
ARTICLE

BRAND NEW LAW! THE NEED TO MARKET HEALTH CARE REFORM

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The most serious problem with the Patient Protection and Affordable Care Act (PPACA) is not its contents but its packaging. Because it requires significant departures from business as usual in health insurance, health care delivery, and health behavior, PPACA is unlikely to succeed unless Americans feel a shared stake in its success. Unfortunately, the new law has been branded only by its opponents. Neither the Obama Administration nor its congressional allies have effectively communicated the law's key elements to the public. Most surprisingly, the groundbreaking program of near-universal health coverage that PPACA creates does not have a name. This Article explores the process of branding major American social legislation such as PPACA and suggests a strategy for improving public understanding and building loyalty. Legal brand equity, like its commercial counterpart, implies a functional, emotional, and expressive relationship between the law and its intended beneficiaries. Accordingly, an effective marketing strategy for PPACA entails creating consistent expectations regarding the law's goals and performance, and ensuring that those expectations are met.

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You've got to
Ac-cent-tchu-ate the positive,
E-lim-mi-nate the negative,
And latch on to the affirmative—
Don't mess with Mister In-Between!

You've got to spread joy
Up to the maximum,
Bring gloom down to the minimum,
Have faith, or pandemonium
Li'ble to walk upon the scene!

To illustrate my last remark,
Jonah in the whale,
Noah in the ark,
What did they do
Just when ev'rything looked so dark?
"Man," they said,
"We'd better
Ac-cent-tchu-ate the positive,

E-lim-mi-nate the negative,
And latch on
To the affirmative,
Don't mess with Mister In-Between—
No,
don't mess with Mister In-Between!"

—Johnny Mercer¹

¹ JOHNNY MERCER, AC-CENT-TCHU-ATE THE POSITIVE (Capitol Records 1944).

INTRODUCTION

Overconfidence is central to the American political psyche. Notwithstanding the length and complexity of the Patient Protection and Affordable Care Act (PPACA),² opinions as to the merits of the recently enacted health reform law are as strongly held as they are widely divergent. In a recent poll, public opinion regarding repeal of the law—an action newly elected Republican members of Congress have urged—remained polarized.³ An overwhelming majority of Republican respondents favored repeal, while Democratic resistance to repeal was nearly as strong.⁴ Independent voters were divided.⁵ Strikingly, only 2-4% of surveyed voters in each party demographic declared themselves “not sure.”⁶

Improving understanding of the new law is an obvious first step toward building support for it. Indeed, the Obama Administration has worked hard to provide accessible information about PPACA. The Administration even created a comprehensive website, www.HealthCare.gov.⁷ This website connects people to new and improved tools for evaluating their health and health care options, such as “Compare Care Quality,” a Bush Administration initiative⁸ that provides patients with comparative information about hospitals and physicians, including formal quality metrics.⁹

² Pub. L. No. 111-148, 124 Stat. 119 (2010) (to be codified as amended in scattered sections of 21, 25, 26, 29, and 42 U.S.C.).

³ See *Zogby Interactive: Majority Wants Healthcare Reform Repealed*, ZOGBY INT’L (Jan. 18, 2011), <http://www.zogby.com/news/2011/01/18/Zogby-interactive-majority-wants-healthcare-reform-repealed> (surveying voters’ views on repealing PPACA and finding that 54% favored repeal while 43% opposed it).

⁴ See *id.* (noting that 94% of Republicans surveyed favored repeal while 82% of Democrats opposed it).

⁵ See *id.* (showing that 54% of Independents favored repeal while 42% opposed it).

⁶ *Id.*

⁷ See HEALTHCARE.GOV, <http://www.healthcare.gov> (last visited Mar. 15, 2011) (urging Americans to “[t]ake health care into [their] own hands”).

⁸ See *Hospital Quality Initiative Overview*, CENTERS FOR MEDICARE & MEDICAID SERVICES (July 2008), <http://www.cms.gov/HospitalQualityInits/Downloads/Hospitaloverview.pdf> (explaining that the program initially launched as “Hospital Compare” in April 2005 as part of a larger “Hospital Quality Initiative” backed by the Bush Administration).

⁹ *Compare Care Quality*, HEALTHCARE.GOV, <http://www.healthcare.gov/compare> (last visited Mar. 15, 2011).

I. BRANDING SOCIAL CHANGE

A key piece of the health reform puzzle is still missing from this approach. The American public must debate, resolve, and ultimately share a collective meaning of health and medical care in our society. Neither partisanship nor ideology need disappear. But public understanding must encompass health and health care as an attribute of citizenship, not merely as a personal choice and associated expense. Social solidarity is not alien to our polity. However, it is a less familiar construct for how we view our health care system than for how we approach such matters as the privilege of the government to tax and spend generally.¹⁰ Awakening ourselves to its critical importance in health is an essential aspect of educating the public about PPACA.¹¹

The Obama Administration has shown little interest in guiding the evolution of public opinion by creating an ongoing relationship between the law and the public—in other words, by imagining health reform as a “brand.” Brand marketing admittedly is an unusual focus for legal scholarship. Still, legislative branding is an overlooked aspect of social change, especially given the many features of American government that favor inaction in domestic policy.¹²

The Administration’s website justifies and explains PPACA in the following limited fashion:

Reforms under the Affordable Care Act brought an end to some of the worst abuses of the insurance industry. These reforms have given Americans new rights and benefits, by helping more children get health coverage, ending lifetime and most annual limits on care, allowing young adults under 26 to stay on their parent’s [sic] health insurance, and giving patients access to recommended preventive services without cost.

Many other new benefits of the law have already taken effect, including 50% discounts on brand-name drugs for seniors in the Medicare “donut hole,” and tax credits for small businesses that provide insurance

¹⁰ See Lawrence R. Jacobs, *Politics of America’s Supply State: Health Reform and Technology*, HEALTH AFF., Summer 1995, at 143, 149-52 (arguing that the American supply-side view of health care places an affordability constraint on access, rather than having the need for broad access drive cost control).

¹¹ See William M. Sage, *Solidarity: Unfashionable, but Still American* (arguing that an individualistic view of health care ignores the interdependent nature of the American health care system along political, social, and economic dimensions), in CONNECTING AMERICAN VALUES WITH HEALTH REFORM 10, 10-12 (Mary Crowley ed., 2009), available at <http://www.thehastingscenter.org/Publications/Detail.aspx?id=3528>.

¹² See SARAH A. BINDER, STALEMATE: CAUSES AND CONSEQUENCES OF LEGISLATIVE GRIDLOCK 32-33 (2003) (contending that both the structure of governmental institutions under the Constitution and the outcome of elections contribute to the problem).

for employees. More rights, protections and benefits for Americans are on the way now through 2014.¹³

This summary is reasonably informative, but it is framed in bland terms (for example, “rights, protections and benefits”), offers largely disconnected examples, and positions PPACA mainly as a response to a familiar but not wholly plausible villain: private health insurers.

Glaringly, neither the summary of PPACA on the Administration’s website,¹⁴ nor the more detailed explanation of the law that the government has made available, confers a name on the nation’s groundbreaking new program of near-universal health coverage or fosters a connection between that program and the beliefs and behaviors of its intended beneficiaries.

Basic marketing theory requires at least these additional steps. A successful branding effort involves more than education. Educating the public about PPACA answers the question, “What is in the law?” and perhaps the follow-on, “Why is it there?” Education is indeed important to PPACA’s long-term success, but education alone does not respond to the next questions, “Why should I care?” and “What should I do?” These answers are provided in the course of forming and nurturing an ongoing relationship between the program and the public. This process begins with a name and continues with a marketing campaign that, if all goes well, strikes a resonant chord that builds into a chorus of approval and engagement.

