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Health Care Reform: Congressional Politics and the Obamacare Policy Implementation in the United States

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Abstract

The changing political climate of Congress and the dilemmas of the Affordable Care Act (Obamacare) in reforming the U.S. health care system is the focus of this work. The author is with the view that most barriers that led to the denial of previous health care reform bills were as a result of the role played by Congressional caucuses and the continuous health care malpractices perpetrated by health care industries in the United States. Healthcare policy making in the United States therefore, owns its hegemonic past from a long standing institutional and ideological politics beginning with Theodore Roosevelt's failed proposal for a national health care system in 1912. The work further examines Congressional path dependency on health care reform and its role in health care policy adoption and implementation. The obstacles faced by Americans in having a relatively rational type of health care coverage system in the United States will also be discussed. The paper argues that the invisible hands of Congressional caucuses and health care industries continue to play integral parts in health care policy making in the U.S. thereby, frustrating government's efforts in order to uphold the privileges and profits enjoyed at the expense of tax payers. The puzzle the work seeks to unravel is to showcase whether the fight to repeal the Affordable Care Act by Congress, States and individual plaintiffs will hold in the light of the unprecedented health care burden on Americans. The work explores John Kingdon's Multiple Streams Framework in public policy making with particular reference to the health care policy reforms in the United States. The author concludes that in order to achieve an efficient market outcome in the case of the prevailing health care externalities in the U.S., the implementation of a policy where mostly everyone is expected to be better off is deemed necessary.

Keywords: United States; Congress; Affordable Care Act; Obamacare; HealthCare Policy; Reform.

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1. Introduction

Healthcare policy making in the U.S. owns its hegemonic past from a long standing institutional and ideological politics beginning with Theodore Roosevelt's failed proposal for a national health care system in 1912. For over a century now, Congress has always followed its traditional path in health care policymaking and strives to stragulate bills that attempt to change the political culture of Congress. This "path dependency" coupled with the constant northern star posture of Congress on health care policy remain a burden for most middle-level and low income families in the United States [1;2;3]. Health care policymaking in the United States lies within the portfolio of the U.S. Congress. The Congressional composition is fragmented and decentralized into sub-committees that mostly discuss and make recommendations on issues that are brought up in Congress for further debates. The Congressional committees especially, those within the health cycle have a considerable impact on the outcome of most healthcare policies [4;5]. Several attempts made by past politicians to reform the health care system have always been unfruitful and a number of past health care policy proposals have been thrown out of Congress unexplained [6]. As argued by Patel, the increased ideological partisan polarization on issues and divided governments serve as barrier for the president and Congress to effectively work together [5].

The invisible hand of the health industries also continue to play an integral part by frustrating government's efforts in order to uphold the privileges and profits enjoyed at the expense of tax payers. Health care industry malpractice is considered a major factor that contribute to the huge healthcare burden on mostly middle-level and low-income earners in the United States. It is argued that if such malpractices are not curtailed as proposed by the Affordable Care Act, Americans will continue to suffer from paying their medical debts. Most bankruptcy between 2001 and 2007 in the U.S. are cited as the result of high healthcare bills that turn most Americans into medical debtors [7;8].

Health care cost accounted about 17.7% of the Gross Domestic Product (GDP) in the United States in 2011 [9]. For these shortfalls in terms of health care provision and its relative high cost as compared to other nations in the world. Ubokundon and Jagdish are with the opinion that different nations required different solutions to their health care problem and that the better way to fully comprehend the U.S. health care system is to study the ecological issues around the U.S. health care system [10].

In view of the above, the changing political climate of Congress and the dilemmas of the Obamacare in reforming the U.S. health care system is the focus of this work. The paper holds the view that the barriers to the denial of previous health care reform bills were as a result of the role played by Congressional caucuses and the continuous health care malpractices by health industries in the United States. The work will examine Congressional path dependence on health care reform and its present role in the implementation of the Affordable Care Act (ACA). The paper will also seek to investigate the obstacles faced by Americans in having a relatively rational type of health care coverage system in the United States. The puzzle this work will seek to unravel is to investigate whether the fight to repeal the Affordable Care Act by Congress, States and individual plaintiffs will hold in the light of the unprecedented health care burden on Americans. This paper subscribes to the view that, in order to achieve an efficient market outcome in the case of the prevailing health care externalities in the U.S., the implementation of a policy where mostly everyone is expected to be better off is

deemed necessary.

