**Health Care Reform in Russia and the United States**

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## I. Introduction

The key to understanding health care policy and reform in the United States resides in knowing two facts. First, there is no such thing as a single health care policy in America; instead it is a highly decentralized and fragmented delivery system that involves a variety of public, private, non-profit (NGO) players operating in an environment that crosses the several layers of government. Second, health care in the United States is neither a constitutional nor a legal right. Instead, health care is provided between two basic delivery systems–a private, market driven for profit system based on the ability to pay, and a second one offered by the government to individuals free or at reduced cost who meet specific statutory requirements.

These two facts are significant because they help explain not only the history of health care policy in the United States but they also clarify and set the context for recent reforms in America. Specifically, in 2010 the United States Congress adopted the Patient Protection and Affordable Care Act (also known as the Affordable Care Act or "ACA"), more commonly referred to as Obamacare by its critics. The ACA was an initiative proposed by President Barack Obama while running for president and it was passed with a near straight party-line vote of Democrats in the US House and Senate in 2010. The ACA received only one vote from the opposition Republican Party. Obamacare is hugely controversial, with significant partisan divides when it comes to its approval. Most Democrats and those who identify with that political party support it, with Republicans opposing it. Since its adoption in 2010 there have many efforts by those opposed to it to repeal the ACA, along with efforts to challenge its constitutionality in court or otherwise to block its implementation.

This part of the paper on health care policy and reform in the United States seeks to accomplish several tasks. First, it will describe the context, origins, evolution, and structure of the health care delivery system in America. This section will summarize recent health care policy reform in the United States, setting the context for the reforms of the 2010. Second, the paper then describes the state of health care policy in America, concentrating upon issues of cost, coverage, access, and outcomes. The purpose here is to again to clarify the political and policy environment for the 2010 reforms. Third, the paper then describes the passage of Obamacare in 2010 along with outlining the main provisions of the law. Finally, the last section describes what has happened to the ACA since adoption, concentrating upon its implementation and legal challenges to the law. The

overall conclusion will be that in many ways it is too soon to tell if the ACA is a success, but there are clearly indications that Obamacare has had some immediate victories and failures, with its long term fate still unclear.

## II. History of Health Care Policy in the United States to World War II

The history of health care policy in the United States can be divided into several periods. The first is from the country's independence to approximately World War II.

The simplest way to describe the historic origins of health care policy in the United States is to state that for approximately the first 150 years of the country's existence there was no health care policy either at the federal (national) or state level. Whatever health care delivery there was in the United States, it was done on an individual fee-for service approach or provided through charity. Paul Starr (1982, 20-22) indicates that the delivery of health care and the formulation of policies surrounding it have to a large extent been shaped by doctors, the medical profession, and the American Medical Association.

From approximately 1760 to 1850 medicine and health services were provided for within the family with women assuming the major role as caregivers for the sick (Starr 1982, 32). There were some guide books to help women, but essentially domestic medicine was the norm. The first medical school was established in the then Pennsylvania colony in 1765 and by 1850 there were 42 in the country (Starr 1982, 41-2) and some individuals did attend this and other schools. But for the most part medical training was often apprenticed, or individuals simply held themselves out as medical doctors. There was no certification, licensing, or formal requirements to be a medical doctor. Perhaps as Starr points out, the best way to describe the stage of medicine prior to 1850 was that there was no real formal health care market. Few people could afford to pay for health care services and in the United States, as was the same elsewhere in the world, medicine was hardly what it was today. In the mid nineteenth century medicine struggled to separate itself from religion and superstition, it was not viewed as a science, and its ability to diagnose, treat, and cure was weak at best. It would be fair to declare that the state of medical knowledge in the US and around the world was poor and it probably did little to save lives.

After 1850, through the American Civil War (1861-1865) and into the remainder of the nineteen century health care delivery developed along with scientific knowledge, the US economy, and the rising status of doctors and the medical profession. Increased knowledge about human anatomy as well as scientific knowledge about diseases led to medicine becoming more of a scientific profession that required training or specialized knowledge. Second, during the Civil War the enormous numbers of casualties led to demands for doctors and nurses to provide some health care treatment. Often this involved surgeries to amputate. However, some contend that health care during the Civil War probably killed as many individuals as it saved. Additionally, demands to provide coverage during the war and to veterans after it probably represent the first example of a government sponsored health care delivery program in the United States. Such a policy, providing health care insurance and actual delivery to the military and its veterans, remains a central part of American health care delivery to this day.

After the Civil War the rising affluence and growing industrialization of the United States

began the process of creating two other prongs of the health care system in America (Hillstrom 2012, 84-5). On the one hand many charities become involved in providing health care for the poor, women, and children. This was done either through poor houses, orphanages, or in other ad hoc means or on an individual basis. In the mid nineteenth century there were few if any hospitals, again with those existing often run by churches or charity (Starr 1982, 149). The delivery of health care as a form of charity or as provided by NGOs remains an important characteristic of the United States to this day with many non-profits involved in the insuring or actual treatment of patients.

On the other hand, as Starr points out, the transformation of the American economy, especially in urban areas, began creating a market for a fee for services delivery of health care. Doctors would provide health care services to patients who could afford to pay for it. Health care delivery became a commodity or service that would be sold for a fee. Individuals lacking the ability to pay would not receive medical coverage. Doctors, forming the American Medical Association in 1847 (formally incorporated in 1897) were central to defining how the health care delivery market would develop (Hillstrom 2012, 48). As Starr points out, the AMA's aim was to preserve physician status and autonomy, making sure that doctors would remain relatively free from government control and regulation (Starr 1982, 88-92). One exception to the regulation was the insistence of licensing of doctors (Starr 1982,102) as an effort to professionalize the discipline and close the practice of medicine to those who had real training, thereby excluding many from the field. The net result was an increase in the status and affluence of doctors.

