

Is higher education following the path set by health care in the U.S.?

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Abstract

The recent emergence of higher education into political and economic debate is reminiscent of the ongoing arguments about the appropriate provision of health care in the United States. Health care reform has been a political battle cry in the United States for years, and there are similar calls for reforms of higher education. These two industries share more than a place in political debate, though: Both are seen by many as necessities, both are characterized by rapidly escalating costs – and neither operates in an economic market that is anything close to “normal.” These similarities position health care and higher education for either increased government intervention or radical change. The purpose of this paper is to draw parallels between these two industries and analyze the implications of these similarities to public policy or private innovations.

Keywords: higher education, health care, cost disease, government regulation, market distortions

Introduction

In ordinary, unregulated markets, producers compete for consumer spending based on price and quality. Consumers shop for products providing the highest quality at the lowest prices, and producers accommodate them by producing an array of products and services from which they can choose. Consumer sensitivity to price forces efficiencies on the producers' side, and there is a resulting tendency for market prices to go down and product quality to go up over time. Examples of this are ubiquitous: consumers expect to pay less for and get more from a fourth generation cell phone than from the first. "New and improved" food products are regularly put on supermarket shelves, but offered at the same price as the original product. Features are added to appliances without corresponding additions to their prices. This is commonplace in a competitive market. The producer who over-prices or under-delivers is punished in the marketplace by falling sales, revenues, and profitability.

Two of the largest industries in the United States, health care and higher education, do not comply with the high quality/low cost expectation, though. In fact, they defy most of the principles taught in basic economic courses. Consumers of neither health care nor higher education react to rising prices by withholding their demand. In fact, demand for the services of both industries have increased over the past decade despite crippling price increases. Consumers do not shop around for the best deals in either, and producers do not attempt to promote themselves as low-cost providers. The reason for these unusual behaviors rests on market distortions present in both industries. Both markets are subject to "third party intervention," which alters the normal relationship between consumers and producers in free markets. In health care, this third party intervention arises through the presence of insurance; in higher education, it occurs through the presence of financial aid. In part, costs go up in higher education because students do not make decisions based on the full tuition charge. Financial aid alters student decision making, causing an escalation in "wants" that would not be considered if the students were required to pay the full cost of their provision. This is closely akin to decision-making in health care, where patients have the tendency to over consume treatments because insurance buffers them from the true cost of their care. Physician John Lilly (2011), described his personal observation of this behavior as follows:

In my office, I hear patients say, "Well, I've met my deductible for the year, so now I want my knee surgery, a heart stress test, a carotid test, or any number of tests done." There are now an excessive number of x-rays, ultrasounds, CT scans, and MRIs due to patient demand and physician compliance because an insurance company is willing to pay for them. ¶ 5

This behavior is not surprising in health care, and it should not be surprising in higher education either. It is human nature to take advantage of an opportunity, whether that opportunity presents itself as a medical test or a college state-of-the-art athletic facility. Patients request tests that are not always necessary, and students try to get as many amenities and services they can for their tuition dollars. Both systems are set up to incentivize providers and consumers to make expensive and inefficient decisions. The markets have broken down.

Necessary services

To many, both medical and higher educational services today are seen as basic necessities. This perception makes the demand for these services less price sensitive, and makes provision of their supply a social and political concern. As a result, in the United States, the government has gotten involved in making both health care and higher education affordable, and, in doing so has contributed to enormous growth in both industries.

Access to health care is seen by many as a fundamental right, and one that government should secure (Roy, 2010). Government's involvement in financing health care is a relatively new phenomenon, though, and started with the tax exemption of medical benefits after World War II. Wage and price controls following the war produced shortages of many goods and services, including labor. To attract scarce workers, firms began to offer medical care as a fringe benefit. This benefit proved to be highly attractive to workers and therefore became widespread (Friedman, 2001). In 1965, the government became directly involved in health insurance with the establishment of Medicare and Medicaid.

Today, approximately 87% of Americans have health insurance. Most of them (57%) get their insurance through their employers. Seventeen percent are over 65 and therefore get Medicare coverage and 15% receive Medicaid. Only 10% of insured Americans purchase their own insurance (Roy, 2010). Because of this, the consumer is far removed from his or her health care decisions. If the intervention of an insurance agency places a third party in the ordinarily two party consumer/producer relationship, the imposition of the employer – who then chooses the insurance company – actually places a fourth layer between the consumer and producer in health care. Needless to say, communication between consumer and producer is stifled by these additional layers.

