The Affordable Care Act: The Current Driver of Healthcare Reform

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Overview

Despite strong public support for healthcare reform, the United States remains the only industrialized country without universal access to health care. The Affordable Care Act (ACA) is changing that landscape. It is a means to fill the gaps that currently exist through the provision of low-cost insurance and high-quality care. It aims to control costs through financial incentives that should improve care coordination and patient outcomes. Although the program met tremendous resistance since it was debated in Congress, it represents an important step to ensure access and quality care for all.

Objectives

- Understand the ideological debates that define the politics of national health insurance in the United States.
- Explain why President Obama made national health insurance a centerpiece of his first-term legislative program and how he succeeded in seeing the bill signed into law.
- Describe the features of the ACA, including the role of the individual mandate, adverse selection, cost control, and quality initiatives.
- Explicate how the ACA addresses problems of access, cost, and quality.
- Assess the status of implementation.

Introduction

Health reform is not a new topic on the public policy agenda. Despite strong public support for universal coverage, it has been an intensely debated issue for more than 100 years. The United States, however, remains the only industrialized country without universal access to health insurance that affords appropriate entry to the U.S. healthcare system (American Public Health Association, 2013). Lacking adequate health insurance means that upwards of 55 million persons have only limited access to this country's costly and complex system of health services (Schoen, Osborn, Squires, & Doty, 2013). This gap in health insurance coverage and access to care exists despite the fact that the United States spends almost twice as much as any other country on health care. In 2011, the World Bank reported that the United States spent 17.9% of its gross domestic product (GDP) on health care, while the average healthcare expenditure for the 13 highest-income countries, which includes the United States, was only 12% (Organisation for Economic Co-operation and Development, 2014; World Bank, 2013).

This chapter examines past efforts to create a program of national health insurance and the rejection of reform legislation. It then looks at how the policy lessons from these earlier efforts enabled President Barack Obama to craft a legislative program that garnered the support of the major healthcare lobbies and the majority of members of Congress. Consideration is then given to what is included in the ACA and what it is expected to achieve in terms of improved access, quality, and cost control. The last section reviews implementation and considers the persistence of opposition to the legislation.

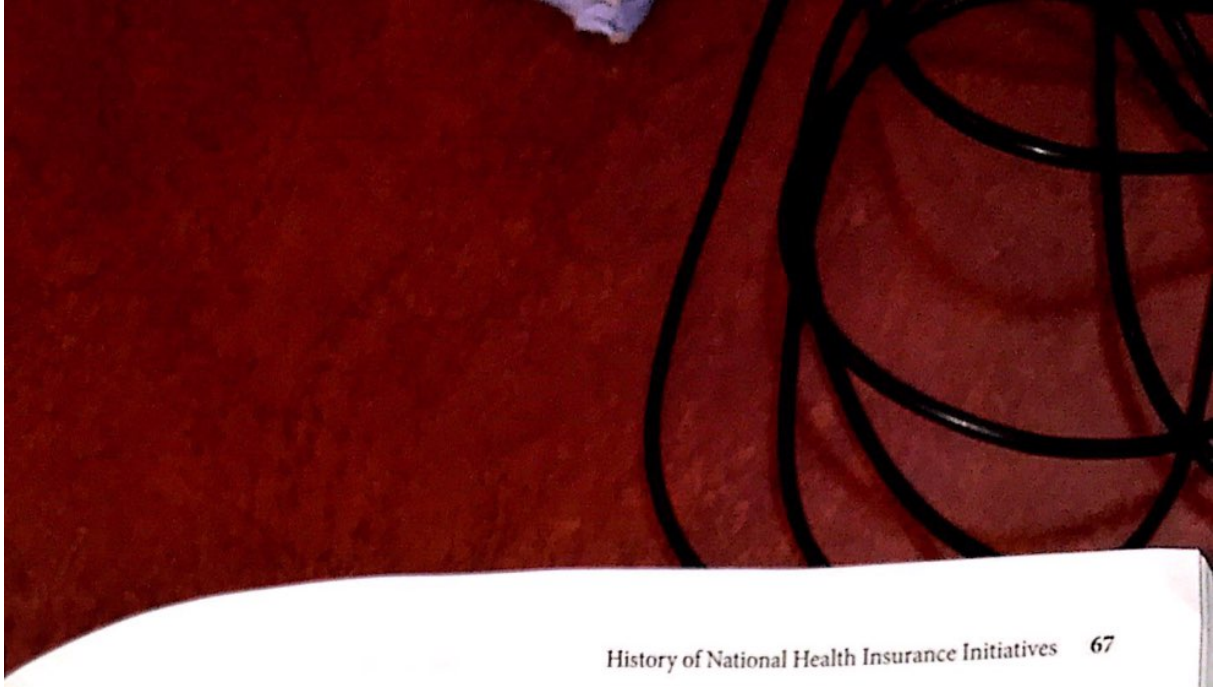
History of National Health Insurance Initiatives

