

Law of the Land: Medicare and the Financial Implications of the PPACA

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America has entertained the idea of health care reform for the past several decades; although slight changes have been made over time, they all pale in comparison to controversial changes under the new laws and regulations that are emerging from recent legislation. On March 23, 2010, President Barack Obama signed the *Patient Protection and Affordable Care Act (PPACA)* into law. The existence of the law is known by many Americans; however, many people do not seem to know that the law has many positive financial implications on the federal health insurance program Medicare.

Medicare is thought by many to be a government funded program that is unsustainable. People who believe the unsustainability of Medicare base their analysis from the tremendous growth and expansion of the program since its inception in 1965. According to Chief Actuary Richard Foster, of Medicare and Medicaid Services; his 2010 memorandum *Estimated Financial Effects of the Patient Protection and Affordable Care Act as Amended*, the Medicare program has grown from a rate of 0.6 percent of Gross Domestic Product (GDP) spending in 1965 to the current rate of 3.6 percent of GDP in 2010. The amount of Americans expected to qualify for Medicare benefits are estimated to double over the next 25 years due to the aging population, a result of the phenomenon known as “baby boomers” (Foster, 2011). With data pointing to unsustainability, United States politicians have taken measures that will slow the growth rate of the Medicare program. The goal of this paper is to show that the Medicare program is more sustainable today than it was yesterday due to the controversial Patient Protection and Affordable Care Act (also known as the Affordable Care Act, or ACA) health care law that will take full effect in the year 2014. (Foster, 2011)

To achieve this goal the organization of this paper is segmented into five main sections and two sub-sections. The first section is a brief history of Medicare to ensure the reader has a fundamental understanding of the Medicare program and major events that helped shape the program over time, as well as a sub-section describing Medicare today. The second section describes the Affordable Care Act with a sub-section describing the qualitative impact the ACA has on Medicare. The third section outlines the financial implications of the ACA on Medicare and how the legislation slows the growth of the program. The fourth section details how health care providers are bracing for the changes to come with the ACA, and other suggestions to make the Medicare program more sustainable. The final section will provide an overall analysis of the paper to support the original thesis. Each section builds off of the previous section and is important to developing a fundamental support of the thesis.

MEDICARE HISTORY

Medicare is a health insurance program that was signed into law in the year 1965 by President Lyndon B. Johnson. The Medicare program was passed as H.R. 6675—P.L. 89-97, as a law under the Social Security Act for Americans over the age 65. The original Medicare law “comprised of two related health insurance plans for persons aged 65 and over: (1) a hospital insurance plan providing protection against the costs of hospital and related care, and (2) a supplementary medical insurance plan covering payments for physicians’ services and other medical health services to cover certain areas not covered by the hospital insurance plan” (Social Security Administration). The enactment of Medicare was important because prior to the law nearly half of United States citizens over the age 65 had health insurance according to the Social

Security Administration. As people get older medical costs typically increase, a factor that was certainly considered when creating a national health insurance program for the elderly.

In July of 1966, Medicare was enacted with an annual budget of three billion dollars. This original Medicare program provided health insurance benefits to more than 19 million individuals over the age of 65. By 1972, the Medicare program had expanded to provide medical benefits to persons under the age of 65 who were severely disabled; those who were receiving Social Security Disability Insurance payments for at least two years and individuals with end-stage renal disease. In 1983 Medicare established a prospective payment system. Prior to the prospective payment system hospitals set the rate to which they would bill Medicare. The prospective payment system set a pre-determined rate that Medicare would reimburse to health care providers (Kaiser Family Foundation, 2012).

