OLSZTYN ECONOMIC JOURNAL
Abbrev.: Olszt. Econ. J., 2014, 9(3)

UNINTENDED CONSEQUENCES. THE FINANCIAL ASSUMPTIONS AND ECONOMIC THEORY OF OBAMACARE: THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

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K e y w o r d s: Affordable Care Act, Obamacare, lobbyists, healthcare.

A b s t r a c t

This article examines the Patient Protection and Affordable Care Act (ACA,) often referred to colloquially as Obamacare, from a financial and economic perspective in order to analyze the potential efficacy of the system. Research was gathered pertaining to the stated objectives of the program, and economic theory was applied in order to reveal if the aims of the program are congruent with economic theory. It was found that the authors of the ACA did not anticipate or under-anticipated several economic effects of the legislation, which will hamper the implementation and effectiveness of the program. Furthermore, the economic theories employed by the Obama administration relied heavily upon classical economic theory, with little or no attention given to Transaction Cost Economics (TCE). Moreover, the law itself is overly complex and controversial due to a myriad of provisions added through the intercession of lobbyists from the healthcare, insurance and special interest sectors. The end result is that Americans may obtain a slightly improved healthcare system, but the United States will most likely still lag behind the rest of the industrialized world in many key health statistics.

NIEZAMIERZONE KONSEKWENCJE. ZAŁOŻENIA FINANSOWE I TEORIA EKONOMICZNA AKTU OCHRONY ZDROWIA PACJENTÓW (ACA) – PLANU OBAMY

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S ł o w a k l u c z o w e: akt ochrony zdrowia pacjentów, plan Obamy, lobbyści, ochrona zdrowia.

Abstrakt

W artykule podjęto próbę oceny aktu ochrony zdrowia pacjentów (ACA), popularnie zwanym planem Obamy, pod kątem finansowym i ekonomicznym, a także z uwzględnieniem jego efektywności. Zwrócono uwagę na możliwości skorzystania z niego przez społeczeństwo amerykańskie. W części teoretycznej odniesiono się do głównych teorii ekonomicznych, zwłaszcza teorii kosztów transakcyjnych. W części badawczej wykorzystano oficjalne dane statystyczne. Podkreślono także znaczenie i działanie towarzystw ubezpieczeniowych, lobbystów branży ochrony zdrowia. Ich postępowanie rzutuje na proces legislacyjny. Mimo że akt ochrony zdrowia pacjentów należy uznać za krok w dobrym kierunku, to i tak USA pozostają w zakresie ochrony zdrowia swoich obywateli daleko w tyle w stosunku do innych krajów rozwiniętych gospodarczo.

Introduction

The aim of this article is to analyze the efficacy of the Affordable Care Act in order to predict if the stated aims of the program are likely to be realized or not, and why. The Patient Protection and Affordable Care Act, often referred to as Obamacare, was enacted in March of 2010 in an effort to increase the health insurance coverage of American citizens. In 2010, only 83 percent of Americans were covered by health insurance, leaving the remaining 17 percent predominantly reliant upon emergency room care if they were in need of medical treatment (CBO 2010). However, in the United States it is the uninsured patient's responsibility to pay for all forms of treatment, including Emergency care. This led to 62.1 percent of American bankruptcies being due to unpaid medical bills (HIMMELSTEIN 2009) and 6 percent of total hospital costs being attributable to uncompensated care; where the patient could not or would not pay for treatment (AHA 2011). Due to these alarming statistics, the then presidential candidate Barrack Obama, campaigned on a platform of universal healthcare for all legal residents of the United States.