Thus, unlike in Germany where in 1883 that country created a national health care delivery system (and subsequently many other European and eventually communist countries) created health care delivery systems that at least in theory guaranteed medical treatment as a right, the United States did not follow that path and it has refused even to this day to adopt this as a policy. To a large extent, much of the health care and its delivery is defined or seen as something allocated on the basis of an ability to pay.

A final characteristic of post Civil war nineteenth century medical care in the United States was the rise of public health departments (Hillstrom 2012, 84-5). In places such as New York City urbanization and rapid population increases created sanitation and epidemiological problems. Lack of access to potable water, problems in disposing of human waste, and the close proximity of individuals living close to one another meant it was easy for diseases and plagues to rapidly move through a population. Thus starting after the Civil War and though the end of the nineteen and into the beginning of the twentieth centuries, cities developed public health departments entrusted to address some of these problems (Starr 1982: 190-196). These agencies dealt with sanitation and disease control. Again, local public health programs, eventually evolving into the provision of other services such as proving potable war, sewer and waste water treatment, fire protection, housing and zoning codes, and slum clearance, all were parts of early government public health programs that began at the local level and which continue to this day.

The twentieth century, especially before World War I, witnessed several changes in health care policy in America. In 1906 the Pure Food and Drug Act was passed by Congress. The law, a major piece of consumer legislation, sought to protect the public from adulterated food and unsafe drugs. The Act required the listing of drugs in products and it also sought some regulation of what would be considered dangerous drugs . The 1906 Act wad the predecessor to the 1938 Federal Food, Drug, and Cosmetic Act, giving the federal government the ability to regulate drugs for medical use.

Most importantly, it created a system whereby some drugs would only be available to consumers upon a written prescription by a licensed medical doctor, and with those drugs only available for sale at licensed pharmacies. In 1916 the federal Harrison Act. According to Shima Baradaran (2014, 13):

> The Harrison Act, a flagship of U.S. drug policy, became the first piece of legislation validating the fears of violence caused by drugs. The Act was designed to limit the amount of narcotics dispensed by physicians and pharmacists; small amounts of Heroin were to remain available over the counter while prescriptions would be required for larger amounts or for cocaine.

Thus, prior to World War I, the first real national health care policy in the United States came in terms of drug regulation.

The final piece of the origins of American health care policy prior to World War II came with demands for private insurance. As noted above, in 1883 Germany became the first country in the world to provide for sickness or illness insurance. Other countries soon followed, including Sweden in 1891, the UK in 1911, and Russia in 1912 (Starr 1982, 237). The reasons why these countries began offering such insurance is varied, with some arguing that the strength of the social democratic and communist movements in these countries forced these governments to offer insurance as a means of buying off workers and reaching economic and social peace. Perhaps this is accurate. Conversely the reasons for why a public insurance system did not develop at this time in the United States had much to do with the strength of the AMA and physicians who prized autonomy, feared government regulation and socialism, and saw a government insurance system as a threat to their livelihood. Other explanations might lie in the strength of a market capitalist logic that took root in the United States, or a general cultural endorsement of individualism. While there were efforts in places such as New York in 1919 sought to enact public health insurance, they were not successful (Starr 1982, 253-54).

What did change the debate on health care insurance and delivery in the United States was the 1930s Depression and World War II. The Depression led to the election of President Franklin Roosevelt whose New Deal legislation ushered in many social welfare programs for the poor and especially the middle class. More importantly, entrance into World War II transformed health care in a critical way. During the war the United States government instituted wage and price freezes and regulations. In short, employers were prohibited from increasing wages unless approved by the government. Given the war time civilian labor shortages, private businesses had to find some way to attract workers. What they offered then was health care insurance (Hillstrom 2012, 218). This employer-provided health care insurance led to a rapid growth in the number of individuals insured. This insurance, generally paid for by the employer, was often free of charge to workers. The rise of private or voluntary employer-provided health care insurance arouse simultaneously with the growth and developed of for-profit insurance companies.

Moreover, their development provided a major impetus for the expansion of health care delivery, including the rapid expansion and creation of hospitals. It would not be an over simplification to declare that by the end of World War II American medicine had been remade into an increasingly corporate enterprise with significant for-profit businesses providing either health care

insurance or the actual delivery of services, or both. Couple this emergence of a corporate yet physician dominant health care system along with an expansion of services for the military, and the basic structure of the American health care delivery system is in place.

By the time World War II ended, the basic structure of the American health care delivery system was in place. It included a separation of insurance from the actual delivery of health care, but with both remaining primarily in private hands or control. With the small exception of charity care and some services provided for the military and veterans, health care was delivered on a free-for service market model where physicians enjoyed a significant amount of autonomy to provide treatment. Finally, as a consequence of World War II, health care insurance was offered by employers though employment and not provided as a universal condition of citizenship or based on medical need.

## III. Health Care Policy in the United States from World War II to 2008

### A. Harry Truman and the Call for National Health Insurance

Health care policy in the United States significantly evolved immediately after World War II, laying the foundation for policy debates and reform that would continue to affect the United States up to the present. The first was President Harry Truman's call for universal health care coverage in 1945. The Second was passage of the Hill-Burton Act in 1946.

In 1944 President Roosevelt called for an economic bill of rights that included a right to medical care (Hillstrom 2012, 289-292; Starr 1982, 280). However Roosevelt soon died after election to his fourth term, leaving his vice-president Harry Truman to succeed him. In a November, 1945 speech Truman called for the creation of a national health care program (Starr 1982, 281).

> Our new Economic Bill of Rights should mean health security for all, regardless of residence, station, or race--everywhere in the United States.
>
> We should resolve now that the health of this Nation is a national concern; that financial barriers in the way of attaining health shall be removed; that the health of all its citizens deserves the help of all the Nation.. .
>
> ...Everyone should have ready access to all necessary medical, hospital and related services.
>
> I recommend solving the basic problem by distributing the costs through expansion of our existing compulsory social insurance system. This is not socialized medicine.
>
> Everyone who carries fire insurance knows how the law of averages is made to work so as to spread the risk, and to benefit the insured who actually suffers the loss. If instead of the costs of sickness being paid only by those who get sick, all the people--sick and well--were required to pay premiums into an insurance fund, the pool of funds thus created would enable all who do fall sick to be adequately served

> without overburdening anyone. That is the principle upon which all forms of insurance are based (Truman 1945).

