Healthcare Policy: Cost versus Solutions

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Healthcare is a dynamic policy issue, encompassing a number of multifaceted problem areas. As a result, legislation often addresses the broader problem piecemeal, on a one-issue-at-a-time basis. In my research I examine this piecemeal process with regard to three facets. Using an original coding system to categorize and compare three case studies, I looked at the proportion of provisions amending other legislation, the proportion of legislation targeting particular populations, and the proportion of legislation devoted to selected solutions. I found that successful reform efforts tend to contain a heavy amount of provisions that amend prior legislation. Additionally, legislation tends to devote a high percentage of provisions to issues of cost compared to a low proportion allocated to medical solutions. This disparity could be rooted in a stronger focus on cost control rather than a focus on providing medical services. I further investigated which groups, problems, or diseases are targeted to find a shift from policy addressing individuals with the highest need of care to individuals with reduced access to care. The traditionally episodic problem-solving of congress, as a reaction to mobilization by affected interest groups, has hindered comprehensive solutions to both economical and medical aspects of the health crisis. This research discloses the aims of health policy in congress as well as what interests and concerns are most often addressed. Moreover, my findings help explain why comprehensive reform efforts are so difficult, and why the problem is addressed in an uncoordinated manner.

Health reform has been sought after for a century in America. Presidential proposals for universal health insurance date as far back as Theodore Roosevelt's first term in 1901. A number of campaigns have been successful in accomplishing progressive change, especially in extending coverage to special populations; however, universal reform advocates consistently face defeat. Healthcare is a dynamic policy issue, encompassing a number of multifaceted problem areas including medicine, economics, insurance, research and development. As a result, legislation often addresses the broader problem piecemeal, on a one-issue-at-a-time basis. This satisficing policy trend is representative of Congress's often incremental decision making, where, "rather than seeking the best solutions to a policy problem, which may be unacceptable, incrementalism strives to satisfy all groups and perspectives, especially established interest groups."[1] This approach becomes problematic when law makers are incapable of taking action when it is necessary.

My research provides empirical evidence for incrementalism in health policy by investigating key forces perpetuating the trend. I conducted three case studies- The Social Security Amendments of 1965, The Health Securities Bill of 1993, and the Patient Protection and Affordable Care Act- looking at three facets- the proportion of legislation amending prior legislation, the targets of legislation, and the solutions of legislation.

First, I illustrate incrementalism through a comparison of the proportion of legislation that is an amendment to prior legislation compared to those provisions which are not amendments. The higher proportion of amended provisions in approved bills exemplifies decision making that address problems rather than proposing solutions. Due to a lack of information or support, health reform occurs gradationally in "small tentative adjustments to existing policies."[2]

The second facet looks at the targets of individual provisions within each bill, meaning the special populations as opposed to the comprehensive whole addressed by the section. Incrementalism is

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[1] Wilson, C. (2006). *Public policy continuity and change*. New York: McGraw-Hill
[2] Wilson, C. (2006). *Public policy continuity and change*. New York: McGraw-Hill

often the result of bargaining and compromise. The allocation of attention to targeted groups over comprehensive reforms shows how decision making is highly influenced by interest groups and majority perspectives.

A final facet addressed the distribution of solution aims within each bill. This investigation is meant to represent the role of congress and the behavior of congressional decision making in health policy. Health care is multifaceted; thus legislation that is incremental or piecemeal is bounded to addressing only part of the more extensive problem. The allocation of solutions of provisions and the patterns of this distribution over time will show that historically, legislation tends to certain policy areas while under-addressing others.

HYPOTHESES

This research tests three hypotheses.

- Because health legislation is often incremental, a higher portion of provisions will be amendments to prior legislation.

- Health legislation targeting particular targets (populations, problems, or diseases) will illustrate a change of focus over time.