II. LEGISLATIVE MARKETING

Political marketing and public policy marketing have points in common with commercial marketing but are not identical to it. The closest analogy is between marketing a product or service and marketing a candidate, which substitutes the act of voting for the act of purchasing. If done successfully, candidate marketing continues to foster loyalty to the individual’s brand and increases the likelihood of future votes. Marketing a political movement is similar because the grassroots activities of supportive individuals and groups continually reinforce the marketing message (although, if unguided, they can also distort that message). Marketing improvements in apolitical social

¹³ *Affordable Care Act: One Year Later*, HEALTHCARE.GOV, <http://www.healthcare.gov/law/introduction> (last visited Mar. 15, 2011).

¹⁴ *See About the Law*, HEALTHCARE.GOV, <http://www.healthcare.gov/law/about/index.html> (last visited Mar. 15, 2011) (highlighting points relevant to the public about PPACA).

outcomes, such as health, is harder because the desired action is a change in personal behavior, such as stopping smoking or increasing physical activity, but without an observable transaction as either an anchor or a metric.¹⁵

Marketing a major social program that intertwines political and personal change has been done. Margaret Thatcher's Tory government in Great Britain furnishes a strong example. In the 1980s, Thatcher presided over the wholesale conversion of state-run industries to private ownership through public markets.¹⁶ A key lesson from that program is that privatization did not begin with ideology, although beliefs eventually changed along with behavior. Another lesson is that successful branding is an evolutionary process, rather than something fully detailed in advance. This suggests that there is still plenty of time for the Obama Administration and its allies to develop and refine a brand strategy.

The Tories recognized that substantial ideological support for privatization could not be achieved simply by indoctrinating large swaths of the British public to believe in free markets and then legislating based on that mandate.¹⁷ Instead, broad, though certainly not universal, support for the Thatcherite agenda grew out of personal experience with purchasing shares in newly privatized companies, such as British Telecom.¹⁸ Through clever, nimble advertising campaigns, the Tories transformed privatization from an elitist academic intervention that threatened to pillage iconic British institutions employing millions into an exercise in populist self-interest—the ordinary citizen making money by doing his civic duty. This tone was captured perfectly by the “Tell Sid” advertising campaign to create word-of-mouth support for the initial share offering in British Gas.¹⁹ Because this pol-

¹⁵ See W. Douglas Evans & Gerard Hastings, *Public Health Branding: Recognition, Promise and Delivery of Healthy Lifestyles* (arguing that commercial branding techniques could be used by public health organizations to change public behavior but noting important differences in the two types of marketing), in *PUBLIC HEALTH BRANDING: APPLYING MARKETING FOR SOCIAL CHANGE* 3, 20-21 (W. Douglas Evans & Gerard Hastings eds., 2008).

¹⁶ See Nigel Allington et al., *How Marketing Changed the World: The Political Marketing of an Idea—A Case Study of Privatization* (arguing that privatization was favorably received in Great Britain largely because the idea was marketed effectively), in *HANDBOOK OF POLITICAL MARKETING* 627, 627-29, 631-41 (Bruce I. Newman ed., 1999).

¹⁷ See *id.* at 628-29 (explaining that the Conservative Party presented privatization as a revenue-generating measure, not as a consequence of a belief in smaller government).

¹⁸ *Id.* at 632-33.

¹⁹ See *id.* at 634-35 (finding this program so successful that it was later adopted for all subsequent privatization measures).

icy change was accompanied by an identifiable transaction—similar in some ways to the initial purchase of insurance through PPACA’s health insurance exchanges²⁰—a commercial marketing strategy seemed appropriate.

In American health care, an illustrative experience involves Medicaid in the 1980s and 1990s. As longstanding state legal prohibitions on selective contracting between health insurers and medical providers eroded, largely Republican presidential administrations sought innovative ways to constrain the costs of entitlement programs. Many states received federal waivers, followed by a change in federal law, allowing them to enroll the majority of Medicaid beneficiaries in private managed care plans.²¹ Medicaid coverage for children had also expanded significantly during the 1980s and accelerated further with the enactment of the State Children’s Health Insurance Program (SCHIP) in 1997.²² Unfortunately, “take-up” (enrollment) and retention among putative beneficiaries often lagged significantly behind statutory expansions in eligibility and benefits.²³

State-based Medicaid managed care initiatives therefore attempted to address simultaneously a range of issues of concern to different political constituencies. Conservatives worried about waste, fraud, and dependency in direct government programs. Liberals sought to provide poor but healthy individuals with reliable access to physician services through organizations that avoided the stigma often associated with welfare programs, and also to induce families that

²⁰ See PPACA §§ 1311–1313, 1501(a)–(b), 42 U.S.C.A. §§ 18031–18033 (West Supp. 1B 2010) (establishing PPACA’s health exchanges); see also *id.* § 1501(b), 26 U.S.C.A. § 5000A (West Supp. 1A 2010) (requiring individuals to maintain minimum essential health coverage).

²¹ See Allen Dobson et al., *The Role of Federal Waivers in the Health Policy Process*, HEALTH AFF., Winter 1992, at 72, 87-90 (analyzing state use of federal waivers between 1982 and 1992); John Holahan et al., *Medicaid Managed Care in Thirteen States*, HEALTH AFF., May–June 1998, at 43, 43-46 (describing expansion both before and after statutory changes to Medicaid requirements in the Balanced Budget Act of 1997).

²² See 42 U.S.C. § 1397aa (2006) (explaining that SCHIP’s purpose is to “expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner”); Karl Kronebusch, *Medicaid for Children: Federal Mandates, Welfare Reform, and Policy Backsliding*, HEALTH AFF., Jan.–Feb. 2001, at 97, 108-09 (describing the Medicaid expansions for children in the 1980s, the effect of welfare reform in 1994, and the enactment of SCHIP in 1997).

²³ See Benjamin D. Sommers, *Why Millions of Children Eligible for Medicaid and SCHIP Are Uninsured: Poor Retention Versus Poor Take-Up*, 26 HEALTH AFF. w560, w560, w563 (2007), <http://content.healthaffairs.org/content/26/5/w560.full.pdf> (arguing that, in addition to poor take-up, poor retention is a major factor in the high number of uninsured children).

were eligible for Medicaid to stay enrolled even if, after the 1994 welfare reforms, they no longer qualified for sustained cash assistance.²⁴

States responded by creating program brands that were both approachable to beneficiaries and attractive to nonbeneficiaries whose tax dollars helped to fund those programs. Program names typically played to state pride and avoided suggesting that private health insurers were potentially profiting from the state's new approach to Medicaid. Minnesota created "MinnesotaCare,"²⁵ Maine chose "DirigoCare,"²⁶ Tennessee chose "TennCare,"²⁷ and Wisconsin called its program "BadgerCare."²⁸ "MassHealth,"²⁹ the Massachusetts formulation, was carried significantly further when that state enacted universal health coverage in 2006. These names communicate the importance of health care to each state by linking it to the state's name or a word most citizens closely associate with their state. In all these states, naming was only one part of a sustained marketing program to attract enrollment and preserve public support.

III. WHY THE SOFT SELL?

A legitimate question with which to launch a discussion of legislative marketing and health care reform is why the Obama Administration has not been more attentive to branding PPACA. The most likely explanations center on the differences between building support for enacting the law in the first place and for preserving and implementing the law once it is already on the books.

