

Chapter 8

Health Care

Attempting a Rational-Comprehensive Transformation



ACCESS TO HEALTH CARE A free dental clinic in the Los Angeles Sports Arena in 2010 attracts thousands of patients. America offers the highest quality of medical care in the world, but not everyone has equal access to it. President Obama’s comprehensive health care reform act in 2010 includes an “individual mandate” that every person acquire health insurance by 2014 or face a tax penalty. (© Wendy Stone/Corbis News/Corbis)

8.1: Health Care in America

Can America transform its entire health care system according to a rational-comprehensive

plan? In 2010, President Barack Obama and a Democratic-controlled Congress acted to transform health care in America with the Patient Protection and Affordable Care Act. National health care had been attempted unsuccessfully by past presidents, including Franklin D. Roosevelt, Harry

Truman, and Bill Clinton. According to President Obama: “Moving to provide all Americans with health insurance is not only a moral imperative, but it is also essential to a more effective and efficient health care system.”¹ But the question remains whether such a rational-comprehensive approach will improve the quality of health care in America, or reduce its costs, or improve access to health care, or achieve any of these goals.

Perhaps the first obstacle to a rational approach in health care is to define the problem. Is it our goal to have *good health*—that is, whether we live at all (infant mortality), or how well we live (days lost to sickness), or how long we live (average lifespans)? Or is our goal to have *good medical care*—frequent visits to the doctor, well-equipped and accessible hospitals, and equal access to medical care by rich and poor alike?

The first lesson in health policy is understanding that good medical care does not necessarily mean good health. Good health correlates best with factors over which doctors and hospitals have no control: heredity, lifestyle (smoking, obesity, drinking, exercise, worry), and the

physical environment (sewage disposal, water quality, conditions of work, and so forth). Most of the bad things that happen to people’s health are beyond the reach of doctors and hospitals. In the long run, infant mortality, sickness and disease, and life span are affected very little by the quality of medical care. If you want a long, healthy life, choose parents who have lived a long, healthy life, and then do all the things your mother always told you to do: don’t smoke, don’t drink, get lots of exercise and rest, don’t overeat, relax, and don’t worry.

8.1.1: Leading Causes of Death

Historically, most of the reductions in infant and adult death rates have resulted from public health and sanitation, including immunization against smallpox, clean public water supply, sanitary sewage disposal, improved diets, and increased standards of living. Many of the leading causes of death today (see Table 8-1), including heart disease, stroke, cancer, accidents, and suicides, are closely linked to personal habits and lifestyles.

Table 8-1 Leading Causes of Death^a

Many of the leading causes of death today are closely linked to personal habits and life styles; the overall death rate has declined significantly since 1960.

Cause of Death	1960	1970	1980	1990	2000	2008	2012
Heart disease	369.0	362.0	334.3	289.0	257.5	203.1	191.4
Stroke (cerebrovascular)	108.0	101.9	80.5	57.9	60.2	44.0	41.4
Cancer	149.2	162.8	181.9	201.7	200.5	186.2	184.6
Accidents	52.3	56.4	48.4	37.3	33.9	39.9	39.4
Pneumonia	37.3	30.9	26.7	31.3	24.3	18.5	17.2
Diabetes	16.7	18.9	15.5	19.5	24.9	23.2	23.5
Suicide	10.6	11.6	12.5	12.3	10.3	11.8	12.3
Homicide	4.7	8.3	9.4	10.2	5.8	5.9	4.9
AIDS/HIV	—	—	—	9.6	5.4	4.0	3.8
Alzheimer’s disease	—	—	—	—	21.8	27.1	27.2

^aDeaths per 100,000 population per year.

