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Government Language and U.S. Health Care

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ABSTRACT

Context: Concerns about the use of language as a reliable communication medium are identified. This review is a foundation for analyzing federal language regarding the healthcare industry and the efficacy of this high-cost paradoxical system. An argument is developed that government language about U.S. health care has unique, predictable features. Methods: This language-use style is exemplified using authoritative federal sources such as Executive Orders, *Federal Register* rulemaking communications, and agency administrative rule promulgations. Findings: Six distinct language attributes are identified and discussed. Conclusion: This federal language style is also a harbinger of future federal involvement in U.S. health care.

Keywords: communication styles, healthcare transformation, government healthcare policy.

INTRODUCTION

A concern exists about the clarity, integrity, and use of language as a reliable communication medium. "Words are losing their power to convince, console, and elicit joy" (Thomas 2018). Regarding the political arena, Orwell's 1946 classic essay, *Politics and the English Language,* expressed this view by concluding that "Political language … is designed to make lies sound truthful and murder respectable, and to give an appearance of solidity to pure wind" (Orwell 1970). Orwell's characterization of political language was amplified in Shuy's (1998) *Bureaucratic Language in Government & Business.* Using linguistic analysis, nine case studies demonstrated how bureaucratic language creates adverse consequences for constituents in healthcare, auto sales, real estate, consumer affairs, and product safety domains. Shuy identifies six negative characteristics of bureaucratic language. He argues that "bureaucracies can do better in their use of clear, comprehensible, accurate language… [Unfortunately,] Bureaucratic language will not go away easily, if at all … If the current state of bureaucratic language is to be improved, outsiders to these bureaucracies will need to take an active role." In 1998, Shuy was prophetic about the current and expanded status of bureaucratic language. In this paper, government language and bureaucratic language will be use as synonyms.

A recent comment about language is that "Airy, abstract words are the currency of democratic politics. Conservatism, nationalism, democracy, socialism, you have to use them, but they can easily gum up your thought" (WSJ 2019).

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In like manner, Washington Post (2021) noted,

> *[A] Pentagon spokesman … recently said that during the long U.S. undertaking in Afghanistan "the goals did migrate over time." Did the goals themselves have agency — minds of their own? Why do so many people, particularly in government, engage in such gaseous talk? Because it envelops in abstract, obfuscating vocabularies things that are awkward to defend.*

Levitin (2017) demonstrates, in statistics, words, and science, the problematic use of language:

> *First, the language we use has begun to obscure the relationship between facts and fantasy. Second, this is a dangerous by-product of a lack of education in our country that has now affected an entire generation of citizens. These two facts have made lies proliferate in our culture to an unprecedented degree.*

Higher education is building student critical thinking skills by alerting them to the deceptive use of language (Capaldi and Smit 2007). Sensitizing them to the art of deception fosters critical thinking skills across disciplines. Doing so also protects students from the deceptive uses of language and bulwarks problem-solving abilities. However, the epidemic of sub-standard writing among graduates testifies to declining vocabulary and language proficiency. This condition follows from a limited emphasis on conceptual clarity as a prerequisite to effective written communication (Zakaria 2016).

Another problem with gaseous talk is that it often involves an indirect style of communication. While direct communication focuses on "giving information" (Storti and Bennhold-Samaan 2011) and relying on the literal meaning of words (Joyce 2012), indirect communication style leaves it up to the information recipient to "decode" the writer's true intentions (Storti and Bennhold-Samaan 2011). Indirect communication places the responsibility for interpreting the message and understanding its implications on the recipient of information, whereas direct communication style places the responsibility for clarity of the message on the messenger (Joyce, 2012). Indirectness in communication can cause confusion and misunderstanding (Tanner 1994: 79). Furthermore, in the U.S., indirectness in communication is commonly distrusted (Tanner 1994: 102) and seen akin to dishonesty (Tanner 1994:85).

This use of language is a growing concern because communication and information transfer are essential for health services participants. Healthcare stakeholders, patients, providers, organizations, and others dependent on valid, reliable, and clearly communicated decision-support healthcare information. In addition, the transition of healthcare from a service to a business and political interest makes governmental communication vital for planning and regulatory compliance (Engel, 2018; Star, 1984).