²⁴ See Sara Rosenbaum & Kathleen A. Maloy, *The Law of Unintended Consequences: The 1996 Personal Responsibility and Work Opportunity Reconciliation Act and Its Impact on Medicaid for Families with Children*, 60 OHIO ST. L.J. 1443, 1446-47 (1999) (describing the unintended reduction in Medicaid enrollment as the result of welfare reform).

²⁵ *MinnesotaCare*, MINN. DEPARTMENT OF HUM. SERVICES, http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_006255 (last visited Mar. 15, 2011).

²⁶ *Health Insurance*, MAINE.GOV, http://www.maine.gov/portal/family/health_safety/health_insurance.html (last visited Mar. 15, 2011). DirigoCare's name is derived from Maine's state motto "Dirigo," which means "I direct." See *Facts About Maine*, MAINE.GOV, http://www.maine.gov/portal/facts_history/facts.html (last visited Mar. 15, 2011).

²⁷ *What's New with TennCare*, TN.GOV, <http://www.tn.gov/tenncare> (last visited Mar. 15, 2011).

²⁸ *BadgerCare+*, WIS. DEPARTMENT OF HEALTH SERVICES, <http://www.dhs.wisconsin.gov/badgercareplus> (last visited Mar. 15, 2011). BadgerCare comes from Wisconsin's nickname, the "Badger State."

²⁹ MASS. OFFICE OF HEALTH & HUMAN SERVS., *MassHealth*, MASS.GOV, <http://www.mass.gov/?pageID=eohhs2agencylanding&L=4&L0=Home&L1=Government&L2=Departments+and+Divisions&L3=MassHealth&sid=Eeohhs2> (last visited Mar. 15, 2011).

One consideration is that the Administration was never sure during the legislative debate who would emerge as its most valuable allies, and therefore was hesitant to adopt a marketing strategy that lionized some constituencies and vilified others. Political issue campaigns typically associate favored positions with popular groups and disfavored positions with unpopular ones. Common health reform villains for Democrats include insurance companies and the pharmaceutical industry, while Republicans usually target overzealous regulators and malpractice lawyers. Conceivably, the Massachusetts health reform succeeded because each stakeholder group was offered some benefits and asked to make some sacrifices.³⁰ At the national level, the Obama Administration learned this lesson and secured promises of support (or at least neutrality) from many powerful groups in exchange for including or omitting particular provisions from the bill. For example, the insurance industry expanded its market reach, pharmaceutical companies avoided price controls, and hospitals and physicians received assurances of greater certainty in their reimbursement systems. As noted, the Administration now portrays PPACA primarily as anti-insurance industry legislation, but that image was never developed in detail as the law's branded identity before it was passed. This is probably good, because insurance reform only partly describes PPACA's contents and public policy objectives.

Another potential explanation for the absence of branding is that, during legislative debate, the Administration strongly preferred to downplay the law's sweeping scope and massive scale, and instead to portray PPACA as making only moderate adjustments to current practices. For one, branding the law as a cohesive whole risked even greater public resistance to PPACA as an overreaching government program imposing "socialized medicine." Moreover, a federal brand would have emphasized the extent of national incursion on state authority, while the law as drafted bent over backwards to preserve the federalist balance by leaving the development of the critically important insurance exchanges to states and perhaps even localities.³¹ Finally, a national brand approach would have made it more likely that the Congressional Budget Office (CBO) would evaluate the law's fiscal impact in a politi-

³⁰ See Christie L. Hager, *Massachusetts Health Reform: A Social Compact and a Bold Experiment*, 55 U. KAN. L. REV. 1313, 1313-29 (2007) (providing an insider's summary of and context for the Massachusetts health reform law).

³¹ See PPACA §§ 1321-1324, 42 U.S.C.A. §§ 18041-18044 (West Supp. 1B 2010) (describing the "flexibility" PPACA grants to states in operating and enforcing health insurance exchanges).

cally devastating manner. Specifically, unifying the trillion-plus dollars of existing employer-based coverage under a federal banner might have caused them to constitute, for accounting purposes, a massive increase in taxation coupled with an equally massive boost to government spending, even though the flow of funds would be substantially the same before and after PPACA goes into effect.

A third possibility for the failure to brand is that the Obama Administration decided that actions would speak louder than words. Instead of emphasizing a name brand, it may have assumed that support for the law would build as the public received tangible benefits that it would not thereafter want to lose. Indeed, a timeline of PPACA's accomplishments and more detailed descriptions of changes that became effective during the new law's first few months of existence feature prominently on the Administration's website.³² However, relying on public attachment to benefits received is risky for two reasons. First, the same fiscal politics that kept the insurance exchanges as vague state entities required the Administration to phase in costly benefits slowly, extending where possible beyond the CBO's 10-year time horizon, lest the apparent price tag of the law prove politically unacceptable.³³ Second, although securing health coverage may be psychologically attractive to some individuals, most people use little or none of their available insurance benefits in a given year³⁴ and may not perceive immediate value in PPACA's requirement to purchase it.

IV. STEP 1: EDUCATING AMERICANS ABOUT HEALTH REFORM

Health care is a complicated subject, and PPACA is a complex and imperfect law. Consequently, few ordinary Americans understand what the country might gain from health care reform or lose without it. Although branding means more than just conveying information

³² *Timeline: What's Changing and When*, HEALTHCARE.GOV, <http://www.healthcare.gov/law/timeline> (last visited Mar. 15, 2011).

³³ See Douglas Holtz-Eakin & Michael J. Ramlet, *Health Care Reform Is Likely to Widen Federal Budget Deficits, Not Reduce Them*, 29 HEALTH AFF. 1136, 1138 (2010) (noting that "the act front-loads revenues and back-loads spending").

³⁴ According to Sherry Glied, "[T]he 50 percent of Americans with the least spending [on health care in 1987] accounted for only 3 percent of total health spending. In fact, about 15 percent of Americans use no health care in any given year." SHERRY GLIED, CHRONIC CONDITION: WHY HEALTH REFORM FAILS 123 (1997). Glied points out, by contrast, that "[t]he 1 percent of Americans with the highest spending on health care in 1987 accounted for fully 30 percent of total health spending in that year." *Id.*

in the hope that people will act on it, an effective marketing approach to PPACA does require a communication strategy that simplifies the new law's principal features and presents them in a credible way.

PPACA itself is surprisingly clear about its priorities. My personal experience suggests that the statute's table of contents can serve as a useful device for explaining PPACA to diverse audiences.³⁵ Moreover, illustrating each part of the statute with a familiar visual image improves both comprehension and recall. The following discussion includes such visual cues.

PPACA has ten titles, with the first five constituting a basic roadmap to the law.³⁶ A core attribute of PPACA is that, arguably for the first time, a single federal law aspires to improve insurance, care delivery, and underlying health simultaneously. Titles I and II address health insurance coverage.³⁷ Title III is concerned with the "health care delivery system," meaning physicians, hospitals, and other health care providers.³⁸ Title IV is about healthy individuals and communities.³⁹ Title V addresses the need for skilled workers in a reformed health care system.⁴⁰ Title IX, "Revenue Provisions," also bears mentioning, but more for its cautious approach to taxation than for its specific content.⁴¹

Title I, "Quality, Affordable Care for All Americans," replaces health insurance as we have known it with a system of near-universal shared risk.⁴² This first and most important part of PPACA addresses the problem of uninsurability, which affects millions of Americans who themselves or whose dependents suffer from a serious disease.

³⁵ See PPACA, Pub. L. No. 111-148, § 1, 24 Stat. 119, 119-30 (2010) (PPACA's table of contents).

³⁶ See *id.*

³⁷ See *id.* tits. I-II, 124 Stat. at 130-353 (to be codified as amended in scattered sections of 25, 26, 29 and 42 U.S.C.) (addressing health care coverage generally in Title I, and public programs for health care in Title II).