With the expansion of Medicare the demand for more medical insurance options grew. Lawmakers decided to create an extension of the Medicare program that would introduce privatized health insurance: “The Medicare Advantage (MA) program, formally Part C of Medicare, originated with the Tax Equity and Fiscal Responsibility Act (TEFRA), which authorized Medicare to contract with risk-based private health plans, or those plans that accept full responsibility (i.e., risk) for the costs of their enrollees’ care in exchange for a prospective, monthly, per-enrollee payment” (McGuire, Newhouse, Sinaiko, 2011). The creation of Medicare Part C essentially introduced Medicare beneficiaries to an option of using Medicare to pay for private insurance. TEFRA was passed in 1982 and private insurance became an option to Medicare beneficiaries by 1985 (McGuire, Newhouse, Sinaiko, 2011).

In 1988, Medicare underwent another major change, “the Medicare Catastrophic Coverage Act, which included the most significant changes since enactment of the Medicare

program, improved hospital and skilled nursing facility benefits, covered mammography, and included an outpatient prescription drug benefit and a cap on patient liability” (Centers for Medicare and Medicaid Services). However, in 1989, “the Medicare Catastrophic Coverage Act of 1988 was repealed after higher-income elderly protested new premiums” (Centers for Medicare and Medicaid Services).

If the Medicare Catastrophic Coverage Act of 1988 would not have been repealed in 1989, this would have been the largest expansion of the Medicare program since its inception. It is clear to see that making changes in a program as large as Medicare is next to impossible. In fact, aside from the addition of Medicare Part C, Medicare underwent only slight modifications in the program since it began in 1966. Prior to the Affordable Care Act, the most successful expansion of the Medicare Program occurred in 2003.

In 2003, “the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) was passed by the House and the Senate in November and signed into law by President Bush on December 8, 2003, providing a new outpatient prescription drug benefit under Medicare beginning in 2006. In the interim, it created a temporary prescription drug discount card and transitional assistance program” (Kaiser Family Foundation). The MMA created a tremendous change in the Medicare program for beneficiaries by having the government subsidize prescription drug payments.

MEDICARE TODAY

According to the Centers for Medicare and Medicaid Services website (the administration that oversees the Medicare program), Medicare today consists of four main parts; Parts A, B, C and D. Part A is hospitalization insurance, which covers inpatient care, skilled nursing facilities

and hospice (for those who are expected to be near the end of their life). Part B provides beneficiaries with medical insurance for preventative care, such as long-term nursing centers, primary care medicine and screenings. Part C of Medicare is simply Medicare Advantage, which provides Medicare beneficiaries the option to purchase private health insurance and having Medicare pay their premium. Medicare Part D is the most recent addition to the Medicare program which provides prescription drug coverage benefits for Medicare recipients (Centers for Medicare and Medicaid Services).

Medicare is one of the largest health care insurance programs in the United States by both membership and annual spending. The Kaiser Family Foundation reports that Medicare currently provides health insurance for nearly 50 million Americans over the age of 65 and severely disabled. Today's Medicare budget is a multiple of 185 times the programs original budget, or \$556 billion in 2012. Total spending on Medicare represents 15 percent of the federal government's expenses. There are three primary sources for financing the Medicare program. The first source is through general revenues (40 percent), the second is through payroll tax contributions (38 percent), and the third main source is from beneficiary premiums (13 percent). The remainder of financing for the program comes from interest and state payments (Kaiser Family Foundation).

According to the U.S. Census Bureau, the states with the highest number of Medicare enrollees are California and Florida with 4.6 million and 3.3 million enrollees, respectively; the areas of the country with the lowest number of enrollees are Wyoming and Washington, D.C. with 78 thousand and 77 thousand enrollees, respectively. The number of Medicare enrollees plays an important political role because of their political influence within these regions (U.S. Census, 2012).

After understanding the historical events that transformed Medicare throughout the United States history, it becomes clear that the program is deeply embedded within the society. Nearly one out of every seven Americans uses Medicare as their primary source of health insurance. However, the costs of the program continue to rise by the day due to higher enrollments and increases in health care costs. These are issues that are addressed in the Affordable Care Act.