The Affordable Care Act is a ten thousand page document divided into ten main headings called „titles". These are further divided into subtitles, sections and provisions (PPACA, 2010). Much of the major newsworthy provisions are contained in the first title, which is entitled „Quality, affordable health care for all Americans", and attempts to establish increased healthcare coverage. The second title deals with public health insurance programs for residents at or below the federal poverty line (FPL), children of families at or below FPL, and the elderly, which are known as Medicaid, CHIP (Children's Insurance Plan) and Medicare, respectively. The third and fourth titles are concerned with increasing the quality and efficiency of healthcare, preventing chronic disease, and improving public health. The fifth title specifically covers methods of increasing the number of healthcare workers, while the sixth title concerns the transparency and integrity of the system. The seventh title improves access to innovative medical technologies, including discounts on pharmaceuticals and

promoting competition in the biologics sector. Title eight establishes a voluntary disability insurance program called CLASS Act, title nine is a list of revenue provisions which include new taxes on both firms and individuals, while the tenth title continues health coverage for American Indians. For an excellent summary of the ACA, please refer to the article „US Health Care Reform" by Harrington which concisely summarizes the majority of the provisions in a six page article (HARRINGTON 2010).

From the beginning, it is possible to see misrepresentation in the naming of the titles of the ACA. For example, the very first title of the ACA is named „Quality, affordable health care for all Americans"; however, the Obama administration themselves have stated that their goal is to see an increase from 83% of Americans insured to 94% of Americans insured (CBO 2010). That would still leave 6% of 300 million Americans uninsured; which calculates to 18 million uninsured American citizens. 18 million uninsured is far from „Healthcare for all Americans". Opponents of the bill claim that 94% is an unrealistically optimistic goal, because it assumes that none of the current 83% will become uninsured. Since the federal government has set strict standards that insurance providers must follow, the insurance industry has responded by canceling or changing the coverage of many policyholders before the ACA comes into effect (WND 2013). Therefore a percentage of the original 83% who were previously insured, have now become uninsured, which will make achieving 94% difficult. Since literally every other industrialized country has nearly full coverage of its citizens, one may wonder why the United States has a stated goal of only covering 94% of its citizens with health insurance. The answer may be that the healthcare and insurance sector has spent billions of dollars over the last 15 years on lobbying efforts to introduce legislation to protect and enrich their industries (opensecrets.org 2014), and nationalizing the healthcare industry would simply put those sectors under direct government control; thereby destroying any profit based business model.

A Short History of Healthcare in the United States

Healthcare in America was mainly based upon the single payer system until the nineteen eighties. The single payer system meant that individuals directly paid the doctor or hospital for services rendered. As the price of medical care increased, medical insurance plans became popular, but were unregulated. In 1986, the United States Congress passed the COBRA act which allows employees to continue their medical coverage for up to eighteen months, even if they would normally have lost their coverage after a job loss

or reduction in working hours, as long as the employee paid the insurance premiums. A portion of the COBRA act that would make a serious impact on American healthcare was the Emergency Medical Treatment and Active Labor Act (EMTALA). EMTALA was an unfunded mandate of the federal government which required nearly every emergency room in the United States to treat patients regardless of their ability to pay or their legal status as a resident of the United States (EMTALA 1986). Therefore, the emergency room became the „de facto national health care policy for the uninsured" as well as for those residing illegally in the country (ACEP 2014). Since the federal government did not provide any funding for EMTALA, either the state or private hospitals were forced to bear the cost. This led to the closure of many emergency rooms, and is one of the concerns that the ACA attempts to solve.

The Lack of a Nationalized Healthcare System for the United States Due to Lobbying Efforts

The original concept of a nationalized healthcare system was originally bipartisan, but has become strongly opposed by the Republican (center-right) party since the election of Barack Obama who is from the Democrat (center-left) party. Republican presidential candidate Mitt Romney and the Democratic president Barrack Obama both agreed in principal to a universal healthcare system (HARRINGTON 2010). Although each industrialized country in the world has variation in the quality of their national healthcare system, each of them has a healthcare system that provides medical insurance for every legal resident of that country; except for the United States. Therefore, one would assume that the United States would simply modify and implement a system similar to that of another country; such as Canada, for example. Unfortunately, the healthcare sector and the insurance sector are two of the three largest lobbying groups in the United States, and they have spent nearly 12 billion dollars on „lobbying" in Washington DC since 1998 (opensecrets.org 2014). Nationalizing the US healthcare system so that it resembles a typical system of the European Union or Canada would have required the United States government to take control of both the healthcare industry as well as the medical insurance sector. Since both of those industries are highly profitable, those industries defended their interests through lobbying (see Fig. 1 and Fig. 2), spending 350 million dollars in 1998 and peaking at 900 million dollars in 2009; the year before the ACA was signed into law (opensecrets.org 2014).