National health insurance is an issue th
has come on and off the public agenda si
the turn of the 20th century. There are al
distinct economic, political, and social iss
that shape the debate in each era, but there
also issues that remain constant over time.
first concern is access to affordable health c
for all Americans and whether universal ac
requires some form of compulsory or natio
insurance. The second is cost and whether
rapidly escalating costs of health care are be
contained through government intervention
or the market. Both are tied to Americans'
unfailing fear of government intervention.
result, there is constant tension about whet
government programs can be understood a
advancing the cause of national health insu
ance or ensuring an adequate safety net for
sons who cannot access the healthcare mar

Social Insurance and the American Context

More than 100 years ago, Germany's cha
cellor, Otto von Bismarck, led his country to
adopt a system of social insurance that inclu
compulsory sickness insurance to protect w
ers from lost wages due to illness (Steinmo &
Watts, 1995). Similar systems were legislated
Austria, Hungary, Norway, Serbia, Britain, R
sia, France, Switzerland, and the Netherland
Social insurance was a political compromise
between the business owners and the workin
class. It responded to the growing political di
content over industrialization by protecting
jobs and income of workers who became sick

In the early 19th century, a program of
national health insurance seemed politically



feasible in the United States following passage of the workers' compensation laws between 1910 and 1913. Social reformers came to believe that a program of compulsory insurance against sickness, like the compulsory insurance against industrial accidents, was possible (Starr, 1982). Similar to the health insurance programs in Europe, it was seen as a way to offset wage losses and reduce the total cost of illness by providing medical care. The first model for a national proposal in 1915 was put forward by the American Association of Labor Legislation (AALL).

Despite high expectations for passage, no action was taken (Fein, 1989). Broad-based support for the proposal was missing because the two major interest groups were internally divided. Among physicians, the proposal was supported by the American Medical Association (AMA), which at the time was dominated by academics. They understood national health insurance as a way to advance the centralization of medical practice in hospital-based specialized group practices. The local medical societies, however, whose members feared that support of specialized group practices would undermine the role of solo practitioners, opposed the proposition. Labor also vacillated in its support of the AALL's proposal. Sickness funds would help build union membership, but they would result in higher dues.

Further undermining the cause was the absence of a clear mandate for federal intervention. The well-being of the population fell under state jurisdiction (Rich & White, 1996). This made it extremely difficult for the federal government to justify a role in protecting the social welfare of the population. Although Theodore Roosevelt supported the proposal, his defeat by Woodrow Wilson, who did not

less political support to advance the program. When America entered World War I in 1917, national health insurance was essentially off the public agenda.

The Great Depression and the Reconsideration of National Health Insurance

Franklin Delano Roosevelt was the first president to support national health insurance while in office. The Social Security Act of 1935 initially included a program of compulsory insurance, which was among the most contested parts of the legislative debate. To avoid jeopardizing passage of a bill that would create a wide array of programs to protect the economic and social well-being of the American public, national health insurance was eliminated from the Social Security Act before the legislation was presented to Congress (Falk, 1977).

Both the proposal for national health insurance and its elimination from the legislation were grounded in the work of the Committee on the Cost of Medical Care (CCMC) (Fein, 1989). The CCMC was a commission supported by eight foundations charged with examining the rising cost of medical care. In forming its recommendations, the committee was split on the same issues that divided the medical profession 20 years earlier. There was no consensus as to whether medical services should be provided through organized group practices or through private doctors. In addition, the committee did not agree on whether there should be compulsory health insurance or a system of voluntary prepayment for medical care. To present a single report, the CCMC came out in favor of group practice and voluntary insurance (Fein, 1989). Because of the CCMC's support

(Skocpol, 1995). Opposition was heavily funded and effectively reached their target market. Republicans were further able to play on the public's fear of large government and the possible loss of freedom that might ensue, and President Clinton did not defend accusations made about the bill. The legislation did not make it to a vote in either house.