SOURCE: Center for Disease Control, www.cdc.gov/nchs

8.1.2: Costs and Benefits: Cross-National Comparisons

The United States spends more of its resources on health care than any other advanced industrialized nation, yet it ranks below other nations in many key measures of the health of its people (see Figure 8-1). Life expectancy in the United States is lower, and the infant death rate is higher, than in many of these nations. The United States offers the most advanced and sophisticated medical care in the world, attracting patients from countries that rank ahead of us in these common health measures. The United States is the locus of the most advanced medical research in the world, drawing researchers from all over the world. This apparent paradox—the highest quality medical care, combined with poor health statistics for the general public—

suggests that our nation's health care problems center more on access to care, education, and prevention of health problems than on the quality of care available.

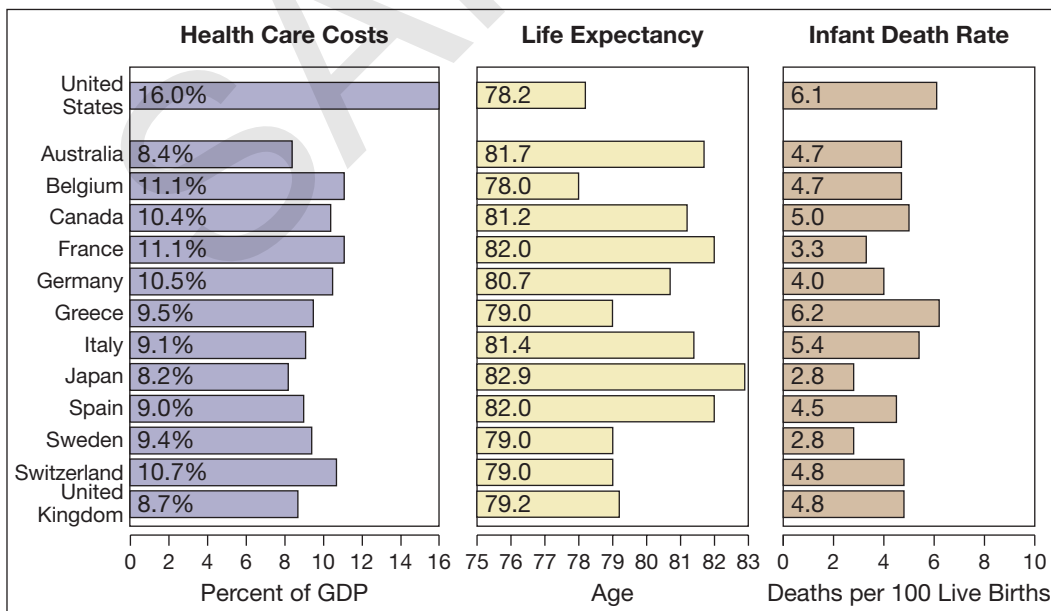
8.1.3: Health Care Costs

The United States spends over \$2 trillion on health care each year—over \$7,000 per person. These costs represent nearly 16 percent of the GDP and they are growing rapidly. It is estimated that by 2017 almost 20 percent of the GDP—more than \$4 trillion—will be spent on health care. The enactment of the Medicare and Medicaid programs in 1965 and their rapid growth since then contribute to this inflation of health care costs. But there are many other causes as well. Advances in medical technology have produced elaborate and expensive equipment. Hospitals

Figure 8-1 Health Care Costs and Benefits: A Cross-National Comparison

The United States spends a larger proportion of its GDP on health care than any other nation, yet people in other nations enjoy better overall health than Americans.

SOURCE: *Statistical Abstract of the United States*, 2013, pp. 842, 843, 845.



that have made heavy financial investment in this equipment must use it as often as possible. Physicians trained in highly specialized techniques and procedures wish to use them. The threat of malpractice suits forces doctors to practice “defensive medicine”—to order multiple tests and consultations to guard against even the most remote medical possibilities. Pharmaceutical companies have driven up spending for drugs by advertising expensive brand-name prescription drugs on television, encouraging patients to ask their doctors for these drugs. (Prior to 1997 direct advertising for prescription drugs was not permitted.) Cheaper generic versions of the same drugs receive no such publicity.

8.1.4: An Aging Population

In the not-too-distant future, an aging population (see Figure 8-2) will drive up medical care costs to near astronomical figures. Currently, one-third of all health care expenditures benefit the aged.