2. Background to the U.S. Health Care System

One major stride in the U.S. health care system could be traced back to the most laudable “New Deal” under the presidency of Franklin D. Roosevelt who enacted the first successful legislation on health care in the United States, the Social Security Act of 1935. The main goal of the Social Security scheme was to help in alleviating the scourge of poverty that engulf most middle and low-income earners during the great depression. The scheme though most costly, but became much favoured and politically sacrosanct and it is thus referred to as the “third rail” of American politics, touch it and die [11].

Several health care proposals followed the Social Security scheme beginning with Harry Truman in 1945 who proposed a voluntary national health plan but was denied by Congress. The Old Age Survivor’s Disability and Insurance (OASDI) scheme was added to the Social Security Act of 1935 in 1950 which provided assistance to contributors in case of accidents that might result to a reduction in individual income such as old age, death or permanent disability [12]. President Lyndon Johnson on his part persuaded Congress in enacting a new program for the elderly, Medicare and Medicaid for low income earners in 1965 [6].

Two more unsuccessful health care proposals followed the foot path of their former predecessors after Congress turned it back on them devoid of the cloud they had in 1974 starting with the proposal of Richard Nixon followed by Bill Clinton in 1993- 1994. President Clinton’s bill was heavily criticized both within and outside Congress by fierce oppositions from the American Medical Association, insurance industries and other interest groups [6]. President Bush on the other hand succeeded in the expansion of the Medicare program (Medicare Part D) adding a prescription drug benefit to the program. Succeeding Bush was the coming to power of Democratic candidate Barack Obama who undoubtedly changed the political status quo of Congress by opening a new chapter of health care reform in the history of the United States for over four decades. According to Oberlander, even when Republican Senator Arlen Specter compromised by voting in favour of the bill in order to prevent a filibuster the Congressional culture still remained unchanged [6]. The sizeable composition of President Obama’s 59 members in the Senate and 257 in the House of Representatives succeeded in enacting the Affordable Care Act in 2010.

The health care reforms of 1935 and 1965 greatly helped in shaping the U.S. health care system though there are several criticisms levied against the system. The major criticisms against the Social Security system was the misplacement of hope in the “Trust Fund.” Many contributors had hope that the “Trust Fund” was going to accrue interest over time which shall be paid to contributors as benefit at retirement, but this remained challenged especially, with the retirement test criteria [12]. Americans had to continue to pay as they lived on in employment. For this deceit, both Republicans and Democrats accuse each other for “dipping into Social Security” [11]. Further criticism is provided by Davies and Martha arguing that the Social Security scheme had racial dimensions that excluded farm workers, self-employed such as seamen, the clergy and charity workers [13]. Blacks and low-income earners were mostly excluded from having access to health assistance because of their colour and geographical locations [14].

Prior to the Obamacare reform in 2010, the U.S. health care financing system was weak not only for low-income earners or the poor, but middle-income earners also suffered a great deal that inflicted financial loss on them as a result of high cost for health care services [7]. The “alternative approach for cost control will be to have a health care system which allows individual decisions of both the provider and patients to be much better aligned with value” [15]. Further suggestion is provided in terms of provider payment reforms as observed by McClellan below:

Traditional provider payment reform debates in the U.S. context have focused on the extent to which provider payment systems should be shifted from fee-for service to capitated or "bundled" payments. However, more recent reforms in provider payment systems, both in the United States and elsewhere, have increasingly considered explicit steps to tie some portion of payments to quality of care as well [15].

The first pillar of the Obamacare Act is tied to the provision of an affordable and quality type of health care system for all Americans. This is done in line with individual decisions through the “Individual Mandate” portion of the Act aligned with both the provider and patients greater values placed on health care cost. The gives the opportunity for quality improvement while lowering cost could be substantial [15].

3. The Patient Protection and Affordable Care Act (H.R. 3590)

The bill was passed in the U.S. Senate by a vote of 60–39 on December 24th 2009 and finally signed by the president on March 23rd 2010 [16]. This historical document served as a breakthrough for all Americans with special compliments to both Democratic Speaker of the House Nancy Pelosi and the Senate Majority Leader Harry Reid. The reform came at a time when the country was still trying to resurrect from its worst economic crisis and most Americans had almost lost faith in government health care services. Majority of Americans were willing to live on with whatever health plan they had prior to the enactment of the bill. However, the bill finally got out of Congress amidst pressure and opposition from Congressional caucuses and the health industry.