Growth in the Number of Uninsured People

With the failure of the Clinton proposal, the number of uninsured people in the United States continued to grow. The U.S. population grew by 15% in the years between 1994 and 2009, while the number of uninsured people increased at more than double that rate. By 2009, the U.S. Census Bureau's Current Population Survey counted 50 million uninsured people—about one of every five U.S. residents younger than age 65. Had the mostly federally financed State Children's Insurance Program (SCHIP) not greatly expanded Medicaid's reach, the number of uninsured people would likely have hit 65 million by 2009 (Kaiser Family Foundation, 2009). At its creation in 1997, SCHIP was the largest expansion of taxpayer-funded health insurance coverage for children in the United States since the establishment of Medicaid in 1965. But the number of uninsured people remained high and could be described in the following ways (Kaiser Family Foundation, 2013a):

- Sixty percent of uninsured people live in families where at least one adult is a full-time worker. Fifteen percent also have a part-time worker in the family.
- Thirty-seven percent of uninsured people are very poor and live in families be
- moderate-income families (below 4[illegible] federal poverty standard) accounted for [illegible] but 10% of the uninsured population.
- Children are the least likely age group to be uninsured. Young adults are the most likely.
- The uninsured population varies greatly across the country. In 2012, 27% of Texans younger than age 65 were uninsured, as were 27% of Nevadans and 25% of Floridians. In contrast, only 4% of Massachusetts residents lacked coverage (as a result of the 2006 reform), as did 9% of Vermont and District of Columbia residents.
- A total of 8 in 10 uninsured people are U.S. citizens.

By the early 2000s, a great deal was known about the effect of being uninsured. First were health impacts. According to the Kaiser Family Foundation, "uninsured patients have increased risk being diagnosed in later stages of disease, including cancer, and have higher mortality rates than those with insurance" (2013d). Although uninsured people are more likely to be admitted to a hospital when suffering from an avoidable health problem, they are less likely to receive needed services. (Kaiser Family Foundation, 2013b). In fact, a 2009 study conducted by faculty at the Harvard University School of Public Health attributed 45,000 deaths to the lack of health insurance (Wilper et al., 2009).

The growing number of uninsured people was also causing problems for safety-net institutions that served them (often in an emergency) and for other providers who were facing an increasing burden of uncompensated care (Hadley & Garrett, 2010). Most uninsured people

in the United States were associated with medical bills. While many in financial trouble had inadequate insurance, a disproportionate number of filings were made by uninsured people.

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Massachusetts Acts Alone

In 2005, about 10% of the Massachusetts population younger than age 65 was uninsured. The Massachusetts legislature chose to take action. Their reasons were the same as those that motivated the Clinton health plan and would greatly influence the development of the ACA: increasingly expensive health care and health insurance that fostered growth in the number of people who were uninsured and unable to receive regular care. The resulting stresses were apparent on individuals and families as well as institutional providers (Symonds, 2006).

Between 2004 and 2006, the Affordable Care Today (ACT) coalition of community, labor, and political groups waged an energetic campaign that included collecting 75,000 signatures on a petition for state action to expand coverage. By April 2006, the Democrat-led state legislature and the Republican Governor Mitt Romney forged a compromise for a comprehensive one-state universal health insurance program. Its design and features presaged many of the elements incorporated into the ACA. Among the key features were the following (Kaiser Family Foundation, 2012a):

- Dependence on the continuation of employment-based coverage as the linchpin of coverage while using state programs to make insurance more affordable and accessible.
- The Commonwealth Health Insurance Connector, an exchange offering curated commercial products under the rubric of either the subsidized Commonwealth Care program for low- and moderate-income uninsured residents or nonsubsidized Commonwealth Choice plans.
- Insurance market reforms that required insurers to offer coverage to any eligible individual regardless of health status and health history. The state also created affordability standards in the commercial marketplace.
- Medicaid and SCHIP expansions to low-income families living below 300% of the federal poverty standard.
- Employer requirements to help pay the cost of coverage by any employer of 11 or more workers.
- Individual mandate to have insurance or pay a substantial penalty.

