Policy Analysis of Patient Protection and Affordable Care Act

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Abstract

In an attempt to reform the American Health Care system, Obama signed the Patient Protection and Affordable Care Act into law on March 23, 2010. The implications and provisions of this law are widespread and Americans and employers have mixed feelings about the law and its influence. In this paper I will discuss the ACA’s impact on existing programs, the associated costs of implementing the ACA, the individual mandate and employer requirements as well as the changing roles of the government and potential problems with the development of the law as well as the implementation of it in the years to come. Ultimately I hope to offer some insight to the question of whether the ACA is fundamentally improving the health care system or not.
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Chapter 1

Review of Patient Protection and Affordable Care Act

Overview

The Patient Protection and Affordable Care Act (ACA) was an act signed by United States president Barack Obama on March 23, 2010 attempting to reform the American health care system. Health care reform has been a widely debated subject for years in America, and this is the first successful attempt at passing law aiming to make comprehensive health care affordable and accessible for all Americans. The law impacts health care coverage and costs, individuals, children and employers, current government programs, state and federal governments, private insurers and health plans, types of covered services, and the quality of care delivered. The law aims to expand health care coverage, regulate and minimize health care costs, and advance the health care delivery system.

The ACA is most distinguished by the transformational changes to the health insurance system regarding access to care and type of care, as opposed to structural changes made to how care is delivered. The ACA changes the regulation, structure, and administration of health insurance in the country by making substantial philosophical and practical changes. The ACA is expected to insure 32 million previously uninsured people, as well as enroll 16 million new people into Medicaid (Teitelbaum & Wilensky, 2013).

The law mandates that almost all legal residents and U.S. citizens obtain health insurance or pay a penalty and it also requires larger employers to offer coverage to their employees or pay a penalty. The ACA also intends to expand Medicaid eligibility and increase Medicaid payments as well as preserve current income eligibility levels for children in Medicaid and the Children’s
Health Insurance Program (CHIP). In fact, one of the largest impacts of the ACA was on already existing programs like Medicaid, Medicare, and CHIP.

**Changes to Existing Programs**

Medicaid is the United States’ federal and state public health insurance program for the poor. The ACA greatly expanded Medicaid eligibility by raising the income level at which individuals qualify for the program to 133% FPL up from the previous 100% FPL. Under the new law, individuals no longer have to meet a resource test or fit within a pre-approved category to be eligible; they only have to fall within the income range mentioned above. In addition to eligibility changes, financing for Medicaid has also changed. As opposed to the traditional system of federal- state matching, now nearly the entire cost of the expansion is being paid for by the federal government through 2019, and also 90% of the cost thereafter. The Supreme Court ruled that each state has the choice as to whether they want to accept the Medicaid expansion or not, and the associated cost is a key factor in making the decision (Kaiser Family Foundation, 2013). Even with the significant amount of help from the federal government, it is estimated that the states would still pick up an extra $20 billion over the next 10 years with the increased cost of the Medicaid expansion if they choose to accept it; this is a big concern for many states taking on this financial burden. The ACA also changes some Medicaid benefits; states now have the option to include community based care, home health care, and family planning under Medicaid services (Teitelbaum & Wilensky, 2013).

The ACA also had several provisions regarding Medicare, the federally funded health insurance program for elderly and disabled people. Some of these changes included covering additional preventive services, extra payments for primary care services, and assistance in
covering the cost of prescription drugs. Despite additional funding for the above mentioned services, there are several changes that will actually reduce the reimbursement to providers. Ultimately however, while Medicare spending is projected to increase by $105 million, the total savings when accounting for all the provisions are anticipated to save the country $533 billion amounting to a net reduction of $428 billion over the next decade (Teitelbaum & Wilensky, 2013).

The ACA also made some changes regarding CHIP. CHIP is the country’s health insurance program for children whose families are above the eligibility level for Medicaid in their state. CHIP was a ten year block grant program that expired in 2007, but was reauthorized by the Children’s Health Insurance Program Reauthorization Act (CHIPRA) when president Obama signed it into law in 2009. The ACA extended this program until 2019, but only helps to fund it until 2015. This expansion and additional funding is expected to provide 6.5 million extra children with either Medicaid or CHIP, but unfortunately there are still eight million children who are uninsured as of 2009 and many of them belong to low income families (Teitelbaum & Wilensky, 2013).

