

Legality and Controversy of the Patient Protection and Affordable Health Care Act

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## Introduction

The Patient Protection and Affordable Health Care Act (PPACA), more commonly referred to as “Obamacare”, was signed into law by President Barack Obama in March 2010 (Stempel 2012). This health care reform act is the biggest action for health care since the introduction of Medicare and Medicaid in the 1960s. This Act will bring about changes over a ten-year span, starting as soon as the bill was signed. The changes start out slow, such as a 10% tax being put on indoor tanning in July 2010 (Pettypiece 2010). As time goes on, bigger and bigger changes will take place.

While there are many positive things that PPACA, there are as many controversies. I have chosen three specific problems to focus on for this paper: the taxes that will be assessed if an individual doesn’t have health care, known as the “individual mandate”, employers having to pay for their employee’s contraception, and the expansion of Medicaid. While analyzing these controversies, I will also look at the legality of the Act.

This Act, and the problems that go along with it, need to be analyzed for several reasons. Many people have questioned if the law is actually constitutional. Recently, the United States Supreme Court upheld the section of the law that lines out the individual mandate (Stempel 2012). Secondly, and just as important, many people are not aware of the mandates laid out in the Act.

## Literature Review

For most of its life, the United States has practiced incrementalism. Policymakers make policy because they’re trying to be rational. To make the most rational decision possible, they look to previously made decisions to help them (Smith 2009). Making decisions by looking at those previous decisions helps policymakers write policy quicker (Smith 2009). This is due mostly to the fact that our founders were wary of giving one branch of government too much power, so the power was distributed across a decentralized government (Patel 1999). Because of the spreading of

power, no one person or entity has had the power to enact radical changes quickly, so nearly all legislative changes happen over time and are based off of previous laws and policies. Policymakers tend to focus on very few alternatives to bring about change, instead of looking at the “big picture”; their main goal is to please everyone, or “satisfice”, instead of actually solving a problem (Patel 1999). Policy also comes from demands of action or deliberate inaction (Weissert 2002).

Health care in America has also followed a similar incremental system. Creating health care legislation requires policymakers to examine existing laws and adding new public laws or amendments to them (Longest 2006). These changes are brought about due to the “interactions of a diverse array of health-related problems, possible solutions to the problems, and dynamic political circumstances that relate both to the problems and their potential solutions (Longest 2006). There have been many pieces of legislation regarding health care that have passed since the founding of our country. The first significant piece of legislation that was passed was in 1798 by President John Adams (Patel 1999). Since that law, which provides relief for sick and disabled seamen and approved the establishment of the first Marine Hospital, many more pieces of legislation and policy have been passed in regards to health care (Patel 1999). With those laws being passed, health care has become more and more socialized. PPACA seeks to broaden the socialization of medicine in the name of trying to provide all Americans with insurance.

Since the 60's, there has been a movement to implement government-ran health care, but scandal and other issues have usually thwarted those plans (Altman 2011). Over the years, health care costs have soared, and left many Americans in massive debt. Since the early 90's, Americans have had a negative view of the health care system and have sought reform (Patel 1999). Now more than ever, the parties are attempting to work together to bring about reform. While each side may not agree on everything that PPACA contains, there is a great deal of interest-based negotiation. The

political parties of our country are now having to collaborate with each other to seek “overlapping objectives” (Marcus 1995).

One of the biggest issues that has plagued health care is the efficiency-versus-cost question. Many people feel like some of the tests that their doctors order are unnecessary. This question comes to the forefront when a test or procedure will provide little to no help to the patient. Altman asks, “should [a] health care plan provide a \$250,000 bone marrow transplant when there is very little or no evidence the treatment will be efficacious?” (2011). People consume the most medical service in the last part of their lives; over 27% of our country’s annual expenditures on health care come from the last year of people’s lives (Altman 2011). PPACA hopes to reduce these expenses by providing preventive care coverage (Healthcare.gov).