8.1.5: Medical Care as a Right

Americans now generally view access to medical care as a right. No one should be denied medical care or suffer pain or remedial illness for lack of financial resources. There is widespread agreement on this ethical principle. The tough questions arise when we seek rational strategies to implement it.

8.2: Incremental Strategies

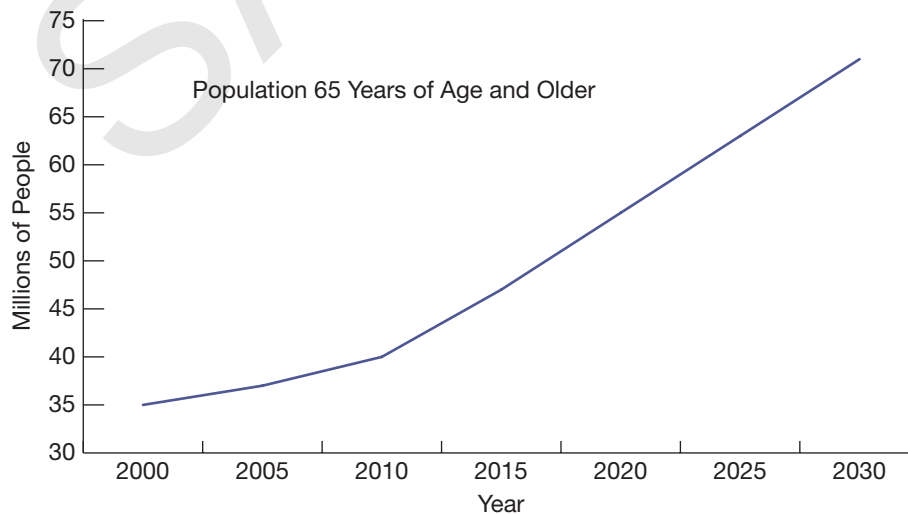
Medicare, Medicaid, SCHIP

America’s national health care policy traditionally reflected an incremental approach. Medicare was enacted in 1965 as an amendment to the Social Security Act of 1935, and it represented an extension of the social insurance principle. It covers persons aged 65 and over regardless of income.

Figure 8-2 The Aging of America

Increases in the nation’s aged population increase health care costs and threaten to exhaust Medicare funds.

SOURCE: U.S. Census Bureau Projections of the Population by Selected Age Groups. www.census.gov



Hospital care is covered from premiums added to the Social Security payroll tax; physician services are covered from modest premiums deducted from recipients of Social Security checks. Medicaid was enacted at the same time to provide health care for the poor. It represented an extension of the federally-aided state welfare programs begun in the 1930s. A State Child Health Insurance Program was added in 1997, with bipartisan support in Congress. It offered grants to states to provide health insurance for children whose family income was less than 200 percent of the poverty level.

8.2.1: Medicare: Health Care as Government Insurance

Medicare provides prepaid hospital insurance and low-cost voluntary medical insurance for the aged, directly under federal administration. Medicare includes HI—a compulsory basic health insurance plan covering hospital costs for the aged, which is financed out of payroll taxes collected under the Social Security system—and SMI—a voluntary, supplemental medical insurance program that will pay 80 percent of “allowable” charges for physicians’ services and other medical expenses, financed in part by contributions from the aged and in part by general tax revenues.

Only *aged* persons are covered by Medicare provisions. Eligibility is not dependent on income; all aged persons eligible for Social Security are also eligible for Medicare. No physical examination is required, and preexisting conditions are covered. The costs of SMI are so low to the beneficiaries that participation by the elderly is almost universal.

Medicare requires patients to pay small initial charges or “deductibles.” The purpose is to discourage unnecessary hospital or physician care. HI generally pays the full charges for the first 60 days of hospitalization each year after a deductible charge equivalent to one day’s stay;

but many doctors charge higher rates than allowable under SMI. Indeed, it is estimated that only about half of the doctors in the nation accept SMI allowable payments as payment in full. Many doctors bill Medicare patients for charges above the allowable SMI payments. Medicare does not pay for eyeglasses, dental expenses, hearing aids, or routine physical examinations.

