

Evolution of Health Reform: The Affordable Care Act

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Hofstra University's Thirteenth Presidential Conference

Barack Obama: 44th President of the United States April 19-21, 2023

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Abstract

President Obama, succeeded in passing the first meaningful health reform in the United States, with the Patient Protection and Affordability Care Act (ACA) since the passage of Medicare and Medicaid in the mid-1960s. Many of ACA's provisions built on those of prior health reform attempts. The process of successful passage included the employment of lessons learned from prior unsuccessful attempts. President Obama through ACA, sought to increase the number of insured individuals, through enhanced availability of affordable health insurance. The multi-pronged approach included: expanding Medicaid financial eligibility for those earning approximately one-third over the Federal Poverty Level (FPL), providing insurance premium subsidies for those earning up to 400% of FPL, mandating equal premium payments without regard to health status or gender, prohibiting denial of insurance for pre-existing conditions, mandating large employers to provide health insurance, and permitting children up to the age of 26 to remain on their parents' health insurance plans. Its passage was successful in reducing the number of uninsured with a drop in non-elderly uninsured by more than 40% or approximately 20 million individuals between 2010 and 2016. For some, the provisions of ACA went too far with its changes. For others it did not go far enough, as the health insurance system is still dominated by for-profit insurers, and continuance of other public health insurance programs. Despite the many challenges and recent elimination of the individual mandate, the success of ACA endures with recent reductions in the number of uninsured and record-breaking enrollments in ACA's marketplace plans. Its accomplishments and continued popularity are a real testament to President Obama's vision, translated into beneficial reality for so many.

Introduction

Oberlander (2010), provided a meaning perspective in this year of passage of ACA, with the following: “For health reform in the United States, this is, given those powerful constraints, probably as good as it gets. Even with all its shortcomings, the Patient Protection and Affordable Care Act is a great leap forward for the American health care system” (p. 1116.)

Opposition to health reform efforts had come from various interest groups, fearful of detrimental effects to their revenue streams. These not only included the health insurance industry itself, but also from provider groups, such as hospitals, physicians and the drug industry. Further, while the public appeared dissatisfied with the status quo, there was also concerns about change. To overcome obstacles, passage of the bill required compromise and tradeoffs.

The bill did not create a new health insurance system, such as perhaps a single-payer system. It was successful in filling some of the gaps in the existing system, which had resulted in so many more individuals without health insurance.

The final bill relied heavily on the continued reliance on private insurance companies. Arrangements were made with health industry groups to ensure their revenues would not be affected negatively and the presence of employer-sponsored insurance would not be affected for the most part. There was also a pledge to lawmakers that reform would be budget neutral. To get the votes needed for passage the provisions for a public option, was deleted, which was a much-desired addition for progressives (Cohn, 2020). ACA narrowly passed both houses, during a period where there were Democratic majorities in both and the reconciliation process was used on the Senate so only 50 votes were required in that House for passage. The bill passed without any Republican support (Oberlander, 2010).

There have been numerous attempts to repeal ACA since its passage. Since 2010 until 2016, there were more than 50 repeal bills passed by House Republicans (ACA did not go into full effect until 2014), but Republicans did not control the Senate until 2015 and did not control the presidency until 2017. (Cohn, 2020). A challenge that went to the Supreme Court resulted in a re-affirmation of the individual mandate, but also permitted each state to determine for itself, whether to expand financial eligibility for Medicaid (Kaiser Family Foundation, 2012, August 1). In two additional challenges that went to the Supreme Court, attempts at repeal were denied (Jost, 2021).

ACA has had enduring popularity and success. A clear majority (55%) of Americans have supported ACA, since Republican efforts to repeal it in 2017 failed. No replacement plan has been able to gain any support from the public. From its “Tracking Poll” the Kaiser Family Foundation found that provisions in ACA to be the most popular: not denying coverage for persons with pre-existing conditions, community-rated premiums, not denying coverage for pregnant women and paying for preventive services. A majority of those polled also felt the following to be important: no lifetime limits on expense reimbursement, states’ expansion for Medicaid eligibility, premium subsidies, and children staying on their parents’ health insurance until the age of 26 (Kirzinger, et al., 2022).