³⁸ See *id.* tit. III, 124 Stat. at 353-538 (to be codified as amended in scattered sections of 21 and 42 U.S.C.) (seeking to improve the "quality and efficiency of health care," in part through transforming the "health care delivery system").

³⁹ See *id.* tit. IV, 124 Stat. at 538-88 (to be codified as amended in scattered sections of 29 and 42 U.S.C.) (focusing on disease prevention and improvement of public health).

⁴⁰ See *id.* tit. V, 124 Stat. at 588-684 (to be codified as amended in scattered sections of 42 U.S.C.) (addressing the "health care workforce" generally).

⁴¹ See *id.* tit. IX, 124 Stat. at 847-84 (to be codified as amended in scattered sections of 26 U.S.C.) (dealing with the revenue considerations of PPACA).

⁴² See *id.* tit. I, 124 Stat. at 130-271 (to be codified as amended in scattered sections of 26, 29, and 42 U.S.C.) (requiring all Americans to have a basic level of health insurance coverage).

Notwithstanding such “pre-existing conditions,” PPACA not only declares these unfortunate individuals insurable, but also dictates that they be charged a premium only marginally higher than healthy individuals.⁴³ Imagine that the visual correlate of Title I is a magic wand, symbolizing government’s power to transform. Perhaps surprisingly, the law’s seemingly arbitrary declarations of insurability are likely to prove successful. PPACA’s magic wand has a plausible mechanism: the requirement that each individual purchase health insurance.⁴⁴ As a functional matter, PPACA’s individual mandate is less about burgeoning federal authority than about avoiding adverse selection that otherwise might cripple private insurance markets if those markets cannot evaluate and price to risk. Put simply, everyone can be insurable because everyone must be insured.

Title II, “Role of Public Programs,” principally expands Medicaid to insure individuals for whom Title I cannot make private coverage affordable through risk pools and tax credits.⁴⁵ Imagine Title II represented by a \$100 bill. A majority of uninsured individuals are employed and healthy enough to be covered for a normal premium through private markets. The problem is that low-wage workers simply cannot afford coverage. The average cost of health insurance for a family of four exceeds a year’s earnings at the minimum wage.⁴⁶ Title I provides subsidies for some of these people, but most will be served by Title II, which requires states to raise the income test for Medicaid to 133% of the federal poverty level and offers states very generous federal support for broadening eligibility.⁴⁷ This redistributive aspect of PPACA is a necessary corollary to its expansion of private coverage.

⁴³ See *id.* § 1331(c)(2)(B), 42 U.S.C.A. § 18051(c)(2)(B) (West Supp. 1B 2010) (“Nothing in this subparagraph shall be construed as allowing discrimination on the basis of pre-existing conditions or other health status-related factors.”); *id.* § 1341(b)(2), 42 U.S.C.A. § 18061(b)(2) (determining rules for calculating premium amounts for high-risk individuals).

⁴⁴ See *id.* § 1501(b), 26 U.S.C.A. § 5000A (West Supp. 1A 2010) (requiring maintenance of minimum essential insurance coverage by all individuals).

⁴⁵ See *id.* tit. II, 124 Stat. at 271-353 (to be codified as amended in scattered sections of 25 and 42 U.S.C.) (expanding and improving the Medicaid and CHIP public insurance programs).

⁴⁶ See Press Release, The Henry J. Kaiser Family Found., Family Health Premiums Rise 3 Percent to \$13,770 in 2010, but Workers’ Share Jumps 14 Percent as Firms Shift Cost Burden (Sept. 2, 2010), available at <http://www.kff.org/insurance/090210nr.cfm> (“[B]usinesses have been shifting more of the costs of health insurance to workers through premiums, deductibles and other cost-sharing . . .”).

⁴⁷ See PPACA sec. 2001(a), § 1902(a)(10)(A)(i), 42 U.S.C.A. § 1396(a) (West Supp. 1B 2010).

Title III, “Improving the Quality and Efficiency of Health Care,” seeks to increase the value of medical services by changing the incentives facing health care providers and inducing improvements in their structure and performance.⁴⁸ It is generally recognized that high-priced medical innovations, such as advanced diagnostic and therapeutic technologies, and their associated physician and hospital services, contribute significantly to persistently increasing health care costs.⁴⁹ It is less well-known that many of these costs are unnecessary and result from the cottage-industry character of American medicine, including piecemeal fee-for-service payment by insurers and the organizational and financial partitioning of physicians’ services from those of hospitals and other industrial actors.⁵⁰ In other words, the problem is not the technology, but how the technology is deployed. If Title III were given a visual, it could be symbolized by an ordinary ballpoint pen, which is in many ways the world’s most expensive medical technology. Each year, hundreds of thousands of American physicians order roughly \$1.5 trillion in tests, referrals, pharmaceuticals, and facility-based treatments for their patients, often with questionable scientific justification and little concern for price or efficiency.⁵¹ Solving the problem of the ballpoint pen requires not only a substantial investment in health information technology, but also a radical re-vamping of the financial incentives and organizational assumptions upon which medical practice has been based for the last half-century.

Title IV, “Prevention of Chronic Disease and Improving Public Health,” recognizes that our health care system will remain affordable

⁴⁸ See *id.* tit. III, 124 Stat. at 353-538 (to be codified as amended in scattered sections of 21 and 42 U.S.C.).

⁴⁹ See David M. Cutler & Mark McClellan, *Is Technological Change in Medicine Worth It?*, HEALTH AFF., Sept.–Oct. 2001, at 11, 11, 24 (acknowledging that “technological change has accounted for the bulk of medical care cost increases over time,” but concluding that the benefits of medical technology outweigh the costs). Cutler and McClellan’s conclusion assumes that the technologies are used when appropriate and as intended.

⁵⁰ See Gerard F. Anderson et al., *It’s The Prices, Stupid: Why The United States Is So Different from Other Countries*, HEALTH AFF., May–June 2003, at 89, 102-03 (highlighting the adverse consequences of aberrant prices for health services in the United States); Kenneth E. Thorpe & Lydia L. Ogen, *The Foundation That Health Reform Lays for Improved Payment, Care Coordination, and Prevention*, 29 HEALTH AFF. 1183, 1183-84 (2010) (discussing the importance of transitioning away from fee-for-service payment).

⁵¹ See, e.g., Elliott S. Fisher et al., *Slowing the Growth of Health Care Costs—Lessons from Regional Variation*, 360 NEW ENG. J. MED. 849, 850 (2009) (“The causes [for geographic variation in health care costs] must . . . lie in how physicians and others respond to the availability of technology, capital, and other resources in the context of the fee-for-service payment system.”).

only if we become a healthier nation.⁵² Even if Title III's delivery-system reforms succeed in resetting both the baseline and the trajectory of health care costs for each individual served, the accelerating national epidemic of chronic disease will rapidly erode those gains and quickly threaten the health care system's financial integrity and sustainability.⁵³ Fortunately, many of these costs, and the disease burdens they represent, are potentially avoidable through improved health behaviors, such as quitting smoking, reducing caloric intake, and increasing physical activity. This problem requires a multi-pronged approach that includes individual responsibility, information exchange, financial incentives, community redesign, and investment in public and community health infrastructure. Title IV could be symbolized by a box of fast-food French fries, which connotes a lifestyle as well as a diet.⁵⁴

Title V, "Health Care Workforce," begins to develop the human capital that will be necessary to assure access to health care for the entire population.⁵⁵ An image of people working together both within and across communities captures the essence of Title V. PPACA's large financial commitment to workforce improvement is significant for four reasons. First, as quickly became apparent in Massachusetts after that state's enactment of health reform, a rapid expansion of insurance coverage requires a parallel expansion of service capacity, especially for primary care.⁵⁶ More providers are needed if bottlenecks

⁵² See PPACA tit. IV, 124 Stat. at 538-88 (to be codified as amended in scattered sections of 29 and 42 U.S.C.).