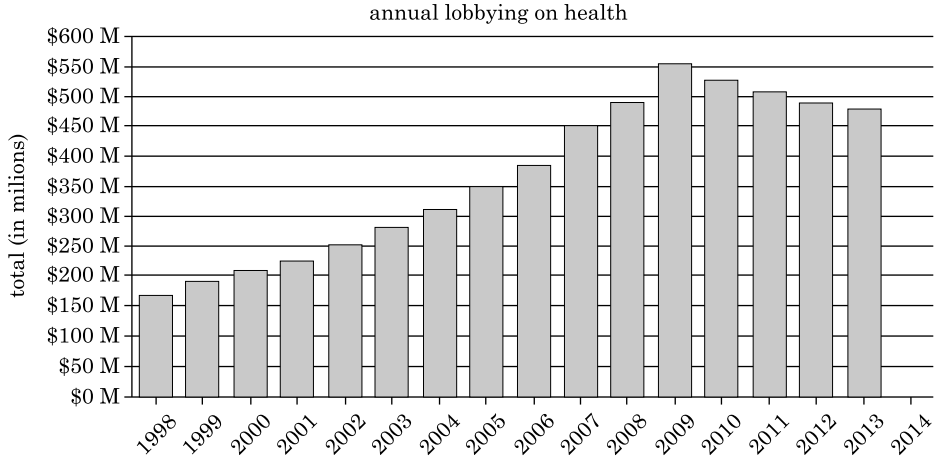

Fig. 1. A breakdown of yearly spending by the healthcare industry between 1998 and 2013 in the lobbying of elected officials

Source: opensecrets.org

Spending peaks in 2009, the same year the public option was deleted from the senate version of the ACA; thereby eliminating competition from a government healthcare insurance program.

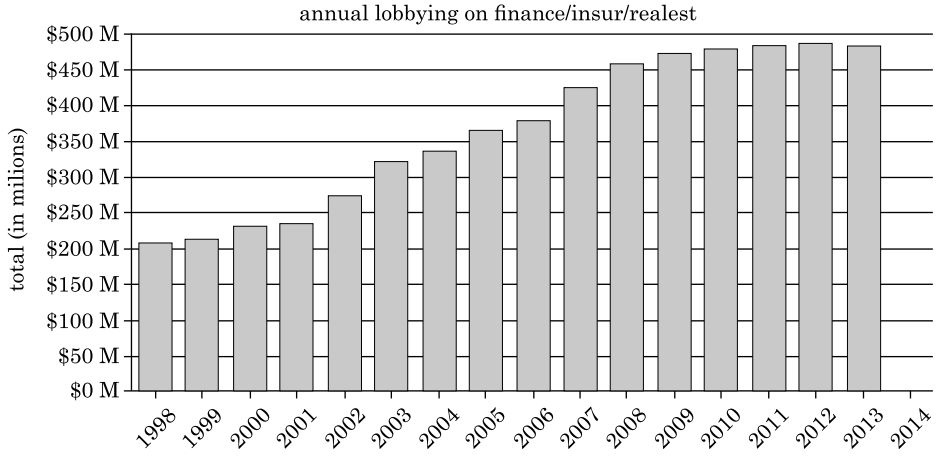

Fig. 2. A breakdown of yearly spending by the Insurance industry between 1998 and 2013 in the lobbying of elected officials

Source: opensecrets.org

Spending peaks and begins to level in 2009, the same year the public option was deleted from the senate version of the ACA; thereby eliminating competition from a government healthcare insurance program. The real estate sector

and non-health related insurance concerns are also included in these statistics, which may skew results.

According to utility theory, those two sectors must have felt that they received a service worth at least 12 billion dollars over the last 15 years. It is logical to assume that the service they received was the preservation of their business activities, and several provisions that will either increase their revenue or at least offset any profit loss that they might incur under the implementation of the ACA.