THE AFFORDABLE CARE ACT

The Patient Protection and Affordable Care Act is arguably one of the most controversial topics in American politics today. The law is health care legislation meant to reform the United States health care and health insurance industry. Signed by President Barack Obama on March 23, 2010, the law gradually makes changes in the United States health care.

The Affordable Care Act document is 974 pages long and contains 10 titles outlining the scope and blueprint of the law. It requires an individual mandate which requires individuals to either purchase health insurance or pay a fine to the Internal Revenue Service, and employers with more than 50 employees must provide health insurance to their employees or pay a similar fine. The law also expands the Medicaid program for those who are not covered by Medicare and incomes less than 133 percent of the Federal Poverty Level. The ACA also creates state-based health care exchanges to provide more options and competition for purchasing health insurance. The long term objective of the law is to get 32 million currently uninsured Americans health insurance and to slow the cost growth of the medical care industry (H.R. 3590, 2010).

Additionally, the law is arguably one of the most controversial topics in modern American politics. The controversy of the law is apparent in the fact that the legality of the law

was questioned by the United States Congress in a legal battle that went all the way to the United States Supreme Court.

“In 2010, Congress enacted the Patient Protection and Affordable Care Act in order to increase the number of Americans covered by health insurance and decrease the cost of health care. One key provision is the individual mandate, which requires most Americans to maintain ‘minimum essential’ health insurance coverage. 26 U. S. C. §5000A. For individuals who are not exempt, and who do not receive health insurance through an employer or government program, the means of satisfying the requirement is to purchase insurance from a private company. Beginning in 2014, those who do not comply with the mandate must make a ‘[s]hared responsibility payment’ to the Federal Government. §5000A(b)(1). The Act provides that this ‘penalty’ will be paid to the Internal Revenue Service with an individual’s taxes, and ‘shall be assessed and collected in the same manner’ as tax penalties. §§5000A(c), (g)(1)” (National Federation of Independent Business et al. v. Sebelius, Secretary of Health and Human Services, 2012). The main argument that the National Federation of Independent Business declared was that requiring individuals to purchase private health insurance (i.e. an individual mandate) was unconstitutional. However on June 28, 2012, the United States Supreme Court deemed the Affordable Care Act as constitutional (National Federation of Independent Business et al. v. Sebelius, Secretary of Health and Human Services, 2012).

Despite the U.S. Supreme Court’s decision, many people still opposed the law. The Affordable Care Act became a controversial talking point during the 2012 Presidential election race; where Republican candidate Mitt Romney swore to repeal the law and President Barack Obama promised to keep the law in place. Eventually, President Obama would win the 2012 election, ensuring that the law remained in place. In fact, in an interview with ABC News, the

Speaker of the House of Representatives, John Boehner, described the Affordable Care Act as “the law of the land” (O’Brien, 2012). This statement solidified the fact that the Affordable Care Act is now embedded within the United States and is here to remain.

In addition to the ACA reforming health care in the United States, the law makes many qualitative and quantitative changes to the Medicare program. Interestingly the changes that the health care reform has on Medicare actually improve the Medicare program for beneficiaries while strengthening the fiscal stability of Medicare.

ACA IMPACT ON MEDICARE

The Affordable Care Act gradually eliminates the Medicare Part D coverage gap known as the doughnut hole by gradually lowering the co-payments that Medicare beneficiaries have to pay over time; by the year 2020 Medicare beneficiaries will make a co-payment of 25 percent on prescription drug payments. Currently beneficiaries must pay 100 percent of prescription drug payments after he or she spends \$2,970 on prescription drugs a year (Q1 Medicare LLC, 2012).

