standards into a set of workable administrative norms.”¹³⁸ Whether or not political history has shown this to be true will require further analysis.

Furthermore, adverse selection presents another problem from an insurance standpoint: “The tendency for sicker people or those disposed to use health care services to want to purchase health insurance and for healthier people to forego

¹³⁵ Epstein pg. 44

¹³⁶ Epstein pg. 48

¹³⁷ Emanuel pg. 39

¹³⁸ Epstein pg. 50

buying coverage.”¹³⁹ The consequences of adverse selection increases the overall costs of health care coverage, which forces those who believe they may not need insurance to drop out of the market. This in turn places a higher burden on those who desperately need health care coverage and are hoping to pay for the insurance at an affordable cost. Traditionally, insurance companies have attempted to diminish the forces of adverse selection by charging more to patients with pre-existing conditions as a way to offset the foregone coverage of healthier people who have decided to leave the market due to higher costs.¹⁴⁰ However, with the implementation of the Affordable Care Act, which will be discussed in-depth in further chapters, insurers can now fight against adverse selection through compulsory coverage. Throughout history, the absence of a compulsory form of health care legislation has been a strong criticism of rising health care costs and the insurance industry as a whole.

Returning to the previous analysis of the Truman administration’s failure to implement universal health care coverage, three foundational conceptions of private health insurance arose out of the mid-20th Century era: indemnity plans, service-benefit plans, and direct-service plans:

1. Indemnity benefits, which reimburse the subscriber for medical expenses, though usually not the entire bill.
2. Service benefits, which guarantee payment for services directly to the physician or hospital, often covering the subscriber’s bill in full.
3. Direct services, that is, the provision of health services to the subscriber by the organization receiving repayment.¹⁴¹

¹³⁹ Emanuel pg. 41

¹⁴⁰ Emanuel pg. 42

¹⁴¹ Starr pg. 291

These primary models served an important function as the basis for the rise in the proliferation of private insurance plans. Moreover, their infusion into the insurance market helps to explain the formation of the Blue Cross and Blue Shield plans, as well as traditional commercial-based insurers.

The impetus for health insurance can largely be attributed to the effects of the Great Depression on both hospital and physician revenues. The consequences of the decline in health care spending among the American public threatened to undermine the very existence of hospital facilities and led to the underutilization of hospitals and physician services: "Hospitals [cannot] continue to rely on patients to pay all their bills when they [are] hospitalized; the costs [have] to be budgeted in advance through insurance."¹⁴² In order to stimulate competition among hospitals and to elevate their levels of income, pre-paid hospital coverage became a viable option for preserving access to health care services and at an affordable cost.

In 1929, at Baylor University Hospital, the introduction of direct-service plans provided "prepaid hospital coverage,"¹⁴³ which would later become the model for the Blue Cross insurance plans. Enabled by the American Hospital Association, the Blue Cross plans proliferated, signaling their success to commercial insurers, who, up until the 1940s, avoided health insurance coverage: "By insuring all the workers at a company, the Blues showed how the problem of adverse selection and high underwriting costs could be overcome."¹⁴⁴ Although a seemingly foreign concept to commercial insurers prior to this time, the Blue Cross plan displayed how

¹⁴² Starr pg. 296

¹⁴³ Emanuel pg. 27

¹⁴⁴ Emanuel pg. 29

risk could be minimized by increasing the pool of people insured among company employees.¹⁴⁵

However, despite the fact that insurers' gained hospital privileges with relative ease, the stance of physicians, and particularly the AMA, did not initially welcome the introduction of insurance into the profession. According to the AMA's national health program of 1938, and in response to their hostility to insurance within medical care, "these plans should confine themselves to the provision of hospital facilities and should not include any type of medical care."¹⁴⁶ Keeping in mind the already established sovereignty and legitimacy of physicians, as well as the sacredness of the physician-patient relationship, the idea or notion of a financial intermediary threatened the direct power structure of the profession.

Yet, in the face of the AMA's opposition to a financial intermediary, studies began to prove that patients under insurance would have a greater likelihood of paying for the cost of physician services.¹⁴⁷ As physicians began to realize the possibilities of insurance, and influenced to a great extent by the successes of prepaid coverage at Baylor, a cooperative movement among physicians emerged: "group practice, prepayment, preventive medicine, and consumer participation."¹⁴⁸ In response, the development of a physician-controlled insurance, known as Blue Shield, arose. Blue Shield differed from Blue Cross by offering "coverage for office visits, house calls, and in-hospital physician services."¹⁴⁹

¹⁴⁵ Emanuel pg. 29

¹⁴⁶ Starr pg. 299

¹⁴⁷ Starr pg. 299

¹⁴⁸ Starr pg. 302

¹⁴⁹ Emanuel pg. 30

In combination with the Blues and commercial insurers, access to health care insurance became a viable option on the national level. Most significantly, private employers began offering their employees various coverage options, which “diminished the likelihood that only the more sickly would buy insurance, and it reduced the huge administrative expenses of individually sold policies.”¹⁵⁰ By 1954, the popularity of employer-based health insurance had soared, as nearly “30 million workers and their dependents”¹⁵¹ received coverage.

From a policy standpoint, the rise of the insurance industry derived much of its progression to the groups holding significant political clout. Garnering reform in their favor, the middle-class, businesses, physicians, and hospitals succeeded in creating insurance coverage that benefited each group economically. Although initially opposed to insurance within the medical field, physicians, as well as hospitals, utilized insurance to raise their level of incomes.¹⁵² From the businesses standpoint, they could now provide employees not only with access to health care services, but more importantly health care at an affordable cost. For businesses, government created cost-saving methods by creating tax-exemptions for employer contributions to employee health care coverage.¹⁵³

As health insurance became ingrained into the American health care model, its legacy from an access and cost standpoint must be noted. Rather than devising a system based on aiding the poor, which traditionally characterizes the European insurance model, the American insurance model developed in large measure on

¹⁵⁰ Starr pg. 311

¹⁵¹ Emanuel pg. 31

¹⁵² Starr pg. 332

¹⁵³ Starr pg. 334

aiding the middle-class: “America [established] an insurance system concerned with improving the access of middle-class patients to hospitals and of hospitals to middle-class patients.”¹⁵⁴ Furthermore, due to this particular formation, hospitals and physicians emerged as the power structure within the insurance industry. As stated above, physicians and hospitals reaped the rewards of the new system through more guaranteed levels of income, and with an overall increase in the amount of spending to raise the financial strength of the health care industry as a whole.¹⁵⁵

Nevertheless, while much of the middle-class benefited from the inherent privatization of this insurance model, many Americans, including the elderly, retired, poor, and chronically-ill were left without coverage altogether. The source of many disproportions in care, between the well off and the under-privileged, can be traced to the establishment of this “fringe benefit”¹⁵⁶ system. From a cost standpoint, the regressive nature of this system led to the necessity of government intervention in future health care policies: “Private social security was not a neutral force on those left out; it hurt them, and much government intervention was required just to redress the inequities it created.”¹⁵⁷ While many Americans gained access during these formative years, the absence of a universal-coverage mechanism secured the fate of inequitable care for many future generations.

¹⁵⁴ Starr pg. 331

¹⁵⁵ Starr pg. 334

¹⁵⁶ Starr pg. 333

¹⁵⁷ Starr pg. 333

IV. Health Care Policy in the Postwar Period

The recurring theme of access continued beyond the initial postwar period, which introduced widespread access to health care services for many members of American society, as health care policy continued to strengthen the development of hospital facilities. Up until this point, much of what has been discussed during the Truman era has focused on the administration's shortcomings, specifically in its failure to pass universal health coverage. However, in 1946, President Truman and Congress signed into law the Hill-Burton Act of 1946, which represented one of the most influential pieces of health care legislation during the 20th Century: "Over the next 25 years Hill-Burton contributed funds to approximately a third of all hospital construction programs."¹⁵⁸ The impact of this legislation spurred the growth of hospitals around America, but did not reach its full impact until the postwar period. In 1954, Congress infused the Hill-Burton act with additional funding in order to create long-term and ambulatory care facilities.¹⁵⁹

Analyzing the expansion of hospital facilities under the Hill-Burton legislation is critical to understanding the historical progression of the hospital-physician relationship. With an enormous impact on both the access and cost areas of health care, the increase in hospital facilities stimulated the total volume of patients available to physicians: "The concentration of medical work in hospitals and doctors' offices made it possible for doctors to increase their volume of practice

¹⁵⁸ Emanuel pg. 20-21

¹⁵⁹ Starr pg. 350

dramatically.”¹⁶⁰ The demand by hospitals to fill their beds to capacity, which tremendously increased in availability for patients, bolstered the status and necessity of the physician to the hospital setting. As hospital growth fostered the volume of work available for physicians, and as overall health care costs increased, hospitals and physicians began to reap the rewards of their thriving earnings.

The redistributive ethos of the 1960s, which characterized the impetus for political reforms throughout the decade, encouraged to a large extent the quest for momentous access-based legislation within the health care field. Before examining the process and outcome of what eventually would become Medicare and Medicaid, two vital access-based health care reforms of the decade, the analysis requires a short discussion of the consequences of postwar period actions.

In continuation with the group’s longstanding tendency to represent the main political opposition, the AMA’s determination to hinder the discussion of universal health care insurance indirectly spawned the introspection of traditional American rights: “the AMA’s efforts to quash national health insurance accomplished something the group never intended: they stirred a national debate among Americans about the right to health care.”¹⁶¹ The widespread dissatisfaction of the current model of care contributed to one of two major trends for the adoption of new health care legislation. First, and in terms of health care costs, the expansion of hospital care, and the medical field in general, presented problems for certain groups in society that had been excluded from employer-based coverage.¹⁶² Second,

¹⁶⁰ Starr pg. 359

¹⁶¹ Brownlee pg. 19

¹⁶² Emanuel pg. 136

and in relation to the latter, many within the elder community, as well as those who were not eligible for employer-based coverage due to retirement, propagated their frustrations with the lack of compulsory coverage.¹⁶³

For the American public, the intensification of these sentiments galvanized policymakers at the congressional level. Championing the early attempts at reform for health care coverage in 1957, Aime Forland (D-Rhode Island), submitted the first proposal for the Medicare bill, which “[included] coverage for hospital costs in Social Security, [while paying] for it through a payroll tax.”¹⁶⁴ Forland’s preliminary efforts, which ultimately fell in defeat to the conservative-dominated House Ways and Means Committee, represented the first vote by this committee in reference to the issue of health care coverage.¹⁶⁵ Although stymied by Congressional opposition, Forland’s sponsorship of the Medicare bill served as the catalyst for a series of future reform efforts by the Democratic Party, which continued to embody the primary health care legislative principle: a willingness to fight for reform.

Furthering the actions taken by Forland, Democratic leadership utilized two other principles during their attempts at legislation: maintain political unity and build on prior reform successes. Senator Kerr (D-Oklahoma), together with representative Wilbur Mills (D-Arkansas), chairman of the Ways and Means Committee, devised a proposal for Eldercare: “[A] program [providing] federal grants to states, which could then provide health coverage to the aged poor.”¹⁶⁶ Yet, despite the defeat by a Republican opposition for a second time, Democratic

¹⁶³ Emanuel pg. 136

¹⁶⁴ Emanuel pg. 136

¹⁶⁵ Emanuel pg. 137

¹⁶⁶ Emanuel pg. 137

leadership would not succumb to the political opposition. Subsequent efforts, one of which was led by Cecil King (D-California), built upon the prior successes within the Medicare bill: “[The] modified Medicare Bill [included] inpatient hospital services, skilled nursing home services, home health services, and outpatient hospital diagnostic services.”¹⁶⁷ Additionally, not only did the quest for reform direct the agendas of congressional leadership, but the prospects for new health care legislation also garnered vocal support from President John F. Kennedy.

In spite of the pressing action taken by the Kennedy administration for the modified Medicare proposal, the opposition’s onslaught of anti-government rhetoric and the AMA’s strength posed yet again another roadblock to reform. In 1961, Ronald Reagan’s video oration regarding his criticisms of the Medicare bill aligned with the all-too-frequent attempts at establishing a synonymous relationship between health care reform and socialized medicine: “One of the traditional methods of imposing *statism* or socialism on a people has been by way of *medicine*. We do not want socialized medicine.”¹⁶⁸ Ultimately, trepidations by the Republicans and other opposition forces thwarted the Medicare bill from passing during the Kennedy Administration.

However, in 1964, the fate of health care history would shift entirely. In combination with Democratic control of the House and Senate, and more importantly President Lyndon B. Johnson’s landslide electoral victory, Medicare legislation appeared to breathe new life. Analogous to the legislative principles implemented by prior Medicare reform efforts, the final push for reform utilized the

¹⁶⁷ Emanuel pg. 138

¹⁶⁸ Emanuel pg. 138

concepts of fight, speed, political unity, and the use of previous reform successes. In relation to the former, President Johnson's commencement speech, which vocalized his strong support for health care reform, served as his acknowledgement of the importance of fighting for reform: "Americans want, need, and can afford the best of health not just for those of comfortable means, but for all our citizens old and young, rich and poor."¹⁶⁹ President Johnson's rhetoric within this speech showcased his commitment to health care reform and its place as the cornerstone of his Great Society initiative.

Furthermore, emblematic of his savvy political skill-set, President Johnson enlisted the aid of key health care reformers, most notably Representative Mills, to swiftly amend the Medicare and Medicaid proposals to fit the demands and needs of the times. With an understanding of speed, as well as recognizing the value of political unity, Mills completed the proposal within two months, which contained Democratic principles from the Forand and King legislation, and also incorporated Republican concepts from Representative James Byrnes, the ranking Republican on the Ways and Means Committee.¹⁷⁰ The ingenuity of Mills' decision to amalgamate the legislation created a "layer-cake" framework necessary for the passage of legislation:

The first layer was the Democratic plan for a compulsory hospital insurance program under Social Security. This became Part A of Medicare. The second layer was the revised Republican program of government-subsidized voluntary insurance to cover physicians' bills. This became Part B of Medicare. And the Third layer, called Medicaid, expanded assistance to the states for medical care for the poor.¹⁷¹

¹⁶⁹ Emanuel pg. 140

¹⁷⁰ Emanuel pg. 140

¹⁷¹ Starr pg. 369

In July of 1965, seven months after taking office, President Johnson signed into law the Medicare legislation. The victory signaled the improvement of health care inequalities and the expansion of access to health care services for a majority of the American population.

Yet, as noted earlier in the chapter, the legislative principles of speed and defending against the opposition do not come without consequence. Inexplicably tied together, the speed required to secure reform meant providing concessions to suppress the opposition, which included the AMA and hospitals. In order to warrant more support, reformers augmented Medicare along the lines of the traditional insurance-based system of payment by requiring the government to use Blue Cross and Blue Shield as the “fiscal intermediaries” for the Part A and B reimbursements.¹⁷² Second, and largely due to the circumstances of speed, the government included a series of ill-advised incentives regarding hospitals: “The government agreed to pay hospitals based on their costs and included depreciation for capital investments in buildings and equipment.”¹⁷³ While seemingly inconsequential at the time, the cost component of this legislation induced extensive hospital expansion as a way to receive higher levels of payment.

Furthermore, one of the major reasons for high health care costs today can be traced back to the payment structures devised under the Medicare legislation. Prior to the implementation of Medicare, physicians used a sliding fee scale based on the elderly patients’ ability to pay. However, as the government became

¹⁷² Emanuel pg. 141

¹⁷³ Emanuel pg. 141

responsible for the bills of the elderly patients, physicians no longer felt an obligation to restrict the rates they had been charging to those who could not afford to pay the higher fees. Furthermore, Medicare also made available to the medical community the rates of other physicians within the area.¹⁷⁴ As a result, physicians began to increase their rates, which led to inflationary increases in medical spending: “Since the federal government—and many private insurers—set fees on the basis of the distribution of what physicians were charging in the previous year, rates began going up, and fast.”¹⁷⁵ The cycle of increased reimbursements caused physician incomes to soar, which in turn required a larger budget for Medicare as a share of total health care expenditures.

While the Medicare legislation certainly provides benefits from an access standpoint, its long-term cost outlook has come under fire. The catch-22 nature of achieving this particular health care legislation is a result of the incentive for expediency throughout reform: “An administration more concerned with the budgetary consequences of concessions than with smooth takeoff would not have yielded as much. The government would pay a price for this choice later on.”¹⁷⁶ Even with the revisionary work that occurred throughout the policy process, the combining forces of speed and defense, necessary for legislative achievement, raise the question of whether or not the ends justified the means.

On a larger policy level, the story of Medicare calls into question the effectiveness of the policy process. Does the nature of the policy process afford

¹⁷⁴ Brownlee pg. 32

¹⁷⁵ Brownlee pg. 32-33

¹⁷⁶ Starr pg. 378

reformers the proper amount of time required to ensure the long-term viability of important policy decisions? Are the inherent institutional checks, which exist to withstand major political changes, useful in their requirement of extensive revisions of reform? While historically, the policy process of health care has shown that adhering to the key legislative principles are essential for attaining success, the legacy of the enduring problems associated with such a reform are cause for concern. Though ideal circumstances for political action may be unattainable, inviting these questions are essential to the consideration and analysis of the ways in which the systematic construct affects the policy process.

V. Consequences of 1960s Access-Based Policies

Though mentioned previously, the antecedents to rising health care costs are a function of the access-based reform policies implemented during the 1960s. As a point of reminder, these health care policies reflected the general concern for an increase in the availability of medical services, in addition to policies that favored private control and management. In contrast, throughout the 1970s, amid growing levels of inflation and bereft of economic growth, American disposition to redistributive programs transitioned from support to general hostility: "Controlling expansion means redrawing the "contract" between the medical profession and society, subjecting medical care to the discipline of politics or markets or reorganizing its basic institutional structure."¹⁷⁷ In the eyes of many, the medical community, and in general the health care industry, had come too far, too fast. As

¹⁷⁷ Starr pg. 380

the reformers of the 1970s attempted to reign in the expansionary programs of their predecessors, policy efforts focused on limiting the expansion of services, controlling the surge in costs, and reconstructing the networks of care.