The economic climate also plays into how health care legislation is passed. When President Obama was first elected, the United States was in the worst economic crisis since the Great Depression. The unemployment rate was staying around 10%, the mortgage crisis was in full swing, and retirement plans were being canceled because the stock market had crashed and emptied their savings (Altman 2011). His proposed health care reform would cost the government about \$1 trillion in its first 10 years, with about half of that would come from raising taxes and fees (Altman 2011). Health care costs are at an all-time high, however, and Americans are tired of the way health care is run. It’s becoming more and more expensive to have health insurance; between 2000 and 2010, wages for the average worker grew only 20% while the cost of health care rose almost 100% (Altman 2011). The United States spends \$2.5 trillion on health care, which adds up to more than \$8,000 a person (Altman 2011). In places with socialized medicine, however, health care costs are less than half of that expense. Health care spending is currently one-fifth of our economy (Altman 2011). These high costs make Americans want a radical change, which is part of the reason why

PPACA was passed despite the current economic climate. Health care in America is outdated, and people are seeking a drastic change.

### Problem Analysis

#### Problem 1: Tax Penalty

During the 2008 Presidential campaign, Democratic candidate Obama made a bold promise: no new taxes on families making less than \$250,000 per year (Hicks 2012). Within PPACA, there have been promises of tax credits instead of tax increases for people between 100 and 400 percent of the poverty level (Hicks 2012). For the young people of America, they are now covered on their parent's insurance until their 26<sup>th</sup> birthday, regardless of their education status or marriage. There is an "individual mandate" section of PPACA that requires all Americans to have health insurance by 2014. Employers are also required to provide health care to their employees. Currently, 96.5% of large businesses provide their employees' health care coverage, while only 43.2% of small businesses providing health care (Altman 2011). Along with this, small businesses with less than 50 employees will receive tax credits (Hicks 2012).

The "individual mandate" clause in PPACA is very complicated: you have to have health insurance that is "minimally comprehensive" if you can afford it (Kliff 2012). The Act states that someone who can afford health insurance is someone who makes more than the Federal poverty line, and that the cost of buying health insurance won't exceed 8 percent of their monthly income (Kliff 2012). To find out where you fit it on the "individual mandate" clause of the Act, President Obama's website has a tool that allows you to enter in your information. After inputting your information, you will be told one of three options: you have to buy insurance, you are excluded from the "individual mandate", or you will receive Medicaid. For individuals that choose to pay the penalty instead of purchasing health care, there is a gradual increase in the amount of the penalty. Starting in 2014, when the mandate starts, the penalty will be \$95 or 1% of the adjusted gross

income per adult (Hicks 2012). In 2015, the percentage charge goes to 2% or \$325 per adult, and again to 2.5% or \$695 per adult in 2016 (Hicks 2012).

This section of PPACA is a political problem for three main reasons. First, the wording of this section is exceedingly complicated. Many people don't know where they fit into the spectrum of health care, so they are worried about this section in particular. A second problem is if this section encroaches on people's right to buy whatever insurance they see fit to purchase. Many people take offense to being "forced" to purchase health insurance, and the right amount of insurance. Recently, the Supreme Court upheld the "individual mandate" section of PPACA in a 5-4 decision, which will be discussed in more detail later (Stempel 2012).

The final problem from this section is that health care is expensive. While PPACA has promised to reduce health care costs, buying health insurance is exceedingly expensive. Many Americans have insurance through their employers. Many employers, however, may start dropping their insurance plans if they decide that paying the penalty is cheaper than providing insurance plans for their employees. This section may also put increased burden on small businesses; they will more than likely try to stay under 50 employees in order to avoid having to pay for their employee's insurance, which will reduce their ability to meet increased demand.

This deviates directly from incrementalism. Never in American history has health insurance been required to be owned by every citizen, and not having health insurance has never caused people to have to pay a tax penalty for not having coverage. Also, this mandate has had a fast timeline: PPACA was passed in 2010, and the mandate will go into effect in 2014. According to a poll, 72% of Americans believe that the individual mandate section of the Act is unconstitutional (Mak 2012). While the idea of an individual mandate may be rational, its timeline for inception goes against the norm that American citizens have become used to.