Obama and the Patient Protection and Affordable Care Act of 2010

The decade since the failure of the Clinton plan was marked by steeply increasing healthcare costs and declining levels of insurance coverage. Between 1999 and 2009, insurance premiums increased by 131% (Jacobs & Skocpol, 2012). The 2008 presidential election took place at the apogee of the 2008–2009 recession, during which, along with the loss of millions of jobs, loss of employment-based coverage accelerated. From its height in 2000, the percentage of people younger than age 65 who were covered through employment had declined each year. In 2009, employment-based insurance covered only 59% of U.S. residents younger than age 65 (U.S. Census Bureau, 2011). At the same time, the dip in the rate of economic growth further highlighted the effect healthcare spending had on the economy. In 2008, it was projected that health care would consume 15.2% of the GDP. It was difficult to imagine how the United States could restore a vibrant economy without finding some way to contain healthcare costs. Paradoxically, both Republican and Democratic candidates for major office argued for investment in national health insurance as a key mechanism to relieve the economic crunch.

As promised in his campaign, Barack Obama undertook health reform as the major initiative of his first term. The Obama administration's proposed health reform legislation was politically and programmatically modeled on the successful Massachusetts program (Kingsdale, 2009). His plan provided for the expansion of private insurance for moderate-income people who were uninsured and the Medicaid program for vulnerable populations. Central to the bill's intent were numerous provisions designed to control health spending through the eventual reorganization of delivery system. The bill also included regarding regulation of the existing insurance market to make commercial insurance more affordable, more comprehensive, and more equitable.

Extrapolating on the 1993 debacle and replicating some of the Massachusetts experience, Obama reached out to representatives from Congress and healthcare stakeholders to build broad-based, nonpartisan support for proposal. From the start, he faced opposition from the minority Republican party. But with enough Democratic strength in the Senate to prevent a filibuster, the administration forged ahead and sought a bipartisan proposal.

To bolster the administration's case, major lobbyists for hospitals, physicians, insurance companies, and the pharmaceutical and medical supply industries, who had been skeptical of health reform efforts in the past, were brought into the process (Jacobs & Skocpol, 2012). They were promised access to 25–30 million newly insured Americans which would increase public healthcare spending by an estimated $1 trillion over the next decade. In addition, negotiations were held with each set of stakeholders to address their concerns regarding overregulation, the prohibition of price negotiations, and the reach of a public option.

The bills that would become the ACA passed the Senate in late December 2009 with no Republican votes. Then in January, the election of Scott Brown to fill the vacancy left by the death of Senator Ted Kennedy made it absolutely incumbent that the House accept the Senate bill so that it need not come back for Senate reconsideration. Despite repeated

rebuffs from Democratic and Republican House moderates, Obama doggedly pushed ahead and kept the possibility of legislation alive. In the hopes of securing his Democratic base in the House of Representatives during the early winter of 2010, the administration conceded such key provisions as the creation of a public option and federal funding for abortion.

In the end, Obama's attempt to craft a bipartisan approach to health reform fell apart, and the legislation passed with the support of every Democrat in the Senate and 219 Democratic members of the House. No Republicans voted for the bill in either house. On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA), and on March 30, 2010, he signed the Health Care and Education Reconciliation Act (HCERA) (Cannan, 2013). Together, these two pieces of legislation are called the *Affordable Care Act* or *ACA*. The term *Obamacare* is often used to refer to the legislation. It was a derogatory term coined by House Republicans, but Obama started using it as a way to destigmatize the expression.

The Affordable Care Act: What Is Included

The ACA was intended to move the United States incrementally closer to universal national health insurance. In doing so, it contained requirements regarding access, cost, quality, and organization and delivery of care that may, if implemented, transform much of the U.S. health system. As can be seen in Table 4-1, the legislation included a broad array of provisions (Kaiser Family Foundation, 2013b).

Table 4-1 ACA Provisions by Year

2010
Review of health plan premium increases
Changes in Medicare provider rates
Comparative effectiveness research
Prevention and Public Health Fund
Medicare beneficiary drug rebate
Small business tax credits
Medicaid drug rebate
Medicaid coverage for childless adults
Reinsurance program for retiree coverage
Preexisting condition insurance plan
New prevention council
Adult dependent coverage to age 26

(continued)