Brought on by the access-based programs of Medicare and Medicaid, the sharp increases in health care costs over the second half of the 1960s shifted the political discourse of the health care landscape. Emanating from the highest form of political leadership, down to the average American family, concerns began to develop surrounding the substantial increases in cost. As newly elected President Richard Nixon stated on assuming office, “We face a massive crisis in this area [and] unless action is taken...we will have a breakdown in our medical system.”¹⁷⁸ The pervasiveness of a crisis sentiment swept across American society, which caused many to question the value and worth of what were seen as excessive investments in health care services.

Although undisputedly serving a tremendous function in providing access to health care services, the lack of financial foresight inherent within the Medicare legislation contributed to the immediate financial burden of health care costs. From the conventional health care theory perspective, the cost components implemented under the legislation violate basic conservative ideologies of economic fairness: “It is easy for A to provide services to B when some impersonal C has to pick up the tab. The benefits to the already-retired group represent in a sense an ‘unfunded’ liability which has to be met out of future contributions.”¹⁷⁹ The rise in national health care expenditures, which increased from \$198 per capita in 1965 to \$336 per capita by

¹⁷⁸ Starr pg. 381

¹⁷⁹ Epstein pg. 150 and 159

1970, levied an extensive financial burden of payment onto the government, and in turn, fellow Americans.¹⁸⁰ Between the demand for hospital expansion, which included the cost for new resources and technology, as well as the rise in physician incomes, the policies contained within the health care system established incentives detrimental to cost containment.

Most importantly, the design of the financial structure, which based itself on a traditional fee-for-service model, encouraged the overutilization of medical services: “Third parties effectively [insulated] patients and providers from the true cost of treatment decisions and so [reduced] the incentive to weigh costs carefully against benefits.”¹⁸¹ As a consequence of the fee-for-service model, patients do not bear the financial burden of their medical decisions, and likewise, physicians are encouraged to maximize the amount of services offered. While this certainly provides benefits on an individual level, it remains a fiscally irresponsible model of financing for care.

Regardless of the cost, the hospital system also incurred incentives to maximize their own rates of reimbursement. As Medicare and Medicaid spurred hospital expansion, the policies did so without any mechanisms of cost control: “The greater its costs, the higher its reimbursements. Thus hospitals were encouraged to solve financial problems, not by minimizing costs but by maximizing reimbursements.”¹⁸² Though largely intended to increase the access available to patients, these misguided policies fueled the unsubstantiated rise of health care

¹⁸⁰ Starr pg. 384

¹⁸¹ Starr pg. 385

¹⁸² Starr pg. 385

facilities and the endless stream of profit. Thru no fault of their own, both the physicians and hospitals benefitted tremendously from the exploitation of the lucrative reimbursement policies created by the health care legislation.

Furthermore, Medicare's fixed fee schedule, which was examined earlier, not only encouraged physicians to raise their fees, but the legislation also bolstered hospital expansion by providing higher rates of reimbursements to physicians who performed their services in the hospital, rather than in offices.¹⁸³ Moreover, even as once-complicated procedures became routine for physicians, the fees for the procedures remained at high levels. For example, this trend propagated the rise of certain service lines in the hospital such as cardiac services: "As a result, some [procedures], like [coronary bypass operations], are financial "winners" because they pay much more than they cost to produce."¹⁸⁴ This had the effect of encouraging the specialization of physicians to more profitable sectors of medicine, rather than more needed areas, such as primary care.¹⁸⁵

The analysis of the perverse model of health care, generated by these specific policies, provides the illustrations necessary to understand the roots of the overabundance of care and unwarranted financial costs. Though based on well-intentioned principles, the consequences of the access-based legislation spurred the vicious cycle of maximization: "Hospitals want to retain their patients, physicians, and community support by offering the maximum range of services and the most modern technology, often regardless of whether they are duplicating services

¹⁸³ Starr pg. 386

¹⁸⁴ Starr pg. 386

¹⁸⁵ Starr pg. 386

offered by other institutions nearby.”¹⁸⁶ The unintended consequences of “the absence of any effective restraint,”¹⁸⁷ are a further outcome of the established sovereignty and authority developed by the physicians and hospitals discussed in previous chapters. It is by no accident that these legislative policies accommodated both the physicians and hospitals to the fullest extent imaginable. Though in the name of patients, the deliberate benefits given to these groups furthered their standing and dominance within society.

Lastly, the inequalities in care that exist today between wealthy suburbs and inner cities are a direct result of the reimbursement policies under Medicare and Medicaid. Due to their ability to charge higher fees in wealthier areas, physicians began to establish themselves in more affluent neighborhoods. This had the effect of negatively impacting hospitals in poorer areas, which were subsequently left without particular services.¹⁸⁸ Additionally, the hospitals located in poorer neighborhoods tended to serve patients that came from lower socioeconomic backgrounds, which again placed them at a disadvantage from a reimbursement standpoint: “The effect of cost-based reimbursement on the solvency of hospitals depends on the relative proportions of charity and privately insured patients.”¹⁸⁹ For these hospitals, which primarily saw patients that lacked private health care coverage, it became extremely difficult to sustain the facility on a limited reimbursement budget.

¹⁸⁶ Starr pg. 386

¹⁸⁷ Starr pg. 387

¹⁸⁸ Starr pg. 387

¹⁸⁹ Starr pg. 387

VI. The 1970s an Era of Cost Containment

For many Americans, emergent frustrations with the cost of health care shifted the discourse on the government's proper role in addressing these fundamental problems. To a large extent, the inefficiencies embedded within the construction of the health care model bred hostility and a belief in the pernicious influence of the medical community: "The doctors created the system. They run it. And they are the most formidable obstacle to its improvement."¹⁹⁰ While up until this point, the medical community had been granted a significant role in the formation of health care policy, future attempts at reform sought to minimize their scale of influence over the policy process. With a focus on reigning in the excessive levels of cost, government assumed responsibility for the task of reforming the delivery of health care services.

The health care policies pursued during the Nixon Administration are a reflection of the potential benefits of utilizing specific legislative principles. In order to reverse the inflationary levels of cost, policy experts emphasized the elimination of the root source of payment most detrimental to the health care model: removal of the fee-for-service system. Coining the term, health maintenance organization (HMO), Minnesota neurologist, Paul Ellwood, led the initial charge for the reconstruction of the health care payment model: "[Ellwood] argued loudly against fee-for-service medicine on the grounds that it incentivized doing more interventions while it also disincentivized keeping patients healthy."¹⁹¹ Based on a

¹⁹⁰ Starr pg. 393

¹⁹¹ Emanuel pg. 142

pre-paid model of care, conservatives within Congress argued that a system of “maintenance” could lead to a more efficient model of management, and as a result, more adept at containing costs.

Enthralled by the potential cost-saving opportunities claimed by the HMO concept, Republicans in Congress encouraged President Nixon to adopt the HMO as one of the foundations for his quest to solve the health care crisis. President Nixon urged members of Congress to consider the major elements of his policy initiative: “The traditional system operates episodically on an “illogical incentive” encouraging doctors and hospitals to benefit from illness rather than health. HMOs [reverse] that incentive.”¹⁹² With this statement, President Nixon initiated his willingness to fight for reform and his determination to use well-favored policy concepts to his advantage.

In February of 1971, President Nixon formally outlined the key areas of his legislation for health care, known as the National Health Insurance Standards Act, which contained both access and cost provisions:

- (1) An Employer mandate to provide health insurance to employees.
- (2) A Family Health Insurance Plan to replace Medicaid for the poor, providing them with subsidized health insurance.
- (3) Requiring each state to establish insurance pools for people who did not qualify for employer coverage, the family health insurance plan, or traditional Medicare or Medicaid.
- (4) Encouragement but no requirement to offer health maintenance organizations.

Ironically, despite favoring a health care principle most associated with liberal theory, President Nixon adopted universal health care legislation antithetical to traditional conservative ideology. Furthermore, by appealing to conservatives under

¹⁹² Starr pg. 396

the premise of cost-control measures and encouraging the prepaid health care concept as a replacement to the elimination of the fee-for-service model, Nixon generated policy consensus on both sides of the aisle.¹⁹³ The importance of including both liberal and conservative theories on health care, allowed President Nixon to gather strong political unity and a greater likelihood of enacting major reform.

In 1974, building upon the initial success of his proposed National Health Insurance Act, President Nixon put forth a final attempt for health care legislation, known as the Comprehensive Health Insurance Plan (CHIP). Holding firm to his stance on universal coverage, Nixon's CHIP plan included various coverage options: "Americans would be covered [either] through their employer, by Medicare, or through a new health insurance plan that would cover all poor and provide income-linked subsidies for purchasing private insurance."¹⁹⁴ Simultaneously, Democratic Senator Edward Kennedy, and key health care legislator Representative Mills, also proposed a health care plan, which aligned with the health care model sponsored by Nixon. The combination of the fight for reform, political unity, defending against the opposition, using prior reform successes, and managing Washington egos, represented a culmination of the legislative policies and the epitome of what could be accomplished when used to their fullest; universal health care would be a reality for Americans.

However, for all of the optimism surrounding the chances for reform, the political unforeseen dealt a tremendous blow to this potential watershed moment in

¹⁹³ Emanuel pg. 144

¹⁹⁴ Emanuel pg. 145

American history. Two scandals, Watergate for President Nixon, and prostitution for Representative Mills, derailed the political agenda focused on implementing health care reform: “If the name on the administration’s plan had not been Nixon and the time not been the year of Watergate, the United States might have had national health insurance in 1974.”¹⁹⁵ In one sense, the scandals unfortunately robbed the American public of their chance of securing universal health care coverage. However, on the other hand, what this example proves is how susceptible legislating for major reform can be to disruptions in the policy process. While the scandals certainly had no bearing on whether or not the policy would be successful or unsuccessful, their level of distraction speaks to the fragility of the policy process as a whole and the precision required for legislation.

While the preceding decade focused on providing access to health care for Americans, political actors during the 1970s sought to reform health care from a cost and efficiency standpoint. Though bolstered by political support, the inability of reformers to ultimately succeed led many Americans to question the effectiveness of the policy process, and government, in addressing these critical issues: “When the decade began, reformers were criticizing the inefficiency of the health care industry; when it ended, the industry was criticizing the inefficiency of reform.”¹⁹⁶ The ambivalence towards the health care industry and government sustained, if not grew, over the decade, with many pointing to the failure of reform and the significant rise in government expenditures. The dissipation of reform had reached

¹⁹⁵ Starr pg. 405

¹⁹⁶ Starr pg. 416

the climax amongst the frustrated American public; reform in this era would not be attainable, and for some, not wanted.

VII. Clinton's Final Effort

Though health care remained on the agenda throughout the 1980s, more significant attempts at reform did not occur until the Clinton administration at the turn of the century. Seeking to mend the prolonged issues within the health care model, economist Alain Enthoven proposed a theory of managed competition, which looked to address both access and cost control measures. Using competition as its main facilitator, managed competition presented itself “as a purchasing strategy to obtain maximum value for consumers and employers [by choosing] among a variety of health insurance options in a structured competitive marketplace for insurers.”¹⁹⁷ Foreshadowing the idea that would come to define the Affordable Care Act nearly a decade later, managed care sought to provide health insurance through government and private options, which would allow consumers to direct their own costs of care. Theoretically, as consumers entered the marketplace for health insurance, overall competition would help to drive down overall prices.

Analogous to the aforementioned legislative efforts, President Clinton utilized the emerging health care concept of the time as the most viable option for the foundation of his proposal. Diverging from conventional liberal ideology, President Clinton's market-based reform, known as the Health Security Act Bill,

¹⁹⁷ Emanuel pg. 148

focused on significant cost containment strategies and improving the overall access to health care for Americans:

- (1) Health Alliances would be established as state and sub-state regional purchasing agents run by states in compliance with federal standards.
- (2) Employers would be required to provide health insurance to all of their employees.
- (3) Employers could select from among competing HMOs.
- (4) Government would subsidize costs so that large employers would not have to pay more than 7.9% of payroll and small employers would not pay more than 3.5% of payroll in health insurance premiums. Government would subsidize individuals with incomes below 150% of the federal poverty line who lacked employer-based insurance.
- (5) Medicare would continue, and seniors would receive a drug benefit.
- (6) Medicaid would pay for the poor to get insurance through the health alliance.
- (7) There would be a 7-member, presidentially appointed national health board that would monitor the health alliances' functioning and delineate and modify the standard benefit package with evolving health needs.
- (8) The bill was supposed to cost \$331 billion, financed by [a] cigarette tax along with proposed savings of Medicare and Medicaid.¹⁹⁸

The focus of the legislation, which stipulated new provisions for purchasing health insurance and cost controls, garnered support from the medical community, as well as employers. With this in mind, President Clinton seemed to have developed the unity necessary to push the reform through the policy process.

Yet, even with support from the business and medical communities, two major opposing forces damaged, and eventually subdued, the potential enactment of reform. For one, the lack of unity within the Democratic party itself, diminished the initial enthusiasm that the reform had generated: "Union support, however, was lukewarm; they preferred a single-payer plan over the Health Security Act's more market-friendly approach, but did not want to oppose a Democratic president

¹⁹⁸ Emanuel pg. 149-150

openly.”¹⁹⁹ As other members of the Democratic Party opposed, and also put forth contrasting health care proposals, President Clinton lost control of his own “home turf,” which severely inhibited the reform from gaining traction in Congress.

If not even more of a threat than the President’s own political partners, the insurance industry stood firm against a policy they deemed would marginalize their role in the health care field. Replicating the same anti-government rhetoric used against the Truman administration, the insurance industry employed ads to deter support for reform: “Government may force us to choose from among plans designed by government bureaucrats...choices we don’t like is no choice at all.”²⁰⁰ Mounting roadblocks along the way, the insurance industry made certain that any reform would not jeopardize their ability to continue their profitable placement. As President Clinton lost the support of his own party, it allowed the opposing forces to develop a campaign determined to sequester the reform efforts. The fragmented nature of the Democrats ensured a disjointed policy process, which created conditions that were not conducive to revising the health care landscape.

VIII. Final Policy Lessons

Throughout American history, policymakers have predominantly focused their reform efforts on legislation designed to improve the failures of the access and cost components within health care. Various political actors, which have ranged from congressional figures to presidential leaders, have lamented to the American public their concern for addressing the inefficiencies and inequities inherent to the

¹⁹⁹ Emanuel pg. 150

²⁰⁰ Emanuel pg. 151

system. Whether reform has developed along the lines of universal coverage, or introduced to revise existing payment structures, the legitimate determination for the enhancement in the delivery of health care services has been present.

However, although health care reform has often appeared, and at times, dominated the legislative agenda, directing reform from start to finish has eluded even the most skilled political actors. Plagued by the gauntlet of the policy process, the failure to adhere to the legislative principles specific to health care have deflated even the most well-intentioned and worthy reform efforts. And while some would most likely agree to the impediments imposed by the policy process, one has to wonder whether or not health care, and for that matter, the American people, have benefitted from this intrinsic political value. How many beneficial reforms have been squandered by the harshness of the political system? And of those, have they gone by the wayside too early? Were they given enough chance? While it may be remiss to understate the harsh conditions necessary to ensure longstanding reform, the analysis begs the question as to whether or not Americans have benefitted, or been made worse off, from the challenges inherent to the policy process.

Chapter Four: The Contemporary American Health Care System

“No country’s health care system is perfect. Every health care system will have problems, but the way the American system in particular has evolved and is currently structured creates many crippling problems.”—Ezekiel Emanuel²⁰¹

As it relates to the 21st Century, the consequences of perpetual ineffective and absent reform has brought with them a level of dysfunction and disarray to the health care landscape. The compounding deficiencies neglected by prior generations, have morphed into the newest generation’s burden of debt: increasing disparities in the level of access, unsustainable expenditure costs, and a quality of care misaligned with the amount of spending on health care services. While historically, policymakers have traditionally focused their reform efforts on addressing the access and cost components within health care, the scale of contemporary problems necessitated a renewal of political action and a broadening in the scope of legislation required.

Before examining the array of problems that necessitated the call for the Affordable Care Act, it is particularly relevant to discuss the contemporary institutional design of the American health care system. In reference to the previous chapter, which outlined the legislative history of health care policy, America’s inability to develop a system based on universal health care coverage resulted in a binary system centered on private and public coverage options. More importantly, noting the distinctions between the various private and public coverage options, which include employer-based coverage, HMOs, Medicare, Medicaid, and others, are

²⁰¹ Emanuel pg. 95

essential to interpreting the shortcomings commonly associated with the health care system.

In conjunction with the actors involved on the “payment” side of health care, it also remains essential to discuss the institutional design of the “providers” of health care services. Including both hospitals and physicians, each represent a significant portion of overall health care expenditures, as well as contain unique payment structures and motives inherent to their delivery of health care services. As a whole, conceptually understanding the intricacies within the health coverage model, as well as the structure of health care providers, allows for a more nuanced approach to the analysis of the ways in which the Affordable Care Act sought to mitigate the growing inequities within these particular access, quality, and cost components.

I. Health Care Payers

According to a study conducted in 2012 by the Kaiser Family Foundation, a prominent US health care policy organization, prior to the implementation of the Affordable Care Act, 85% of all Americans held insurance coverage and 15%, roughly 48 million Americans, were uninsured.²⁰² While the amount of uninsured Americans was, and certainly is today, a problem in and of itself, a more in-depth analysis of the institutional design of private insurance sheds light on the reasons why this resulted in a significant access problem. First, of the 85% who were

²⁰² The Kaiser Family Foundation’s State Health Facts. *Data Sources:* Centers for Medicare & Medicaid Services, US Census Bureau, Current Population Survey, Indian Health Service, Department of Defense, Veterans Administration, *AIS’s Directory of Health Plans: 2013*, 2013 by Atlantic Information Services Inc., www.AISHealth.com.

privately insured, 54% of those Americans obtained insurance through their employers. Examining these numbers from a closer perspective, a stark advantage existed in working for a large firm over a smaller one: “[In 2012] 45% of employers with 3 to 9 workers [offered] coverage, [compared to] virtually [92%] of employers with 1,000 or more workers offering coverage.”²⁰³ Not only do these numbers reveal the importance of employment as a requisite for health care coverage before the ACA implementation, but also health insurance’s impact on the labor market.