8.2.2: Medicaid: Health Care as Welfare

Medicaid is the federal government’s largest single welfare program for the poor. Its costs now exceed the costs of all other public assistance programs—including family cash assistance, SSI, and the food stamp program. Medicaid was begun in 1965 and grew quickly.

Medicaid is a combined federal and state program. The states exercise fairly broad administrative powers and carry almost half of the financial burden. Medicaid is a welfare program designed for needy persons: no prior contributions are required, monies come from general tax revenues, and most recipients are already on welfare rolls. Although states differ in their eligibility requirements, they must cover all people receiving federally funded public assistance payments. Most states also extend coverage to other “medically needy”—individuals who do not qualify for public assistance but whose incomes are low enough to qualify as needy.

States also help set benefits. All states are required by the federal government to provide inpatient and outpatient hospital care, physicians’ services, laboratory services and X-rays, and nursing and home health care. They must also develop an early and periodic screening, diagnosis, and treatment program for all children under Medicaid. However, states themselves decide on the rate of reimbursement to hospitals and physicians. Low rates can discourage hospitals and physicians from providing good care. To make up for low payments, they may schedule too many patients

in too short a time, prescribe unnecessary tests and procedures to make treatment expensive, or shift costs incurred in treating Medicaid patients to more affluent patients with private insurance.

8.2.3: SCHIP: Health Care for Children

Under the State Children's Health Insurance Program (SCHIP), the federal government provides grants to states to extend health insurance to children who would not otherwise qualify for Medicaid. The program is generally targeted toward families with incomes below 200 percent of the poverty level. But each state may set its own eligibility limits and has flexibility in the administration of the program. States may expand their Medicaid programs to include children or develop separate child health programs.

8.3: Health Care Modifications

Over the years significant modifications were made in both private and governmental insurance programs.

8.3.1: Managed Care Programs

Skyrocketing costs caused both governments and private insurance companies to promote various types of "managed care" programs. Both Medicare and Medicaid shifted many of their beneficiaries to managed care programs.

Health maintenance organizations (HMOs) are the most common type of managed care program. They try to control costs by requiring patients to use a network of approved doctors and hospitals, and by reviewing what these "preferred" caregivers do. For example, a managed care organization might insist that doctors prescribe cheaper generic drugs in place of brand-name products. In many cases, patients must get the organization's

approval before undergoing operations or other treatments. And patients have to pay more to visit a doctor who is not in the network. In contrast, under traditional "fee-for-service" health insurance plans, the patient chooses a doctor, gets treated, and the bill is sent to the insurance company. The patient may have to pay a deductible for a percentage of the total bill—a "co-pay."

8.3.2: Controversies over Managed Care

Efforts of private insurers and government to control costs created new political controversies. Many of the cost-control regulations and restrictions instituted by insurance companies and HMOs frustrate both patients and physicians. For example, both doctors and patients complain that preapproval of treatment by insurance companies removes medical decisions from the physician and patient and places them in hands of insurance company administrators. Patients complain that HMOs refuse to allow them to see specialists, limit the number and variety of tests, and encourage doctors to minimize treatment.

8.3.3: Patients' Bill of Rights

The growth of managed care health plans, with their efforts to control costs, fueled the drive for a "patients' bill of rights." The most common proposals are those allowing patients to see specialists without first obtaining permission from a representative of their health plan, provide emergency care without securing prior approval from their health plan, allowing immediate appeal if the patient is denied coverage for a particular treatment, and giving patients the right to sue their health plans for medical mistakes. Various states have adopted these proposals. But the health care industry, including HMOs, argue that these proposals increase the cost of health insurance and open health care providers to patients' lawsuits.