The non-profit organization *Medicare Rights Center* describes that prior to the ACA Medicare beneficiaries were required to pay 20 percent of most preventative services out of pocket; meaning that they had an incentive to not seek preventative care due to the fear of a co-payment. The ACA directs Medicare and Medicare Advantage not to charge a co-payment to Medicare beneficiaries. Another flaw in the Medicare program prior to the ACA changes is that it offered a one-time wellness visit to enrollees during the first year of enrollment into Medicare. The ACA entitles each Medicare beneficiary to an annual wellness visit, rather than the one-time wellness visit. This advancement of the Medicare program is important because it will enable health care providers to catch medical conditions in Medicare patients sooner. Many people wait

to get medical treatment until they feel extreme symptoms, and many times symptoms go unnoticed. Checking a Medicare recipient more frequently will likely lower the long term costs of expensive procedures (Medicare Rights Center, 2013).

“The Affordable Care Act tests a variety of delivery system reforms and care models to improve care quality and care coordination by promoting better communication and coordination among providers, patients and caregivers to help prevent problems like harmful drug interactions, unnecessary hospitalizations, conflicting diagnoses and failures to connect people with community based services that can help them manage their health” (Medicare Rights Center, 2013). Increasing communication and efficiency in the United States health care system will alter the way that health care providers do business with Medicare patients. Prior to the ACA health care providers were paid by the quantity of patients that they saw. Under the ACA health care providers will be paid a lower reimbursement rate if they have high readmission rates for Medicare patients, creating an incentive for health care providers to place an emphasis on quality rather than quantity of care provided.

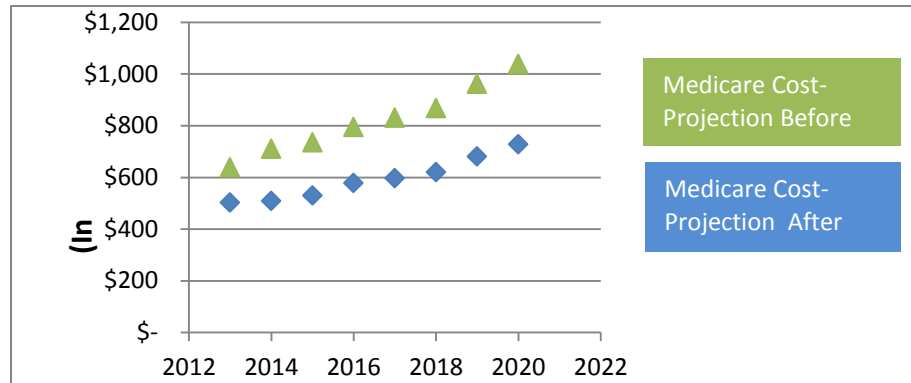
The most interesting change that the Affordable Care Act makes to Medicare is the long-term fiscal stability of the program. The ACA not only improves the benefits for Medicare beneficiaries, it slows the long term financial growth of the program. This detail is important because of the cost of medical technology is on the rise and the size of Medicare and number of enrollees expected to increase in the coming years.

ACA FINANCIAL IMPACT ON MEDICARE

The *Center on Budget and Policy Priorities* analyzes federal and state budgets to help policymakers in decision making. They provide a breakdown of the federal government’s

spending by sub-categorization. In fiscal year 2012 the federal government spent approximately \$3.5 trillion, which is roughly \$1.1 trillion higher than the federal government's revenues. Spending on Medicare represented 13.5 percent (\$472 billion) of the federal government's outlays (Center on Budget and Policy Priorities, 2013).