Consequently, as America allowed the insurance system to develop exponentially, it gave rise to a health insurance model based on employer- sponsorship, which designates the employer as the primary source for providing coverage. While no law stipulates that employers must provide coverage, historically it has been a vital component for attracting high quality workers and has also helped to alleviate total insurance costs through group coverage.²⁰⁴ Furthermore, the preferential tax treatment afforded to employees who receive health care coverage has incentivized the continuation of financing this system. While the provisions of health insurance may result in lower overall compensation for employees, the wages paid in the form of this coverage go untaxed, which provides a significant benefit to employees.²⁰⁵

²⁰³ The Kaiser Family Foundation and Health Research and Educational Trust. “Employer Health Benefits: 2013 Annual Survey.” 2012. <http://kaiserfamilyfoundation.files.wordpress.com/2013/08/8465-employer-health-benefits-20132.pdf>.

²⁰⁴ Emanuel pg. 43

²⁰⁵ David M. Cutler and Richard J. Zeckhauser. “The Anatomy of Health Insurance.” In *Handbook of Health Economics*, ed. Anthony J. Culyer and Joseph P. Newhouse, 563-643. Amsterdam: Elsevier North-Holland, 2000, pg. 569.

In terms of the scale of advantages given to employees who qualify for the tax benefits, “the tax exclusion is the single largest tax break in the entire US tax code, worth about \$250 billion in 2013.” However, this preferential tax treatment does not benefit all workers equally. The inherent regressive nature of the tax law favors employees who work at larger firms, but does not alleviate the burden of payment for workers at smaller firms, who may not receive employee-sponsored coverage. Overall, the financing regulations within the contemporary American health care system significantly bolstered the position of the affluent firms, as well as their employees, while providing little to no cost mechanisms to aid smaller firms or firms that did not provide health care coverage.²⁰⁶

With regard to the types of private insurance that Americans utilize, three major types have developed historically: “(1) for-profit commercial insurers, (2) Blue Cross and Blue Shield Plans, and (3) health maintenance organizations (HMOs).”²⁰⁷ Examples of the major for-profit commercial insurers, which earn upwards in the hundreds of billions in profit, include, United, Aetna, WellPoint, Cigna, and Humana. Second, the Blue Cross and Blue Shield Plans, which were founded on communal values, traditionally have based their model of care on providing similar premiums to all members, regardless of their age, condition, etc. Lastly, HMOs, such as the Kaiser Permanente Medical Group, provide coverage through “integrated delivery systems,” which are intended to contain costs by

²⁰⁶ Emanuel pg. 46

²⁰⁷ Emanuel pg. 51

“providing the health care services, hospitals, [and the] physicians” all within one model of care.²⁰⁸

II. Medicare and Medicaid

At the opposite end of the health insurance spectrum, according to 2012 data, 97 million Americans receive some form of health insurance assistance through public health coverage.²⁰⁹ Primarily, Americans obtain public insurance in connection with two major programs: Medicare, a social insurance program, and Medicaid, a means-tested, needs-based program.²¹⁰ In relation to the former, Medicare, which covers people over the age of 65 and young adults with permanent disabilities, provides coverage to nearly 50 million Americans, while also “comprising an estimated 12 percent of the federal budget and more than one-fifth of total national health expenditures in 2010.”²¹¹ Though Medicare offers substantial access-based benefits, which help to cover health care costs, the compulsory nature of the Medicare program is concerning from a financial standpoint, especially as the level of expenditures will soon have to keep pace with the onset of the Baby boomer generation.

From a structural standpoint, Medicare is split into four main parts. Part A, which covers inpatient hospital costs, is funded through 2.9% of the payroll tax: 1.45% from employees, 1.45% from employers.²¹² The second component, Part B,

²⁰⁸ Emanuel pg. 51-53

²⁰⁹ The Kaiser Family Foundation’s State Health Facts

²¹⁰ Emanuel pg. 47

²¹¹ The Kaiser Family Foundation. “Medicare: A Primer.” April I, 2010. www.kkf.org/medicare/upload/7615-03.pdf. Introduction.

²¹² The Kaiser Family Foundation. “Medicare: A Primer,” pg. 1.

includes physician visits, hospital outpatient and ambulatory services, and “other nonhospital services.”²¹³ Part C, known as Medicaid Advantage, acts as a private plan for patients, which provides a variety of options, such as HMOs, preferred provider organizations (PPOs), or a private fee-for-service plan. Lastly, Part D covers “outpatient prescription drug benefits.”²¹⁴

In contrast to Medicare, the Medicaid program, which covers 57 million Americans at any given time,²¹⁵ does not provide social insurance, but rather is devised structurally as a means-tested, need-based program. Unlike Medicare, the administrative powers of Medicaid are split between the federal and state levels of government. At the federal level, the government has mandated a list of minimum benefits, quality, and eligibility standards that must be followed by the states. However, it remains within the discretion of the states to determine the extent to which the eligibility standards will be followed, as well as the various payment rates: “Consequently, rather than having one benefit package for the whole country, there is a common core set of benefits that the federal government mandates, while actual Medicaid benefits differ from state to state.”²¹⁶ Thus, the dual power structure created by the Medicaid legislation has led to inequitable care on a state-by-state basis.

Moreover, due to the excessive costs that can result, many states attempt to discourage the amount of people enrolling in the program by “requiring many forms and documentation as well as frequent re-enrollment with all the required

²¹³ Emanuel pg. 56

²¹⁴ The Kaiser Family Foundation. “Medicare: A Primer,” pg. 1.

²¹⁵ The Kaiser Family Foundation’s State Health Facts.

²¹⁶ Emanuel pg. 62

paperwork.”²¹⁷ Additionally, due to the low reimbursement rates provided for the treatment of Medicaid patients, many hospitals discriminate against and “fewer than half of all physicians actually take Medicaid patients.”²¹⁸ The distinctions made between the two programs, in terms of their administrative functions and financial liabilities, conveys the extent to which they have been beneficial, and at times problematic, to both access and cost, as well as to the health care system as a whole.

Yet, the fundamental issues stemming from the health care model, prior to the implementation of the ACA, remained the 15%, or roughly 50 million Americans, who at any given point did not have access to health care coverage.²¹⁹ Although most would typically assume that the characteristics of the uninsured population would include purely the unemployed, the actual representative group is quite to the contrary. Not only do 62% of uninsured family households include one or more full-time workers, but 10% of those families earn more than \$94,200 per year.²²⁰ Furthermore, even with many uninsured Americans holding full-time or part-time positions, it is not within their fiscal ability to purchase health care coverage not provided by their employer: “The problem is that even if they are working, they are poor: 40% of all uninsured have incomes under 100% of the poverty line.”²²¹ Additionally, the amount of uninsured Americans also stems from simply failing to

²¹⁷ Emanuel pg. 49

²¹⁸ Emanuel pg. 63

²¹⁹ The Kaiser Family Foundation’s State Health Facts.

²²⁰ The Kaiser Family Foundation, March 13, 2013. *Data Source*: KCMU/Urban Institute analysis of 2012 ASEC Supplement to the CPS.

²²¹ Emanuel pg. 49

enroll into public health insurance programs, as well as the ability of the insurance companies to reject people due to costly pre-existing conditions.²²²

III. Health Care Delivery: Hospitals

While the discussion up until this point has dealt mainly with the access and financing mechanisms pertaining to payers, the ensuing analysis of the contemporary health care model will focus on the delivery aspects within the American system. To put into perspective the influence of the two main providers, hospitals and physician services, over half of the total national health care expenditures in 2010 went to these two sectors: \$921 billion to hospitals, while physician services received \$555 billion.²²³ As the numbers reveal, these two major providers are of particular relevance to the structure of the existing health care model and how they affect the access, quality, and cost categories is important for understanding the impetus to reform.

Prior to analyzing the institutional design of the hospital system, it is necessary to discuss the overarching theme inherent in contemporary hospitals: profit. As the ensuing analysis will show, the current structure of the hospital system places considerable emphasis on volume, rather than on the quality and cost of the care they are providing: “Hospitals get reimbursed for how *much* care they deliver, rather than how well they care for patients—let alone how efficiently they deliver that care.”²²⁴ This specific rhetoric has rooted itself within the hospital

²²² Emanuel pg. 50-51

²²³ Altarum Institute. Health Sector Economic Indicator Spending Brief. February 2013.

²²⁴ Brownlee pg. 78

system by encouraging capital investments based solely on gaining profitable patients and bolstering profitable service lines, regardless of what may be best for the patients and the community itself.²²⁵

Yet, to only give one side of the story would be unfair to the realities of maintaining a hospital and all the services it provides. In spite of all the profits generated by hospitals, they also absorb significant costs from Medicaid or uninsured patients, which places a heavy burden on hospitals to provide all that is asked of them: “[Here at Johns Hopkins] we can’t pick and choose what we will take care of. So we try and develop programs that do make money to [be able to] run the programs that don’t.”²²⁶ As a result, hospitals attempt to use their profitable departments as a way to help keep afloat the departments that do not generate high levels of revenue, but still provide important and necessary services.

Logically, one might ask how a system intended for caring purposes developed organizationally on a system based on profit motives. The answer to this question, therein, lies within the specific payment systems that hospitals have acquired historically. For Medicare patients, hospitals are paid through what is known as the DRG system, which reimburses the facility on a predetermined basis depending on the type of procedure or service, or in particular, the diagnosis-related groups (DRG): “The DRG system developed to identify discrete conditions or products that hospitals provided, and then provide a uniform price for providing the package of services.”²²⁷ Theoretically, due to the price transparency of this system,

²²⁵ Brownlee pg. 81

²²⁶ Brownlee pg. 81

²²⁷ Emanuel pg. 70

hospitals should in effect, become more efficient in their care by utilizing the proper amount of resources depending on the specific case.

However, despite the intended benefits suggested by this specific payment system, in reality, it has led to significant unintended consequences. Although supposedly containing market-based principles to control costs, critics have claimed that the DRG system has failed in maintaining efficient levels of payment: “Even though DRG fees are supposed to reflect actual costs, in reality they overpay for many procedures, especially many surgeries.”²²⁸ Thus, from a business standpoint, hospitals will pursue those procedures and surgeries that yield the most profit to the hospital.

This concept, known as “throughout,” which encourages hospital administrators to promote the maximum usage of profitable services lines, has directed the types and cost of care that occur within the hospital systems. While this may be the result of the need to maintain financial viability, or purely the reality of 21st Century hospital care, the DRG payments have induced a system of care that does not put care first: “When hospitals focus not on profits, but instead on providing care that helps patients, they often wind up being punished financially.”²²⁹ For example, the area within the hospital most affected by this system has been the Emergency Rooms. Mainly due to the unprofitable patients that can wind up in Emergency Rooms, many hospitals around the country have either limited the amount of beds available or closed down their ER departments completely.

²²⁸ Brownlee pg. 84

²²⁹ Brownlee pg. 85

Although these types of decisions do not benefit patients, their underwhelming levels of profit hamper the choices of care that hospital administrators can provide.

With that being said, for the most part, hospital payment methods have drawn significant criticism from many leaders within the health care industry. According to William McGowan, CFO of the University of California, Davis, Health System, “There is no method to this madness. As we went through the years, we had these cockamamie formulas. We multiplied our costs to set our charges.”²³⁰ In all likelihood, Mr. McGowan’s frustrations are the result of the six different payment rates for hospitals, which has caused many to question the lack of payment uniformity and also why there has not been a central mechanism to guide the payment structure within the system.²³¹

One of the main payment rates for hospitals is referred to as the charge master rate: “A lengthy list of the hospital’s prices for every single procedure performed in the hospital and for every supply item used during those procedures.”²³² Though given as a rate, it would be highly unlikely that an individual or insurer would have to pay this price. The second rate, which deals with Medicare, was discussed earlier and is known as the DRG system. Third, and attributable to roughly one-third of all hospital revenues,²³³ commercial insurers and the Blues negotiate a predetermined rate, which depends on a variety of factors including: “a hospital’s bargaining power, how many patients the insurer covers, whether the

²³⁰ Uwe Reinhardt. "The Pricing Of U.S. Hospital Services: Chaos Behind A Veil Of Secrecy." *Health Affairs* 25, no. 1 (2006): pg. 57.

²³¹ Reinhardt pg. 63

²³² Reinhardt pg. 58

²³³ Reinhardt pg. 61

hospital wants those patients, and whether the insurer perceives it *needs* to have the hospital in their network of hospitals.”²³⁴ Due to this variability, no uniform payment rate exists among insurers.

Additionally, the fourth payment rate, known as the usual, customary, and reasonable price (UCR), deals with out-of-network payments. Fifth, as a result of the institutional design discussed earlier, the Medicaid rate generally contributes the least amount of reimbursement to providers: “Medicaid’s payments to hospitals fall well short of fully allocated costs. That shortfall must be covered by other payers—mainly private insurers.”²³⁵ Lastly, the final payment rate is called the actual cost, which includes “the actual cost of supplies, technology, time, and labor.”²³⁶

While navigating through the hospital payment rates certainly reflects the level of confusion within the system, understanding these critical cost components help to explain the driving factors behind the conglomeration of hospitals into large-scale networks. As stated above, hospitals want to increase their bargaining power relative to insurers in order to maximize their reimbursement rates, and hence their profits. Using conventional business rationale, as more hospitals within a certain area create and join a network, the more leverage they will have in determining the reimbursement rates: “This consolidation of hospitals allows one hospital with high rates to get those same rates applied to the other hospitals in its system.”²³⁷ Without even improving their services or quality of care, the actions by hospitals seem to reflect a singular thought of profits before patients.

²³⁴ Emanuel pg. 74

²³⁵ Reinhardt pg. 61

²³⁶ Emanuel pg. 73

²³⁷ Emanuel pg. 75

Indeed hospitals also engage in other practices, which help to maximize the total amount of revenue they can earn. In order to help offset the loss in revenue by serving Medicaid, and at times, Medicare patients, hospitals attempt to maximize the amount of patients that hold commercial insurance. The idea of the payer-mix, which is defined by “what percentage of patients are Medicaid versus Medicare versus privately insured,”²³⁸ determines the financial standing of the hospital, as well as encourages hospitals to settle in locations where there will be large numbers of privately insured patients. This concept remains detrimental from an access standpoint, because it means that high-quality hospitals will not want to serve lower-income communities, thereby exacerbating the inequities in care.²³⁹

Another profit-seeking venture that is pursued, which also incentivizes hospitals to direct their attention away from the quality of care and its cost to society, remains the emphasis on the case mix. Though more attention should be given to preventative care maintenance, these services do not bring in money for the hospital: “Hospitals tend to make profit only on a limited range of services, and those profits subsidize other services for which payments may not cover costs.” While completely undermining the case mix would understate the importance of maintaining financial viability, its emphasis on a few particular services reduces the ability of hospitals to provide a wide range of services that may have more need among patients.

²³⁸ Emanuel pg. 76

²³⁹ Emanuel pg. 76

IV. Health Care Delivery: Physicians

Although hospitals certainly account for a large percentage of total national health expenditures, they represent only part of the equation responsible for the delivery of health care services. Their provider counterparts, physician services, constitute 20% of those same expenditures and have been known to share similar profit motives.²⁴⁰ In terms of a national industry breakdown, and according to data conducted by the Association of American Medical Colleges, in 2013 the United States had a total of 829,962 physicians, or 381 Americans per physician.²⁴¹ While critics have often pointed to the lack of physicians per person, data also reflects the common practice for American physicians to choose a specialty, rather than a more needed area of practice, such as primary care: "Of the 643,000 physicians who provide direct patient care, just 48% could generously be classified as primary care physicians."²⁴² The implications of this deficiency will be discussed later in the chapter, as it relates to the access and quality components.

In comparison to hospitals, physicians in America have also shifted their areas of care to align with specialties, which result in higher wages: "The average pay for a family medicine physician was \$199,850, whereas for cardiac surgeons it was \$522,875, and orthopedic surgeons who specialize in spine surgery make \$625,000 per year."²⁴³ From a profit standpoint, the high levels of payment have induced physicians to choose specialties that can allow them to reap these economic

²⁴⁰ Emanuel pg. 77

²⁴¹ Association of American Medical Colleges, "2014 Physician Specialty Data Book." 2014, pg. 10

²⁴² Emanuel pg. 77

²⁴³ Emanuel pg. 77

rewards in care. As the hospital-physician relationship has evolved in recent years, physicians have essentially become feeders to the hospital systems. As a result, a dual benefit has occurred: Hospitals can better manage their case mix index, while for physicians, the facility privileges increase the opportunities available for them to maximize their case volume.

Moreover, while pursued unintentionally or not by physicians, the model of care based on maximizing health care services has its foundations in health care theory. According to Milton Roemer, a prominent health services researcher in the 1960s from the University of California, Los Angeles, stated: “A built hospital bed is a filled hospital bed.”²⁴⁴ The result of these vast hospital networks, which stipulates increased access for physicians, encourages physicians to use the space provided, regardless of its overall necessity to patients: “By admitting millions of patients who may not need to be in the hospital, or by putting them in more expensive beds than necessary, physicians are needlessly driving up the cost of health care.”²⁴⁵ Referencing the earlier passage on hospital capital investment, physicians, and especially specialists, will be more inclined to make use of these available resources even if they do not coincide with what may be required medically.

The consequences for hospitals, and mainly the physicians who have institutionalized this system, has led to “supply-driven” medical care, which fosters excessive, and often needless, costs. While the model in place bases itself on promoting greater efficiency, the insistence on sustaining profitable sectors, which are then maximized by physicians, has impacted the cost in care: “What we want are

²⁴⁴ Brownlee pg. 111

²⁴⁵ Brownlee pg. 114

efficient hospitals, places where patients can be sure they will get high-quality care, care that gives them the procedures and tests and drugs they need—and doesn't give them what they don't need—for the most reasonable cost.”²⁴⁶ The culture surrounding the delivery of health care services has failed to live up to its purpose in providing high-quality care, at a reasonable cost, and in the most efficient way possible.

