On March 23, 2010, the Patient Protection and Affordable Care Act (ACA) became law with President Barack Obama’s signature. The signing of this document began the most significant fundamental government transformation of the American health care system since the enactment of Medicare and Medicaid. This new form of health care has taken years of planning from the United States (US) government as it affects nearly every level of health care for all Americans from getting health insurance coverage to the actual delivery of patient care. The intricacies of overhauling the health care system in the US has included heated political debates which has led to confusion among the American people about what the true impact of this new law will be on the population and the individual.

The ACA is divided into ten titles and it contains provisions that went into effect starting on June 21, 2010, with the majority of provisions going into effect in 2014. The goal of the ACA is to expand access to health care for Americans who are uninsured through a number of these provisions such as individual and employer mandates, health insurance exchanges and the expansion of Medicaid. According to the White House, the ACA will result in an estimated 32 million uninsured Americans obtaining needed medical insurance coverage and 105 million Americans who will no longer have lifetime dollar limits on their health care coverage (The White House, n.d.). The policy also states that for those Americans who already have health insurance, the only change that will occur to their current health care benefits, is better protection from the abuses by health insurance companies, such as denials for pre-existing conditions. It also extends coverage to young adults on their parent’s health insurance plan until the age of twenty-
The Role of the Government in Health Care

The role of the government, as it relates to individual rights, was tested very early on in our country’s history and resulted in the first ten amendments to the US Constitution, the Bill of Rights; which guarantees several rights of the individual (Bovbjerg, Wiener, & Houseman, 2003). The Tenth Amendment of the US Constitution reads “the powers not delegated to the United States by the Constitution… are reserved to the States respectively…. ” (Teitelbaum & Wilensky, 2013). These principles of separating the power of authority as established by our forefathers are still there. However, as they apply to the health care delivery systems of today, the lines are not clearly established.

The states generally have control over the public health matters individually, but the federal government controls a large amount of funding given to the states for various causes. By tying federal funding of state programs to federal efforts of behavior reform, such as smoking cessation, the federal government overlaps state government’s role of health care leader. One example of this, according to an article in the Journal of Health Politics, Policy and Law, for health care reform to work, the authors feel that there would need to be a strong federal role; which is imperative to overcome the limitations of the states in financing redistributive programs, such as coverage expansions (Greer & Jacobson, 2010). This is different to the current policy and reform provisions, in which the federal government level makes the standards and policies and shifts coverage responsibility to the states.
There is always the question of federal versus state power and the US Supreme Court has the task of examining and governing this power. Historically, the US Supreme Court followed the same precedence as the framers of the US Constitution; which vested Congress with enormous powers to regulate individual economic conduct, even as they limited congressional authority over noneconomic activity. The source of this power to regulate economic activity down to the individual level is found in the Constitution’s Commerce Clause. This clause explicitly grants Congress the authority to regulate interstate commerce (Teitelbaum & Wilensky, 2013).

While both the Democratic and Republican sides of the government agree that there needs to be health care reform, the views differ on the process to achieve it. This heated debate was not limited to just Republicans and Democrats, as the public and health care providers also found themselves right in the middle of the debate. Supporters of the ACA founded their beliefs on the reform expanding benefits to every American with the potential to help millions. The opponents of the ACA claimed that it would transfer one-sixth of our economy into the hands of politicians “leading us down the road to a single payer ‘Medicare for All’ system that, in their opinion, virtually guarantees a spectacular failure” (Manchikanti, Caraway, Parr, Fellows, & Hirsch, 2011). Health care reform became a major component in the 2010-midterm elections for the 112th Congress. After tallying the votes, the Republicans gained control of the House of Representatives and gained additional votes in the Senate due largely to the widespread dissatisfaction of this country’s economic performance and lack of confidence in the ACA.
Individual and Employee Mandates

In 2006, Massachusetts Republican governor Mitt Romney signed an individual mandate into Massachusetts state law requiring individuals purchase health insurance, or pay a penalty fee. In the senate, there was broad support from both the Republican and Democratic sides for this individual mandate to be included at the national level. When the ACA was signed into law in 2010, it included an individual mandate that was then challenged by the federal courts on the grounds of constitutionality based on the Commerce Clause.

On June 28, 2012, the US Supreme Court upheld the constitutionality of the ACA’s individual mandate, stating the federal government is taxing individuals, not penalizing them. With this ruling, the Supreme Court is allowing the federal government to have influence over individuals by charging them a penalty for not having health insurance. Under the ACA, unless you qualify for a waiver, you must obtain health care coverage or pay a penalty. Unfortunately, some Americans, even those who previously had health coverage, are finding the new costs for premiums too expensive and they are electing to go without health insurance and pay the penalty. The penalty fee in 2014 is one percent of your yearly income, or $95 per person for the year, whichever is higher. This fee is going to increase on a yearly basis. In 2016 the planned increase will make it two and a half percent of your income, or $695 per person, whichever is higher. This is quite a dramatic jump in penalty costs. These penalty fees are paid when a person files their yearly income tax beginning with the 2014 taxes that are due in April 2015 (Healthcare.gov, n.d.). Chief Justice John Roberts stated, the framers of the Commerce Clause “gave Congress the power to regulate commerce, not to compel it”, but according
to an article in *The New England Journal of Medicine*, “this is now a constitutional way to regulate people who are doing nothing” (Mariner, Glantz, & Annas, 2012).

