

**A Reflection of the German Experience:
Modern American Health Reform**

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Introduction

President Barack Obama signed the Patient Protection and Affordable Care Act (Public Law 111-148) into law on March 23, 2010. For American citizens, the Patient Protection and Affordable Care Act¹ is one of the most monumental and controversial pieces of American legislation passed in the 21st Century. In fact, it is the first major federal reform of the health system since Medicare and Medicaid were introduced in the 1960s as Amendments to the 1935 Social Security Act. In context of the rich, industrialized world², however, many provisions of the legislation are not new ideas.

Despite the momentous nature of the Law's passing in 2010 for Americans, many of its components are similar, if not identical, to health care schemes already in place in other advanced countries. Germany, for example, provides a uniquely powerful comparison, and will serve as the primary source of comparison for this thesis. The basic aim of this paper is to highlight the specific similarities between salient components of the Affordable Care Act and the current German system as a whole. Based on a close analysis of the Affordable Care Act, there appears to be areas of significant overlap between the Law and Germany's contemporary health system from which future policymakers may learn.

Because of similarities between the Affordable Care Act and the German system, German citizens have found the controversy surrounding the Act to be rather alien. *Der Spiegel*, a popular German magazine, even went so far as to say that German citizens are "baffled" by the controversy over the Affordable Care Act in the United States (Widman 2012). This confusion stems primarily from the fact that "even pro-market politicians" view

¹ The Patient Protection and Affordable Care Act will be primarily referred to as the

² North America, Europe, and Japan, primarily

the highly regulated German healthcare system, which already maintains many of the most controversial aspects of the PPACA, as a salient and untouchable element of German society (Altenstetter 2003).

The popular German reaction to the American debate over the Affordable Care Act highlights the important political and cultural differences at work in the comparison of American and German healthcare. Foremost, Germans and Americans have fundamentally contrastive views on the role of government and the market, especially in healthcare. Whereas Americans view the state with suspicion and generally favor market-focused policies, Germans view the market with a degree of suspicion and the state as powerful force to promote German communitarian principles (Altenstetter and Busse 2005). This work is foremost focused on comparing components of the Affordable Care Act to the German health system, but it is also a demonstration of the differences between German and American ideology regarding what the acceptable role of the state and the market is in society.

Why Compare Germany and the Affordable Care Act?

With such differences, why compare the Affordable Care Act to the German system and not another system at all then? First, the German system is largely decentralized, privately financed, and organized through non-governmental actors. Because the system in the United States (outside of Medicare and Medicaid) is also highly decentralized and private, the German system provides similar structural struggles as the United States (e.g.,

uncoordinated care, indirect control of prices, increased risk of adverse selection) from which American policymakers could borrow German solutions to these issues. The system also leaves room for a practically meaningful comparison; it is far more feasible for Americans, politically and philosophically, to adapt components of a fundamentally decentralized, non-governmental system with no nationwide public plan than adopt provisions of a heavily centralized system, like those in the U.K. or Canada.

During President Clinton's attempt to reform health care in the early 1990s with the Health Security Act, Germany was mentioned as a potential model system for reform in the United States. The Executive Vice-President of the American Medical Association, James S. Todd, stated: "The German system... has more relevance to the need for reform in this country than any other nation we've looked at yet... we don't see [for example] the deficiencies in the German system that we see in the Canadian system," a reference to rising costs and role of government (Knox 1993, 2). Although his statement does not refer directly to the Affordable Care Act, the issues in the American health system necessitating reform during the 1990s were still present (if not worse) in 2010 when President Obama signed the PPACA.

Germany's ability to maintain low and stable health spending growth compared to other federal states is also important. Brown (2009) posits that it may not be a coincidence that federally organized states have the highest healthcare costs, due merely to the increased complexity. Because 17.4% of American GDP was spent on healthcare in 2011, comparing the recent healthcare reform in the United States to the German health system is appropriate because of Germany's ability to maintain smooth and modest annual growth in spending, even as a federal system (Stolpe 2011). Although Canada and Germany are both

federal, and spend similar proportions of their GDP on healthcare costs currently (11.3% and 11.6% in 2010, respectively), Germany has managed to maintain slower, and more stable increases compared to Canada and the other OECD³ countries (Machildon et al 2005;Squires 2011). Up until the 1990s, Germany was able to keep the rise in costs down just below inflation (Knox 1993, 3). The OECD average annual growth rate of total spending on healthcare costs was 4.3% between 2000-2010. Germany’s growth was the slowest at 2.0%, while Canada saw one of the highest rates of annual growth at 4.5%. Germany’s annual growth rate is not only low, but also stable. Compared to Canada especially, Figure

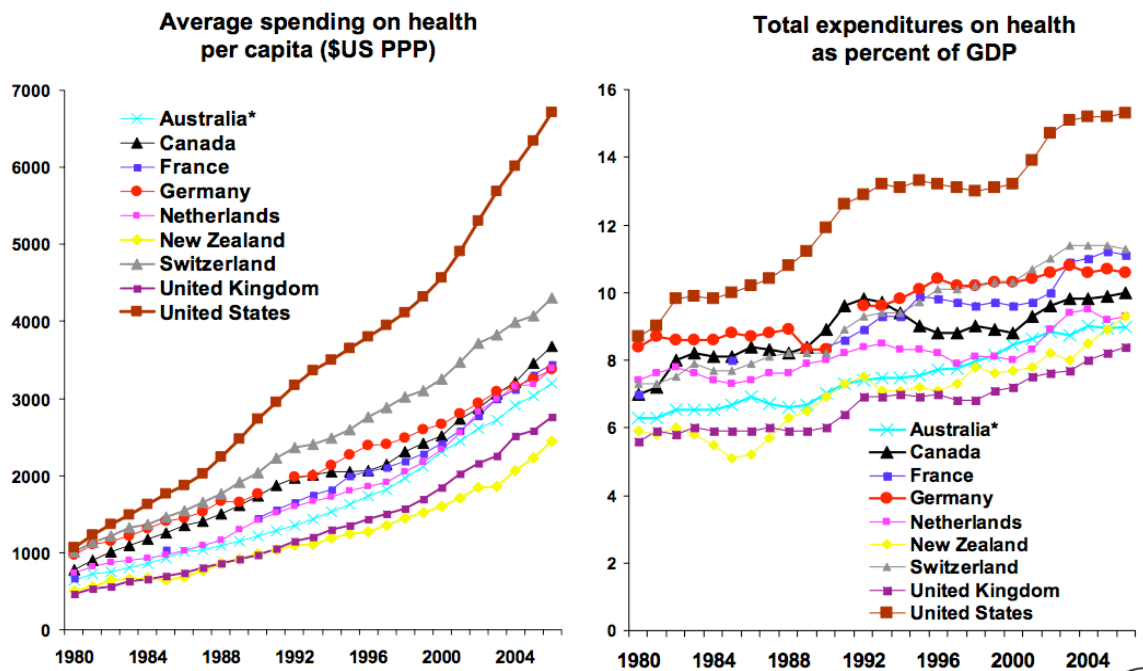


Figure 1

¹⁴ below graphically demonstrates the stability of German health spending growth as percent of GDP and per capita between 1980 and 2004. The curves representing the United States (invariably higher the others especially since the 1990s) indicate the massive the

³ The “Organisation for Economic Co-operation and Development,” which is often practically used as a synonym for the wealthiest, most developed countries of the world.

⁴ Adapted from the Common Wealth Fund report by David Squires.

increase in health spending that has occurred in the United States, and the importance for American policymakers to find solutions that curb this steep rise in spending. Therefore, although Germany does not have the lowest total spending among all OECD countries⁵, maintaining stable growth is an important venture for American policy.

In addition, Germany has demonstrated success in solving corresponding health delivery issues that principal areas of the ACA seek to address. For example, one of the most fundamental pillars of the ACA is simply increasing health insurance coverage to under-insured or uninsured Americans. Before the Act was passed, some form of health insurance covered about 85% of the United States, and the ACA is estimated to increase coverage by about 32 million people approximately over the next decade (Reinhardt 2011; Rosenbaum 2011).⁶ Germany on the other hand does not have a coverage issue; effectively 100% of Germany is covered by private or social health insurance. Furthermore, the German system also has many health insurance regulations already in place, whose ACA counterparts have proved to be some of the most popular measures of the ACA, such as not allowing insurance companies from denying people who have pre-existing conditions. Therefore, many of the popular goals of the Affordable Care Act are at least nominally similar to what already exists successfully in Germany (AICGS 2012).

Germany and the United States also face similar health-related issues, such as cost of care and chronic illness, which Germany has been able to address with more frequent and consistent reform (Göpffarth 2012; Reinhardt 2009). Both Germany and the United States face aging populations, rising costs, increases in preventable chronic illnesses like obesity,

⁵ Germany does, however, have the lowest spending of federally organized countries, which appear to often have higher spending.

⁶ This number is controversial, due primarily to flexibility written into the bill that allows states to deny increases in Medicaid funding and coverage.

and a disconnected system of delivery unique to the decentralized style of health care prevalent in both systems (Göpffarth 2012). These problems, and rising costs especially, have been a major focus of the stepwise reform in Germany over the last forty years. The United States, on the other hand, has not passed any substantial federal reforms to Medicare and Medicaid since their conception, two of the most costly federal expenditures. Although the German system is not perfect⁷, Germany has demonstrated to be more effective at containing costs, providing comprehensive health benefits to virtually 100% of its population, and producing overall stronger health outcomes than the United States (World Health Organization 2000; Squires 2011). The basis of the Affordable Care Act is to obtain many of the broad cost- and health-related successes that Germany has already demonstrated in key areas of mutual concern.

Germany has also had a lot of practice at healthcare reform. Germany's political culture of incremental reform in the health system has presented Germany with a unique ability to solve and adapt to systemic healthcare issues, and learn from mistakes (Knox 2011; Altenstetter 2003; Riesberg 2004). Between 1989 and 2000 alone, the German government legislated 6 major health care reforms (primarily aimed at containing costs) (Riesberg 2004). Some of the measures introduced throughout these reforms have not proved successful and were dropped, such as fixed budgets for sickness funds, demonstrating Germany's trial and error advantage (Stolpe 2011; Riesberg 2004). The United States, in comparison, has had only a single serious attempt to pass substantial federal healthcare reform with President Clinton since the 1960's. With a lack of unified, democratic support, however, Clinton's bill was defeated under pressure by conservatives,

⁷ Specifically, the widening gap in health outcomes and utilization between the high earning privately insured population and the SHI population is a growing concern.

libertarians, and the healthcare industry (Patel and Rushefsky 1998; Starr 2011). The important impact of this difference in political culture here is that Germany provides an example of a country with key similarities (e.g. decentralized) and differences (e.g. non-profit coverage) in healthcare structure, but with significantly more tries at healthcare reform, which could provide an abundance of lessons for U.S. health policy. In some senses, the ACA reflects forty years worth of German reform in one piece of legislation.

In addition, Germany's unique, decentralized Bismarckian system offers a more practical policy comparison than the centralized and government-run systems of Canada, U.K., or France. The transition to a system like that of Canada (single-payer) or the U.K. (unilateral government control) is substantial, in terms of policy alone, when only about 28% of Americans are covered under government-run programs in the United States (U.S. Census Bureau 2008). Although Canada also has a federal system and services are provided through private organizations and doctors, the Canadian system collects the majority (70% in 2005) of its revenue for health expenditures through general taxation by the provincial, territorial, and federal governments (Marchildon et al 2005, 39-41), and is organized far more directly by the government.