While not as complex as the hospital payment process, the payment system for physicians also remains complicated. To reiterate, physician payments are a function of the fee-for-service model, which utilizes a three-step process to determine payment. The process begins with medical coding, which converts all medical services into codes, known as current procedural terminology (CPT) codes, that “aggregate and link [the CPT code] to a specific diagnosis.”²⁴⁷ Second, each CPT code is converted into a bill, which is then given to an insurer, Medicare, or another payer. Third, and the final step of the process, payers utilize what is called the relative value unit (RVU) system, which in essence serves as the DRG form of payment for physicians.²⁴⁸

However, upon closer examination, the incentives purported within this system reflect motives contrary to the containment of costs and consumption of medical services. In more precise terms, the RVU system is separated into four distinct steps:

- (1) The RVU for a particular service is based on 3 components: physician work, practice expense, and malpractice. (2) These different RVUs are

²⁴⁶ Brownlee pg. 115

²⁴⁷ Emanuel pg. 81

²⁴⁸ Emanuel pg. 81

adjusted to reflect the cost of living variations in different geographies. (3) The 3 adjusted RVUs are then added up to determine the RVU for a particular service. (4) The RVU is then turned into dollars paid when it is multiplied by a conversion factor. Medicare and each private insurer set their own conversion factors.²⁴⁹

For one, and as discussed earlier, physicians receive higher reimbursement rates for services performed within the hospital, which could have similarly been performed in offices. Second, the RVU system incentivizes physicians to perform procedures and particular services that will require more cost, rather than a preventative care visit, which could provide more potential benefits to the patient.²⁵⁰

Thus, the payment structure's inherent bias towards complexity and the overutilization of services has contributed to the rise in costs, with a comparable loss in the quality of care. Additionally, this profit-driven payment system has benefitted, and arguably contributed to the amount of physicians who have chosen to become specialists because of its ability to generate large incomes. While it would certainly be a blanket statement to suggest that all physicians put profit ahead of their patients, undermining the impact of the payment structure would be equally misguided and diminish its negative influence on the cost and quality components within health care.

As the analysis of the contemporary health care structure has shown, both payers and providers have been incentivized to increase their volume of care, with no restraining mechanism to keep costs in check. Moreover, the perverse payment structures have encouraged a health care system more concerned with areas of profit, than with the quality and outcomes of the patients they exist to serve: "[The

²⁴⁹ Emanuel pg. 81-82

²⁵⁰ Emanuel pg. 82

systematic deficiencies] highlight the need for a new way to pay doctors and hospitals, a system that doesn't allow financial imperatives to propel clinical decisions."²⁵¹ The ineptitude of the system before the implementation of the Affordable Care Act suffered in part from the misalignment of the intrinsic values that are necessary to guide a health system. Understanding these particular institutional flaws, which have been enabled and supported over time, helps to enhance the identification process for the major problems that prompted the impetus for systematic health care change.

V. Contemporary Health Care Problems: Access

Prior to the onset of the Affordable Care Act, the institutional design of the contemporary health care system had given rise to a series of problems within the access, quality, and cost components. From the uninsured, to the significant variations in the quality of care experienced by Americans, the institutional structure precipitated numerous problems in need of attention. The ensuing analysis will discuss the extent to which these issues became detrimental to the health care of Americans, as well as how these growing frustrations fueled the necessity to address these inefficiencies through paradigmatic reform.

From an access standpoint, the insurance arrangement within the American health care system allowed for 15% of Americans to be uninsured at any one point. The striking nature of this access deficiency seemed all the more remarkable when considering the scope of health care spending within the United States: "That one

²⁵¹ Brownlee pg. 95

out of 7 Americans lacks health insurance in the richest country in the world, a country whose GDP is about 22% of the world's total economic output, seems hard to defend."²⁵² For liberals, this "indefensible," and inexcusable quantity of uninsured Americans, stood antithetical to traditional American values and morals.

Yet, even for the most cost-focused conservatives, neither they could deny the consequences presented by the growing amount of uninsured Americans. Despite their uninsured status, what had gone unnoticed for many was that these specific Americans still utilized a large percentage of health care services, with the costs being passed on through an increase in health care financial burdens. According to the nonprofit advocacy organization Families USA, who conducted a study on uninsured Americans, "in 2008, the uninsured received \$116 billion worth of care from hospitals, doctors, and other providers."²⁵³ As these health care services went unpaid, the costs were shifted to Americans through the concept of a "hidden tax." For American families, the added financial burden of paying for the insured resulted in a \$1,000 premium increase, while for individuals the premium increased by \$368.²⁵⁴

Whether standing on the left or on the right, the problem of the uninsured could not be denied. Not only did the lack of coverage for many violate American ideals, but also from a financial standpoint, their unpaid benefits resulted in substantial increases in costs, which undeniably created a higher burden on the average American individual and family. The consequences of the failure to modify

²⁵² Emanuel pg. 95

²⁵³ Families USA, "Hidden Health Tax: Americans Pay a Premium." *May*, 2009.
http://familiesusa.org/sites/default/files/product_documents/hidden-health-tax.pdf, pg. 2.

²⁵⁴ Families USA pg. 2

and reform the origin of the access problem, which resulted from the inequities associated with the structure of American health care coverage, led to its fusion with the growing dilemma of rising cost expenditures in the health care system.

VI. Contemporary Health Care Problems: Cost

Evoking sentiments of a “fiscal death spiral,”²⁵⁵ both conservatives and liberals alike had begun to feel tremendous uncertainty regarding the fiscal outlook of the health care system. The foundations to the concerns of future fiscal instability of health care costs begin with the discussion of the level of health care spending prior to the ACA implementation. For one, the degree of spending on health care in the US rivaled the amount of spending by *world* economies: “In 2012 the [US] spent over \$2.8 trillion on health care. This makes the US health care system the 5th largest economy in the world—larger than the entire GDP of France.”²⁵⁶ In addition to these figures, spending on health care appeared all the more exorbitant when discovering that Americans spent “40% more per person than the next highest country.”²⁵⁷

Furthermore, according to a study conducted by McKinsey & Co. consulting firm, the findings revealed the degree of excess health care spending and the necessity for reform in relation to cost containment:

[Americans] spend more on health care than the next 10 biggest spenders combined. [Americans] may be shocked at the \$60 billion price tag for cleaning up after Hurricane Sandy, [but Americans] spent almost that much last week on health care. [Americans] spend more every year on artificial knees and hips than what Hollywood collects at the box office. [Americans]

²⁵⁵ Arnold Kling. <http://mercatus.org/publication/simple-solutions-long-term-budget-challenge>, 2010. pg. 2.

²⁵⁶ Emanuel pg. 100

²⁵⁷ Emanuel pg. 100

spend two or three times that much on durable medical devices like canes and wheelchairs, in part because a heavily lobbied Congress forces Medicare to pay 25% to 75% more for this equipment than it would cost at [Walmart].²⁵⁸

By discussing this issue through the lens of contemporary American culture, it helps to provide greater context to the severity of the cost components within health care, which are a consequence of the institutional design of the system.

As a result of the excessive spending historically, the American economy confronted tremendous fiscal instability facing its future. Research conducted by several economists produced grim results on the rates of spending on health care by reviewing trends over the last half century: "On average, over the past 40 years health care costs have grown more than 2% faster than the economy. Economists express this by saying health care spending grows at GDP+2% per year."²⁵⁹ In terms of how this relates to overall economic expenditures, in 2012, federal health care spending represented 26.1% of the total federal budget, with the projections also showing the unsustainability of spending if health care continued to grow at GDP+2% per year.²⁶⁰

A major contributor to these rising costs has been the result of spending on government health care programs. According to the Heritage Foundation, a prominent conservative think tank, as well as supported by leading conservative health policy analyst Arnold Kling, Medicare, Medicaid, and other health care

²⁵⁸ Steven Brill. "Bitter Pill: Why Medical Bills Are Killing Us." *TIME*, February 20, 2013, pg. 4.

²⁵⁹ Emanuel pg. 100

²⁶⁰ Emanuel pg. 107

spending represented 23% of total federal spending in 2012.²⁶¹ The rising health care costs have made it particularly difficult for state governments that have had to choose between spending on health care or other state-sponsored programs. For example, between FY2011 and FY2012, overall Medicaid spending by states increased by \$19.4 billion, while K-12 education received only \$1.3 billion, and Higher Education, Public Assistance, and Transportation each declined or were not changed.²⁶² Confined to either increasing taxes or cutting other state programs, states remained limited in their options in order to maintain their level of expenditures for health care services.

However, not only have rising health care costs created significant problems for the economy as a whole, but the high costs themselves have also been responsible for contributing to the cycle of uninsured Americans. As health care costs increase, firms and individuals decide they can no longer afford the costs of coverage. According to leading Harvard economists, their conclusions support this traditional line of thought: "each \$1,000/year of increased premiums leads to declines in coverage of 2.6 percentage points."²⁶³ So, not only did health care costs represent an issue from a cost standpoint, but in fact, they also led to the decline in access to health care services for many Americans.

²⁶¹ The Heritage Foundation, "2014 Federal Budget in Pictures." January 1, 2014. <http://www.heritage.org/federalbudget/pdf/2014/all-budget-chart-book-2014.pdf>. pg. 2.

²⁶² National Association of State Budget Officers, "SUMMARY: FALL 2011 FISCAL SURVEY OF STATES." November 28, 2011. [http://www.nasbo.org/sites/default/files/Fall 2011 Fiscal Survey - Summary.pdf](http://www.nasbo.org/sites/default/files/Fall%202011%20Fiscal%20Survey%20Summary.pdf). pg. 2.

²⁶³ Emanuel pg. 103

VII. Contemporary Health Care Problems: Quality

Yet, despite the exorbitant amount of spending on health care, the fact remains, Americans are simply not getting the bang for their buck: “Despite spending 20% of the [GDP] product on health care, in every measurable way, the results our health care system produces are no better and often worse than the outcomes in [other developed] countries.”²⁶⁴ While the American health care system may lead the world in scientific advancements or cutting-edge treatment, the overall quality of care is less than inspiring. For example, studies conducted by the RAND Corporation have shown that the actual value of care received by Medicare patients in hospitals does not align with traditional expectations: “Overall, the chances that Medicare patients discharged from hospitals received proven beneficial care were basically the flip of a coin—55%.”²⁶⁵ The same study on children reflected even worse quality measures, which claimed that children only received on average “46.5% of the indicated care.”²⁶⁶

The quality metrics looked even more jarring when analyzing the rates of infections and other mistakes, which happened within hospitals, facilities where expected errors should be minimal. According to a paper conducted by the Centers for Disease Control, “roughly 1 of every 20 people hospitalized suffers a hospital-acquired infection,”²⁶⁷ with roughly “more than 90,000 people a year [dying] from

²⁶⁴ Brill pg. 4.

²⁶⁵ Emanuel pg. 110

²⁶⁶ Emanuel pg. 111

²⁶⁷ Emanuel pg. 111

infections that are contracted in hospitals.”²⁶⁸ While this data would certainly not convince anyone of high quality care, the preventative nature of these infections is what remains the most baffling. In terms of reducing hospital-acquired infections, many can be prevented through simple measures such as hand washing, sterilization procedures, and more.²⁶⁹

Moreover, data on the quality of care for cancer treatment, as well as certain heart procedures, has reflected poor results. Regardless of the supposed exceptional nature of American medical resources, the quality of the treatment for common cancers such as breast cancer and colon cancer has been mediocre. Breast cancer patients received quality care 86% of the time and chemotherapy 82%, while colon cancer patients received quality of care 78% of the time and for chemotherapy just 64%: “This is not an A-level grade. For life-and-death treatments, this is not impressive.”²⁷⁰

Additionally, data on common stent procedures, such as the percutaneous coronary intervention (PCI), reflected the degree of poor quality care. In a study conducted by the American College of Cardiology, of the 150,000 PCIs in the United States, “only half were medically appropriate” and 11.6% of the procedures were deemed misguided and unnecessary uses of care: “Thus, at least 15,000 Americans a year—and maybe as many as 75,000—are getting stents and undergoing other procedures that entail serious risks, and yet the procedure neither improves

²⁶⁸ Arnold Kling, "Government and Health Care: The Good, The Bad, and the Ugly." Cato Institute. November 28, 2007, pg. 3.

²⁶⁹ Emanuel pg. 111

²⁷⁰ Emanuel pg. 112

survival nor quality of life.”²⁷¹ When considering the rates of spending, as well as the resources available for high levels of treatment and relatively routine procedures, the quality metrics have not kept pace with the cost components within the American health care system.

VIII. Contemporary Health Care Problems: Transparency and Medical Malpractice

Furthermore, the lack of transparency within the health care system exacerbated the extent of these cost and quality problems. As it relates to the cost of care, the underlying transparency issue made it especially difficult for physicians to be cost efficient when providing treatment: “If hospitals cannot give the total price for a procedure, it is no wonder most physicians prescribing a test or treatment have no idea of the price of that test or treatment.”²⁷² Referring back to the discussion regarding hospital reimbursements, the roots of this problem were largely a function of the absence of a unified payment mechanism. If physicians did not know the level of prices for the care, it would not make sense to assume that physicians would refrain from providing care, even if unnecessary for their patients.

From a patient perspective, the lack of price transparency also did not allow patients to choose prices at a lower cost. Not only has research shown that prices for procedures and treatment can vary depending on the geographic location, but even if the patients did know the prices, assessing the value of the treatment would be particularly difficult. According to prominent health care theorist Uwe Reinhardt,

²⁷¹ Emanuel pg. 114

²⁷² Emanuel pg. 115

even if the veil of secrecy for prices became more transparent, patients would still not be able to distinguish whether or not they were receiving care at a reasonable cost:

Inducing [patients] to shop around for cost-effective health care, so far has been about as sensible as blindfolding shoppers entering a department store in the hope that inside they can and will then shop smartly for the merchandise they seek. So far the application of this idea in practice has been as silly as it has been cruel.²⁷³

While many health care theorists have called for more consumer-directed health care as a way to reduce costs, systematically, the current health care design does not allow for such action. Moreover, it seems illogical that a health care system concerned with high costs cannot provide accurate cost information for both physicians and patients.

A final reason as to why physicians have treated patients needlessly, which has led to unnecessary costs, could be linked to the growing problem of medical malpractice. In 2011, research conducted by the Department of Medicine, Massachusetts General Hospital, and Harvard Medical School, Boston group, revealed the high rates of probability that physicians would face a malpractice lawsuit over the course of their career: "By the age of 65 years, 75% of physicians in low-risk specialties and 99% of those in high-risk specialties were projected to face a claim."²⁷⁴ Furthermore, data compiled by another group of Harvard researchers indicated that within a study of 30,000 cases, only 4% resulted in adverse events

²⁷³ Uwe E. Reinhardt. "The Disruptive Innovation of Price Transparency in Health Care." *JAMA* 310, no. 18 (2013), pg. 1927.

²⁷⁴ Anupam B. Jena, M.D., Seth Seabury, Ph.D., Darius Lakdawalla, Ph.D., and Amitabh Chandra, Ph.D. "Malpractice Risk According to Physician Specialty." *New England Journal of Medicine* 365, no. 7 (2011), pg. 633.

and of that number, “[280] adverse events, representing 1 percent of all discharges were judged to have been caused by negligence.”²⁷⁵ Therefore, the prevalence of medical malpractice has unnecessarily induced wasteful spending, in spite of the fact that the majority of cases do not accurately reflect the quality of the physicians or the hospitals.

As a result, the rates of medical malpractice have come at a consequence to the cost of medical care. For physicians, the fear of being sued became widespread within the profession, causing them to engage in a practice known as “defensive medicine,” which led to excessive uses of care in order to shield themselves against potential lawsuits: “Medical malpractice suits encourage high levels of defensive medicine and excessive costs, such as MRIs after mild trauma that are unnecessary according to professional guidelines but are done just in case of a lawsuit.”²⁷⁶ The problems associated with medical malpractice represent another example of how the absence of a restraining mechanism in the delivery of health care services can lead to higher overall costs, while also doing little to ensure anything in terms of providing better quality care.

IX. The Impetus for the Affordable Care Act

Prior to the implementation of the Affordable Care Act, the American health care system confronted a tremendous set of problems from an access, quality, and cost standpoint. As the analysis has shown, the issues confronting the system were

²⁷⁵ A.R. Localio et al. “Relation between malpractice claims and adverse events due to negligence: results of the Harvard Medical Practice Study III.” *New England Journal of Medicine* 325.4 (1991), pg. 246.

²⁷⁶ Emanuel pg. 122-123

the result of the failure to address the flaws that occurred throughout the historical evolution of the institutional structure. By and large, the system's inability to create mechanisms of uniformity and methods of restraint engineered the complexities that plague contemporary care. As prominent health care theorists and other research has shown, the actors within the payer and delivery sectors of health care have enabled the system to grow without boundaries, which exceedingly threatens and burdens the overall standing of the American economy.

The combination of problems between the access, quality, and cost components provided the necessary impetus for generating health care reform in the 21st Century. From an access standpoint, the disparities in the access to health care coverage meant that 15% of Americans lived without health insurance at any given point. Additionally, the inefficiencies within the health insurance structure, as well as the amount of uninsured Americans, garnered sentiments of inexcusability when considering the overall spending on health care services. Lastly, the ineptitude of the extortionate cost components to render a superior, or even adequate quality of care, presented itself as serious problem to the integrity of the health care profession and to the system as a whole.