Table 4-1 ACA Provisions by Year *(continued)*

	Consumer protections in insurance
	Insurance plan appeals process
	Health centers and the National Health Service Corps
	Health Care Workforce Commission
2011	
	Minimum medical loss ratio for insurers
	Closing the Medicare drug coverage gap
	Medicare payments for primary care
	Medicare prevention benefits
	Center for Medicare and Medicaid Innovation
	Medicare premiums for higher income beneficiaries
	Medicare Advantage payment changes
	Medicaid Health Homes
	Chronic disease prevention in Medicaid
	National quality strategy
	Funding for health insurance exchanges
	Nutritional labeling
	Medicaid payments for hospital-acquired infections
	Graduate medical education
	Medicare independent payment advisory board
	Medicaid long-term care services
2012	
	Accountable care organizations in Medicare
	Uniform coverage summaries for consumers
	Medicare Advantage plan payments
	Medicare provider payment changes
	Fraud and abuse prevention
	Annual fees on the pharmaceutical industry
	Medicaid payment demonstration projects
	Data collection to reduce healthcare disparities
	Medicare value-based purchasing
	Reduced Medicare payments for hospital readmissions

2013

- State notification regarding exchanges
- Medicare Bundled Payment pilot program
- Medicaid coverage of preventive services
- Medicaid payments for primary care
- Flexible spending account limits
- Medicare tax increase
- Employer retiree coverage subsidy
- Tax on medical devices
- Financial disclosure
- Co-op health insurance plans
- Medicare disproportionate share hospital payments
- Medicaid disproportionate share hospital payments

2014

- Expanded Medicaid coverage
- Presumptive eligibility for Medicaid
- Individual requirement to have insurance
- Health insurance premium and cost-sharing subsidies
- Guaranteed availability of insurance
- No annual limits on coverage
- Essential health benefits
- Temporary reinsurance program for health plans
- Medicare Advantage plan loss ratios
- Wellness programs in insurance
- Fees on health insurance sector
- Medicare payments for hospital-acquired infections

2015

- Employer requirements
- Increase federal match for CHIP

2016

- Healthcare choice compacts

2018

- Tax on high-cost insurance

The Affordable Care Act: What Will Be Achieved?

More People Covered: The Individual Mandate

A central goal of the ACA is to extend affordable health insurance to uninsured American citizens and legal immigrants through a variety of mechanisms: Medicaid expansion for people with very low incomes and commercial products that would be affordable through sliding-scale tax subsidies for everyone else. The law requires near universality of participation through the individual mandate that, in 2014, requires all American citizens and legal immigrants to have basic health insurance or pay a tax penalty. Through these mechanisms, the framers of the ACA anticipated expansion of public and private health insurance to 30 million currently uninsured people.

Half of that expansion is to be through recalibration and federalization of Medicaid eligibility. The federal government is budgeted to pay virtually the full cost for all individuals and families with incomes under 138% of the federal poverty level. With the goal of helping young people with very low incomes to have coverage, the ACA has a special Medicaid entitlement provision for them (Jacobs & Skocpol, 2012). The impact of this provision, however, was limited by the Supreme Court decision in 2013 that upheld the constitutionality of the ACA but left the option of Medicaid expansion up the states. Twenty-four states have yet to opt in—leaving nearly 5 million adults ineligible for their home state's Medicaid program and too poor to qualify for federal assistance to purchase insurance on their own (Kaiser Family Foundation, 2013c).

Individuals younger than age 65 who a
not eligible for Medicaid are expected to
health insurance either through their em
or by purchasing it through a health exch
There are a variety of provisions to encou
age employers to provide coverage for the
employees and their dependents. Employe
with more than 50 full-time employees m
offer minimal affordable coverage or be su
ject to fines. In addition, the law provides
significant tax credits to incentivize small
employers of low-wage workers and not-for
profit organizations to provide health bene
for their employees. The law also requires
employers who offer family coverage exten
it to young adult children, and it sets certa
minimum standards and coverage provisio
(American Public Health Association, 2012
the ACA succeeds in expanding coverage a
lowering healthcare cost increases, employe
and their workers will be among the prima
beneficiaries of the law.

Most people who do not have employer-
based plans can purchase insurance throug
state-run health insurance exchanges or ma
ketplaces. The principle behind the exchan
is that by pooling many people, no individu
or small group will have to bear a dispropo
tionate share of the cost. In some ways, the
exchange will act as a surrogate for a large
employer, where insurance pooling happens
naturally.