The "ideological" transition to a system like that of Canada or France would also be substantial and prohibitive, considering the history of American healthcare reform. As mentioned previously, the conventional American relationship to government is hardly enthusiastic towards increased governmental regulation and oversight in the ACA, and the opposition to a model that actually provides health care through general taxation and direct government control would easily be stronger. Germany provides, in this sense, a more realistic source of comparison for the sake of building future policy (Brown 2009;

Knox 1993). During the Clinton Administration, Marc Fisher from the *Washington Post* in Bonn wrote: “Germany’s approach to health care boasts much of what Americans say they want: private physicians, job-based insurance, and no bloated federal bureaucracy” (Fisher 1992, 1). Although Canada also has a federal system and services are provided through private organizations and doctors, the Canadian system collects the majority (70% in 2005) of its revenue for health expenditures through general taxation by the provincial, territorial, and federal governments, and is organized far more directly by the government than the German system (Marchildon et al 2005, 39-41).

In summary, utilizing components from a system like Germany’s may be more plausible than others, albeit still difficult. The German system offers an example of providing compulsory insurance, along with a rich private insurance system, that is not financed or provided directly through the state at all. Ostensibly, this makes Germany’s system of universal coverage appealing to the ideological values of Americans that seek to limit government involvement, while also appealing to progressive reformers (Rudiger 2010). Although some would claim that the Swiss “libertarian mentality” would also make Switzerland an appropriate comparison, the Swiss experience has never realized the same quality of health outcomes and lower costs that Germany has⁸ (World Health Organization 2000; Noble 2007, 2).

The Comparison

⁸ The Swiss are the second highest spenders in the OECD next to the United States.

Despite the fact that both the pre-ACA health care system and the political culture surrounding health reform in the United States are very unlike Germany in many fashions⁹, there appears to be significant overlap between components of the current German health policy and provisions in the 2010 Affordable Care Act. This thesis will not work to argue for or against the normative value of these different components, however, but rather simply demonstrate the comparisons. To make these points, I will establish 5 main areas of comparison: the broad category of stricter federal regulation on the private health insurance market, the health insurance mandate, federally regulated health insurance competition, funding and regulations for wellness programs and preventative services, and the use of quasi-governmental organizations.

These areas of overlap provide a unique opportunity to compare health policy between two countries facing similar problems, with seemingly very different approaches to healthcare. While only a very small step, the Affordable Care Act establishes a stepping-stone of legal and political precedence in the United States for the style of healthcare delivery established in other Western countries, such as Germany. The project of this paper is not to argue for the political possibility of this move in the future, but readers could nonetheless be convinced in the end that the Affordable Care Act has borrowed ideas from the German system to a certain extent, and that there is some purpose or rationality to the Affordable Care Act from an international perspective.

The following work is thus divided into four main chapters. Chapter 1 will give an overview of the German health system and its financing. Chapter 2 provides a brief background to the history of American health reform and the basics of the ACA itself.

⁹ Especially, that Germany does not have any programs similar to Medicare and Medicaid.

Chapter 3 then dives into the main areas of comparison between provisions of the Affordable Care Act and their comparable German counterparts. The fourth chapter will explore the influence Germany had directly on the writers of the ACA and the history of American health reform. Lastly, the conclusion will discuss exactly why and how these two health systems became so different and the significance of ObamaCare as a symbol of public philosophy.

Chapter 1: The German Health System

Overview

In 1883, Germany was the first nation-state in the world to develop a system of compulsory health insurance. During a series of social and political reforms that marked the initial steps of creating a cohesive nation, Chancellor Otto Von Bismarck established the Health Insurance of Workers Law (Knox 2009;Wehler 1973;Pascal 1969). Over the next 130 years, a tradition of “patchwork reform” would eventually evolve this initial law into the comprehensive model of modern health care delivery seen in Germany today (Altenstetter 2003;Altenstetter and Busse 2005;Knox 2009). Since 1977, the modern health care system, and the various federal reforms of the health care system since 1911, is codified in the fifth book of the German Civil Code: *Sozialgesetzbuch - Fünftes Buch (SGB-V)* (Riesberg 2004). All components of the following overview are contained within this government document.

Key principles from German history regarding health insurance are essential to understanding the rationale behind the fundamental design and philosophy of the contemporary system. Foremost, there are three fundamental principles upon which the federally mandated health insurance system, the *gesetzliche Krankenversicherung*¹⁰ (SHI), is founded. These principles are: solidarity, subsidiarity¹¹, and self-governance (Altenstetter 2003, 39;Altenstetter and Busse 2005; Knox 2009). In contemporary practice, these pillars

¹⁰ *Gesetzliche Krankenversicherung* translates to statutory health insurance.

¹¹ I use “decentralization” as synonymous with this principle.

come together to define an employer-based system of statutory health insurance, which is provided through federally mandated non-profit organizations.

Despite undergoing a myriad of reforms in the last 130 years, these main pillars that define the statutory German healthcare system have transcended almost all reforms and political regimes of the German nation (Altenstetter 2003; Weindling 1989; Wehler 1973). The notable exceptions are of course changes that occurred during the era National Socialism and in the German Democratic Republic (East Germany), but this subject is outside the scope of this work. For the purposes of this paper, the “contemporary” German system is effectively referring to the West German model primarily adopted after reunification of East and West Germany in 1990.

The first theoretical foundation of German healthcare is the principle of solidarity, which most importantly informs the philosophy behind the financial organization of the statutory health insurance system of Germany. Solidarity is established in the first clause of the SGB-V: “Health insurance as a solidarity-community, has the task of preserving the health of the insured or to improve their health.” Weide defines solidarity broadly as a “system of social ethics that lies between collectivism and individualism” (Weide 2005, 1147). Additionally, Knox describes solidarity in Germany as “the collective agreement to share the risks and costs of a necessary good [health care]... so that the rich subsidize the poor, the healthy support the sick, the young pay for the old, workers help the unemployed” and so on (Knox 1993, 19). In other words, health insurance is financed based on an individual’s ability to pay.

Because of its role in defining how German health care is financed and distributed, solidarity is perhaps the most salient feature of 20th and 21st century health care reform

discourse in Germany. Cost containment, and ways of preventing exploding costs as seen in other countries such as the United States, is a top priority for government lawmakers, but efforts to contain costs are simultaneously constrained by this fundamental principle from German history: price-based market competition and cost-sharing could be especially damaging (Brown 1999;Reinhardt 2009). Compared to other Western countries, Germany has seen relative success in cost-containment and stabilizing growth since the 1980s but still faces relatively high costs compared to other European countries (Squires 2010;Stolpe 2011).

The second and third principles of German health care are decentralization and the importance of self-governance in healthcare delivery. The main mechanism for these pillars is the *Krankenkasse* (sickness fund), the SHI equivalent of an insurance company. Sickness funds are privately run, non-profit organizations that are federally mandated and regulated, but are not directly administrated by the central government. The federal state, therefore, does not directly control health care, but does have a role in the basic regulations and legislation that form the foundation of the system as a whole. There are many motivations for this particular non-governmental, decentralized institution from German history. That sickness funds operate independently from government and as separate entities on a daily basis was born from a popular liberal movement¹² during the late 19th century in Europe, which aimed at limiting the power of government and expanding markets for trade (Weindling 1989, 17;Wehler 1973).

German SHI is different than national insurance from other countries that also have universal coverage. A common misconception of German-style, universal healthcare is that

¹² In the general European sense of the word, i.e. limited governmental control.

the government provides health insurance directly or is financed through general taxes, as it is in other countries. The national health insurance in Germany is not a centralized function of the state, however, but rather a complex network of corporatist agents that are robustly regulated by the federal government (Altenstetter 2003, 39). In this scheme, therefore, the federal government plays a role, but primarily as a regulating body that can pass laws and negotiate prices with state hospitals and insurance providers, rather than providing care or paying for it directly with tax revenue. The U.K. and Canada, for example, have different variations on national health care, and are distinctly different than Germany, although they are all considered to have “universal coverage.” The United Kingdom, for example, has a universal health system that is paid for and provided through the government directly. In this system, hospital and ambulatory physicians are almost entirely employed and paid by the government through tax revenue (Grosios 2010). Although still grouped together as “socialized medicine” in the United States, the U.K.’s “Beveridge” system is very different than the Bismarckian system in Germany that emphasizes decentralized operations and uses private bodies to deliver health care. Canada is also a “Western” country with universal health coverage. Although physicians are not entirely employed by the government in Canada, the Canadian government does act as a single payer. In addition, it is worth noting that the Japanese system is often compared to Germany because of its employer-based structure.

Financing German Statutory Health Insurance

The SHI system in Germany is primarily financed through a system of employment-based contributions, which functions like a payroll tax as a percent of the employee's wages. Prices and contribution rates are negotiated on between the non-profit sickness funds, regional hospitals, physician's associations, and the government. The negotiations among the regional associations, providers, and sickness funds are a formalized process established by federal statute, and the prices are binding within each *Land* to avoid price discrimination (Reinhardt 1999, 93; Reinhardt 2011; Riesberg 2004).

Based on the principle of solidarity, employees, employers, and the state contribute to purchasing health insurance for all citizens, ensuring that costs and risks are justly shared (Wysong & Abel 1990, 530). For an employee and an employer, there is a "uniform, legally fixed payroll contribution of 15.5% of gross wages" which is shared by employee and employer (in 2009, employees covered 8.2% of gross wages and employers covered 7.3%, for example). This system functions effectively like a payroll tax for the insured, although the government does not collect these funds; sickness funds have the right and obligation to collect these premiums in order to carry out the provision of care to their insured. Unemployed persons are provided health insurance in the SHI system through an unemployment insurance fund run by the government and the retired pay 50% of their contribution, and their pensions pay the rest. Considering that the German statutory health insurance system supports approximately 90% of the German population (upwards of 68 million people), this allows for a wide distribution of risk. In order to ensure actuarial

fairness among sickness funds, however, the premiums do not go directly to sickness funds, but are rather distributed to sickness funds through a filter: the Central Health Fund (CHF).

The Central Health Fund was developed, however, as an essential component of the financing system because it prevents adverse selection among sickness funds; it prevents certain sickness funds from earning more money off of an inherently healthier and less costly population (Göpffarth and Henke 2012). According to Reinhardt (2011), The Central Health Fund “effectively performs the risk-pooling function for the entire system”. This filter, therefore, compensates for regional differences in health, dangerous occupations, or companies that may have higher risk compared to others for some reason. Through the Central Fund, and Germany’s highly formalized system of negotiations that set standardized payment rates to sickness funds and providers, sickness funds do not compete for enrollees based on price, but rather quality of care.

The German healthcare structure also utilizes a unique relationship between government and private organizations. The relationship between the government and the private bodies that provide healthcare (sickness funds, doctor associations, hospital groups) was described by Peter Katzenstein as series of relationships, which allow for the public oversight of interest group power. Katzenstein defines this unique feature of German society as “parapublic institutions” (Katzenstein 1987). Furthermore, he states that these parapublic institutions, what would “otherwise [be] called interest groups in other countries, are combined in Germany with certain quasi-governmental agencies so that together they have a much more parapublic role” in society. Through these relationships, the government and different private bodies negotiate prices, patient contributions, services, doctor compensation, and other essential components of the

German system. In a talk to the “Alliance for Health Reform,” Dr. Karl Lauterbach calls these self-governing, quasi-governmental institutions “the heart of the German system.” These institutions decide: “what is reimbursed, on what evidence, and for what prices,” which works to reduce costs through evidence-based medicine (Alliance for Health Reform 2009).