8.3.4: Prescription Drug Costs

Prescription drugs are more costly in the United States than anywhere else in the developed world. The American pharmaceutical industry argues that the higher prices that Americans pay help to fund research on new drugs, and that drug price controls would curtail the development of new and potentially life-saving drugs. Likewise, they argue that laws mandating the early expiration of drug patents, or laws encouraging the use of generic competition, would adversely affect research and development in pharmaceuticals. In effect, Americans are being asked to subsidize drug research that benefits the entire world.

Many Americans have resorted to importing drugs from Canada or other nations that have much lower prices than those being charged in the United States. The Food and Drug Administration contends that this practice is illegal. Drug companies claim that imported drugs may not be safe, a highly dubious claim, inasmuch as they are the same drugs shipped by the American drug companies to Canada and other nations.

8.3.5: Prescription Drug Coverage Under Medicare

The long battle over adding prescription drug coverage to Medicare finally came to an end in 2003 when Congress passed and President George W. Bush signed such a bill. The bill was welcomed by the AARP and most seniors, but it promises to significantly increase the costs of Medicare over the long term. Prescription drugs have been covered by Medicaid since its inception.

8.4: The Health Care Reform Movement

Over the years health care reform efforts centered on two central concerns: controlling costs and expanding access. These concerns are related:

expanding access to Americans who are uninsured and closing gaps in coverage increases spending, even while the other thrust of reform is to slow the growth of overall health care costs.

8.4.1: The Single-Payer Plan

Liberals have long pressed for a Canadian-style health care system in which the government would provide health insurance for all Americans in a single national plan paid for by increases in taxes. In effect, a single-payer plan would expand Medicare to everyone, not just the aged. The plan boasts of simplicity, savings in administrative costs over multiple insurers, and direct federal control over prices to be paid for hospital and physician services and drugs. Single-payer universal coverage would require major new taxes.

8.4.2: America's Reliance on the Private Market

"Socialized medicine" was never very popular with the American people. They enjoyed the finest medical care in the world, with the most advanced treatments, state-of-the-art equipped hospitals and clinics, the world's best medical schools, and the best-trained medical specialists. American pharmaceutical companies led the way in research and development of life-saving treatments. The nation relied largely on the private market and individual choice in providing health care. Employer-sponsored private health insurance, together with individually purchased policies, covered over half of the population. Medicare covered the aged and Medicaid covered the poor. Over 85 percent of Americans were covered by private or government insurance. Heavy majorities of Americans expressed satisfaction in national polls with their own health care.

8.4.3: The Uninsured

Prior to health care reform, many working Americans and their dependents had no health

insurance; about 15 percent of the nation's population. Many of these uninsured postponed or went without needed medical care; many were denied medical care by hospitals and physicians except in emergencies. Confronted with serious illness, many were obliged to impoverish themselves to become eligible for Medicaid. Their unpaid medical bills, including emergency room visits, were absorbed by hospitals or shifted to paying patients and their insurance companies. Many uninsured people work for small businesses or were self-employed or unemployed.

8.4.4: Portability, Preexisting Conditions

People with preexisting conditions, such as heart disease, hypertension, or cancer, faced formidable problems in obtaining and keeping health insurance. Some modest reforms were enacted in 1996 when Congress guaranteed the "portability" of health insurance—allowing workers to maintain their insurance coverage if they change jobs. Their new employer's health insurance company cannot deny them insurance for "preexisting conditions." But the act did not bar increases in premiums, nor did it require the coverage of preexisting conditions in new policies. The failure of insurance companies to address the issue of preexisting conditions contributed heavily to support for more comprehensive reforms.

8.5: Health Care Transformation

President Barack Obama and a Democratic-controlled Congress acted to transform health care in America with the Patient Protection and Affordable Care Act of 2010. Incremental change was rejected in favor of a 2600-page rational-comprehensive plan.

America's health care system will continue to rely primarily on private health insurance

companies. However, private insurers will no longer be permitted to deny insurance for preexisting conditions, or to drop coverage when patients get sick, or to place lifetime limits on coverage. Dependent children under age 26 can be covered under their parents' insurance plan. These particular reforms faced no serious opposition in Congress.