One triggering question that will eventually come to mind based on the analysis leading to the collapse of the Congressional northern star posture on health care reform is that; why Barack Obama succeeded in getting the Affordable Health Act (ACA) passed? The answer however, lies within the notion of change which at times is inevitable. The President started well on a good footing with his campaign and given the political situation coupled with the war in Iraq, the national mood in the U.S. was also agitating for a change towards politics and the continuous health care burden on Americans. The success can be also attributed to the lessons learnt from Bill Clinton’s failed proposal. The President acted fast enough by taking necessary reconciliatory measures in featuring the bill into the Federal Budget and also making the bill flexible by giving Congress the freedom to make necessary input. Americans were also given the freedom to stick to their old plans and also exclude small business owners from the plan with the provision of allocative support [6].

3.1 Policy Goals, Requirements and Penalties

The goal of the Act can be simply put into two broad categories. First, is to expand health care coverage to 32 million uninsured Americans. Second, is to slow down the rising cost of health care coverage that accounts for

18% of the Gross Domestic Product (GDP) in 2010. The focus is to provide coverage to more than 94% of Americans with support from the Congressional Budget Office (CBO) pegged at \$ 900 billion to cover cost [16]. The Act made provisions through Medicaid expansion for families with income below the Federal Poverty Line (PFL), (133 – 400 percent) by providing them subsidies to cover cost [17]. The policy also had nine distinctive pillars addressing almost the pressing problems Americans faced with the health care system. The nine pillars include: (a) Quality, affordable health care for all Americans, (b) The role of public programs, (c) Quality improvement and health care efficiency, (d) Improving public health and the prevention of chronic disease, (e) Health care workforce, (f) Transparency and program integrity, (g) Improving access to innovative medical therapies, (h) Community living assistance services and supports, (i) Revenue provisions [18].

The eligibility requirement for the Affordable Care Act (ACA) also have a number of provisions and conditions that required all Americans to fulfil in order to be able to benefit from the health care plan. The Act has the provisions for ending insurance malpractice & abuses with a premium rule of 80/20. It also makes health care more affordable by providing tax credit for small businesses. The Act also strengthens Medicare for Americans with a 50% discount on coverage. Medicaid is also expected to be expanded by 138% of Federal Poverty Level and providing Americans alternatives and better options for children at 26 years to continue to live on their parent's health plan. There is also the options for chronic illnesses and the ‘Individual Mandate’ allowing Americans to choose their own health care plan [16;19].

The Act does not affect individuals that pose religious objections and undocumented immigrants and the incarcerated. American Indians and Alaskan Natives are also exempted from the law. People with income below the tax filing threshold are also exempted and those lowest cost plan options that exceeds 9.5 percent of their individual income. The law also excludes people that have been previously covered under any of the Federal government programs, Medicare, Medicaid, Children's Health Insurance Program (CHIP), individual insurance purchased at the bronze level and those on grandfathered health plan before the passing of the bill.

There are also penalties that will be levied by the Federal government failure to adhere to the provisions described above. By 2014, the sum \$ 95 will be charged per adult and \$ 47.50 for a child and up to \$ 285 for a family that represent 1% of income. In 2015, \$ 325 will be charged per adult, \$ 162.50 per child and the sum of \$ 975 for a family representing 2% of income. By 2016, \$ 695 will be charged per adult, \$ 347.50 per child and a total sum of \$ 2, 085 for a family which represent 2.5% of income failure to comply with the above provisions [16].

3.2 The Level of Obamacare Policy Implementation

The Act has a number of provisions with those that has already taking effect beginning 2010 and those that kick off from December 2014 to January 2015 during the online enrolment process. The entire process is ongoing till the close of 2019 at which time the rate of uninsured Americans is expected to have reduced drastically. However, the focus of this work is to look at some of the key policy implementations that have already taken place with particular attention being paid to the individual mandate and the expansion of the Medicaid program at State levels. The work will also look at the ratio of individuals already with a health plan under the Act and

those that have not been able to secure a health plan under the Act. The strengths and weaknesses of the Act on Medicaid expansion at States levels, and the enrolment process through the available options at the online market places for the individual mandate will be assessed.

According to the Kaiser Family Foundation, the full implementation of the Act is a gradual process, but a considerable job has been done looking at the level of achievements in the entire implementation process. Although there are conflicting statistics regarding the actual enrolment process, but most reports agree that the “uninsured rate have dropped since 2014. There were about 41.3 million nonelderly uninsured Americans in 2013. Presently, there still remain 30 million people uninsured. Out of the 41.3 million people that were uninsured in 2013, 11 million of nonelderly have already enrolled into one of the affordable health care programs by December 2014. The reasons for such a low level of participation into the health care program are that 30% of the people considered the coverage to be too expensive, 37% were told they were ineligible and 37% gave other reasons according to the report. The report further shows that 48% remained all-uninsured, 53% are eligible under the Affordable Care Act and 43% are not eligible under the Act. This means that people lack accurate information about the actual health care program and the benefits it entails for both individuals and families. There were confusion in the dissemination of information regarding the health care program. It is argued that half of the already 30% uninsured nonelderly people lack Medicaid assistance under the current Act. The reasons are that 13% of the uninsured are undocumented immigrants and about 24% of the uninsured have incomes that exceed the tax credits or can access coverage through employment. The rest live under the estimated poverty level but their states have not been able to expand the Medicaid program. The report concluded that it is very likely that an estimated number of 29 million individuals will go without any health plan and will remain uninsured in 2018, [20].