Although the system of solidarity, and subsequently its financial scheme, has given German employers the “unenviable position of enduring the highest nonwage costs in the OECD,” Germans spend 3% less of their GDP on publicly-mandated healthcare expenditures than the United States, and with this Germans buy “substantially more comprehensive medical services than under any US health maintenance organization or commercial insurance plan” (Altenstetter 2003, 41). In addition, public opinion, business leaders, and policymakers still find solidarity to be the best mechanism to support the national SHI system, which has been the case for 130 years. In terms of popular opinion, the German healthcare system is widely supported by German citizens and businesses alike, which believe having comprehensive, universal health insurance increases their international competitiveness (Altenstetter 2003; Widman 2012).

As mentioned earlier, German SHI is different than national insurance from other countries that also have universal coverage. The U.K. and Canada, for example, have different variations on national health care, and are distinctly different than Germany, although they are all considered to have “universal coverage.” The United Kingdom, for example, has a universal health system that is paid for and provided through the government directly. In this system, hospital and ambulatory doctors are almost entirely employed and paid by the government through tax revenue (Grosios 2010). Although still lumped under the category of “socialized medicine” in the Western world, the U.K.’s

“Beveridge” system is very different than the Bismarckian German system that emphasizes decentralized operations and uses corporatist bodies to deliver healthcare. In addition, Canada is also a “Western” country with universal health coverage. In Canada, physicians are not entirely employed by the government, but the Canadian government does act as a single payer.

Private Health Insurance in Germany

In addition to the 154 sickness funds that provide care under the SHI system, there are approximately 50 private health insurance companies in Germany that offer private insurance through standard commercial means (Reinhardt 2009). These private health insurance companies make up the Private Health Insurance (PHI) system of Germany, making the overall German system a dualistic system like the United States. One of the fundamental differences between the PHI and SHI systems, of course, is that the cost of private insurance is based on individual (actuarial) risk, rather than standardized through negotiations between sickness funds, the government, and providers. This means that private health insurance premiums could be more expensive or could fluctuate more freely based on the health of the insured population. PHI covers about 8% of the population and can be purchased completely independently of SHI. The statutory system, in turn, covers about 90% of the population (Riesberg 2004; Reinhardt 2011). The remaining population, typically civil servants and government officials, have a separate insurance provided by the government directly.

Who can purchase private health insurance is based on income. Because every citizen in Germany must have health insurance, an individual is automatically enrolled in a system based on how much he or she earns. Those who do not meet a certain level of income, under approximately 49,500 euros as of 2003, are required to purchase health insurance through sickness funds, whereas employees who earn more than that amount are able to purchase private health insurance if they chose (SGB-V chap. 6, Sec. 6). Automatic enrollment in SHI for all citizens without private insurance began in 2009, although the vast majority of the population was already covered under SHI before this change. To prevent individuals from taking advantage of the system, German law does not allow citizens to switch freely between PHI and SHI. Unless one becomes “totally pauperized,” if one chooses to switch to the PHI system, one must remain in that system (Reinhardt 2011).

Chapter 2: The American Health System

Prior to the Affordable Care Act

The contemporary American healthcare system is highly complex and unique to the advanced, industrial world. American healthcare combines a highly decentralized and relatively unregulated private health insurance market combined with various public programs with a mix of federal and state control. The main public programs include Medicare, Medicaid, CHIP (Children's Health Insurance Plan), TRICARE (civilian care component of the Military Health System), and the Veteran's Health Administration. In terms of federal spending, public expenditures on direct health care programs made up 21% of the U.S. federal budget in 2010 (CPBB 2013). Unlike Germany's Statutory Health System, public programs in the United States are limited to only certain groups of the population, such as Medicare for the elderly and Medicaid for persons living under certain conditions (e.g. single mothers) and at different percentages of the federal poverty line. Medicaid is jointly funded through federal and state taxes and provided on a state-by-state basis, which can significantly affect who is eligible for coverage.

Access to healthcare and cost are significant issues in the American healthcare system. As mentioned previously, the United States spends more money on healthcare than any other country in the OECD. The United States spent about 17.9% of its GDP on healthcare in 2010 (Kaiser Family Foundation 2012), and this number is projected to reach around 19.5% by 2017 (Keehan 2008). Approximately 84.7% of Americans have some form of health insurance through either private or public insurance, which means around

50 million citizens do not have health insurance (The Uninsured 2012; Rosenbaum 2011). A staple of the Affordable Care Act's mission is to reduce this number through Medicaid expansion in the states.

The United States has a dualistic system of both private and public options¹³. The majority of the insured population is covered through insurance provided through an employer as a tax-deductible benefit. Private health insurance can be obtained through employers, individually, or through government programs. The majority (59.3%) of the population is covered under private, employer-based insurance.¹⁴ American companies may choose a single, or a slate of limited options, to offer employees, whereas in Germany sickness fund insurance is portable and one can freely choose any sickness fund (Altenstetter 2003). Because most Americans are insured through their employers, Americans have arguably less choice in their insurance plan than Germans.

The remaining insured population is either covered individually or through public programs. About 8.9% of insured choose to be insured independently through private insurance. With some overlap, public programs then cover around 27.8% of the remaining insured population (US Census Bureau 2008). For those who are not covered by insurance, the Emergency Medical Treatment and Active Labor Act of 1986 mandates public access to emergency services regardless of ability to pay or citizenship status. The American Institute of Medicine reported in 2004 that the United States, along with Turkey and Mexico, were the only OECD countries that did not have some form of "universal" or "near-universal" insurance coverage for citizens by 1990 (National Research Council 2004).

¹³ The SHI system is a different form of public program, however, in that it is not funded through federal or state taxes nor is care provided through the government.

¹⁴ A person can be covered under their parent's or spouse's employer-insurance.

Despite having several disconnected publicly funded health insurance programs only for specific portions of the population, there has been low popular and political will for some form of national health insurance system available to the general population.

The majority of the population is covered under for-profit private health insurance companies and pay risk-based premiums. Private insurance premiums are based on the risk pool from which the insurance draws. Less healthy pools, for example, will drive costs up for everyone because the insurance company must pay more for benefits. These risk-based premiums are then shared between employee and employer. Employers receive large federal subsidies¹⁵ and tax credits to help pay for the insurance provided to employees, but most economists agree that the bulk of the cost supposedly paid for by the employer is actually covered by the salaries of the employees collectively (Reinhardt 2011;Blumberg 1999). In this sense, the majority of American health insurance is subsidized or paid for by the government, either in the form of direct public programs (like Medicare) or federal subsidies to corporations to help pay employee health benefits. Private health insurance in the United States also generally has complex systems of cost sharing, which includes co-pays and deductibles. Cost sharing is typically used a way of balancing out-of-pocket costs with premium costs depending on the needs of the pool. Cost sharing methods are limited in Germany by contrast, but not unknown in the PHI system.

Nationwide regulation of private health insurance was limited prior to the Affordable Care Act. Although regulations existed prior to the ACA to help hedge or prevent severe adverse selection (only covering healthy, low-risk individuals), private health insurance in the United States was far less regulated than its contemporaries. Insurance

¹⁵ Estimated to be around \$200 billion a year, for 2011.

companies, for example, could deny coverage to someone based on pre-existing or genetic health conditions or set lifetime caps on insurance benefits, meaning that coverage could be terminated if an insured got too sick.

History of National Health Reform in the United States

The historical path that led to the passing of the Patient Protection and Affordable Care Act of 2010 effectively started in 1912 and is dominated largely by attempts to pass some form of progressive national health insurance. The progressive era of the early 20th Century marked the first attempts to borrow the idea of “government-sponsored” health insurance from America’s European counterparts, notably the German system of sickness funds established by Bismarck in a few decades previously and the passing of the British National Insurance Act in 1911 (Starr 2011, 29; Hoffman 2003, 1).

In 1915 the American Association for Labor Legislation (AALL), a small group of Progressive era reformers, published a proposal for a national system of compulsory insurance. The proposal would significantly affect health policy reform for the century to come (Chasse 1994 1063; Hoffman 2003, 1). Among other provisions, the system depended heavily on compulsory insurance for individuals up to a certain income level and the costs of the insurance shared between employees and employers (AALL 1916, Hoffman 2003). The original proposal was, however, interrupted by World War I.

The First World War negatively affected the perception of Germany and consequently affected any plans to promote a German-based system of health insurance.

Most notably, the War caused the American Medical Association (AMA), the prominent American lobbying organization for physicians, to rescind its support for the AALL's proposal. And thus, a century of debate around compulsory or government-sponsored insurance in the United States would begin (Chasse 1994, 1063).

A multitude of subsequent attempts to pass some form of nationally organized health insurance all failed (Chasse 1994, 1069). Throughout the Century long debate, "advocates of a public program to provide all Americans access to health care and shield them from costs of illness tried virtually every course possible in a federal system" (Starr 2011, 4). The measures taken by such advocates include passing laws in states, proposals for federal programs carried out through states, and even purely federal measures. The political environment, however, never favored passing comprehensive national insurance.

According to Paul Starr, contemporary U.S. governmental health programs developed over time as the result of a series of compromises benefiting particular groups that were somehow special or vulnerable (Starr 2011). After the First World War, for example, Congress established the forerunner for the modern Veterans' Health Administration system in place today and after the Second World War the federal government began providing subsidies to companies to provide employment-based, private health insurance to workers. Then in 1965, Congress passed amendments to the Social Security Act of 1935, which established Medicare, a purely federal program, to secure the elderly and Medicaid, a mixed federal-state program, for those living at some level of poverty (Starr 2011, 5). The passage of Medicare and Medicaid as amendments to the Social Security Act of 1935 is arguably the most significant change in American healthcare in the 20th Century, especially in terms of a discussion regarding the Affordable

Care Act.

In *The Politics of Medicare*, Marmor (2000) provides a comprehensive history of state sponsored health care in the United States. Although other industrialized, Western states had some form of national insurance or government organized health care system by the 1940's, the United States did not have any form of national insurance until the enactment of the Social Security Act of 1965. Originally this came in the form of Medicare, which is an age restricted form of social welfare intended to alleviate the burden of rising health care costs on the elderly (which often do not have health insurance from employers because of retirement).

Health care reform in the United States endured a lot of political resistance, mostly fueled by the American ideology of individualism and powerful interest groups. Marmor explains the extent to which the American Medical Association, as a lobbying organization, had a significant impact on the political discourse and trajectory of national healthcare or health insurance reform. Except for the original proposal by the AALL in 1915, the American Medical Association has never supported any substantial reform. Little attention was given to the subject of health reform since the First World War until the era of Roosevelt politics in the 1930's (in the era of the "New Deal" and other forms of government programs run by Roosevelt). As was the case for most of Roosevelt's policies, the Great Depression reignited discussions of a state subsidized national health insurance, especially for the poor. In the early 1930's this newfound momentum was mitigated by the American Medical Association, citing "fear of government control of working men." Later, during the post-Kennedy Cold War era, the AMA lobbied against national health insurance by "holding out horrific visions of a socialized America ruled by an autocratic federal

government” to gain sympathy from the growing anti-communism of the 1950’s and 60’s in America. The AMA, therefore, had a part in establishing the anti-governmental “political environment” towards healthcare in the United States. The AMA claimed that without people paying for their care, it would undermine “the willingness of individuals to save and take care of their own problems”. Marmor also claims that the AMA “wav[ed] the red flag of socialism” as a warning against compulsory insurance, even for the aged. Furthermore, in her article comparing German and American healthcare, Altenstetter attributes the historical failure of American universal health insurance as part and parcel of the American “rugged individualism;” the same ideology promoted by the AMA (Altenstetter 2003, 43).

