Abstract

“Obamacare” is properly referred to as the Patient Protection and Affordable Healthcare Act. Dubbing the act “Obamacare” has political implications that have since the acts inception, limited proper understanding of what it actually does and is intended to do. The Patient Protection and Affordable Healthcare Act is the United States most comprehensive attempt at health reform to date. However, political brainwashing has ensured the average person does not understand it properly. Unacceptable. This citizen’s primer on the act will assess a variety of factors leading to the PPACA in its current form, and assess some tangible consequences of the Act today. We will discuss why health reform is necessary in the first place, this materialized in its current form as a law, how the act addresses health reform issues, what claims against the PPACA rose during its inception in Congress and the Courts, discuss credible, scholarly concerns with PPACA, dispel some popular but misinformed concerns with the act, and explore in brief how the law is working in practice today among states and in the country today.

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A Healthy Dose of Truth

**Why is Health Reform Necessary?**

A professor of American politics began a lecture to his students with the point, “The Challenges facing the U.S health care system-expanding access, reducing costs, ensuring quality and transforming how care is delivered” (David Keepnews, 2) are the basis of health reform legislation as it is formed today. Although this is not readily apparent, the manner in which these challenges are framed reflect the definition of Universal Health Care given by the World Health Organization. They define it as “A strong, efficient, well-run health system that meets priority health needs through people-centered integrated care,” which prevents illness by detecting health conditions early, has the capacity to treat illness, and that helps patients recover adequately. Additionally, this system should be affordable for the people that use it, provide access to essential medicines, and provide well trained workers to administer care of all forms. This is the standard of care which industrialized countries adhere to.

This being said, although the United States without doubt has access to the best medical technology available; this does not make this technology automatically accessible to everyone at a low cost with a good, consistent care provider and reasonable affordability. Also, healthcare is a significant percentage of the United States GDP, but this does not mean Americans are better cared for. The “Health Care Reform and American Politics” book written by Oxford scholars Lawrence R. Jacobs and Theda Skocpol help show among many other key points, that “Advanced technology can raise costs if it used wastefully…Despite extra tests and procedures and defensive medicine…international measures of health care results show Americans patients in general often do worse than people with comparable conditions in other, more frugal health care systems,” (Jacobs, Skocpol, 22) another symptom of illness in the United States healthcare system. Examining health expenditures in the United States show it is not getting the proper quality of care for the amount of money being invested within it.

Aside from health care costing “15.3% of the U.S GDP in 2006, one-fifth of the 120 million people to visit emergency rooms that year were without health insurance.” (Jacobs, Skocpol, 23) Emergency rooms not only do not provide preventative care or deal with ongoing medical conditions, but the chances of an uninsured person being able to fully pay back bills are not high. These costs are recycled through the system and shifted onto those with health insurance, making the system more expensive for those paying for health insurance coverage through their premiums.

It seems natural the apparent lack of ease in establishing Universal Healthcare might lead lawmakers to look into other countries like ourselves for cues. However, the American health care system is not very similar to that of other industrialized nations. “All other industrial nations provide their entire populations with health coverage,” (Jacobs, Skocpol, 22) leaving the supposedly most powerful nation lacking when it comes to ensuring its citizens are properly cared for. Health reformers had to deal with the particular United States healthcare system issues. These reformers “have been determined to work with the mixed public-private system, protecting and regulating private insurance while using existing government programs and modest subsidies to help Americans of modest means gain coverage,” (Jacobs, Skocpol, 68) as those who are rich can pay for healthcare with or without insurance, and the middle class and lower are likely to face financial hardship as a result of exorbitant healthcare costs. Scholar William P. Marshall in the *Harvard Journal of Law & Public Policy* asserts in “National Healthcare and American Constitutional Culture” “the importance of healthcare to social mobility cannot be overstated” because “there is a demonstrated correlation between poor health and downward mobility” therefore “the unavailability of healthcare to redress poor health issues can therefore freeze an individual in lower class for life” which is potentially problematic considering the “8.1 million children in the United States without insurance” (Marshall, 19) before the law finally passed in 2010.

In sum, health reform needed to occur because the U.S system had inefficiencies in delivering access to coverage for everyone in the United States (which inadvertently increases costs) and managing costs for everyone from insurers to consumers. A lack of universal healthcare in the United States is not necessarily less expensive, especially because the mixed public and private system left unchecked allows individual parties to pursue their own individual interests, not those that are best for everyone.