The context of the speech was military preparedness. Truman noted that many individuals who were drafted or volunteered for the armed forces were too sick to serve or had physical problems that affected their readiness. Truman's speech was a call for better delivery of medical services and it inspired passage of the Hill-Burton Act and hospital construction and other expansions of health care services. But the most important part of the speech–the call for universal health care insurance for all–would become a defining policy objective for many political liberals and Democrats, including Massachusetts Senator Ted Kennedy, up to and through the passage of the ACA in 2010.

The quest for expansion and universal health care insurance in the United States would dominate health care policy and reform for the next 60 years. It pitted two contrary ways to think about health care–as a fee for service market commodity or something that should be provided to all regardless of ability to pay. This debate, along with cost containment, would be central issues for health care reform in the US, with the debate structured along the lines of whether, despite what Truman said, universal coverage was or was not a form of socialism, despite arguments by Republicans such as Senator Robert Taft who made such an equivocation (Hillstrom 2012, 295-6). Given the cold war mentality in the US and the fears of the USSR and communism, any policy initiative viewed as socialist would have little chance of passing. The question of how to label health care reform and insurance coverage would remain tainted by the socialism label, thereby creating a significant policy and partisan divide over the issue.

Prior to World War II there were few hospitals in the United States, the exception being those for the military. The Veterans Administration operated 91 hospitals, making it the largest health care system in the country (Starr 1982, 348). Physicians did many procedures and treatments in patient homes or in the small city or community hospitals that existed. There were also hospitals owned by NGOS, especially those which were religious affiliated. The 1946 Hospital Survey and Construction Act, otherwise known as the Hill-Burton Act, initially made available $75 million for five years. The Act was extended and between 1947 and 1971 nearly $4 billion dollars in federal money for new hospital construction (Starr 1982, 350). Money would be made available based on demonstrated community need. Hill-Burton worked with the NGO the American Hospital Association to develop state-wide plans for the construction of hospitals and the delivery of specific services.

Hill-Burton was a major success in many ways. By the mid 1960s it had funded 8,200 projects that provided 349,318 beds. Hill-Burton also required that any project or entity using its funds had to provide charity care in perpetuity (Schulte 2009, 108). It gave many communities their own hospitals, and it certainly expanded services to many populations who might not have been served. The charity care provision also made health care more accessible. But Hill-Burton also created problems. First, the emphasis on hospital construction soon became costly. More hospitals meant that they would compete against one another for patients, since health care was being offered on a fee for service basis. Hospitals made money by attracting patients and therefore they had incentives to offer more services (especially with insurance paying for them). Hospitals also centralized services, spent heavily on new costly medical technologies. All this was expensive and created huge overhead costs that in turn drove up the cost of health care (Schulte 108).

A second unintended consequence of Hill-Burton was the charity provision. Charity health care was a great concept but free health care is not free, except perhaps to the patient. Hill-Burton did not clarify what the extent of charity care was, leaving open an erratic pattern of what services were delivered and to whom. Moreover, charity care did not mean that hospitals did not have costs–they did. Free health care to some had to be paid for by others–either by those insured or by public tax dollars. This then meant that either hospitals had an incentive not to tell patients about the Hill-Burton charity–leaving some patients who needed care without coverage–or treatments were provided and costs had to be absorbed by the hospital, the insured, or by the taxpayers in some situations. It was an unsustainable business model.

## B. Johnson and the Expansion of Health Care Coverage

The presidencies of Eisenhower and Kennedy saw little if any change in health care reform in the United States. In 1953, at the start of the Eisenhower presidency, approximately 71 million or 44% of the population of the did not have health care insurance (Sullivan 2006, 17). The Hill-Burton Act continued funding to encourage hospital construction and private sector unions negotiated for its members health benefits with private employers (Starr 1982, 310). Private insurance companies such as Blue Cross (originally founded in Dallas, Texas in 1929) expanded (Sullivan 2006, 14-15). But otherwise there was no real changes in health care policy until after President Kennedy was assassinated in 1963 and his Vice-President Lyndon Johnson succeeded him. Estimates are that in 1963, 63 million or 33% of the population lacked health care insurance (Sullivan 2006, 17).

As part of Johnson's Great Society social programs two major health care programs were adopted. The first was the Medicare program that provided health care insurance for the elderly (age 65 or older). Eventually Medicare was extended to covered the disabled. Medicaid provided the same for the poor and indigent, especially those who were not working and therefore ineligible for employer funded health insurance programs. Under the original Medicaid and Medicare plans, any individual who met the eligibility rules for these plans would receive health care coverage for free. Both plans paid for health care on a cost or fee for service basis, allowing hospitals and other service providers to charge costs plus a 2% profit (Schulte 109). Medicaid and Medicare thus served several objectives. It extended health care insurance to populations who were not served by the private health insurance plans. By some estimates, by the early 1970s this reduced the number of individuals without health care coverage to 10-12% of the population (Starr 2011, 5). Second, these two programs provided reimbursements to hospitals losing money on the charity care provision of Hill-Burton. Three, it reinforced the fee for service of health care model in the United States and also created incentives for health care providers to order additional services in an effort to maintain or secure profits.

Over time Medicaid and Medicare have grown to become some of the largest expenditures and programs of the United States government. Medicare when first implemented was budgeted for $1.6 billion, growing to $7.6 billion by 1970 (Schulte 127). By 2005 it had grown to an annual budget of more than $400 billion, insuring by 2008 more than 45 million individuals. Conversely, Medicaid is a joint feral and state program where states receive federal money if they wish to participate in the program. All states participate in Medicaid, but not all, as shall be discussed

below, have decided to expand participation to cover more individuals under the ACA. In 2006 Medicaid expenditures were $320 billion, covering 55 million individuals in 2004 (Schulte 131). These expenditures also paid for many elder to stay in nursing homes.