- Health care legislation tends to allocate a high percentage of provisions to issues of cost in comparison to a low proportion allocated to medical solutions

METHODOLOGY

To test these hypotheses, I coded legislation to amass empirical data that could be analyzed and applied to my research questions. I selected the Social Security Amendments of 1965, the Health Securities Bill of 1993, and the Patient Protection and Affordable Care Act of 2010 as my three case studies to represent an example of a reform success, failure, and an undetermined outcome,

respectively. I acquired copies of each bill from Hein Online and Thomas Congress databases, which I

formatted into an excel spreadsheet for coding.

For each of the three facets, I set up an individual coding system. To look at amendment

content, I used a basic bilateral code. If a provision was found to act as an amendment to prior

legislation, it was coded as a one. Zeros were given to legislation that was not an amendment to prior

legislation.

For the more complex Target and Solution facets, I outlined a codebook before beginning

encrypting the legislation (Appendix I). Health policy targets a number of special populations, which are

groups of individuals characterized by increased risk or need. The Department of Health and Human

Service's Agency for Healthcare Research and Quality's (AHRQ) defines a list of eleven priority

populations, which I used as a foundation for coding.[3] Edits to this original list were made to best suit

legislative content. The resulting list became: Women and Children, Minorities, the Elderly, the

Geographically Underserved, Populations with Pre-Existing Conditions and Disabilities, Low- Income, the

Health Care Workforce, Chronic Care patients, and Illegal Immigrants. Provisions targeting for a

particular Disease, condition or service were coded separately, as well as comprehensive or untargeted

provisions, which were coded as a control group. The coupled description of each population can be

found in the Codebook (Appendix I). Each population was assigned a two-digit numerical code, ranging

from 02 to 15, which are also outlined in the Codebook.

For the solutions facet, I implemented a similar system. I first outlined five broad categories that

can encompass the number of more specific problem areas, including medical, economic, insurance,

research and education, and operational solutions. Each category was then broken down into a number

of more specific groups. For example, sub categories of medical solutions were information technology,

quality measurement and control, extending or improving access, reducing the disease burden, and

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[3] U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2011). *Health care: Priority populations*. Rockville: Agency for Healthcare Research and Quality.

pharmaceutical access, distribution, and regulation. Each of these sub categories were then associated with a two-digit code. Many provisions address issues that were not specifically represented by the limited list of subcategories; however, most ambiguities are cleared up in the Codebook, where an outline of subcategory descriptions and coding rules for this facet are available (Appendix I).

Each bill was coded for, and then recoded to check for errors and inconsistencies. With the empirical data produced, I used functions in excel to transform the codes into graphical depictions for analysis.

For the amendment facet, I added up the provisions coded as ones, and divided over the total number of provisions to calculate the proportion amending and not. This data was then made into a pie chart for each case study (See Appendix II).

The codes from the target facet of each bill were manipulated with a logic test. The test was run in each excel row, in each of twelve columns for each target code number. If the provision in the particular row was coded as the tested target in that column, a one was placed in the cell. The remaining 11 cells in that row would be attributed a zero. By this method, the column totals could be added, giving the total number of provisions within each bill for each target. These numbers were then divided by the total number of provisions of each bill to calculate the proportion of each target. This numerical data was then used to create a pie chart for each case study (See Appendix III).

Again, a similar system was used to calculate the proportion of solutions in each case study. A logic test was run for each coded solution on each provision. The column totals were divided by the total number of provisions to calculate the percent of each subcategory. These percents were summed to give the value of the five broader categories as well. The numerical data of this facet was used to composited to construct a stacked bar graph (See Appendix IV). , To analysis the data, the graphs of the three case studies in each of the three facets were compared.

RESULTS AND FINDINGS

Regarding the first facet of my research, I hypothesized that, because health legislation is often incremental, a higher portion of provisions will be amendments to prior legislation. Such provisions are likely acting to fix existing problems resulting from prior legislative reforms, rather than focusing on the implementation of new solutions. Data analysis from the three case studies provides empirical support that this notion is true.

Medicare is considered a landmark reform effort in health insurance because it established an entirely novel insurance program for the elder; however, nearly its entire content is amending an already existing program, Social Security. The successful Social Security Amendments is composed of 99% provisions that are amendments to prior legislation (AII, FIGII.1).