President Biden had promised to strengthen and build on the successes of ACA, by facilitating processes for enrollment for affordable and quality coverage. improve on implementing the goals of ACA. Since taking office, the number of people who have signed up for insurance through the Marketplaces has increased by almost 50%. Premium reductions have been evident for many. Nearly one quarter (22%) who utilized the Marketplaces did so for the

first time. More people have accessed health insurance through the Marketplaces than ever before (Department of Health and Human Services Press Office, 2023).

According to a National Health Interview Survey, in early 2022, the uninsured rate among U.S. residents reached an all-time low of 8.0%. The most recent drop in the uninsured since 2020, can be attributed to enhanced market subsidies associated with the American Rescue Plan, recent state expansions of financial eligibility for Medicaid, continuous enrollment provisions for Medicaid and enhanced enrollment outreach efforts from 2021-2022 (Lee, et al., 2022).

The following sections describe the impetus, goals and descriptions for health system reform, beginning with Truman's national health plan of 1945. With the exception of Medicare and Medicaid, which were limited in scope, none were adopted as law, up until ACA although incremental changes did occur. President Johnson publicly credited the passage of Medicare and Medicaid as having been built on Truman's plan. It is apparent from what is contained in ACA, it too built upon the plans of its predecessors.

TRUMAN AND UNIVERSAL HEALTH COVERAGE

Twenty years before the passage of Medicare and Medicaid, President Truman in 1945, proposed a national health plan. The plan sought to: increase the number of trained health care personnel, expand public health services, increase medical education and research funding, decrease individual's health care costs and focus on lost income of individuals with severe illness (Harry S. Truman Library & Museum, n.d).

The plan was envisioned as an expansion of Social Security in which monthly fees and taxes would be imposed to cover increased costs. Despite a Democratic-controlled House of Representatives, Truman's plan failed. Fears were evident concerning increased taxes, giving

too much control of health care to the federal government (A fear promoted by the American Medical Association). Some feared the program as a “Communist” act (Harry S. Truman Library & Museum, n.d) and warned of “socialized medicine.”

In his November 1945 message to Congress, Truman asserted that too many people are dying prematurely and from preventable diseases. He felt that many reductions in death rates resulted from public health and other community efforts, and there has been unequal availability of the benefits that could be achieved from medical progress. Pointing out the poor have more sickness but receive less medical care, he stated this needed to change. He expanded on this pointing out disparities for those who live both in rural areas and in the cities. He went on to say that the benefits of modern science would not be shared equally for all, unless there were system changes. He felt that national health was a national concern and financial barriers to care should be removed (Harry S. Truman Library & Museum, 1945). The themes expressed by Truman appear in the subsequent attempts at health reform, including those in ACA.

SENATOR JOHN KENNEDY AND A FOUNDATION FOR MEDICARE

In his 1960 speech to the Senate, the then Senator John Kennedy proposed amendments to the Social Security Act and to the Internal Revenue Code to provide the elderly with health insurance for hospital and nursing home costs. To justify the need for change, Kennedy pointed to the growth in the elderly population and associated increased health care needs with related costs. He also pointed to the prevalence of poverty in the elderly population, with fixed incomes barely adequate for living expenses with looming, devastating health care expenses. Kennedy believed the elderly were already burdened with the increased costs of chronic illness, which did not meet or keep up with Social Security payment increases. Kennedy asserted the current health insurance system did not meet the needs of the elderly population. “The very competition

between insurance companies tends to either exclude older people or limit their protection. If benefits are restricted the very purpose of the insurance is defeated” (Kennedy, 1960). Kennedy believed that payments would be made through the Social Security Fund, and would not pose an undue financial burden on any particular group. Everyone participating in the social security system “would receive paid-up health insurance for life in return for a small increase in his contribution rates (Kennedy, 1960). The proposal was made prior to the enactment of Medicare, and is believed to be a foundation for the program.

PRESIDENT JOHNSON: MEDICARE AND MEDICAID

After decades of political battles, shortly after the death and strong support of President Kennedy, President Lyndon Johnson signed the Social Security Amendments of 1965 into law on July 30, 1965. The passage of the amendments created Medicare and Medicaid. Medicare, as initially envisioned was limited to benefits for those 65 and over, and focused on the hospital rather than physician care, with what came to be known as Medicare Part A, which all in the age group were automatically enrolled. Accepted into the program was the use of what came to be called fiscal intermediaries to administer billing operations, at the time by not-for profit Blue Cross plans. By doing so, it was felt government agencies would not be involved with health care finance routines. Medicare Part B, was included as a public option, with an imposed premium to cover other medical expenses (Berkowitz, 2005).