**What led to the Patient Protection and Affordable Healthcare Act?**

If this is not apparent, the passing of the Patient Protection and Affordable Healthcare Act is very significant in the United States, especially given the anti-healthcare reform atmosphere preceding its passage. The politically astute on healthcare legislation are aware that “none of the over one hundred proposals introduced in Congress between 1991 and 1994 was enacted,” (Rich, Chueng, Lurvey, 5) the healthcare battles during Bill Clinton’s presidency a bad memory in the minds of democrats in 2009 before the passing of the affordable healthcare act. There have been numerous battles for healthcare reform during the Presidential administrations of “Franklin Roosevelt, Harry S. Truman, John F. Kennedy, Lyndon B. Johnson, and Richard Nixon,” (Rich, Chueng, Lurvey, 4) and a recurring reason for failure of reform is “the major stakeholders in the American health care system-providers, consumers, and third-party payers-could not agree on what needed to be done.” (Rich, Chueng, Lurvey, 5) None of the parties involved, providers, consumers, or third party payers want their personal costs to rise. Consumers do not want lose their doctor, insurance, or quality of care. Employers do not want to face higher costs in providing coverage for employees, and Insurance companies want to maximize their profits, not see reductions in them. A balancing act between the parties needed to occur with the same grace a circus performer walks a tightrope.

In Congress, law makers had their hands full. They maintained a health reform debate between 2008 and 2010 which began with a bipartisan atmosphere, which slowly deteriorated throughout the process of passing of the Patient Protection and Affordable Act. Initially, “Democrats and many Republicans agreed that health insurance should be much more extensively available,” (Jacobs, Skocpol, 89) an attitude backed by polls from both parties which showed the majority of most constituents favored this attitude, which opened the door into amicable negotiations. The process looked as if it was proceeding smoothly, especially because “Hundreds of amendments proposed by House or Senate republicans received enough bipartisan support to make it into advancing legislation, and many concrete ideas about how to expand access or control costs came from Republican sources,” (Jacobs, Skocpol, 85) a counterintuitive fact in the forming of the PPACA. Furthermore, a special committee with encouragement from the White House formed called the “Gang-of-Six” (Jacobs, Skocpol, 23) was composed of three Democrats and three republicans to see if the two sides could find common ground. While Republicans and Democrats were making headway into the specifics of the law, special deals with parties that previously opposed healthcare reform were necessary in order to prevent the loss of reform legislation, yet again. However, as discussed later on in this project, separate issues regarding funding and final legislations of the PPACA eventually split the parties to the form as we know it today.

This proposed legislation would not work without health care providers, big drug companies, and private health insurance companies were brought along to back Congress. Therefore, deals were cut with each of these parties in order to make sure they would not pressure their legislators to make changes in the law. One discovery made during this research is that in order to assure laws are passed, sometimes deals like this were necessary. The PPACA had to please “employers, insurers, pharmaceutical companies, and for-profit providers” before the law was introduced in Congress. This tactic worked. How? They were significant enough to make a historical difference in the country. For example, health care providers were told health reform would “pay big, $171 billion for hospitals and $228 billion for doctors-and in turn the American Hospital Association agreed to accept $155 million less in Medicare payments over 10 years, while the American Medical Association consented to future payment reductions that amounted to $80 billion,” (Jacobs, Skocpol, 70) the American Medical Association in particular a significant contributor of support because of having a notoriously credible opposition to healthcare reform. Big drug companies were proposed a different deal. Private health insurance companies, significantly, were promised an “individual mandate” of health insurance, one of the most significant sections on the PPACA. These series of deals made with various parties were ultimately successful and other issues that occurred during the drama of health reform aside, the law passed in both the House and Senate.

The PPACA did not become law without facing opposition so deep that it eventually contested within the Supreme Court in 2011. Why? We are all aware on some level that this issue became very polarized. The partisan atmosphere faded as different voters became dissatisfied with particular aspects of the law. One significant factor of the law is how it is paid for. A significant part of the funding for the PPACA comes from taxes, particularly taxes of the rich. Since the rich are more likely to use their political representative, it is not surprising that some Republican politicians came to speak out against the law on this section of it alone. The tax rate of Medicare will “increase by 0.9%-from 1.45% to 2.35%-on earnings over $200,000 for individuals and $250,000 for families,” a fairly liberal aspect of the legislation. Aside from this, a 3.8% tax is imposed on unearned income of the affluent. It is almost like the battle is invited. Why should the rich have to spend their hard earned income on healthcare for the rest of the country? Professor Keepnews claimed “it is difficult not to let this polarization have an impact on how the issues are framed” (Keepnews, 3) and made the mistake of framing a block grant proposal as a republican proposal vs. a democratic view of supporting the act, and this language in describing health reform has become average discussion about health care. This comes into play much more fully later, before the PPACA goes into the Supreme Court.