4. Case Study: Kingdon’s Multiple Stream Framework

The ingredients of Kingdon’s policy streams still provides a major source for U.S. health care policymaking [21]. To fully digest Kingdon’s three streams is to take a look at the existing problem that Americans faced in the health care system. The U.S. continues to be seen as one of the developed countries that has the highest cost in terms of health care as compared to other OECD countries. The rate of uninsured Americans before the coming into effect of the Affordable Care Act was pegged at 32 million in 2008. Based on this fact, there was indeed a need for a legislation that will help to address the above problems. This as a result led to an agenda setting for the Affordable Care Act under Obama’s administration in 2009 and 2010 respectively. There still exist different perceptions whether the Obamacare was the right choice in solving American’s health care problems, but that still remained a challenge as the reform continues to take effect until it reaches it required target by 2019. Kingdon’s second stream deals with the policy aspect where different players such as policy entrepreneurs and advocates working out different ways for a solution. This can happen at times within a short period or it may continue to remain in what Kingdon calls the “primeval soup” for decades with Congress either accepting or disregarding the various proposals as in the case of Bill Clinton’s proposal for a comprehensive health care coverage for all Americans [21]. The last of Kingdon’s stream is considered as one of the important streams based on its characteristics. Change of President and Congressional compositions play a greater role in this direction. However, it is expected that the three streams have to merge in order to be able to

seek a solution to a particular problem. This merger took Americans almost four decades with policy advocates seeking solution for reform of the health care system before finally having the Affordable Care Act in 2010.

4.1 The Problem Stream of the U.S. Health Care System

Health care cost is cited as one of the most challenges for Americans. The shifting of health care cost by employers to employees also play a greater role for most bankruptcy in the United States beginning 2001 to 2007 [7]. The National Patient Foundation also reported the same as the primary cause for most bankruptcy in the U.S. in 2012. Health care malpractices by insurance industries in the U.S. contributed to patient problems by denying coverage to most people for an alleged preexisting conditions and lack of legislation to address these issue denied most Americans access to an affordable health care coverage. The Hispanic and African American suffered a great deal from racial issues regarding health coverage. Inequality and the gap between the poor and the rich especially when health care coverage was tied to employment based insurance coverage. This category of people thought they have employment but still continue to live below the Federal poverty line. According to the Pew Hispanic Center report in 2006 and the Kaiser Family Foundation 2014, most of the undocumented immigrants work in the service industry on low minimum wages which disqualifies them from having coverage through the States run Medicaid and Children Health Insurance Programs (CHIP). The geographic location of the undocumented immigrants is also another barrier where as some States have still not been able to implement the State run Medicaid programs even with the coming into effect of the Affordable Care Act. Some States have even opted to get out of the Medicaid programs through the Affordable Care Act leaving almost these people not provided with health care coverage. The provisions of the Affordable Care Act aimed at providing quality and affordable health care coverage to all insured Americans, reduce health care cost and prevent insurance industries from health care malpractice. However, this still remained a challenge given the fact that only 11 million people have access to health care coverage since the beginning of the reform and by the close of the open enrollment in February 2015.

4.2 The U.S. Health Care Policy Stream and Reform

It has been a huge problem for Americans for over a century trying to reform the health care system. The U.S. health care system is further complicated with the presence of health care systems practiced in other countries in the world. For example, Reid classified these systems into four different types of health care systems. The first category is the “Bismarck” model found in (Germany) after Otto Von Bismarck. It is employer and worker based, private and government sponsored health care coverage system [22]. Health care coverage are mostly for non-profit making and the regulations on health care are solely the responsibility of the government. This is common with the U.S. health care system such as the employer mandate. The second type of health care system that is evident in the U.S. is the “Beverage” system found in (Great Britain). This type of health care system is known in the U.S. as “socialized medicine” where the State owns the institution and workers but in essence individuals have to wait for a long time in order to have access to health care and doctors can as well receive payments from patients for quick access to health care. In the U.S. veterans and military personnel fall under this category through (VHA). Third, is the National Health Insurance (NHI) component that is practiced in (Canada). This type of health care system uses the private sector as health care provider but it is paid for by