Medicare was open to all 65 and older, without regard to income, health status or illness. In 1972, the program was expanded to those under the age of 65 with certain long-term disabilities. Medicare Part A covers care in a hospital and short term skilled nursing facility, plus limited home health services and hospice care. Medicare Part B covers physician visits, other outpatient services, preventive services, and some home health visits. Medicare Part D covers

prescription drugs through commercial insurers. Medicare Part C, (Advantage Plans), cover patients enrolled in a commercial plan, e.g. and HMO or PPO, receive all Medicare Part A and B benefits, usually part D and other varying benefits (Kaiser Family Foundation, 2019).

Medicaid is public health insurance for the poor. It serves as the primary source for long term care coverage. It covers a broad array of other health services with some variability and eligibility among states. The program is structured as a partnership between the federal government and the states. All Americans who meet eligibility requirements are guaranteed coverage. The federal government guarantees matching dollars without a cap for qualified services provided by the states to eligible enrollees. The match rate is determined within the law through a formula, which must be at least 50% and could be higher for poorer states. With the passage of the Affordable Care Act, financial eligibility was expanded to 138% of the Federal Poverty Level. Following a Supreme Court ruling, states could “opt out” of the financial eligibility expansion. Most Medicaid enrollees now receive their health insurance through commercial managed care plans (Rudowitz, et al., 2019).

PRESIDENT RICHARD NIXON: COMPREHENSIVE HEALTH INSURANCE PLAN

President Nixon provided the following as the impetus for his health insurance plan: Nixon recognized major portions of the population were uninsured or under-insured and increasingly when medical care is provided, it can be accompanied by “staggering bills.” He felt that: For the average family, it is clear that without adequate insurance, even normal care can be a financial burden while a catastrophic illness can mean catastrophic debt.” Acquiring appropriate health care is vital for individuals make full use of their abilities and it is extremely important to eliminate financial social and racial barriers to care. Nixon felt that those who were uninsured often needed the insurance the most, but were also most likely to acquire it. These

include the exact same population as ACA targeted, i.e. those just above the poverty level, who because of that are not eligible to enroll on to the Medicaid program. Under-insurance posed a great financial risk for those who have major medical bills. “These gaps in health protection can have tragic consequences. They can cause people to delay seeking medical attention until it is too late. Then a medical crisis ensues, followed by huge medical bills--or worse. Delays in treatment can end in death or lifelong disability (Nixon, 1974).

The guiding principles of the Nixon’s plan included:

All Americans would have “an opportunity to obtain a balanced, comprehensive range of health insurance benefits,” which will be affordable. The plan builds on the existing public and private systems of health care financing. No new federal taxes will be required, and public funds will only be utilized when needed. Patients would have freedom of choice, and doctors will work only for their patients. Effective use of health care resources would be encouraged. All parties become stakeholders to make the system work (Nixon, 1974).

The Nixon health insurance plan envisioned the following options:

Employee Health Insurance: Would cover most citizens as currently existed. Policies would be provided through the employer and premium costs would be shared by employers and employees.

Assisted Health Insurance: Would cover low-income persons, and those not eligible for the other two programs. Public funds would be utilized to pay for premiums as needed. Those currently covered by the Medicare for the disabled program would also be included in this plan. This program would for the most part replace state-based Medicaid. National, uniform benefits and standards for eligibility would be established.

An Improved Medicare Plan: Modifies the current to cover additional benefits. It would provide the same benefits offered under the other two plans. There would be maximum annual out-of-pocket costs and premium subsidies through public funds as needed.

Other Salient Characteristics: All three plans would provide the same array of benefits. Insurance could not be refused due to the nature of a person's illness. All citizens would have a health card, which would be honored by all providers (Nixon, 1974).