Unlike health care, higher education was not always considered a fundamental necessity (Halaska & Manganiello, 2008). Over the past fifty years, however, the public's perception of higher education has shifted from that of a luxury available only to the wealthy to an essential service which should be accessible to all qualified adults (McPherson & Shapiro, 1991). The expansion of public higher education and the provision of government financial aid, to a large degree, contributed to that change in mindset.

The expansion of college access started in the 1960s and 1970s, as state and federal governments took steps to ensure that postsecondary education was available to all regardless of economic status (McPherson & Shapiro, 1991). Belief in the necessity of higher education has escalated over time, though, and today a college education is seen as the ticket to economic success and entry into the middle class (Merisotis, 2012). Access to this ticket, though, is expensive. As a result, the federal government has attempted to make college affordable to a large segment of the population through myriad subsidized loan and grant programs.

Prices consumers pay

Consumers of both higher education and health care services rarely pay the full price of the services they consume. Indeed, in the case of health care, the patient may not even know the full price of the treatments provided. In higher education, while the student may be aware of the published tuition rate, a large percent never pay that price, and even the published tuition does not cover the total cost of the student's education. In health care, this disconnect is caused by insurance: the consumer considers the relevant price of the service to be the copayment required.

In higher education, the distortion is caused by institutional discounting and federal financial aid. In both health care and higher education, disruption of the price signal to consumers causes irreparable damage to the functioning of the market.

Direct financial aid to provide access to higher education began as benefits to World War II veterans, and then moved to the provision of grants to low income students. Today it has expanded further, with the government involved in providing subsidies to students through Pell grants, guaranteed loans, and federal resources for work-study programs. On top of this, institutions themselves discount their tuitions to enroll students with characteristics they desire. According to the National Association of College and University Business Officer's 2010 Tuition Discounting Study Report, the average discount for entering freshmen was 42.4 percent (Fain, 2010). When choosing their college, students obviously consider this discounted out-of-pocket cost instead of the published college tuition rate. In this case, a high listed tuition, reduced by a substantial discount, actually could make a college more attractive to an applicant because the student is led to believe he or she is getting a bargain.

Not all colleges can monopolize on this type of consumer psychology, though. The ability of a college to discount is determined, to a large degree, by its access to donative resources. Colleges with large endowments, which tend to be among the most prestigious institutes, are able to offer students heavily discounted tuitions and draw upon their endowments to balance their budgets. Tuition-driven intuitions, on the other hand, which tend to populate the less-prestigious tiers in American higher education, are much more limited in their ability to discount heavily. This provides a market distortion unique to higher education. In most markets, consumers pay more for higher quality products. Prices ration most goods in the economy. The notable exception to that is with higher education. In this industry, the most desirable products – e.g. an Ivy League or elite liberal arts college education—also tend to be the most heavily discounted, and therefore the most affordable, student options. Assuming the student is able to gain admission, he or she is likely to pay lower out-of-pocket tuition expenses at the most prestigious of United States colleges than he or she would in the local, tuition-driven commuter college. This is akin to a market in which a Rolex consistently sells for a lower price than a Timex. This distortion further confounds the higher education marketplace. The fact that some students can, in fact, get “more for less” makes them unwilling to settle for the scaled-down amenities lower tier institutions can easily afford. Therefore, to remain competitive, all institutions strive to offer attractive physical, academic, and social amenities regardless of the strain this may put on their budgets. Once a student gains admission and has been offered comparable aid packages at several similarly-ranked colleges, he or she will shop around for the other perks that make college life pleasant. Today, college tours show students restaurant-style cafeterias, beautiful recreational facilities, and fitness centers that could compete with stand-alone health clubs. Once one college has added these amenities, the ones who do not lose a competitive edge.

A similar phenomenon occurs in health care facilities. Patients are charged the same copayment for services regardless of the accommodations of the doctor's office or medical center, and, all other things being equal, therefore logically will select the services of the most attractive, convenient, and up-to-date facility. As a result, doctor's offices today are much more likely to have state of the art (and expensive) technologies available onsite than they did in the past. Once one office has an ultrasound and EKG machine, for example, offices of competing

practices also purchase them to remain attractive to their patients. Once one hospital offers a beauty salon and massage center, others follow. For both health care and higher education, expensive “arms races” like these drive up costs – and commensurately cause prices to escalate (Callan & Yarrow, 2009).

In any market, though, it is the price consumers pay – not the sticker price – that affects buying behavior. In both health care and higher education, consumers make decisions based on prices far lower than the cost of the services’ provision. It is no wonder costs have risen rapidly in both industries.