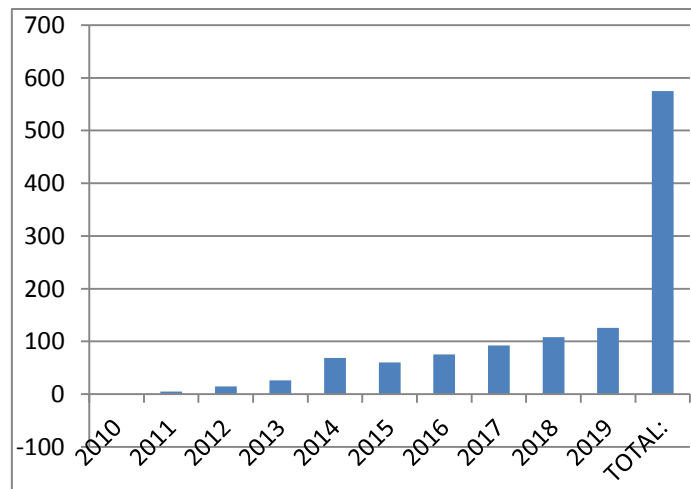
The spending on Medicare utilizes a sizable percentage of the federal government's total spending per year. However, it is not the



current spending rate on Medicare that Americans should be concerned with; it is the projected spending on Medicare that is worrisome. According to the non-partisan *Congressional Budget Office* spending on Medicare is projected to increase at an exponential rate. Costs were expected to exceed one trillion dollars a year on Medicare spending within the coming decade by the year 2020. With changes made in Medicare from the ACA, Medicare spending is projected to reach \$728 billion in the same time period as seen in Figure 1.

The total 10-year savings on the Medicare program from the ACA is estimated at a cumulative \$711 billion. (CBO, 2013) The majority of the savings will be attributed to savings in Medicare parts A, B and C, according to the *Centers for Medicare and Medicaid Services* chief actuary

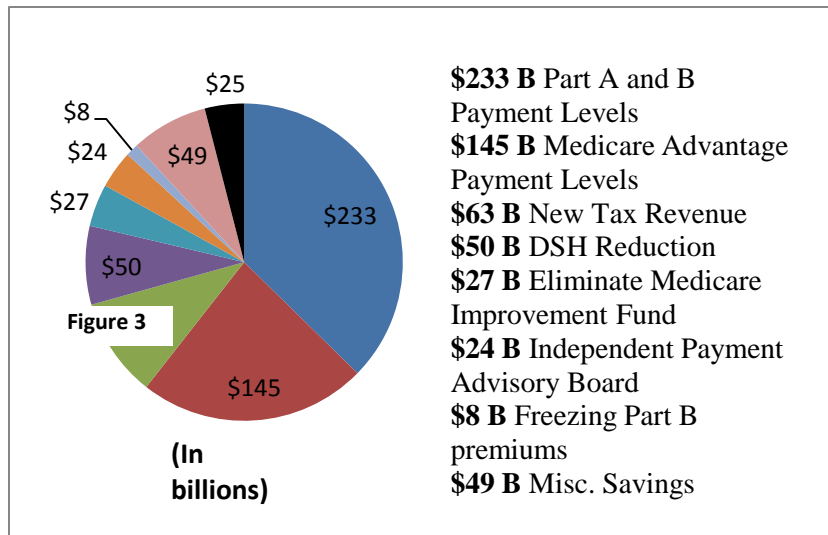
Figure 2: Savings per year (In USD Billions)



Richard Foster’s 2011 testimony before the United States House of Representatives. Chief Actuary Richard Foster projects total savings by the year 2020 to equal \$575 billion, as shown in Figure 2 (Foster, 2011).

Figure 3 displays exactly where the Centers for Medicare and Medicaid Services predict where the cost savings will come from. The largest portion of cost savings comes from slowing the rate of growth of the

reimbursement to Medicare provides Part A and B health care providers by \$233 billion. The second largest portion of cost saving measures comes from slowing the growth of Medicare part C payments for a



total savings of \$145 billion. Since Medicare enrollees can opt for having Medicare pay for a private insurer in lieu of using Medicare as their primary source of health insurance, Medicare

pays the private insurer nine percent above of what would normally be paid for by Medicare. Under the new laws within the ACA, this nine percent gap will remain frozen until Medicare reimbursement payments catch up, reducing the gap to nothing. Medicare Advantage private insurers were previously allowed to charge higher rates for expensive medical procedures; however the ACA stipulates that the private insurers of Medicare Advantage beneficiaries will not be able to charge rates higher than those charged by Medicare.