**How is the final form of the PPACA intended to reform health?**

The Patient Protection and Affordable Healthcare act is supposed to reform health by easing the burdens of cost on the participants in the healthcare system and extending coverage to consumers without breaking the entire system by imposing costs that cannot be managed by consumers, providers, or the government as a whole. President Obama asserted many claims during the passage of the act, but his most important claim about the act is that it will provide cost control. Robert F. Rich, Eric Cheung, and Robert Lurvey in the *Journal of Health Care Law & Policy* complete an extensive write up of the PPACA in 2013. During their description of the stages of implementation of the law, they list the intended health insurance and health care delivery issues: “the growing number of adults and children who are uninsured, the inability of individuals with “pre-existing conditions” to obtain health insurance or affordable health insurance, the loss of health insurance for those who contract a serious health condition, the affordability of health insurance in general, and the general lack of access to health insurance for critical populations.” (Rich, Cheung, Lurvey, 6) The United States health care system is closely connected with the health insurance system, and without reforming it, cutting down on healthcare costs for individuals is not particularly practical. People need care. They pay for this care most often out of insurance, unless they can afford not to have it because they are affluent.

The biggest health insurance legislation of the entire law is referred to as the individual mandate. This mandate states “for those who are not exempt and who not receive health insurance through an employer or government program, insurance must be purchased through a private company” (NFOIB vs. Sebelius, 2) or face a penalty in 2014 called a “shared responsibility” payment to the government, collected through the IRS as a tax. The reasoning behind this mandatory payment is easily compared to the auto insurance industry. Everyone must have insurance to offset the costs on every person within the system. The PPACA makes the same argument for the individual mandate, that every person having insurance offsets costs on the entire system, especially those with insurance whose premiums must go up to pay for care that is never repaid, such as the care that is given by emergency rooms some cannot afford. Furthermore, the act takes insurance reform a step further by establishing “state health insurance exchanges, which allow individuals without employer-sponsored health insurance, Medicare or Medicaid to obtain insurance via the exchanges.” These steps of reform are made more significant because the Congressional Budget Office, a non-partisan organization which throughout the process of building health reform assessed how much particular laws are likely to make or save, estimates “that twenty-four million Americans will buy into the exchanges, and it is estimated that the average subsidy will be worth about $5,000 per year in 2011 dollars for a family of four,” (HealthCare.gov 2012) a good sign for those people are their concurrent lawmakers. The second major aspect of the law is from a mandated expansion of Medicaid.

Lilliard E. Richardson and Tansel Yilmazer wrote an article titled “Understanding the Impact of Health Reform on the States: Expansion of Coverage through Medicaid and Exchanges” published in the *Journal of Consumer Affairs* analyzes the effects of the Medicaid expansion and elaborates more closely on what is, and could happen in states as a result of the expansion. Following the passage of the law, they state “Medicaid eligibility can be immediately expanded by the states, and by 2014 everyone with household incomes under 133% of the Federal Poverty Level,” (Richardson, Yilmazer, 191) with 100% of the payment of the expansion paid for by the federal government in total for the first two years. The CBO estimates “an additional seventeen million Americans becoming eligible for Medicaid by 2014” (Richardson, Yilmazer, 191) although whether or not that many people will obtain insurance through Medicaid is not certain. It is not only the fact that people who were ineligible for Medicaid previously are now able to afford it, but the expansion is significant also because of more classes of people who are able to use Medicaid in general. Scholars have argued “the most significant change for Medicaid is the extension of Medicaid eligibility to adults with low income, particularly childless adults” because “currently, only five states offer full Medicaid benefits to childless adults,” (Rich, Chueng, Lurvey, 52) a startling change.