The Prepaid Group Practice/Health Maintenance Organization Model- The "Original" Kaiser-Permanente Health System Model (Kaiser)

The health maintenance organization model obtained its directional boost from the Nixon administration's acceptance of the model as central to his national health program. This was underscored with the passage of the HMO Act of 1973. The act "...provided for a Federal program to develop alternatives to the traditional forms of health care delivery and financing by assisting and encouraging the establishment and expansion of HMOs." The act provided financial assistance to HMOs through grants loans and contracts; provided access for HMOs to be offered as a health insurance option and sought to remove state laws and practices which could serve as a barrier to the development and operations of qualified HMOs. (General Accounting Office, 1978).

The Kaiser HMO was one such qualified HMO which was based on the following principles:

- Prepayment- The cost of care was spread over a defined population, which provided an adequate and stable revenue stream, for the organization of health services.
- Group practice- Care is to be provided by a full time, autonomous medical group.

Payment for the medical group would be on either a capitation or other method, not to include a fee-for-service basis.

- Hospital-based-The medical group would be hospital-based, within an organized and integrated system of care to include satellite clinics to provide care in surrounding communities.
- Voluntary enrollment- Members must be able have a choice of care programs and chose to select this model.
- Comprehensive service benefits- The model includes the availability of a comprehensive array of services, including prevention (Greenlick, 1972).

Advantages of the Kaiser Model:

By integrating care within a hospital-based system, coordination of all necessary resources can be facilitated through centralized administration, including the use of a common medical record. Financial incentives associated with over-utilization of un-necessary services seen in fee-for-service models of care are eliminated. Instead, a capitated model encourages the use of preventive services, thereby reducing the likelihood of increased demand for more costly future services (Greenlick, 1972).

The Kaiser model included a closed panel (no choice), group practice. The reputation of each individual reflects on the rest of the group. Each member of the full-time medical group would be included in the same malpractice conditions. With a closed panel, there is a maximum likelihood of patients who are seen by one physician in the group will be seen by multiple physicians in the group. The readily availability of and ease for specialty consultation, along with the sharing of information can result in timely care delivery and coordination. The model also provided ease of opportunity for peer review as physicians jointly may care for patients and again, there is a common medical record (Greenlick, 1972).

Luft (1998) provides additional detail to the characteristics of the “group and- staff model” HMOs, such as Kaiser: With the staff model, the physicians are employees of the HMO. The HMO may contract with a hospital for its services which may also be on a capitated arrangement for its defined population. With hospital-based plans, depending on the corporate structure, the hospital may already be responsible for care through the capitation payment.

MANAGED CARE-A BLURRING OF CONCEPTS AND STRUCTURE

HMOs-There is common agreement regarding what is a staff model HMO, i.e. “...an organization that employs and controls physicians directly and pays them a salary” (Welch et al., 1990, p. 221). There is little in the way of a common agreement regarding how to define other commonly present models of HMOs, e.g. group, network and Independent Practice Association models. In general, however, a group model HMO contracts directly with a single group practice and with IPA models, the HMO contracts with individual physicians in private practice. With most HMOs, there is a primary care physician (PCP) coordinator and gatekeeper. The PCP is responsible for authorizing and controlling specialty and other health care functions and expenditures. PCPs may themselves be paid on a capitated basis, or instead may be salaried or paid on a fee-for-service basis (Welch et al., 1990).

Preferred Provider Organizations (PPOs)-There is no widely accepted definition for what is a PPO. Its general characteristics include: Providers are paid on a discounted fee-for-service basis and do not accept capitated risk, which resides with the insurance company or with a company that is self-insured. Enrollees may seek care from out-of-network providers but will have greater out-of-pocket costs when doing so. With some PPO plans there is no requirement for a PCP gatekeeper function to access specialists. However, there may be greater out-of-pocket costs for self-referral (Kongstvedt, 2001).

There was significant growth in PPOs beginning in the late 1980s into the 1990s. Strong backlash to prior restrictive models of managed care with limited choice, strict gatekeeper functions and prior approval requirements have been considered reasons for the growth in less restrictive models such as PPOs (Ausitn & Hungerford, 2010; Marquis, et al., 2004/2005). With the growth in types of plans which became available, there was a growth in employers offering choices to employees among competing plans, for those willing to pay higher premiums for increased choice (Ausitn & Hungerford, 2010)

CLINTON AND THE HEALTH SECURITY ACT

In his October 1993 letter to “My Fellow Americans,” President Clinton expresses why health reform was needed. Security was one major theme, which he characterized as follows:

“Every American must have the security of comprehensive health benefits that can never be taken away... we will never surrender -our right to choose who treats us and how we get our care...Millions of Americans are just a pink slip away from losing their health coverage, one serious illness away from losing their savings. Millions more are locked into jobs for fear of losing their benefits” (White House Domestic Policy Council, 1993).