Along with the individual mandates that began in 2014, there are also employer mandates that were slated to begin in 2014, but they have now been delayed until 2015. These employer mandates require businesses with more than 50 full time employees to provide health insurance for their employees or pay a penalty fee on their federal tax return. The annual fee is $2,000 per employee if insurance isn't offered, not including the first 30 full-time employees. If at least one full-time employee receives a premium tax credit because coverage is either unaffordable or does not cover 60 percent of total costs, the employer must pay the lesser of $3,000 for each of those employees receiving a credit or $750 for each of their full-time employees total. The fee is a per-month fee due annually on employer federal tax returns starting in 2015. This penalty fee is called the “Employer Shared Responsibility Payment” as the collected funds will go to help marketplace subsidies and to compensate for unreimbursed emergency health care provided to those who are uninsured (Kaiser Family Foundation, 2013). Under the ACA, the federal and state governments, insurance companies, employers and employees are given shared responsibility to reform and improve the availability, quality and affordability of health insurance coverage in the United States.

**The Impact on Existing Healthcare Programs**

Prior to the implementation of the ACA, nearly 50 million Americans relied on Medicare and the aim of the health care reform is to make the Medicare program stronger by adding new benefits, fighting fraud, and improving care for patients. The processes that will be put in place will help seniors get lower cost prescription medications; free
preventive services, such as vaccinations and annual wellness visits; and fighting fraud through tougher screening procedures and stronger penalties for those caught scamming the system. Through this reduction in the current level of wasteful spending and Medicare fraud, the life of the Medicare Trust Fund will be extended to at least 2029, which will provide the Medicare recipient future saving on premiums and payments on co-insurance.

The ACA aims to significantly reduce the number of uninsured primarily by expanding coverage through Medicaid and new Health Insurance Exchanges to millions of people. However, the impact of the law will vary by geographic region depending on current coverage patterns and socio-demographic or economic factors, among other things. The June 2012 Supreme Court decision effectively allows states to decide whether to adopt the Medicaid expansion in 2014 and some states are implementing it and some states have elected to not move forward yet. State policy makers will evaluate the health coverage, new costs, potential savings, and political and economic implications of the decision to implement the Medicaid expansion (Kaiser Family Foundation, 2013). Unfortunately, in the states that have yet to move forward, many of the low-income adults will likely remain uninsured as those states continue to weigh their coverage options. According to the Kaiser Family Foundation, under the ACA Medicaid will expand eligibility to include more low-income adults by changing the eligibility requirement to be up to 133% of the federal poverty level (Kaiser Family Foundation, 2013).

The Children's Health Insurance Program (CHIP) provides health coverage to nearly eight million children in families with incomes too high to qualify for Medicaid,
but can't afford private coverage. Signed into law in 1997, CHIP provides matched federal funds to states to provide this coverage. The ACA maintains the CHIP eligibility standards in place as of enactment through 2019. The ACA also provides an additional $40 million in federal funding to continue efforts to promote enrollment in Medicaid and CHIP (Medicaid.gov, n.d.). Prior to the ACA, insurance companies could deny coverage to children who had certain disorders such as asthma or were born with a heart defect. They could put a lifetime cap on the amount of health care they would pay for, or cancel insurance coverage when you got sick just by finding an accidental mistake in your paperwork. The Department of Health and Human Services (DHHS), Labor Department, and the Treasury Department all collaborated on writing a Patients’ Bill of Rights, to protect Americans from these abusive practices. These new Patients’ Bill of Rights entitles the American people the ability to make informed health care choices. It will help children, and eventually all Americans, with pre-existing conditions gain coverage and keep their coverage, it will protect all Americans’ with their choice of doctors, and end lifetime limits on the medical care consumers may receive (United States Senate, 2009).

Health care reform is not only to help the uninsured become insured it is also aimed to help the underinsured have access to needed healthcare coverage. Some of the other main priorities of the ACA can be seen in the provisions that are aimed at making the insurance market work for millions of Americans who, because of their income, health status, or both, have been locked out of affordable, accessible, and stable coverage and must therefore try to pay for care at the point of service (The White House, n.d.). Through affordable insurance Exchanges consumers can choose a private health
insurance plan that fits their health needs. Starting in 2014, these health care Exchanges will offer to the public select health plans that ensure appropriate coverage; facilitate consumer assistance, shopping and enrollment; and coordinate eligibility for the Exchange and potential premium assistance. Already, 33 States and the District of Columbia are on their way to building Exchanges, having received at total of nearly $670 million in Exchange Establishment Grants (The White House, n.d.).