**What were the Legal and constitutional challenges to the PPACA?**

The law itself is long and complicated, therefore the one-hundred ninety three page “National Federation of Independent Business vs. Sebelius” is also long, but helpful for understanding of the law. The article, written and edited by employees of the court explains “There are two key provisions, constitutional challenges which are the subject of this article, the individual mandate, and a Medicaid expansion that will be able to cover Americans up to 133 percent of the poverty line” (NFOIB v. Sebelius, 1) 26 states, several individuals, and the National Federation of Independent Business brought suit in federal district court, challenging the constitutionality of the individual mandate and the Medicaid Expansion. (NFOIB v. Sebelius, 2)

“Unprecedented,” a Wall Street Journal credited book by Josh Blackman and Randy E. Bartlett writes on the Supreme Court case and the unusual manner in which the healthcare law circumvented the typical legal process and reasoning regarding the PPACA. In 2013, after the case is properly settled in the Supreme Court, the two explain there are six particularly compelling victories for the American people resulting from the case. Below:

“The federal government lacks power to compel people in economic activity, the government’s authority to solve problems that affect the “national economy” is not a blank check for expansion of federal power, Congress may not simply invoke the Necessary and Proper Clause to do an end-run around the limits of the commerce power, Congress cannot avoid the limits that Constitution places on its powers to govern by simply something a “Tax” after a law is enacted, any tax must be low enough to be non-coercive and preserve the choice to conform or pay the fine, and lastly, they show Congress’s power to compel states may be unconstitutional.” (Blackman, Bartlett, xii-xiv)

Another fact worth noting is law escalated to the Supreme Court in only two years, an unusually short amount of time for any case to advance from the state to the highest possible federal body. This is an indication of how politically charged the issue became, strong enough to attract the interests of the Supreme Court, and even have them rule on the issue differently than what is typical or expected. Michelle Biddulph and & Dwight G. Newman, authors of “Comparativist-Structural Approaches to Interpretation of the Post-Obamacare Spending Power” published in *Cardozo Journal of International & Comparative Law* elaborates on the justices legal reasoning during the case in comparison with what is normal for them. The final vote affirming the PPACA is 5-4, but “a number of the justices who form part of the majority on the spending power issue would typically be considered to be “originalists, who in principle, prioritize historical meaning or framers’ intent concerning the meaning of spending power Clause,” (Biddulph, Newman, 21) deviated from this reasoning and instead based their rulings on whether or not the law coerced the states into a behavior they could not control, which the fundamental rule in the joint opinion describes.

**What are credible concerns with the PPACA?**

**-The Medicaid Expansion will affect the separate states differently**

This statement is true. Not only is the statement true, but because it is true it has implications that affect the entire Medicaid expansion part of the law. The Supreme Court declared it unconstitutional for the federal government to make the expansion of Medicaid mandatory for the states to accept, therefore, they can make their own decisions on the issue. This is important particularly because different states have different amounts of people already registered for Medicaid. For those states that do not have a large amount of people enrolled already, the expansion is more of a burden because they need to change their markets to accommodate accordingly. This leaves states with some important decisions to make. For instance “the establishment of health insurance exchanges,” (Richardson, Yilmazer, 193) is left to state jurisdiction.

These exchanges are important because they will help “establish rules for insurance pricing, provide information to consumers regarding the options available to them, and provide for the selection and oversight of qualified health plans,” (Richardson, Yilmazer, 195) which are supposed to be for the interest of consumers. An article called “Medicaid Expansion: The Dynamic Health Care Policy Landscape” in *Nursing Economics* further elaborates on the effects of states decisions not to take funding for the government and expand their Medicaid program as of November 2013. According to this article, “Disproportionate share payments…to hospitals” (Joyce A. Hahn, Brenda Helen Sheingold, 267) will result in hospitals getting less funding as a part of the PPACA, but also not receiving the Medicaid expansion, which is not originally intended to be optional. Essentially, hospitals in states where the Medicaid expansion is passed lose. These kinds of conflicts in regards to the law are important to understand.

“There is no existing model in the United States for a full scale PPACA exchange,”(Robert E. Moffit, 2) despite the success of the exchanges in Utah, and budget concerns of separate states in particular will determine how well they take care of their citizens, as well as how much the people in different states without the exchange are able to push for it. As more positive impacts of the law emerge, they will. If not, they will not.

**-The law is a violation of Personal Liberty/Federalism**

This kind of reasoning is exactly what led to opposition of the act in the Supreme Court. Why? An article called “Enough About the Constitution: How States Can Regulate Health Insurance Under the ACA” is published in the *Yale Law and Policy Review* and helpful for explaining meaningful changes states must accommodate towards as a result of the legislation. They explain: “well over 150 million people are covered by employment health insurance plans, which are mostly or totally governed by ERISA,” (Brenda S. Maher, Radha A. Pathak, 286) the government body in place that managed healthcare plans before the PPACA replaced it.

