Healthcare reform has been debated in the United States for much of the last century. In 2008, it was a major issue in the presidential election, and Barack Obama was elected on a platform that included an overhaul of the nation’s healthcare system. The year following his inauguration was noted for intense debate over healthcare reform, but eventually the Affordable Care Act (ACA), now more commonly known as “Obamacare,” was passed in March 2010. Because of the controversial and complex nature of this legislation, a great deal of misinformation is often accepted as fact.

A part of Utah Foundation’s mission is to provide “thorough, well-supported research that helps policymakers, business and community leaders, and citizens better understand complex issues.” To that end, this policy paper will present the history and facts about the Affordable Care Act in a straightforward and nonpartisan manner, to enable citizens and policymakers to fully understand its complexities and nuances. It also provides a broad overview of the history of healthcare reform, presents various healthcare models used throughout the world, and explains how the ACA compares to those models. It also addresses healthcare within Utah, and assesses how the implementation of the ACA will affect this state.

Healthcare reform has been the fourth highest priority for Utah voters in each gubernatorial election since 2004, however, concern with this issue increased this year, with 69% of voters saying they were concerned or very concerned with healthcare.

The issue of healthcare is also divisive, with 75% of Utah Republican voters saying the ACA should be repealed, compared to only 12% of Democratic voters.

Healthcare expenditures have grown dramatically over the last half century. They made up just over 5% of GDP in 1960; by 1980 this was over 9%, and nearly 14% by 2000. In 2010, health expenditures made up nearly 18% of the nation’s GDP.

Healthcare reform has been an important issue in American politics for over a century. There have been many attempts to enact universal health care coverage, but none succeeded until the Affordable Care Act was passed in 2010.

In National Federation of Independent Business v. Sebelius, the Supreme Court ruled that the individual mandate was constitutional, but allowed states to opt out of the Medicaid expansion. Governor Herbert has indicated that he will wait until after the election to decide on the expansion.

Healthcare as a Priority

During each major election year since 2004, Utah Foundation has conducted the Utah Priorities Survey in order to prioritize the concerns of Utah voters. In the 2012 Utah Priorities Survey, 69% of respondents indicated that they were concerned or very concerned with healthcare, making it the fourth most important issue to voters in this election year. Healthcare has consistently been an important issue to voters throughout the past decade, ranking as the fourth priority for voters in each major election since 2004. In the survey, respondents were asked to rate each issue on a scale of one to five, five meaning they are very concerned about the issue and one meaning they are not at all concerned. In this year’s survey, the mean score of healthcare was 3.98, the highest this issue has received in any of the surveys. In addition, more respondents indicated that healthcare was their top election concern than in any of the previous surveys. Therefore, although its ranking has remained consistent, voters are more concerned with healthcare than in previous elections.
Democratic delegates regarding these issues were even more drastic. U.S. as there was in Europe.3 working-class support for broad social insurance in the United States failed, in part because there was not powerful rather inexpensively, efforts to reform healthcare in the “sickness insurance” could be purchased through employers develop into their current healthcare programs. While “sickness insurance” could be purchased through employers rather inexpensively, efforts to reform healthcare in the United States failed, in part because there was not powerful working-class support for broad social insurance in the U.S. as there was in Europe.3

Healthcare is not only an important issue to voters, but a divisive one as well. The Utah Priorities Survey of Party Delegates and Voters, which was conducted two months after the Priorities survey, showed that Democratic delegates and voters were more likely to prioritize healthcare issues than Republicans. When asked about important issues that state officials should address, 67% of Democratic voters felt it was important to lower the costs of healthcare, compared to 47% of Republican voters. Similarly, 74% of Democratic voters felt it was important to expand the availability of healthcare coverage, compared to just 40% of Republican voters. The starkest difference between the parties concerned the ACA. When asked if it should be repealed, 75% of Republican voters agreed, compared to only 12% of Democratic voters.2 Not surprisingly, the differences between Republican and Democratic delegates regarding these issues were even more drastic.

HEALTHCARE REFORM IN THE UNITED STATES

Healthcare reform has been an important issue in American politics for over a century. Reform efforts often come as advocates argue that costs for medical care have grown too high. As shown in Figure 2, health expenditures per capita have grown significantly over time, from just $1,083 (in 2010 dollars) per capita in 1960, to over $6,000 in 2000 and over $8,400 in 2010. In addition, national health expenditures have grown to make up more of a share of the national GDP each year. As shown in Figure 3, health expenditures made up just over 5% of GDP in 1960; by 1980 this was over 9%, and nearly 14% by 2000. In 2010, national health expenditures made up nearly 18% of the nation’s GDP.