## Problem 2: Contraception

A big headline-grabber from this Act has been over the issue of contraception, namely who pays for it. Starting on September 23, 2010, many types of preventive care were required to have no cost sharing; i.e., they were to be offered by doctors to give to patients without the patient having to pay any copayment (Healthcare.gov 2012). Starting on or after August 1, 2012, this list was expanded to include “FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs” (Healthcare.gov 2012). Religious organizations, such as Catholic hospitals, have been given an extra year to implement these changes (Culp-Ressler 2012). Also, even more controversially, is the “abortion surcharge”: insurances that will pay for abortions. These insurance plans will be required to “provide a notice to enrollees” about their coverage (Bassett 2012). If someone decides to purchase a health care plan that covers abortions, they will have to pay at least \$1 to a separate account that will fund abortions, so the Federal government won’t have to pay for them (Bassett 2012).

The people that take the most offense to this mandate are Catholic voters. Historically Democratic, 53% of Catholics identified as Democratic as compared to 37% Republican during the 2008 election year (EWTN 2012). As of May 21, 2012, 43 Catholic institutions have filed 12 separate lawsuits against the contraceptive mandate (Beadle 2012). They argue that this mandate goes directly against their beliefs; Catholics don’t believe in using any form of birth control. As part of a compromise, the White House has amended PPACA to state that employers can opt-out of providing contraceptives, but they must refer them to an insurance company that will provide contraceptives at “a no higher cost than the employer would have paid for it” (Volsky 2012). Catholics don’t support this compromise, either. A Cardinal from the Catholic church stated that “the concept...is you don’t have to do this, you just have to refer people to this” (Volsky 2012).

The main problem from this section of PPACA is a religious and privacy issue. Requiring religious businesses, such as Catholic hospitals, to pay for their employee's contraception is a hot-button issue. Also, people are up in arms about health insurance plans providing coverage for abortions. This is an issue about the separation of church and state: is PPACA's requirement of states and employers having to provide insurance options that pay for contraceptives and abortions meddling in people's personal and religious lives too much? This is an issue that will continue to be debated for months to come, with both personal and political opinions coming into the argument.

This clause of PPACA also goes against our nation's traditional usage of incrementalism. Not only does it go against the theory most used in the United States, it may encroach on the personal and religious lives of citizens. This decision, in my opinion, isn't rational either. Why should all employers have to provide insurance that pays for those services? Most insurance does already pay for contraception. Abortion, on the other hand, is too hot of an issue to easily be solved. Requiring insurance plans to pay for this will surely fire up the abortion debate once again.

### Problem 3: Expansion of Medicaid

A part of PPACA is an expansion of Medicaid that starts in 2014- the biggest overhaul of the system since its inception. The government will pay each state to expand Medicaid to those who make up to 133% of the Federal poverty level- which is equal to about \$29,000 for a family of four (Amedeo 2012). This expansion will cover 7 million American adults, and will cost the Federal government \$1.2 trillion in addition to the current cost of Medicaid. There are currently about 62 million people on Medicaid and states are largely responsible for the costs (Fox 2012). For the first three years of the expansion, the Federal government will fund the entire project (Fox 2012). After those first years, the government will cut back funding to 90% and leaving individual states to pay for the final 10% (Fox 2012).

Originally, the Act gave states no choice as to whether they would participate in the expansion: if a state didn't want to be a part in the expansion, they would lose other Federal funding for funding of their current residents receiving Medicaid. In the decision where the Supreme Court ruled that the "individual mandate" penalty was nothing more than a tax, they decided that states should be able to opt out of the expansion without fear of losing their previous level of Medicaid funding (Fox 2012). So far, five states have chosen to "opt-out" of the expansion: Texas, Florida, Mississippi, Louisiana, and South Carolina (Allen 2012).

The obvious political issue with the expansion of Medicaid is the cost. Health care is a huge part of our nation's debt, and expanding Medicaid will only add to that. Where will government get the money to pay for this expansion? After the government reduces its support of the Medicaid expansion to 90%, where will cash-strapped states get the money to pay for the last 10%? Taxes will most certainly have to be increased to pay for the expansion of Medicaid.

This clause in PPACA is, in my opinion, the one that stays the closest to our traditional usage of incrementalism and rational decision making. When the Act was first introduced, the expansion of Medicaid was required by all states with punishments for those who didn't participate in the expansion. This violated state's rights, however, and the Supreme Court decided that states should be able to choose to participate in the expansion or not. The ability to "opt out" of the expansion puts states in control of what they do, and it keeps with incrementalism and is a rational decision that has the opportunity to please everyone.