At this point, the American health care system stood at a crossroad; its exorbitant costs did not lead to better outcomes or improvements in care, and the inefficiencies within the institutional design appeared ready to engulf the system entirely. While the historical precedent of the paths to health care reform had proved its likelihood of failure, the state of the contemporary health care system necessitated political action. As health care reform would again emerge onto the

political agenda in 2008, President Obama and Democratic leadership entertained the possibility of not only undertaking health care reform, but also more importantly addressing all three of the major health care components within a single act of legislation. Enacted in 2010, The Patient Protection and Affordable Care Act put forth an attempt to reconcile the contemporary health care issues, culminating a history of inspired, but mostly unsuccessful, health care reform movements.

Chapter Five: The Affordable Care Act

"Today, after almost a century of trying; today, after over a year of debate; today, after all the votes have been tallied -- health insurance reform becomes law in the United States of America."—
President Barack Obama²⁷⁷

As history has shown over the last century, legislating for major health care reform has undeniably been a challenging, tumultuous, and at times, unwinnable process. Confounding even the savviest political actors of their era, the policy process has demonstrated both the relentlessness to mitigate innovative reform policies, while conversely, enacting reforms, which unquestionably carry with them, long-term economic consequences. Although a framework for the legislative principles critical to health care reform has been outlined, the historical analysis reveals that even when applied appropriately, health care reform remains elusive. While certainly the ethos of the times may have provided either an impetus to reform, or suggested that political action may have been frivolous, the American public, to an extent, has also played a role in influencing the policy process. Despite its unique characteristic of providing an intrinsic value to society, the correlation between legislative action and the improvement of the various health care components remains inequitable, and by and large, unsolved.

Precipitating the call for what would later become known as Obamacare, the contemporary health care issues discussed in Chapter Four generated the impetus for the eventual enactment of The Patient Protection and Affordable Care Act on March 23rd, 2010. Designed specifically to contend with the access, quality, and cost

²⁷⁷ President Barack Obama. Intellectual Takeout. March 23, 2010.
<http://www.intellectualltakeout.org/content/president-barack-obama-patient-protection-and-affordable-care-act>.

components of health care, President Obama's defining moment in the history of health care legislation represented arguably the first policy attempt to successfully incorporate each element within a single reform. President Obama's innate ability to withstand the historical precedent of legislative complexity is a remarkable achievement given the extent to which the problems within health care were deemed characteristic of a crisis.

However, for such an all-encompassing legislative act, it begs the question, what about this particular reform makes it different from those that preceded it? And even more important for our purposes, which legislative principles did President Obama utilize that enabled him to progress the 906-page law through the grueling and unremitting policy process? The ensuing discussion and analysis will consider these various questions, and in addition, will focus on how the Affordable Care Act came into being, how it addresses prior reform efforts, which have not been achieved previously, and whether or not the legislation can successfully address access, quality, and cost.

I. Passage of the Affordable Care Act

Perhaps partly due to exceptional political wisdom, with an added touch of political logic, and a sprinkling of political luck, President Obama's successful enactment of major health care reform can be viewed through the lens of the key policy process features: fight, unity, maintain egos, speed, prior reform success, and defense against the opposition. For President Obama, the recognition of health care reform as a foundation not only for his presidential campaign, but also his political

agenda, echoed his belief in the necessity for reform: "It was a test, really: Could the country still solve its most vexing problems? If [Obama] abandoned comprehensive reform, he would be conceding that the United States was, on some level, ungovernable."²⁷⁸ Although recognizing those who had tried their hands before him, President Obama believed he could defy the odds; comprehensive health care reform would be his.

Once President Obama established his intentions and commitment to major health care reform he then focused his efforts on maintaining and building unity within the Liberal political base. In the President's mind, if reform were to pass successfully, legislation would require confirmation by three major committees: The House Ways and Means Committee, Energy and Commerce Committee, and the Education and Labor Committee. Leading the charge to garner political reinforcement, President Obama enlisted the help of Speaker of the House Nancy Pelosi (D-California) to create unity among the three committees. Helping to form what would be known as, "Tri-Com," Pelosi's political expertise allowed her to tactfully generate the consensus among the three groups: "More than any recent Democratic leader, Pelosi asserted her control over the institution, easing out unfriendly [Energy and Commerce] chairmen (John Dingell) and replacing them with loyal allies ([Henry] Waxman."²⁷⁹ Pelosi's political savvy ensured that any potential reform would transition smoothly through the committee process.

²⁷⁸ Jonathan Cohn. "How They Did It (Part One)." New Republic. May 20, 2010. <http://www.newrepublic.com/article/politics/75062/how-they-did-it-part-one>.

²⁷⁹ Jonathan Cohn. "How They Did It (Part Three)." New Republic. May 14, 2010. <http://www.newrepublic.com/article/politics/75122/how-they-did-it-part-three>.

Furthermore, Senator Max Baucus, chairman of the Senate Finance Committee, represented the final key piece towards legislative unity. Baucus, who published his own “white paper” on health care reform, was identified by President Obama not only for his staunch interest on the policy area itself, but even more so for his traditional conservative elements: “Reaching across party lines was Baucus’s specialty—and, early on, he had Obama’s enthusiastic support. For Obama, bipartisanship was partly a matter of principle. [However] Obama also understood the math—and that the surest path to 60 votes went through Finance.”²⁸⁰ If Obama could successfully group together the Liberal bloc, he believed a man such as Senator Baucus could assist in encouraging a few Republicans to cross party lines.

Finally, Obama understood the significance of the historical Liberal health care belief, which favored universal health care coverage in some form or another. Obama knew that by catering to traditional Liberal ideas he needed to add a “public option” to his agenda, which would help to generate more support for his legislative plan and overall legislative success.²⁸¹ As the unification of the Liberals and Democrats began to turn into a reality, the willingness to put aside shared differences for the betterment of the group, epitomized the reform efforts: “Whatever the final piece [of legislation], it will need to be passed. Something that cannot pass is useless.”²⁸² By utilizing various key actors in Congress to his advantage, Obama created a determined force that could withstand the pressures of the vigorous policy process.

²⁸⁰ Cohn Part Three

²⁸¹ Emanuel pg. 161

²⁸² Emanuel pg. 163

Although President Obama effectively assembled his cast of characters to lead the reform effort, managing the egos of essential Democrats would not come without concession. For one, Obama allowed Congress to assume much of the responsibility during the debates and committee meetings, which helped to increase overall involvement. Second, and more importantly to the success of reform, Obama decided to compromise on parts of the legislation as a means of maintaining the necessary votes required. Two moderate senators Joe Lieberman (I-Connecticut) and Ben Nelson (D-Nebraska) opposed the reform due to the public option within the bill and a specific abortion clause.²⁸³ Lieberman's opposition to the public option forced President Obama to manage the egos appropriately: "Because Lieberman's vote was essential, the Senate Bill contained no public option."²⁸⁴ Although the concept had been a foundational liberal value, Obama did what was necessary for the reform's success.

Fourth, and arguably the most important legislative principle historically, Obama utilized the concept of speed. As prominent Conservatives, such as Senator Lamar Alexander (R-Tennessee), began to voice their opposition to the bill, the imperative for speed became a necessity: "We think [for successful reform] that we have to start by taking the current bill and putting it on the shelf starting from a clean sheet of paper."²⁸⁵ Obama, acknowledging the opposition forces, ushered his famous phrase of "Let's just get it passed. We will work it out in conference," as well as continuing his adamant support for the reform through a series of rousing

²⁸³ Emanuel pg. 163-164

²⁸⁴ Emanuel pg. 164

²⁸⁵ Emanuel pg. 165

speeches.²⁸⁶ While this mantra certainly highlights the consequences of speed that has been discussed in earlier chapters, had Obama allowed the process to last longer than the 14-month window, reform may not have ultimately succeeded.

Moving forward, President Obama promoted the use of prior reform successes as the foundation for the main components within the health care legislation. In order to ensure as much stability and support as he could allow, Obama maintained numerous provisions of the contemporary health care structure, which included “the existing complex financing mechanisms, including employer-based health insurance, Medicare, Medicaid, and the rest.”²⁸⁷ While the analysis of the preceding chapter focused on the problems associated with these fundamental elements, the compromising nature of the policy process did not create the conditions to address all issues at once. Even though it can be argued that these areas had been detrimental to the health care system, in order for reform to pass Obama had to tailor his reform not only to align with members of Congress, but also to appeal to the factions of the American public that benefitted from the prevailing system.

Finally, President Obama had to defend against the Conservative opposition, which led a campaign of anti-government rhetoric rooted in labeling the legislation as a form of “socialized” medicine and a “government takeover.” As in prior health care reform attempts, similar actors, such as physicians, insurers, and others, voiced their opinions in opposition: “Obama’s health care plan would socialize medicine even further. Reasonable people can disagree over whether Obama’s health plan

²⁸⁶ Emanuel pg. 166

²⁸⁷ Emanuel pg. 167

would be good or bad. But to suggest that it is not a step toward socialized medicine is absurd.”²⁸⁸ Going even further, various leading Republicans such as Sarah Palin, Newt Gingrich, and Michele Bachmann levied an onslaught of charges focused on the fictional concept of death panels within the legislation.²⁸⁹

In order to diminish the presence of the opposition, Obama sought out powerful forces, most notably the Washington lobbying group, PhRMA, the Pharmaceutical Research and Manufacturers of America, to help align their support with the legislation. Armed with Democratic leadership, the Obama administration persuaded PhRMA to strike a deal in favor of reform: “Armed with estimates suggesting that the drug industry stood to make up to \$100 billion over ten years if reform expanded coverage, Baucus asked the industry to reduce its revenues by about the same amount.”²⁹⁰ The deal, which would wind up at roughly \$80 billion, gave Obama a tremendous political tool that could lessen the influence of the opposition. Furthermore, in what could be seen as an unlikely turn of events, Obama also gained backing from the American Medical Association, who historically had been unwilling to support major health care reform.²⁹¹

Yet, even as President Obama had seemed to effectively implement each aspect of the legislative principles, the unexpected almost derailed the political efforts entirely. First, Scott Brown’s special election victory threatened the “60 vote filibuster-proof Democratic majority,”²⁹² which dissipated Democratic enthusiasm.

²⁸⁸ Michael F. Cannon, "Does Barack Obama Support Socialized Medicine?" *Cato Institute Briefing Papers*, no. 108 (2008), pg. 1.

²⁸⁹ Emanuel pg. 168-169

²⁹⁰ Cohen Part Two

²⁹¹ Emanuel pg. 171

²⁹² Emanuel pg. 167

Consequently, it seemed as if the House would have to accept the unfavorable bill passed by the Senate, which failed to include certain House provisions. However, the resiliency shown by President Obama and House Speaker Nancy Pelosi reinvigorated the quest for reform, despite the general unwillingness to compromise: “Pelosi could have said the votes in the House just weren’t there, Obama could have said the country and most of the party just wanted to move on. But they didn’t say any of those things. They pushed ahead. And, whether it was because of idealism, ego, a political hunch, or some combination, they got the job done.”²⁹³ After 14 grueling months of the political process, Americans finally received the major health care reform they had been desperately seeking: “On March 23rd, 2010 President Obama signed the Affordable Care Act into law.”²⁹⁴

Throughout the policy process, the Obama administration remained steadfast in its willingness to fight for reform at all costs. Unlike prior reform efforts, Obama engaged with political leadership, forming meaningful bonds that would prove to be essential when navigating through the various political roadblocks. Furthermore, President Obama’s political efficacy cannot be understated. His acknowledgement of when to fight, while also knowing when to compromise, translated into the perfect blend of policy activism and restraint. In essence, Obama’s fusion of political awareness with policy acumen, consummated the longstanding tradition of failed health care reform efforts:

[Obama] inherited a crusade that liberals launched in the early twentieth century and carried it to completion—transforming life for tens of millions of

²⁹³ Jonathan Cohn. "How They Did It (Part Five)." New Republic. May 26, 2010. <http://www.newrepublic.com/article/politics/75163/how-they-did-it-part-five>.

²⁹⁴ Emanuel pg. 173

Americans, reorganizing the most dysfunctional part of the U.S. economy, and proving that the United States can at least make a serious effort to solve its biggest problems. [Obama and his team] were lucky, yes. They were also good.²⁹⁵

Although President Obama successfully utilized all six legislative principles, a feat that had not been accomplished by former health care actors, the nature of his success also deviated from the traditional path. While this example may prove the true value of the policy principles, successful policy still requires the right people, at the right place, at the right time; ingredients that cannot be followed, but rather unique circumstances of a particular political climate.

II. Institutional Framework: Access

The institutional framework addressed within the 906-page Affordable Care Act can be separated into three distinct components: access, quality, and cost. To reiterate, as momentous of a reform as there has ever been, the Affordable Care Act represented the first legislative act to address all three major health care components within a single reform. Whether through the creation of health exchanges, to cost savings mechanisms, or the introduction of meaningful quality metrics focused on patient outcomes, the ACA instituted a new era of health care guidelines and standards to reinvigorate the American health care system. The following discussion will clearly examine and outline the various sections included within the ACA, as well as analyze how the ACA intended to rectify contemporary health care problems.

²⁹⁵ Cohn Part Five

Beginning the analysis focused on the access-based section within the ACA, the legislation sought to concentrate on reducing the total number of Americans without health insurance coverage. Two major provisions helped to provide an immediate decline in the total amount of uninsured. For one, the ACA implemented certain requirements in relation to health insurance coverage. According to Section 2714, insurers must “provide dependent coverage for children up to age 26 for all individual and group policies.”²⁹⁶ This had the effect of allowing 3 million young Americans to obtain health insurance coverage.²⁹⁷ Second, Section 1511 of the legislation, also stipulates further insurance regulations by “[requiring] employers with more than 200 employees to automatically enroll employees into health insurance plans offered by the employer.”²⁹⁸ These requirements will also aid the expansion of coverage and access to health care services.

Yet, the largest strides taken in the improvement of access to health care occurred within the Medicaid program, as well as the creation of insurance exchanges. In regard to the former, the ACA attempted to reform the lack of unified standards, which the previous chapter discussed in greater detail, by creating a set of national regulations that all states are required to follow. The law states that Medicaid will expand to all “individuals under age 65 with incomes [below] 133% [of the federal poverty line]. All newly eligible adults will be guaranteed a benchmark benefit package that meets the essential health benefits available

²⁹⁶ The Henry J. Kaiser Family Foundation, "SUMMARY OF THE AFFORDABLE CARE ACT." The Henry J. Kaiser Family Foundation. April 25, 2013. <https://kaiserfamilyfoundation.files.wordpress.com/2011/04/8061-021.pdf>.

²⁹⁷ Emanuel pg. 205

²⁹⁸ Kaiser ACA Summary

through the Exchanges.”²⁹⁹ Therefore, the ACA reduces the discretionary aspects of Medicaid coverage and instead provides unified national standards, which also contain a specific set of health care benefits that all recipients must receive.

In order to address the reimbursement issue associated with treating Medicaid patients, “the ACA mandated that primary care physicians be paid at Medicare rates.”³⁰⁰ This will aid the access to health care benefits for Medicaid patients who traditionally would not have received the necessary, or high quality care, due to the low reimbursement rates; the ACA changes that: “The CBO estimates the ACA will add 9 million new Medicaid beneficiaries in the first year and 12 million by 2020.”³⁰¹ Lastly, the ACA also takes measures to reduce the burden of payment for state funding of Medicaid. As the last chapter showed, the Medicaid program consumes a large majority of state budgets, leaving them with little funding for other important expenditure areas. In order to encourage states to expand their programs, the federal government agreed to fund almost all of the accrued costs. Data analysis conducted by White House economists projected that even for some states, they will in fact *save* money by adopting the Medicaid expansion.³⁰²

The other main access component found within the ACA was the creation of state-based insurance exchanges. From a structural outlook, the insurance exchanges are a mechanism to provide various different coverage options:

Basically, these are marketplaces in which insurance companies offer different plans with different hospitals, physicians, drug formularies, and co-

²⁹⁹ Kaiser ACA Summary

³⁰⁰ Emanuel pg. 208

³⁰¹ Emanuel pg. 209

³⁰² White House Council of Economic Advisers, “The Impact of Health Insurance Reform on State and Local Government,” September 15, 2009, www.whitehouse.gov/assets/documents/cea-statelocal-sept15-final.pdf.

pay and deductible levels. The plans are standardized to 4 price points—bronze, silver, gold, and platinum. People then shop, comparing these plans, and they select the one they prefer.³⁰³

According to the legislation, states can either set up their own exchanges or use a federally run exchange. Also, states are mandated to provide two sets of exchanges: one for individuals and one for small businesses. In addition, states can organize their exchanges based on “open” principles, which allow for a wide variety of plans, or conversely, “active” exchanges that include more requirements and provisions from insurers.³⁰⁴

In terms of assisting with the purchasing of health insurance coverage, the ACA also includes a series of subsidies to help make insurance more affordable for Americans. The *premium subsidy* “helps people pay for the insurance premium,”³⁰⁵ while the *cost-sharing subsidy* “[provides] subsidies to eligible individuals and families [under a] specified income level.”³⁰⁶ Under the ACA legislation, subsidies were also made available not just for individuals and families, but for small businesses as well: “The subsidies provide small employers with no more than 25 employees and average annual wages of less than \$50,000 that purchase health insurance for employees with a tax credit.”³⁰⁷ The impact of these subsidies not only meant that health care coverage could become a reality for many Americans, but also that employers and employees no longer felt constrained by the burden of employer-sponsored insurance.

³⁰³ Emanuel pg. 209

³⁰⁴ Emanuel pg. 214

³⁰⁵ Emanuel pg. 215

³⁰⁶ Kaiser ACA Summary

³⁰⁷ Kaiser ACA Summary

Regardless of the plan consumers decided to choose, each would require a series of ten services that had to be covered:

(1) Ambulatory patient services, (2) emergency services, (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance abuse services, (6) prescription drugs, (7) rehabilitative and habilitative services and devices, (8) laboratory services, (9) preventative and wellness services and chronic disease management; and (10) pediatric services.³⁰⁸

The mixture of quality measures within the coverage options underscores the legislation's emphasis on providing more equitable and higher quality care.

