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# Healthcare Reform in Two States: A Comparative Analysis of Georgia and Massachusetts

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Executive Summary

Healthcare has been an ongoing conversation throughout the formation of America's sense of values and rights based on its Constitution. The role that the state plays in ensuring access to care based on legislation passed by the United States Congress is crucial for the public administrator to understand. This paper attempts to review the nature of the relationship between two states, Georgia and Massachusetts, and the federal government since the passage of the Healthcare Reconciliation Act of 2010 and the politics surrounding the controversy that has since ensued since the Act's enactment.

Access to healthcare is an important part of the lives of all American's and one would assume, based on the Constitution of the United States of America, that access to care is an infallible right which the federal government is responsible for upholding. Equity is the most prevailing democratic theme behind the passage of this Act and would seem to supersede the other democratic values of efficiency and effectiveness, though all democratic values are important. Equity is more important than profits, more important than personal politics or positional stature. As the administrators of the new Act step forward to implement its provisions it will be important to understand how they can succeed with its implementation. This paper will cover several recommendations regarding the successful enactment and highlight a few obstacles that will be faced. At the conclusion of this paper one should have a reasonable understanding of the role that the aforementioned states play in the implementation of the new healthcare act.

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## Acknowledgements

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## Introduction

Healthcare in the United States has been a topic of public policy for several decades. The enactment of legislation geared toward providing access to care has been largely successful throughout this time. Although, many changes have been made in our current healthcare system these changes do not address all issues concerning the enactment and maintenance of the new legislation. Various people, ranging from citizens, healthcare professionals to the politicians, government officials themselves feel that the healthcare system in the United States has been in need of a complete overhaul (Bodenheimer and Grumbach 2009, 193-202). Others have feel that some change is mandated, but the healthcare system does not need to be completely transformed (Bodenheimer and Grumbach 2009, 193-202).

Equity and universal access to healthcare is an imperative aspect of the concern for healthcare reform. The availability and the democratic value of equity is paramount to the argument of universal healthcare. Efficiency in the current healthcare system and the ability to effectively utilize the tax and other income revenues received by federal and state governments is another part of the concern over healthcare reform. However, those two challenges are not necessarily mutually exclusive (Bodenheimer and Grumbach 2009, 193-202). The United States is one of the only developed western countries to provide access to healthcare based on employment insurance programs. The citizens of the United States are dependent upon their ability to maintain employment and the feasibility of the company for which they work, to provide healthcare. Healthcare in the United States is an employment-based healthcare system contingent, on the individual's ability to earn a wage to qualify for healthcare. This basis allows

for grey area on the part of the federal government to intervene on behalf of its citizenry due to the fact that healthcare is dependent on an individual's ability to pay for premiums, deductibles, prescriptions and other related costs. It would seem that only recently the United States federal government has realized that access to healthcare is a serious concern. Other developed countries such as Japan, Germany, France, and Canada have some form of nationalized healthcare for its citizens for years (Bodenheimer and Grumbach 2009, 163-177). These countries see healthcare as a right, and not a privilege, that is contingent to employment. In the United States, healthcare is not a right; it is a privilege for those who work. Some employers pay for full healthcare coverage, while other employers share the costs with their employees (Bodenheimer and Grumbach 2009, 17-28).

The United States healthcare system does ensure access to healthcare for certain individuals while at the same time stifling others due to inequities in the factors that allow access to insurance plans (Bodenheimer and Grumbach 2009, 17-28). The inequities that stifle others are directly related to entrepreneurship. Those who seek to start small businesses have to compete in a market that is filled with larger corporations that are able to bargain more reasonably because of head count (Bodenheimer and Grumbach 2009, 7-10,176). Smaller corporations face disproportionate healthcare fees as compared to the larger corporations because bargaining power is significantly reduced for corporations that have fewer plan participants (Bodenheimer and Grumbach 2009, 7-10,176). Although entrepreneurship is inadvertently affected by the United States capitalist policy practice, the United States federal government does provide provisions for its most desperate citizens, namely, the elderly and severely impoverished individuals. The United States healthcare system does allow citizens over the age of 65 to qualify for Medicare funded by taxes on the current labor force (Bodenheimer and

Grumbach 2009, 10). The aforementioned program has not been without its share of revisions since its enactment. Our nation does provide coverage for the indigent under the auspices of Medicaid (Bodenheimer and Grumbach 2009, 10-12). Georgia and other states have state funded plans to cover poor people and children (Bodenheimer and Grumbach 2009, 10-13). Still there are limitations for a variety of reasons.

In recent news coverage of the thoughts concerning healthcare and its seemingly nationalization, have shown that both positive and negative sentiments permeate throughout society. These reasons are important to consider when evaluating the United States healthcare system. It has been shown that there are still many who oppose federal intervention and control of the basic rights of citizens and states as seen in the various Tea Party protests and rallies held across the country and covered by many large television networks. Healthcare and its costs is largely a complex issue that involves many interested parties and various states and federal rights to consider when passing any kind of reformative legislation. The United States healthcare system is expensive and is perceived to have a higher quality of healthcare in comparison to other countries (Bodenheimer and Grumbach 2009, 177-179). The aforementioned statement is largely based upon imperialistic views from those who would rather promote the United States' agenda as being without flaw when in fact the United States trails many other developed nations in terms of the quality of care, affordability, and points of access to care (Bodenheimer and Grumbach 2009, 168-179). Another proverbial "white elephant" in the system stems from our litigious society that also creates additional healthcare administration costs.

The purpose of this research is to examine the history of healthcare reform, the origins of employer provided healthcare, and the modern healthcare reform. Specifically the paper provides a comparative analysis of reform efforts in the state of Georgia and Massachusetts. It will give

also provide the reader with insight into some of the political factors that surround the issue of United States healthcare reform. The analysis concludes with recommendations for successful implementation of reform.

**Literature Review**

> In 1730, the most disastrous fire to rage in Philadelphia's history burst from the timbers of Fishbourn's wharf, a Delaware River structure. All the stores on the wharf burned and the fire spread across the street destroying three more homes. Damage ran into several thousand pounds. Benjamin Franklin commented in his Gazette that as there was no wind that evening, if people had been provided with good engines and firefighting instruments, the fire would likely have been contained (U.S. History 2010).