⁵³ See, e.g., Roland Sturm, *The Effects of Obesity, Smoking, and Drinking on Medical Problems and Costs*, HEALTH AFF. Mar.-Apr. 2002, at 245, 247-49 (calculating the substantial cost effects of poor health behaviors); Darius N. Lakdawalla et al., *The Health and Cost Consequences of Obesity Among the Future Elderly*, HEALTH AFF., Sept. 26, 2005, at W5-R30, W5-R31 to -R38, <http://content.healthaffairs.org/content/early/2005/09/26/hlthaff.w5.r30.full.pdf+html> (explaining that obesity increases morbidity and costs but does not substantially reduce longevity, which consequently imposes serious financial burdens on the health care system).

⁵⁴ See, e.g., Marice Ashe et al., *Local Venues for Change: Legal Strategies for Healthy Environments*, 35 J.L. MED. & ETHICS 138, 139 (2007) (discussing potential improvements to school environments, land use policy, community facilities, and retail sale of food with the goal of improving public health).

⁵⁵ PPACA tit. V, 124 Stat. at 588-684 (to be codified as amended in scattered sections of 42 U.S.C.).

⁵⁶ See Doug Trapp, *Most in Massachusetts Met Individual Insurance Mandate*, AMED-NEWS.COM (June 23, 2008), <http://www.ama-assn.org/amednews/2008/06/23/gvsb0623.htm> ("[A survey in Massachusetts] found that 6.9% of adults in families earning less than 300% of poverty reported in fall 2007 that they did not get needed care in the past year because of trouble finding an available doctor or other health professional.

in accessibility are to be avoided. Second, community-based health care workers are likely to prioritize health in their personal behavior and social interactions, which helps to leverage Title IV's investment in public health. Third, health care workforce development emphasizes the deep connections between health and education. People who are highly educated will likely be healthier,⁵⁷ and healthier people will be more likely to continue their education. Fourth, even a markedly more efficient health care delivery system will be a continuing source of skilled employment opportunities, especially during economic downturns, and individuals and families who are working and prospering are likely to be healthier as well.⁵⁸

V. STEP 2: NAMING THE NEW NATIONAL PROGRAM OF NEAR-UNIVERSAL COVERAGE

After basic education, naming is the next step in designing a marketing strategy for health reform. In recent decades, American legislators—far more than, say, their British counterparts—have labeled their output with catchy acronyms or adopted bill titles that resonate emotionally with voters.⁵⁹ These include No Child Left Behind (NCLB),⁶⁰ Megan's Law,⁶¹ the James Zadroga 9/11 Health and Compensation Act,⁶² and the USA PATRIOT ACT.⁶³ In the early 1990s,

That is up from 4.1% in fall 2006. For all adults, that percentage increased from 3.5% in fall 2006 to 4.8% in fall 2007.”).

⁵⁷ See ROBERT WOOD JOHNSON FOUND. COMM'N TO BUILD A HEALTHIER AM., REACHING AMERICA'S HEALTH POTENTIAL: A STATE-BY-STATE LOOK AT ADULT HEALTH 3 (2009), available at <http://www.commissiononhealth.org/Documents/AdultHealthChartbookFullReport.pdf> (“Compared with the most-educated adults . . . the least-educated adults . . . were more likely—more than three times as likely, in some states—to be in less than very good health.”).

⁵⁸ For a thorough discussion of the multifaceted relationship between health and economic success, see Angus Deaton, *Policy Implications of the Gradient of Health and Wealth*, HEALTH AFF., Mar.–Apr. 2002, at 13.

⁵⁹ See Jess Bravin, *Congress Finds, in Passing Bills, That Names Can Never Hurt You*, WALL ST. J., Jan. 12, 2011, at A1 (describing how ulterior motives may factor into the naming of congressional bills).

⁶⁰ No Child Left Behind Act of 2001, Pub. L. No. 107-110, 115 Stat. 1425 (codified as amended in scattered sections of 20 U.S.C.).

⁶¹ Jacob Wetterling Crimes Against Children and Sexually Violent Offender Registration Act, 42 U.S.C. § 14071 (2006).

⁶² H.R. 847, 111th Cong. (2010) (enacted).

⁶³ Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism (USA PATRIOT ACT) Act of 2001, Pub. L. No. 107-56, 115 Stat. 272 (codified as amended in scattered sections of 8, 15, 18, 22, 31, 42, 49, and 50 U.S.C.).

Rhode Island Senator John Chafee announced that he was introducing a health reform bill called the HEART Act: “Asked by a reporter what HEART stood for, Chafee said he would figure it out later; the important thing was getting people to start using the warm-and-fuzzy acronym.”⁶⁴

This trend has pros and cons. No Child Left Behind shows the power of naming,⁶⁵ but also illustrates the danger of a program falling short of its lofty, evocative title.⁶⁶ Megan’s Law and the James Zadroga 9/11 Health Compensation Act associate laws with identified people, framing the policies they contain as both tributes to and lessons learned from lives that had been lost. However, ethical and factual issues can arise when a person’s name is assigned to legislation.⁶⁷ The USA PATRIOT Act offers a different moral for legislative marketers. There can be little doubt that Congress chose an acronym that would evoke American patriotism immediately following the events of September 11, 2001, as well as suggest that the law’s critics were unpatriotic or were failing to support American troops overseas.⁶⁸ Over time, the name “Patriot Act” became a shorthand “symbol for all of the domestic anti-terrorist law enforcement actions.”⁶⁹ In his recent memoir, former President George W. Bush described his discomfort with the

⁶⁴ Marilyn Werber Serafini, *Rebranding ‘Obamacare,’* KAISER HEALTH NEWS (Jan. 3, 2011), <http://www.kaiserhealthnews.org/Stories/2010/December/27/rebranding-obamacare.aspx?p=1>.

⁶⁵ See Coulter M. Bump, Comment, *Reviving the Coercion Test: A Proposal to Prevent Federal Conditional Spending That Leaves Children Behind*, 76 U. COLO. L. REV. 521, 552-56 (2005) (arguing that many states and school districts were coerced into adopting NCLB by a naïve public that was fooled by the Act’s name).

⁶⁶ See Susan L. DeJarnatt, *The Philadelphia Story: The Rhetoric of School Reform*, 72 UMKC L. REV. 949, 1007 n.344 (2004) (characterizing NCLB’s rhetoric as cynical and hypocritical due to its failure to live up to its name).

⁶⁷ See, e.g., Anthony DePalma, *City Says Prescription Misuse Caused Death of Detective Who Worked at 9/11 Site*, N.Y. TIMES, Oct. 26, 2007, at B3 (suggesting that Zadroga’s death was caused by prescription drugs and not 9/11 toxins); Raymond Hernandez, *House Passes 9/11 Health Care Bill*, N.Y. TIMES.COM CITY ROOM BLOG (Sept. 29, 2010, 3:46 PM), <http://cityroom.blogs.nytimes.com/2010/09/29/911-health-care-bill-passes> (indicating that the name of the legislation is “deceptive” because Zadroga’s death was not “directly related to the 9/11 attacks”).