Alternatively, the failed Clinton Health Securities Bill proposed an innovative system of comprehensive health insurance for all Americans, and consisted of only 17% provisions amending prior legislation (AII, FIGII.2). This comparison would suggest that bills with higher proportions of provisions amending prior legislation are more likely to succeed, meaning pass into law, than bills with low proportions. The Patient Protection and Affordable Care Act has approximately 40% of provisions acting as amendments to prior legislation (AII, FIGII.3). Because a threshold cannot be determined by only two case studies, the success or failure of the PPAC cannot be accurately evaluated.

Legislation often targets the needs of particular populations, due in part to the mobilization of specialized interest groups who advocate for the interests of the groups they represent. The results from Facet Two illustrate the influence of varied interest groups. In the 1960s, the private insurance system inadequate covered the elderly population of America leaving, "roughly half of the elderly [with no insurance] . . . and those with polices often with caps of only $10 per hospital day."[4] In response, Medicare was established as a social insurance program designed for the elderly. The targeted initiative

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[4] McCelellan, M., & Skinner, J. (1999). Medicare reform: Who Pays and Who Benefits?. *H E A L T H A F F A I R S*, *18*(1),

of this reform effort is represented by my data: 87% of the provisions of the Social Security Amendments are targeted, with 44% aimed at the elderly populations, and 16% Women and Children (AIII, FIGIII.1). The Health Securities Bill was meant to be a policy response to the growing number of uninsured Americans; therefore, the majority of provisions were comprehensive in nature (AIII, FIGIII.2). This variation suggests a trend of legislative success when reform targets populations versus aiming for comprehensive reform. The PPAC targets a range of populations, and is less than half (40%) comprehensive (AIII, FIGIII.3). Again, with the limited data of this study, we cannot reliably predict its success or failure; therefore, we can predict it to be successful

Additionally, I hypothesized that Health legislation targeting particular populations, problems, or diseases will illustrate a change of focus over time. There has been a notable shift from policy addressing individuals with the highest need of care to individuals with reduced access to care. The Social Security Amendments implemented a program to mollify the disease burden of the elderly specifically. Modern reform efforts, such as the Health Securities and Patient Protection Bills seek to stabilize the growing rate of uninsured.

My results from Facet Three revealed that there is a consistently higher allocation of solutions to economic and insurance issues as compared to medical solutions (AIV, FIG1). This disparity could be rooted in a stronger focus on cost control rather than a focus on providing medical services. The congressional branch is said to yield the power of the purse, and their innate purpose lies in the realm of economics; thus, these findings are reasonably explained by congresses role in health care. Additionally, American medical care ranks highly next to global standards, and the health crisis has little to do with care and a lot to do with access and insurance. The problem which modern health reform attempts to address is a fundamentally economic one, therefore, it is only logical that legislative solutions are also found to be largely economic

Though this explains the phenomenon, I would argue that a truly comprehensive reform would have to address all facets of healthcare. The unequal allocation of solutions is further support for the idea that health policy addresses concerns piecemeal, rather than addressing the overall disease burden. This underrepresentation of medical solutions has stifled more all-inclusive proposals. It should, however, be noted that research & education and medical solutions have increased proportionally over time.

DISCUSSION AND FUTURE RESEARCH

This research provides political scientists and citizens with a better understand the aims of health policy in congress as well as what interests and concerns are most often addressed. Moreover, this research presents an explanation to why comprehensive reform efforts are so difficult, and why the problem is addressed in an uncoordinated manner. My analysis reinforces the idea that policy makers often function as pluralists, and special populations will amass the most awareness, impeding more universal reform.

The past century is littered with health reform legislation and failures. To refine the trends revealed by my original three case studies, I plan to additionally code the CHIPA, COBRA, HSA, SCHIP, and USNHCA. If the data is consistent, the trends could be used to predict potential outcomes of future reform efforts by determining a threshold, or highest proportion of provisions. For example, legislation could be predicted to pass if the proportion of provisions that are not amendments to prior legislation is below the calculated threshold. Similarly, if the proportion of provisions that are targeted is above the calculated threshold for this facet, its outcome could be predicted as passage.