But many provisions in the lengthy bill stirred intense controversy. Republicans in both the House of Representatives and the Senate were unanimous in their opposition to the overall bill. Among its many provisions:

8.5.1: Individual Mandate

Every American is required to purchase health insurance beginning in 2014 or face a tax penalty up to 2.5 percent of their household income. The Internal Revenue Service is charged with enforcing this individual mandate.

8.5.2: Employer Mandate

Employers with 50 or more workers are obliged to provide health insurance to their employees. Companies that fail to do so will face substantial fines. Small businesses are offered tax credits for offering their employees health insurance.

8.5.3: Medicaid Expansion

State Medicaid eligibility is expanded to include all individuals with incomes up to 133 percent of the federal poverty level. The federal government will initially fund this new state mandate, but eventually the states must fund increasing shares of it themselves. However, the U.S. Supreme Court held that states can decline to participate in Medicaid expansion without losing all of their federal Medicaid funds.²

8.5.4: Health Insurance Exchanges

The federal government assists states in creating "exchanges" or marketplaces where individuals

and small businesses can purchase health insurance from private companies. Health plans offered through the exchanges must meet federal requirements, including coverage for preventative care. Federal subsidies are available for individuals who earn between 133 and 400 percent of the federal poverty level. High risk pools are created to cover individuals with preexisting conditions.

8.5.5: Taxes

A surtax of 3.8 percent is imposed on personal investment income of individuals with adjusted gross income of \$200,000 or couples with adjusted gross income of \$250,000 or more. An excise tax is placed on high cost (“Cadillac”) private health care plans as well as on medical devices. New fees are imposed on health insurance companies and on brand-name drug manufacturers.

8.5.6: No “Public Option”

Congress rejected President Obama’s proposed “public option”—a government-run nonprofit health insurance agency that would compete with private insurers. The president had argued that a public option was necessary “to keep them honest” by offering reasonable coverage at affordable prices. But critics warned that the public option threatened a “government takeover” of the nation’s health care system. Over time private insurance companies would lose out to the public program, eventually creating a single national health insurance system or “socialized medicine.” Liberals in Congress were disappointed when the public option was dropped from the bill.

8.5.7: Costs

President Obama argued that the cost of health care reform could be recovered in savings from the existing health care system—“a system that is currently full of waste and abuse.” The president claimed that eliminating waste and inefficiency in Medicare and Medicaid could pay for most of

his plan. But critics doubt that such savings exist. Indeed, the proposal to cut waste and abuse in Medicare inspired critics to claim that health care reform is coming at the expense of the elderly.

Controversy surrounds estimates of the true costs of the Act. The addition of millions previously uninsured Americans into the nation’s health care system is likely to produce strains on hospitals and physicians. Costs are likely to increase, and there is the possibility that health care will be rationed. End-of-life care accounts for a substantial portion of total health care costs; critics of the Act fear that such care will become the target of cost-cutters.

8.6: Challenges to “Obamacare”

Republicans in Congress were unanimously opposed to the Patient Protection and Affordable Care Act of 2010—“Obamacare.” They promised to repeal it, if possible, or if not, to obstruct its implementation. Attorneys General in twenty-six states and the National Federation of Independent Business brought suit in federal court challenging the constitutionality of the Act.

8.6.1: The Constitutionality of the Individual Mandate

At the heart of Obamacare is the requirement that every American must obtain health insurance. The health-insurance industry itself strongly supports this provision; it generates customers including younger and healthier people. It also enables insurers to accept the risks of covering people with costly preexisting conditions. The Supreme Court decided to hear the case in 2012 even though the individual mandate was not scheduled to go into effect until 2014.³

Chief Justice John Roberts wrote the majority, 5 to 4, opinion in this important case. He first determined that the individual mandate *cannot* be

upheld under Congress's power to regulate interstate commerce. Allowing Congress to command people to buy a product—health insurance—would open a vast new domain of federal power. The Founders gave Congress the power to *regulate* commerce not to *compel* it. Ignoring this distinction would undermine the principle that the federal government is a government of limited and enumerated powers.