government through taxes and premiums. The U.S Medicare program fits in this category. The last of the different models is the ‘‘Out of Pocket’’ model which mandates individuals to acquire health services from their pocket requiring the uninsured to acquire health care coverage out of pocket. The individual mandate under the Affordable Care Act also served this purpose provided if patients can afford the cost. The U.S. health care system therefore, has been a victim of the above models and the possibility of merging the above models into a comprehensive type still remained a challenge in terms of health care reform. The reasons for this are that Congressional politics has always resisted a comprehensive health care coverage. Conservative Republicans are mostly interested in programs that rely on the private sector and market based mechanisms whereas Liberal Democrats welcome programs that expand the role of government on health care related issues.

4.3 The Politics Stream of the U.S. Healthcare System

The politics stream in terms of policies is located within the national mood, change of the political administration through election such as the change of the Republican President George W. Bush Administration with the current Democratic President Barack Obama, Congress and partisan ideological variations and pressure group campaigns. With the coming into effect of these changes, there is every possibility that some policy proposals will receive recognition by Congress while others will be disregarded [21]. The Obamacare came through this process with Democrats having a sizeable majority in Congress coupled with some Congressional bargaining and compromises. The change of political actors in the administration and jurisdictional issues also contribute for the successes and failures of certain policy proposals such as the U.S. September 11 events in 2001 under the Bush administration followed by the war in Iraq and Afghanistan [21]. On the side of campaign, public opinion on the U.S. Iraq war gave an edge to the Democrats in their election victory and push for their anticipated reform of the U.S. health care system in 2008. There has been several strides from the Democratic side on health care reform since the time of John Edward, Bill Clinton and now Obamacare. ‘‘Leaders have a greater capacity and stronger incentives than non-leaders to champion reforms that benefit diffuse over special interests’’ based on their position in society’’ [23]. The role played by interest groups is also not underestimated in terms of policy matters. They play a crucial part in pushing policy proposals to the agenda. In the case of the Obamacare, interest groups such as the Health Care for Americans which comprises of a coalition of influential individuals that work with Labour Unions, Campaign for New America, Women’s Minority Groups and Community Based Organizations (CBOs) play a greater role in the success of the Obamacare. The industry groups were at times critical but to some extent also played some important role in the process. The entire legislative process of the Obamacare was however not an easy task with the threat of a filibuster which has contributed in the past years for government shutdown and closures in the United States. The process created political polarization with the two parties always at war and at times even degenerating to some verbal abuses in Congress. Political discussions at ‘‘Town Hall’’ meetings and ‘‘Tea Parties’’ at times turn into national issues with both Democrats and Republicans always having their different opinions on health care related issues in the United States. This is mostly common with health care policy related issues in Congress. There are mostly ideological differences among policy researchers, Congressional Staff and interest groups coupled with the national mood and these political climate and motions have serious impact on the policy agenda and the actual outcome at the end of the day [21].

4.4 Policy Entrepreneurs and the Window of Opportunity

Policy entrepreneurs always seek for a window of opportunity in order to push their ideas and policy proposals on the agenda for recognition. It is a crucial moment and the time varies in terms of need and necessity. Policy windows can be opened within a short notice and long time period. The window can also be at times narrow and other times wide. Therefore, it is very crucial for policy entrepreneurs to make good use of this great opportunity in time to push for the necessary policy change in order to prevent any severe potential constraints [21]. The dynamics of these windows are that they can be easily recognized at times and other times difficult to identify. Some key examples are the high cost of health care which are mostly hidden from patients in the United States. The success for the expansion of Medicare and Medicaid under President Lyndon Johnson could be mostly attributed to the Liberal Democratic elections of 1965. Democratic Party had 68 legislators in the Senate and 295 members in the House of Representatives whereas as Conservative Republicans had only 32 Senate majority and 140 Representatives in the House. This was a great window of opportunity for policy entrepreneurs that led to the amendment of the 1965 Social Security Act with Medicare and Medicaid in the United States. Another great opportunity for policy entrepreneurs showed up in 2008 with the coming to power of Barack Obama in 2009. The Democrats sizeable majority votes of 60 to 39 Republicans and 236 to 199 in the House of Representatives gave birth to the Affordable Care Act in the United States paving the way for health care policy reform in the U.S. after decades of trial and error attempts by former Presidents. These event is considered as a historic moment for Americans with much hope in the new reform to solve the health care burden faced by most Americans in the United States.