Even with the addition of additional case studies, a number of important variables remain uncontrolled. To accomplish thoroughly reliable trends, these variables would have to be addressed. For instance, it can be assumed the passage or failure of health reform legislation would significantly

depend on the timing of the proposal. Due to this, the state of social and economic affairs must be considered before the data trends could be valid. One method I could use to address this is to choose case studies that were proposed at similar historical eras, meaning the economy and popular opinion are congruent.

Another variable to consider is the fiscal size of proposed legislation. The measured cost-effeteness of legislation would play a crucial role in its passage. Assumingly, a five billion dollar proposal would pass over a comparable proposal at 15 billion. Furthermore, a reform effort that proposes to significantly decrease national debt figures arising from health care costs would theoretically be more successful than a proposal that increases or does not affect debt levels. However, Historical examples discredit these assumptions. For example, one incidence of contradiction is the passage of Medicare Part D. Because the effect of fiscal size is inconsistent on legislative success or failure, it is a difficult variable to control. The best method of control may be to implement a similar method as proposed for controlling the effects of variable historical eras. Coded legislation of similar fiscal size should be compared in analysis.

A number of other economic, political, and social factors, such as party influence or public opinion would need to be considered in data analysis, but are difficult to control for. The greater number of case studies preformed would decrease the statistical significance of uncontrolled variables.

Overall, my analysis reinforces the idea that policy makers often function as pluralists, exhibiting traditionally episodic problem-solving in reaction to mobilization by affected interest groups. This has hindered comprehensive solutions to both economical and medical aspects of the health crisis. In future research I plan to code more reform legislation to refine these established patterns, which could be used to predict the outcome of future reform attempts. I would also like to identify the factors and influences driving the patterns my results have revealed.

APPENDIX I: CODEBOOK

Facet 1: Amendment
0 **Not an amendment of prior legislation**
1 **Amendment to prior legislation**

Facet 2: Targets
2 **Maternal & Pediatrics**
> Provisions that target care for women and/or children; including natal and gynecological care, family planning, abortion, CHIP, public school health education, etc.

3 **Minorities**
> Provisions that target particular minority groups , such as Native Americans, Latin Americans, African Americans, or refer to minority groups in general (EX no discrimination based on race or ethnicity)

4 **Elderly/ MEDICARE**
> Provisions that concern geriatrics or target the elderly; including sections amending or referring to Medicare unless better fit elsewhere:
>> Medicare revision to extend chronic care codes as (9)
>> Concerning dual eligibility for Medicare and Medicaid codes as (15)

5 **Geographically Underserved (PPAC CODED AS MENTAL HEALTH)**
> Provisions that target individuals in geographically underserved areas, encompassing both rural and urban health.
>> This is coded for over (4) & (7) if geographic restrictions are mentioned

6 **Pre-existing Conditions & Disabilities**
> Provisions addressing pre-existing conditions or individuals with disabilities.
>> Chronic care for disabled individual should be coded as (9)

7 **Low Income/ MEDICAID**
> Provisions that target Low Income (both above and below the poverty line) populations; including sections amending or referring to Medicaid unless better fit elsewhere:
>> Provisions concerning CHIP (2)

8 **Healthcare Workforce**
> Provisions that directly concern the healthcare workforce, such as loans and funding to improve education and training. Note, the benefits of this category would be considered comprehensive (14)

9 **Chronic Care**
> Provisions concerning chronic care; including post operational care, nursing homes, etc as well as end of life care/ euthanasia

11 **Particular disease, condition or service**
> Provisions that are specific to one facet of health are coded and the case is adjacently specified
>> Provision targeting cancer research (11)- CANCER

12 **Illegal Immigrants, Non- citizens**
> Provisions referring to healthcare for illegal immigrants and other non-citizens

14 **Comprehensive or no specified target**

Provisions that are comprehensive in nature, such as regulations to public industry, as well as those which do not clearly target any group or program. Note, this category is meant as a control

15   Multiple Programs

Provisions that address two or more programs, of which two or more populations are included (EX Provision concerning Medicare, Medicaid, and CHIP)

Facet 3: Solutions

10   MEDICAL

11   Information Technology

Solutions to inadequacies in health information technology; including improving the simplification, transparency and efficiently as well as new systems

12   Quality

Provisions outlining quality measurement and control or means of improvement.