President Clinton expressed the following additional need for health reform as follows:

“This health care system of ours is badly broken... our health care is too uncertain and too expensive, too bureaucratic and too wasteful. It has too much fraud and too much greed... “ He believed that too many stayed in their jobs, for fear of being unable to obtain another health insurance policy. He was aware that at the time, there were more than 37 million people who were uninsured, many of whom had jobs. He was concerned that health care expenses were growing at a rate twice that of the general inflation rate and Americans spend more on health care than any other nation (Clinton, 1993). The themes expressed here were also evident in the impetus for the provisions within ACA.

President Clinton's Health Security Act (HSA) was rooted in six principles: security, simplicity savings, quality, choice and responsibility:

- Security: HSA guaranteed comprehensive benefits. No one would be denied coverage; there would be no lifetime limits of expenses; all would have the same premium, without regard to age or illness. Premium costs would have limits as would annual cost increases, with limits on out-of-pocket expenditures. Medicare would include drug coverage as well as an initiative for long term care.
- Simplicity: Everyone would have a Health Security Card; all health plans would adopt one standard claim form; there would be a uniform benefits package.
- Savings: Insurers would compete on quality and price. Individuals and small businesses could combine into insurance purchasing groups to obtain lower health insurance premiums. Simplification will result in cost savings. Health care fraud, including overbilling would be criminalized.
- Quality: Increased information systems and technology would be provided to physicians and hospitals. Consumers would have access to quality information, which in turn would facilitate health plans to compete on the basis of quality and cost. HSA would invest in research relative to prevention and treatments, would emphasize preventive care and target the training of primary care physicians, nurses and other health professionals.
- Choice: Patients would keep their chosen physician. Plan choice would be up to the patient, not the employer; patients could switch plans annually; the elderly would have additional options to live in their homes and community and receive long-term care services.

- **Responsibility:** While not setting prices, drug companies were asked to assume the responsibility of holding down prices. Patients and doctors would be encouraged to settle their disputes before they escalate to the courts. All employers and employees would be required to pay something toward their health coverage (White House Domestic Policy Council. (1993).

For those working, employers would contribute a major portion of premiums. Medicare would remain intact and enhanced. Americans would choose from private insurance companies, who would compete on the basis of both quality and cost. It was expected there would be a decided shift to managed care insurance models. No new taxes were envisioned for the plan. The plan would be financed through the employer mandate, increases in federal taxes and savings were projected from Medicare and Medicaid spending cuts (Oberlander, 2007). The proposal did not pass into law as it was rejected by Congress.

Managed Competition

While the HSA was not adopted, elements of HSA, evolved and have become important elements of health insurance structure today, e.g. managed competition (Enthoven, 1993). The concept is foundational to the development of health networks, relationships between providers and insurers, the establishment of health insurance purchasing cooperatives (HIPCs) and mechanisms through which the public enrolls in insurance plans.

“Managed competition is a purchasing strategy to obtain maximum value for money for employers and consumers.” Through the managed competition model employers and consumers are expected to select insurers “that do the best job of improving quality, cutting cost, and satisfying patients” (Enthoven, 1993, p. 29). Within the managed competition model, “sponsors,” not individuals are the pre-dominant purchasers of health insurance. These are most often

employers, but could also be a branch of government, a labor/management health and welfare fund or an HIPC. Through contracting processes with insurers sponsors can establish and enforce principles of equity for their employees and members. These include for example: All eligibles: are covered or offered coverage; have subsidized access to the lowest cost plan; those selecting a plan more than the lowest cost must pay the difference; continuous coverage which cannot be cancelled except for nonpayment; in general there is community rating; have no exclusions or limitations for pre-existing conditions (Enthoven, 1993).

Within the model, it is the sponsor that selects the insurance plan(s) for its employees/members and manages the enrollment process. The elements contained in coverage contracts are standardized, which enable sponsors to make selection decisions based on price comparisons and deters market segmentation. Sponsors are the agencies to survey their employees/members regarding their experiences with the insurers and also publish the results. Sponsors need to monitor access to and quality of specialty and tertiary care. (Enthoven, 1993).