Health insurance and accident coverage have been long standing issues in the United States, and the origin of health insurance dates back to the days of Benjamin Franklin and his establishment of the fire department. The early thoughts around property insurance as seen in the quote above are worth mentioning. It is also important to note that healthcare coverage based on social need and interest is nothing new to the various cultures established in the United States. "In 1887, the African American workers in Muchakinock, Iowa, a company town, organized a mutual protection society. Members paid fifty cents a month or $1 per family for health insurance and burial expenses" (Brothers 2010). Health insurance was not as ubiquitous in the first part of the 20$^{th}$ century as it is now (Palmer 2010) Americans purchased their health care largely on a fee-for-service basis (Bodenheimer and Grumbach 2009, 5). Those who were unable to pay for their healthcare usually sought refuge in local hospitals and some workers got free doctor visits at their factories, which kept physicians on staff to limit sick days (Palmer 2010).

Some workers were able to receive treatment through early health maintenance organizations (Bodenheimer and Grumbach 2009, 7-8).

Others were able to collectivize their monies and provide healthcare coverage through their fraternal orders—clubs that were limited to members of a particular religious or ethnic group (Palmer 2010). The organizations paid physicians a set fee to care for the members of the group that contributed to the pooling of resources (Palmer 2010). Some professional medical organizations opposed the arrangements citing purely subjective bias' for their arguments (Palmer 2010). Others still were able to receive healthcare from doctors who made house calls as a part of fee for service transactions (Bodenheimer and Grumbach 2009, 5-9). During this time insurance was known as accident insurance. In 1911, the Equitable Life Assurance Society of New York issued a "yearly renewable term employees' policy" to the Pantasote Leather Co. and its 121 employees (Bucci 1991). This group policy provided each member employee with life insurance coverage financed through group rate premiums paid by Pantasote Leather (Bucci 1991). At the time, the life insurance industry and the general public took little notice. Instead, both continued to rely on the individual policies that had been the lifeblood of the life insurance industry since its inception (Bucci 1991).

It is important to note that these events in history have helped to shape current thoughts concerning healthcare and its accessibility. As technology continued to advance and shape the practice of medicine in the 20$^{th}$ century more physicians began to shy away from fee for service payment methods (Bodenheimer and Grumbach 2009, 31-39). This deference from the older methods of payment may also provide and interesting corollary to the rising cost of procedures performed in the United States. As one evaluates the history of healthcare in the United States it is interesting to the note the dramatic increase in care as opposed to quality of care (Docteur and

Berenson 2009). In the early part of the 1900's the cost of healthcare was largely based on fee-for-service, which required individuals to pay for medical services out of pocket (Scofea 1994). The rising costs of healthcare did provide incentives of standardization and strict requirements for obtaining medical licensure. The American Medical Association (AMA) formed the Council of Medical Education in 1904 to create the standards for all medical schools and certification testing (Thomasson 2010). The standards created competition among medical schools and hospitals that produced higher quality of service. One could argue that the higher quality of healthcare has an inverse relationship to costs and, by the end of the 1920s, families were looking for ways to elevate some of the costs burden they were acquiring during hospital visits. (Bodenheimer and Grumbach 2009, 5-9)

In 1929 a group of Dallas teachers contracted directly with Baylor hospital to provide 21 days of hospitalization for a fixed dollar amount (Bodenheimer and Grumbach 2009, 8). Through these efforts the insurance company known today as Blue Cross Blue Shield was established. Pre—paid plans have continued to persist in our nation to this day. The establishment of these plans during the years preceding the Great Depression helped solidify them in the spirit of American healthcare. The establishment of such programs has created a continuity of belief surrounding healthcare that has been difficult to overcome.

The Wagner Act of 1935 proved to be a critical turning point during the years following the Great Depression (Mikva 1986). The passage of this bill, signed into law by then President Franklin Deleno Roosevelt, during wartime and the establishment of government healthcare programs are a few significant events that led to employer-based provided health insurance (Mikva 1986). Though, the act was hailed by workers, it caused immediate controversy because of its seemingly socialist efforts. This kind of reaction was caused by the principles seen in the

act that established that workers had the right to collectively bargain with employers to demand higher wages and better standards of work. According to President Roosevelt "The right to bargain collectively is at the bottom of social justice for the worker, as well as the sensible conduct of business affairs. The denial or observance of this right means the difference between despotism and democracy" (Ransel 2010). However, this act did not cover railway workers, agricultural employees, or government employees, and independent contractors.

Furthermore, the years of 1939 and 1945, the federal government placed a wage freeze on all jobs (Perkins 2009). By law companies were no longer allowed to attract workers by offering an increased salary. These laws forced states to implement regulations on companies to start focusing on improved benefit packages that included providing healthcare coverage. It should also be noted that during the 1950s and 1960s government programs were formed to cover some healthcare costs for the poor, elderly, and disabled.

During the formulation stage of these government programs, the AMA put up great resistance. The organization was defiant against any legislation that would allow government to subsidize healthcare and suggested that it was socialist in nature interfering with a physician's livelihood and the relationship between physician and patient (Thomasson 2010). The AMA did succeed in defeating many healthcare proposals, but President Lyndon B. Johnson signed the Medicare program into law on July 30, 1965 (Social Security 2010). This established a reform of healthcare that would be long lasting and greatly impacting on the nation. The battle between the AMA and the federal government would be one of the beginning struggles between associations, states, and the federal government. The struggle lives on for years, especially now with modern healthcare reform.

In order to understand the healthcare system as of today and its implications, one has to look into the history of the issue of healthcare reform in the United States, which has been the subject of political debate since the early part of the 20th century. One of the earliest healthcare proposals at the federal level was the 1854 Bill for the Benefit of the Indigent Insane. Though the bill did not come into effect, it would have established asylums for the indigent insane, as well as the blind, deaf and dumb, through federal land grants to the states. United States efforts to achieve universal coverage began with President Theodore Roosevelt, who had the support of progressive healthcare reformers in the 1912 election but in the long run it was defeated.

**Role of the Local Government**

When one attempts to understand healthcare policy and its reform efforts, it is important to understand the relationships between the federal, state and local governments. One should understand that each participatory government entity has a significant part to play in the enactment of any legislative effort to reform or create new healthcare laws. To truly understand the relationships between each of the key governments involved, it is important for the individual to understand state, federal and local government rights and responsibilities. As seen in the Constitution of the United States of America's Tenth Amendment, "The powers not delegated to the United States by the U.S. Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people" (Library of Congress 2010). By understanding this Amendment as well as the Articles I, II and III of the Constitution one will understand federal authority and states responsibilities, the concept of devolution, more concisely. It should be noted that local governments are usually the implementation group of any programs that are passed in Congress and devolved to the states for enactment. The political administrative

dichotomy plays a slight role in this because the federal government, in some cases has mandated States to provide certain programs to the citizens. After one has reviewed the U.S. Constitution it becomes clear that the federal government will always have the upper hand on a topic that it chooses to address through the passage of any form of legislation. Though this may be the case, many government officials have been examining the new Patient Protection and Affordable Care Act of 2010 to determine its constitutionality (Barkin 2010). The new healthcare reform is said to be, "one of the most prominent and complicated pieces of legislation to emerge from Washington, D.C. in more than a generation" (Barkin 2010). Whether the local government officials supported Democrats in pushing through the historic legislation or fought it, the local leaders will bear much of the responsibility of implementing the change that the bill envisions, as seen in when one understands devolution.