A compromise solution to full nationalization of the American healthcare system was the „public option". The public option would have established a government run healthcare insurance program that would have been available to consumers. In essence, the public option would not have nationalized the healthcare system, but would have given consumers a choice between government healthcare or private insurance options (GAUVEY 2011). The public option was included in all original versions of the ACA, was included in the legislation passed by the House of Representatives (lower house), but was completely dropped by the senate finance committee (CNN 2009). The public option would have been completely paid for by premiums, and would not have cost the government any additional outlays, other than money to start the program (REICH 2009). Therefore, it is not logical that the Senate Finance committee would object to the public option on financial grounds. The senate finance committee is much smaller than the full senate. Is it possible that lobbyists influenced this committee to eliminate the public option? There would be few other reasons, if any, to exclude the public option except under the influence of lobbyists. It would also be in the favor of the private healthcare insurance sector to eliminate a government program that would be in direct competition.

There are many controversial provisions in the ACA, which can be traced back to the healthcare industry and special interest groups who paid to see their interests represented in the ACA through lobbying. For example, the ACA mandates completely free birth control to all insured women in the United States regardless of income, but other important medications (including ones that are medically necessary) require a copayment from the patient (BLANEY 2012). All employers with 50 or more full-time employees are required to provide this insurance. From basic economics, if a regular commodity becomes less expensive, then consumers will use more of it. Therefore, the pharmaceutical industry stands to earn more from increased sales of birth control pills and abortion inducing drugs (morning after pill), while manufacturers will earn more from increased sales of diaphragms and intrauterine devices. Voluntary sterilization is also free to consumers, and will increase revenues to clinics who provide this service (PPACA 2010).

Another controversial aspect of the ACA is the abortion issue. Abortion as a means of birth control is legal and used with great frequency in the United States. Between 800 thousand to 1.2 million abortions occur annually in the US, with less than 3% being medically necessary to protect a woman's health (CDC 2013). According to the Guttmacher institute, the average price of a first trimester abortion in the US is 468 dollars (GUTTMACHER 2001). Therefore the abortion industry in the United States is significant. The largest provider of abortions in the United States is Planned Parenthood, who also collects around 500 million dollars per year in state and local government funding (Planned Parenthood 2013). According to the Hyde amendment, the United States federal government is not allowed to provide any money for abortions. However, a controversial provision in the ACA allows a full government subsidy of insurance plans for any qualifying person at or below 133% of FPL, and limited subsidies for those up to 400% of FPL. The majority of those insurance plans will cover voluntary abortion services, thereby allowing planned parenthood to collect federal money for abortions by circumventing the Hyde amendment (Foxnews 2014). Planned Parenthood spends on average 1.5 million dollars annually in lobbying efforts (opensecrets.org 2014).

A solid argument can be made that lobbying groups have not only repressed the formation of a nationalized universal healthcare system in the United States, but they have gone so far as to repress competition from the public option. Furthermore, they have also used their lobbying money to introduce legislation favorable to their business activities, and it seems that more attention has been paid to controversial legislation benefiting lobbyists than to a thorough economic analysis of the provisions. The next section analyzes some of the effects of the ACA that will have or are having unintended consequences.

Flaws in the Economic Theory of the ACA

The first title of the ACA increases coverage by specifically banning limits on insurance usage. There are no limits on the number of doctor visits or emergency room visits, and there are no monetary limits either (Obamacarefacts 2010). The assumption was that as patients visited their primary physicians more often, there would be a decrease in the number of emergency room visits. The assumption being that patients who regularly see a physician will be less likely to need emergency services. The Office of the Actuary estimated that there would be an increased cost of 311 billion dollars over 10 years due to increased visits to primary physicians, but they assumed a decrease in Emergency room visits would help to offset this cost (Office of the Actuary 2010). Unfortunately, since there are no limits, basic economic theory

suggests that patients will use all available services to their maximum benefit, including emergency services. A study published in the journal Science, confirms this. Researchers recorded a 40% increase in emergency visits as well as the expected increase in primary care physician visits, yet key health statistics remained unchanged (TAUBMAN 2014). Patients used more resources, but were not significantly any healthier.