Purpose

The purpose of this paper is to define a government language style regarding U.S. health care. This communication approach is unique to federal pronouncements about health services. When translated and understood, this language style defines and foreshadows government intent toward health services. This study does not argue whether federal healthcare

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pronouncements are accurate, justified, or relevant. Rather, the goal is to describe federal communications about U.S. healthcare and to presage a governmental healthcare role.

MATERIALS AND METHODS

This language-use style is found in federal Executive Orders, the *Federal Register,* rulemaking documents, and agency administrative promulgations. The following sequence of federal language examples about and actions toward U.S. health services is presented chronologically. They represent an ongoing expansion of government interest in, responsibility for, and involvement in the health industry. Each action is defined via its stated purpose, with language examples used to *describe* the necessity of federal involvement.

RESULTS

Executive Order 13335 and Electronic Health Records

President Bush's 2004 Executive Order 13335 directed the establishment of "leadership for the development and nationwide implementation of an interoperable health information infrastructure to improve the quality and efficiency of health care" (Bush, 2004). Table 1 summarizes the Order's key features.

Table 1: Executive Order 13335 Sections

No.	Focus/Issue	Description
1.	**Sec. 2. *Policy***	a) Ensures that appropriate information to guide medical decisions is available at the time and place of care; b) Improves health care quality, reduces medical errors, and advances the delivery of appropriate, evidence-based medical care; c) Reduces health care costs resulting from inefficiency, medical errors, inappropriate care, and incomplete information.
2.	**Sec. 3. *Responsibilities NHIT Coordinator***	a) … shall to the extent permitted by law, develop, maintain, and direct the implementation of a strategic plan to guide the nationwide implementation of interoperable health information technology in both the public and private health care sectors that will reduce medical errors, improve quality, and produce greater value for healthcare expenditures. b) (i) Serve as the Secretary's principal advisor on the development, application, and use of health information technology, and direct the [DHHS's] health information technology programs.
3.	**Sec. 4. *Reports***	To facilitate the development of interoperable health information technologies, the Secretary [of HHS] shall report to the President within 90 days of this order on options to provide incentives in HHS programs that will promote the adoption of interoperable health information technology.

This Executive Order heralds a unilateral federal action designed to exercise oversight of the design, adoption, and use of electronic health information management (HIM) technology. The language also reaches beyond technology to the intended impact of HIM on care delivery. Section 2 of the order (*Policy)* identifies six specific nationwide consequences that "developing a nationwide interoperable health information technology infrastructure" will have on care delivery.

Though Section 2 is a *vision* for a nationwide health information technology (HIT) infrastructure, the language conveys a government-determined intent to have positive, far-

reaching value for U.S. health services. Also, since these intended enhancements are compellingly positive, it is difficult to fault the pursuit of these objectives. Here, a hallmark of government healthcare language is its presumed positive context and tone. An additional, yet silent feature is the accusation that those responsible for health services outside of government have not performed as needed. Thus, one can "hear," in Sec 2(a), the *implicit* criticism that heretofore "appropriate information to guide medical decisions" has not been available. Yet it will be once government oversight has been established by the newly created Office and its Coordinator.

The justification for a government-established national health information technology infrastructure is the insufficiency of voluntary market actions to build this health service necessity. Therefore, the government must induce the technological development that the market failed to provide and to correct the decisions made by economic actors. This approach to the development of technologies is guided by the premise that market failure necessitates government intervention (Fritsch, 1995) and that only through government intervention can market failure be corrected and social benefit be realized (Weimar & Vining, 1992) without any admission that such solutions themselves can create failures of their own (Cirone & Urpelainen, 2013; Grossman, 2009).

Executive Order 13410 Promoting Quality & Efficient Health Care

This 2006 Order from President Bush expands his 2004 Order by a declaration to "promote federally led efforts to implement more transparent and high-quality health care" in healthcare programs administered or sponsored by the federal government (Bush, 2006).