Various government agencies heavily researched the new legislation to ensure that it would be feasible for their agencies to handle. Healthcare costs are expensive and governments must be mindful of certain expenditures when dealing with their budgets. One of the major concerns of many local governments is the affordability of healthcare. "Local governments are the fourth largest employer in the nation," says Neal Bomberg, healthcare lobbyist for the Washington-based National League of Cities (Committee of the Whole 2010). "They spend $87 billion on healthcare. Our interest is so great on this issue. We have a huge work force, and we spend a huge amount on healthcare" (Committee of the Whole 2010).

Like the cities, the National Association of Counties members were particularly concerned that the costs of healthcare were passed from the federal and state governments to the local level, where much of the direct service is provided. In view of this, the healthcare reform will have a significant financial impact on the counties because they bear an immense deal of

safety net responsibility. Some feel that the federal government responds hastily to social issues without allowing the state and local governments time to respond. This sentiment is expressed by the fact that the local governments will be primarily responsible for delivering healthcare (Barkin 2010).

The local health departments will be at the center of much of the implementation effort, because they are often responsible for providing services to many uninsured that the bill targets for new coverage. These local health departments will be involved in the primary initiatives of the new law, the expansion of community health centers due to their unique positions to analyze and draw conclusions about local data gathered through assessments. Based on their assessments, they can then make relevant recommendations to boards and other elected officials. Effective policy requires local identification, familiarity with and responsibility for priorities based on needs, and community resources.

Both state and local governments have assumed a greater role in the planning, financing, organizing, monitoring, and delivery of personal health services. This is reflected in the steady growth of their budgets, personnel, activities, and services in the field. However, the role of the federal government has increased much faster, with the pace of this growth so rapid that the federal government has become the single most influential organization in the field of personal health services in the country. Furthermore, the federal government, because of its dominant legislative authority and access to vast resources, has acquired an unprecedented ability to influence and manipulate the role and functions of state and local governments, and that of the private sector, in relation to personal health. By exercising these powers, the federal government has tended to steadily reduce the state and local role to a reactive posture, and has placed the private sector in a highly defensive mood (Palmer 2010).

Public Administrators at the local, state, and national levels will be tasked with exploring new and innovative ways to fulfill their responsibilities within the U.S. Constitution as a thorough understanding of this historic document is essential in the application of implementing certain programs. The central issue is not simply whether local health departments ought to involve themselves more extensively in the delivery of personal health services, but to what extent will the local health departments be an integral part in the formulation and implementation of national health policy—whether for primary care or preventive services.

**Modern Healthcare Reform: Massachusetts and Georgia Compared**

Mitt Romney Proclaimed, "that every citizen in Massachusetts would have affordable health insurance" that costs would be reduced through 'market reforms' encouraging 'personal responsibility' and that the plan would not require any new taxes or government take over (Tanner 2008). In 2006, Massachusetts passed its own healthcare reform, with the goals of 1) expanding coverage to the poor and uninsured, and 2) reducing healthcare costs (Moffit and Owcharenko 2006). When the legislation was passed, the share of uninsured residents was 12 to 14 percent by 2008, this figure had fallen to 2.6 percent (Doonan and Tull 2010). As a result, approximately 97 percent of the state's population is now insured, by far the highest rate in the United States and similar to the coverage in Western European nations (Doonan and Tull 2010).

Massachusetts expanded certain federal programs to make its legislation of healthcare more effective. Massachusetts expanded Medicaid eligibility to all children below 300 percent of the federal poverty line (FPL) and all adults below 150 percent of the FPL (Doonan and Tull 2010).

*New Subsidized Health Insurance Exchange*

Commonwealth Care is a program that provides access to health insurance for individuals with incomes between 150 percent and 300 percent Federal Poverty Line (Doonan and Tull 2010). The government subsidizes these plans depending on the individual's income. The state moved individuals who were previously in the state's uncompensated care pool (UCP) to Commonwealth Care by restricting the UCP so that co-pays, deductibles, and premiums were similar to those offered in Commonwealth Care (Doonan and Tull 2010).

*Insurance Exchange for Individuals and Small Businesses*

Commonwealth Choice is another program that provides a number of unsubsidized insurance plans to individuals and small businesses with 50 or fewer employees (Doonan and Tull 2010). An interesting aspect of the state's reform is that Massachusetts merges the small business (less than 50 employees) and non-group insurance markets (Doonan and Tull 2010). "Health insurance in Massachusetts has actually become considerably less expensive in the non-group or individual market and more expensive in the small-group market" (Doonan and Tull 2010). Non-group premiums fell from 40 percent over this time period even though similar plans rose 14 percent nationally (Moffit and Owcharenko 2006).

Mandated health insurance has been a tensely battled form of legislation in Massachusetts. It has had many opponents as well as passionate proponents. Since its inception it is believed, by proponents, that residents have been able to satisfy regulatory requirements through the purchase of catastrophic coverage (Doonan and Tull 2010). With this regulatory change, the plan will promote HSA/high-deductible plans and make healthcare coverage more accessible and somewhat more affordable for individuals. The state will also provide lower-

income individuals with a subsidy (essentially a voucher) to help them purchase health insurance, an approach similar to the refundable health tax credits that many support at the federal level (Doonan and Tull 2010). These changes make the mandate far less of a burden on individuals than it otherwise would have been (Doonan and Tull 2010).

*The Insurance Marketplace*

The new healthcare legislation allows for a classical economic approach to the accessibility of healthcare. Largely based on a capitalist model it does not allow for true access to care under values of democracy and, therefore, is not real universal healthcare rather it is, even the explanation of the Mass healthcare policy, near-universal healthcare. Massachusetts created a market based healthcare access point called the "Connector," that allows individuals to participate in the purchase of healthcare much like they would shop for car insurance or any other consumer driven product or service (Doonan and Tull 2010). Insurance providers are able to advertise their rates and plans on state's website and allow potential applicants calculate what would be affordable to them (Doonan and Tull 2010). It is also similar, to the Federal Employee Health Benefit Program (FEHBP), which allows federal employees to choose from a variety of competing, private health insurance plans and keep the plan of their choice if they change jobs within the federal government (Moffit and Owcharenko 2006).