Early in the 20th century, many European countries were developing social welfare programs that would eventually develop into their current healthcare programs. While “sickness insurance” could be purchased through employers rather inexpensively, efforts to reform healthcare in the United States failed, in part because there was not powerful working-class support for broad social insurance in the U.S. as there was in Europe.3

Figure 1: 2012 Utah Priorities Survey of Voters and Delegates

How important are the following for the State of Utah’s elected officials to address?

Lowering the costs of healthcare

<table>
<thead>
<tr>
<th></th>
<th>Republican Delegates</th>
<th>Democratic Delegates</th>
<th>Republican Voters</th>
<th>Democratic Voters</th>
<th>Independent Voters</th>
<th>Voters All Voters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Important</td>
<td>10%</td>
<td>2%</td>
<td>9%</td>
<td>8%</td>
<td>8%</td>
<td>8%</td>
</tr>
<tr>
<td>Relatively Neutral</td>
<td>46%</td>
<td>28%</td>
<td>43%</td>
<td>23%</td>
<td>35%</td>
<td>37%</td>
</tr>
<tr>
<td>Important</td>
<td>43%</td>
<td>69%</td>
<td>47%</td>
<td>67%</td>
<td>55%</td>
<td>53%</td>
</tr>
</tbody>
</table>

Expanding the availability of healthcare coverage

<table>
<thead>
<tr>
<th></th>
<th>Republican Delegates</th>
<th>Democratic Delegates</th>
<th>Republican Voters</th>
<th>Democratic Voters</th>
<th>Independent Voters</th>
<th>Voters All Voters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Important</td>
<td>17%</td>
<td>2%</td>
<td>13%</td>
<td>8%</td>
<td>9%</td>
<td>11%</td>
</tr>
<tr>
<td>Relatively Neutral</td>
<td>56%</td>
<td>16%</td>
<td>47%</td>
<td>18%</td>
<td>38%</td>
<td>38%</td>
</tr>
<tr>
<td>Important</td>
<td>25%</td>
<td>82%</td>
<td>40%</td>
<td>74%</td>
<td>52%</td>
<td>50%</td>
</tr>
</tbody>
</table>

To what extent do you agree or disagree with the following statement?
The 2010 federal healthcare law should be repealed.

<table>
<thead>
<tr>
<th></th>
<th>Republican Delegates</th>
<th>Democratic Delegates</th>
<th>Republican Voters</th>
<th>Democratic Voters</th>
<th>Independent Voters</th>
<th>Voters All Voters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree</td>
<td>90%</td>
<td>80%</td>
<td>5%</td>
<td>39%</td>
<td>28%</td>
<td>20%</td>
</tr>
<tr>
<td>Relatively Neutral</td>
<td>7%</td>
<td>13%</td>
<td>16%</td>
<td>21%</td>
<td>23%</td>
<td>19%</td>
</tr>
<tr>
<td>Disagree</td>
<td>2%</td>
<td>80%</td>
<td>5%</td>
<td>39%</td>
<td>28%</td>
<td>20%</td>
</tr>
</tbody>
</table>

During the Great Depression, medical costs rose and access to healthcare worsened as people could not afford medical services. Citizen groups began to organize calling for social policies to secure employment, retirement, and medical care. In 1934, President Roosevelt appointed a Committee on Economic Security to report on all these issues. While the committee’s report did address national health insurance reform, President Roosevelt did not press the policy because he did not want to risk the passage of the Social Security Act.4 The American Medical Association had strong opposition to such a plan, arguing it would increase bureaucracy, limit physician freedom and interfere with doctor-patient relationships.5

President Truman pushed for a national health insurance plan several times during his presidency, but each attempt failed. During this time, hospitals began to offer insurance programs, in part to protect themselves from reduced revenues and occupancy caused by the Great Depression.6 The first of these was Baylor Hospital, which introduced a pre-paid hospital insurance plan for a group of schoolteachers in 1929. This plan is considered the forerunner of future nonprofit Blue Cross plans.7 As more hospitals and physician groups began selling group health insurance policies to employers, it became more commonplace for Americans to access health insurance through their employers. These policies also became more widely offered as “fringe benefits” designed to attract employees since employers were forbidden to increase pay because of wage controls during the Great Depression and World War II.8