Later, in the post Cold War 1990s, Clinton offered new control for American liberals and a new attempt at health reform. Pantel and Rushefsky discuss the failure of attempts to pass health care reform in the twentieth century in their book, *Politics, Power, and Policymaking: The Case for Health Care Reform in the 1990s* (1998). They state that “one of the reasons all previous efforts at comprehensive health care reforms, especially for the establishment of a national health insurance system¹⁶, had failed in the twentieth century” was because of “powerful organized interests” in the healthcare industry, despite the eventual consensus among these groups in the 1995-1996 reform period that “something” needed to change with Medicare, Medicaid, and the uninsured. The “window of opportunity” for the passing of substantial healthcare reform, established by the intersection of political will and emerging recognition of wide-spread problems in the health care system (namely exploding costs in all parts of the system), closed before the

¹⁶ Although debated and originally a major component of the PPACA, a “public option” for citizens outside of Medicare, Medicaid, or the Veteran’s system was later abolished from the PPACA.

Clinton Administration could overcome hurdles presented by, among other things, the Republican party and the “democratic disunity:” Democrats could not agree on one form of health reform proposal (Rushefsky and Patel 1998, 109).

With the failure of health reform in the 1990s, therefore, the American healthcare system had not seen substantial change since the enactment of Medicare and Medicaid until the ACA was signed. The result of lacking reform is largely demonstrated in the rise in cost of healthcare in the United States, especially between 1970 and 2010. Although the United States spent an internationally comparable percentage of its GDP in healthcare expenditures in 1970 (about 7%), by 2007 Americans were spending “more than 50 percent more than the next highest spenders—Norway and Sweden” (Starr 2011, 5). Notably, this variation is not explained by higher income in the United States, by changes in disease rates, or by utilization of services. The U.S. healthcare system therefore faced rising costs due primarily to high prices for drugs, doctor visits, hospital care, and medical equipment, lack of insurance for many Americans (16.9% of population in 2007), and weak health outcomes compared to other industrialized nations (U.S. Bureau of the Census 2008; Kaiser Commission on Medicaid and Uninsured 2012; World Health Report 2000).¹⁷

Despite these issues, similar resistance towards health reform in the United States continued for the Obama Administration. Faced with these troubles, significant reform would have to overcome three hurdles: the power of special interests (such as the AMA and “the Big Five”¹⁸), national values, and the sheer complexity of the issue. In his book, *Remedy*

¹⁷ In 2000, the World Health Organization ranked America’s healthcare system 37th in the world (World Health Report, 2000).

¹⁸ A lobbying group comprised of the top 5 health insurance companies that insure approximately half of the insured population: Wellpoint, Inc., CIGNA, Aetna, Humana, and United Healthcare.

and Reaction, Paul Starr (2011) argues that it is not one of these factors alone, but really the combination of these factors that establishes the perfect, and peculiar, political climate against health reform in the United States. Specifically, he states:

Each of the impediments to change that I have mentioned has been formidable in its own right, but they have been devastating in combination. American political institutions make innovation difficult but the barriers are especially large when reform has the potential to provoke so many different sources of interest group ideological, and popular opposition. (Starr 2011, 11)

This “trap,” as he calls it, has created a system that would require a very well crafted policy and special leadership, and leadership that would “[seize] opportunities created by a shift in the underlying conditions,” such as changes in the party makeup of Washington (Starr 2011, 11). Building off of the Massachusetts health plan enacted in 2006, The Patient Protection and Affordable Care Act, although far from a “perfect” piece of legislation in the eyes of both Democrats and especially Republicans, would prove to be the right bill at the right time.

Summary of the Act

The foremost aim of the Affordable Care Act is to achieve “near-universal” status, which means increasing the percentage of insured Americans to 94%. The ACA attempts to do so “through shared responsibility among government, individuals, and employers” (Rosenbaum 2011, 130). Functionally, the ACA attempts to accomplish this primarily through increased subsidies to employers for health benefits, expanded funding to state Medicaid programs, and requiring all citizens to maintain health insurance. “In expanding existing coverage, the Act fundamentally restructures Medicaid to cover all citizens and legal U.S. residents with family incomes less than 133% of the federal poverty line” (Rosenbaum 2011, 131). In addition, the Health Benefit Exchanges and new federal regulations on private health insurance companies attempt to set a federal minimum level of care and reduce barriers to insurance by “eliminating discriminatory pricing and coverage practices” that adversely favor already healthy populations (Rosenbaum 2011, 131). The ACA also promotes employers providing workplace Wellness incentives to reduce health costs and promote prevention. The other aims include increasing quality and reducing waste, through independent or quasi-governmental panels and organizations that make recommendations on costly healthcare practices (mostly on the administrative level), as well as increased funding for public health training and programs¹⁹ (Rosenbaum 2011).

¹⁹ For a complete summary of the Affordable Care Act, see the Kaiser Family Foundation website: <http://www.kff.org/healthreform/8061.cfm>

Chapter 3: Comparisons

The aim of this chapter is to fully elucidate the similarities between the Affordable Care Act and the contemporary German health system. Specifically this chapter will detail the exact lines, sections, and provisions of the Affordable Care Act that are functionally or conceptually comparable to important components of the German system. Each section of the chapter will address the categories mentioned in the introduction: the broad category of stricter federal regulation on the private health insurance market, the health insurance mandate, federally regulated competition, funding and regulations for wellness programs and preventative services, and the use of quasi-governmental organizations. These five main areas encompass in some fashion the basic goals of the Affordable Care Act as a whole, which are to expand coverage to more Americans, control health care costs, and improve health outcomes.

The five salient components of PPACA focused on in this paper vary in function and organization, but fit broad concepts in the German organization and theory of healthcare. First, the controversial individual mandate of the ACA is based on the quintessentially German tradition of compulsory insurance since the late 19th Century, and Germany recently enacted a universal mandate of its own in 2009. Second, PPACA incentivizes federally regulated competition in privately provided healthcare. Although the vast majority of insurance in the United States is for-profit, competition inspired by Insurance Benefit Exchanges and CO-OPs established and funded through the PPACA is similar to the federally regulated competition within the Germany sickness fund system. Third, the

PPACA also promotes prevention, public health, and wellness efforts, similar to Germany's tradition of promoting preventative benefit packages and encouraging healthy lifestyles as part of its statutory health insurance system. Additionally, quality control through independently operated organizations in the PPACA has also been instrumental in recent cost containment reform in Germany, and represents the tradition of parapublic institutions in Germany. Lastly, the new sweeping federal regulations on private health insurance compare well to German regulations that have been in place for decades in both private and statutory health insurance.

Federal Regulations on Private Health Insurance

The American health care system is largely unregulated compared to its counterparts in Europe (Wierling 2010). As Giaimo and Manow (1999) describe it, the "American health care system is part of a liberal welfare state in which social provision is made through the private market or through limited social insurance programs." Although the government has a lot of power over programs in which the government acts directly as payer, such as Medicare and Medicaid, state leverage over private health insurance providers has been historically limited. Medicare and Medicaid, which are exclusively designed to cover the elderly and the poor, leave a relatively large portion of American society to find insurance through employment or through private markets. For many Americans, private markets are often "prohibitively expensive" (Giaimo and Manow 1999). As described by Giaimo and Manow, in a 1999 *Comparative Political Studies* essay: "the federal government [has] at best an arm's length relationship with the employer-based,

private insurance market,” mainly exerting influence through regulations to Medicare and Medicaid which private insurers may or may not choose to adopt (Giaino and Manow 1999).

As part of the Affordable Care Act’s aim to provide “quality, affordable health care for all Americans,” the Act institutes a range of regulations on the private health insurance market (PPACA Title I). First, the ACA eliminates the ability of insurance companies to “establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan or coverage based any... health status-related factors in relation to the individual or dependent” (Sec 2705). In other words, an insurance company may not turn down new clients because of pre-existing medical conditions. Section 2705 of the ACA goes on to explain specifically that, starting in 2014, insurers cannot restrict someone from getting a plan based on

health status, medical condition (including both physical and mental illness), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), disability, [and] and other health status-related factor determined appropriate by the Secretary. (PPACA Sec. 2705)

Furthermore, other regulations starting in 2014 are especially important to currently vulnerable populations, including the poor and the chronically ill. These regulations include provisions that insurance is only terminable by the insured; insurers must accept everyone who applies for coverage, and insurers must renew coverage for

everyone who has it (PPACA Sec. 2702, 2703, and 1302). In addition to guaranteed coverage if one applies, insurance premiums cannot be increased on individuals without due cause and notice. Section 2701 details what considerations can be made towards premiums. Essentially, the only thing an insurance provider can take into consideration when determining individual premium rates is whether that person wants to cover a family or an individual, one's age and tobacco use, and other factors that can be determined by individual states. In addition, Section 2794 details the Secretary's responsibility to review premium increases in the State exchanges, and if the Secretary deems any premium increases to be "unreasonable" (conducted too fast or without prior announcement of changes), the insurer may be dropped from the health insurance exchange.

The regulations described above are perhaps the most popular parts of the Affordable Care Act in terms of public opinion (Blendon 2011; De Pinto 2012). Demonstrating the similarity between German health insurance regulation and regulation established in the ACA is important; it is important to note the subtle gravity of these changes. The federal regulations in the ACA on private health insurance markets arguably affect the individual American's fundamental experience with healthcare the most of any portion of the Act, especially considering the number of Americans that are insured through private insurance.

The law also establishes a risk-adjusted health fund for insurance providers operating in the insurance exchanges. Section 1343 is dedicated to establishing a mechanism for risk adjustment in the insurance exchanges. The risk adjustment fund acts to "discourage insurers" from only insuring relatively healthy, low-cost populations by requiring insurance providers "to pay into a risk-adjustment fund; conversely, the fund

compensates insurers if they sign up a more costly group of subscribers” (Starr 2011, 241). In this way, insurance companies are given incentives from the government to insure higher-risk populations; “ the system prevents individuals from being charged according to their risk, [but] it pays insurers on this basis” (Starr 2011, 241).

Perhaps the most interesting private health insurance market reform, especially in a comparison with Germany, is the establishment of a standardized minimum level of care. Section 1302 details how the Secretary will determine minimum standards, and establishes the general areas in which insurance plans must cover the bare minimum: ambulatory services, emergency services, hospitalization, maternity and newborn care, mental health services, drugs, rehabilitative services, preventative services, and more. Simpler portions of this same section detail how cost sharing will be capped. Starting in 2015, deductibles will be capped at \$2000 for individuals and \$4000 for couples. Although there is not a comparable institution in Germany, this section in particular is also important for Americans because it establishes the standardized categories in which insurance plans on the exchanges will be labeled: catastrophic, “bronze”, “silver”, “gold”, and “platinum.” With the exception of the catastrophic plans, which are only available to young adults under 30, the plans are categorized based on medical loss ratios. In the silver plan for example, 70% of insurance company expenses should go towards benefits and only 30% can go towards administrative costs. Among other things, this has implications for the minimum care being expanded to Medicaid recipients; Medicaid participants must receive coverage comparable to their areas comparable Bronze level plans in their exchange programs. The ACA therefore establishes various standardized levels of care across all private insurance, as well as mandates what an insurance company can provide at the very minimum.