Medicare Advantage private insurers would typically charge lower premiums for people with inexpensive health conditions, thus attracting healthier clients. The ACA recognizes this as unfair practice and insurers may no longer profit off of healthier Medicare beneficiaries. Not only does this create an incentive for healthier Medicare enrollees to opt for private insurance, it serves as an incentive for leaving Medicare with the burden of paying for the more expensive Medicare beneficiaries. To help ease the transition that this major change the ACA places on Medicare, the ACA also dictates that private insurers who take on Medicare Advantage beneficiaries must spent at least 85 percent of all monies received from Medicare on those patients (Foster, 2011).

The rest of the savings projected by Foster come from increasing Medicare premiums on higher income Medicare beneficiaries and the creation of an *Independent Payment Advisory Board*. The federal government identifies high income Medicare enrollees as those earning more than \$85 thousand per year for an individual or \$170 thousand a year for a married couple (Foster, 2011).

Along with saving money spent on Medicare the ACA raises new money to fund Medicare in the form of income taxes. The current tax rate for Medicare is 2.9 percent of all income earned. Typically, an individual will pay 1.45 percent, which would be matched by

his/her employer. The ACA places an additional tax burden of 0.9 percent on all income over \$200 thousand earned by an individual or \$250 thousand for a married couple. The increase of 0.9 percent on income that falls in this category is estimated to raise an additional \$63 billion by the year 2020 (Foster, 2011).

The reductions in the long-term spending of Medicare are significant without a doubt. The billions of dollars saved and raised will be essential to keep Medicare solvent in the future. The cost reductions being implemented to Medicare by the ACA will slow Medicare's estimated growth rate from 6.8 percent to 5.3 percent, which, though impressive, it is simply not enough.

Spending on health care in America is growing at a rate faster than our national income. In 1980, the United States spent \$256 billion on health expenditures. Over the next three decades spending increased by a factor of ten, reaching a total of \$2.6 trillion in 2010. Although growth slowed during the recent recession, projected growth in health expenditures is estimated to grow at 5.7 percent a year for the next decade. Many of the costs increases can be attributed to the advancement of medical technology. However, baby boomers will soon be reaching the age 65, becoming eligible for Medicare relatively soon. The baby boomer generation is projected to double in size by the year 2035, which implies a vast expansion of Medicare (Kimbuende, 2011).

The United States needs to figure out a way to make Medicare more sustainable. The future of the program is in not stable with the current trend of increases in the older population and medical costs. Many lawmakers debate privatizing Medicare or making drastic cuts to the program as a means for stabilization. The truth of the matter is that changes will need to be made to keep the program as an option in the future. The changes will not come from just laws but from everyone in the nation, and in the health care industry in particular.

BRACING FOR ACA CHANGES AND STABILIZING MEDICARE

On March 12, 2013, I was given the opportunity to sit down and discuss the ACA and Medicare's impact on health care providers. I interviewed was Lancaster General Hospital's Chief of Staff Genevieve J. Mak, or Genny, as she prefers. Genny is a graduate of the College of William and Mary in Williamsburg, Virginia. She was hired by Lancaster General Hospital specifically for the purpose of consolidation of departments and making their health care system more efficient.

When asked if Medicare influences the way hospitals conduct business, she said "yes, because many insurance companies set their premiums to match Medicare rates." She also said "since the passing of the Affordable Care Act, we have had to change the way that we do business." I then asked if the ACA impact the way that hospitals do business in the year 2014, when the law is in full effect. Genny replied "Lancaster General Hospital has established what has been termed Accountable Care Organizations (ACOs). These are groups of health care providers who develop policies to provide high quality healthcare to Medicare patients." ACOs are a newer concept but will play a larger role in the future for conducting business with Medicare patients (G. Mak, Personal Communication, March 12, 2013).