However, these health plans were widely self-insured. Therefore, the federal government pre-ACA managed self-insured plans through ERISA, but now deeper federal involvement “amounts to a direct restraint on liberty” (Maher, Pathak, 287) in part because of the extensive media coverage without proper elaboration on the act. This Yale document intends to show a proper understanding of how states powers are enhanced/retracted is necessary in order to states to regulate themselves in an informed manner rather than by constituents who do not know and have no intention of finding out.

What is interesting here is that ERISA is a government fixture, just like the PPACA. It has been in place since 1974. The authors employ “Federalism-in-fact,” a perspective that shows the balance between state and federal power how it actually works vs. just talking about it. In sum, they offer

“the pre-ACA world was about employment-based, federally regulated health insurance with no serious private alternative…while the post-ACA world offers employment-based, federally regulated insurance that faces competitive pressure from individual, but group-rated, health insurance that is regulated cooperatively between federal and state governments” (Maher, Pathak, 306)

Attempting to show the reality vs. what is said, like the purpose of the project.

This argument against the act is given more consideration when one looks at the behavior of President Obama, who stated “the penalty of the ACA is not a tax,” but indeed the Supreme “Court's majority found that it was a tax pursuant to Congress's Taxing Power,” (Rich, Cheung, Lurvey, 14) and therefore were able to uphold it. If there were any credible concern to liberty, it comes from a report on the Heritage Foundation titled “Obamacare and the Individual Mandate: Violating Personal Liberty and Federalism.” They have a quote from the IRS Deputy Commissioner for Services and Enforcements saying “the IRS would withhold tax refunds if persons could not demonstrate that they purchased federally approved levels of insurance coverage,” (Robert E. Moffit, 2) certainly unwanted and questionable audits.

**-Will the Act really positively affect the Economy**

This honestly remains to be seen. The Medicaid expansion as written is supposed to cut down on healthcare costs eliminating care that is not paid for, estimated to cost “$18 billion between 2013-2022, as opposed to $8 billion” (Hahn, Sheingold, 270) if all states were to take in the program. Furthermore, although the Congressional budget office as issued claims of what savings may occur with the PPACA, they are based on the law being followed as written. Complications occurring from opposition of the law will alter what savings may occur. Still what is hopeful is “those who fashioned the Affordable Healthcare Act inserted into the legislation a multipronged framework for ratcheting down future payments, and delayed the start of many of these provisions,” (Jacobs, Skocpol, 145) meaning that the implementation of legislation “between 2011 and 2014, 2014 thru 2019, and beyond 2019” (Rich, Cheung, Lurvey, 6) will gradually see reduced costs in healthcare if things proceed as planned.

**What are less credible, popular claims against the PPACA?**

**-The Patient Protection and Affordable Healthcare Act is a “job-killer”**

The claims that the PPACA is a job killer are overblown. They are initially based on a 2010 report from the Congressional budget office that stated there would be a labor decrease amounting “one-half of one percent,” which the CBO explained would come about “primarily by reducing the amount of labor workers choose to supply. Other sources have reported small net job losses. These claims were at their height before and during the election of Mitt Romney, but there is no credible evidence to support the PPACA will result in significant job loss.

**-Premiums are going and up and down because of the healthcare law**

Republicans claim premiums are going up; Democrats say premiums are going down. In fact, premiums go up and down, and have for years, with or without the act. This is something else which remains to be seen, and even then, it will be hard to tell exactly how the act is responsible for the law without years to observe.

**How is the PPACA working in practice today in states?**

**Accepted/Rejected**

As of November 2013-December 2013, “25 states and the District of Columbia are moving forward with the expansion, 22 have decided not to move forward and the remaining three are still debating the issue,” (Hahn, Sheingold, 267) which sounds about right. 26 states raised suit against the act, the remaining are likely those who have not resisted. As mentioned earlier, hospitals without the expansion are suffering with funds that are removed and not replaced. However, a significant finding is “several new state-level studies find positive macroeconomic effects of the expansion for states,” (Dorn, Holahan, Caitlan, & McGrath, 2013) such as increased production, employment, wages, and state tax revenues directly related to new spending on Medicaid. This is some good news. This is to be watched closely in the coming years.

**Conclusion**

It is not “Obamacare,” it is the Patient Protection and Affordable Healthcare Act. It is a comprehensive attempt at Universal Healthcare that may ultimately cause more harm than good or more good than harm, but its effects remain to be seen. Some of its effects have already occurred and some of these are really good. Partisan issues separate truth from fiction. Research on what is true and what is not must continue, only through this will we move forward.