In 1954, Congress passed the Internal Revenue Act, which excluded employee benefits such as pensions or contributions to health plans from taxable income.9 By this time, it is estimated that 77 million people, or half of the nation’s population, had purchased some type of voluntary sickness or accident insurance.10

The establishment of Medicare and Medicaid in the 1960s represented the most significant healthcare reform of the 20th century. As employer-based health coverage grew, private plans began to use “experience ratings” to set health premiums, making it more difficult for the sick and elderly to get affordable coverage. Federal grants to help the states provide coverage failed, leading Congress to pass more comprehensive legislation.11 After an intense congressional

Figure 2: U.S. Health Expenditures Per Capita (2010 Dollars)

Source: Centers for Medicare and Medicaid. Inflation adjustment calculated by Utah Foundation.
battle in which supporters argued these policies were necessary, and opponents claimed they represented socialized medicine. President Johnson signed the Social Security Act in July 1965. This legislation established three programs: Medicare Part A paid for hospital care and limited skilled nursing and home healthcare for those over the age of 65, or who met other criteria; optional Medicare Part B (paid in part by premiums) helped pay for physician care for the elderly; and Medicaid, which was established to assist states in covering long-term care for the poor and in providing health insurance coverage for the poor and disabled.

As inflation and healthcare costs increased in the 1970s, several plans for national health insurance were proposed, including proposals from Senator Edward Kennedy and President Richard Nixon. Each of these plans, however, splintered support for any one reform. Action on national health insurance was eventually overshadowed by the Watergate scandal and Nixon’s resignation, as well as the 1973 oil crisis and the 1973-75 recession. Later in the decade, President Carter prioritized national health reform, but these efforts were stalled in the face of more economic difficulties, inflation and a second oil crisis.

Throughout the 1980s, Congress passed several bills that essentially expanded Medicare and Medicaid coverage. In 1986, President Reagan signed the Consolidated Omnibus Budget Reconciliation Act (COBRA) into law, which allowed employees to stay on their group health insurance plans up to 18 months after losing their jobs, provided that they pay the premiums.

In 1993, President Bill Clinton proposed the Health Security Act, which called for universal coverage, employer and individual mandates, and competition between private insurers, which was to be regulated by government to keep costs down. Under the plan, private insurers and providers would compete for groups of businesses and individuals in what were called "health-purchasing alliances," and every American would have a "health security card." The size and complexity of the plan not only stymied its passage in Congress but also made it difficult to generate popular support. This was compounded by partisan politics, powerful lobbying groups, and a Clinton administration policy that was viewed as combative and secretive. Eventually, the divided Democratic majority in Congress could not garner enough votes to pass the legislation, and attempts to push it forward stopped after the election of 1994 when Republicans took control of both the U.S. House of Representatives and the Senate. Later in the decade, with a Republican Congress and bipartisan support, the Children’s Health Insurance Program was enacted, building on the Medicaid program to provide health coverage to more low-income children.

In 2003, President George W. Bush signed the Medicare Modernization Act into law, which expanded Medicare to include prescription drug coverage. Similar legislation had been passed by Congress in the late 1980s, only to be repealed a year later. This type of policy was still controversial, in part because it included a significant financial gap for seniors that came to be known as the “donut hole,” and the program’s cost was not offset in the budget by increased revenues.

During the 2008 presidential election season, healthcare reform was a major issue. Barack Obama was elected on a platform that included an overhaul of the nation’s healthcare system. Throughout 2009 and into early 2010, healthcare legislation dominated political discourse throughout the country. After months of formal debate in Congress, President Obama signed the ACA into law on March 23, 2010; this legislation comprises the Patient Protection and Affordable Care Act (Public Law 111-148) and the healthcare provisions of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152). The law established comprehensive health insurance reforms that would roll out throughout the following decade, with most changes taking place by 2014. The passage of this law did not mark the end of the debate, as opponents introduced legislation to repeal the ACA the day after the president signed it.
Since it was passed, dozens of votes have taken place to repeal or defund portions of the law.