Under the new Massachusetts plan, instead of picking a plan for their employees, small businesses can let their employees participate in the Connector and provide a cash contribution to the plan of each employee's choice. Individuals can also choose to use the Connector. All participation is voluntary: The Connector is not a regulatory agency; it does not purchase health plans on behalf of individuals or businesses; and it does not impose a comprehensive

standardized health benefit package requirement. Thereby, it enables small businesses and individuals to purchase coverage from insurers competing for their business. In addition, individuals are allowed to buy personal, portable health insurance of their choice, outside the place of work, without losing the tax benefits afforded by federal law to employer-sponsored coverage.

For years, employers in Massachusetts that purchased coverage for their employees have had to pay a health insurance premium tax to the state's uncompensated care pool. This tax applied only to employers paying for insurance, not to employers that did not provide coverage, despite the fact that many of their employees benefited from the uncompensated care pool. Massachusetts' legislature enacted an employer mandate and an individual mandate. The employer mandate states that employers with more than 50 people who do not provide insurance must pay a "fair share" assessment of $295/employer/year (Moffit and Owcharenko 2006). The state also mandates that all residents purchase insurance through an individual mandate. Each year, each Massachusetts resident must submit a Schedule HC to the Massachusetts Department of Revenue to verify that they do indeed have Connector-approved insurance. After a 90 day grace period, individuals are penalized each month that they are not insured in the previous tax year (Doonan and Tull 2010). Massachusetts tax filers who failed to enroll in a health insurance plan that was deemed affordable for them, lost the $219 personal exemption on their income tax (Doonan and Tull 2010).

The healthcare reform plan achieves four regulatory changes. First, it allows small businesses and individuals to buy insurance through the "Connector," which will expand coverage options, especially for those in the individual market. Second, it allows Health Maintenance Organizations to also offer HSA-qualified high-deductible health plans, which are

more affordable than other plans. Third, it permits insurance plans offered through the Connector to contract with healthcare providers as they choose, relieving them of the costly "any willing provider" requirements that prevent plans from steering patients to providers that offer the best value. And fourth, it permits insurers to offer plans to individuals between the ages of 19 and 26 subject to fewer costly state mandates and puts a two-year moratorium on any new insurance mandates while the state conducts a review of all mandated benefits (Doonan and Tull 2010).

Although many of the Massachusetts mandates may decrease resident choice, health reform regulations have increased health insurance options for many employees. Additionally, Massachusetts now offers a young adult plan (YAP). This is a less expensive, less comprehensive insurance product for individuals 19 to 26 years old (Doonan and Tull 2010).

One difference between the Massachusetts health reform and the federal one is the treatment of pre-existing conditions. That is said in Massachusetts, “pre-existing condition exclusion periods can last up to 6 months” (Doonan and Tull 2010). In the federal case, there is no exclusionary period and thus the incentive to purchase insurance is much stronger in Massachusetts. Additionally, Massachusetts has guaranteed issue and modified community rating, whereby premiums can only vary by age and geography and the state legislature even regulated the maximum premium ratio (Doonan and Tull 2010).

Cities and towns would save tens of millions of dollars in healthcare costs for employees, retirees, and elected officials by joining the state’s much larger, more flexible healthcare system, according to a report by the Boston Foundation. The foundation’s detailed study of four municipalities illustrates how healthcare expenses are severely hampering communities across Massachusetts. Boston, for example, could reduce its fiscal year health insurance premiums by up to 17 percent, or $45 million, by joining the state’s Group Insurance Commission (GIC) the

Boston Foundation found (Murphy 2010). Currently, communities can join the GIC only with the approval of local unions. But with some exceptions, unions across the state have rejected such a move because it would end up costing their members more money, particularly in the form of higher copayments (Murphy 2010). Cities and towns are pushing for a change in the law so communities can join the state system without union approval.

GIC would save municipalities not only by shifting more costs to subscribers, but also by lowering overall costs. GIC saves money in part by steering subscribers to those medical providers whom the plan rates as most cost-efficient. It does so by providing a financial incentive (Murphy 2010).

The healthcare reform in Massachusetts, though benevolent in nature, did increase the costs in healthcare (Docksai 2010). Massachusetts issued mandates to individuals and businesses to buy insurance, in government created market exchanges in which residents can buy government-approved policies, and whereby subsidies are provided for individuals who cannot afford insurance on their own (Docksai 2010). As a result, there was an increase in the percent of state residents covered, but at a hefty price. The state's Medicaid program cost has increased from $7.5 billion to $9.2 billion, and although more than 400,000 uninsured have since purchased insurance, 68 percent of them received a taxpayer-funded subsidy (Docksai 2010).

In addition to all these problems, costs are skyrocketing because of special—interest pleading the politicians. Thus the program is now costing Bay State taxpayers $400 million more than the originally advertised, 85 percent more than the promised cost (Docksai 2010). Massachusetts experienced double-digit increases in health insurance costs for many employers and individuals, and a considerable amount of taxpayer money still underwriting free care. Hence, the Massachusetts law expanded health insurance coverage to almost every resident of

the Commonwealth, by redirecting existing healthcare spending and without raising taxes. It did not and was not an attempt to control costs.

Comprehensive healthcare reform is difficult, especially in a divisive political environment. It contains complex and likely contentious provisions. The Massachusetts plan is not perfect; however, much can and should be learned from its efforts. But the first big step was to get everyone under the insurance umbrella. Successful healthcare reform in the United States is much more likely to come from such experimentation and its lessons, than from imposing solutions from Washington. State experimentation in healthcare follows in the footsteps of welfare reform and embodies the benefit of federalism.

*Georgia's View of Healthcare Reform*

National healthcare reform is the hot issue that the states now have to deal with. Georgia is another state whose own ambitions toward healthcare reform, started before the passage of the new act into law. Though the Healthcare and Education Reconciliation Act of 2010 has a more comprehensive approach, the State of Georgia has tried, to establish a better healthcare system for its citizens. In 2008, then governor, Sonny Perdue gave his support for the state health insurance reform legislation proposed by both Senator Judson Hill and Representative Mickey Channell (Office of Communications 2008). This legislation runs parallel with many who believe states' authority and responsibility to their own citizens is more on target than sweeping federally mandated reform efforts. State efforts are responsive to the specific needs of citizens and are funded by various taxes proposed by the state. The legislation was proposed to insure more Georgia citizens by expanding the availability and affordability of High Deductible Health Plans and Healthcare Savings Accounts in Georgia (Office of Communications 2008). Governor

Purdue stated that, "More insured citizens mean lower costs for all taxpayers, and preventative care means a healthier population" (Office of Communications 2008).