⁶⁸ See Josh Lederman, *A Bill’s Name Is Part of the Game*, MEDILL REP. CHI. (June 8, 2010), <http://news.medill.northwestern.edu/chicago/news.aspx?id=166509> (“‘Right after 9/11, there was a patriotic fervor in this country,’ . . . Media organizations all over were scrambling not to appear un-American or not supportive of the troops. ‘[The Act’s name] really did allow its proponents to seize the higher ground in the public affairs campaign.’”).

⁶⁹ Paul Rosenzweig, *Civil Liberty and the Response to Terrorism*, 42 DUQ. L. REV. 663, 664 (2004).

accusations inherent in the bill's title and his preference for its plainer original name, the Antiterrorism Act.⁷⁰

In contrast to these examples of legislative salesmanship, the new health reform law has been strikingly anonymous. One might describe Obama health reform as the Act that dare not speak its name. Its full acronym, PPACA, sounds like a sputtering engine, or, as one news article mused, a kind of llama.⁷¹ As a result, the Administration informally adopted the shorter but equally non-descript "Affordable Care Act."⁷² This was a mistake. Despite the Administration's reluctance to connect the dots in its complex but cohesive initiative too explicitly, successful implementation of health reform requires a sense of social solidarity and collective progress as well as individual benefit.⁷³ It is hard for a nameless law to achieve such broad acceptance.

At this late date, however, renaming the statute would be unproductive. The Administration already won the battle over its enactment and seems to have already lost the battle over its descriptor. Without a strong alternative, media outlets and opponents quickly dubbed the law "Obamacare."⁷⁴ Instead of emphasizing the solidarity necessary for the program's success, "Obamacare" promotes the idea that health reform was the product of presidential overreaching and furthers the conservative characterization of President Obama as an egocentric philosopher-king. More recently, the health reform repeal bill passed by the newly Republican-led House of Representatives refers to PPACA as the "job-killing health care law,"⁷⁵ making it plain that opponents

⁷⁰ Bravin, *supra* note 59.

⁷¹ See Serafini, *supra* note 64 ("Puh-pack-uh? Is that some kind of llama?").

⁷² See, e.g., *Affordable Care Act: One Year Later*, HEALTHCARE.GOV, <http://www.healthcare.gov/law/introduction> (last visited Mar. 15, 2011) ("Reforms under the *Affordable Care Act* brought an end to some of the worst abuses of the insurance industry." (emphasis added)).

⁷³ See Sage, *supra* note 11, at 10 (noting three sources of health solidarity in Americans that may help in creating a successful health care system: mutual assistance, patriotism, and coordinated investment).

⁷⁴ See, e.g., Jeff Simon, *Crist, Meek Spar over Use of 'Obamacare'*, CNN.COM POL. TICKER BLOG (Oct. 19, 2010, 8:54 PM), <http://politicalticker.blogs.cnn.com/2010/10/19/crist-meek-spar-over-use-of-obamacare> (describing how in a debate between U.S. Senate candidates in Florida, Charlie Crist "railed" against "Obamacare," and how one of Crist's opponents was "shocked" by the "new lingo" Crist was using in reference to health reform); George Will, *Searching for Obamacare's Silver Lining*, TOWNHALL.COM (Mar. 22, 2010), http://townhall.com/columnists/GeorgeWill/2010/03/22/searching_for_obamacares_silver_lining (referring to the law as "Obamacare").

⁷⁵ Repealing the Job-Killing Health Care Law Act, H.R. 2, 112th Cong. (2011).

share none of the Administration's qualms about a forceful label (regardless of either accuracy or relevance).

What matters now is naming the program of insurance coverage that PPACA creates. Medicare and Medicaid, both household names, were products of the blandly titled Social Security Amendments of 1965.⁷⁶ These programs, like Social Security itself in the 1930s, received their own names almost accidentally, but well in advance of their enabling legislation. *The Washington Post* was apparently the first to associate the term "social security" with the pending legislation proposed by the Committee on Economic Security.⁷⁷ The origin of "Medicare" is even more obscure, with no indisputable provenance.⁷⁸ PPACA can do better. For the sake of discussion, imagine that the Obama Administration and its allies decided to consolidate the many strands of health insurance coverage PPACA makes available using a single patriotic descriptor, "Americare."⁷⁹

VI. STEP 3: GOING FROM NAME TO BRAND

How might "Americare" become the cherished national brand that the Obama Administration hopes to establish? A complete brand strategy for implementing PPACA would recognize that the law's goals include purchasing behavior, personal conduct, and regard for the collective interest. Specifically, in order to fulfill PPACA's promise individuals must: (1) buy health insurance; (2) demand better medical care; and (3) live healthier lives. All of these conditions depart from current circumstances, and they are complicated to understand and difficult to achieve. Purchasing health insurance seems the most straightforward, as it reflects a specific legal obligation; however, the variety of sources for coverage that will continue to exist make both

⁷⁶ Health Insurance for the Aged Act, §§ 101–111, 121, 42 U.S.C. §§ 1395–1396 (2006).

⁷⁷ DENNIS W. JOHNSON, *THE LAWS THAT SHAPED AMERICA: FIFTEEN ACTS OF CONGRESS AND THEIR LASTING IMPACT* 184–85 (2009).

⁷⁸ See PETER A. CORNING, *THE EVOLUTION OF MEDICARE: FROM IDEA TO LAW* ch. 4 n.3 (1969), available at <http://www.socialsecurity.gov/history/corningchap4.html> (explaining that "Medicare" was "coined by some unknown newspaper headline writer").

⁷⁹ See William M. Sage, *Why the Affordable Care Act Needs a Better Name: 'Americare'*, 29 HEALTH AFF. 1496, 1496 (2010) (arguing a name like "Americare" would foster "a sense of solidarity among ordinary Americans" that would help realize the legislation's goals and make it more widely accepted). Representative Fortney Stark proposed a Medicare-for-all system called the "AmeriCare Health Care Act" in 2007. See H.R. 1841, 110th Cong. § 1 (2007). Private health care companies have also used names resembling Americare. E.g., AMERICARE COMPANIES, <http://www.americareny.com/07c/about.html> (last visited Mar. 15, 2011).

compliance and monitoring a challenge. The other goals are more complex. Demanding better health care is a function of provider supply, information, incentives (including the moral hazard implicit in insurance), and wishful thinking about the quality of one's own care. Living healthier goes beyond daily personal choices to encompass physical environment, family and community dynamics, and the structure of schools and workplaces.⁸⁰

Moreover, medical patients and insurance beneficiaries are not the only relevant stakeholders. For example, physicians and other health care industry participants will form strong views about Medicare. Unlike the typical commercial context, these individuals and organizations will bear an uncertain and evolving relation to the new federal program, sometimes acting as suppliers, other times as competitors, and yet other times as self-regulatory monitors.

A. *Elements of Brand Equity*

In marketing parlance, the value of a brand is called "brand equity." Brand equity develops over time and is cultivated by close, continuous interaction between a branded product and its customers.⁸¹ For this reason, a good way for the Obama Administration to approach the branding of Medicare is by learning directly from its constituents through focus groups, test markets, and other strategies familiar to marketing professionals.

Brand equity in a commercial context is sometimes described as requiring three types of messages: functional, emotional, and expressive.⁸² The first is the equity associated with the function of a product or service. Does it perform as expected? Is it reliable? Second, there is equity associated with the internal emotions it produces in the buyer. Does the consumer feel good about using it? How does it change the consumer's self-image? Third is the equity associated with the way that using the product or service enables the buyer to express favorable qualities to other people and interact more productively with them. Do others react positively to the buyer?

⁸⁰ For further discussion of living healthier lives, see Ashe et al., *supra* note 54, at 139.