5. Congressional Politics and the Obamacare Policy Implementation

In the United States, Congress served as the citadel of legislations. It is mostly perceived that Congress posed an obstacle to the success of bills in the United States. This is one of the main reasons that led to the compounded health care problems in the United States. Health care bills suffer in the hands of Congressional caucus and a battle field is always drawn between Liberal Democrats and Conservative Republicans on issues relating to health care reform. The composition of Congress recently resembles a parliamentary system type of government where oppositions are always at war defending their different political ideologies. According to Wilson, to “discover the best principle for the distribution of authority is of greater importance, possibly, under a democratic system, where officials serve many masters, than under others where they serve but a few”. For the United States which practices Constitutional Democracy, Congress is normally composed of caucuses that serve two different political ideological masters, the Conservative Republican and the Liberal Democrat [24]. Congressional powers and authorities are decentralized at sub-committee levels which is at times referred to as a “kind of confederation of little legislatures”. The structural composition of Congress leads to the coming together of Congressional caucuses within both houses in defence of issues that represent the interest of these small Congressional groups through “bargaining and compromises”. What is common among these groups is that their actions at times promote racial and gender problems when dealing with sensitive political and policy issues in Congress. Following the proposition of Levi, that once a “country or region has started on a particular path, the cost of returning will be very high” [2]; Pierson agrees by further introducing the concept of an “increasing return”. Pierson argues that in an increasing returns process, the probability of moving further

along the same path increases with each additional steps towards that same direction [3]. Arguably, Congressional politics could be seen to have been a victim of the above proposition for almost four decades on health care reform. However, the coming to power of the Democratic candidate Barack Obama undoubtedly succeeded in breaking the chain of Congressional path dependence by bringing with him a new agenda for the reform of the U.S. health care system that has always followed the traditional path of Congress on health care policymaking in the United States. The reason for such attitude towards the reforming of the U.S. health care system is that the fringe benefits attached to the previous health care system such as the Social Security Act of 1935, the further expansion with Medicare and Medicaid all had benefits for conservative Americans, political elites and veterans that increases over time as compared to other options. Therefore, Congress always posed a challenge for possible health care reform alternatives that seek to change the status quo. President Obama succeeded in breaking the Congressional path dependency chain giving all Americans a new hope for a better health care system when the bill was finally passed.

5.1 Dilemmas of the U.S. Healthcare System

Research on health care provision in the U.S. focus mostly on the high rate of health care cost as compared to other OECD countries and the burden it posed on Americans. Looking at the other side of the debate on health care, the trade-off between government expenditure on health care and the tax levied on individuals is also another aspect that must be taken into serious consideration. It is obvious that the Federal government pay for major parts of the health care coverage through its public assisted programs such as Medicare and Medicaid. This aspect is captured by Mechanic with the skepticism that any further investment role played by the Federal government, there should always be returns justifying such cost [8]. With the coming into effect of the Obamacare, employers are required to provide 80% of coverage for their employees and the employee paying the remaining 20% of the coverage. The payment of this minimal percentage by individuals also posed a serious challenge considering the nature of employment and the living condition of most American families. The other argument is that health care consumers are seriously hurt by paying directly out-of-pocket for health care coverage. The dilemma is that individuals paying a certain percentage of their healthcare either to government through taxes or to the health care provider through employment based find both methods hurting let alone talk of those paying directly out-of-pocket for their health care. One solution offered for the individual consumer's problem is to shift the method of payment through government tax supported systems considering the way medical payment is structured in the United States [8]. The challenge continues to rage if medical malpractices are not curtailed. Patients are only made aware of these problems when they are asked to pay out-of-pocket bills that are not covered by third party. A radical alternative to this problem has long been suggested by Mechanic for a private marketplace which now forms part of the Obamacare, but mostly controlled by Federal and States institutions [8]. The dilemma now individual health care consumer's faced under the new law is to either stick to the individual old plan or enroll in the marketplace in a coverage program that mostly suits individual pocket. The bronze package seems to be the lowest and mostly preferred by both low-income and middle-level income earners. The focus of government to have cost control are mostly geared towards costs that emanate from Federal spending on publicly sponsored programs such as Medicare, Medicaid and the Children Health Insurance Programs (CHIP). This also has its effect on the poor, elderly and the chronically ill. The final dilemma is the present court case by States opting for legislation to move out of the Obamacare Medicaid

expansion program at State and local levels. If this happens, then the fate of the uninsured, poor, elderly and undocumented immigrants will be out of coverage under the current Obamacare reform.