Soon after the ACA was passed, a number of parties sued the federal government, claiming that the law was unconstitutional for various reasons. These cases eventually were merged into *National Federation of Independent Business v. Sebelius*, and decided upon in the U.S. Supreme Court. On June 28, 2012, the Court upheld the individual mandate, a provision in the ACA requiring individuals to purchase healthcare or face a penalty, declaring the penalty implemented as a tax was constitutional. Immediately following the Supreme Court decision that upheld the ACA, opponents once again vowed to repeal it.

**MAJOR COMPONENTS OF THE ACA**

The final version of the ACA was over 2,400 pages, and the Supreme Court case regarding the law was nearly 200 pages. The breadth and depth of this law make understanding it difficult. However, this section of the report explains the major components of the law.

**Individual Mandate**

All individuals are required to have insurance, with some exceptions, beginning in 2014. Those who are not covered by an employer-sponsored health plan, Medicaid, Medicare or other public plan, must purchase an insurance policy unless they fall under one of the few exemptions provided in the law. Those who do not purchase coverage will be required to pay a yearly financial penalty of $695 per person or 2.5% of household income, whichever is greater. The penalty will be phased in over a number of years according to the following schedule: $95 in 2014, $325 in 2015, and $695 in 2016; or 1.0% of taxable income in 2014, 2.0% of taxable income in 2015, and 2.5% of taxable income in 2016. After 2016, the penalty will be increased annually by cost of living adjustments. Exemptions are given for financial hardship, for religious objections, to American Indians, or to people who are uninsured for less than three months. This portion of the law was especially controversial, but the penalty was upheld as a tax in the Supreme Court decision.

**Changes to Private Insurance**

The ACA enacted several policies that will profoundly influence private insurance:

- Individuals may not be denied insurance coverage because of pre-existing medical conditions. In addition, insurers will be required to offer the same premiums to all applicants of the same age and location regardless of gender or pre-existing conditions.
- Young adults will be allowed to remain on their parent’s health insurance up to age 26.
- Health insurers will be prohibited from imposing annual or lifetime limits on coverage or from rescinding coverage.
- New health plans will be required to cover certain preventive services with no co-pays or deductibles.
- Insurers will be required to spend at least 80% of premiums on medical costs.

**Health Insurance Exchanges**

Each state will offer a health insurance exchange where individuals and small businesses can compare policies and premiums and ultimately purchase insurance. Low-income individuals and families will receive federal subsidies if they choose to purchase insurance through such exchanges. Access to these exchanges will be limited to U.S. citizens and legal immigrants.

**Expansion of Medicaid Eligibility**

Medicaid eligibility will expand to include all individuals and families at or below 133% of the poverty level, which for a family of 5 in Utah, is equal to $2,859 a month. This creates a new minimum Medicaid eligibility level for adults and eliminates the limitation that prohibited most adults without dependent children from enrolling. The federal government will provide 100% of the funding for the costs of the newly eligible Medicaid recipients from 2014 to 2016, 95% in 2017, 94% in 2018, 93% in 2019, and 90% beginning in 2020. The U.S. Supreme Court ruling allowed states to opt out of this expansion. Utah’s Governor Gary Herbert has indicated that he is not completely against this expansion, but...
believes the federal government should allow states more flexibility to provide healthcare.  

Preventive Care

Co-payments and deductibles will be eliminated for certain healthcare insurance benefits considered to be preventive care, such as annual doctors’ visits or certain types of screenings.

Medicare Part D Coverage Gap

Currently, when beneficiaries of Medicare reach the prescription drug coverage limit, they become financially responsible for the entire cost of prescription drugs until the expense reaches the catastrophic coverage threshold. The ACA will provide significant personal savings to individuals who fall in this “donut hole.” Beginning in 2010, Medicare beneficiaries who reached the Part D coverage gap received a $250 rebate. The gap will then be phased down gradually until 2020. For brand-name drugs, pharmaceutical manufacturers are now required to provide a 50% discount on prescriptions filled in the coverage gap. Additionally, federal subsidies of 25% of the brand-name drug cost will begin to be phased in beginning in 2013. For generic drugs, federal subsidies of 75% are now provided for prescriptions filled in the coverage gap.