If there is one staple of the German health care experience, it is the high level of formalized federal regulation on the private provision of care in both the PHI and SHI systems. In the SHI system, although the contribution rates and covered benefits are negotiated between corporatist actors such as the sickness funds and physician associations, Germany's federal government lays the basic legal framework for all health insurance. Compared to the United States, the German state has always had a tighter control on what health insurance companies and sickness funds can offer in their benefit packages and how much they can charge patients, among many other regulations similar to the ACA.

Germany has the same regulations on both SHI and PHI that are represented in the ACA, even in the PHI system. According to a report from the Kiel Institute:

Where insurers charge premiums based on individual risk (like in the United States), assessed before signing up, regulation [in Germany] ensures: all contracts for life (terminable only by insured), may not exclude pre-existing conditions, nor increase premiums for any other reason than general expenditure increases in the entire pool of insured persons. (Stolpe 2011)

Germany's SHI and PHI system, therefore, contain almost identical regulations as those found in the ACA: no lifetime limits on benefits, applicants cannot be turned down regardless of pre-existing conditions, and even private health insurance is required to have a basic, standardized minimum level of coverage available for anyone who applies.

Additionally, the Central Health Fund that plays an integral part in the financing

system of German healthcare, as described in Chapter 1, is also conceptually represented in the ACA. To prevent sickness funds from adversely selecting, for one reason or another, inherently healthier, low-cost populations, the Central Health Fund works to filter the nation's sickness fund premium contributions and redistribute the payments in a way that compensates sickness funds for higher-cost populations. The Central Health Fund, as a risk-adjustment mechanism for the SHI system in Germany, is comparable to the risk-adjustment scheme presented in Section 1343 of the ACA, which protects patients from being charged actuarial-based premiums while still compensating insurance companies as such.

Self-governed sickness funds and private health insurance companies under heavy federal regulation has allowed for provider and patient freedom while also maintaining a SHI system that provides comprehensive coverage for German citizens. Other countries in Europe utilize high federal regulation, but Germany is unique in its mixture of federal regulation and decentralization. Although small, the Affordable Care Act moves the United States in the direction of similar style of federal regulation; the ACA increases federal regulation on insurance companies but does not interfere with their independent operation (Wierling 2010;Reinhardt 1999). This is directly represented in the new regulations on private health insurance companies in the U.S. mentioned above.

In Germany, federal regulation of health insurance is part and parcel of both the PHI and SHI systems. Although the care in Germany is provided and, for the majority of the population, financed independently of the government, government agencies and actors have a large say in how care is provided. As previously discussed, the history of consistent patchwork reform on the federal level is a telling example of the role that the federal

government plays in health care in Germany. In short, the abovementioned regulations established in the Affordable Care Act are staple pieces of federal German healthcare law, the decentralized and corporatist organization of German health care, and the social tradition of health care.

The most striking comparison between the ACA and the German system, however, goes beyond basic health insurance regulations. Rather, it is more interesting to note that the ACA mimics a fundamental principle of the German welfare state as a whole: providing the means for a minimum existence. Pursuant to Article 1 PPACA Sec. 1 and Article 20 PPACA Sec. 1 of the German Constitution (*Grundgesetz*), one of the fundamental tenants of the German social state is that the government has the obligation to provide all of its citizens with a minimum standard of existence, and private or statutory insurance are part of this system²⁰. Germans are very intent on maintaining this tradition of society, which includes providing a minimum level of healthcare to Germany's inhabitants.

In this vein, the 2007 "Act to Strengthen Competition in Statutory Health Insurance" in Germany established a basic category for PHI that private companies must offer to guarantee basic coverage under any plan in Germany (*Standardtarif*). The basic category states that private insurers must provide a level of minimum coverage, which "mimics the conditions of the SHI" (Federal Constitutional Court 1009;Stolpe 2011). The idea of federally mandated minimum coverage in private health insurance is comparable to the abovementioned provisions in the ACA that require similar, basic benefits to be included in private insurance plans in the United States.

²⁰ And through means outside of health insurance altogether, like unemployment benefits.

The Individual Mandate

The individual mandate is one of the most important and controversial components of the Affordable Care Act. The mandate is detailed specifically in Section 5000A of the Affordable Care Act, titled “Requirement to Maintain Minimum Essential Coverage”. The basic function of the individual mandate is to increase insurance coverage among the entire population of the United States by levying a tax on those who chose not to have health insurance, with some exceptions.

The individual mandate provides an essential service for the ACA as a whole (Starr 2011, 21). In short, without the individual mandate, many of the other provisions of the Affordable Care Act would not be possible, such as the federal regulations on the health insurance market. Indeed, a main health insurance lobby, America’s Health Insurance Plans (AHIP), submitted a brief shortly after President Obama’s election pushing for a universal coverage (Zirkelbach 2008). AHIP was also aware that health insurance reforms, such as not allowing insurance companies to deny coverage to those with pre-existing condition, would not function without every citizen being required to carry insurance; insurance companies needed the protection of healthy individuals joining their plans to offset the increased risk and costs associated with patients with pre-existing conditions. The mandate therefore functions as a method to increase coverage and distribute risk among a greater pool of people, hoping healthy individuals will not take the tax, to allow for other changes in the health system to occur.

With exceptions, starting in 2014 the individual mandate makes it “illegal” for

United States citizens to not own health insurance of some form, whether private or public. In other words, every applicable citizen must hold a certain level of minimum coverage or face a penalty. Specifically, the law states:

An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual... is covered under minimum essential coverage for such month. If an applicable individual fails to meet the [above] requirement... there is hereby imposed a penalty with respect to the individual.

Minimum coverage is defined in the PPACA by several classifications. In general, the terms “minimum essential coverage” means that an individual is covered by either government-sponsored programs, an employer-based insurance program, or individual private insurance purchased on the market. Government programs include: Medicare, Medicaid, CHIP (Child Health Insurance Plan), the TRICARE for Life program, the Veterans’ Health program, and health coverage provided to Peace Corps volunteers. Under the ACA, minimum essential coverage could also be obtained by “other coverage,” which is defined as “such other health benefits coverage, such as a State health benefits risk pool.” But according to the Law, the Secretary of Health and Human Services must approve these plans.

The mandate is monitored and enforced through the Internal Revenue Service (PPACA Sec. 1502, Reporting of Health Insurance Coverage). Enforcement is detailed as follows: “In the case of any failure by a taxpayer to timely pay any penalty imposed by this

section, such taxpayer shall not be subject to any criminal prosecution or penalty...” (PPACA Sec. 5000A). There is, therefore, no criminal recourse for not having insurance; rather, one will receive a penalty on his or her tax return. If health insurance (based on one’s area and employment) costs less than 8% of an individual’s income, and that individual does not own insurance, he or she will be assessed a \$95 tax or 1% of his or her income, whichever is greater. By 2016, this is scheduled to rise to \$695 or 2.5% of income. After 2016, the cost will be \$750 multiplied by the cost of living adjustment determined for that calendar year. There are limitations established in this section as well on the maximum amount one would ever have to pay.

Section 4980H of the PPACA outlines the effect this will have on businesses. Starting in 2014, if an employer has over 50 employees and does not offer them insurance, the employer has to pay a \$2000/ per employee fee. If they employ part-time employees, their hours are to be added together to see how many full-time employees they would represent. The law designates the Secretary of Labor to report what effect this has on employee wages in the future. Small businesses have historically not been able to afford health insurance for employees, but to help small businesses pay for the extra cost of healthcare, the Affordable Care Act provides funding through tax credits to small businesses to mitigate the costs of offering health benefits to employees.

Germany also has a mandate that requires all inhabitants of Germany to have some form of minimum coverage, regardless of whether that coverage is through PHI or SHI. In 2009, the *Bundesverfassungsgericht* (the German Federal Court) upheld the constitutionality of a universal requirement for all Germans to hold insurance (Federal Constitutional Court 2009). The German version of the individual mandate was part of the

“Act to Strengthen Competition in Statutory Health Insurance” mentioned above, which included provisions to “[make] statutory or private health insurance compulsory for all inhabitants of Germany” (Federal Constitutional Court 2009). German federal law therefore makes it illegal for any long-term inhabitants of Germany to live without health insurance, even non-citizens.

Previous to enacting the universal requirement in 2007, Germans earning an income under a certain amount (49,500 euros in 2003) were already required to hold *Gesetzliche Krankenversicherung* (SHI), which covered the majority of population. Above that income level, citizens were allowed to opt out of the SHI and purchase private health insurance (as they are still now). The difference now is that individuals who make enough to opt out of SHI cannot also opt out of PHI and not be covered at all, covering a small but potentially important sliver of the remaining German population that could contribute to the system. The amount of people who opted out of the SHI, and also did not purchase PHI, was very low in the past (some estimates say about 0.2% or 200,000 people), mostly consisting of the self-employed or very wealthy (Sullivan 2008;Crema 2007). In the beginning, Bismarck’s original National Health Insurance for Worker’s Law set the tradition for compulsory insurance, but this statute only applied to certain industries (e.g. factory labor).

A complete comparison between the ACA and the German healthcare system cannot be made without addressing the individual mandate. The broad concept of compulsory insurance is a quintessential characteristic of German healthcare dating back to its roots in the 19th Century, and the foundation of the solidarity on which the SHI system is based. In the end, the individual mandate at least moderately modifies the American status quo in

the direction of a communitarian system that relies on a contribution from the entire population to provide for the sick; The mandate ensures the ACA's ability to protect the most vulnerable in a private health insurance system: the sick. The politics of the individual mandate aside, the individual mandate is certainly more of a step towards the German style of solidarity-based healthcare than any previous federal reform of the private health insurance market.

Prevention and Wellness

In general, there exists a multiplicity of sections in the ACA that relate to the expansion of funding for public health, wellness incentives, and preventive services. Title IV of the Affordable Care Act is appropriately titled "Prevention of Chronic Disease and Improving Public Health," which contains the majority of the ACA provisions related to these areas.

Wellness incentives that aim to reduce costs and morbidity are integral to this Title of the ACA. The ACA "aims to expand the permitted scope of wellness incentives," which are defined by the Common Wealth Fund as rewards (often financial) to individuals for participating in programs that develop healthy lifestyle choices or if individuals meet certain health targets. Because of the ACA, starting in 2012 "the levels of reimbursement that may be offered as incentives will increase from the previous 20 percent of the cost of coverage to 30 percent, and... may be as high as 50 percent" (Schmidt 2012, 6). This move by the ACA is primarily an effort to reduce costs on tertiary care (pharmaceuticals,

emergency care, chronic illness, hospitalization) by reducing illness altogether, especially in vulnerable populations. According to the Common Wealth Fund, the wellness incentives from the Affordable Care Act could function similarly to the wellness incentives already available under public insurers in Germany. In short, “Both the German and the U.S. wellness incentives attempt to promote health while reducing costs” (Schmidt 2012, 7).

Wellness and prevention measures of the PPACA are, therefore, another form of cost containment. Preventative services in schools, for example, are designed to reduce rates of diabetes, obesity, and other chronic diseases that burden the healthcare system. As mentioned previously, the United States faces an aging population; The ACA hopes to mitigate some costs of chronic care by preventing morbidity in the elderly community.

According to an issue brief distributed by the American Public Health Association (APHA), the Affordable Care Act provides moves the country towards the type of wellness and preventative services the APHA advocated in their 2010 Issue Brief on prevention. Specifically, the brief states that the “Affordable Care Act... represents a bold step for the nation in creating a system that promotes wellness” (Shearer 2010, 2-3). These initiatives can be grouped into three categories:

- 1) Investing in public health through grant programs, contracts, support and infrastructure that will develop a national prevention, health promotion and public health strategy and coordinate federal programs;
- 2) Educational campaigns aimed at improving health learning from experience through research and demonstration;
- 3) And requiring that evidence-based preventive health care services be covered in

both public and private health coverage, without cost sharing.