Escalating Costs

The United States currently spends 2.6% of its GDP on higher education (OECD, 2006) and 17.9% on medical care (Kaiser Family Foundation, 2012). Both industries have been faced with price increases far outpacing the rate of inflation: health care expenses have increased 7% per year for the past 10 years (Roy, 2012) and the cost of a private college education has risen from 80% of per capita income in 1980 to 112% today (Butler, 2012). These rapidly rising costs for services deemed essential in the United States have put both higher education and health care in the political spotlight. Of course, the explanations for these skyrocketing costs are the subject of some disagreement.

One explanation for the price escalations in both industries rests on the demand side. In higher education, a large number of students, with access to government loans, demand more educational services. Similarly, insured Americans have increased their demand for health care services. In education, the U.S. government will subsidize the student loan, regardless of the wisdom of the lending decision. In the same way, the U.S. government will pay for medicine, regardless of how high the price and minimal the benefits. Partially as a result of this, demand in both the higher education and health care industries have risen rapidly. Escalating health care costs are the leading cause of personal bankruptcy and three quarters of the American public are deeply concerned about skyrocketing college debt (Callan & Yarrow, 2009). Today, total student loan debt has surpassed United States total credit card debt and, naturally, concerns are raised about the ultimate repayment of these loans (Butler, 2012).

A second, and complementary, reason for the rising prices focuses on the supply side of the equation. Part of the explanation for these increases is the arms race, described above, occurring in both industries. Health care and higher education also share a similar production function which provides an additional explanation, though. Costs facing both the education and health care industries have been driven up by the need for technology and expensive human labor. Both health care and higher education can be seen as suffering “cost disease” because of their labor-intensive production (Winston, 1999). In most industries, adopting technology pushes costs down, because the technology is used to reduce the need for additional, and costly, manpower. This does not hold, though, in industries such as higher education and health care that are subject to cost disease. Higher education and health care are dependent upon highly skilled and educated workforces, and the need for this expensive labor is not mitigated by the integration of technology. Because of this, when investments in technology are made, these costs are incurred on top of, rather than instead of, labor costs. Educational investments in computer labs, classroom technology, and student data systems are made in addition to, rather than instead of, faculty and staff salaries. Likewise, health care expenditures on advanced diagnostic equipment

does not reduce the need for physicians and medical staff. In fact, arguments could be made in both industries that salary expenditures rise with the adoption of technology as either existing staff are trained to use the new machines or new employees are hired to maintain them or interpret their output.

A final, and more controversial, explanation for cost escalation is waste and inefficiency in both health care and higher education operations. Again, a distinction between normal market behavior and the behavior present in these industries is useful. In most markets, producers strive to reduce their costs so that they can keep their prices low and remain competitive. Neither health care nor higher education institutions compete on the basis of price, however. This masks the destructiveness of cost disease, and increases in costs caused by investments in technology and other amenities are passed forward in the form of increased prices. The price that is increased, though, is the list price – not the one actually facing the patient or student. As discussed above, consumers of neither industry generally pay the sticker price of the service provided, so price competition is ineffective.

Instead, there even may be a perverse tendency for both types of institutions to drive up prices to glean higher revenues, paid primarily through insurance or subsidized loans (McPherson & Shapiro, 1991). In education, the oft-quoted “Bennett Principle,” named for the 1980s Secretary of Education, poses the argument that the presence of federal financial aid encourages colleges and universities to increase their tuitions to capture additional government dollars (Bennett, 1987). Research has not been able to support this principle, but there is still agreement that, if nothing else, the presence of federal financial aid drives up student demand and makes universities less sensitive to changes in their own costs. Wolfram (2005) warned that, regardless of the validity of the Bennett Principle, government’s increased involvement in financing higher education is likely to produce deleterious results, and claimed that simple economic theory supports the claim that the increased demand for higher education, fueled by government policy, has driven up tuition costs (p. 4). Given this pattern, it appears that higher education is following the path forged by health care in the United States.

The Future

If left unregulated, both health care and higher education are prime targets for creative destruction. The theory of creative destruction, advanced by Austrian-American economist Joseph Schumpeter in the 1940s, describes how radical innovation, launched by entrepreneurs, fuels economic growth by replacing older, inefficient businesses with creative and highly productive upstarts.