Proponents of the healthcare reform bill believe that the legislation is geared toward market principles that equally share cost and risk. According to Senator Hill, "This is a market-based solution focused on empowering individuals and rewarding them for making healthy choices. This plan will make affordable health insurance more accessible for the uninsured and working families" (Office of Communications 2008). The strategy proposed by the legislation is geared for competitive market-based approaches that reduce costs and increase access to care. Representative Mickey Channell agreed by stating, "By harnessing the power of the free market, we'll see more Georgians able to purchase and maintain their own healthcare coverage" (Office of Communications 2008). The reform effort had been codified into several key issues that the state hopes to implement over a period of time.

*Reviewing the Legislation*

Georgia's proposed legislation was creative and promising. By using two types of health insurance plans, the State hoped to create a better and more affordable healthcare system. These plans included: High Deductible Health Plan (HDHP) that offered consumers lower premiums and higher deductibles than a traditional health plan; and Health Savings Account (HSA) which allowed consumers to set aside funds for future qualified medical health expenses on a tax-free basis (Office of Communications 2008). Both of these plans are not new to the current healthcare system but Georgia's proposed use of the insurance plans is indeed innovative. Georgia's proposal incentivized small businesses to provide HDHPs with HSAs. As a result, according to the Center for Health Transformation, approximately 500,000 Georgians would become insured

when the legislation was passed in the Georgia General Assembly (Office of Communications 2008).

There are several insightful provisions of the health insurance reform legislation that offer key enhancements to the previous healthcare system. The changes and rebates seen in Georgia's healthcare reform would share the risk and reward for health insurance participants. The rebates for plan participants are seen in programs such as: smoking cessation, weight loss, control of diabetes, and blood pressure can positively impact participant behavior (Office of Communications 2008). The participant could use the rebate to increase the savings in his or her HSA (Office of Communications 2008). Some additional incentives for providers and participants occur when restrictions on plan reimbursements to out of the network providers are lessened (Office of Communications 2008). This gives flexibility to insurance companies to reimburse at lower rates when a patient chooses an out-of-network provider but to pass those reductions along by offsetting premiums to the consumer (Office of Communications 2008).

Some additional highlights of the plan include: the removal of restrictions on Health Reimbursement Arrangements (HRA), which allow companies that provide HRAs to reimburse employees using pre-tax dollars; premium tax exemption, the removal of state and local premium taxes in Georgia (aimed at saving Georgians millions over the course of a year); income tax deduction which allowed consumers to deduct HDHP premiums from state income taxes, if they are not already deducting premiums from federal income taxes; and small business tax credit which allowed employers with 50 employees or less to take a tax credit of $250 per employee that enrolled in a HDHP through a Section 125 plan (Office of Communications 2008).

Health reform is not a new issue. Governor Perdue disclosed his plans for healthcare reform in 2007. He introduced the Health Insurance Partnership (HIP), under which, small

businesses were encouraged to provide health insurance to employees who were under 30 percent of the poverty level through cost sharing and government subsidies (Office of Communications 2008). The Georgia legislature enacted his motion into law in 2008 which eventually led to the insuring of more Georgia citizens than ever before (Office of Communications 2008).

Georgia's view towards federal healthcare reform is more adversarial than welcoming. The Georgia view has always been very conservative and thus more oriented toward allowing the state to self-determine its strategies for dealing with the healthcare issue. To the contrary, current evidence shows upsides to the new federal legislation. Small businesses in Georgia will be helped by a new small business tax credit that ease the cost of coverage. In the past small businesses have paid a considerable amount over that of which larger businesses have responsible for the same amount of coverage, roughly 18 percent more (HealthCare 2010). Employees have also seen an increase in their costs for healthcare coverage over the last 10 years as well. (Jackson and Nolen 2010). There is little doubt to the cause of this. The tax credit can be seen as a positive a course of action toward reducing the costs of healthcare and making coverage affordable for small businesses and employees. Medicare Part D has a coverage gap widely known as a donut hole and one immediate benefit of the new federal legislation is that Medicare beneficiaries in Georgia will see a one-time credit of $250 to cope with the cost of their prescription drugs (Jackson and Nolen 2010). Another important political factor that seems to be glossed over in the national debate on reforming healthcare involves the sense that the federal government is overstepping its boundaries in regards to states rights (Jackson and Nolen 2010).

*Accountability*

One of the more complex obstacles to healthcare reform has historically been accountability. Determining which agencies, and at what levels of government, would be responsible for determining procedure, requirements, and eligibility has resulted in a lack of agreement amongst federal, state, and local levels of government in how or who should be accountable for healthcare. With the passage of the Patient Protection and Affordable Care Act of 2010, accountability is now in the forefront of how this act will affect American citizens and small business, as well as the different levels of government.

Accountability is the process of individuals taking responsibility for a set of activities, and for explaining or accounting for their actions. In healthcare, accountability is up to the individuals or organizations that set standards and regulations, determine who is to be held responsible to the standards and regulations, and monitor the delivery of services and ensure that the information necessary for accountability is delivered or accessible to those who will be required to abide by the regulations (Emanuel and Emanuel 1996). Understanding the role of accountability in healthcare makes it possible to understand the different roles of government agencies in the accountability process.

There are several federal agencies involved in the process of healthcare accountability. The Center for Medicare and Medicaid Services (CMS) is one of the primary agencies that are responsible for accountability. The CMS is responsible for the delivery of regulations, requirements, and policies to the state and local governments to ensure the effective delivery of quality healthcare (Center for Medicare and Medicaid Services 2010). The CMS is responsible for not only Medicare and Medicaid, but also children's health operations (Center for Medicare

and Medicaid Services 2010). Monitoring of state and local agencies, as well as service providers is one of the main responsibilities of the CMS (Center for Medicare and Medicaid Services 2010). The new healthcare reform has altered some of the policies that the CMS manages. These include better access to healthcare, access to preventative care, and lower prescription drug costs (The White House 2010). The CMS will deliver the new policies to state and local governments, as well as the individuals utilizing these healthcare programs, to ensure that the new measures are met and delivered (Center for Medicare and Medicaid Services 2010).

Another agency at the federal level that will be involved in healthcare accountability is the Government Accountability Office (GAO). This office will be required to review and monitor use of the Medicaid and Medicare systems as well as other aspects of healthcare (United States Government Accountability Office 2010). Through the monitoring of these programs, it is possible to detect fraudulent practices and calculate the costs of different healthcare programs (WIBW 2010). In the past, the GAO has produced reports detailing the healthcare costs as a function of the entire United States Gross Domestic Product. The GAO will be able to monitor and report on the costs of the new healthcare reform to determine whether savings and reductions in healthcare spending are occurring.