Financial incentives are coded as (23)

13   Reducing the disease burden, Public Health

Provisions aimed at directly reducing the overall disease burden of the population or improving public health initiatives.

14   pharmaceutical access, distribution, and regulation

Financial aspects of pharmaceutical industry are coded as (24)

Prescription drug coverage is coded as (34)

15   Access

Provisions involving an extension or improvement of access to medical care or a particular service.

20   Economic

21   Appropriations

Provisions concerning the allocation of governmental funding

22   Financing Insurance Industry

Provisions concerning strictly economic aspects of the insurance industry; including tax credits to employers/ employees, risk-adjustments, etc.

Provisions addressing insurance other than/ more than economically should be coded in (30) categories.

23   Financing Care Industry

Provisions concerning strictly economic aspects of the care industry;including physician's fees, regulating service prices, governmental loans to healthcare education and training, etc.

Provisions addressing insurance other than/ more than economically should be coded in (10) categories

24   Financing Pharmaceutical Industry

Provisions concerning strictly economic aspects of the pharmaceutical industry; including regulating drug prices, etc.

30   Insurance

31   Extending Coverage and Eligibility

Provision providing means of coverage extension and increased eligibility for pre-existing programs N

New insurance programs code as (32)).

32   New Programs

Provisions creating new insurance programs.

Amendment to existing programs code as (31) coverage or (33) regulation, typically

33   Regulations

Provisions providing means or standards for regulation of the insurance industry; including means of simplification, transparency, and increase efficiency

34   Drug Coverage

Provisions providing solutions to drug coverage or concerning what drugs are/ not covered

40   Operational or Not Specified- (role delegations, associated dates, etc.)

42   Legal Matters

Provisions addressing legal matters; for example, lawsuit activity, terms of criminal action for insurance fraud, etc.

50   Research and Education

51   Research aimed at economic goals

such as pilot payment systems or demonstrations

52 Research aimed at medical goals

such as clinical trials

53   Public Health Education and promotion

such as efforts to educate and promote health to the public

54   Healthcare workforce education and training

Such as new programs or methods of teaching.

Loans, Scholarships, or other financial allocations code as (23)

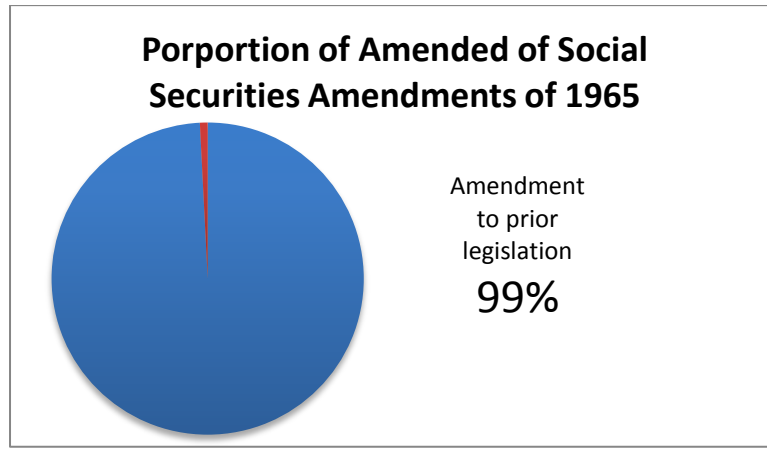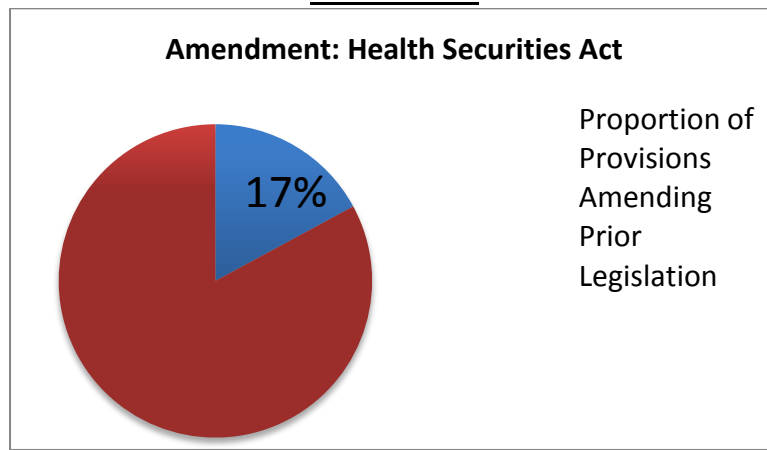# APPENDIX II: FACET 1- AMENDMENT GRAPHS