Table 2: Executive Order 13410 directives

No.	Focus/Issue	Description
1.	**Sec. 1. *Purpose***	…to ensure that health care programs administered or sponsored by the Federal Government promote quality and efficient delivery of health care using health information technology, transparency regarding health care quality and price, and better incentives for program beneficiaries, enrollees, and providers. … to make relevant information available to these beneficiaries, enrollees, and providers in a readily useable manner and in collaboration with similar initiatives in the private sector and non-Federal public sector. Consistent with the purpose of improving the quality and efficiency of health care, the actions and steps taken by Federal Government agencies should not incur additional costs for the Federal Government.
2.	**Sec. 3. *Directives for Agencies***	**(b) Transparency of Quality Measures.** Each agency shall implement programs measuring the quality of services supplied by health care providers to the beneficiaries or enrollees of a Federal health care program. Such programs shall be based upon standards established by multi-stakeholder entities identified by the Secretary or by another agency subject to this order. **(c) Transparency of Pricing Information.** Each agency shall make available … to the beneficiaries or enrollees of a Federal health care program (and, at the option of the agency, to the public) the prices that it, its health insurance issuers, or its health insurance plans pay for procedures to

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		providers in the health care program with which the agency, issuer, or plan contracts. **(d) Promoting Quality and Efficiency of Care.** Each agency shall develop and identify, for beneficiaries, enrollees, and providers, approaches that encourage and facilitate the provision and receipt of high-quality and efficient health care. Such approaches may include pay-for-performance models of reimbursement consistent with current law. An agency will satisfy the requirements of this subsection if it makes available to beneficiaries or enrollees consumer-directed health care insurance products.

This Order identifies the government as a vanguard in proving high-quality health care provision. The Order does not directly fault non-government healthcare providers. Rather, it defines itself as a model leader using health information technology and providing quality care for federal program beneficiaries. As such, the Order is an example of communicating about healthcare by not comparing federal initiatives to other health service providers. It follows that President Bush's two Executive Orders focus on the application of information technology to healthcare delivery. Once increasing government interventions in health care are understood in the context of the transition to a post-industrial society, it follows that information management becomes a vanguard of this shift (Bell 1999). Here, the presumption of market failure and the necessity of government action is reinforced. This executive order will guide increased quality and price transparency to correct for absence of essential information. The government assumes that it has correctly diagnosed a problem and has devised an applied solution.

American Recovery & Reinvestment Act (2009)

Within a month of the 2008 election, President Obama signed the American Recovery & Reinvestment Act (ARRA). This is an allocative policy requiring the distribution of $784 billion as funds to stimulate segments of the U.S. economy, including healthcare. Specifically, $150 billion was allocated for health purposes from comparative effectiveness research to prevention and wellness initiatives (Steinbrook 2009).

HITECH Act (2009)

The Health Information Technology for Economic and Clinical Health Act (HITECH Act) is an extension of the ARRA's stimulus funds allocated for health care. The ARRA allocated $19.2 billion for incentives for hospitals and physicians to enhance the use of health information technology (HIT) and electronic health records (EHR). The HITECH Act intensified statutory leverage to adopt HIT and EHR and strengthen regulatory oversight of Protected Health Information (PHR).

The Patient Protection & Affordable Care Act of 2010

The Affordable Care Act (ACA) was enacted on March 10, 2010, with three core objectives (Berwick, Nolan, and Whittington 2008). The following table captures components of the Act that exemplify the federal language associated with each intervention (CMS 2011a; CMS 2011b; CMS 2018; IRS 2013).

Language-wise, the ACA represents a mix of engaging, encouraging, incentive-oriented opportunities with a list of highly prescriptive compliance demands and requirements.

Independent of this communication paradox, the statute is an expansive, highly directive federal intervention into U.S. health services. There are 1,200 statements noting that the "[DHHS] Secretary shall…" Each one requires a federal initiative impacting U.S. health services.