Together Medicaid and Medicare (along with Social Security–a federally administered retirement system created under President Roosevelt in the 1930s and funded by a tax on employees and employers) constitute the single largest set of expenditures by the federal government. These two programs are costly, and because of the basic fee for service reimbursement system employed, the have tended to encourage health care spending. Moreover, as the ranks of the number of elderly have increased along with life spans, Medicare spending has increased. Additionally, because of costs to private insured programs, as unemployment has increased or as companies in the late twentieth and early twenty-first centuries have restructured and replacement full time workers with part time, or simply laid off workers or cut health benefits, more individuals have been added to Medicaid. The consequence of all of the above is that these two programs have become increasing more expensive and have helped drive up health care costs in the United States, even while they have also extended coverage. To a large extent, the twin goals expanding coverage to more individuals while addressing cost containment have been the two major policy goals of health care reform from the 1970s to the present in the United States.

### C. Health Policy from Nixon to Bush

From the presidency of Richard Nixon (1969-1974)) until the end of the presidency of the first George Bush (1989-1992), a variety of programs were adopted in an effort both to expand coverage and address costs.

Under Nixon in 1973 two pieces of legislation were adopted. The first was the Health Planning and Resources Development Act which instituted a certificate of need (CON) (Schulte 110). The CON required states to create planning agencies to coordinate health services and ensure that needs were being met by communities. A second goal was to limit duplication or expansion of services driven by the Hill-Burton Act and Medicare and Medicaid. The idea here was that before a hospital could expand or institute new services it would be required to have issued to it a CON. It was unclear whether the CON process was successful and it was repealed in 1987. Many states which had adopted their own CON also repealed their laws. The second law adopted in 1973 was the Health Maintenance Organization (HMO) Act. HMOs are entities (NGOS or for profit) that coordinate health services. They use a combination of primary and preventive care to treat patients and they use a variety of case management and cost-containment mechanisms. HMOs often group physicians or medical services together, and they use referral services and monitoring of patients and expenditures to maintain costs. The 1973 Act did not so much create HMOs as it made it easier for them to expand and flourish because of federal recognition.

In 1982 under President Reagan Congress adopted the Tax Equity and Fiscal Responsibility Act (TEFRA). TEFRA was supposed to change the incentive structures for hospitals and medical providers who made more money the more services they provided TEFRA provided a set or predetermined fee based on a patient diagnosis. Hospitals were then given incentives to treat the patient for this fee. In theory the Act meant that medical providers would treat a patient in the least

costly way possible because they could then retain excess reimbursement as profit or overhead. However, the Act created a different incentive that discouraged medical providers from offering services in a effort to save money.

Finally, 1986 Congress adopted the Emergency Medical Treatment and Active Labor Act. This law outlined the rules hospitals must follow if a patient (including a woman in labor) shows up at an emergency room but is unable to pay. The law described was type of care all patients (especially the uninsured) must receive, when services may be refused, and what protocols must be followed when transferring patients to another medical facility. The purpose of the law was to prevent hospitals from refusing to treat patients without coverage and sending them to another hospital to absorb the treatment costs.

**D. Clinton and Health Care Reform**

By the time President Bill Clinton became president in 1993 it was clear that the United States health care delivery and insurance system was unsustainable.

Consider first the number of individuals covered by insurance. In 1992 during the presidential election the total population of the United States was 256,830,000. Of that population, 148,796,000 million were covered in private insurance plans (57.9% of the entire population) whereas another 66,244,000 were covered though Medicare, Medicaid, or the military (25.8% of the entire population). This left approximately 38,600,000 or 15% of the population uninsured. This percentage had ticked up from 31,000,000 or approximately 12.9% in 1987.

Second, the percentage of the US GDP expended on health care had gone up dramatically. In 1960 5.1% of the US GDP was spent on health care (Sullivan 2010, 20). In 1970 the US and Canada each spent about 7% of their GDPs on health care. In 1971 Canada then instituted a single-payer universal coverage program. By 1990 Canada spent 9% of its GDP on health care, the US 11.9, with 38.9 million uninsured (Starr 2011, 84). Canada's single-payer system appeared to contain costs, especially by reducing administrative expenditures. America's growth in the percentage in how much of its GDP it would spend on health care would continue to grow such that by 2008 it would reach 18%, 50% greater as a percentage of the GDP in comparison to other Western European or OECD economies (Starr 2011, 79). Simply put, compared to other OECD countries, the United States spent significantly more of its GDP on health care with Great Britain at 8.4% and Switzerland at 11.3% (Jacobs and Skocpol 2010, 21). Health care premiums for individuals, and costs for medical procedures in the US, are among the highest in the world (Sullivan 2006, 42-43).

Third, the United States private insurance system was costly. Between 1987 and 1993, insurance premiums increased by 90% while salaries increased by 28% (Starr 2011, 79). Not a surprise, these premium increases were a powerful factor driving up the percentage of uninsured. Finally, when compared to other countries, the health care outcomes of the US were not necessarily better as a result of all the money spent (Woolf and Aron 2013). In short, the US had a very expensive health care system with limited access and impact in terms of making the public healthier.

It was the above conditions that placed the issue of health care reform on the political agenda. This first it occurred in 1991 in a special US Senate race in the state of Pennsylvania. Here Democratic Harris Wofford won a come behind victory by running on the campaign themes of health care for all (Starr 2011, 79. His election was then credited with other Democrats winning in 1992,

including presidential candidate Bill Clinton. He another others made health care reform (access and affordability) among the prominent issues of the national elections that year. During that year incumbent President George Bush discussed the use of tax credits to extend health care coverage and there were also proposals in Congress to do the same (Starr 2011, 80).