THE AFFORDABLE CARE ACT AND THE FEDERAL BUDGET

In March 2011, the Congressional Budget Office (CBO) estimated that for the 2012–2021 period, the insurance coverage provisions of the ACA would have net costs of over $1.1 trillion, but when other provisions that affect spending and revenues were taken into account, government outlays would increase by a cumulative of $604 billion. It is expected that the costs of the ACA will be offset by an $813 billion increase in revenues, resulting in a $210 billion reduction in the federal deficit over the ten-year period. In March 2012, the CBO and Joint Committee on Taxation (JCT) revised the projected costs of the ACA to reflect new legislation, technical changes and updated economic data. According to the new estimates, the insurance coverage provisions of the ACA will have a net cost of $1.25 trillion over the 2012–2021 period. In July 2012, the CBO released analysis of H.R. 6079, a bill that aimed to repeal the ACA. The CBO and Joint Committee on Taxation (JCT) estimated that this bill would increase federal budget deficits. Deficits would be increased because the net savings from eliminating the insurance coverage provisions would be offset by the combination of other spending increases and revenue reductions. In total, H.R. 6079 would reduce direct spending by $890 billion, but reduce revenues by $1 trillion over the 2013–2022 period, thus adding $109 billion to federal budget deficits over that period. The CBO also noted that the estimated budgetary effects of repealing the ACA are not equivalent to an estimate of the budgetary effects of the ACA with “the signs reversed.”

HOW THE AMERICAN HEALTHCARE SYSTEM COMPARSES

There are many ways in which countries throughout the world attempt to manage healthcare. Despite these variations, healthcare systems tend to follow general patterns and can be grouped into four basic systems: the Beveridge Model, the Bismarck Model, the National Health Insurance Model and the Out-of-Pocket Model. The healthcare system in the United States has elements of each of these models. This section will also compare the ACA to the healthcare system in Massachusetts, which was significantly reformed in 2008 and served as a model for some of the national reforms in the ACA.

The Beveridge Model

In the Beveridge Model, healthcare is provided and financed by the government through tax payments. Medical care is treated as a public service, much like public education or the police department is treated in the United States. These systems tend to have low costs per capita, because the government controls what doctors can charge. England is the birthplace of the Beveridge Model, and there, healthcare is provided to all residents through the National Health Service (NHS), including hospital and physician services and prescription drugs. The NHS is financed primarily through general taxation and requires very little patient cost sharing. The Beveridge Model is also utilized in Spain, most of Scandinavia and New Zealand. In the United States, the treatment of military veterans through the Department of Veterans Affairs is similar to the Beveridge Model.

The Bismarck Model

The Bismarck Model, also known as the Socialized Medicine Model, uses a non-profit insurance system that is required to cover all citizens, and is usually financed jointly by employers and employees through payroll deduction. Costs are controlled through tight regulation of medical services and fees. This model originated in Germany, and is named for Prussian chancellor Otto von Bismarck, the father of the welfare state. In Germany, most residents receive statutory coverage through competing nongovernmental social insurers, or “sickness funds.” The statutory system is financed through employer and employee contributions, which are pooled into a central fund and redistributed among the sickness funds. These offer a uniform benefit package covering most medical care, prescription drugs, and dental care. The Bismarck Model is also used in France, Belgium, the Netherlands, Japan, Switzerland, and, to a degree, in Latin America. The U.S. approach resembles the Bismarck Model when insurance is provided through employers but differs in most other respects.
National Health Insurance Model

The National Health Insurance Model (NHI), also known as the Single-Payer Model, uses private-sector providers, but payments come from government-run insurance programs that every taxpayer pays into. This type of plan controls costs by giving the single payer considerable market power to negotiate lower prices, by limiting the medical services they pay for, or by making patients wait to be treated. The most well-known national health insurance system is found in Canada, where each province is responsible for delivering care within its borders according to a broad set of principles laid out in the Canada Health Act. Medically necessary hospital and physician services are fully covered across provinces, although there are variations in prescription drug coverage.29 This type of system can also be found in Taiwan and South Korea. The U.S. utilizes this model when treating Americans over the age of 65 on Medicare.

Out-of-Pocket Model

The final model is the Out-of-Pocket Model, which basically applies to most developing countries. Such countries are generally too impoverished to provide any kind of mass medical care. Industrialized nations are almost exclusively the only countries which provide some type of universal healthcare.30 In impoverished nations, however, only those who can afford medical care receive it. This type of system can be found in rural or impoverished regions of Africa, India, China and South America, where hundreds of millions of people go their entire lives without ever seeing a doctor.31 Under the ACA, the U.S. system will theoretically no longer resemble the Out-of-Pocket Model, to the extent that individuals comply with the mandate.