Table 3: Affordable Care Act Features

No.	Focus/Issue	Description
1.	**The Three-Part Aim**	The Affordable Care Act is a new approach to the delivery of care aimed at: (1) Better care for individuals; (2) better health for populations; and (3) lower growth in Medicare Parts A and B expenditures.
2.	**Value-based Purchasing Program**	The Centers for Medicare & Medicaid Services (CMS) promotes higher quality and more efficient health care for Medicare Beneficiaries. In recent years, we have undertaken a number of initiatives to lay the foundation for rewarding health care providers and suppliers for the quality of care they provide by tying a portion of their Medicare payments to their performance on quality measures. … The overarching goal of these initiatives is to transform Medicare from a passive payer of claims to an active purchaser of quality health care for its beneficiaries.
3.	**Medicare Shared Savings Program and Accountable Care Organizations (ACOs)**	The intent of the Shared Savings Program is to promote accountability for a population of Medicare beneficiaries, improve the coordination of FFS items and services, encourage investment in infrastructure and redesign care processes of high quality and efficient service delivery, and incent higher value care.
4.	**Medicare Shared Savings Program; Accountable Care Organizations – Pathways to Success**	Currently, 561 ACOs participate in the Medicare shared Savings Program … CMS continues to monitor and evaluate program results to look for additional ways to streamline program operations, reduce burden, and facilitate transition to risk that promote a competitive and accountable marketplace, while improving the quality of care for Medicare beneficiaries.[3] The policies … in this final rule provide a new direction for the Shared Savings Program by establishing new pathways to success through redesigning the participation options … program to encourage ACOs to transition to two-sided risk (in which they may share in savings and are accountable for repaying shared losses). These policies are designed to increase savings for the Trust funds and mitigate losses, reduce gaming opportunities, and promote regulatory flexibility and free-market principles. This final rule also provides new tools to support coordination of care across settings and strengthen beneficiary engagement; and ensure rigorous benchmarking.[4]
5.	**Community Health Needs Assessments (CHNA) for Charitable Hospitals**	**Section 501(r)(3)** requires a hospital organization to conduct a CHNA at least once every three years and adopt an implementation strategy to meet the community health needs identified through the CHNA. The CHNA must consider input from persons who represent the broad interests of the community served by the hospital, including those with special knowledge of … public health. The CHNA must also be made widely available to

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		the public. Section 4959 imposes a $50,000 excise tax on a hospital … that fails to meet the CHNA requirements for any taxable year.

Arguments giving rise to the original legislation, the subsequent language used to introduce the law, and the resultant administrative rules employed to implement the statute are examples of governmental language. The statute is bugled using social justice language yet undergirded with market justice methods. Such a mix of metaphors indicates that the original intent of government healthcare reform was only partially accomplished. The Act, in retrospect, was enacted as a foundation for building toward universal coverage (Fidler et al. 2019).

The ACA represents an expansive foray into U.S. health services, so much so that it is viewed as a reform initiative. Others contend that the Act was a simple insurance reform inroad. Independent of these characterizations, the ACA has impacted a wide scope of the health industry. The statute continues to reverberate with additional administrative regulations. It serves also as a foundation for further federal initiatives established by the 2015 Medicare Access and CHIP Reauthorization Act (MACRA).

Medicare Access and CHIP Reauthorization Act (MACRA)

This statute was enacted in 2015 with final rules promulgated in 2016 with a full implementation date of January 2017. It is important to note that MACRA focuses on physician payment and alternatives to fee-for-service (FFS) methods (CMS 2016). This emphasis is conveyed by the phrase *alternative payment models* (APMs).

Table 4: Key MACRA Elements

No.	Focus/Issue	Description
1.	**Medicare Program; MACRA Quality Payment Program**	The MACRA, landmark bipartisan legislation, advances a forward-looking, coordinated framework for health care providers to take part in the CMS Quality Payment Program that rewards value and outcomes in one of two ways: [Nos. 2 and 3] The MACRA marks a milestone in efforts to improve and reform the health care system… By implementing MACRA to promote participation in certain APMs … and by paying eligible clinicians for quality and value under MIPS, we support the nation's progress toward achieving a patient-centered health care system that delivers better care, smarter spending, and healthier people and communities. By driving significant changes in how care is delivered to make the health care system more responsive to patients and families, we believe the Quality Payment Program supports clinicians in their successful transition into APMs.
2.	**Medicare Program; Advanced Alternative Payment Models (APMs)**	This final rule…establishes incentives for participation in Advanced APMs supporting the Administration's goals of transitioning from fee-for-service (FFS) payments to payments for quality and value, including approaches that focus on better care, smarter spending, and healthier people. For clinicians interested in APMs, we believe that by setting ambitious yet achievable goals, eligible clinicians will move with greater certainty toward these new approaches of delivering care. … To these ends … we further recognize that we must provide ongoing education,