Furthermore, the *qualified health plans*, which are the certified plans included in the exchanges, contain provisions that prohibit the denial of a patient based on a pre-existing condition. As a whole, the ACA's access-based regulations increase the availability of insurance for many Americans who had previously been unable to acquire coverage.³⁰⁹

Finally, there is the issue of the individual and employer mandates. While certainly a contentious point of debate among policy analysts, the importance of the mandates assure the long-term viability of the system: "The long history of health insurance shows that a *voluntary* insurance system will inevitably collapse because of adverse selection, mandates are necessary to ensure everyone, whether healthy or sick, purchase insurance."³¹⁰ The mandate provisions safeguard the ideals of widespread access and punish those who do not follow the new institutional design. For individuals without coverage, they will face a "tax penalty of \$695 per year up to a maximum of three times that amount (\$2,085) per family or 2.5% of household

³⁰⁸ Emanuel pg. 216-217

³⁰⁹ Emanuel pg. 217

³¹⁰ Emanuel pg. 218

income.”³¹¹ Additionally, employers with 50 or more workers will be subject to financial penalties if they do not provide health care for their workers.³¹²

The enactment of the ACA has generated new opportunities that have led to the expansion of access to health care services. From subsidies to insurance exchanges and even program expansions, the ACA increases the ability to gain coverage, while also declining the likelihood of being uninsured. Projections conducted by the Congressional Budget Office estimate that by 2023 the amount of uninsured Americans would decrease from 50 million to 31 million. Of the 31 million, 30% of those people will be unauthorized immigrants, 20% will be eligible for Medicaid, but choose not to enroll, and 45% will be people who have access to insurance through an employer or could buy it directly through an exchange, but have not yet done so.³¹³ While predicting the future success of any legislation is subject to debate, the access provisions included within the law suggest, that in the long run, the severe coverage problem will have dissipated for many Americans.

III. Institutional Framework: Cost

In the same way the ACA introduced considerable reform to reconcile the access problems within contemporary health care, the legislation also presented viable policies intended to reduce the unsustainable cost measures. To reiterate, the impetus for cost control measures was a consequence of the growing cost expenditures and the level of health care spending relative to the rest of the

³¹¹ Kaiser ACA Summary

³¹² Kaiser ACA Summary

³¹³ Congressional Budget Office. “The 2013 Long-Term Budget Outlook.” September 17, 2013. www.cbo.gov/sites/default/cbofiles/attachments/44761-Wharton.pdf.

economy: “[In 2012] national health spending [totaled] \$2.8 trillion, or 18% of the gross domestic product (GDP). By 2021, national health spending will account for nearly one fifth of our economy.”³¹⁴ To the extent that the legislation could achieve cost containment and future budget reductions, the ACA attempted to “bend the cost curve” by enacting reform, which focused on cutting the prices of health care services, in addition to reigning in the total utilization of health care services.³¹⁵

In connection with the effort to slash prices, the legislation focuses on two specific areas of high cost: Medicare and hospital payments. Under the ACA, reforms are aimed at decreasing the prices paid by Medicare to Part C, the insurance-based plans within the Medicare program. According to CBO data estimations, reducing the payment prices to Part C “will save \$8 billion [in 2014] but will grow to nearly \$20 billion per year by the end of the decade.”³¹⁶ Furthermore, the ACA also intends to scale back aspects of the Medicare rates paid to hospitals. Traditionally, the prices paid for hospital services increase year to year as a reflection of the increase in goods and services. However, due to the automated nature of many activities that occur within the hospital, the rates have failed to take into account these increases in efficiency and productivity.³¹⁷ In order to address this longstanding issue, the ACA has implemented reforms aimed at scaling back these particular cost expenditures: “[The ACA] reduces annual market basket updates for inpatient hospital, home

³¹⁴ Joseph R. Antos, Ph.D., Mark V. Pauly, Ph.D., and Gail R. Wilensky, Ph.D. "Bending the Cost Curve through Market-Based Incentives." *The New England Journal of Medicine* 367, no. 10 (2012): pg. 954.

³¹⁵ Emanuel pg. 219-220

³¹⁶ Emanuel pg. 221

³¹⁷ Emanuel pg. 222

health, skilled nursing facility, hospice and other Medicare providers, and [adjusts] for productivity.”³¹⁸

Additionally, the ACA attempts to reduce the costs within Medicare by progressively eliminating the “donut hole” under Part D. The donut hole concept has been a significant criticism of the Part D program under Medicare, which leaves patients financially responsible for large sums of money if the costs of their prescription drug fall between the theoretical hole of \$2,970—\$4,750. Over time, the ACA reduces this hole, and as a result, the costs of health care services for many Americans.³¹⁹ While these various Medicare cuts may seem small in scale, their immediate and long-term reductions help to contain at least a share of total health care costs.

In addition to the finite cost decreases from the price cuts, the majority of the ACA legislation concentrated on “bending the cost curve” occurs through a series of new systematic approaches to health care delivery. Though largely a function of the medical profession and the established payment structures over time, the new cost measures attempt to redefine the fee-for-service culture of health care delivery by providing more efficient health care models as alternatives to the current structure of care: “At best, influencing physician practices is indirect: no one can order them to do anything. All policymakers can do is alter incentives.”³²⁰ While the legislation’s scope of influence may be limited initially, the policies offer revolutionary changes

³¹⁸ Kaiser ACA Summary

³¹⁹ Emanuel pg. 223

³²⁰ Emanuel pg. 224

to the way patients receive their health care, as well as reducing the extent to which it burdens the system financially.

One of the major organizational reforms within the ACA intended to reduce health care delivery costs is through the implementation of accountable care organizations (ACOs): “networks of physicians or physicians, hospitals, and other providers that take both clinical *and* financial responsibility for the care of patients.”³²¹ The purpose of the ACOs is to provide better chronic care management, while also encouraging greater efficiency through coordination. ACOs achieve these goals by developing organizational interaction between care providers, which in turn will help to also reduce the amount of unnecessary, and thereby wasteful services.

While the ACOs strive to improve the quality of the care that patients receive, as well as emphasize preventative health care measures, the ACOs also contain various financial arrangements, which help to promote these goals. From a design standpoint, the ACOs are divided into three different payment models, all of which are based on a fee-for-service payment structure: Shared Savings, Advanced Payment, and Pioneer. The Shared Savings model, which is the most common of the ACOs and also represents the basic structure for the other forms, utilizes a CMS calculated benchmark score to denote whether or not savings have occurred: “[Shared Savings] retain the fee-for-service payment system but gives [them] a share of the savings if they meet certain quality metrics.”³²² ACOs will receive payment by reducing costs below the designated CMS benchmarks. Moreover, by

³²¹ Emanuel pg. 224

³²² Emanuel pg. 226

directing the delivery of their care based on the 33 quality metrics, ACOs will in theory, become more efficient, which will increase their probability of reaching the required saving levels.

Another structural financial arrangement introduced by the ACA to help contain costs is referred to as bundled payments. Under the authority of the Centers for Medicare and Medicaid Services (CMS), “bundled payments empower physicians to determine how best to treat patients without government interference and without worrying about what tests or treatments will be paid for.”³²³ Similar to the ACOs, bundled payments also encourage coordinated and high quality care, but differ on the financial reasoning. While ACOs promote high quality care for cost saving reasons, bundled payment models provide the reimbursements up front. If the care providers are efficient with the funds, meaning they have minimized unnecessary and wasteful spending, they will be rewarded with excess profit. However, if they engage in practices not conducive to efficient and high quality care they will be penalized by having to pay the difference.³²⁴

The final cost initiative implemented by the ACA also ties into the quality of care received by patients. As it relates to health care expenditures, the consequences of a decline in the quality of care to patients has a direct effect on overall health care costs per year: “Millions of patients experience hospital-acquired infections, falls, drug reactions, and other avoidable problems. These conditions cost billions.”³²⁵ According to a study conducted by the Joint Commission on the preventable costs of

³²³ Emanuel pg. 228

³²⁴ Emanuel pg. 228

³²⁵ Emanuel pg. 228

central line-associated bloodstream infections, estimates reported, “adverse harm events associated with hospital care cost Medicare more than \$300 million in just a single month in 2008. Most of these costs were associated with additional lengths of stay due to the harm of the events.”³²⁶ In order to contain costs from preventable hospital-acquired conditions (HACs), the ACA will impose a penalty of a 1% reduction on Medicare payments to hospitals with high levels of HACs.³²⁷

Correspondingly, the ACA penalties extend to hospital readmission rates, which are highly preventable as well. Data conducted by the Kaiser Institute revealed “[25%] of fee- for-service Medicare patients [return] to the hospital within 30 days of being discharged.” Even more troublesome, from a financial standpoint, the high rates of readmissions are estimated to have cost Medicare “\$26 billion per year, \$17 billion of which is potentially avoidable.”³²⁸ In response to these numbers, the ACA will “reduce Medicare payments that would otherwise be made to hospitals by specified percentages to account for excess (preventable) hospital readmissions.”³²⁹ Through these penalties, the ACA has essentially tied patient outcomes to cost expenditures. In effect, the inclusion of this liability will incentivize hospitals to ensure proper discharge procedures, as well as to perform follow-up visits with the patients as a way to prevent hospital readmissions. According to preliminary data, “within 18 months readmissions are down to 18.4%.”³³⁰

³²⁶ The Joint Commission, “Preventing Central Line–Associated Bloodstream Infections: A Global Challenge, a Global Perspective.” Oak Brook, IL: Joint Commission Resources, May 2012. <http://www.PreventingCLABSIs.pdf>. pg. vii.

³²⁷ Kaiser ACA Summary

³²⁸ The Henry J. Kaiser Family Foundation, “Findings from Recent CMS Research on Medicare.” 2013. <https://kaiserhealthnews.files.wordpress.com/2014/10/brennan.pdf>, pg. 28.

³²⁹ Kaiser ACA Summary

³³⁰ Emanuel pg. 229

Under the enactment of the ACA, the law takes necessary steps to help reduce costs both in the short term and in the long run. While the legislation does not address the perverse fee-for-service payment model, the various payment structures it has included offer innovative payment methodologies that have the potential to reduce health care costs exponentially. Furthermore, the legislation's unprecedented ability to fuse together quality initiatives with cost components represents a changing rhetoric within the health care system as a movement towards fostering positive patient outcomes, rather than solely focusing on the volume of care provided.

IV. Institutional Framework: Quality

While pundits may direct their attention to the access and cost initiatives brought forth by the ACA, the transformative nature of the various quality metrics and regulations provide much-needed value to the American health care system, which has often lost focus of arguably its most important purpose: patient outcomes. As the policy examination has revealed, quality reforms have embedded themselves into the legislation; for access, more opportunities to coverage, and as it relates to cost control, by promoting ACOs, as well as tying reimbursements to the success of preventing HACs and hospital readmissions. The aspects of the ACA specifically focused on quality take further steps through the promotion of electronic medical records, quality measurements and reporting, as well as other patient-centered initiatives.

A main component responsible for promoting high quality care is the adoption of electronic health records (EHRs) as a foundational component of health care delivery. In order to ensure the “meaningful use” of the EHRs, the ACA has also tied their application to financial incentives: “Medicaid provides physicians who adopt EHRs and show meaningful use up to \$63,750 over 6 years, and Medicare provides \$44,000 over 5 years.”³³¹ Similar to the other quality initiatives within the legislation, failure to implement EHRs, as part of the care routine, will reduce total payment levels by a certain percentage. The potential applications for using EHRs for improving the delivery of health care services are endless: tracking patients to see if they are getting the right care and if not making the necessary adjustments, minimizing prescription drug mistakes by showing drug-drug interactions, giving the right medication to the right patient, and so forth, and finally the ability to track physicians’ quality metrics and outcomes.³³²

In addition, the ACA hopes to facilitate these quality measures by mandating quality measurement and reporting by physicians and hospitals. While in the past, physicians could voluntarily report their quality metrics, under the ACA physicians will be penalized if they do not report their scores. Furthermore, hospitals and other care facilities are required to report their quality metrics as well.³³³ Although these particular aspects of the legislation may seem insignificant, the requirements not only place the onus of providing quality care more so than ever on health care

³³¹ Emanuel pg. 232

³³² Emanuel pg. 233

³³³ Emanuel pg. 235-236

providers, but even more importantly, the requirements help transition the culture of care to emphasize patient outcomes, rather than patient volume.

Furthermore, the ACA introduces pay-for-performance programs that utilize a value-based purchasing (VBP) model. VBP, which will eventually be applied to all acute care hospitals, “[uses] Medicare to pay hospitals based on performance on quality measures,”³³⁴ which are focused on four specific areas: “(1) processes of care, (2) patient experience, (3) health outcomes, and (4) efficiency.”³³⁵ The benefits of the VBP system extend beyond the purpose of high quality care; the process encourages high quality, but does so by also fostering care based on outcomes and efficiency. Lastly, VBP rewards hospitals for their year-to-year quality improvements, which should foster greater care in facilities that may not have had an incentive to do so otherwise.³³⁶

While the quality initiatives will take time to establish themselves as part of the daily routine of care, they nonetheless bring systematic change to a rather unhealthy system. Moreover, the legislation’s increase in the accountability among health care providers, provokes a conscious shift towards decision-making focused on the quality of care received by their patients:

Maybe the most important impact of the ACA is psychological. It marks a point of no return on quality. The various provisions that improve the measures and require more reporting on quality shattered the idea that somehow physicians and hospitals could avoid objective assessment and public reporting on their quality of care.³³⁷

³³⁴ Kaiser ACA Summary

³³⁵ Emanuel pg. 236

³³⁶ Emanuel pg. 236

³³⁷ Emanuel pg. 239

The magnitude of the quality initiatives not only help to ensure that patients will be receiving the care that they deserve, but also as providers utilize the quality metrics and provisions, they will help to reduce the overall costs of providing the care through greater efficiency and less costly medical errors.

Although the ACA contains many provisions focused on addressing the access, quality, and cost of health care, the legislation also has built-in revenue components in order to adequately fund all of its goals. The revenue categories can be divided into five main sections: “(1) adjusting the tax treatment of health insurance, HSAs, and other health programs; (2) changing Medicare’s payroll tax; (3) assessing tax penalties for not fulfilling the mandates; (4) assessing fees on health insurers, manufacturers, and others; and (5) levying new taxes.”³³⁸

Preliminary data projections conducted by the CBO suggests that the ACA will actually generate revenue from these sources, thereby not adding to the national debt or deficit.³³⁹

V. Affordable Care Act Significance

The enactment of the Affordable Care Act signaled a turning point in the history of the access, quality, and cost components within the American health care system. Considered revolutionary by most standards, and innovative among others, President Obama’s innate political ingenuity, underlying a deep-rooted desire for change, brought forth a legislative campaign to challenge the contemporary health care problems. The pursuit of elusive health care reform echoed sentiments of a

³³⁸ Emanuel pg. 248

³³⁹ Emanuel pg. 252

commitment to the restoration of American health care prominence, affording the intrinsic values of health care services to all citizens. For Americans, this message resonated loud and clear: gone would be the days in which health care would exist solely for the privileged few, health care would be a right enjoyed by all.

With any grand pursuit of reform, the trials and tribulations of subjectivity, in addition to the realities of concession, warrant a final product that may only exhibit a fraction of the initial vision. As such, the provisions enacted under the Affordable Care Act initiated a renewed faith in the legislative process and the partial restoration of the concerns surrounding the American health care system. No longer would uninsured Americans, regardless of their age, employment status, or health condition, endure the uncertainty of obtaining coverage; the ACA ends those fears. No longer would the American economy experience rising, insurmountable health care costs, which threatened to consume federal and state budgets; the ACA ends those fears. And no longer would inefficient, uncoordinated, and low quality care be considered acceptable forms of health care delivery; for this too, the ACA ends those fears. The legislation may not be perfect, but even perfect may not have been enough to solve the health care woes. Altogether, the ACA is a step in the right direction, a change in the course of path, a shift in the navigation from sea to safety.

Chapter Six: Where Are We Today?

“Reforming the equivalent of the 5th largest economy in the world cannot occur in just a year or 2 or even 3; rather, it requires a long-term perspective and needs to be assessed by how the health care sector is performing in 2020 and beyond.”—Ezekiel Emanuel³⁴⁰

In spite of the political triumph by President Obama enacting historic health care reform in March of 2010, the preliminary enthusiasm surrounding the Affordable Care Act dissipated amidst inexcusable errors of implementation and a determined effort to delegitimize the policy at its core by the opposition. Although undeniably temporary in its nature, the egregious failure by the Obama administration to inadequately ensure the initial success of the health insurance marketplaces, afforded opposition forces a gauntlet of ammunition to fuel their onslaught of anti-government rhetoric. From proclamations of a government takeover, to general assertions of hostility, the Republicans made certain that implementing the Affordable Care Act would be an exceedingly difficult task for the President and his health policy supporters.

Yet, even as administrative improvements would streamline enrollment into the health marketplaces, the concept of reform implementation as, by and large, a process, all but escaped the conscience of the American public. Irrespective of whether or not the reform could provide a long-term solution to a system in much need of attention, the temporary glitches, combined with a deep-rooted ambivalence towards government, sequestered public support from the beginning. However, if the historical precedent of the American policy process has proven

³⁴⁰ Emanuel pg. 291

anything, hostility to change should not come as a surprise, rather, it should be expected.

As we move forward to the present day, American public opinion towards the Affordable Care Act remains static, as many are still opposed, and even others with little faith in its capability to transform the health care system. While Americans have continued to drink the proverbial “Kool-Aid” presented by the major media outlets and conservative political elements, which suggest its failure and call for its repeal, recent health care data may provide evidence to the contrary. For each of the access, quality, and cost components, current trends reveal positive shifts within the three areas. Not only has the uninsured rate declined and quality metrics have shown improvement, but also overall health care spending has continued to grow at a slower pace in comparison to recent years.