However, Roberts concluded that the individual mandate is actually a *tax*, and as such it is a constitutional exercise of Congress's power to "lay and collect taxes" (Art. I Sect 8). The Act itself refers to a "penalty" for noncompliance. But Roberts held that "every reasonable construction must be resorted to, in order to save a statute from unconstitutionality."⁴ He reasoned that the individual mandate can be interpreted as a tax on those who choose to go without insurance. He observed that the tax is administered and collected by the Internal Revenue Service.

8.6.2: State Compliance with Medicaid Expansion

The Act authorizes the Secretary of Health and Human Services to withdraw existing Medicaid funds from any state that refuses to participate in the Act's expansion of the program. However, Roberts held that this provision of the Act "runs counter to this nation's system of federalism." The threatened loss of *all* Medicaid funds leaves the states with no real option but to acquiesce in Medicaid expansion. To be constitutional under the spending clause of the Constitution, states must voluntarily accept the terms of the program. States cannot be compelled to participate in a federal program.

8.6.3: IRS Enforcement

Americans who do not purchase health insurance by 2014 are subject to a fine to be levied by the IRS at tax time. The Act authorizes IRS to determine who is not in compliance, to levy fines, and

to withhold the fines from tax refunds. Opponents in Congress may seek to prevent IRS from enforcing the law, perhaps by "defunding" the cost of administration. But President Obama has pledged to veto any attempt to weaken the individual mandate or its enforcement.

8.6.4: State Participation in Exchanges

States are authorized by the Act to create health insurance exchanges to provide coverage for individuals and small businesses by pooling them into larger groups to buy insurance from private companies. States can refuse to participate, which might complicate the administration of a key provision of the Act. But the federal government is authorized to step in where the states fail to create these exchanges.

8.6.5: The Supreme Court Rules on State Exchanges

The Act provides for patient insurance subsidies if the patient is enrolled in an insurance exchange "established by the state." However, over half of the states refused to create such exchanges; in these states the federal government stepped in and created its own exchanges. But the wording of the Act provided subsidies *only* to exchanges established by the states. The Obama administration, however, proceeded to provide subsidies to both state and federal exchanges, in apparent violation of the wording of the law.

The Supreme Court held, however, that the "broader structure of the Act" was designed to provide subsidies to all qualifying Americans. Chief Justice John Roberts ruled that Congress intended to provide subsidies to both state and federal exchanges.⁵

8.6.6: "Rationing" Care

Health care reform will expand health insurance coverage to virtually all Americans. Millions of

people will be brought into the nation's health insurance system. But critics fear that this influx of patients will overload doctors and hospitals, leading to long waits and perhaps "rationing" of care. Government limits on physicians' fees may cause doctors to turn away Medicare, Medicaid, and government-subsidized patients.

8.6.7: No Tort Reform

Health care reform largely fails to contain the nation's burgeoning health care costs. Congress failed to include any provision for the reform of medical malpractice litigation. Lawsuits against physicians, hospitals, and insurers are a major cause of increased health care costs. Physicians must pay exorbitant fees for malpractice insurance. More importantly, physicians are inspired by fear of lawsuits to order numerous tests and procedures not necessary for good medical practice. Tort reform would pay for the actual lifetime cost of medical errors but place a cap on "pain and suffering" damages.

8.6.8: Administrative Failures

Obamacare got off to a poor start in 2014 with citizens unable to enroll in the program because

of glitches in Internet access. Later, the President was forced to postpone various provisions of the Act including the employer mandate.

The President while campaigning for the Act had promised that "if you like your healthcare plan, you can keep your healthcare plan." But his promise was misleading at best. Insurance plans that do not meet new federal criteria must be canceled. Millions of existing plans have been canceled because of the Act. Indeed, many of the new signees under state Obamacare exchanges turned out to be people whose former plans were canceled. It is not clear how many of the new enrollees were persons who previously had no insurance.