5.2 Health Care Repeal and Fate of the Obamacare

The Affordable Care Act is at the moment its implementation stage but the fear of its repeal still remains a challenge at different quarters in the United States. Following the Court case of 2012 regarding the Constitutionality of the bill helped in resolving some of the burning issues relating to the full implementation of the Act in 2014. The Supreme Court decision on the Individual Mandate of the Affordable Care Act remained intact as it is considered Constitutional under the Congressional taxing power. The Expansion of Medicaid posed a serious challenge in 2012 as there were 25 States led by Florida, National Federation of Independent Business (NFIB) and some individual plaintiffs that took up lawsuit against the expansion of Medicaid. A total of 13 States including New York supported the expansion of Medicaid and 2 States, Iowa and Washington DC were found to be on both sides. However, nothing considerably changed from the content of the Expansion of Medicaid according to the court’s decision, the expansion of Medicaid is now voluntary and the Secretary of the Health and Human Services (HHS) office only have the authority to withhold funds geared towards the expansion of Medicaid when States failed to participate. The table below shows votes on the court’s decision for the expansion of Medicaid in 2012.

Table 1: Votes on the Court’s Decision for the Expansion of Medicaid – 2012

No	Court Outcome	In Favour	Against
1	Court’s right of jurisdiction	9	0
2	Congressional power to tax	5	4
3	Medicaid expansion as risk of funds, unconstitutional and Coercive of States for Voluntary participation	7	2
4	Remedy on the powers and limitations of HHS Secretary for States compliance with Medicaid expansion	5	4

Source: National Federation of Independent Business Vs Sebelius 567 U.S. (2012)

Funds for the expansion of other components of Medicaid prior to the Act still remained the same based on the court’s final decision in 2012. There is also a partisan divide on the Act and opinion polls according to research conducted by the Kaiser Family Foundation shows about 63% of Liberal Democrats in favour of work to improve the bill whereas 33% of Conservative Republicans favour work to repeal the law and replace it with something else. Further research in 2015 by Kaiser Family Foundation shows a total of 29 States including Washington DC to have adopted the expansion of Medicaid, 7 States are still discussing on the need for

expansion and 15 States have opted not to expand Medicaid in their States. The implication for this is that States that failed to expand their Medicaid program will have negative impact on the uninsured which are mostly the poor and undocumented immigrants living in those States.

6. Conclusion

One major conclusion that can be drawn from the literature is that Congressional politics has great impact on the outcome of most policies in the United States especially, Health care related reform policies. The Congressional path dependency and the Conservative Republicans overreliance on the private sector for health care provision with some market mechanisms are key factors that led to the long term effect of health care burden on Americans. Liberal Democrats on the other have always favoured programs that expand the role of government on health care provision but their method of approach partly contributed to their failure such as Bill Clinton's 1993 - 1994 proposal for a comprehensive health care coverage for all Americans.

The success of the Obamacare should therefore, serve as a lesson for future policy proposals if they are to be considered by Congress. Future Policymakers should always consider the position of Conservative Republicans as well as Liberal Democrats political ideologies on certain policy matters. Former presidents failed to take these factors into serious consideration and only rely on the legislative majority they have in both Senate and the House of Representatives. The Obama Administration even though with a sizeable majority in both Houses still employ other mechanisms in order to have the health care Bill passed in Congress. The involvement of Congressional Staff, policy researchers such as the American Medical Association, the insurance industry and influential interest groups are all important components for success in health care reforms.

Based on Kingon's model of the multiple streams framework, it is always necessary to act fast whenever there is a window of opportunity for policy proposals to be pushed to the agenda since it involves variations in politics, change of political administration and Congress. Policies that follow these pattern by employing the necessary mechanisms such as the Obamacare is likely bound to have a safe passage through Congress. With these swift political tactics and the mode of galvanizing support for policy proposals help in changing the Congressional path dependence and northern star posture on health care policy reforms in the United States.

References

- [1] J. Clinton, "US healthcare and the Affordable Care Act: why the U.S. does not have a UK style National Health Service." *Hydra Interdisciplinary Journal of Social Sciences* 1.2 (2013): 1-12. Print.
- [2] M. Levi, "A Model, a Method, and a Map: Rational Choice in Comparative and Historical Analysis." In *Comparative Politics: Rationality, Culture and Structure*, Ed. Mark I. Lichbach and Alan S. Zuckerman. Cambridge: Cambridge University Press. 1997. 19-41. Print.
- [3] P. Pierson, "Increasing Returns, Path Dependence and the Study of Politics." *American Political Science Review* 94.2 (2000): 251-266. Print.