Out of curiosity I decided to ask Genny how closing the Medicare part D prescription drug doughnut hole will affect access to quality prescription drugs. Genny responded "prescription drugs don't affect the hospital too much because we don't provide pharmacy services to the general public; however, what we're seeing is that the ACA has changed the behavior in organizations who we do business with. For example: a pharmacy may offer discounts to Lancaster General Hospital patients if we refer our patients to them" (G. Mak, Personal Communication, March 12, 2013).

By Lancaster General Hospital increasing the supply of prescription drug patients to a particular pharmacy, they are essentially increasing the supply of customers; the effect is a lowering in the price for the customer due to the higher volume of prescriptions able to be sold, which is mutually beneficial for both Lancaster General Hospital, their patients and the pharmacy selling the prescription.

I proceeded to ask the next question: Since the majority of cost savings from the Medicare program will come from a reduction in payment levels for health care providers, is Lancaster General Hospital preparing for the lower reimbursement rates? Genny's response was that "the majority of solving the changes in Medicare reimbursements will be tasked to the ACOs, who will figure out ways to consolidate departments and get rid of waste to recoup funds lost" (G. Mak, Personal Communication, March 12, 2013).

The last few questions that that I asked Genny were: is the ACA a good thing for the country? In your view, what can be done to reduce the growth rate of Medicare and health care costs? Her response was, "I'm not 100 percent sure if the Affordable Care Act is the best thing for the country, but I do believe that changes need to be made to reduce the rate of health care growth in general. I think that ACOs will play a major role in the future, as well as establishing partnerships with other organizations to help reduce the costs." Genny acknowledges the fact that the main purpose of her employment was to help figure out solutions to reduce some of the administrative costs Lancaster General Hospital incurs. It can be assumed that many other health care organizations are making similar changes to brace for the coming changes in the ACA (G. Mak, Personal Communication, March 12, 2013).

According to the non-governmental official Medicare beneficiary organization *AARP*, a variety of viewpoints can be taken in shaping the future of Medicare's sustainability. Some of the

major choices currently being considered by lawmakers to increase the sustainability is to rise the Medicare eligibility age, raise premiums, privatize Medicare so that the whole program becomes more like Medicare part C, redesign the payment system, or pay for performance versus pay for quantity of patients (Butler, 2012).

Americans are living longer today, and costs of medical care are increasing as the field of medicine advances. Therefore, raising the age requirement and taxes or fees for Medicare makes logical sense. In terms of slowing the total growth rate of the Medicare program, these options are only short-term fixes for the United States' long-term problems.

ANALYSIS/CONCLUDING REMARKS

The Affordable Care Act's financially slows the long-term growth in Medicare spending. The ACA works to increase the benefits of Medicare, while also cutting inefficient programs that Medicare operates. The ACA comes at a time in Medicare's history where fiscal stability and quality of care for senior citizens is needed the most. This is mainly due to the increasing number of people that will rely on Medicare as their sole provider for quality medical insurance, both now and in the future. The ACA has a positive impact on the Medicare program. Changes will likely be made in the future to stabilize the program and ensure that it remains a health insurance option for the elderly and severely disabled in the future. Medicare plays too large of a role in our economy for us to ignore or get rid of it.

Some of the options that I would like to see further explored in the future are the scope and power of the Independent Payment Advisory Board. This 15 member board will play a big part in making sure that Medicare is not growing faster than our capability to pay for it is. I also believe that changing the incentive for health care providers to focus on the quality of patient

care rather than the quantity of patients seen will play a much larger role in lower the costs in the future. After my conversation with Genny I understand that ACOs are already having a part in ensuring the quality of healthcare provided to Medicare beneficiaries. ACOs will have more responsibility when the ACA takes full effect in the year 2014 by making sure health care providers diagnose and treat Medicare patients properly the first time they are admitted, in order to gain the full reimbursement rate.

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