**Associated Costs**

While the ACA is projected to cost $940 billion over the course of the next ten years, it is also estimated to ultimately reduce the federal deficit by $124 billion during the same time frame (Teitelbaum & Wilensky, 2013). The cost of the ACA has been financed mainly from savings on Medicare and Medicaid, taxes and fees on the health care industry, changing the income tax code, and taxing some health insurance plans. Many of the forms of funding for the ACA were due to deals that the Obama administration made with multiple stakeholders. Some of the financing from these deals includes rebates that drug manufacturers give to state programs,
productivity adjustments, and reducing reimbursement rates in Medicare provider reimbursement as well as Medicare advantage payments.

**Mandates**

One main provision of the ACA is the individual mandate. As mentioned previously, this law mandates that all U.S. citizens and legal residents obtain health insurance. In order to do this, the ACA has created state-based American Health Benefit Exchanges where individuals can purchase coverage if they don’t have it offered through their employer. This coverage may involve cost sharing with premiums. If an individual does not obtain health insurance coverage, they are subject to pay a penalty. This penalty starts off smaller in 2014 and is phased in over time increasing annually by one’s cost of living. Some individuals will be able to get exemptions from this penalty, but it is intended to provide incentives to obey the law as well as raise resources to cover the price of health care for people who choose not to get health insurance (Teitelbaum & Wilensky, 2013). Essentially the mandate helps to share risks as well as cover costs.

In order to make it realistic and affordable for individuals to purchase health insurance, the ACA included a range of premium tax credits and cost sharing subsidies. The amount of the tax premium credit was relative to an individual’s income so that no person would have to pay more than a certain percentage of their total income on health insurance premiums. The cost sharing subsidies were designed to limit out of pocket spending on health insurance for low income individuals so that their plan would pay a higher percentage of costs of services received. These subsidies, like the tax premium credits, are tiered by income level (Teitelbaum & Wilensky, 2013). These provisions allowed low income individuals to comply with the individual mandate law by still being able to obtain health insurance.
The individual mandate has sparked controversy about its constitutionalism. Some people believe that the mandate is a mark of the government intruding on what should be private decision making. These people feel that Congress doesn’t have the legal authority to instate a law like this. In spite of the controversy, the Supreme Court ruled the individual mandate to be constitutional in 2012 (Kaiser Health News, 2012). Ultimately the system is dependent on the individual mandate. If not everyone obtains health insurance then the insurance pool tends to be sicker because of the premise that people who need care are the ones who will purchase it, driving up the cost of health care. An additional potential problem that exists without the mandate is if healthy individuals choose not to purchase health insurance and then fall ill then they become free riders when they receive care, especially if they have the means to have purchased insurance in the first place. Another reason that the health care reform system wouldn’t function without the individual mandate is because it was the reason many health insurers decided to support health reform (Teitelbaum & Wilensky, 2013). When all individuals are insured it helps to balance the insurance pool and the healthy individuals help to offset the health care costs of the ill.

In addition to the individual mandate, the ACA also developed requirements for employers regarding offering health insurance coverage. According to the new law, larger employers with fifty or more full time employees must offer acceptable and affordable coverage or pay a penalty. If even one employee out of 50 receives a premium tax credit then the company could be subject to penalties (Summary of the Affordable Care Act, 2013). The employer mandate ensures that employers are helping to absorb some of the cost of health care as opposed to more of the financial burden being placed on the public sector and taxpayers (Teitelbaum & Wilensky, 2013).
For smaller employers (those with fifty or less employees) they have been exempted from the employer mandate. To help employees of smaller businesses Congress included a small business tax credit designed to encourage smaller employers to provide coverage. This credit would cover a part of the cost of the employer’s contribution toward premiums if the company is eligible. Small businesses can also help provide their employees with health insurance coverage via the exchange (Summary of the Affordable Care Act, 2013).

**Quality Improvement**

The individual mandate and employer mandate are in part aimed to improve the quality of health care received. One of the main goals of the ACA is to improve the health care delivery system. The quality improvement goals are highlighted by the new National Quality Improvement Strategy: improving delivery of health care services, patient outcomes, and population health. To ensure these goals are met, quality measures will be developed in addition to a network of community based care providers to collaborate, integrate, and coordinate services. The Patient Centered Outcomes Research Institute is also working to determine which procedures, devices, and pharmaceuticals provide the most value for a given issue. In addition to improving the treatment side of health care, the ACA also aims to invest more resources into prevention and health promotion efforts.