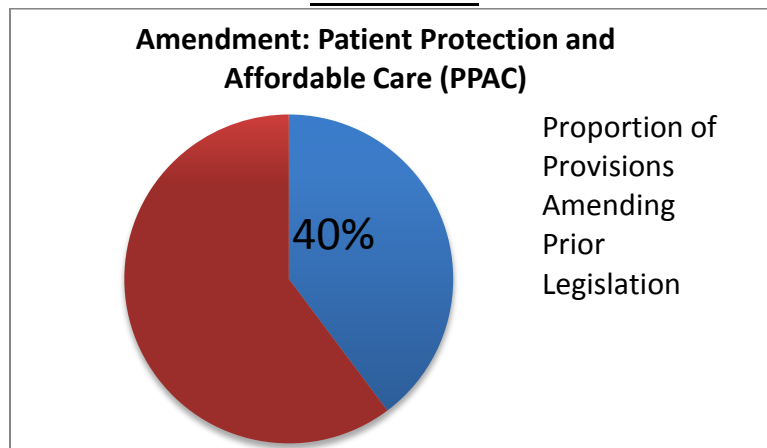### Porportion of Amended of Social Securities Amendments of 1965

Amendment to prior legislation

99%

FIGURE II.1

Amendment: Health Securities Act

17%

Proportion of Provisions Amending Prior Legislation

FIGURE II.2

Amendment: Patient Protection and Affordable Care (PPAC)

40%

Proportion of Provisions Amending Prior Legislation

FIGURE II.3

Targets of The Social Security Amendment 1965

Legend:
- Women & Children
- Minorities
- Elderly
- Geographically Underserved
- Pre-Existing Conditions & Disabilities
- Low- Income
- Healthcare Workforce
- Chronic Care
- End of Life Care
- Particular Disease, Condition, or Service
- Illegal Immigrants, Non-citizens
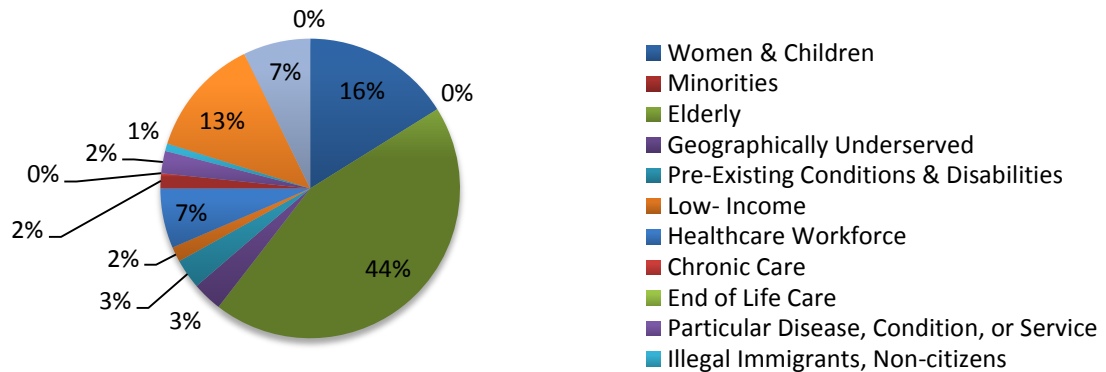
FIGURE III.1