The Internal Revenue Service (IRS) will also have an expanded role that will play a part in the federal government's accountability of healthcare. In the new healthcare policy, individuals will be required to purchase an insurance policy. Disregarding this requirement will result in the individual being assessed to a penalty that will be enforced by the IRS (Bell 2010). This penalty is imposed in an effort to get healthy individuals to maintain health coverage. Ensuring that healthy people are covered creates a larger pool of funds to pull from when paying for the costs of treating the sick. The IRS will also monitor business under the new healthcare

policy. Business will be required to provide proof of the insurance plan's they provide for their employees (Bell 2010). Similar to individuals, if the businesses do not provide coverage, the business will incur a penalty that is enforced by the IRS. Both businesses and individuals are provided tax discounts that are intended to help cover the costs of purchasing and providing insurance (HealthCare 2010).

States share the costs of providing healthcare with the federal government. The federal government provides broad requirements and policies that states must comply with concerning Medicare and Medicaid, however, the states are allowed the freedom to develop their own system of delivering the Medicare and Medicaid benefits to their citizens (Center for Medicare and Medicaid Services 2010). This creates a system where states are not only accountable for delivering the benefits of these systems to their citizens, they are also accountable for monitoring the system they have created to ensure that it is effective and efficient. Although, states have different systems in place, and how they disperse responsibility for accountability can vary, however, each state must ensure that they are meeting the requirements set forth by the federal government.

The new healthcare reform has made considerable changes to the healthcare system in the United States. Accountability is shared by different agencies at the federal, state, and local level. The purpose of healthcare reform is to make healthcare more affordable and increase the access Americans have to quality healthcare (The White House 2010). The success of the reform act will not be visible for some time. It is possible that further changes could enhance or improve the success of such a vital program.

*Comparative Analysis*

Since the passage of the United States healthcare reform act, there have been large calls of protest toward the implementation of its policies and regulations. There are also very interesting similarities and disparities in how healthcare is administered in both Massachusetts and Georgia. Each state has peculiar nuances that give rise to concerns in how healthcare is administered and how it is funded. This section will provide the reader with some points to consider when evaluating the overall efficiency and effectiveness as it relates to the administration of the current healthcare plans for each state. This section will also provide additional information behind the political process that has served as a pivotal influential power in the overall healthcare debate.

*Massachusetts and Healthcare Politics*

Massachusetts' healthcare system, though praised, is not infallible. There have been recent discussions linking increased costs to ineffective use of tax-payer dollars to fund the program. According to recent articles, the healthcare system in Massachusetts has several underlying flaws that are attributed to equity and efficiency concerns.

Opponents argue that the legislation does not achieve its overall objective of providing universal healthcare access even when the insurance industry is achieving government support through the establishment of the artificial insurance markets (King 2009). Massachusetts' has also experienced a large proportion of its citizenry without coverage, since enactment of the reform, and with the recent economic crisis more people will be added due to unemployment (King 2009). Opponents also argue that the legislation does not address the inexplicable tie of employment to the ability to afford healthcare insurance. Individuals run the gamut of not having

coverage should they decide to change jobs or if they are down-sized. Small businesses bare a considerable brunt of expense for healthcare insurance for employees (King 2009).

It has been argued that though the state government enacted market system provides access to insurers who compete for business, many of the individuals and families find the insurance unaffordable (King 2009). Those considered middle-income families are still faced with expensive coverage because they do not qualify for the state subsidized coverage. "For an individual earning $31,213, the cheapest plan can cost $9,872 in premiums and out-of-pocket payments" (King 2009). Local citizens of Massachusetts have voiced their opinions by speaking out at rallies and other forums to discuss their disapproval of the healthcare system provided.

> 'I know the plan is all wrong,' she said. What exactly was wrong? It was just like the one in Massachusetts, which makes people buy unaffordable insurance, she explained. 'The Connector [the state's shopping service] wants to determine your affordability. They don't care if you have past loans or alimony to pay,' she said. Her daughter makes $32,000 working two jobs and can't afford coverage; she pays the penalty for not having it (Lieberman 2010).

The legislation has also been seen as counterproductive because it forces individuals with limited access to capital, who were previously able to receive free care, to purchase insurance policies for which they have limited ability to pay (King 2009). The costs of the reform for the state have been viewed as tremendous for the state to fund (King 2009). The costs for the program have increased dramatically over the years going from $630 million in 2007 to roughly $1.3 billion in 2009 (King 2009).

*Georgia and Healthcare Politics*

Georgia has several issues to overcome that are related to healthcare. Opponents see the proposed "trickle down" effect toted by many insurance lobbyists as being a clever way of manipulating the public into believing that larger conglomerates are seriously concerned about public welfare and not concerned with their bottom line. They would argue that the process for improving healthcare has been largely political in both of these two states and at the national level. This can be seen in recent analysis performed by social watchdog organizations that seek to maintain a balance in the political process. These organizations have conducted relevant studies geared toward ensuring the transparency of the legislative process. Political action committees, insurance lobbyists, and various other interested parties have been carefully followed in regards to their contributions to certain political candidates who have the ability to influence legislation in their respective favor (Federal Election Commission 2010).

It should be noted that former Insurance Commissioner John Oxendine, a controversial political figure, supported fellow Republican Ralph Hudgens during the primaries (Jones 2010). It is important to note this because, although Oxendine placed fourth in the GOP gubernatorial primary, he raised the most money, believed to have been contributed mainly by insurance lobbiest (Jones 2010). He has been cited as having "lax ethical standards" due to the close association he shares with insurance agencies (Jones 2010). Oxendine was even accused of receiving illegal campaign contributions, and is under investigation by the State Ethics Commission for receiving money from out-of-state political action committees connected to an insurance company in Rome, Georgia (Jones 2010). It should also be noted that his previous opponent, Ralph Hudgens, also had allegations brought against him by the commission because he improperly transferred money from his legislative re-election campaign to his insurance-

commissioner campaign fund, but he reversed it and received no fine or sanction from the Ethics Commission (Jones 2010). As one reviews the data surrounding healthcare and insurance agencies in Georgia, accusations of ethical improprieties should raise red flags in terms of state insurance commissioners ability to transparent and hold solidarity with the mass constituency.