**Private Insurance Market**

The ACA also made some provisions with regard to the private insurance market, quality of care and affordability. These new policies cover an array of changes like rate setting, benefits and who must be allowed coverage. The ACA stopped insurance companies from excluding coverage to those with preexisting conditions, extended dependent coverage up to age 26, stopped cost sharing for preventive services like immunizations and screenings, and ended
lifetime and annual coverage limits. Regarding costs, the ACA prevents insurance plans from increasing rates based on preexisting conditions, and contends that premium rates may only vary based on age, geographic area, family composition, and tobacco use (Teitelbaum & Wilensky, 2013).
Chapter 2

Potential Problems with the Law

While the ACA has a lot of potential and makes a lot of improvements to the health care system, there are also several potential problems with the development of the law and its implementation that may pose various problems over the next few years.

Divided Americans

Americans were and still are widely divided on their feelings about the ACA and its implications. The political climate at the time the ACA was passed was not necessarily ideal given the economy, and Republicans and Democrats were much divided in their opinions about the country’s priorities. Republicans opposed the bill and Democrats have consistently ranked health care as a higher priority than Republicans for years. Many Americans felt that health reform shouldn’t be such a high priority on the president’s agenda at a time when the economy was very seriously struggling. Shortly before Obama was elected as president, 43% of voters indicated their top priority was repairing the economy. Health care concerns fell second to economy concerns with economy trumping health care by a 2-to-1 margin. In a poll, nearly fifty percent of those who answered expressed disapproval to the ACA (Teitelbaum & Wilensky, 2013). Part of the effectiveness of the ACA also depends on American’s willingness to accept it and understanding of it.

Development and Implementation Challenges

The legislative process for finishing the bill was also lengthy and problematic. Democrats and Republicans were very split in their beliefs regarding the bill and therefore a bipartisan agreement couldn’t be reached. Special interest groups also had an impact with opposition to the passing of the law. Scott Brown, a representative elected to fill a seat in the Senate complicated
matters because he was very opposed to health care reform. This meant that Democrats no longer held the majority and left democratic congressional leaders with few options. Ultimately however, a compromise was reached and the Senate bill was amended as well as a companion reconciliation bill enacted (Teitelbaum & Wilensky, 2013).

There are also several implementation challenges that lie ahead including the creation of new state and federal regulations and policies in accordance with the ACA. Additionally, there is the issue of whether providers and delivery systems are prepared to handle all the newly insured patients who will be seeking health care that previously did not.

**State Government Responsibilities**

States governments have a huge undertaking handling much of the reform implementation concerning Medicaid expansion, running the health insurance exchanges, and regulating the private health insurance market. The ACA has multiple state obligations even though it is a federal law and requires the states to expend significant efforts on implementation. Multiple states are also pursuing legal challenges to the federal government against the bill, as well as Republican politicians trying to repeal it (Teitelbaum & Wilensky, 2013).

**Pilot Projects**

Another potential problem of the ACA is that many of its provisions were pilot projects and did not include permanent fixes to the root of the problem. Much of the law’s containment and delivery measures were in the form of these temporary pilot programs, leaving their future uncertain (Teitelbaum & Wilensky, 2013). At the end of the pilots, changes in political will or available funding may play a role in the lasting impact of the ACA. The pilots may help to improve the health care system before they while they are in place, but the country may be faced with similar problems as before the enactment of the ACA once they expire.
Coverage

As much as the ACA provides near universal health insurance coverage, not everyone will be insured under the new system. The new system only covers U.S. citizens and legal immigrants, not those who are undocumented. Also, not everyone will get insurance as many will opt to pay the penalty instead or may not have a solid understanding of the new law and what it entails.
Chapter 3

Summary and Recommendations

The ACA makes many efforts to improve the health care system in the United States but there are still lingering questions to be answered concerning whether the subsidies and provisions of the ACA are enough to make health insurance affordable and accessible. In addition, there are still unanswered questions regarding whether Congress will find it necessary to implement unpopular financing measures to fund the continuation of the laws down the road once current funding expires. Time will tell how America handles the ACA and what will need to be done to refine and improve the health care system further. With the changes come many benefits and a learning process and the United States has made several improvements in refining and preserving the health of Americans across the country by passing the ACA. There are definitely still gaps to be filled and changes to be made with the law as time progresses, but it is a step in the right direction.

The law will not be successful if Americans cannot try to give it a chance. It takes time to implement any change and with so much resistance our government may spend more time fielding the resistance and fighting for the law than on refining and implementing the laws to do what they are intended to.
REFERENCES