Emergency room care in the United States is not funded directly by the federal government. Instead, responsibility for the funding falls upon the Medicaid program along with state and local governments or upon a private hospital (EMTALA 1986). Since the uninsured and illegal residents of the United States rely heavily upon emergency rooms for primary care, it was assumed that as more Americans became insured, there would be fewer emergency room visits and lower costs. Therefore, funding to Medicaid was cut by 22 billion dollars (HAMILTON 2013). However, the United States has approximately 11.7 million illegal residents who are not allowed to participate in the ACA, and will continue to use emergency rooms as primary care providers (NILC 2014). The continued pressure from illegal residents, plus funding cuts to Medicaid will strain emergency rooms tremendously. If the results from the studies of Taubman, et.al. also hold true with a 40% increase in insured patients visiting emergency rooms' the results would most likely be the closure of more emergency rooms and a decreased standard of care for those who require emergency treatment (TAUBMAN 2014).

Other serious flaws in the basic economic theory of the ACA have emerged. The ACA requires all firms with 50 or more full-time employees to provide healthcare coverage, with full-time being defined as 30 hours or more of work per week. This is termed the „employer mandate" (HARRINGTON 2010). The result is that smaller firms have an incentive to hire 49 full-time employees or less, and hire more part-time employees in an effort to avoid purchasing health insurance for their workers or pay large fines. According to a 2013 Gallop poll of small businesses, 40% have frozen hiring, 50% plan to replace full-time workers with part-time workers, and 24% will cut staff to below 50 full-time employees (ANDERSON 2013). There seems to have been no provision given for addressing this issue in the ACA, and the result will most likely be an increase in unemployment and / or underemployment. The Obama administration has been continually postponing the implementation of this provision, with critics suspecting that implementation will be delayed so as not to interfere with American election results in 2016 (WSJ 2014).

Nearly all issues concerning Transactional Cost Economics (TCE) have been disregarded in the ACA, with only a focus on classical economics being considered. For example, since the ACA limits healthcare insurance compensation to healthcare workers, there will be fewer healthcare workers entering the

profession. Title five addresses this problem specifically by introducing scholarships, grants and loans to students who enter the healthcare profession (PPACA 2010). However, in the United States students must first earn a typically five year bachelor's degree with many scientific courses, before they may apply to a four year medical school. Therefore, a physician in the United States will have spent nine years as a University student before becoming an entry level doctor. After the completion of medical school, many years are required for internships and specialization. When it was possible for physicians to become extremely wealthy, the time and expense could be justified; but this is no longer the case. The time factor is a type of bargaining transaction cost that the Obama administration has not considered, and may lead to a shortage of physicians even with more financial aid being available (WILLIAMSON 1981).

A key feature of the ACA is an online marketplace where consumers can read the differing coverage options, compare prices, and purchase plans (PPACA 2010). Search and information costs were not considered. In the United States, one in seven Americans cannot read anything more complex than a children's picture book, and can barely understand the warnings on the side of a prescription bottle (PARENTING 2014). A considerable number of these undereducated people would most likely need to purchase health insurance. However, the online marketplace requires consumers to have internet access and be capable of not only reading but critical thinking in order to choose the best option (WILLIAMSON 1981). This transaction cost was completely ignored. The risk of online fraud is a policing and enforcement cost of TCE (WILLIAMSON 1981). It seems that internet security was not considered, and several fake healthcare exchanges have been established so that potential victims will enter their personal information. Other criminals have used calling, faxing, or email in an effort to collect sensitive information all the while claiming they are representatives of the Medicare program for the elderly. There is also the potential for identity theft from workers who have been hired by the ACA program. The California Insurance Commissioner has voiced serious concerns about lax screening of new employees hired by the program (WND 2013).