It is pertinent to note that Kaiser Permanente is a large healthcare maintenance organization with a regional office based in Georgia (Kaiser Permanente 2010). This is an important aspect of understanding the relationship that Georgia has in terms of being against the new healthcare legislation. Kaiser currently has 19 healthcare facilities in the metro Atlanta area alone and hopes to have over 35 by the end of 2011 (Kaiser Permanente 2010). There is a strong propensity for this agency to keep healthcare privatized in order to keep profits growing. Overall one should consider this most recent report when questioning the motive to file suit against the federal government for infringing on states rights to provide equitable access to healthcare.

> For the six months ended June 30, 2009, total operating revenue was $21.1 billion, compared to $20.2 billion in the same period last year. Year-to-date operating income was $1.0 billion, which is equivalent to the operating income reported in the same period last year. Net non-operating income was $15 million in the first six months of the year, compared to a net non-operating loss of $443 million in the same period last year. As a result, year-to-date net income was approximately $1.1 billion, versus net income of $601 million in the same period last year. Total membership declined by nearly 36,000 members and remained at approximately 8.6 million in the first six months of the year. Capital spending totaled approximately $1.1 billion in the year-to-date period, which is comparable to the capital spending reported in the same period last year (Little 2009).

The aforementioned article points to clear disparities in how healthcare, by one insurance

provider, is largely overlooked. There should be more oversight to such agencies and the power that they wield over state and federal governments.

There is another interesting fact to note about the current healthcare plans provided by insurers in Georgia. A recent study performed in California yielded interesting data surrounding High Deductible Health Plans (HDHP) and Healthcare Savings Accounts (HSA). High-deductible health insurance plans have been seen as a deterrent to seeking care timely because of the financial burden the premiums carry (California Health Line 2010). The study noted that HDHP's typically offer low monthly premiums but require higher out-of-pocket spending for health services (California Health Line 2010).

The report states that previous research shows that high levels of cost-sharing can discourage people from seeking necessary and unnecessary medical treatment (California Health Line 2010). The report also shows that HASs can improve the affordability of medical care for people with high-deductible health plans but noted that HASs were not used by 80 percent of commercial Kaiser Permanente Healthcare Maintenance Organization (HMO) enrollees with high-deductible plans (California Health Line 2010).

*National Politics*

In order to understand the unrest surrounding the recent United States healthcare reform issue, one must understand the seeming opaqueness of the current legislative process, which stems back to the previous presidency, under George W. Bush. Under his administration, Medicare reform efforts were achieved whereby senior citizens were promised easier, more affordable access to essential prescriptions (Center for American Progress 2004). Some opponents of the Medicare reform viewed it as an enrichment tool for major drug card

companies (Center for American Progress 2004). The cards do not guarantee any price savings for consumers, allowing drug card companies to change their "discounts" at any time in order to maximize profits (Center for American Progress 2004).

Unscrupulous dealings with political campaign contributors mark a lack of public trust when it comes to the ability of the government to present altruistic reform toward social welfare programs and policies. All told, the 73 companies selected gave President Bush and conservatives in Congress more than $5 million since 2000 (Center for American Progress 2004). Of those 73 companies approved by the administration, 20 (almost one third) have been involved in fraud charges (Center for American Progress 2004). Those 20 companies made more than 60 percent of the total contributions to Bush and conservatives by drug card companies, calling into question whether the administration overlooked those companies' records because of their financial ties to the Bush Campaign (Center for American Progress 2004).

The purpose for disclosing this information is to address a more interesting paradigm associated with the devolution of responsibility of the creation of new healthcare initiatives to be carried out by states. Many interested parties, such as those cited in this text, believe that the nation's healthcare system is in need of dire reform but also argue that those interested parties, with significant financial power, will be able to systematically manipulate state governments into producing favorable outcomes for them at the expense of the consumer. The more powerful the lobbyists and privately owned corporations are, the less likely average income earning citizens will have a say in the distribution of United States healthcare and its accessibility. This is an inferred concern given only as it relates to the concerns addressed in recent articles and social commentaries.

It is important for individuals to understand what HMOs are and why they were created and under what guise they were created. President Richard M. Nixon signed into law the Health Maintenance Organization Act of 1973, or the HMO Act. In the HMO Act, Congress required that employers with 25 or more employees offer them federally certified HMO options if they offered health insurance at all (Health Maintenance Organization Act of 1973). The HMO Act also provided grants and loans to support the formation of new HMOs or the expansion of existing ones. After the passing of that act, HMOs grew in popularity (Luft 1987,1-4). An important aspect of Paul Ellwood's health maintenance strategy was to provide a contract between the enrollee and the HMO that allowed for a fixed fee to be paid annually for comprehensive medical services (Luft 1987,1-2). This idea is very similar to the prepaid plans that Keiser-Permanente Health Plan, Health Insurance Plan of Greater New York, and Group Health Association (Luft 1987,1-2). Listed below are some of the key factors in regards to the roles that the HMOs play.

1. It assumes a contractual responsibility to provide healthcare services to the enrollee, to include ambulatory and inpatient hospital care
2. It serves a group of individuals defined by enrollment in the plan.
3. The subscription process is purely voluntary.
4. The enrollee pays an annual or monthly, fixed premiums not including incidental co-payments.
5. Lastly, both the plan and the enrollee assume financial risk and gain in the provisions of the services provided (Luft 1987, 2-3).

As outlined above these factors would seem to pose as positive attributes for the enrollees of such programs. One should consider the contractual agreement that the plan has to the enrollee

very closely, though. The insurance that the individual receives from this agency does not ensure that the enrollee will gain adequate access to healthcare. Physicians and other healthcare providers must be willing to accept the payment arrangements offered by these large organizations (Luft 1987, 2-3). In the past, individuals living in areas with limited access to "in-network" physicians have been forced to pay higher fees to insurance carriers for receiving care from out-of-network physicians (Luft 1987, 3-4). This fact also opens an interesting caveat to the assumption that healthcare insurance is even worthy of individual participation, not because of the possibility of lack of access to care in an out-of-network area. The aforementioned is purely anecdotal but does suggest the legality of health insurance in terms of the U.S. Constitution- which states that everyone has the right to life, liberty, and the pursuit of happiness under the Fourth Amendment. There is an inherent profit motive and incentive to reduce or eliminate services to enrollees for profit making and cost reduction (Luft 1987, 3-5).

*Healthcare and Education Reconciliation Act of 2010*

Throughout this paper the discussion of healthcare and its reform in American government and politics has been shown to be controversial and subject to a large-scale debate amongst state federalism and the role of the federal government. To better understand the implications of the Healthcare and Education Reconciliation Act of 2010, it is imperative to understand some key elements of the legislation and how certain provisions that are in effect immediately:

1. Small businesses will receive tax credits of up to 35 percent of employer premium contributions for those small businesses that choose to offer coverage. Effective

beginning for calendar year 2010. (Beginning in 2014, offers credits of up to 50 percent of employer premium contributions, for up to 2 years.)