Targets of Health Securities

Legend:
- Women & Children
- Minorities
- Elderly
- Geographically Underserved
- Pre-Existing Conditions & Disabilities
- Low- Income
- Healthcare Workforce
- Chronic Care
- Particular Disease/ Condition
- Illegal Immigrants, Non-citizens
- Comprehensive or Not Specified
- Other or Mulitiple Programs
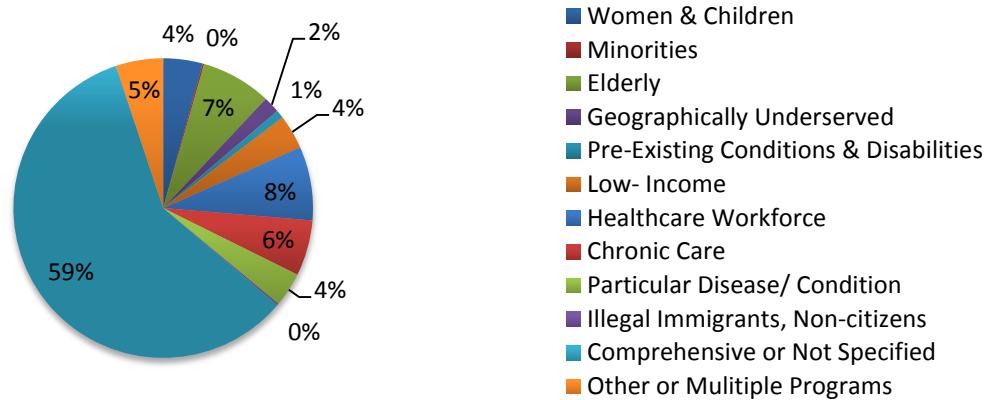
FIGURE III.2