⁸¹ See Evans & Hastings, *supra* note 15, at 10-12 (using the example of Classic Coke and New Coke to illustrate the interaction of brand loyalty and consumer choices).

⁸² See Jonathan L. Blitstein et al., *What Is a Public Health Brand?* (explaining three components of brand equity as corresponding to three types of problems consumers seek to resolve), in PUBLIC HEALTH BRANDING: APPLYING MARKETING FOR SOCIAL CHANGE, *supra* note 15, at 25, 28-29.

The following are desirable attributes in each of these three domains that an Americare brand might cultivate among the millions of individuals who would buy health insurance in accordance with PPACA:

Functional messages:

- “Americare is affordable, effective health insurance.”
- “Having Americare improves the quality of medical care that I receive.”

Emotional messages:

- “With Americare, I am protecting myself and my family from financial ruin.”
- “Americare makes me feel even prouder of my country.”

Expressive messages:

- “My Americare card makes me welcome wherever I choose to go for care.”
- “My health care team knows me and my medical history better because of Americare.”
- “With Americare, I feel closer to other people who have similar health concerns.”

Once the functional, emotional, and expressive dimensions of the Americare brand are identified, a marketing strategy could be designed to achieve several critical goals that characterize most successful commercial brands. These objectives include awareness, loyalty, perceived quality, and positive associations.⁸³

B. Awareness

Building brand awareness for Americare is relatively straightforward. Each insurance product offered to Americans pursuant to PPACA’s requirements could be identified using the national brand name. For example, private health plans offered through health insurance exchanges could be sold as “Americare—Blue Cross” or “Americare—United Healthcare,” while public plans could be denominated “Americare—Medicare” or “Americare—Federal Employees.”⁸⁴

⁸³ DAVID A. AAKER, BUILDING STRONG BRANDS 7-8 (1996).

⁸⁴ The Massachusetts health reform program operates along similar lines. MassHealth consists of eight programs funded by state and federal funds: (1) MassHealth Standard (Medicaid/SCHIP equivalent); (2) MassHealth Limited (noncitizen coverage); (3) CommonHealth (disabled children and high-earning, disabled adults); (4) MassHealth Family Assistance (CHIP and HIV-positive people); (5) MassHealth Buy-In (premium assistance); (6) MassHealth Basic (chronically unemployed); (7) MassHealth Essential (unemployed not covered by Basic); and (8) MassHealth Prenatal.

Over time, it would be important for Medicare to be thought of as an independent aspect of American citizenship rather than as a government program. The oft-told, likely apocryphal story about senior citizens protesting to keep the government out of Medicare, which resurfaced again during the debate over PPACA,⁸⁵ contains an important grain of truth. After forty-five years of focused benefits for the elderly, brand awareness of Medicare is so strong that it exists in beneficiaries' hearts and minds apart from the governmental institutions that enacted the program and that continue to control it.

C. Loyalty

Developing brand loyalty for Medicare entails a reversal of the marketing strategies currently employed by PPACA's opponents. Critics of health care reform are careful to describe PPACA as an alien presence in American society, challenging its constitutionality (and sometimes the constitutional legitimacy of the president who created it), linking it to polarizing figures (President Obama, former Speaker Pelosi, Democrats, liberals), and identifying it as a burden to the majority of Americans but a benefit mainly to socially and politically marginalized groups.⁸⁶

Messaging to build loyalty therefore should take the opposite approach. Ownership of an Medicare policy should mean an ownership stake in America and belief in its ideals as a nation. Medicare should be portrayed as beneficial across the political spectrum, even to its harshest critics. Most importantly, every individual should be

Applicants and Members Under Age 65 and Families, MASS.GOV, [http://www.mass.gov/?pageID=eohhs2subtopic&L=5&L0=Home&L1=Consumer&L2=Insurance+\(including+MassHealth\)&L3=MassHealth+Coverage+Types&L4=Applicants+and+Members+Under+Age+65+and+Families&sid=Eoohs2](http://www.mass.gov/?pageID=eohhs2subtopic&L=5&L0=Home&L1=Consumer&L2=Insurance+(including+MassHealth)&L3=MassHealth+Coverage+Types&L4=Applicants+and+Members+Under+Age+65+and+Families&sid=Eoohs2). An applicant need only complete an online form to determine his eligibility for any of these policies. See *Medical Benefit Request (MBR)*, MASSHEALTH, available at <http://www.mass.gov/Eoohs2/docs/masshealth/appforms/mbr.pdf>.

⁸⁵ See, e.g., Paul Krugman, *Why Americans Hate Single-Payer Insurance*, THE CONSCIENCE OF A LIBERAL, N.Y.TIMES.COM BLOG (July 28, 2009, 11:45 AM), <http://krugman.blogs.nytimes.com/2009/07/28/why-americans-hate-single-payer-insurance> (recounting the story of a man who told a U.S. congressman at a town-hall meeting to "keep your government hands off my Medicare").

⁸⁶ See, e.g., Mark A. Hall, *Health Care Reform—What Went Wrong on the Way to the Courthouse*, 364 NEW ENG. J. MED. 295, 296-97 (2011) (examining legal challenges to PPACA's constitutionality); Theda Skocpol, *The Political Challenges That May Undermine Health Reform*, 29 HEALTH AFF. 1288, 1290-91 (2010) (discussing the redistributive effects of PPACA and predicting that those with entrenched interests will wage a vigorous campaign to minimize redistribution to the less well off).

asked to think of PPACA's health insurance expansion as "my Americare," never "their program" or "that program." Ultimately, Americare might come to be seen as a shared treasure—participation in and allegiance to which is a comfortable act of minor patriotism. This is how citizens of many other countries, including the United Kingdom and Canada, tend to view their universal health care systems.⁸⁷

D. *Perceived Quality*

For PPACA to succeed, the perceived quality of Americare coverage, and by extension mainstream American health care, must be high. Critics of PPACA have been quick to tarnish the law with images of government intrusion into the doctor-patient relationship. These opponents aim to trigger consumers' recall of the worst excesses of 1990s managed care,⁸⁸ as well as raise a new specter—the "nanny state"—that would violate privacy and undercut personal freedom in the name of public health. Sarah Palin followed this strategy with her attacks on PPACA, especially her allegations about government "death panels."⁸⁹ She also brought cookie trays to a school in order to portray public health efforts such as First Lady Michelle Obama's anti-obesity initiative as elitist propaganda.⁹⁰

A more measured set of criticisms suggests that government cost-cutting and controls will harm quality by sapping the motivation of American physicians and eroding the innovative capacity of the pharmaceutical, medical device, and biotechnology industries.⁹¹ Be-

⁸⁷ See DANIEL CALLAHAN & ANGELA A. WASUNNA, *MEDICINE AND THE MARKET: EQUITY V. CHOICE* 52-53, 93-95 (2006) (explaining Canada's reluctance to adopt market strategies in health care because market competition might threaten "the idea of community and solidarity in the provision of welfare for its citizens" and noting the popularity of the National Health Service in the United Kingdom).

⁸⁸ See Jim Rutenberg & Jackie Calmes, *Getting to the Source of the "Death Panel" Rumor*, N.Y. TIMES, Aug. 14, 2009, at A1 (linking conservative criticism of government "death panels" that would purportedly be created by enacting proposed health care reform to similar conservative attacks against Clinton's health care reform efforts in the 1990s).

⁸⁹ See *id.* (mentioning Palin's use of term "death panels" in reference to proposed health care reform).

⁹⁰ See Andy Barr, *Sarah Palin Brings Cookies, Hits 'Nanny State,' POLITICO* (Nov. 10, 2010, 9:55 PM), <http://www.politico.com/news/stories/1110/44936.html> (describing Palin's use of cookies to portray a proposed sweets ban in Pennsylvania public schools as the "nanny state run amok").