Bill Clinton was elected president in November 1992. On January 25, 1993, just days after he was sworn into office President Clinton announced the creation of the President's Task Force on National Health Care Reform, chaired by his wife and future senator and Secretary of State Hilary Rodham Clinton. On the agenda were a series of possible reforms, including the Bush suggestion of tax cuts to extend coverage, a single-payer universal coverage system (similar to that found in Canada) which had been repeatedly advocated by Senator Ted Kennedy, a pay-or-play system which required employers to provide health care coverage or pay into a public program, and a managed care system. A manager care system was where consumers would have a choice of competing managed care plans. The managed care plans would require insurers to offer standard insurance packages, prevent them from excluding coverage (or setting rates) based on an applicant's background or health history, and it would also encourage other mechanisms to encourage savings by requiring individuals to assume responsibility for maintaining their health (Starr 2011: 81-86).

President Clinton in September 22, 1993 gave a speech to Congress declaring a need to reform the American health care system. He basically proposed a managed competition system, delegating to his task force 100 days to draft a formal proposal to be sent to Congress. He directed that his plan should have both universal coverage and cost control mechanisms in it. Initially there was strong public support for his proposal but that soon fell apart for many reasons.

First, while Democrats initially supported it, Republicans increasingly grew wary, fearing a significant government take over of the economy. There was also the criticism that drafting of the bill was done by the White House and in relative secret, thereby undermining congressional buy-in for the law. Third, a fall in President Clinton's political popularity, brought on by allegations of illegal behavior by him and his wife before he was president and still governor of Arkansas, also distracted attention from health care reform (Starr 2011, 94-95). There was additional allegations that the reforms that Clinton wanted were too broad in scope, thereby lacking support necessary to achieve reform of approximately 12% of the economy. The simple scale of the reform scared many.

In addition, one can cite many specific groups either for ideological or economic reasons who opposed the changes. The AMA was in opposition to many of the cost containment features, fearing how it would hurt physician income. Tax proposals to finance the reforms ran into public and Republican opposition, and businesses and many unions were generally opposed to any taxes or proposals that affected them (Starr 2011, 115). Consumers perceived the reforms would affect their ability to choose doctors or seek medical care. Finally, a combination of Democrat Party disunity, Republicans making opposition to health care reform a major 1994 campaign issue, and a series of well-crafted political ads equating the Clinton reforms with socialized medicine all helped to defeat the Clinton plan and, with it, it also brought about significant losses for the president's party in the 1994 elections. Health care reform was effectively dead and with Republicans in control of Congress for most of the next decade (and then the presidency with George Bush starting in 2001), issues such as tax cuts and government spending dominated the agenda. However while there were no reform to health care, the underlying problems such as affordability (individual and as a percentage of the

GDP) persisted, as did concern about access and outcomes.

## E. Health Care Reform 1996-2008

Despite the collapse of the Clinton health care initiative, smaller reforms did take place under his presidency and his successor George Bush. Most of the reforms could be described as rather incremental.

In 1996 Congress and the president agreed to the Health Insurance Portability and Accountability Act (HIPPA). HIPPA is mostly noted in the United States for protection of patient and employee medical records. HIPPA's privacy provisions mandated standard procedures for protection, storage, and transmission of medical data. But the Act also sought to address another problem. This was the difficulty people face when leaving one job for another and the fear that a new employer plan might exclude them from coverage because of some pre-existing medical condition. HIPPA forbid new employers and their health insurers from discriminating against new employees in the provision of health benefits. Employers were also required to give new employees credit for time in previous employment if there was a waiting period before eligibility for benefits. All of these provisions were meant to facilitate or at least not discourage individuals from leaving one job and taking another for fear that they would lose medical benefits (Schulte 115-117).

In 1997 the State Children's Health Insurance Program (SCHIP) was adopted. SCHIP built on the existing Medicaid program and extended health care coverage to uninsured low-income children then ineligible for Medicaid. SCHIP worked by providing federal dollars to states to extend Medicaid coverage. States were free to refuse SCHIP money and extend coverage, but the amount of money available to states for this program was generous compared to the regular matching Medicaid program, and the idea of covering children who needed health care was politically popular (Schulte 134). Given that the year before that the federal government had adopted major welfare reform that resulted in many families no longer being eligible for public health care programs, SCHIP was seen as a way again to encourage individuals to seek employment. But despite support for the program, when Congress in 2007 sought to expand SCHIP to cover more children president Bush vetoed it, instead forcing a simple reauthorization of the existing program (Starr 2011, 177).

The final federal initiative prior to the election of President Obama was adoption of prescription drug coverage for elderly on Medicare. When Medicare was originally adopted the law did not provide for prescription drug coverage, leaving it up to the elderly to buy drugs on their own or purchase separate supplemental health care plans to cover them. In the 2000 presidential race between Clinton's vice-president Al Gore and George Bush the former called for prescription drug coverage for all elderly, extending SCHIP to cover all uninsured children, and reducing the eligibility age of Medicare from 65 to 55 (Starr 2011, 146-147). Bush was elected, in part because of support from older voters, and he eventually endorsed the addition of drug coverage to Medicare. Thus, in 2003 The Medicare Prescription Drug, Improvement, and Modernization Act was signed into law. It committed the federal government to an additional $400 billion in government spending over the next ten years. The Act gave senior citizens a variety of options on how to purchase additional insurance to obtain prescription drug coverage. For many, the options seemed confusing, for the economy and health care reform, it added to the budget deficit, did little to encourage cost containment, and further increased the overall projected GDP spending on health care in the United States.

### F. Mitt Romney and Massachusetts Health Care Reform

A significant amount of health care reform in the United States in the decade or so before Obama became president took place at the state level. Consistent with an American myth or belief that states are laboratories of democracy, the federal government in the 1990s and into the twentieth-first century often gave states waivers from federal regulations to encourage them to experiment with different ways to provide health care coverage for their citizens. Among the most notable example was that of Massachusetts which in 2005 became the second state to move toward universal health care insurance for all its citizens (Hawaii was the first state to do this in 1974).