To address the issue of affordability, those
with an income less than 400% of the poverty
level can receive tax credits to reduce their
premiums when they buy coverage through
the exchange. To further enhance afford-
ability, those who earn less than 250% of the
poverty level can participate in cost-sharing
programs. With cost sharing, the coverage ha
lower deductibles and copayments that are pa

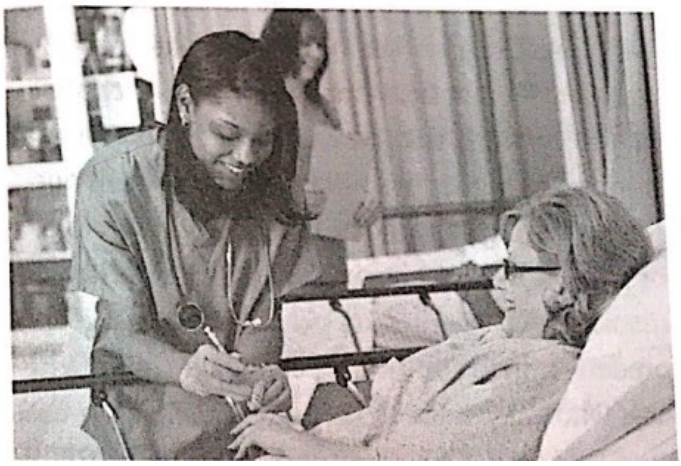
cannot be denied
anticipated health care utilization or cost (insurability). This is called guaranteed issue. In 2010, children and adults in some states who had previously been turned down for insurance because of preexisting conditions and had been uninsured for 6 months or longer were able to obtain coverage. In 2014, the ACA extended guaranteed issue to all adults in all states. Not covering people who are expected to use healthcare services makes insurance less costly. For insurance to be affordable and at the same time eliminate insurability requirements means that everyone—healthy or sick—must be in the pool. Without the individual mandate, some healthy people would opt out of insurance and pay for it only when they need it. The result would be ever-escalating premiums because only the sickest people would be in the pool (Alliance for Health Reform, 2012).

The exchanges are intended to simplify much of the complexity of health insurance by allowing consumers to comparison shop for the best affordable option. They have an overview of premiums versus deductibles, copays versus network size, and so forth. The theory is that the information available on the mostly online exchanges will provide an incentive for higher quality treatment at a lower cost. In some ways, the exchange model is a return to Clinton's

(Kaiser Family Foundation, 2014).

More Benefits and Protections

Public and private insurance companies must now provide 10 essential health benefits to participate in state exchanges: outpatient (ambulatory) care; emergency services; hospitalization; maternity and newborn care; mental health and addiction services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive services, such as vaccines and chronic disease management; and pediatric services, including oral and vision. In addition, many preventive services—such as mammograms and colonoscopies; flu, mumps, and measles vaccinations; and blood pressure and cholesterol screenings—are included for free; neither copays nor deductibles can be charged.



The exchanges offer four tiers of coverage plus a limited catastrophic plan. The tiers are based on the percentage of costs (actuarial value) that the health plan can be anticipated to cover based on a typical group of enrollees. The coverage options ranges from the bronze tier, which covers 60% of expected costs, to the platinum tier, which covers 90% of costs. In between are gold (80%) and silver (70%) tiers. Every enrollee's out-of-pocket expenses are capped at $6,250 in 2014. The caps in subsequent years will be adjusted for inflation. Regardless of tier or plan design, the plan is responsible for all covered expenses in excess of the out-of-pocket maximum. Within these broad limits, insurance companies are free to invent plans with widely different features—networks, coinsurance, deductibles, and copays. They are required only to explain their offerings in a common prescribed format that was developed to allow consumers to compare one plan with the next (Levitt, Claxton, & Pollitz, 2012).

The ACA does not regulate insurance company premiums—that job is left to state insurance agencies—but it does impose some restrictions on rate setting. First, insurance companies may not charge higher premiums for individuals due to preexisting conditions, use of health services, or gender. Depending on preemptive state law, insurance companies are permitted to charge a predetermined additional percentage for individuals who smoke, are older, and reside in high-cost medical areas (Kaiser Family Foundation, 2012b). Insurance companies are required to spend at least 80 or 85% of insurance premiums on medical services depending on group size. This is called the medical loss ratio. In the year after the ACA was passed, many Americans received payments from their insurance companies because a greater percentage of their premiums was being spent on administrative support than allowed by law.

There are a number of new transparency requirements, including annual reports on track quality improvement efforts. To a large extent, the areas that are being tracked align with the National Quality Strategy. Measures include strategies to improve health services, patient outcomes, and population health. They include harm reduction, promotion of patient-centered care, and the proper use of electronic records, among others. A new not-for-profit organization, the Patient-Centered Outcomes Research Institute, will identify, research, and compare clinical effectiveness treatments (Kaiser Family Foundation, 2012a).