Under traditional models of health insurance, it was to the benefit of health insurers to group customers according to expected health expenditures and charge each group premiums that would cover expected costs, i.e. experience rating. Those in a high expenditure group would pay high premiums, often unaffordable for many. In many instances, health insurers felt the risk of taking on the sick, was too high and refused health insurance coverage to those in this category. By contrast, healthy individuals were more likely not to enroll in an insurance plan or have only minimal coverage, unless or until they became ill. (Enthoven, 1993).

Within the ACA provisions, there is a required community rating system as the basis for premium setting. Further, within its provisions, prospective insurance enrollees cannot be denied coverage due to past medical conditions and there are no annual or lifetime expense limits.

An outgrowth of the managed competition model was the emergence and growth of health care networks. The North Shore Health System merger with Long Island Jewish Medical Center was an example of how an organization with insurers from a position of strength. In this case it was for a provider negotiating reimbursement rates as opposed to sponsors purchasing health insurance. The following is quoted material from the late Jack Gallagher, founding CEO for North Shore-Long Island Jewish Health System (now Northwell Health) regarding this:

Mr. Gallagher noted that for the first time since the merger, the system would end the year in the black, with a surplus in excess of \$25 million... Mr. Gallagher attributed the improved financial picture to the system's ability to negotiate better reimbursement rates with the 40 insurance companies with which it deals. It was this promise of negotiating clout that gave impetus to the merger of the two hospitals, fierce rivals since each was founded in the early 1950's (Ain, 2000).

From Jeff Kraut, Senior VP for senior planning and network development: "We were expecting almost a decline in admissions because we expected managed care to aggressively keep people from coming into the hospital...the merger has made this environment more attractive to patients. (Ain, 2000).

GOVERNOR ROMNEY THE MASSACHUSETTS HEALTH REFORM ACT OF 2006: THE MODEL FOR ACA?

Massachusetts was the first state to institute an individual mandate, in which all individuals who could afford premiums were required to purchase health insurance. The state provided premium subsidies for families earning up to 300% of the poverty level on a sliding scale. Health insurance market reforms were implemented to improve coverage availability and affordability. Employers which did not provide insurance to employees were required to pay a fee to help finance subsidies provided by government. (Doonan & Tull, 2010).

The state required premiums to be based on community rating, with standards for coverage and affordability. Premiums for individuals and small groups were moderated through

the employment of merging into a single risk pool. A state-wide exchange (marketplace) was created from which individuals and small groups could compare plans' costs and benefits. The penalty for an individual refusing to enroll in a health insurance plan was 50% of the lowest premium available under the established exchange (Kaiser Family Foundation, 2012).

Individuals could be exempted from the mandate, based on affordability factors (Doonan & Tull, 2010; Waldman, 2009).

PRESIDENT OBAMA AND THE PATIENT PROTECTION AND AFFORDABILITY CARE ACT

The Need for Health Reform and Initial Plan Structure

President Obama, in his September 9, 2009 speech to Congress provided some of the same themes as expressed by former Presidents as to the need for health reform. These include for example: The uninsured face severe hardships and financial ruin in the face of substantial medical bills. Many of those who are uninsured are included with the middle class. For some, health insurance is not part of their employment benefits. Others are self-employed. For those seeing health insurance as individuals, it can cost as much as three times what the cost is for employer-based insurance and is therefore unaffordable. Even for those who might be able to afford the premiums, for those deemed to have prior illnesses or conditions coverage might still be denied. Many who leave their job end up losing their health insurance coverage as well. In some instances, even if premiums are paid, employees are discovering their coverage is dropped when they succumb to an illness or the insurer won't pay for the full cost of care. (And has been mentioned by other Presidents, we in the United States pay more than any other country per person than in any other country. Costs keep rising "but we are not any healthier for it." Because of the increases in health insurance costs "many employers – especially small businesses – are

forcing their employees to pay more for insurance, or are dropping their coverage entirely” (Obama, 2009).

