Fall 2019

The Benefits of the Affordable Care Act

Melanie Ramage
melanie.ramage@outlook.com

Running Head: THE BENEFITS OF THE AFFORDABLE CARE ACT

The Benefits of the Affordable Care Act:

Providing and Improving Health Care for Everyone

Melanie E. Ramage

Murray State University

Abstract

The Affordable Care Act (ACA) is a health care reform law enacted in March 2010. The Affordable Care Act was signed into law by President Barack Obama. The ACA has been the most all-inclusive reform of healthcare in the United States. It is the first time that the government has mandated health insurance. The ACA has significantly expanded public insurance, both Medicare and Medicaid. The government also provides payment assistance for individuals who seek their own health insurance coverage through the health insurance marketplaces. While the poor has benefited the most, the middle class have been forced to make major adjustments to the amounts they pay monthly, in addition to increased deductibles. The Affordable Care Act has had many changes since its implementation. It has not lacked in controversy. According to HealthCare.gov, some of the goals for the ACA are: to provide affordable insurance to everyone; provide ways for the poor and uninsured to be covered at an affordable rate through tax credits and expanded Medicaid programs; to provide advanced medical care designed to lower the costs of healthcare for everyone. This paper provides a discussion of the benefits of the Affordable Care Act. It will provide important objectives such as: the coverage of the act, eliminating pre-existing conditions rules, and the affordability of coverage, including coverage for the poor. It will also provide the benefits for women, children, young adults in college, as well as the care provided, such as preventive care and mental health.

Outline

I. Introduction 3

II. History 4

III. Benefits 11

a. Impact on Health Coverage 21

b. Improved Coverage of Behavioral Health 25

IV. Challenges 27

V. Impact on Well-Being 32

VI. Measuring Success 34

a. Access to Health Care 36

b. Cost Reduction 38

c. Quality of Care 42

VII. Conclusion 43

Introduction

The Affordable Care Act (ACA) is a health care reform act that was signed into law in 2010 under the Obama administration. The ACA is often referred to by the nickname "Obamacare" due to President Barack Obama's push for the legislation throughout his campaign and early into his presidency. Although the ACA had numerous goals, one of the primary objectives of the ACA is to provide affordable health insurance coverage for all citizens of the United States. Unfortunately, the act became a controversial topic from its fruition and still remains a sensitive subject for many Americans. The second objective of the ACA is to expand the federal Medicaid program. This feature of the act is sanctioned due to the majority of uninsured Americans remaining below the federal poverty line and being unable to afford adequate health coverage. The third objective of the ACA is to ultimately improve the delivery of health care to the U.S population, or in other words, improve the overall quality of the health care received by U.S. citizens.

A majority of the controversy surrounding the ACA is due to a lack of understanding of the act and misconceptions regarding the entire policy. It is important for Americans to have a general knowledge of the legislation and comprehend the benefits and challenges of the Affordable Care Act. It is vital for Americans to understand the ACA fully in order to form an informed opinion, whether for personal reasons, business reasons, or even just to have a deeper understanding of the policy. Since the passing and implementation of the Affordable Care Act nine years ago, there have been numerous notable changes within the healthcare system for the betterment of the people. Unfortunately, there has also been some downsides to the law that have only perpetuated the negative misconceptions. However, current research demonstrates that the

Affordable Care Act is beneficial to the American population. The ACA has allowed for more citizens to access to insurance and quality health care than ever before in U.S history. In order to fully understand the Afford Care Act, the history of the legislation must be understood, the benefits and challenges of the law needs to be examined, and the measure of success must be determined.

History

The Affordable Health Care Act has a lengthy and somewhat confusing history, that not only expands the creation of the legislation, but began before and is continued to be shaped until present time. Health care legislation remained in political conversation long before President Obama's administration. President Richard Nixon actually proposed health care reform almost 30 years before Barack Obama signed the Patient Protection and Affordable Care Act. Health care reform has been a long-standing issue in U.S. politics for the simple fact of necessity.