In addition to provisions that cover the above, the ACA also establishes that preventative services should be a part of the “minimum coverage” discussed earlier. Preventative services were previously not required under federal mandate to be included in private health insurance, therefore many insurance companies did not cover preventative services. This private health insurance market reform is, however, only one provision under the ACA that promotes preventative services. According to the Common Wealth Fund, the wellness incentives from the Affordable Care Act could function similarly to the wellness incentives already available under public insurers in Germany. In short, “Both the German and the U.S. wellness incentives attempt to promote health while reducing costs” (Schmidt 2012, 7).

In addition to mandating insurance cover preventative procedures, a different section of the Affordable Care Act directs the President to establish a National Prevention, Health Promotion, and Public Health Council, headed by the Surgeon General and staffed by various Secretaries (ranging from Homeland Security to Secretary of Health and Human Services) (PPACA Sec. 4001). The council is to make recommendations to the President regarding ways to promote healthy lifestyles. Under this section the President is also expected to establish an “Advisory Group on Prevention, Health Promotion, and Integrative Public Health,” which is comprised off 25 Presidential appointees who are health care professionals. The Secretary of Health and Human Resources and the Comptroller General are to conduct reviews every 5 years to evaluate these programs’ effectiveness. Similarly, Section 4002 even goes on to create the “Prevention and Public Health Fund” which is designed to increase funding for programs in the Public Health Service Act. This fund is to

appropriate \$500 Billion in 2010, gradually ramping up every year until 2015, where the fund will appropriate \$2 Billion.

The bill goes on to establish more programs, boards, and funds to promote prevention and wellness. Section 4003, for example establishes the U.S. preventative Services Task Force, an independent panel of health experts whose job will be to review the scientific evidence related to the effectiveness and, appropriateness, and cost-effectiveness of preventative services, and to develop recommendations for improvement in the health care community. They are also to submit yearly reports to Congress on gaps in scientific research on preventive services. Additionally there are a variety of programs designed to fund research, demonstration projects (such as for obesity in children), and improvements to evidence-based community level prevention and wellness programs. These programs often target schools, work place, and reducing access barriers to similar programs for Medicare and Medicaid participants, which is a population often underrepresented in wellness programs (PPACA Sec. 4106, 4104, and 4103).²¹

The wellness-related reforms enacted in the PPACA share broad similarities to well-supported wellness and prevention programs already established by most sickness funds in Germany. A report by The Commonwealth Fund notes, in fact, “[that] in Germany, the German Social Security Code allows... sickness funds... to offer their members bonuses to participate in health promotion, screening and checkup programs.” And it is not only a small collection of funds that do so: “All major sickness funds offer a wide range of programs and actively promote them to their members.” Similar to what is outlined in the

²¹ For further information on the ACA and its impact on Public Health, Wellness, and Preventative services, see the October 2010 Issue Brief by the APHA: *Prevention Provisions in the Affordable Care Act* by Gail Shearer

ACA, participants in these programs must meet certain targets (such as Body Mass Index target), and document these achievements, in order to receive the incentives (PPACA Sec. 4003).

Wellness programs are already offered in Germany and their popularity is growing. Between 2004 and 2008, the amount of participants in wellness programs doubled in Germany, “reaching one quarter of the publicly insured population,” which has been attributed to reduced costs for insurers and subsequently increased competitiveness (Schmidt 2012, 2;Baicker 2010 304-311).

In addition to prevention efforts facilitated through sickness funds, Germany has also established non-governmental groups that recommend health prevention policy changes, such as the German Forum on Prevention and Health Promotion, which was established in 2002. Although less broad in scope, the German Forum could be easily compared to the National Prevention, Health Promotion, and Public Health Council or the U.S. Preventative Services Task Force established by the ACA. The German Forum is a “voluntary joint venture of relevant actors in prevention” including government officials, physicians, and sickness fund representatives. The goal of the German Forum, similar to that of the Council, is “to work together and create synergy... on four topics: healthy kindergartens and schools, health promotion in firms, and healthy aging” (Winter 2005, Abstract). These target areas are almost identical to those outlined in the Affordable Care Act.

Prevention, however, is not merely a chance component of sickness funds government agencies, but prominent component of the general law under which the SHI is established (the SGB-V). The second line of the Book states:

[The insured] are jointly responsible for their health; they should lead a health-conscious lifestyle through early participation in preventative health measures and through active participation in health care and rehabilitation to avoid the occurrence of disease and morbidity.

Subsequently, insurance companies are charged with aiding their patients through the process of achieving healthy life-styles. In this sense then, as a step towards ensuring that Americans maintain healthy lifestyles, the Affordable Care Act significantly overlaps with a half-century old fundamental principle of health policy in Germany: healthy living as an integral part of providing health insurance to its citizens and the German welfare state as a whole. Subsequent articles of the SGB-V set out a range of provisions through which sickness funds may implement this approach, including financial incentives. Specifically, the third and fourth sections under Chapter 4 of the SGB-V, which establishes health insurance benefits, are titled: “Services for the prevention of diseases, health promotion and prevention of work-related health risks, promotion of self-help as well as pregnancy and motherhood” and “Services for the early detection of disease.” Outside of the laws themselves, in Germany there is also the concept of the *mündiger Bürger* (the responsible citizen), which means in the case of health that one should maintain a healthy, individual lifestyle for the betterment of the collective community. The German system therefore widely and systematically supports efforts to promote wellness incentives and preventative services, institutionally and socially, as a fundamental aspect of German healthcare. The ACA attempts to at least partially mimic this approach to health by

prioritizing prevention and wellness as a major component of the law, and establishing a basic legal framework that makes preventative services more available.

Quasi-governmental Organizations for Quality Control

The Affordable Care Act seeks to contain costs, especially in Medicare and Medicaid spending, through the evaluation of Medicare practices. A majority of this evaluation of practices is conducted by independent, expert and non-profit organizations that consist of experts in healthcare from a range of fields within the health system. Independent quality assurance is important to any health system, because of information asymmetry in the economics of health insurance, especially private health insurance.

The economics of information asymmetry suggests provider competition without stringent external quality controls could deteriorate into a race-to-the-bottom or trigger systematic discrimination against costly-to-treat patients. Policy makers seem to have understood the need for quality standards and continuing improvements, as provider competition is unleashed. (Stolpe 2011)

The quasi-governmental panels and organizations therefore conduct a variety of operations from treatment efficacy research to Health Technology Assessment (HTA) and quality assurance, with the goal of increasing efficiency and lowering the costs of Medicare.

One such organization is the Independent Payment Advisory Board (IPAB)²², which provides recommendations to lawmakers regarding treatment efficiency and ways to reduce administrative costs within Medicare. The IPAB is intended to give recommendations on how to save Medicare costs per person, deliver more efficient and effective care, improve access to services, and eliminate waste. Unfortunately, however, the IPAB has little authoritative power to influence changes in Medicare on the whole. Congress votes upon the recommendations that the Board makes, and the President has the right to veto the recommendations. This specific panel, in addition, is designed to find ways that will not ration health care, alter cost sharing, or affect eligibility for Medicare, which significantly limits the scope of their power (PPACA Sec. 3403). Their function, therefore, is mainly to find ways to save money from administrative costs (PPACA Sec. 3403). A similar organization to the IPAB is the Center for Medicare and Medicaid Innovation (CMI)²³, meant to test new ways to make Medicare services and payments easier and more efficient, while keeping or improving quality of care (PPACA Sec. 115A). In addition, the ACA establishes a variety of similarly parapublic organizations to perform similar functions in prevention and wellness as discussed in the previous section.

The ACA also establishes the Patient-Centered Outcomes Research Institute (PCORI). The government funds but does not directly control PCORI and the body is charged with “examining the relative health outcomes, clinical effectiveness, and appropriateness” of various medical treatments by evaluation existing studies and conducting its own research (PPACA Sec. 6301). The panel includes a 19-member board,

²² The name was originally “Independent Medicare Advisory Board,” but was changed due to subsequent misconceptions of the Board’s scope of power (i.e. “death panels”).

²³ <http://innovation.cms.gov/>

which will include representatives from different areas of healthcare: patients, physicians, nurses, hospitals, pharmaceutical representatives, insurers, payers, and government officials. Similar to IPAB above, PCORI has no official power in front of Congress, but may make recommendations regarding Medicare expenses. These recommendations, however, must also not ration healthcare (described in the ACA as “dollars per quality adjusted life year” measurement) (PPACA Sec. 6301). This type of restriction deviates from similar organizations in other countries, such as the National Institute for Health and Clinical Excellence²⁴ in the United Kingdom, which is controlled directly by the government and can make such recommendations.

Germany has a strong tradition of quality and cost control through independent commissions and organizations designed to assess health technology and treatment effectiveness. In Europe as a whole, there is a general trend towards evidence-based medicine that aims to lower healthcare costs by evaluating the efficiency of expensive medical technologies and treatments and restricting the provision of inefficient or unnecessary procedures.

After a 2005 reform, for example, Germany established the *Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen* (Institute for Quality and Effectiveness in Health Care), also known as IQWiG. From their website, the IQWiG is described as “an independent scientific institute that investigates the benefits and harms of medical interventions for patients,” which “regularly [provides] information about the potential advantages and

²⁴ See [://www.nice.org.uk/](http://www.nice.org.uk/) for more information.

disadvantages of different diagnostic and therapeutic interventions.”²⁵ This organization in general conducts “cost-effectiveness research,” with the “legal mandate to assess the medical benefits of new and established technologies and procedures” and “help create treatment guidelines... using evidence-based medicine” (Stolpe 2011). Because it is federally mandated and funded, but independently run and non-profit, the American PCORI (and similar organizations within the PPACA) provides the best direct example to institutions in Germany.

In Germany there are further institutions, organized and supervised by broad legal framework, but directly controlled by the government. Specifically, the Federal Joint Committees (or *Gemeinsamer Bundesausschuss- GBA*), who are comprised of patients, providers, physicians, and sickness funds, decide what is actually covered under the basic benefit packages in the SHI system, why, and at what prices. Because of its structure, the decisions depend heavily on “bipartisan” agreement between the various different agents involved in the healthcare system. The IQWiG, mentioned above, makes recommendations to these committees based on its findings.

The main difference between the agencies in Germany and those established in the ACA is their scope of power. The decisions of the GBA are legally binding (Alliance for Health Reform 2009). Based on the language of the ACA, the types of decisions made by the GBA are theoretically made by the Secretary of Health and Human Resources at this time. Regardless, although limited in their direct power, the new committees, panels, and task forces established throughout the ACA represent a stronger commitment on the federal

²⁵ www.iqwiq.de

level to promote the type of evidence-based medicine that drives the basic health packages of the Germany SHI system.

Managed Competition

In an effort to place stricter regulations on the insurance market while also maintaining American ideals of the marketplace, the ACA contains a series of provisions that create federally regulated and mandated competition through “CO-OPs” and State-level insurance exchanges. Although the status quo of the American health insurance market as a whole has remained relatively untouched (for-profit, employer-based, no public option), the ACA attempts to institute standardized mechanisms with which these for-profit insurance companies must now compete in new ways (insurance exchanges), and means with which Americans can form non-profit insurance groups to increase competition and lower costs (the CO-OPs).