**Special Interest Groups and the Affordable Care Act**

There were many special interest groups involved with the passing of the health care law. Since this law was such a hotly debated topic, there were, of course, special interest groups that acted in favor of the health care law and some that were opposed. The American Hospital Association (AHA) spent more than $20 million on lobbying in 2011 in favor of the ACA. In its brief to the Supreme Court, the AHA argued against undoing the health care law stating “while the legislation is not perfect, it would extend coverage to millions more Americans. To undo the ACA now would be to maintain an unacceptable status quo -- a result that is neither prudent nor compelled by the Constitution,” (American Hospital Association, n.d.). Other special interest groups that fought in favor of the health care law were the American Federation of Laborers and Congress of Industrial Organizations (AFL-CIO), the American Association of Retired Persons (AARP), the American Nurses Association (ANA), the National Women’s Law Fund and the American Cancer Society, who spent $5.1 million lobbying that the ACA will be beneficial to cancer patients.

There were also organizations that lobbied opposing the health care bill and fought against the constitutionality of the employer mandate. One of these organizations
was the US Chamber of Commerce, which spent over $62.2 million lobbying for the
repeal of the Patient Protection and ACA. The Family Research Council, a conservative
Christian group that advocates against abortion and same-sex marriage, has spent
$107,000 in lobbying against the ACA regarding its concern about the bill's
potential and the requirement that Americans buy health insurance, stating "We have high
hopes that the US Supreme Court will recognize that the individual mandate is
unconstitutional, and will act to safeguard the freedoms of all Americans by holding the
individual mandate 'non-severable,' and strike down every part of Obamacare”
(McClusky, n.d.).

Cost to Implement the Affordable Care Act

The IRS has reported that during fiscal year 2010 to fiscal year 2012, it cost $488
million to implement the ACA. The cost of which was paid for by the Health Insurance
Reform Implementation Fund administers this fund through the Department of Health
and Human Service (Treasury Inspector General, 2013). Since Medicaid services are
offered at the state level, the coverage and budget impacts of this expansion would vary
state to state. States such as Maine, Maryland, Massachusetts, New York, and Vermont
which had already expanded coverage to adults may actually see some savings under the
ACA due to higher matching rates for already covered populations. On the other hand,
states such as Florida, Mississippi and Nevada, which previously had a large uninsured
population, are likely to see higher state costs. It is believed that over time these
increases will become small relative to the decreases in the uninsured and increases in the
federal matching funds. There are many predictions on what the future costs of the ACA
will be. The Congressional Budget Office (CBO) and Joint Committee on Taxation’s
(JCT) current projection of these costs is $1.36 trillion over the 2014-2023 timeframe (Banthin & Masi, 2013).

**Quality of Health Care and Promoting Prevention**

Another goal of the ACA is to promote the quality of health care that is received in this country. Under the ACA, the Department of Health and Human Services secretary is tasked with developing a National Strategy to Improve Health Care Quality and establishing an interagency working group to coordinate and streamline federal quality activities. One of the ways that health care will be improved will be through linking payments for services to quality patient outcomes and by developing new programs for community health teams supporting medical home models. Medical home models have proved to increase access to community-based, coordinated care that implements and supports improvements and best practices that improve the quality, safety, and efficiency of health care delivery. The ACA also supports medication management services by local health providers to help patients better manage chronic disease.

With the implementation of the new health care policy, there will be a new interagency prevention council that will be supported by a new Prevention and Public Health Investment Fund. One of their priorities will be to develop healthy communities by removing barriers to the access of clinical preventive services. The Health and Human Services Secretary will award grants to eligible entities to promote individual and community health that work towards preventing chronic diseases. They will also convene a national public and private partnership to conduct a national prevention and health promotion outreach and education campaign to raise awareness of activities to promote health and prevent disease across the lifespan. In preventing disease and promoting health and wellness, the ACA breaks new ground. According to an article in
the *New England Journal of Medicine*, it is believed by some that the health care policy law reaffirms the principle that “the health of the individual is almost inseparable from the health of the larger community and the health of each community and territory determines the overall health status of the Nation” (Koh & Sebelius, 2010).

According to the US Senate, the Congressional Budget Office (CBO) has determined that the Patient Protection and ACA is “fully paid for, ensures that more than 94 percent of Americans have health insurance, bends the health care cost curve, and reduces the deficit by $118 billion over the next ten years and even more in the following decade” (The United States Senate, n.d.). This statement would lead me to believe that this policy will be successful in making sure everyone has health care insurance. I believe that this policy is fundamentally changing and improving the health care system in the United States. The intricacies of overhauling the health care system in the US has led to heated political debates and confusion amongst the American people about what the true impact of this new law will be on the population and the individual. I feel that there is a true need for health care reform in the US and that there needs to be a penalty for not having health care, if you have affordable access to it. Unfortunately at this time of initial rollout of the reform, there are families going without coverage that previously had coverage due to the higher costs. While I do believe that it is an individual responsibility to get health insurance coverage, I also think it is the responsibility of the US government to assure that there is affordable health care coverage available to everyone.
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