⁹¹ See, e.g., John E. Calfee, *Stop Taking R&D for Granted*, AM. ENTERPRISE INST. FOR PUB. POL'Y RES. (Dec. 24, 2009), <http://www.aei.org/article/101468> (critiquing health reform proposals that constrain, rather than foster, research and development within the pharmaceutical industry).

cause, as noted above, any insurance program has many contributors but relatively few claimants, it will be hard to disprove these accusations from personal experience.⁹² Similarly, it will be hard to refute the occasional horror stories that opponents will attribute to PPACA, while simultaneously ignoring millions of successful care encounters. Moreover, some of these concerns will materialize over a long period of time, if at all, and are therefore as much a matter of belief as of empirically supportable prediction.

Cost may also become a marketing challenge, even if growth in overall health expenditures slows. Prohibiting medical underwriting and limiting variability in premiums by age implies that many healthy Americans are likely to pay somewhat more for coverage so that a smaller number of unhealthy Americans can pay substantially less. Redistribution is a much harder sell than direct personal savings.

Brand messaging therefore should seek to instill a direct sense of the health system's superior quality, emphasizing both its continued devotion to traditional compassionate values and its futuristic capabilities (including advances in information technology). A quality-oriented marketing campaign should not only tout the results of formal quality metrics, an essential but underdeveloped aspect of health system management, but should also appeal to the public's seemingly boundless appetite for compelling narrative (a frequently misleading but very familiar mechanism for evaluating medical care). For example, a word-of-mouth campaign analogous to the Thatcherites' "Tell Sid" strategy might well prove effective. The campaign would ask people to share with their friends some good experience they had with care received under the new program.⁹³ Quality attributes that are likely to prove important to this campaign include: ready access to both routine and specialized services, a chance to receive care from the "best" physicians and hospitals in the community, pride in the health care system's lifesaving capacity, transparent processes for making coverage and care decisions without rationing, and the presence of state-of-the-art technology during each patient-provider encounter.

⁹² See *supra* Part III.

⁹³ See *supra* notes 16-19 and accompanying text (describing the Thatcher Administration's use of marketing strategies to recast privatization as a part of a national civic duty).

E. Associations

Based on the foregoing discussion, it is not difficult to identify the sorts of positive associations that PPACA's marketers should attempt to create in the minds of health-coverage purchasers and medical-care users. Nor is it difficult to determine which negative associations they must overcome. The following provides a rough guide:

*"Accentuating the positive"*⁹⁴:

- Affordable
- Safe and secure
- Private
- Independent
- Open to choice
- Easily available and convenient
- Technologically advanced

*"Eliminating the negative"*⁹⁵:

- Nosy and "Big Brother"-like
- Bureaucratic and impersonal
- Wasteful and expensive (for insurance)
- Cut-rate and rationed (for medical care)
- Untrustworthy because controlled by profit-oriented special interests

F. Protecting the Brand

Needless to say, messaging alone has little chance of accomplishing these extensive and complicated tasks, no matter how lavish the advertising budget, how diverse the media strategies, or how persuasive the spokespersons. The products and services delivered through Americare must also perform as promised. In other words, "latch[ing] on to the affirmative"⁹⁶ is essential to protecting any brand that the Obama Administration succeeds in establishing.

In the course of implementing PPACA, the Obama Administration must set consistent expectations for the phase-in of major statutory elements, and it must meet those expectations in terms of both timing and performance. For example, there is a long gap between PPACA's date

⁹⁴ MERCER, *supra* note 1.

⁹⁵ *Id.*

⁹⁶ *Id.*

of passage and the effective date of both the coverage mandate and its associated restrictions on medical underwriting. This gap will make it necessary for the Administration to shelter those covered by the law from serious adversity—both medical and financial—during the transition. PPACA's temporary high-risk pools, which help sicker individuals find health insurance before the law's universal coverage mandate takes full effect, therefore constitute essential brand protection. Conversely, the Administration will have to be cautious about sweeping every health-related program or intervention under the PPACA tent. Doing so may sometimes gain temporary goodwill for the newly associated program; however, it risks diluting the Medicare brand and draining the insurance expansion process of much-needed collective commitment.

Setting up state insurance exchanges and managing initial enrollment in health plans meeting PPACA's requirements in 2014 will be the critical test of the Medicare brand. It may be desirable to build public excitement in advance of the formal launch, but it is equally important to avoid widespread apprehension or dread. The enrollment process therefore will need a consistent branded message, clarity and accessibility of information, and sufficient resources for providing direct customer support. Most importantly, the choices among health plans that people currently expect must in fact materialize. On a smaller scale, many of these issues were anticipated and addressed in connection with the launch of Medicare Part D prescription drug plans three years after the enactment of the Medicare Modernization Act⁹⁷ in 2003.⁹⁸

Finally, protecting the Medicare brand means that insurance offered through the new exchanges must perform as promised. Coverage must be reliable and renewable, avoiding the annual in-and-out-of-the-market behavior of many HMOs that has long plagued the Part C managed care program for Medicare beneficiaries.⁹⁹ Health care pro-

⁹⁷ Medicare Prescription Drug, Improvement, and Modernization Act of 2003, § 101(a)(2), 42 U.S.C. § 1395w (2006).

⁹⁸ See Patricia Neuman & Juliette Cubanski, *Medicare Part D Update—Lessons Learned and Unfinished Business*, 361 NEW ENG. J. MED. 406, 406-11 (2009) (assessing Medicare's prescription drug program after three years and finding it to be generally successful). But see Jerry Avorn, *Part "D" for "Defective"—The Medicare Drug-Benefit Chaos*, 354 NEW ENG. J. MED. 1339, 1339-41 (2006) (describing initial problems with the Medicare Part D program).

⁹⁹ See Robert A. Berenson & Bryan E. Dowd, *Medicare Advantage Plans at a Crossroads—Yet Again*, 28 HEALTH AFF. w29, w32 (2008), <http://content.healthaffairs.org/content/28/1/w29.full.pdf+html> (acknowledging the drop in private plan participation in Medicare under the Medicare+Choice plan).

viders and referral services must be easily available. There should be no nasty financial surprises for families that expected generous coverage. Information must be readily accessible through familiar phone and web-based technologies. Finally, the health care workforce, including physicians, should appear happy to discharge their responsibilities under PPACA. Front-line health care providers are the key ambassadors for Americare and should not feel the need to disparage the program or undercut beneficiaries' high expectations.¹⁰⁰

CONCLUSION

The Patient Protection and Affordable Care Act fought an uphill battle to gain passage and now faces an equally difficult struggle for successful implementation. There are enormously challenging substantive tasks associated with making this massive and complicated federal law function effectively. At the same time, developing and sustaining support for the new law will require a much more advanced marketing approach than has yet been taken by the Obama Administration. Three critical steps are urgently needed: explaining the law in more intuitive terms, naming the new program of near-universal coverage the law creates, and building brand equity through an ongoing relationship between the government and individual purchasers of health insurance.

¹⁰⁰ A cautionary anecdote illustrates what to avoid. Years ago, David Letterman opened his late-night show by chatting with two United Airlines flight attendants who were in the studio audience. Asked how they really felt about passengers, one flight attendant blurted out "Passengers are the enemy!" For the rest of the show, the host periodically stopped his normal activities to intone, in mock advertising fashion, "United Airlines—where passengers are the enemy!" Thomas Swick, *Forward to the Past*, S. FLA. SUN-SENTINEL, Dec. 27, 1998, at 1, available at 1998 WLNR 6847378.