Potentially one of the least known provisions of the ACA under this topic is the establishment of “CO-OPs.” Within PPACA, Section 1322 specifically establishes the rules and instructions to obtain loans and grants for the creation of non-profit, member-run insurers called CO-OPs (Consumer Operated and consumer Oriented Plans). Section 1322 is titled “Federal program to assist the establishment and operation of nonprofit, member-run health insurance issuers.” In short, what credit unions are to banks, this aims to be for traditional insurance companies. The ACA aims to make it easier for a group of people, within an organization or business, to band together to provide insurance to the members

of their group, without involving larger insurance companies. The specific language, summarized, is as follows:

The Secretary shall establish a program to carry out... the [CO-OP] program to foster the creation of qualified nonprofit health insurance issuers to offer qualified health plans in the individual and small group markets... The Secretary shall provide... loans to provide assistance to such person in meeting its start-up costs and grants to provide assistance to such person...

Such qualified programs would receive IRS 501(c) tax exemption and must fit the same criteria of any other non-profit organization (e.g. must not be governmentally affiliated and the “majority” of its operations must be towards providing the service). Not only do these create new competition for for-profit insurance companies, these CO-OPs mimic some of the fundamental principles of sickness funds in Germany (privately run, non-governmental, and non-profit). In the past, like CO-OPs, sickness funds could be created within companies, factories, or workplaces, so that co-workers were subsidizing each other’s healthcare if someone were to fall ill or not be able to work.

The Patient Protection and Affordable Care Act also establishes another mechanism for federally regulated market competition: insurance exchanges. One of the largest and most known components of the Affordable Care Act is a new system of insurance exchange that aims to increase competition and standardize coverage for more Americans. As noted above, the United States has a legacy of unaffordable health insurance in the private market. Section 1311 of the Affordable Care Act establishes plans to assist States in the

establishment of “American health benefit exchanges.” In general, individual States are mandated (starting January 2014) to establish an Exchange program within their state that “facilitates the purchase of qualified health plans” and meets certain benefit requirements established by the Secretary of Health and Human Resources. In practice, state Exchanges are required to:

Maintain an Internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans and assign a rating to each [health plan] ... and utilize a standardized format for presenting health benefits... and a calculator to determine the actual cost of coverage [and any cost-sharing for the insured].

The Law goes on to state that if a State declines to establish an exchange, or is unable to do so, the federal government will do so instead. As stated by Jon Gruber, an MIT professor who served as a main architect of health reform nationally and in Massachusetts, the law is geared towards expanding private insurance, rather than direct government control: “this law expands private health insurance by 20 million people... it provides tax incentives to increase private health insurance and [it provides] private health insurance exchanges,” ostensibly to increase the market-based competition of private insurance plans (Reuters 2012). The Exchanges are therefore an attempt to create an easy-to-use system of market-based, price competition coordinated by the government.

In recent years, Germany has also established a variety of measures to increase

market competition among sickness funds, as a means of reducing costs for the insured. Although on a different scale, both Germany and the United States spend a relatively high percentage of its GDP towards healthcare costs compared to other countries, and the rising costs of healthcare in the 21st Century have been a mutual concern. Although not the only method of reducing costs implemented by the Germans²⁶, cost sharing (co-payments and deductibles) and market competition have been a rising, albeit unpopular, trend of German healthcare reform (Giaino and Manow 1999, 960). Other forms of cost containment, such as universal budgets for sickness funds, were implemented in the 1990's, but were later repealed (Riesberg 2004).

Competition between sickness funds organized by the government is used as a cost control method in Germany and to promote higher quality health care. Because of "the difficulty in getting the powerful self-governing actors" of the German corporatist model "to adhere to the principle of stable contributions", the Kohl government of the 1990s implemented a string of market-like mechanisms for competition (Giaino and Manow 1999). These "carefully controlled" mechanisms were primarily focused increasing competition among sickness funds, but later reforms would also impact private health insurers as well. The first round of reforms in the 1990s came in 1992 with the Health Structure Act, the majority of which was introduced because previous cost containment measures, such as universal budgets, have thus far been deemed "unsuccessful" (Riesberg 2004) Because of this Act, starting in 1996, patients were allowed to freely choose their sickness fund, rather than be automatically enrolled in one, in hopes of increasing competition amongst sickness funds to improve quality of care and spread the risk pool. In

²⁶ Healthcare Technology Assessment and evidence-based medicine are also important cost-containment mechanisms in Germany.

effect, this reform is similar to the exchanges because both reduce barriers to switching plans and increase the options available to individual insurance holders, forcing providers in the United States to lower prices or sickness funds in Germany to increase quality of care to attract more customers.

To strengthen this competition movement further, a 1997 reform matched contribution increases in sickness funds with increases in cost sharing, which aimed to encourage patients to switch sickness funds that increase contributions by raising out of pocket costs. In practice, “each contribution hike of .1% increment lead to a co-payment increase of DM 1 for pharmaceuticals of 1% ... for other co-payments” (Giaino and Manow 1999, 982). In addition, the 1997 reform eliminated waiting periods for switching sickness funds if the contribution rate was increased, this provides “strong incentives to avoid any hike in contributions” for fear of losing members.

In the late 2000’s, Germany implemented another string of laws designed to increase market competition, most notably in the PHI system. Specifically, provisions of the “Act to Strengthen Competition in Statutory Health Insurance” and provisions of the “Act for the Reform of Private Insurance Law” aimed to strengthen competition in the PHI system. The first of these two laws was noted earlier as the Act that introduced the German equivalent of an individual mandate, but it also includes provisions that allow greater freedom for the insured (especially aging populations) to switch private health insurers. The acts also establish a standardized, minimum level of coverage private health insurance. The ACA directly follows suit in regards to both of these changes in the German PHI system.

Germany, therefore, has decades of experience of implementing federally regulated market competition to lower costs and improve quality. The Affordable Care Act, drawing

from this type of policy strategy, also implements regulated market competition strategies, like those highlighted in the Exchanges and the CO-OPs. The Affordable Care Act's utilization of managed competition reflects the German tradition of combining regulated market tools to indirectly control the PHI and SHI: a method of maintaining self-governance and independent administration, while also influencing pricing and quality through broad federal legal framework. In this respect, the ACA very closely matches Germany, at least conceptually. Through the Exchanges, for example the ACA does not directly change prices or intervene in the private insurance market, but rather establishes a legal framework strongly encouraging changes to encourage in the market. In the future, because Germany also must navigate often powerful, non-governmental actors when implementing policy decisions regarding market competition, it seems reasonable that American policymakers could borrow from Germany's history of managed competition.

Conclusion

As demonstrated in detail above, reforms established by the Affordable Care Act are analogous to several core features of the German health system, both in function and in broad philosophy. In addition, it is worth noting that there are two overarching themes throughout the comparisons: reducing health care costs through federal reform and maintaining (or building in the American case) a level of minimum care. Cost containment is not a coincidence considering that both Germany and the United States face high and rapidly increasing healthcare costs. The Affordable Care Act therefore not only matches

specific components of the German system as it is now, but also fits the general historic pattern of German healthcare reform over this past half-Century, which has focused primarily on attempts controlling costs through a mixed approach of federal regulations and regulated competition. Essentially, it appears that the ACA attempts to combine 50 or more years worth of reform as seen in Germany, into a singular, giant piece of American healthcare reform.

Most importantly, however, is how well the Affordable Care Act's various core provisions match the three major German pillars of healthcare: Solidarity, decentralization, and self-governance or non-state operations. The comparisons and components above explicitly represent an attempt by American policymakers to transform America's relationship to healthcare in a direction that aligns with a German-like philosophy towards healthcare that emphasizes those three foundations. The ACA's individual mandate, and the subsequent regulations on private insurance, allow for greater solidarity in healthcare in the United States than ever before. Another example, the quasi-governmental institutions for quality control and prevention in the United States (e.g. PCORI), demonstrate an increasing involvement of parapublic institutions in the American system. While any shift in policy is limited, specifically because many of the reforms pertain to Medicare and Medicaid that have literally no comparison in Germany and because health insurance is still primarily provided through for-profit institutions in the U.S., the comparisons are still meaningful reflections of a change in American policy that is functionally or philosophically very German.

It should be noted, however, that the ACA is not by any means a complete overhaul of the American health system towards the German system, despite the abovementioned

connections. There are key ways that the ACA does not reflect the German system. For example, how interest groups are organized and the reliance on contractual relationships between these groups to set prices and services is at the heart of German SHI design. The Affordable Care Act does not change America's system in this way at all; the ACA does very little to create a framework for formalized negotiations between interested groups that is so important to the German SHI system. In addition, the ACA does not significantly change the responsibilities of employers. In Germany, employers are responsible for contributing approximately half of the premium that pays for an individual's sickness fund insurance. The ACA may impose fines on employers who do not provide health insurance to employees, but it does not significantly change the overall relationship between employee and employer (which is important in a system that is predominantly employer-based). Not to mention, the American system will remain predominantly for-profit, whereas the vast majority (approximately 90%) of the German population is insured through the non-profit sickness funds. In the end, any transformations towards a system based on solidarity, decentralization, and self-governance represented by the components of the bill are important, but still within a broader system that relies heavily on private markets, federal and state tax credits, and a mixed bag of direct government programs.

Chapter 4: The German Link

The German presence in the Affordable Care Act is unmistakable, as demonstrated in Chapter 3. The concrete analysis of the previous chapter has demonstrated that the overarching aim of the Affordable Care Act is to mimic the German philosophy towards health in several key components, within the constraints of the American status quo. When the Act is stripped to its core, not only does it attempt to establish a framework to ensure individuals can be healthier through prevention and public health measures, the fundamental base of the Law aims to empower (or force) as many individuals as possible to acquire privately provided health insurance so that the healthy individuals of society can provide for the sick: essentially the definition of German solidarity laid out in the SGB-V. Furthermore, the previous chapter demonstrated that the three pillars of German healthcare that define its uniqueness (solidarity, decentralization, and non-governmental operations) are elementary threads that weave throughout central provisions of the ACA. This, in addition to the advantages of the German system discussed in the Introduction, should fully satisfy why comparing the ACA to Germany is both appropriate and important.

Finding a direct link through primary sources or secondary literature demonstrating that the main architects of the Law were specifically influenced by Germany, however, is a difficult task. Historically speaking, the difficulty of this task is not surprising: Although health systems in foreign countries have always influenced American health reform legislation since 1915, overtly drawing from other countries has always become politically dangerous. In Paul Starr's narrative of the 1915 health reform proposal created

by the American Association for Labor Legislation, he notes that the death of the AALL's plan was due primarily to the entrance of the United States into the First World War in 1917 and the subsequent anti-German war propaganda, effectively destroying the proposal's future despite initial support of critical interest groups such as the AMA. It was simply "un-American," as he puts it, to establish a plan so heavily based on German policy: "The opponents of the compulsory health insurance emphasized that the idea had originated in Germany and attacked it as un-American" (Starr 2011, 34).

This negative attitude towards external influence in American health policy can be seen throughout the 20th Century, and is not limited to just Germany. The next most obvious example is the anti-Russian (anti-Communism) movement in the 1950s and 1960s discussed in Chapter 2. Any proposed national health insurance system, developed with open consideration of foreign inspiration, was compromised under the concern that the plan would be "communist." It may also be reasonable to assume that, after another World War against Germany, Americans would be unwilling to renegotiate a plan openly influenced by the German system (which continued highly intact through the Nazi regime) in its immediate aftermath. Even contemporary, "extreme" political opinions of the Affordable Care Act relate provisions of the Act to Nazi Germany directly; they that the federal government is attempting to take over healthcare for the purposes of racial and class-based cleansing (LoFiego 2010;Rufino 2010).