While the proper evaluation of any reform should, for the most part, concentrate on quantifiable performance measures, the characterization of the ACA as ineffective, or simply a failure, is a reminder of the enduring concept of “perception is reality.” Although untimely blunders rendered the reform inadmissible by some, is it fair to conclude the reform a failure before it has been given time to fully implement itself? In an effort to expose the flaws of perception and provide legitimacy to reality, the ensuing discussion will shed light on the preliminary mistakes executed by the Obama administration, as well as a present-day evaluation of the ACA through data analysis. Additionally, attention will be given to the ways in which the reform can improve moving forward.

I. Affordable Care Act Implementation Problems

The problems of implementation associated with the ACA can be divided into two separate components: first, the technical debacle of healthcare.gov, and second, the conservative political opposition. Primarily speaking, the implementation process of legislation falls under the authority of the administration and bureaucracy. However, the absence of congressional oversight during the process can potentially foster conditions unwelcoming to implementation: “Lawmaking is not focused on execution, and its inflexibility makes the constant adjustments needed for effective implementation much more difficult.”³⁴¹ As a result, the intricacies inherent to the implementation process do not always receive the required support necessary to contend with the inevitable complications that arise.

The technical complications witnessed during the initial rollout of healthcare.gov were directly attributable to the consequences of poor decision-making. Rather than hiring a private sector manager with proven technical expertise, the Obama administration granted the responsibility to White House policy advisers and “smaller offices within CMS;” both parties ill-equipped to handle a project of that magnitude.³⁴² Though arguably at the time, the decision could be seen as a defense against the underlying political partisanship, the dumbfounded nature of this leadership choice undermined overall policy implementation: “The health policy advisers running the implementation did not understand how to

³⁴¹ Emanuel pg. 279

³⁴² Emanuel pg. 287

develop or manage for a new web start-up, and yet that is what they were doing.”³⁴³ Had the Obama administration been more forthright in confronting the congressional hostility, and not succumbed to the political pressures by failing to anoint a more qualified “healthcare czar,”³⁴⁴ implementation may have taken a different route.

The implications of the failure to properly implement the ACA strengthened the Republican-led campaign against the legislation. While the Obama administration certainly faced challenges in their attempt to correct the implementation blunder, defending against the opposition would pose another significant problem for the success of the reform: “Politicians and the conservative media were literally rooting for the ACA to crash and took [each] glitch as an opportunity to declare it a total failure. In such a context, short-term political calculations often overshadowed longer-term focus on effective execution.”³⁴⁵ The Republicans seized every opportunity to weaken implementation and continued to compound this level of difficulty by encouraging Republican states to reject operation of their own insurance exchanges, as well as to refuse federal funding.³⁴⁶

While the Obama administration may have been capable of manufacturing a response to a single threat on its own, the amalgamation of the two secured the fate of a challenging implementation process. As a consequence, not only did initial enrollment within the health exchanges reduce considerably, but also the expected number of insurers did not enter the marketplace. Even more troublesome, the

³⁴³ Emanuel pg. 288

³⁴⁴ Emanuel pg. 284

³⁴⁵ Emanuel pg. 280

³⁴⁶ Emanuel pg. 280

impact of the mismanaged rollout of healthcare.gov provided legitimacy to the criticisms surrounding the legislation: "It gave the ACA's critics an opening to cast doubt on everything related to reform. At least temporarily, the bad rollout reduced support for health care reform not only among the public but also many in the health sector."³⁴⁷ In the short-term, President Obama and his team failed to sustain enthusiasm for the ACA, and by doing so, led many to question the effectiveness and purpose of health care reform as a whole.

II. Present Day Affordable Care Act

Since the inception of the Affordable Care Act in 2010, the concept of perception as reality has held true. If there has been an area where the Obama administration has failed in its reconciliation, it has been within its inability to overcome the antagonistic precedent set forth by the conservative campaigns opposed to the reform. In laymen's terms, President Obama has failed in his responsibility to win over the hearts and minds of the American public. According to Gallup public opinion polls, and as recent as May of 2014, only 43% of Americans supported the ACA, and in January of that year approval stood at just 38%.³⁴⁸ Furthermore, many Americans questioned the sheer ability of the ACA to positively impact the health care system: "Fewer than four in 10 adults (37%) [said] the law

³⁴⁷ Emanuel pg. 291

³⁴⁸ Andrew Dugan. "Despite Enrollment Success, Healthcare Law Still Unpopular." Gallup. May 29, 2014. <http://www.gallup.com/poll/170750/despite-enrollment-success-healthcare-law-remains-unpopular.aspx>.

will ultimately make the healthcare situation better in the U.S. [and] a plurality of Americans (44%) [said] it will make things worse.”³⁴⁹

Yet, despite the shortcomings that characterized its early implementation, the Obama administration has made considerable improvements to stabilize the problems confronting the Affordable Care Act. Following the repair of the glitches that undermined the introduction of the healthcare.gov website, current indications have shown no signs of technical malfunction, and thus, the ability for consumers to purchase coverage within the healthcare exchanges. In addition, the latest data has presented optimistic results within the access, quality, and cost components, which confirm that the ACA has been effective, and arguably successful, in addressing the main areas of its goals.

With that being said, what explains the discrepancy between public opinion and the recent policy analysis? Why, if the Affordable Care Act has in fact benefitted the health care system, do most Americans continue to view it as a failure? While these answers may deal entirely with the fundamental issues of transparency as related to contemporary media coverage, it nonetheless provides the American public with a flawed interpretation of the legislation. The subsequent analysis of current policy trends, as well as data from prominent research institutions, will help to reconcile the prevailing assumptions with a more accurate representation of the Affordable Care Act and its effect on the American health care system.

³⁴⁹ Dugan “Despite Enrollment Success, Healthcare Law Still Unpopular.”

III. Contemporary Access

While arguably the greatest problem confronting the health care system prior to the enactment of the Affordable Care Act, the amount of uninsured Americans has experienced a steady decline following the legislation's implementation. The increase in the access to health care services can be attributed to two main factors: one, the repairs to the health insurance exchanges by the U.S. Department of Health and Human Services (HHS)³⁵⁰, and two, the 28 states that have chosen to expand their Medicaid programs.³⁵¹ Though on their own, each has contributed to the decline of the uninsured population, together, they have garnered historic decreases, and even more importantly, provided the long-awaited defense against Republican and other opposition forces.

The access-based reforms within the ACA have garnered optimistic results from a data standpoint. According to a recent study conducted by Gallop, the percentage of American adults without coverage fell to 13.4% during the first quarter of 2014, its lowest mark since January of 2008.³⁵² Additionally, when viewing these numbers from a different perspective, the correlation between the ACA reforms and the improvements in access become even clearer: "The number of uninsured Americans has fallen by about 25 percent [from 2013-2014], or about

³⁵⁰ David Blumenthal, M.D., and Sara R. Collins. "Assessing the Affordable Care Act: The Record to Date." The Commonwealth Fund. September 26, 2014. <http://www.commonwealthfund.org/publications/blog/2014/sep/assessing-the-affordable-care-act>.

³⁵¹ U.S. Department of Health and Human Services "The Affordable Care Act Is Working." February 3, 2015. <http://www.hhs.gov/healthcare/facts/factsheets/2014/10/affordable-care-act-is-working.html>.

³⁵² Jonathan Cohn. "Gallup: Uninsured Rate Is Lowest We've Ever Recorded." New Republic. May 14, 2014. <http://www.newrepublic.com/article/117644/gallup-says-uninsured-down-134-percent-lowest-theyve-recorded>.

eight million to 11 million people.”³⁵³ More importantly, these figures have now been accepted across the health care industry. Along with data conducted by the CBO, which has released similar estimates,³⁵⁴ prominent health care leaders, such as Dan Witters, research director of the Gallup-Healthways Well-Being Index, have stated: “There’s no question [the uninsured rate has] come down.”³⁵⁵ Undeniably, the ACA has improved the ability of Americans to receive health care coverage.

In terms of a more in-depth examination of the populations of uninsured Americans now obtaining coverage, many are classified as either a young adult, a minority, or low-income. As a result of the implementation of the ACA, three to four million young adults have now received coverage,³⁵⁶ a feat directly attributable to the provisions within the legislation. Moreover, had the ACA failed to contain the provision that allowed young Americans to stay on their parent’s coverage until the age of 26 years old, the increases in access to health insurance would not have been possible. In addition, uninsured rates among the black population dropped 7.1%, Hispanics 5.5%, and low-income Americans, families that earn annual household incomes of less than \$36,000, also falling 5.5%.³⁵⁷ The importance of these figures not only reveals the extent to which health care coverage has become more widely

³⁵³ Margot Sanger-Katz. "Has the percentage of uninsured people been reduced?" The New York Times. October 24, 2014. <http://www.nytimes.com/interactive/2014/10/27/us/is-the-affordable-care-act-working.html#/uninsured>.

³⁵⁴ Blumenthal and Collins "Assessing the Affordable Care Act"

³⁵⁵ Sanger-Katz "Has the percentage of uninsured people been reduced?"

³⁵⁶ Sanger-Katz "Has the percentage of uninsured people been reduced?"

³⁵⁷ Jenna Levy. "U.S. Uninsured Rate Drops to 13.4%." Gallup. May 14, 2014. [http://www.gallup.com/poll/168821/uninsured-rate-drops.aspx?utm_source=alert&utm_medium=email&utm_campaign=syndication&utm_content=more-link&utm_term=All Gallup Headlines](http://www.gallup.com/poll/168821/uninsured-rate-drops.aspx?utm_source=alert&utm_medium=email&utm_campaign=syndication&utm_content=more-link&utm_term=All%20Gallup%20Headlines).

available, but also even Americans with limited incomes health insurance still remains a strong possibility.

As stated above, the success of the health insurance exchanges has been one of the major reasons why evidence continues to show decreases in the amount of uninsured Americans. According to HHS data from August of 2014, 7.3 million people secured health care coverage through the exchanges, “including many who might otherwise be shut out of the market because of costly medical conditions.”³⁵⁸ Yet, just purely stating the overall number would not do justice to the legislation. Of the 7.3 million people, “[85%] qualified for federal subsidies to help pay premiums. For those who qualified for subsidies through the federal exchanges, the subsidies lowered the cost by 76 percent on average.”³⁵⁹ As a point of emphasis, these figures are by no accident. Rather they are the result of specific ACA provisions that provided subsidies to increase the access to health care services for millions of Americans.

Additionally, the accomplishments of the ACA and its subsidies do not end here. Recent polls have discovered that 62 percent of Americans claimed that they would not have been able to purchase the health care coverage otherwise.³⁶⁰ Even more remarkable, purchasing coverage under the ACA has been in fact more affordable for some Americans than their previous health insurance: “The tax credits, which offset part or all of the increase for most people, actually reduces the

³⁵⁸ Abby Goodnough, Reed Abelson, and Anemona Hartocollis. "Subsidies Lower Costs for Most People, but Some See Their Premiums Rise" The New York Times. October 24, 2014. <http://www.nytimes.com/interactive/2014/10/27/us/is-the-affordable-care-act-working.html#/uninsured>.

³⁵⁹ Goodnough, Abelson, Hartocollis “Subsidies Lower Costs for Most People, but Some See Their Premiums Rise”

³⁶⁰ Blumenthal and Collins “Assessing the Affordable Care Act”

price of coverage for people who once [had] higher rates because they were relatively old or in poor health.”³⁶¹ Taking this discussion a step further, as well as to appease those who have criticized the potential plan changes due to the new ACA requirements, of those Americans that had to switch, “46% of respondents said they ended up paying less, while just 39 percent said they were paying more.”³⁶² On the whole, preliminary trends would suggest that Americans are paying less for their coverage, while also receiving more comprehensive benefits as a result of the preventative services requirements.³⁶³

Yet, as if the prospects surrounding the health insurance exchanges could not be more positive, their overall success indicated by recent data, points towards more progress on the immediate horizon. In response to rising consumer demand, as well as the growing confidence by insurance companies in the effectiveness of the marketplaces, data reported by the White House claims that marketplaces in 2015 will see a 25% increase in the participation of insurers.³⁶⁴ Gary Glaxton, vice-president at the Kaiser Family Foundation, echoes these encouraging sentiments regarding the future of the marketplaces: “It does reflect new confidence in this approach to health insurance coverage. It reflects a market that’s turning out to be stable, it’s turning out to be a robust market, and it’s turning out to be a market

³⁶¹ Jonathan Cohn. "7 Charts That Prove Obamacare Is Working." *New Republic*. September 29, 2014. <http://www.newrepublic.com/article/119623/obamacare-one-year-seven-charts-show-law-working>.

³⁶² Cohn "7 Charts That Prove Obamacare Is Working."

³⁶³ U.S. Department of Health and Human Services "The Affordable Care Act Is Working."

³⁶⁴ Suzy Khimm. "Obamacare's Good News Week." *MSNBC*. September 27, 2014. <http://www.msnbc.com/msnbc/obamacares-good-news-week>.

that's quite competitive."³⁶⁵ Despite what American public opinion may show, the expansion of insurers within the exchanges provides another form of legitimacy to the legislation.

Equally, and if not more important to the decline of the uninsured American population was the expansion of the Medicaid program. Despite the Supreme Court's decision to render Medicaid expansion a state option, the 28 states that chose to move forward with their Medicaid programs proved its worth by generating new health care coverage for 8 million Americans:³⁶⁶ "All 10 states that [reported] the largest declines in uninsured rates expanded Medicaid and established a state-based marketplace exchange."³⁶⁷ For the states that chose to nullify Medicaid expansion, the consequence has been a higher uninsured rate by nearly 4.5%, in comparison to those states that opted for the expansion.³⁶⁸

Furthermore, states with expanded Medicaid programs have not only made it more accessible to obtain health care coverage, but also it has provided benefits to their hospitals as well: "Hospitals in states that expanded Medicaid saw a big decrease in the number of uninsured patients admitted, which fell about one-third on average compared to the previous year."³⁶⁹ For example, states with expanded Medicaid programs saw fewer uninsured patients during emergency department visits compared to states that declined expansion. While on the surface this may

³⁶⁵ Suzy Khimm. "Obamacare's Good News Week."

³⁶⁶ Blumenthal and Collins "Assessing the Affordable Care Act"

³⁶⁷ Dan Witters. "Arkansas, Kentucky Report Sharpest Drops in Uninsured Rate." Gallup. August 5, 2014. http://www.gallup.com/poll/174290/arkansas-kentucky-report-sharpest-drops-uninsuredrate.aspx?utm_source=alert&utm_medium=email&utm_campaign=syndication&utm_content=morelink&utm_term=Well-Being#1.

³⁶⁸ Witters. "Arkansas, Kentucky Report Sharpest Drops in Uninsured Rate."

³⁶⁹ Suzy Khimm. "Obamacare's Good News Week."

seem insignificant, the costs of uncompensated care “[are] expected [to] drop by \$5.7 billion in 2014, which would be a 16% drop from the previous year. The vast majority of those savings—74% overall—will come from states that chose to expand Medicaid.”³⁷⁰ As state governments will inevitably face growing pressure from hospitals and other groups, the positive trends witnessed during the Medicaid expansion should encourage more states to implement this essential aspect of reform.

The combination of the health insurance exchanges, along with the implementation of the Medicaid expansion, has promoted significant decreases in the amount of uninsured Americans. Unfortunately, while the legislation does not secure universal coverage, the access components provide formidable and effective mechanisms to increase overall coverage: “States that implemented these core mechanisms of the Affordable Care Act reduced their uninsured rates three times more than states that did not implement these core mechanisms.”³⁷¹ To insinuate that the Affordable Care Act has failed in its attempt to adequately address the problems confronting the access to health care services can only be characterized as a statement lacking in validity. Whether the naysayers choose to accept the facts or not, uninsured Americans are receiving affordable, comprehensive health care coverage at historic rates; that cannot be an arguable claim.

³⁷⁰ Suzy Khimm. "Obamacare's Good News Week."

³⁷¹ Witters "Arkansas, Kentucky Report Sharpest Drops in Uninsured Rate."

IV. Contemporary Cost

As stated by President Obama, the objectives of the cost-based reforms within the Affordable Care Act were intended to “bend the cost curve” of the health care budget.³⁷² While the ACA has gradually improved the cost problems associated with the health care landscape, it would be more accurate at this point to suggest that the ACA has in fact contributed to a slowdown in overall health care costs. From the legislation’s impact on the cost components related to consumers, as well as its ability to induce a slower increase among the growth of government programs and health care costs as a whole, the cost reforms can certainly be considered a victory in and of themselves. Thus, the capacity of the ACA to generate greater efficiency, in addition to managing costs, signals a more sustainable future for the American economy relative to its historically high levels of health care costs.

From a consumer standpoint, the costs to purchasing health care coverage have improved following the implementation of the Affordable Care Act. First, premiums for health care coverage have remained stagnant despite initial predictions that they would rise tremendously: “Premiums are holding stable and nearly 8 in 10 current consumers could get covered for \$100 or less after tax credits.”³⁷³ Furthermore, as foreshadowed in preceding sections, consumers have been able to utilize various subsidies to their advantage, which has helped to lower the costs of care. Additionally, as the competition within the insurance marketplace

³⁷² Margot Sanger-Katz. "Has the law contributed to a slowdown in health care spending?" The New York Times. October 24, 2014. <http://www.nytimes.com/interactive/2014/10/27/us/is-the-affordable-care-act-working.html#/uninsured>.

³⁷³ U.S. Department of Health and Human Services "The Affordable Care Act Is Working."

increases, consumers will benefit from a wider variety of options that could potentially result in lower prices in the long run. Lastly, the provisions intended to reduce the donut hole within Medicare continue to benefit the financial standing of seniors: “8.2 million seniors have saved more \$11.5 billion on their prescription drugs since 2010—an average of \$1,407 per beneficiary.”³⁷⁴

While the provisions aimed at easing the financial burden of individuals and families were essential aspects of the cost reforms within the ACA, the main focus of the cost legislation was implemented to address excessive and unsustainable health care costs. When assessing the major elements of health care spending, recent trends reveal that “nearly every measure—medical price growth, employer insurance premiums, per capita Medicare spending—[has] increased by much smaller margins than the nation is used to.”³⁷⁵ Although critics have stated that these decreases are more so a result of the recession and changes to health care delivery, Peter R. Orszag, the former Obama administration budget director, believes that the ACA has still played a necessary role: “I view [the legislation] as kind of an accelerant and reinforcement.”³⁷⁶ While an argument can be made to question the true role the ACA has played in reducing cost expenditures, there can be no denial of the correlation that exists between the ACA and recent declines in overall costs.