Cost Control through Medicare Reconfiguration

The implementation of all health insurance subsidies built into the ACA was projected to cost $1 trillion between 2013 and 2022. None of the money will be paid from the government's tax-generated general fund. Instead, all the money is expected through reductions in federal spending on Medicare and Medicaid, additional revenue from taxes on insurance companies and other parts of the healthcare industry, higher premiums from higher income Medicare beneficiaries, an increase in Medicare tax from people who earn $200,000 or more, and a general slowdown in healthcare spending over what was projected prior to enactment of the ACA. In other words, the ACA is premised on reducing the rate of growth of healthcare costs. The largest reduction in the rate will come from changes in the way Medicare pays for care. Embedded in the ACA are plans to reduce Medicare payments to providers by $716 billion over a 10-year period.

Medicare spe... in the special allowance the gover... to the Medicare Advantage plans. There are numerous provisions related to provider payments to reduce the growth in future Medicare payments, including smaller annual adjustments and reducing special payments to hospitals that currently serve the uninsured population. Most of the details were to be designed by a new Independent Payment Advisory Board, whose 15 members were to be appointed by the president and confirmed by the Senate. Although the ACA contains the legislative authority to create the board, its establishment has been caught in the web of partisan politics, and as of June 2014, no appointments had been made.

Among the most promising payment reform initiatives is Accountable Care Organizations (ACOs), in which groups of doctors and hospitals or other healthcare providers take responsibility for the care of 5,000 or more Medicare beneficiaries. The federal government will share savings with an ACO if, at the end of a period, costs are contained and care is not compromised. Quality standards must be met. If, on the other hand, costs rise more than expected or quality is not maintained, the federal government may penalize the ACO. On January 1, 2014, there were 366 federally qualified Medicare ACOs across the country (Muhlestein, 2014).

The ACA also addresses the problems of persons who receive both Medicare and Medicaid or are dually eligible (McDonough, 2011). There are 9 million people who are dually eligible. On average, they are far less healthy than other Medicaid or Medicare beneficiaries and account for a disproportionate share of both Medicare and Medicaid payments (Coughlin, Waidmann, & Phadera, 2012). The ACA is responsible for coordination be... federal government and the states to improve access and care coordination for this population. Improving care coordination is essential to reduce hospital and nursing home admissions, improve outcomes, and lower costs.

Increasing Primary Care Capacity

By expanding access to health insurance, it is important that there is the capacity to serve people who are newly insured. Several initiatives have been put into place. The ACA aims to induce more MDs and nurse practitioners to practice primary care by increasing reimbursement for their services. Medicare provider payments are increasing 10% for primary care services and for general surgeons who practice in underserved communities from 2011 through 2015. Medicaid will increase provider payments for primary care services to be equal to Medicare Part B. States will receive 100% matching funds from the federal government to fund the payment increase (Centers for Medicare and Medicaid Services, 2014).

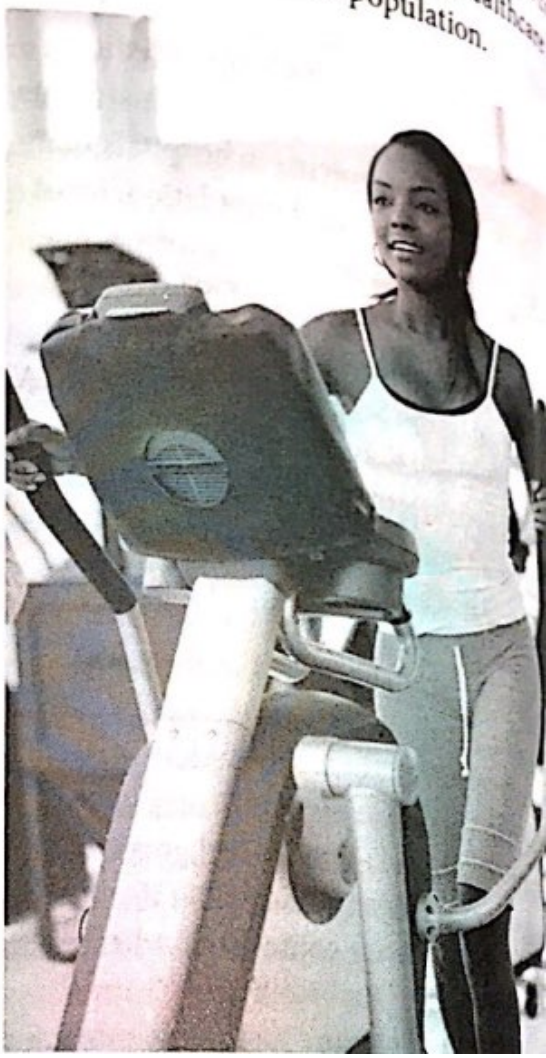
Grants are available for primary care residencies in underserved areas and teaching hospitals that help low-income students become physicians, as well as graduate-level nursing education, under Medicare. The loan repayment program is offering primary care professionals, such as nurses and physicians, funds to repay student loans in exchange for 2 years of service working in underserved areas. Grants for nurse practitioners who are providing primary care in federal health centers and clinics are also available (Kaiser Family Foundation, 2012a).