Targets of PPAC

Legend:
- Women & Children
- Minorities
- Elderly
- Geographically Underserved
- Pre-Existing Conditions & Disabilities
- Low- Income
- Healthcare Workforce
- Chronic Care
- Particular Disease, Condition, or Service
- Illegal Immigrants, Non-citizens
- Comprehensive or Not Specified
- Other or Mulitiple Programs
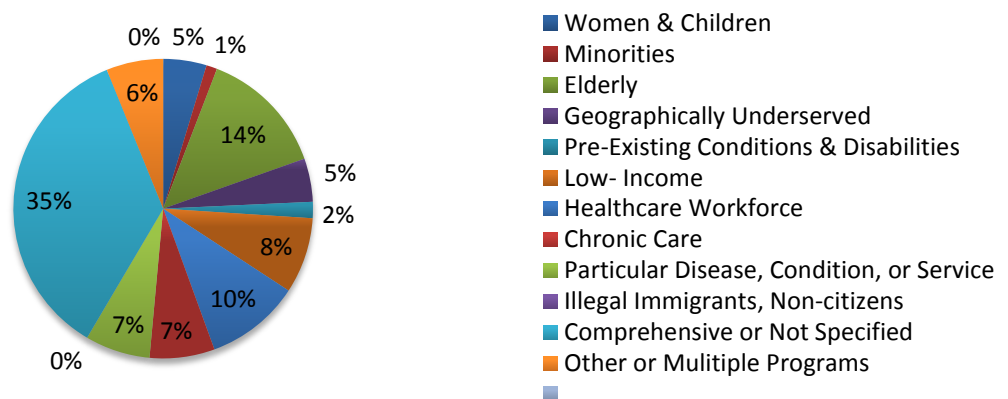
APPENDIX IV- FACET 3- SOLUTIONS
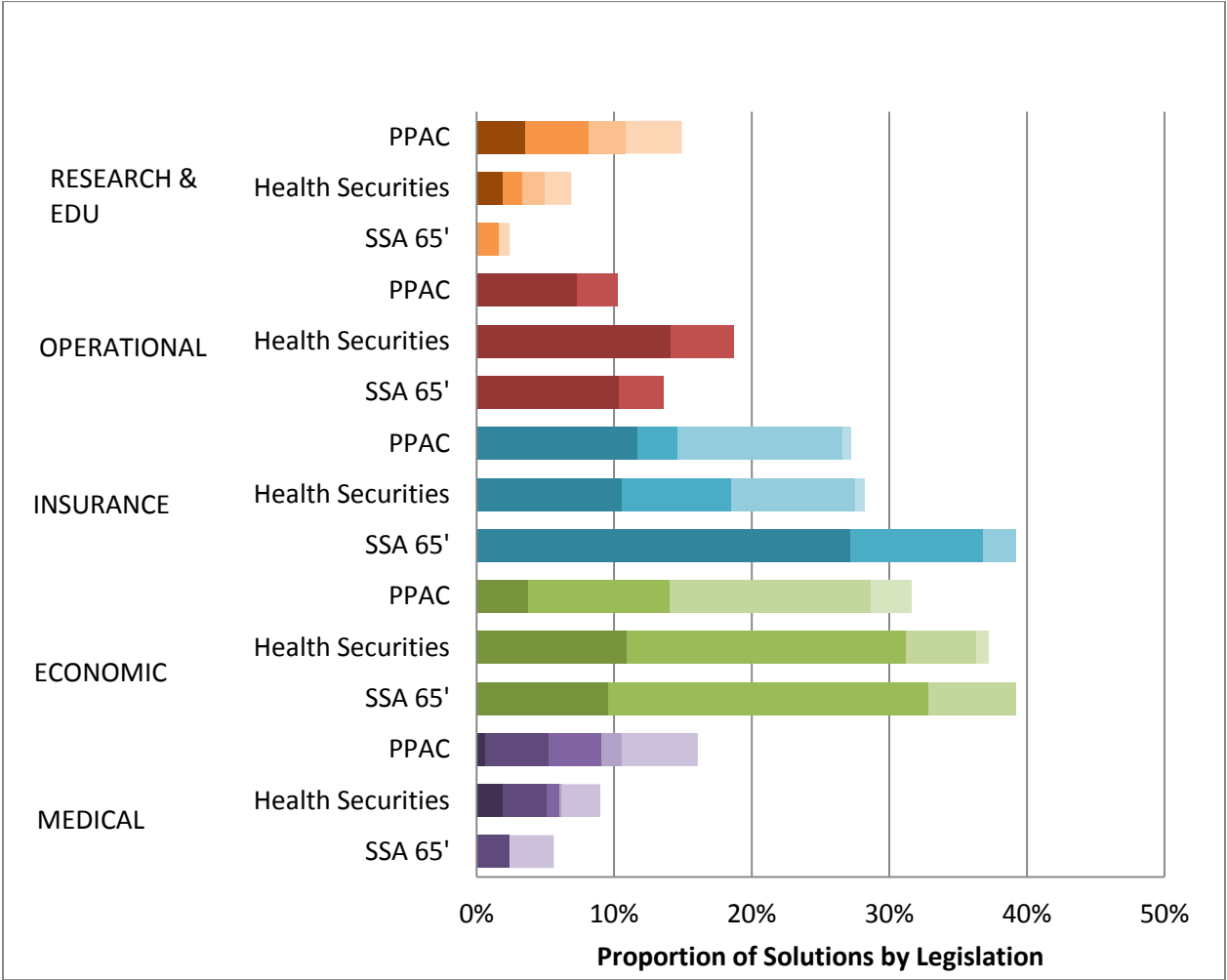
FIG IV.1

KEY

21	Appropriations	
22	Financing the Insurance Industry	
23	Financing the Care Industry	
24	Financing the Pharm Industry	

11	Information Technology	
12	Quality	
13	Reducing the Disease Burden	
14	Pharmaceutical Acess, Distribution, and Regulation	
15	Acess to Medical Care	

51	Research aimed at Economic Goals	
52	Research aimed at Medical Goals	
53	Public Health Education and Promotion	
54	Healthcare Education and Training	

40	OPERATIONAL OR NOT SPECIFIED	
42	Legal Matters	

31	Extending and Defining Coverage and Eligibility	
32	New Programs	
33	Regulations	
34	Drug Coverage	