Massachusetts is one of the most politically liberal and Democratic states in America. It is home to the Kennedys, with former Senator Ted Kennedy defining his entire career as an advocate for universal health care insurance for all Americans. Massachusetts had also been an early and important innovator in health care reform. In 1988 then Governor Michael Dukakis signed legislation requiring employers to provide insurance to employees or pay a special tax. The law also provided for health care for students and the unemployed. The bill's enforced was delayed by the next governor and state legislature, but still this represented a step toward expanding coverage (Starr 2011, 166).

In 2004 Republican Mitt Romney became governor who presided over a state legislature controlled by the Democratic Party. Working with both the Heritage Foundation (a conservative think tank), Senator Ted Kennedy, and the Bush administration in Washington, Governor Romney came up with a health care proposal that included several features. First, it contained a Medicaid waiver to allow the state to depart from federal health law requirements. Second, it required employers to provide insurance to their employers or pay a fee to the state. Third, it included an individual mandate, calling for individuals to purchase their own health insurance (if they did not receive it through work or already have it) or demonstrate an ability to pay for health care. Fourth, for individuals who could not afford to pay for their own insurance it either expanded eligibility for Medicaid, SCHIP, or provided tax credits or subsidies, and it created a health care exchange for individuals to shop for insurance. The plan also expanded coverage and eligibility for the state MassHealth, the state health care plan. (Starr 2011, 167-174).

The Massachusetts health care law is notable for several reasons. First, it rejected the idea of a single-payer government financed system in lieu of the use of private insurance and employer and individual mandates. Second, the law seemed to have an immediate impact in lowering the uninsured rate in Massachusetts. Third, the law did not really have any provisions to address cost containment Finally, and perhaps most importantly, the Massachusetts plan was in many ways the basis of eventually what the Obama Administration would support and which would pass as the Affordable Care Act in 2010 (Hillstrom 2012: 616; Starr 2011, 172-174).

## IV. Barack Obama and the Affordable Care Act

### A. 2008 Elections and the Congressional Debates

More than a generation after the failed efforts by the Clinton administration to pass health insurance reform, the basic problems underlying health care persisted. According to the US Census Bureau, in 2008 15.4% or 46.3 million individuals in the United States lacked health care insurance (Census 2009, 20). Two-thirds of the American public was covered by private insurance with a total

of 58.5% receiving it through their employer (Census 2009, 20). Not a surprise, young adults, people of color, and the working people making too much money to be eligible for government provided or subsidized insurance were the most likely to be without coverage. Additionally, by 2008 the United States was spending 16.6% of its GDP for health care, or approximately $2.4 trillion. Projections were that this would increase to more than 20% of the GDP by 2018, in part as a consequence of the aging Baby Boom generation. Insurance premium costs were also increasing in percentages far exceeding the rate of inflation or general cost of living, resulting in an affordability crisis for both the United States as a whole and individuals and families. According to the Kaiser for Democrats health insurance was the number one concern in 2007 (Starr 2011, 182).

Health care insurance reform thus became a major issue in the 2008 Democratic Party presidential primary (Jacobs and Skocpol 2010, 30-31). Former senator and 2004 vice-presidential candidate John Edwards ran on the promise of supporting an individual and employer mandate, expanding state health care exchanges and eligibility for Medicaid, and expansion of a federal government health care exchange (Starr 2011, 182-3).

Former first lady and then presidential candidate and Senator Hilary Clinton too called for more universal coverage, with her plan emphasizing expansion of Medicaid for the poor, tax credits and subsidies to allow for individual purchases, some health care exchanges, a modest creation of a government health care insurance system, and an employer mandate, but only for larger companies, and an individual mandate (Starr 2011, 185-6). Senator and then candidate Barack Obama did not originally embrace the individual mandate, instead opting to criticize Clinton for her position on it, arguing she was forcing people to buy insurance when they could not afford it. Obama took a mode moderate approach, opting for expansion of coverage for children. He also advocated for expansion of Medicaid, some form an employer mandate, and some form of a national health care exchange. His plan was vague on critical details. Over the course of the Democratic presidential primaries his views evolved and he eventually seemed to endorse the Clinton individual mandate. On the Republican side, senator John McCain called for tax incentives and tort or malpractice reform to address insurance coverage, but largely health care was not a major topic of debate for Republicans (Jacobs and Skocpol 2010, 36-7).

Obama defeated McCain in 2008 for president and the Democrats had a politically very good year. They picked up enough seats in the House to have a commanding majority and eventually in the Senate they secured 60 votes–enough to guarantee them enough votes close a potential filibuster or a blocking of a vote by Republicans. As president Obama was immediately preoccupied with the 2008-9 global economic crash. His attention first turned to passing an economic stimulus bill to help the economy. The president turned health care reform essentially over to Congress, perhaps leaning the lesson of the failed Clinton reforms which had the White House write the legislation (Jacobs and Skocpol 2010, 56). This was not the only difference from 1993.

Unlike under Clinton, many of the major health care players such as the pharmaceutical industry, the private insurance companies, and the AMA eventually lined up behind reforms. In many ways these industries were then being economically squeezed or saw that the addition of millions of additional insured customers would be profitable to them, or they received special rules that would be of benefit to them (Jacobs and Skocpol 2010, 70-71). For example, the pharmaceutical industry stood to make billions of dollars from the new customers it would receive, as well as some protections from the use of generic drugs. Bringing these groups into negotiations

thus eased some of the opposition. Second, Congress was even more polarized ideologically along party lines that in 1993, with Republicans firmly opposed and opposing the eventual passage of the Affordable Care Act.