2. Seniors will have Medicare Part D donut hole closed-Provides a $250 rebate to those Medicare beneficiaries who hit the donut hole in 2010. Beginning in January 2011, there is a 50 percent discount on prescription drugs in the donut hole. (Also completely closes the donut hole by 2020.)
3. Free preventive care under Medicare -Eliminates co-payments for preventive services and exempts preventive services from deductibles under the Medicare program. Effective on January 1, 2011.
4. Helps early retirees by creating temporary re-insurance programs (until the Exchanges are available) for employer health plans providing coverage for early retirees, protects coverage and reduces premiums for employers and these early retirees age 55-64. Effective on June 21, 2010.
5. No discrimination against children with pre-existing medical conditions prohibits all employer plans and new plans in the individual market from denying coverage to children with pre-existing conditions. Effective for plan years beginning on or after September 23, 2010.
6. Healthcare plans are banned from rescissions are banned from dropping people from coverage when they get sick. Effective for plan years beginning on or after September 23, 2010.
7. Prohibits all health plans from placing lifetime caps on coverage. Effective for plan years beginning on or after September 23, 2010.

8. Restricts the use of annual limits by all employer plans and new plans in the individual market, to ensure access to needed care. Effective for plan years beginning on or after September 23, 2010 (Jackson and Nolen 2010).

After considering some of the new provisions outlined in the healthcare plan, it is interesting to note the controversy over such a progressive and helpful piece of legislation. Yet, as seen earlier, there are certain aspects of the bill, namely, all of it, that can potentially hinder insurance providers from maximizing profits. One can postulate that the profit motive is more important than that of a human life based on reactions given by some interested parties.

**Recommendations**

The passage of the Healthcare and Education Reconciliation Act of 2010 offers new challenges for the two states and their local governments in terms of carrying out the policies outlined in the Act. In implementing this new legislation it is also important to understand the effect that it has on past legislation as well. One sees this when considering the discussion of the enactment of the HMO Act of 1973. Some believe that rather than championing for the elimination of Medicare and Medicaid on the principle of individual rights the presidential administration, of the time, sacrificed the principle of a free market in medicine (Parker 2001). Some believe that the HMO Act of 1973 produced a rationing of medicine and the gradual enslavement of physician and patient to insurance giants (Parker 2001).

The guidelines stipulated in the Act will be crucial in ensuring the successful implementation of the new policies and how state and local governments administer the programs within the Act. The administrative tasks encompassing this new legislation are tremendous for state and local governments, and require thorough understanding of the

legislation and how other federally-funded state run programs will interact under this new legislation. Some of the concerns that have been addressed in the paper involve administrative oversight and accountability over the expansion of Medicaid, the establishment of insurance exchanges, and new market rules for insurance. The mid-level bureaucrats in the state agencies must have a solid understanding of the strategic objectives of implementing this new legislation as well as how federal oversight will affect its implementation. The tasks to be carried out in implementing this new legislation rests on the shoulders of not only the states and federal government but on the shoulders of the constituency that will be directly impacted by this ground breaking piece of legislation.

The governing bodies must be willing to listen to their constituents, and also be able and willing to stand against the large insurance agencies that pose direct threats in the enactment of the legislation. The insurance agencies may choose to increase rates across the board for all plan participants or reduce coverage to ensure that their profits maintain a certain level. Bureaucrats must be willing to make tough choices in terms of dealing with these insurance companies.

For both states to be effective in implementing this new piece of legislation, they must be willing to perform the following, well:

1. Understand the law and be willing to work with claimants who testify of insurance wrongdoing.
2. Be willing to work closely with the various healthcare organizations to ensure timely and efficient care is being given.
3. Discuss the options, openly, that health insurance carriers have in regards to implementing new contracts under this new legislation.

4. Provide street level bureaucrats with continuing education as this legislation continues to transform the normal course of healthcare policy.
5. Provide timely feedback to the federal agencies tasked with providing oversight to the enactment of the legislation.
6. Educate the public as to the steps that they will need to take to ensure that their rights are understood under this legislation and answer any questions that they may have. The bureaucracy must also be willing to listen to and address the needs of the constituency by performing policy analysis over the course of the enactment of the legislation. They must be willing to raise the valid issues or concerns that the citizens may have in regards to any inconsistencies in the implementation of this legislation.

If the two states are willing to accept the challenges faced with implementing this new legislation and work closely with the federal government to ensure its success the outcomes will produce confidence from the citizenry. The parties involved and benefactors of this monumental piece of legislation are the American people. These people rely heavily on their government to take care of matters that are of high importance to their plight of liberty and justice (United States Government Accountability Office 2010). This legislation does not provide simple answers towards implementation but it does allow for true entrepreneurial spirit to shine forth in the areas of federal, state and local government in terms of ensuring its success. There are going to be many opportunities for reform and several obstacles that must be overcome in order for it to be successful (United States Government Accountability Office 2010). Though this reform has caused a massive outcry from many who have opposing interests to the legislation, it is up to the states to implement the legislation.

## Conclusion

To conclude, the paper discusses the purpose of the healthcare reform. It looks at the history of healthcare, origins of employer provided healthcare, and some of the landmark laws such as Medicare and Medicaid, along with the Patient Protection and Affordable Care Act. The paper addresses the role that local government plays in health care reform and examines the modern healthcare reform for the State of Massachusetts and the State of Georgia's reforms on healthcare. It discusses the difference between Georgia's reform and national reform. The reform includes expansion of Medicaid, new subsidized health insurance exchange, and insurance exchange for individuals and small businesses. This is the first time that a reform provided health insurance for everyone.

The paper looks at accountability by determining which agencies, and at which levels of government, would be responsible for determining procedure requirements and eligibility. It emphasizes that accountability is the process of individuals taking responsibility for a set of activities and for explaining their actions. It also addresses the critical role that history has in understanding the nature of controversy surrounding the implementation of the Healthcare and Education Reconciliation Act of 2010. The paper looks at recommendations for effective implementation for healthcare reform. It explains some of the many strategies that state government will need to use to implement healthcare reform. Implementation is an extremely challenging task to complete but if one has strong leadership, vision, commitment and the willingness to take a risk you can be successful. The new healthcare legislation will face challenges in its enactment but it is an important, groundbreaking piece of legislation that will provide critical access for millions who have previously gone without healthcare. Although the bill faces many obstacles, the legislation is important for the American public and paves the way

for more opportunities to enact laws that will further ensure life, liberty and the pursuit of happiness which the authors of the United States Constitution had in mind.

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