Harvard’s Clayton M. Christensen is the author most often associated with the application of Schumpeter’s theory to the modern technological environment. His initial work, *The Innovator’s Dilemma*, identified the principles of “disruptive innovation” and provided examples, ranging from disk drives to mechanical excavators, of industries that were fundamentally changed by small fringe firms which competed with established and highly respected frontrunners in their fields. In subsequent works by Christensen and others (Christensen & Eyring, 2012; McMahan & Loyola, 2011; Topol, 2012), the principles of disruptive innovation have been applied to both health care and higher education.

Disruptive innovation takes root when industry leaders, in the attempt to satisfy their customers more fully, overshoot their goal and begin to produce products that exceed their customers' needs. The simplest example of this might be the production of a desktop computer with more speed and memory than home users would ever require. This overkill creates a field ripe for the production and sale of an admittedly lower quality, but lower priced, product by a newcomer. The existing players dismiss the cheaper competitor as inferior and not worth worrying about. Meanwhile, a new market is born.

The cost escalations in both health care and higher education make them prime candidates for innovations. In unregulated markets, services in both industries would be unbundled, and the stripped-down, simpler, and less expensive alternatives would be made available. However, existing health care and higher education organizations are protected from this type of competition. Not only are the economic markets for both industries distorted by third party interventions, but both also are subject to the strict and complex rules of governmental and private regulatory agencies.

Although both health care and higher education executives publicly bridle against increased regulations, it is, in fact, these very regulations that shield them from competition and permit them to resist innovations. Existing firms never relish being rendered obsolete by innovative start-ups. Hallmark Cards could not have appreciated the unexpected assault by eCards. Charles Schwab could not have celebrated the launch of eTrade. In these cases, though, despite their reluctance to do so, the established firms needed to adapt their own product offerings or be left behind.

The situations facing health care and higher education are somewhat different from those typically referenced as undergoing disruptive threats, though. Regulatory agencies, both governmental and private, serve as barriers to many of the disruptive innovations in these fields. As a result, established health care and higher education organizations tend to cling to the status quo, counting on their regulators to protect consumers from the "inferior" products offered by fringe institutions appearing in their fields. This immobility, however, lays the groundwork for additional future regulatory protection. As innovators continue to emerge, more governmental controls and private agency regulations are needed to keep them at bay. The traditional firms in the industry are faced with a tradeoff between dealing with strict external control or competing head-on with their innovators.

Health care innovations that challenge the existing market include the development of retail clinics, medical tourism, and technology-enabled self care. As expected, each of these changes has been disparaged by traditional organizations in the field. In health care, though, the disdain of these newcomers has been buttressed by the protection of the existing health care regulators. Each of these innovations have been painted as low-quality, and even dangerous, intrusions into the traditional physician/patient relationship. Regulations through states, counties, and municipalities, the Food and Drug Administration, the U.S. Department of Health and Human Services, and the Joint Commission on Accreditation of Hospital Organizations have slowed progress enough to permit the existing, approved, health care providers to continue escalating their costs (Conover, 2004).

If changes are adopted in health care at this point, therefore, they will not arise from entrepreneurs, but rather through the cooperation of the federal government. The Patient

Protection and Affordable Care Act, which was signed into law on March 23, 2010, was driven by the fact that the United States health care system is one of the most expensive in the world, and that the United States spends more on health care than any other country in the OECD (Jackson & Nolen, 2010). Disruptive innovation has been blocked, and costs continue to rise. More government control has been chosen as the answer to repairing this broken market model.

Of course, this increase in government involvement is subject to heated political debate, and multiple challenges to President Obama's health care reform now are being heard in the federal courts. The challenges revolve primarily around three concerns: the penalty for not buying health insurance; the power to regulate interstate commerce; and the propriety of the mandate itself (Levy, 2011).

Regardless of the conclusion of this debate, the essential question for this research is this: Will the involvement of government in higher education escalate in the same way? Like health care, higher education is seen as an industry that is failing to fulfill its responsibility in the United States. In addition, as in health care, attempts at destructive innovation currently are thwarted by government and private agency regulations.

The story of American colleges and universities follows a refrain similar to that of other industries ripe for innovation. Costs are escalating as institutions add more and more "frills" to their existing products. Opportunities for unbundling prevail. Why should an adult student hoping to earn the credits necessary to complete his or her career pay a high tuition that covers services and facilities he or she will never be interested in using? Why should the "degree" be the ultimate measure of learning at all? Why can't students avail themselves with free open courseware throughout their lives and be recognized for the learning they have achieved in this manner?