Although perhaps outside of the scope of this paper, one could look to American exceptionalism to begin explaining the absence of international recognition. The American public is more confident about health policies that come from the United States and do not trust European policies, potentially based on popular misconceptions that these systems

are ubiquitously “socialist” in their design, or centralized single-payer functions of the state, which is clearly not the case in Germany. McDonough, one of the main authors of the ACA, would attribute these misconceptions to a failure to “think in terms of continuums,” claiming that Americans “cling to the mental model that everything must be one or the other:” free market or completely socialist (McDonough 2011, 307).

This project’s largest weakness is its failure to deeply investigate congressional debate or primary sources regarding whether or not primary architects of the ACA intended to convey Germany in the ACA. It is possible, in fact, that there was no direct intent, but rather that the ACA merely represents the “best possible market-based approach for the United States” with higher federal regulation, which naturally reflects much of the German model because of similar structures (Knox 1993;Reuters 2012). Outside of allusions to Bismarck establishing the Health Insurance of Workers Law in 1883 (as the foundation of modern social insurance), authors do not widely discuss the idea that Germany could have played a role in the ACA’s construction, despite clear connections and similar overarching themes.

Writers of the ACA, such as Dr. Jonathan Gruber and Dr. John McDonough who both played a large role in the development of the Massachusetts’s health reform in 2006 as well, have certainly drawn from German health policy in other writings, however. In a health policy brief regarding health reform in Vermont, for example, Gruber does use the German health system to propose different plans for the state (Hsiao et al 2011). Despite this, the main publications of these two writers on national reform, however, rarely cite

international influences²⁷. Additionally, academic pockets of international study, such as the American Institute for Contemporary German Studies at Johns Hopkins University, promote the importance and effectiveness of exchanging policy between the United States and Germany, but most popular and academic writing connecting authors or lawmakers of the Affordable Care Act to Germany is limited.

Because of its more immediate connection, and the fact that two main architects of the Law were heavily involved, the Massachusetts health reform is typically cited as the precursor to the national PPACA. While true in terms of function, to gain a complete perspective of the health reform debate in the United States and the future of health reform, the history of and contemporary organization of German healthcare should not be ignored. As mentioned, previous chapters clearly demonstrate large potential overlap and similarities between contemporary German healthcare and the ACA, functionally and philosophically, whether lawmakers intended to do so or not. Germany, therefore, provides a suitable basis of comparison from which future American health reform could build and learn.

²⁷ For selected publications by McDonough and Gruber, see their Harvard School of Public Health and MIT Economics faculty profiles, respectively.

Conclusion

The German similarities in the Affordable Care Act may not be widely recognized but the goal of this investigation was to make them obvious. The German health care system and the German history of health reform have had a significant influence on the creation of the Affordable Care Act, directly or historically, as shown throughout this thesis. Many of the basic principles of the contemporary German health system are reflected in provisions of the ACA. Because of this, lessons from the German health reform experience moving forward could provide powerful lessons and policy tools for the United States to continue increasing insurance coverage, improving quality of care, and stabilizing costs and growth of spending, through mixed methods of governmental regulation, managed competition, and solidarity.

Stepping back from specific legal provisions and policy, the ACA is also indicative of an emerging philosophy in the future of American health reform. As noted by authors on the German health system such as Reinhardt, Altenstetter, Knox, and others, the success of the German health insurance scheme over time is a testament to its strength as a model system for health reform. Since the time of Bismarck, the main premises that define the health insurance system have transcended almost all of the regimes of modern Germany, except for the periods of centralization that occurred during the time of National Socialism and East Germany. Some argue the “success” of the system to endure such radically different political regimes is due in part to a political process of patchwork reform and the formal, balanced relationships between interested political factions (Knox 1993;

Altenstetter 2003). More importantly, however, the endurance of the system over time is also a product of the German popular and political culture towards the market and state that has established an environment very much unlike the American experience of health reform in the past. Specifically, this cultural environment is based on trusting (and entrusting) the government to ensure equality and personal freedom, which has allowed the *Solidaritäts-Prinzip* to prosper throughout health law in Germany. The passing of the Affordable Care Act, in its similarities to the German system, represents a shift in the political framework of health reform to something aligned closer to the German conservative, communitarian relationship with healthcare.

The success of the German system, therefore, is arguably more attributable to the German relationship between market and state, rather than any particular German institution. Germany has the largest economy in Europe, but has always viewed market fundamentalism as individualistic and selfish, favoring instead governmental regulation in the market to ensure an equitable society. Germans are indeed uniquely distrustful of the market, as evidenced by the fact that only approximately 6% of the population directly owned shares on the German stock market in 2010. These numbers are low even compared to other European countries: In the same year, direct stock ownership was 15% in France and 10% in the U.K. (Cruz 2010;DAI 2012). More strikingly, including all types of investments, 56%²⁸ of Americans owned investments in the stock market in some fashion, compared to 10.3% in Germany in 2010 (DAI 2012;Jacobe 2011). In the end, German policies tend to view the market as untrustworthy and something to be curtailed for the betterment of society.

²⁸ This number is actually low for the U.S; the highest percentage in the last decade was 67% in 2002, for example.

The liberal²⁹ political culture of the United States, on the other hand, leans towards market-based solutions as a means of creating a just society, resistant to government intervention. This internationally unique liberal and individualistic viewpoint has undoubtedly been the driving force behind the country's healthcare structure today, and the lack of national health reform over the 20th Century, despite numerous progressive attempts to do so. In her article comparing German and American healthcare prior to the ACA, Altenstetter states:

Health policies are the product of politics and a particular institutional and ideological context... US stakeholders and the American public share similar convictions, have similar anti-government attitudes, [and] endorse a firm belief in 'rugged individualism'... all of these factors mitigate against collective solutions for universal health [regardless of its organization] (Altenstetter 2003).

Perhaps the interruption of the First World War is to blame for the defeat of the original proposal to create a nationally organized health structure in the United States, but the American "rugged individualism" and anti-governmental culture that only expanded thereafter has since been the primary force against national health reform.

The wildly different histories of health reform between the United States and Germany demonstrate that health reform is not dependent on particular institutions, but rather the convergence of political and cultural contexts. As Susan Giaimo insists, recent reforms in both Germany and the United States work towards a combination of market and

²⁹ Liberal as in Americans like to distance government from the economy and society.

tight state regulation, a political tradition already present in Germany, but something only recently possible in the United States (Giaino and Manow 1999). The liberal political culture of American politics has historically blocked the development of a tighter government controls and national reform, whereas the collective conservatism that defines the German approach has allowed for consistent reform of social insurance.

Bismarck, being a Prussian aristocrat himself, based the 1883 Health Insurance for Workers law on the concept of *noblesse oblige*,³⁰ meaning the duty of the privileged in a society to protect the weak and the lower classes. Although lauded in Germany as a foundational social principle and an essential component to the concept of solidarity, as evidenced by the popularity of the German welfare system, opponents of the Affordable Care Act most often use the same phrase and concept derisively. In the United States, opponents to ObamaCare claim that this type of relationship between upper and lower classes “induces dependency” and “subservience,” intended to contradict the American individualist ideal of the unencumbered citizen. In contrast, the German opinion would be that this type of social contract could promote communal equality, especially in the form of well-supported social programs (Moffit 2011, 7).

In the end, therefore, the fundamental basis of these distinct political cultures is divergent conceptualizations of “freedom.” What may define why the United States and Germany have experienced such different histories in health reform, and subsequently the structure of their contemporary healthcare, is the overarching concept of freedom in society, and whose role it is to protect that freedom. Through the long-established concept of solidarity, Germans support the idea that health is part of personal freedom, and to be

³⁰ *Noblesse oblige* literally translates to “nobility obliges”.

sick is to be less free in this sense. Hence the construction and longevity of a system that is designed to promote health equality amongst inhabitants.

To maintain freedom among the inhabitants of Germany, the German state therefore organizes a system of social welfare that includes health insurance to the entire population, financed based on ability to pay. The state's role in this German system is to protect collective good by highly regulating the system against inefficiencies that arise from purely market-based systems (e.g. adverse selection) and establishing the legal framework for non-profit, self-government. Indeed, the German government is seen as having an integral role in the tradition of the German *Sozialstaat*, of which health insurance is an integral part. *Der Sozialstaat* is the constitutionally established and nationally salient tradition of the German welfare state which aims to “[bind] a people sharing the same geography into a genuine nation” and support a “minimum existence” for all citizens through (Reinhardt 1994, 23; *Grundgesetz*). Based on the German constitution, although there is still a relatively small commercial, private health insurance market, health insurance in Germany is viewed less as a market commodity but rather a true public good that is organized by the government (Rudiger 2012).

The more liberal America in turn, and especially the Republican Party, conventionally views freedom in a fundamentally different fashion. Freedom is defined more so by freedom from the government: individual liberty separate from the state. This definition almost especially applies to government at the national or federal level. The legitimate grounding of this philosophy is the desire to be individually free from “arbitrary and capricious power” of the state (Starr 2011, 247). Accordingly, the American healthcare system is established to promote individual liberty instead: ensuring the free desires of

citizens to be covered by insurance or not. According to Starr, the American public does not trust American institutions and “suspicions of malevolent intent [of the government] are pervasive” (Starr 2011, 11). This distrust of the government and the corresponding philosophy of freedom, which is also long-standing in American history and correlated with the American view of the state and market (Blendon 2011), is arguably the backbone of the differing political cultures that have existed throughout the 20th Century in the U.S. and Germany. If nothing else, it is certainly the basis of the major controversy surrounding the Affordable Care Act’s provisions, including the 2012 Supreme Court ruling to uphold the ACA’s individual mandate.

The political context of the Affordable Care Act was therefore essential to its passing. Because Democrats conventionally view freedom more in the “German” sense described above, the domination of Democrats in the Washington in 2010 and the bill’s passing are not a coincidence. Although I will not argue whether or not the American public majority liked or disliked the Law when it passed, the Act and its passing firmly represent a conventionally Democratic view of equality and freedom: a perspective with far more overlap with the general political culture in Germany.

It is perhaps in this overlap of political ideology that really indicates why much of the ACA is analogous to German philosophy towards healthcare. The particular political context that happened to coalesce in 2010, combined with similarities in organization and the advantages of utilizing components of the German system outlined in the Introduction, made it a natural process to incorporate fundamental components of the German system into a massive federal reform in the United States. The Affordable Care Act, as a statement of “public philosophy” towards healthcare, is indeed much more “German” than it is

“American,” in that its opponents claim it reduces individual liberty in the conventional sense (especially in the form of the individual mandate) in order to promote ideals more commensurate to Germany’s conservative collectivism.

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Glossary

AALL – American Association for Labor Legislation

ACA – Affordable Care Act, same as PPACA

AMA – American Medical Association

APHA – American Public Health Association

BVerFG – *Bundesverfassungsgericht*

CHF – Central Health Fund

CMI – Center for Medicare Innovation

CO-OPs – Consumer Operated and Consumer Oriented Plans

GBA – *Gemeinsamer Bundesausschuss*, (Federal Joint Committees).

GDP – Gross Domestic Product

GKV – *gesetzliche Krankenversicherung*, same as SHI

IPAB – Independent Payment Advisory Board

OECD – Organisation for Economic Co-operation and Development

PCORI – Patient-Centered Outcomes Research Institute

PHI – Private Health Insurance

PPACA – Patient Protection and Affordable Care Act

SGB-V – *Sozialgesetzbuch – Fünftes Buch*

SHI – Statutory Health Insurance