Third, most prominently or publicly initially, president Obama largely left it up to Congress to draft and develop the health care legislation. This posed a problem when some Democratic senators from Republican-leaning states such as Nebraska and Louisiana were unwilling to support health care reform. Obama seemed to provide little leadership on this issue, with many worried by mid-2009 that the law was going nowhere. Finally, Senator Ted Kennedy's death in 2009 and his replacement by Republican Senator Scott Brown changed the political dynamics in a couple of ways (Hillstrom 2012, 622). First, Kennedy had been the leading figure for health care reform and single-payer for 40+ years and his departure created a power vacuum or void in terms of an advocate for reform. Second, Kennedy's death also meant the Democrats lost their super-majority status in the Senate, meaning Republicans could block votes on reform. However, using a variety of parliamentary procedures and special Senate rules, the Affordable Care Act was passed in 2014.

So why did the ACA pass? Why success on health care reform this time as opposed to other efforts since the Harry Truman speech in 1946 calling for it? There is no one reason. Some had to do with the mounting costs of health care to businesses and families. Part of it was due to the buy in by major health care industry players. Part of it was also due to Obama's and the Democrats' huge victory in 2008. Part of it also could be attributed to the fact that Obama and Democrats eventually put more effort on this reform than others, such as addressing the environment (Starr 2011, 236-38). Finally, the relative modesty of the ACA, relying significantly on use of private insurance, employer coverage or mandates, a conservative individual mandate, modest expansion of current government programs, and an overall continued embracing of a most market-based approach to health insurance all could be counted as factors explaining its eventual passage.

## B. Major Provisions of the Affordable Care Act

The final version of the Patient Protection and Affordable Care Act (ACA) (Public Law 111-148) or Obamacare contained several provisions to extend health care to cover the 47 million Americans who did not presently have insurance. The law is a complex package of many provisions that use government and private insurance systems and market incentives to expand the quality and overall coverage and access to health care services. The ACA also contains provisions to address costs. The main provisions or points of the law can be grouped around a series of provisions (Kaiser 2011).

First, the ACA has an individual mandate requiring all US citizens and legal residents to maintain qualifying health care coverage. By "qualifying" the law specifies certain conditions and services to be provided in the policy. Second, the ACA does not require undocumented aliens or individuals who are not legally residing in the country to maintain health insurance. The estimates are that this number is approximately 12 million individuals. Others such as those incarcerated, who are American Indians, or who object on religious grounds, are also exempt. These individuals may or may not seek medical services and they may or may not be able to or be eligible to purchase health insurance. Individuals required to have health insurance may meet the requirement by receiving it though their workplace or from the government if they are eligible for Medicare or Medicaid.

Individuals who do not have health insurance will be required to pay a tax penalty. Individuals who cannot afford to purchase health insurance will receive subsidies to buy a plan.

The second provision to extend coverage is an employer mandate. Companies with 50 or more employees would be required to provided health insurance for their workers or pay a fine of $2,000 per employee. Businesses under 50 employees are exempt from this mandate and those with more than 200 employees would have to automatically enroll employees into a plan if they have it. Third, states would be provided incentives to expand Medicaid coverage to individuals under the age 65, who quality based on income. Fourth, small businesses (25 or fewer employees) would be provided tax incentives or subsidies to provide health care insurance.

Fifth, the ACA mandated the creation of health care exchange by states. These exchanges would be places where individuals and business could shop for and purchase health care insurance. The idea behind the exchanges is to create a central location where purchasers can locate qualified health insurance plans and presumably shop for the best priced plans that meet their needs. Between 2013 and through 2017 various rules regarding how the exchanges would operate, who could use them, and types of plans that would be available (such as multi-state plans) would eventually kick in or change. The exchanges would be operated by the individual states unless they decided not to do it and then the federal government would operate exchanges on behalf of the states.

Sixth, the content and the terms of conditions of the health care plans to be offered would be mandated under the ACA. Adult children would be allowed to stay on their parents' private insurance plan until age 26. Insurance companies would not be permitted to deny individuals coverage for pre-existing illnesses. Four levels of health plans plus a catastrophic illness plan would need to be offered though the exchanges. Each of these plans would have varying levels of coverage and deductibles or out-of-pocket expenses for purchasers. Additionally, states would be permitted to prohibit plans in the exchanges from covering abortions.

Seventh, the ACA imposed a series of cost containment rules. These included a simplification of rules to determine eligibility. There are also new rules for reducing or restructuring Medicare payments to hospitals and other providers, creating innovation centers to explore new ways to fund or save money on health administration and medical treatment. Finally, there would be a stronger emphasis on using generic drugs and developing programs to combat waste and fraud through the development of new compliance procedures and reporting systems.

In terms of efforts to improve health care outcomes, money would be committed to doing comparative research on ways to improve treatment and care. And also health care plans would be required to fund various preventive or wellness care programs.

To pay for the ACA the law budgeted approximately $800 billion. Of that, $500 billion would come from cuts in existing health care spending, such as for Medicare. The additional $300 billion would come from various taxes on items such as medical devices, so called Cadillac or high-benefit private plans, elective cosmetic surgery, certain pharmaceutical manufacturers, and through the elimination of current tax deductions for some medical and health expenses.

Finally, according to the Congressional Budget Office's initial projections, the ACA will result in 32 million individuals receiving health insurance. Overall insurance coverage for Americans will move from its current 83% to 94% by 2019 (CBO 2010, 21; Jacobs and Skocpol 2010, 122). The CBO estimated also that the Affordable Care Act would have some impact on reducing the federal budget deficit by $143 billion by 2019 (CBO 2010, 2).

## C. Implementation History

Initial implementation of the Affordable Care Act got off to a difficult start. It was plagued by political, legal, and administrative problems that have had various impacts and results on the continued viability of the law.

Perhaps the most significant variable impacting the efficacy of the ACA has been its political opposition and lack of public support for the law. For example, right after its passage of the Act public opinion was divided in support (40%) and opposition (54%) (Starr 2011, 271). More significantly, 75% of Democrats supported the law while 80% of Republicans opposed it. The ACA effectively passed without any Republican Party votes in Congress and support and opposition toward the law has become a politically polarizing issue.