#### Legality and Constitutionalism of the Act

On June 28, 2012, the Supreme Court upheld the individual mandate requirement in a 5-4 decision (Stempel 2012). Chief Justice John Roberts wrote in the decision that that the Act's requirement to purchase health care or to pay a fine can "reasonably be characterized as a tax" (Stempel 2012). He went further to say that the Constitution permits such a tax, so they have no

right or role to forbid it (The Week 2012). Conservatives, including Justice Anthony Kennedy, dissented against this decision. In his dissent, Justice Kennedy stated: “in our view, the entire Act before us is invalid in its entirety” (The Week 2012). They also claim that the Act is unconstitutional because of the expansion it would give to the Federal government’s power (The Week 2012). Also in this decision, the section of PPACA that required employers to provide contraceptive coverage in its employee’s health care plans was amended; religious institutions were given an additional year to implement this section of the law (Culp-Ressler 2012).

While the majority upheld the individual mandate requirement and the contraception clause was amended, the Act was not agreed upon in its entirety. In the majority, Chief Justice Roberts said that the expansion of Medicaid “infringed on state rights” (The Week 2012). The Supreme Court has not yet heard many lawsuits that have been filed against the Federal government about the different sections of PPACA, so their Constitutionality is still to be decided.

#### Comparison to Other Socialized Health Care Plans

The United States isn’t the only country with socialized health care. Most notably, Canada has had socialized health care since Minister of National Health and Welfare MacEachen introduced the Medical Care Act in 1966 (Canadian Museum of Civilization 2007). Canada’s plan is “a group of socialized health insurance plans that provide coverage to all Canadian citizens (Canadian-Healthcare.org 2007). All Canadian citizens receive this health care, which includes preventative care, medical treatments, visits to primary care doctors, access to hospitals, dental surgery, and several other services (Canadian-Healthcare.org 2007). This system is free to all citizens, in a differentiation from America’s currently proposed PPACA. Canada boasts one of the highest life expectancies and lowest infant mortality rates in the developed world, which is directly credited to their health care system (Canadian-Healthcare.org 2007).

Also within our own country, there are other health care plans. In 2006, Massachusetts passed its own health care plan, dubbed “Romneycare” (Symonds 2006). Governor Romney’s health care plan is extremely similar to President Obama’s plan: both require citizens to purchase health care which has been called the “individual mandate” and have “employer mandates” which require employers to provide insurance to employees based on their number of employees, both include government subsidies to pay for health care for the poor, and both have monetary penalties for those who don’t have insurance by a set date (Massachusetts’ penalty began in 2008) (Symonds 2006).

### Conclusion

There is no easy way to solve the health care crisis. For decades, the United States has been trying to fix our health care system, to no avail. PPACA is the biggest health care reform since the inception of Medicaid and Medicare, but it may not be what our nation currently needs. This law does have many positive changes it should bring about, such as making sure that the young people of our country have health insurance, making sure employers provide enough health insurance to their employees, and covering preventive care for young and middle aged people that will lower health care costs in the later stages of life. It is not without controversy, however. Americans are split on if they think a repeal of PPACA is necessary. 47% of Americans want the Act repealed, while 44% do not (Mak 2012). Such a socialized form of health care brings cries of too much government power. Citizens of the United States have always had the free will to choose when and how much health care they will purchase, but PPACA dictates when and how those actions should take place.

It is also a very expensive bill, one that will put more burden onto the already burden-laden middle class of this country. PPACA will help those who do not have insurance due to the high cost of it by providing them with Medicaid, but the funding for that has to come from somewhere. Taxes will most surely rise in the wake of this bill’s full implementation. Freedom to practice religion as

we see fit may also be in jeopardy with the contraception and abortion clauses of PPACA. Many religions teach that birth control should not be used, but this bill states that employers must provide contraception coverage to their employees. The abortion clause has angered, and will continue to anger, many pro-life supporters, who believe that no insurance should pay for women's abortions.

There isn't an easy way to fix America's health care. PPACA, however, may assist in doing just that, if the controversies within it can be worked down to a middle-ground area. As the Supreme Court decides its Constitutionality, we shall see if this act encroaches on our rights declared by our founding fathers, and we may get to solve this crisis once and for all.

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