Through the ACA, new funding has been allocated for community health centers and school-based health centers. The funds will be used to create centers in underserved areas and expand preventive and primary care services at existing centers.

Improved Public Health

The United States healthcare delivery system is often referred to as *disease care*. The ACA endorses an evolution toward a system that is grounded in prevention and health promotion. A number of initiatives have been put forth in support of this shift in thinking and practice. The Prevention and Public Health Fund (PPHF) was created "to provide for expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public health care costs" (Patient Protection and Affordable Care Act, 2010). Over 10 years, $15 billion will be spent on state and local public health initiatives (American Public Health Association, 2013). This is the first mandatory public health fund. The PPHF supports the work of the Centers for Disease Control and Prevention and the Health Resources and Services Administra-

underserved populations (Centers for Dis
Control and Prevention, 2012). CTGs are
sector collaborations that bring healthcare
delivery systems to the population.



calorie labeling on menu boards, drive-through windows, and vending machines. Additional nutritional information must be available at the customer's request (McDonough, 2011).

Politics of the Transition

Court and Medicaid Expansion

The opposition to the ACA has been strong. Not a single Republican member of the House or Senate voted for the law in 2009–2010. Since then, thousands of business, political, religious, and community groups have lobbied and demonstrated against the law. Approximately once per month, the Republican-controlled House passes a defunding bill that has no hope of passage in the Democratic Senate.

The most significant challenge to the law came through the courts. Twenty-five Republican governors, together with the National Federation of Independent Business and a number of related organizations, challenged the constitutionality of the individual mandate and the Medicaid expansion. On the last day of the 2011–2012 term, the Supreme Court found the individual mandate to be constitutional but issued a complicated decision on the Medicaid issue. A majority of the justices found that states did not have adequate notice to voluntarily consent, therefore the secretary of Health and Human Services could not make payment of all Medicaid funds contingent on agreeing to expand. The court's majority did not invalidate the expansion section of the law, but it eviscerated the federal government's ability to enforce it. Medicaid expansion has now become a state option (Liptak, 2012).

The Disaster of Going Live

Political opposition to the ACA gathered momentum after October 1, 2013, when the much-anticipated exchanges opened for business. Despite many heartwarming stories about persons who did not have health insurance for 6, 8, or 10 years due to preexisting conditions, the process of purchasing insurance through the exchanges proved more difficult than anyone imagined (Cohn, 2013). While some people were easily able to purchase insurance, others made multiple failed attempts. Somewhat fewer problems were reported by the states that opted to run their own exchanges. Correcting these problems has been a top priority for the Obama administration.

Many people were disappointed by what they were offered on the exchanges—plans that were too costly, too few providers, deductible or copays that were too high. One person reported looking for a family plan but could not find one that had a pediatrician within 20 miles of her home. Another found that her life-sustaining prescription drugs would not be covered. Even with the significant technological and information difficulties, the exchanges reached more than 100% of their target enrollment by March 31, 2014, the official end of the open enrollment period. As of that date, 8 million people had enrolled in an exchange plan, and another 4.8 million had been found eligible for Medicaid and CHIP (Assistant Secretary for Planning and Evaluation, 2014).

Conclusion: Change the American Way, an Incremental Step

The ACA is changing the landscape of the healthcare delivery system in the United States. Designed to fill insurance gaps that currently

Discussion Questions

1. How would you explain the political and cultural resistance to national health insurance in the United States?
2. How does the ACA move the United States closer to providing health insurance coverage to all Americans?
3. How will the ACA help control costs and improve the quality of care?
4. Given the limits of the ACA and the difficulties encountered in implementing the exchanges, what policy changes would you recommend to provide health insurance to those who remain uninsured?

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