In 2009 a very conservative political movement known as the Tea Party formed in the US, taking as one of its major positions opposition to the ACA and calls for its repeal (Hillstrom 2012, 617-18; Jacobs and Skocpol 2010, 76-77). The Tea Party moved into the Republican Party and politically recruited candidates to oppose the ACA. Public opinion opposition to the law was also significant, as noted above, and the 2010 midterm congressional elections were in part cast as a referendum on the Affordable Care Act. Those elections saw the Democrats lose control of the House of Representatives and also lose seats in the US Senate. In 2012 the Republican Party again made Obamacare a major campaign issue, but was less successful in using it as a campaign theme. This was due, in part, to the fact that their presidential candidate Mitt Romney was unable to articulate this theme as an issue because in many ways his health care reform law in Massachusetts was the model for Obama's. Romney also proved to be a less than stellar candidate.

The significance of the political opposition has had at least four results. First, the Republican controlled House of Representatives has voted nearly 50 times to repeal the Affordable Care Act. Opposition to the law has impacted many congressional-presidential negotiations on issues from taxes, the budget, and debt reduction. Second, the polarization over the ACA has precluded the president from going back to Congress to seek changes in the law that might be necessary or discovered as a result of implementation. This has meant that the president has used his rule-making authority to make some changes, raising charges or allegations that he is acting illegally or improperly. In the summer of 4014, the Republican House of Representatives voted to authorize a lawsuit against the president challenging his implementation of the ACA. Such charges have only added to the partisanship polarization surrounding the law.

Third, the political polarization has lead to a scenario where only 14 states and the District of Columbia have created their own health care exchanges. Republican governors and state legislatures have generally been unwilling to run their own health care exchanges, leaving it up to the federal government to do that. Such partisan opposition to the ACA and refusal on the part of many states to create their own exchanges was not anticipated and it forced the federal government into a situation where it did not expect–operating the vast majority of the exchanges and becoming a prime implementor of the law. The ACA really anticipated federal-state cooperation and in many cases this is not occurring.

Fourth, partisan opposition to the ACA has also led to numerous legal attacks (Starr 2011, 276; Jacobs and Skocpol 2010, 154-55). Led by state Republican attorneys general or governors, one argument was that the federal government lacked the constitutional authority to mandate that individuals purchase health insurance. A second argument was that the federal government lacked

the authority to require states to expand Medicaid coverage. In *National Federal of Independent Businesses v. Sebelius* (2012), the Supreme Court held that while the individual mandate exceeded the federal government's power under the Commerce Clause, it did uphold the mandate as a valid exercise under the national government's tax and spend authority. Specifically, it was within the power of Congress to impose a tax on individuals who were insured yet refused to purchase health insurance. However, the Court also ruled that the federal government could not penalize states if they did not expand Medicaid coverage by withholding all Medicaid funding. The significance of this ruling was that it meant that states effectively could refuse to expand Medicaid coverage to more uninsured individuals. In many states under Republican Party control, this is exactly what has occurred, thereby blunting the number of individual's that the ACA will cover.

A second challenge to the Affordable Care Act has come from businesses or corporations contending that it violates their First Amendment Free Exercise of Religion Rights to be required to pay for health insurance policies that provide for birth control or contraception. Lower federal courts were divided on this issue and in *Burwell v. Hobby Lobby Stores* (2014) the Supreme Court ruled that the contraceptive mandate under the Affordable Care Act violates the religious rights of closely-held corporations because they are persons under the Religious Freedom Restoration Act

A third legal challenge addresses where the ACA allows for subsidies to low income individuals who purchase health insurance through the federal health care exchanges. Some have argued that the language of the Affordable Care Act only allows for subsidies in cases where states runs a health care exchange. On July 21, 2014 the D.C. Court of Appeals in *Halbig v. Burwell* issued a split decision invaliding the tax subsidies to individuals in states where the federal government was operating the health care exchanges under the ACA. But just a few hours later the Fourth Circuit Court of Appeals in *King v. Burwell* the court unanimously upheld the subsidies as constitutional. The legal status of the subsidies is potentially headed to the US Supreme Court for resolution.

In addition to legal challenges the ACA has faced other problems. At both the state and more notably at the federal level the roll out and implementation of the websites for the health care exchanges have been fraught with many problems. These include difficulty to navigate, incomplete information, or otherwise bad design making it difficult for individuals to use them. When the health care websites and exchanges premiered on October 1, 2013, they were criticized as failures and initial enrollments in health insurance was slow. Originally the Obama Administration had anticipated 7 million enrollees by April1, 2014. That was then revised down to 6 million. In the end, approximately 8 million did enroll, but it is unclear how many were previously uninsured or simply switched insurance.

The difficultly with the federal health care exchanges has also led to a criticism that the Obama Administration has largely been inept or politically weak in rolling out the ACA. One example is that when candidate and later President Obama was trying to sell passage of the law he stated several times that the law would not require individuals to give up their existing coverage. His statement was that "if you like our existing policy you can keep it." The problem was that many of the existing policies were no longer legal or meet the minimum requirements under the ACA. In 2013 many individuals received notice of policy cancellations and Obama was accused of lying. In response to criticism regarding these cancelled policies the president issued a moratorium and allowed individuals to continue with existing policies for another year.

Some have contended that the president issued this moratorium in order to limit political damage to his party, especially in anticipation of the 2014 elections. But either because of the elections, slowness in implementation, or fairness, Obama has also delayed enforcement of several of the employer mandates so that they will not take effect until after the 2014 elections.

Finally, beyond all of the implementation problems, there are questions regarding whether the ACA will achieve its objectives. Revised CBO estimates question whether as many new individuals will receive health care coverage as originally estimated. There have also been mixed signals regarding cost projects. Third, one of the other main goals of the ACA was to reduce health care spending in the USA, especially as a percentage of the GDP. Some have argued that the ACA never really included significant cost controls (White 2013). Moreover, the Act has not really addressed the demographic issues surrounding the increased health care costs associated with an aging American population. It is also unclear whether the Act will be able to decrease individual premium costs for purchasers of health care insurance.

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