State health insurance exchanges frequently offer only a limited number of plans. They determine, based on the enrollees stated income, how much of the cost of each plan can be covered by a federal subsidy. Plans and subsidies are often confusing to enrollees. New plans are generally more expansive, with higher deductions, and limited numbers of doctors available. However, government subsidies based on income reduce the monthly costs to qualified enrollees.

Summary: Health Care

The Patient Protection and Affordable Care Act of 2010 represents an attempt to transform the American health care system according to a rational-comprehensive government plan. Prior to 2010, the nation relied primarily on market-based, private, employer-sponsored group and individual insurance, together with Medicaid for the aged and Medicare for the poor. These government programs were amendments to the original Social Security Act of 1935 and represented incremental modifications of social insurance and welfare programs. "Obamacare"

is a rational-comprehensive departure from previous policy. It is true that Obamacare retains the private insurance principle, but the federal government now plays the leading role in deciding about health care for all Americans.

1. Is the principal objective of health care policy good health, as defined by lower death rates, less illness, and longer life? Or is it access to good medical care? If good health is the objective, preventative efforts to change people's personal habits and lifestyles are more likely

- to improve health than anything else. Many of the leading causes of death—heart disease, stroke, cancer, cirrhosis of the liver, accidents, and suicides—are closely linked to personal habits and lifestyles.
2. The United States spends more of its economic resources on health care than any other nation in the world. Currently about 16 percent of the nation's GDP is devoted to health care, a figure that appears to rise each year. An aging population promises to drive up medical costs even further.
 3. The United States boasts of the finest medical care in the world, the finest medical schools, and the best-trained medical specialists. Yet despite high costs and quality medical care, the United States ranks well below many other advanced nations in overall health statistics, including life expectancy and infant mortality rate.
 4. Medicare was enacted in 1965 as an extension of the nation's Social Security program for the aged. It includes a basic health insurance plan covering hospital costs which is financed out of payroll taxes collected under Social Security payroll deductions. It also includes a voluntary supplemental medical insurance program that pays 80 percent of government approved charges for physicians' services and other medical expenses, financed in part by contributions from the aged.
 5. Medicaid is the federal government's largest single welfare program. Medicaid is a federally aided, state-administered welfare program designed for needy persons; no prior contributions are required; financing comes from general tax revenues. States pay about half of the costs of Medicaid, and they have considerable flexibility in its administration. The federal government also provides grants to states to extend health insurance to children under the State Children's Health Insurance Program (SCHIP).
 6. Over the years, various incremental modifications were made in both private and government insurance programs, including the growth of health management organizations (HMOs) designed to control costs. Other modest changes included a patient's bill of rights, portability of health insurance, and prescription drug coverage under Medicare.
 7. But reformers continued to be concerned with the plight of the uninsured. Employer-sponsored private health insurance, together with individually purchased policies, covered over half of the population. Medicare covered the aged, and Medicaid covered the poor. Over 85 percent of the American people were covered by either private or government insurance. But about 15 percent of the nation's population were uninsured.
 8. President Barack Obama and a Democratic-controlled Congress rejected incremental change in favor of a rational-comprehensive government plan—the Patient Protection and Affordable Care Act of 2010. Among its many provisions: an individual mandate requiring every American to purchase health insurance by 2014 or face a tax penalty; a mandate that employers with 50 or more workers provide health insurance to their employees; the mandated expansion of Medicaid to include all individuals with incomes up to 133 percent of the federal poverty level; the creation of state "exchanges" or marketplaces where individuals and small businesses can purchase government-approved health insurance from private companies. Congress rejected President Obama's proposal for a "public option"—a government-run health insurance agency that would compete with private insurers.
 9. Republicans in Congress were united in their opposition to the Act. They pledged to repeal

“Obamacare” but that strategy is doomed to failure as long as Barack Obama possesses a presidential veto. Rather, Republicans in Congress may try to curtail funding for various provisions of the Act.

10. Chief Justice John Roberts, writing for a 5-4 majority of the Supreme Court, in 2012 held that the individual mandate under Obamacare was a constitutional exercise of Congress’s power to tax.

SAMPLE