Major Provisions of the Law Passed by Congress, i.e. ACA (Public Law 111-48)

Insurers cannot impose either annual or lifetime limits for health expense coverage. Preventive services are covered without requirements for any patient cost sharing. Dependent group health insurance eligibility is extended to the age of 26. All residents were required to enroll or be enrolled in a health insurance plan (Individual Mandate), or pay a penalty. Financial eligibility for Medicaid was expanded to 133% of the Federal Poverty Level (Kaiser Family Foundation, 2013).

The plan established the structure for a health insurance exchange/marketplace for individuals not already covered by either an employer-based or public health insurance plan. For an insurer to be listed as part of the exchange, they had to provide coverage for ten essential benefits (Abortion coverage was excluded from the essential benefits.). Premium subsidies were provided for those earning up to 400% of the Federal Poverty Level. The establishment of premiums utilized four benefit categories, with different levels of percentages paid for services, but with a maximum out-of-pocket payment for enrollees. Insurers within the exchange were required to market their plans “...have adequate provider networks, contract with essential community providers, contract with navigators to conduct outreach and enrollment assistance, be accredited with respect to performance on quality measures, use a uniform enrollment form and standard format to present plan information.” Plans were required to provide rebates to their enrollees if they spent less than 80%-85% of premium dollars on patient care and quality programs (Kaiser Family Foundation, 2013).

Regarding Quality:

The provisions of ACA included responsibilities for insurers to implement and report on activities related to improving their customers' health outcomes. These activities include: "effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including through the use of the medical homes model" (Patient Protection and Affordability Act, 2010, p.135). Insurers were also expected to engage in activities to prevent hospital readmissions, to include more effective discharge planning, including patient education and counseling with post-discharge follow up. Further, insurers were also expected to "implement activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology ...[and] implement wellness and health promotion activities" (Patient Protection and Affordability Act, 2010, p.135).

While Medicare and Medicaid were reported to be unaffected by ACA, there were elements within the law that had effects on both programs and providers. These include the following array: An Independent Payment Advisory Board to be established charged with submitting legislative proposals to reduce Medicare spending if it exceeded a target growth rate. Significant, initial payment reductions to Disproportionate Share Hospitals (DSH) were to take effect, which would then be adjusted upward based on each hospital's provision of both uninsured and uncompensated care provided. Within the Medicare program, providers would be permitted to organize as accountable care organizations, if they met designated quality thresholds. Savings from target expenses would be shared between ACO and CMS. An Innovation Center within CMS would be created evaluate and test different payment methodologies to reduce expenditures while maintaining quality. Medicare payments to hospitals

would be reduced by specific percentages, in relation to what are deemed to be preventable readmissions as well as for hospital acquired conditions. A pilot program is to be developed and evaluated paying for services within a bundled payment model. A demonstration program is to be developed provide primary care services to Medicare beneficiaries in need. Value-based purchasing programs, paying facilities on the basis of performance on quality measures for various types of health care providers is to be established (Kaiser Family Foundation... 2013).

Concluding Comments

ACA has had both support and opposition since it passed. For some progressives, ACA did not go far enough as they would like to have seen an insurance public option at a minimum with a vision for a single payer system. Republicans have made numerous attempts to repeal ACA, including three failed attempts which ended in the Supreme Court. There have not been any Republican health reform proposals that have gained serious popular support. However, the individual mandate has been deleted from ACA, and there are still states that have not embraced expanding financial eligibility for enrolling in Medicaid. For some conservatives and Libertarians, ACA might be viewed as too much national government in health care. And finally, there has been so much intentional mis-information, which continues to foment fear and distrust in government (Rovner, 2017).

Despite some continued opposition, ACA enjoys more popularity than ever. Further, ACA has undoubtedly made steps in the right direction toward solving the challenges within the U.S health system. Payment system processes have begun transformation with the employment of alternative to the fee-for-service model. Rates of those uninsured have never been lower, wh ACA has been the vehicle to provide affordable health insurance to tens of million of people,

who would otherwise have not been insured. This has resulted in increased access to care and improved health outcomes for many. ACA is now considered an asset for Democrats, and for now, serious attempts to repeal and replace ACA have seemingly disappeared.

In 2016, reflecting on progress made in health reform, President Obama stated the following: “Americans can now count on access to health coverage throughout their lives, and the federal government has an array of tools to bring the rise of health care costs under control. However, the work toward a high-quality, affordable, accessible health care system is not over” (Obama, 2016).

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