		support, and technical assistance so that clinicians can understand program requirements, use available tools to enhance their practices, and improve quality and progress toward participation in alternative payment models if that is the best choice for their practice.
3.	**Medicare Program; Merit-Based Incentive Payment System (MIPS)**	MIPS is a new program for certain Medicare-participating eligible clinicians that will make payment adjustments based on performance on quality, cost, and other measures, and will consolidate components of three existing programs. … As prescribed by Congress, MIPS will focus on: Quality-both a set of evidence-based, specialty-specific standards as well as practice-based improvement activities; cost; and use of certified electronic health record (EHR) technology (CEHRT) … Many features of MIPS are intended to simplify and integrate further during the second and third years.
4.	**Medicare Program; Incentive Under the Physician Fee Schedule**	Alternative Payment Models are payment approaches, developed in partnership with the clinician community, that provide added incentives to deliver high-quality and cost-efficient care.
5.	**Medicare Program: Criteria for Physician Focused Payment Models**	The Secretary seeks [physician-focused payment models] PFPMs meets the following criteria: (i) Value over volume: provide incentives to practitioners to deliver high-quality health care. (ii) Flexibility: provide the flexibility needed for practitioners to deliver high-quality care. (iii) Quality and cost are anticipated to improve healthcare quality at no additional cost, maintain health care quality while decreasing cost or both improve health care quality and decrease cost.

MACRA implementation, its administrative rules, and amendments display the federal language associated with expanding government involvement in U.S. health care. Subsequent reviews question whether MACRA will alter provider's clinical behavior using amended payment approaches (Spivack, Laugesen, and Oberlander 2018; Takvorian, Bejekman, and Press 2018; Wilensky 2018). Also, MACRA is a decisive federal intervention designed to amend provider behavior using the leverage of amended payment approaches (e.g., Shared Savings Program, Medical Home Models, innovative episodes payment models for cardiac and joint care). All APMs are a transition from FFS payments that diminish providers' ability to drive payments based on volume of care. This shift enables a payer to make payment contingent on achieving defined outcomes or complying with quality benchmarks.

Hospital Readmissions Reduction Program & Value-Based Purchasing Program

Government healthcare language is not unique to the *Federal Register*. It exists on other federal websites. For example, CMS.gov provides information about the Hospital Readmissions Reduction Program (HRRP) that penalizes hospitals for excess readmissions (Table 4). The HRRP is introduced in a positive way as a program that "encourages hospitals to improve" their processes related to discharge planning. The maximum 3% penalty for excess readmissions that HRRP imposes is also described in a positive tone - a "payment adjustment factor" that is "capped at 3%."

Another example of a positive and encouraging tone is in the description of the Hospital Value-Based Purchasing (VBP) program that withholds 2% of payments and allows hospitals to earn

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it back. The VBP is introduced on CMS's website as a program that "adjusts payments" and "rewards" hospitals for quality of care.

Table 5: Readmissions Reduction and Value-Based Purchasing Requirements

1	**The Hospital Readmissions Reduction Program (HRRP)**	HRRP is a Medicare value-based purchasing program that encourages hospitals to improve communication and care coordination to better engage patients and caregivers in discharge plans and, in turn, reduce avoidable readmissions. The program supports the national goal of improving health care for Americans by linking payment to the quality of hospital care. ... The payment adjustment factor is the form of the payment reduction CMS uses to reduce hospital payments...The payment reduction is capped at 3 percent (that is, a payment adjustment factor of 0.97).
2	**The Hospital Value-Based Purchasing (VBP) Program**	The VBP Program is part of our ongoing work to structure Medicare's payment system to reward providers for the quality of care they provide. This program adjusts payments to hospitals under the Inpatient Prospective Payment System (IPPS), based on the quality of care they deliver...

GOVERNMENT LANGUAGE CHARACTERISTICS

The following summarizes the distinct characteristics of government healthcare language. Knowing these features explains a federal position on health care and clarifies the vision of an expanded government industry role. Understanding the intent embedded in government language also facilitates an anticipation of future involvement – a vision accomplished via new legislation, frequent executive orders, and expanded administrative rulemaking.

Establishing Authority

One language attribute is the statement of unquestioned government authority — a position established at the outset of federal notices of action. The legislative and/or executive branch is identified as the authority for creating or implementing a healthcare initiative. Also, authority is established by referencing prior legislation as the foundation for subsequent action. "Congress passed" or "the Secretary shall" are phrases used to confirm federal authority and intended action. Also, embedded in federal expressions of authority is language conveying positive, supportive, collegial, benefits-for-all outcomes of proposed and final healthcare rules such as - "This document provides guidance for meeting the requirements and reporting obligations enacted …."