- [4] E. Burgen, "Congress, Health Care, and Congressional Caucuses: An Examination of the Diabetes Caucus" *Journal of Health Politics, Policy and Law* 28.5 (2003): 789-820. Print.
- [5] K. Patel, and M. E. Reshefsky, *Healthcare Politics and Policy in America*. 4th Ed. M.E. Sharpe, Inc. New York, 2014. Print.
- [6] J. Oberlander, Jonathan. "Long Time Coming: Why Health Reform Finally Passed." *Health Affairs* 29.6 (2010):1112-1116. Print.
- [7] Himmelstein et al. "Medical Bankruptcy in the United States, 2007: Results of a National Study" *American Journal of Medicine* 122.8 (2009): 741-746. Print.
- [8] D. Mechanic, "Some Dilemmas in Health Care Policy." *The Milbank Memorial Fund Quarterly* 59.1 (1981): 1-15. Print.
- [9] Organization for Economic Co-operation and Development. *Health at a Glance: OECD Indicators*, Paris. OECD Publishing. 2013. Print.
- [10] S. E. Ubokudom, and Khubchandani, Jagdish. "The Ecology of Health Policymaking and Reform in the United States of America." *World Medical & Health Policy* 2.1 Article 19. (2010): Print.
- [11] T. R. Dye, *Understanding Public Policy*. 10th ed. Upper Saddle River, N.J.: Pearson Prentice Hall, 2002. Print.
- [12] A. M. David, "Old-Age, Survivors and Disability Insurance: Twenty Five Years of Progress." *Industrial and Labour Relations Review* 14.1 (1960): 10-23. Print.
- [13] G. Davies, and Martha Derthick. "Race and Social Welfare Policy: The Social Security Act of 1935." *Journal of Policy History* 112.2 (1997): 217-235. Print.
- [14] Davis, Karen. "Inequality and Access to Health Care: Essay in Honour of David P. Willi's Editorship" *Health, Society, and the Milbank Quarterly* 69.2 (1991): 253-273. Print.
- [15] M. McClellan, "Reforming Payments to Healthcare Providers: The Key to Slowing Healthcare Cost Growth While Improving Quality?" *Journal of Economic Perspectives* 25.2 (2011): 69-92. Print.
- [16] S. E. Harrington, "U.S. Health-care Reform: The Patient Protection and Affordable Care Act." *The Journal of Risk and Insurance* 77.3 (2010): 703-708. Print.
- [17] A. N. Hoffer, Jean Marie Abraham and Ira Moscovice. "Expansion of Coverage under the Patient Protection and Affordable Care Act and Primary Care Utilization" *The Milbank Quarterly* 89.1 (2011): 69-89. Print.

- [18] Health Care Education and Reconciliation Act. Pub. L. 111-152. 124 Stat. 1029. 30 Mar. 2010. Print.
- [19] Rosenbaum, Sara. “The Patient Protection and Affordable Care Act: Implications for Public Health Policy and Practice.” In *Public Health Rep* 126.1 (2011): 130–135. Print.
- [20] Kaiser Commission on Medicaid and the Uninsured. *Quick Take, Timing Matters: States Waiting for a Supreme Court Decision to Plan an Exchange*. Kaiser Family Foundation, 2012. Web. 4 Mar. 2015.
- . *A Guide to the Supreme Court’s Affordable Care Act Decision*. Kaiser Family Foundation, 29 Jun. 2012. Web. 4 Mar. 2015.
- [21] Kingdon, John. *Agendas, Alternatives and Public Policy*. Updated 2nd Ed. Glenview, IL: Longmann. 2010. Print.
- [22] Reid, T.R. *The Healing of America: A Global Quest for Better, Cheaper, and Fairer Health Care*. New York, Penguin Publishing Group. 2010. Print.
- [23] G. Mucciaroni, “The Garbage Can Model & the Study of Policy Making: A Critique.” *Polity, Palgrave Macmillan Journals* 24.2 (1992): 459-482. Print.
- [24] W. Wilson, “The Study of Administration” *Political Science Quarterly* 2.2 (1887): 197-222. Print.

Bibliography

- [25] W. Gellner and Eva-Maria Hammer. *Policy Research*. Munchen: Oldenbourg, 2010. Print.
- [26] Majerol, Melissa. Vann Newkirk and Rachel Garfield. “The Uninsured: A Premier, Key Facts about Health Insurance and the Uninsured in America.” Kaiser Family Foundation, 2015. Web. 5 Mar. 2015.
- [27] Patient Protection and Affordable Care Act. Pub. L. 111-148. 124 Stat. 119. 23 Mar. 2010. Print. Sabatier P. A. *Theories of the Policy Process*. Colorado: Westview Press, 2007. Print.