The Canadian Model versus the ACA

The Canadian government has had full healthcare coverage for all of its legal residents for quite some time. It is a major source of government spending, and something that needs to be managed carefully. For the average well-educated European, it seems incredulous that the United States did not simply modify and implement something very similar to the Canadian model. However, the American media has consistently criticized the Canadian model

for being inefficient and „socialist", often citing a marginal decrease in healthcare efficiency of 0.7% over the last 20 years (SHUFELT 2012). The United States has acted isolationist in its healthcare reform, with very little word in the American media that every other industrialized country has a nationalized healthcare system that delivers better healthcare statistics in most areas. The United States does have one advantage over countries with nationalized healthcare. In the United States, patients who are covered by insurance wait on average a very short time for a specialist or a referral appointment. In countries such as Poland, England or Canada, patients must wait much longer for this type of care (OECD 2013). On the other hand, the 17% of uninsured Americans, must depend upon emergency room services and have no right to anything except basic care. According to the OECD, the United States ranks extremely low in many key health statistics. The most striking statistic is the infant mortality rate. The United States has the highest infant mortality rate in the industrialized world, with the 24 hour infant mortality rate being 50% higher than all other industrialized countries combined. The reason cited for this statistic is that poor mothers are not receiving enough access to medical care (Savethechildren.org 2013). When compared to Canada, Canadians were healthier than Americans in every key category except cancer prevention and treatment. The United States was below the OECD average in life expectancy, heart disease mortality, suicide mortality, infant mortality, low birth weight infants and diabetes. Curiously, Americans had the world's highest rate of people self-reporting that they are in good health (OECD 2013).

Discussion

It has been well-established that the United States is in need of urgent medical care reform, since, according to the OECD, most of their key healthcare statistics are below the OECD average. This would be shocking for any industrialized nation, but when these statistics belong to the world's wealthiest country, it is tragic. Unfortunately, the ACA is not the complete solution to healthcare. Perhaps it is better than the old system which left 17% of the population dependent upon emergency care with bankruptcy often the only answer to resolving the debt burden from unpaid medical bills. However, the United States could have done much better if they had simply modified and implemented a system similar to those of Canada or the European Union.

Unfortunately, the very large healthcare and medical insurance sectors have spent billions of dollars to stop any talk of a nationalized healthcare system, and have even stopped the entry of a competing government insurance option. The influx of billions of dollars from a single business sector with the

clearly expressed intent of „influencing" politicians should be considered corruption, but has become institutionalized as „lobbying". It would be very informative to see exactly how billions of dollars in lobbying money is spent without directly giving cash to politicians, but the author could not find such information. Only from anecdotal evidence while the author lived in the United States, has the author heard of donations to political campaigns through complex channels in order to avoid corruption laws. It would seem that the politicians paid far more attention to provisions favoring lobbying groups, than they did to a good solid economic analysis of the ACA. Some aspects of basic economic theory were ignored, such as increased unemployment from the employer mandate and that emergency room visits would increase when they became free of charge. Other aspects were underestimated due to little or no thought being given to Transaction Cost Economics, such as the time required for medical students to become doctors while salaries in the medical profession are falling, the search and information cost of using the online marketplace by undereducated consumers, or enforcement costs such as protecting against identity theft in the on-line marketplace. In general, the ACA was not given a rigorous enough economic analysis. It seems that most analysis focused more on financial aspects in order to prove politically that it was a good program, but little attention was paid to the motivations of consumers. Almost no effort was made to do an analysis of Transaction Cost Economics.

Conclusions

The end result is that the lobbyists had more influence than voters in the ACA. While the American public required meaningful healthcare reform from their government, instead their government drafted legislation based upon the requirements of lobbyists because lobbyists donated billions to the political campaigns of politicians or found other ways to circumvent corruption laws. More focus was placed upon provisions in the ACA that benefited lobbyists, and less focus was given to economic analysis. Almost no focus was given to the most recent trends in economic theory such as Transaction Cost Economics. One is left to wonder if there is anyone in the administration of the ACA who has ever heard the name of Oliver Williamson?

Translated by AUTHOR

Accepted for print 19.09.2014

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