Justifying the Intervention

Justifying the necessity of a healthcare initiative is a major feature of federal language. Government language is not shy about conveying that federal interventions are transformational for health services. If the government had not acted, none of the essentials would have emerged within today's health service industry. The language is not always explicitly critical of current health services. Rather, these interventions are defined as generating transformational operating and performance outcomes that would not have otherwise occurred. This language is compelling when describing initiatives focused on quality of care, cost of services, meeting patient needs, and fee-for-service payment alternatives. An increased intensity of these justifications can be seen in federal initiatives from 2004 to the present.

Presuming of Rulemaking Collaboration and Collegiality

Federal language is paradoxical by simultaneously establishing its authority to act yet professing the pursuit of collaborative input as an expression of collegiality. Independent of language confirming that an initiative is finalized after consultation with industry stakeholders, federal authority remains preeminent. The federal rulemaking sequence unfolds with a) notice of proposed rulemaking, b) proposed rule, c) interim rule, d) interim final rule, e) final rule with comment period, and f) final rule — all conveying that stakeholders were process participants. A *Federal Register* section entitled Provisions of the Proposed Regulations and Responses to Comments confirms the nature and extent of the collaborative collegiality nature of stakeholder participation.

Amending the Behavior of Organizations and Providers

Further, federal initiatives are designed to amend the behavior of organizations and providers regarding care delivery, payments models, technology applications, clinical outcomes, and reporting results. These new performance guidelines are portrayed in engaging, enthusiastic terms that render compliance an exciting, rewarding opportunity. This language style conveys an encouraging goal of helping the provider embrace the performance benefits of adopting and complying with expanded federal healthcare regulations. *Shared savings* discussions are examples of the hospital-physician benefits derived from participation.

Outlining Non-Compliance Consequences

Federal healthcare language can define non-compliance with administrative rules in positive, encouraging ways. MACRA portrayals are excellent pervasive examples of this approach. For example, who would not want to be an *eligible professional* and be supported in improving the health of patients and encouraged in a successful transition into alternative payment models (APM)? All of this is accomplished as the burden on eligible clinicians is minimized. In the 824-page MACRA final rule, the positive terms *successful, encourage,* and *participate* are used 106, 419, and 434 times respectfully. *Sanction* and *penalize* were used 0 and 12 times respectfully. *Penalize* was frequently modified with *not* – indicating penalties are not features of MACRA provisions (CMS 2016).

Hearing What Is Not Said

Government language often conveys the opinion that healthcare stakeholders have not provided the affordable, quality healthcare the country needs and should have. However, the President's 2006 Executive Order never mentions the typical shortcomings identified in other federal healthcare pronouncements. Instead, the Order's focus is on what the government will accomplish for its program beneficiaries. In doing so, it rings a silent-but-loud faulting of non-federal healthcare leaders for being behind the service-to-others curve.

CONCLUSION AND DISCUSSION

Orwell's (1970) further characterization of government language underscores the communication difficulties created by this style. He also accounts for the intensity of partisan political language:

> *"Two qualities are common in today's writings. These are staleness of imagery and lack of precision. The writer either has a meaning and cannot express it, or he inadvertently says something else, or is almost indifferent as to whether his words*

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> *mean anything or not. This mixture of vagueness and sheer incompetence is the most marked characteristic of modern English prose and especially of any kind of political writing."*

Despite the political origins of the following promise, it does reveal the root federal-political attitude toward the country's established health industry: "We are going to at last build the health care system the American people have always deserved: … We will build a health care system that is driven by the needs of patients and the people who care for them, instead of the profit motives of big corporations" (DNC 2020). This deserved health system will provide universal coverage, control drug prices, reduce total health expenditures, and resolve health service inequities.

This review supports the argument that an escalating federal intent to regulate expanded aspect of U.S. health services is embedded in government language. This awareness heralds future healthcare policies and regulatory activities. In addition, government language is a unique, skilled language style that adumbrates aspects of governmental intent and assumptions about the essential value of federal oversight of health services. This language arena is anchored in unspoken, yet assumed, conclusions about the limitations or weaknesses of current health services. The federal communication style is rife with indirectness, a feature that places an interpretative burden about legislated implications for health care on organizations and administrators. The cost of reading between the lines or hearing what was not said is difficult to quantify. Thus, discerning federal intent is often left to outsiders (Fidler et al. 2019). Finally, there is every reason to believe that healthcare bureaucratic language will continue and amplify an essential government role for assuring nationwide access to affordable quality healthcare.

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