Massachusetts

The Massachusetts State Legislature passed a healthcare reform law in 2006, informally referred to as Romneycare. This law mandated that all Massachusetts residents, with a few exceptions, obtain health insurance and show evidence of their coverage on their income tax return or face a tax penalty. The statute also created a clearinghouse for insurance plans and payments, and established the subsidized Commonwealth Care Health Insurance Program, which allows residents who do not have health insurance and make below 300% of the federal poverty level access to certain subsidized private insurance health plans. The law also expanded MassHealth (Medicaid) and the Children’s Health Insurance Program coverage for low-income children.

The Massachusetts healthcare reform statute and the ACA are similar in several ways. For instance, in Massachusetts, companies with more than 10 employees must offer health insurance or pay penalties; at the federal level this requirement applies to companies with 50 employees or more. In Massachusetts, dependents up to age 25 can be covered on their parents’ plans; the federal law allows dependent coverage up to age 26. Young adults in Massachusetts from age 19 to 26 can purchase special lower-cost, lower-benefit plans through the exchange; the federal law creates a similar type of plan in the exchange for those up to age 30 who cannot find affordable coverage. Both plans reformed the private insurance markets. In Massachusetts, the law merged the individual and small-group markets; the federal law placed new regulations on those two markets but kept them separate. Finally, both plans put limits on the ratio between the highest and lowest premiums. In Massachusetts, the highest premiums can only cost twice as much as the lowest; at the federal level, premiums can only vary based on age and geographic area.

There are also important differences between the Massachusetts plan and the federal law. The Massachusetts plan has no cost-containment provisions, while the federal law makes changes that are intended to lower program costs. Both plans are financed in part by revenue generated from the individual and employer mandates, but the Massachusetts plan’s financing is heavily dependent on leveraging federal matching funds, while the federal plan taps cost savings from levying new taxes on, for example, high-cost healthcare plans.
A majority of people in Utah had coverage through employment-based private insurance (59.5%) in 2010-2011, followed by coverage through Medicare (10.5%), Medicaid (9.5%) and individual private insurance (5.7%). At the national level, a plurality of people had coverage through employment-based private insurance as well (48.5%), followed by Medicaid (16.5%), Medicare (13.0%), individual private insurance (5.0%), or other public-based insurance (5.0%). Within Utah, 14.3% of the population is uninsured, compared to the national average of 16.5%.

Within Utah, 17.5% of children were on Medicaid in 2010, and 34.9% of children within the United States were on Medicaid; this means a larger proportion of children than adults were on Medicaid at both the state and national levels. This is because Medicaid and CHIP, or the Children’s Health Insurance Program, provide no-cost or low-cost health coverage for eligible children. This makes it so fewer children are uninsured in Utah (11.2%) and at the national level (9.7%).

As shown in Figure 8, the proportion of people who are uninsured has increased over the last decade, both in Utah and at the national level. In 1999, fewer than 12% of Utahns were uninsured, in 2011, it was over 14%. At the national level, the proportion of uninsured grew from 14% in 1999 to 16% in 2011.

One of the requirements of the ACA is that each state establishes a health insurance exchange where individuals and small businesses can purchase health insurance by 2014. However, Utah developed its own exchange in 2010, making it the second state in the nation to do so.35 The exchange is a virtual market where people can compare health insurance plans using a fixed amount of money from their employer. The “defined-contribution” design helps employers better predict out-of-pocket costs and allows employees to pick the policy that best suits them. This exchange was renamed Avenue H in 2012, in part to differentiate it from a government-run program.34

In National Federation of Independent Business v. Sebelius, the U.S. Supreme Court allowed states to opt out of the Medicaid expansion. Utah’s Governor Gary Herbert has indicated that he has several important questions for the federal government before he decides whether to accept or opt out of the expansion. He has also indicated that he wants to wait until after the presidential election, saying “If President Obama is re-elected that will tell us one thing about the direction of healthcare in this country. If Gov. Romney is elected...it will change the direction of healthcare and hence, Medicaid as we go forward for the next four years.”35

ENDNOTES

The mission of Utah Foundation is to promote a thriving economy, a well-prepared workforce, and a high quality of life for Utahns by performing thorough, well-supported research that helps policymakers, business and community leaders, and citizens better understand complex issues and providing practical, well-reasoned recommendations for policy change.

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