³⁷⁴ U.S. Department of Health and Human Services “The Affordable Care Act Is Working.”

³⁷⁵ Margot Sanger-Katz. “Trajectory of Costs Levels Off, but There Are Many Reasons?” The New York Times. October 24, 2014. <http://www.nytimes.com/interactive/2014/10/27/us/is-the-affordable-care-act-working.html#/uninsured>.

³⁷⁶ Margot Sanger-Katz. “Trajectory of Costs Levels Off, but There Are Many Reasons?”

According to a 2013 report from the Council of Economic Advisers, their data provides evidence in support of the ACA's net effect on cost reduction. Primarily speaking, their research shows that the slowdown in health care spending has reached historic levels: "Real per capita health care spending has grown at an estimated average annual rate of just 1.3 percent over the three years since 2010. This is the lowest rate on record for any three-year period and less than one-third the long-term historical average stretching back to 1965."³⁷⁷ Moreover, their report suggests that the slow growth will provide real economic benefit to the economy: "The [CBO] has reduced its projections of future Medicare and Medicaid spending in 2020 by \$147 billion since August 2010."³⁷⁸ Lastly, the historic trend continues as the report stated "health care price inflation is at its lowest rate in 50 years."³⁷⁹

As stated above, a major reason for the decline in future budget projections is due to the current and expected declines in Medicare spending. Recent CBO estimates claim that the Medicare budget in 2019 will be \$95 billion less than the anticipated budget estimates in 2010.³⁸⁰ Furthermore, overall spending on Medicare per person is expected to decrease: "In 2019, the C.B.O now estimates the United States will spend about \$11,300 in 2014 dollars in Medicare. That's down from

³⁷⁷ Jason Furman. "New Report from the Council of Economic Advisers: The Recent Slowdown in Health Care Cost Growth and the Role of the Affordable Care Act." Council of Economic Advisers. November 20, 2013. <http://www.whitehouse.gov/blog/2013/11/20/new-report-council-economic-advisers-recent-slowdown-health-care-cost-growth-and-rol>.

³⁷⁸ Furman "New Report from the Council of Economic Advisers: The Recent Slowdown in Health Care Cost Growth and the Role of the Affordable Care Act."

³⁷⁹ Furman "New Report from the Council of Economic Advisers: The Recent Slowdown in Health Care Cost Growth and the Role of the Affordable Care Act."

³⁸⁰ Margot Sanger-Katz, and Kevin Quealy. "Medicare: Not Such a Budget-Buster Anymore." The New York Times. August 27, 2014. <http://www.nytimes.com/2014/08/28/upshot/medicare-not-such-a-budget-buster-anymore.html?abt=0002&abg=1>.

around \$12,700 since 2010.”³⁸¹ A proportion of the reductions in Medicare spending are believed to be a result of the changes to the delivery of health care services: “Medicare beneficiaries are using fewer high-cost healthcare services than in the past—taking fewer brand-name drugs, or spending less time in the hospital.”³⁸² Even as patients are receiving more access to health care services, the efficiencies in care have directly translated into cost savings.

Although it would be premature to suggest that the Affordable Care Act has achieved its main objective of “bending the cost curve,” the slowdown in health care spending, as well as the declines within the budget projections, reflect a more sustainable future for the American economy. Unlike various provisions within the access and quality components of the legislation, curtailing costs and reducing spending does not happen over night. Arguably more so than any other area, reforms aimed at cost are largely based on a process, and given the appropriate time, have the potential to reach their full effect. As the legislation continues to embed itself within the health care landscape, the expectations are promising that the cost provisions can succeed in fully reversing the historic trend of rising health care costs.

V. Contemporary Quality

In comparison to the preliminary observations of the access and cost-based reforms under the Affordable Care Act, the data regarding the quality initiatives

³⁸¹ Margot Sanger-Katz, and Kevin Quealy. "Medicare: Not Such a Budget-Buster Anymore."

³⁸² Margot Sanger-Katz, and Kevin Quealy. "Medicare: Not Such a Budget-Buster Anymore."

within the legislation has also reflected positive trends. From improvements on hospital readmission rates, to the extension of comprehensive benefits within coverage, the quality reforms have established an emphasis on patient care for health care providers. The changes to the delivery of health care services, which utilize payment reimbursements and penalties to improve patient outcomes, have been effective thus far. As the analysis will reveal, the impetus provided by the ACA quality legislation has motivated health care providers to reassess their delivery of care.

In terms of how the surge in access relates to quality, people who have obtained health care coverage are now receiving more comprehensive benefits: “Millions of Americans now have access to preventive services like vaccines, cancer screenings, and yearly wellness visits at no out-of-pocket cost. [Also] Americans cannot be denied or dropped from coverage because of pre-existing condition.”³⁸³ Additionally, research has shown that young adults who have received insurance are more likely to receive mental health treatment, as well as have a regular primary care doctor.³⁸⁴ The quality measures that are now inherent to insurance coverage ensure a foundation of solid health for the next generations of Americans.

Additionally, the financial incentives to improve the quality of care within hospitals, both in terms of HACs and readmission rates, have produced promising results. According to data conducted by the U.S. Department of Health Services, “pressure ulcers, central line associated infections, and falls and traumas are down

³⁸³ U.S. Department of Health and Human Services “The Affordable Care Act Is Working.”

³⁸⁴ Sabrina Tavernise. “To Gauge Impact on Nation’s Health, More Time Will Be Needed.” The New York Times. August 27, 2014. <http://www.nytimes.com/2014/08/28/upshot/medicare-not-such-a-budget-buster-anymore.html?abt=0002&abg=1>.

17% since 2010. [Also] data [shows] that between 2010 and 2013, there was a decrease in these conditions by more than 1.3 million events.”³⁸⁵ Not only have the improvements in these quality metrics meant safer hospitals for patients, but the emphasis on limiting these events has also translated into \$12 billion in cost savings.³⁸⁶ Similarly, readmission rates among hospitals have declined over the course of the ACA’s implementation: “Between 2012 and 2013, readmissions among Medicare beneficiaries were driven down by 150,000.”³⁸⁷

The quality of care delivered by health care providers is vastly improving due to the introduction of payment incentives, as well as improvements to follow-up care. Together, each has helped to reduce preventable HACs and the readmission rates of patients. Jonathan Blum, a top official at the Centers for Medicare and Medicaid Services, has been one of the leading health care officials to voice his support for the quality measures within the legislation:

What I think is exciting is that a couple years ago the general reaction to these policies was that it was impossible to reduce hospital readmissions. And what this data shows me is that it *is* possible...I believe that what we are seeing is a fundamental structural change.³⁸⁸

As more health care providers begin to integrate the quality metrics into their health care models, it will only add more benefit to the patients they serve. Lastly, the emphasis on both patient outcomes, and becoming more efficient with health

³⁸⁵ U.S. Department of Health and Human Services "The Affordable Care Act Is Working."

³⁸⁶ U.S. Department of Health and Human Services "The Affordable Care Act Is Working."

³⁸⁷ U.S. Department of Health and Human Services "The Affordable Care Act Is Working."

³⁸⁸ N.C., Aizenman. "Health Law's Rules Help Hospitals Cut Patient Readmission Rate." The Washington Post. February 27, 2013. http://www.washingtonpost.com/national/health-science/health-laws-rules-help-hospitals-cut-patient-readmission-rate/2013/02/27/6d1fe3a2-8105-11e2-8074-b26a871b165a_story.html.

care resources, will encourage health care leaders to discover new and innovative methods to help keep patients healthy.

VI. The Affordable Care Act Moving Forward

With any new legislation, opportunities for improvement are a natural element of the progression of reform. Although the Affordable Care Act has demonstrated its effectiveness following its implementation, a potential reform that could increase the access to health care coverage relates to the fines given to people who do not purchase coverage. According to a study conducted by Gallup, increasing the fines could induce more people to choose coverage rather than paying a fine: “At a hypothetical \$95 fine level, uninsured Americans are as likely to say they would not get insurance as to say they would. At a \$500 fine level, the percentage saying they would get insurance jumps to 60%.”³⁸⁹ Increasing the fines given to uninsured Americans, who choose not to purchase coverage, could help to decrease the overall figures of the uninsured population.

Furthermore, given the recent success of the Medicaid expansion, it will be interesting to see whether or not hospitals and others can produce enough pressure on state governments, who have chosen not to expand, to change their policy stance. As of now, the impact of the non-expansion by some states has generated a significant coverage gap: “About [4] million low-income Americans are caught in a policy gap in those states that have not expanded Medicaid. Some may be difficult to

³⁸⁹ Charlie Richter and Stafford Nichols. "Higher Fines Compel Uninsured Americans to Sign Up." Gallup. April 16, 2014. <http://www.gallup.com/poll/168542/higher-fines-compel-uninsured-americans-sign.aspx>.

reach; others may still find insurance coverage unaffordable.”³⁹⁰ Despite the provisions within the ACA that stipulate federal coverage of at least 90% of Medicaid costs after 2016, it seems rather illogical that these states would not expand their Medicaid programs.³⁹¹ Though largely a sign of political partisanship, and the unwillingness to support the ACA at all costs, Republican states are directly withholding essential health care benefits from their populations.

While the Affordable Care Act undoubtedly came into existence amidst tremendous political opposition and implementation blunders, its ability to respond to adverse circumstances should give credence to its resiliency, as well as its ability to reform, if not transform, the American health care system. For each of the areas it had intended to address, which includes access, quality, and cost, the Affordable Care Act has proven its effectiveness and its capacity to achieve positive results. Starting with its reductions of the uninsured population, from its determined slowdown of health care spending, and to its improvement in the quality of care for patients, the Affordable Care Act has rewritten a new future for American health care.

Although it cannot be definitively said that the Affordable Care Act has solved each problem to its fullest extent, the legislation has certainly infused a sense of optimism into a system that has grown comfortable with the notion of path dependency and complacency. Yet, when President Obama enacted the Affordable Care Act in 2010, he did not just set out on a quest to implement each health care

³⁹⁰ Margot Sanger-Katz. "Has the percentage of uninsured people been reduced?"

³⁹¹ Robert Pear. "How has the expansion of Medicaid fared?" The New York Times. August 27, 2014. <http://www.nytimes.com/2014/08/28/upshot/medicare-not-such-a-budget-buster-anymore.html?abt=0002&abg=1>.

pillar into a single legislation, he did so with the intent of succeeding. Despite what the opposition may say, the Affordable Care Act has stood the test of trial and error, it has defended itself against mounting political partisanship, and above all else, it has challenged the historical conceptions of reality. One does not have to look far to see the legislation's positive impact on the health care system; the proof is in the performance. The Affordable Care Act is here to stay.

Coda: Concluding Remarks

“The ACA revealed a classic tension between politicians fighting for the next election and policy makers looking over the horizon to the next generation. In the case of the ACA President Obama and the Democrats had their eyes fixed on the next generation. And Americans will be better off for it.”—
Ezekiel Emanuel³⁹²

The major themes that have dictated the evolution of American health care, deal in large measure with the fundamental questions surrounding efficiency or equity, access versus cost, profit against quality. The constant push and pull between these various issues, including the influence of leadership within the medical community and political actors, guided the formation of the institutional design of the American health care system. Traditionally characterized as a vehicle predicated on path dependency, the problems confronting the American health care system both prior to, and following the enactment of the Affordable Care Act, are the direct consequence of this haphazard structural development. Consequentially, American health care has become victimized by its own challenging political climate, which has produced a health care system littered with institutionalized blemishes related to inequitable coverage, overutilization of services, intent on maximization of profit, and a modest emphasis on care.

Beginning with the established sovereignty and authority acquired by the medical profession and hospitals, their dual rise in prominence facilitated the process of early path dependency. As each rose from relative obscurity, and at certain times, were the object of public scorn, their imposition on the health care foundation produced a system that favored their particular interests. Whether this came in the form of unhealthy payment mechanisms, such as the fee-for-service

³⁹² Emanuel pg. 349

model and Medicare reimbursements, or rather acting as impediments to the policy process, their vested interests dictated the progression of health care in America. The dominance exhibited by these particular health care providers led to the inequities in care that existed well into the 21st Century, both from an access and quality standpoint.

Throughout the story of health care reform in America, legislating within the confines of the policy process has proven difficult. Whether potential reforms have been derailed as a result of fragmented political leadership, or rather commonly due to fierce opposition forces, enacting health care reform has evaded the most-skilled political actors. Even while abiding by the principles specific to legislating for health care reform, which include fighting for reform, maintaining unity, preserving egos, legislative speed, utilizing prior successes, and defending against the opposition, historical precedent has shown the instability of the policy process as it affects major health care change. Although at times exceptional political virtue enabled reform to emerge, the legislative successes represent moments that defied the political odds stacked against them.

From the susceptibility of health care reform under President Nixon and the Watergate Scandal, to the AMA's employment of Whitaker and Baxter against Truman's health care proposal, the recipe for successful reform requires near perfect execution. Moreover, for the reforms that have made it through the policy process, such as the enactment of Medicare and Medicaid, attainment of the elusive policy has often been the result of utilizing the concept of policy speed, which has brought with it consequences in its own right. While the challenging nature of the

legislative process requires the use of this central principle as a way to maintain unity and as a defense against opposition campaigns, it limits the extent to which long-term policy implications can be discussed and evaluated.

As it relates to the history of health care policy, the majority of reforms have dealt with the access and cost components. While efforts at universal health care coverage were stymied in the early 20th Century, the inability of political leadership to implement reform throughout this era enabled the health insurance system in America to prosper. However, during the 1960s, as a response to aid those Americans lost between coverage options, significant expansionary attempts at access-based reforms provided a stimulus to the accessibility of health care coverage. The programs of Medicare and Medicaid would revolutionize the access to health care services for many Americans. Yet, while the era of the 1960s increased access, the inherent language within the provisions simultaneously encouraged policies of maximization. As a response to these realities, the political reforms throughout the 1970s could be interpreted as a way to contain the overutilization policies put forth in the preceding decade.

Yet, despite momentary efforts to address the problems associated with the health care system, the path dependent model remained virtually intact. At the onset of the present day, the various inequities and inefficiencies within the health care model led to rising uninsured populations, soaring costs, and failures in the quality of care. On the whole, the system's inability to create mechanisms of uniformity and methods of restraint facilitated the complexities that plagued contemporary health care. Truth be told, the American health care system prior to

the introduction and implementation of the Affordable Act was not only unsustainable, but more importantly unwelcoming. In 2010, as an American living with pre-existing conditions, unable to afford coverage, or unemployed, surviving in a system supposedly predicated on providing care simply did not hold true to its creed.

As the Affordable Care Act set out to address these issues, it did so by increasing the affordability of coverage and removing the barriers to access, reconciling the future cost projections with more attainable and balanced fiscal expenditures, and reintroducing quality as an emphasis to guide health care delivery. While the preliminary implementation of the legislation incurred technical problems and political opposition, current trends provided evidence that suggest its effectiveness on moving the health care system in a more positive direction. The law is reforming health care at historic rates; not only have more Americans received insurance coverage, but also CBO budget projections reflect a more sustainable growth model, as well as a decline in the rates of infections and readmissions within hospitals.

However, even when reform can defy the political odds and reach the implementation phase, the politics of politics remain inescapable. It is known that the American political system has historically been unwelcoming to large-scale change. While one would assume that such a belief would dissipate in the face of time and data reflecting effectiveness, the Affordable Care Act has been unable to rid itself of the politics intended to repeal its very existence. Although the opposition has continually failed in their efforts to prevent reform enactment, as well as during

implementation, they have not shifted their political stance in spite of the benefits the reform has provided.

As it stands today, the opposition has yet to concede, as they continue to focus their efforts on the courts in a final attempt to destabilize the legislation. In reference to the recent case heard by the Supreme Court, *King v. Burwell*, the plaintiffs have challenged the legality of the use of federal subsidies in states that have not set up their own state-run health care exchanges.

The text of the ACA directs states to create an exchange. If they don't, the federal government steps in and creates one itself. But Congress made clear that subsidies are only available for coverage that is "enrolled in through an Exchange established by the State"—and the federal government is not a state.³⁹³

As a reminder, 87 percent of Americans qualified for subsidies under the law. However, the plaintiffs argue that the states that have deferred to the federal exchanges, which are in fact the conservative states opposed to the legislation, would be ineligible to use the subsidies. With that being said, if the courts were to rule in favor of the plaintiffs nearly 8 to 10 million Americans could go insured due to the loss in subsidies. In fact, the legislation could implode entirely as many Americans would be unable to fulfill the individual mandate without the subsidy assistance, thereby endangering the balance of the risk pool, which would raise premiums for all others.³⁹⁴

³⁹³ Amy Howe. "Justices to Weigh Subsidies for Health Insurance: In Plain English." Supreme Court Of The United States Blog. February 23, 2015. <http://www.scotusblog.com/2015/02/justices-to-weigh-subsidies-for-health-insurance-in-plain-english/>.

³⁹⁴ Lori Robertson. "Fact Check: *King v. Burwell* Fallout." USA Today. March 11, 2015. <http://www.usatoday.com/story/news/politics/2015/03/11/fact-check-supreme-court-obamacare/70167628/>.

While the ruling will not be announced until June, the livelihoods of many Americans hang in the balance by this very decision. With the history of health care policy in mind, it remains inexcusable that politics should again attempt to disrupt the well-being of American society. The political misconduct embodied by the opposition forces can only be considered selfish and short-sided; they are not for the prosperity of the American people, they are simply against the legislative progress set forth by President Obama. At a time when the health care system has given hope to so many for a better future, the actions taken against the Affordable Care Act threaten the health of all individuals, families, and most importantly, the nation.

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