These questions have been raised repeatedly, and responded to by multiple innovators in higher education. As would be expected, these innovations began in the fringes of the industry, as fully online career-focused programs offered credentials to busy working adults. Predictably, the established institutions downplayed the significance of these upstarts. Today, however, the innovators in higher education are arising from the most prestigious corners of American universities, and the traditional, lower-tiered corners of brick-and-mortar colleges are beginning to take note. Like health care institutions, though, these traditional colleges still feel protected by government and accreditation regulations.

While the higher education establishment continues to rest behind the protection of rules and regulations, critics continue to argue that U.S. colleges and universities are unable to provide the economy with the workers needed for the country to remain competitive globally, and there is public outcry for politicians to "do something" about the rising costs and falling productivity of existing institutions. Taxpayers are angry about the large commitment of federal funds allocated to student loans which may never be repaid. Higher education is under scrutiny, and government involvement in it is escalating.

The most recent and obvious government intervention in the industry was the signing of the Higher Education Opportunity Act (HEOA) of 2008. This act, which was passed five years overdue after a decade of work, promised to make higher education more accessible, affordable,

and accountable for its actions. The act weighed in at 1,150 pages and created 64 new programs designed to make higher education “more consumer friendly” (CHEA, 2008).

While the HEOA was reportedly about securing student access to higher education, some critics argued that the underlying motivation for much of the Act was Congressional intervention in how colleges are run (Leberman, 2008). As with health care, the public has a large investment in higher education, and the inherent cost inefficiencies of the industry, borne of the market distortions described earlier in this paper, open the door for increased government involvement. The similarities between health care and higher education are striking. Both industries provide what are deemed to be essential services with the assistance of large infusions of federal money, both are subject to cost disease and its inherent escalation of expenses, and both are the subject of public scrutiny and outrage.

Perhaps it is not too late for higher education to choose the path of innovation instead of increased regulation to repair itself. The adoption of groundbreaking changes and the unbundling of services could potentially circumvent the cost spiral that made government intervention inevitable in health care.

According to a Deloitte study, disruptive innovation can help troubled industries learn to get more from less. Although the innovations start out “less good but cheaper” than market leaders, they improve over time – and become even less expensive (Eggers, Baker, Gonzalez, & Vaughn, 2012).

In sectors of the economy where disruptive innovation is commonplace, consumers are accustomed to steady price reductions and performance improvements over time – think of computing, electronics, steel manufacturing, and telecommunications. In sectors with little or no disruptive innovation, by contrast, costs and prices generally rise over time. (Eggers, Baker, Gonzalez, & Vaughn, 2012, p. 1)

It may be too late for disruptive innovation to prevent government intervention in health care, but higher education is poised to move in one of these directions or the other. In response to the cost and price crisis in this industry, exacerbated by the threat of greater federal involvement, innovations are emerging from every corner of the higher education environment. As Kirschner (2012) wrote in the April 8, 2012 issue of *The Chronicle*, “You can hardly mention higher education today without hearing the word ‘innovation,’ or its understudies ‘change,’ ‘reinvention,’ ‘transformation’” (§ 1).

The question, of course, is whether traditional higher education is willing and able to change enough to avoid further regulation. The McKinsey (2010) study, *Winning by Degrees*, recommends new approaches for traditional colleges to streamline pathways to degrees, consolidate or shut down underperforming programs, and institute competency based programs. If existing institutions are unwilling to change, technological innovations such as massive open online courses may force many into obsolescence. Government, too, claims to endorse innovation, with the Obama administration recently threatening to tie colleges’ eligibility for campus-based aid programs to institutions’ success in improving affordability and value (Kirschner, 2012).

Innovation has the potential of transforming higher education, but the current structure of regulation, by both government and private accrediting bodies, tends to stymie this change. The barriers in place today include (1) state and federal financing systems that reward enrollment instead of efficiency; (2) accreditation based on inputs instead of outcomes; (3) a complex 50-state regulatory structure; and (4) federal regulations that discourage innovation and drive up costs (McMahan & Loyola, 2011). Established educational institutions in the United States are protected by these regulations, and therefore pose weak, if any, resistance to them. As long as the rules are in place, the competitive positions of existing institutions in the higher education landscape are preserved.

Therefore, the industries of health care and higher education have been faced with the same quandary. Each has been faced with two relatively undesirable alternatives. On the one hand, the industries could be subject to greater degrees of regulation, which would undermine their independence but keep them safe from competition. On the other hand, they work to block increased regulation, and face the formidable competition of the destructive innovators. Health care, to date, has followed the course of greater government involvement. The question is still outstanding regarding the path to be chosen by higher education.

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