In comparison to other developed nations, the United States is significantly lacking in several areas associated with health and health care. The United States has some of the highest rates of injuries, teen pregnancies and sexually transmitted diseases, greater obesity, diabetes, heart and lung disease, and disability rates when compared to other developed nations (Fitzgerald, Bias & Gurley-Calvez, 2017). These heightened health issues, partnered with the corporate, money-making industry of health insurance is the leading factor in why the United States ranks last when compared to our allies in health care. "The United States ranked last on three indicators of healthy lives: (1) deaths prior to age 75 that are potentially preventable with

effective, timely health care (a measure known as mortality amenable to health care), (2) infant mortality, and (3) healthy life expectancy at age 60" (Fitzgerald et al., 2017).

In the United States, access to health care is greatly dependent on the socioeconomic characteristics, including income, education, employment, and wealth of the individual (Griffith et al., 2017). "Compared to Americans who are better off, those in lower socioeconomic strata are less likely to be insured, are more likely to avoid medical care due to cost and to enter hospitals through emergency departments, and have twice as many avoidable hospitalizations" (Griffith et al., 2017, p.1503). The sad reality in the United States is that individuals that need health care and have actually been shown to have greater medical needs, do not have the means to access medical care. "These health care access gaps are compounded by—and may contribute to—the large and widening socioeconomic disparities in health and longevity in the United States" (Griffith et al., 2017, p.1503). The Affordable Care Act was created and implemented to mend the gaps that existed in America's health care system. One of these gaps being access to affordable health insurance coverage for all citizens, no matter the individual's socioeconomic position.

For many years, there was debate on how a program such as this should be implemented. Even greater debate exhumed on how it would be paid for, would it be paid for by the federal government through the rearrangement of the national budget? Would the costs be left to the employer, or employee, as well as how the poor would be able to pay for or access health care? During Barack Obama's campaign and throughout his term, health care reform was a priority. Shortly into his first term, President Obama began the process towards drafting up a bill that would allow a greater amount of the American population access to health care, improve the

quality of care, and ultimately lower health care costs for everyone. “Rather than having the executive craft the bill that would ultimately be introduced in Congress, as had been done in President Clinton’s failed effort more than fifteen years earlier, President Obama laid out the broad principles and goals that he wanted in a health care bill and left it to the House and Senate to provide the legislative detail” (Cannan, 2013, p.137). In March of 2009, three chairmen of the House committees, Education and Labor, Energy and Commerce, and Ways and Means, agreed to collaborate on drafting a legislation for health care reform (Cannan, 2013). Collaboration was vital to the success of this bill, as the battles between the committees are what crippled health care efforts during President Clinton’s term. March through May of 2009, hearings were held regarding the health care legislation. On June 19, 2009, the committee chairmen, with direction from Nancy Pelosi, the Speaker of the House, released a “discussion draft” proposal for health care reform (Cannan, 2013). “It included provisions for a health insurance exchange, where consumers could “shop” for insurance; a public health insurance option; an expansion of those covered by Medicaid; a mandate for individuals to either have insurance coverage or pay a fee (with hardship exemptions); and a mandate for employers to provide insurance or pay a contribution fee (with some exemptions)” (Cannan, 2013, p.137). Unfortunately, the committee chairmen left the funding details somewhat vague. Additional hearings were held that June through July to amend the original draft. Then, on “July 14 the committee leaders introduced House bill 3200—America’s Affordable Health Choices Act of 2009” (Cannan, 2013, p.137). However, by October, new ideas had emerged, and the House introduced the House bill 3962, Affordable Health Care for America Act. The new bill was a result of negotiations among different factions of the House Democrats. Although the bill resembled House bill 3200, “..it contained health exchanges, a public option, individual and employer mandates, Medicaid

expansion, and a surcharge on those with high incomes" (Cannan, 2013, p.141). Although the House bill 3962 was not referred to committee for any substantive review or was even listed on the House Union Calendar, which would make the bill eligible for consideration by the House, it was called up on the House floor on November 7, 2009, less than two weeks after it had been introduced (Cannan, 2013, p.141). The rules resolution allows a bill to jump ahead in consideration, the House Rules Committee moved the bill to the floor via House resolution 903. "House resolution 903 passed the House in the early afternoon of November 7, 2009, after an hour of debate. House bill 3962 was passed at 11:15 that same evening, after four hours of scheduled debate. It was received in the Senate three days later" (Cannan, 2013, p.143).

However, while all of this legislation was being created, discussed, and amended in the House, two Senate committees where commissioned with an almost identical task. The Committee on Health, Education, Labor and Pensions (HELP) and the Committee on Finance had already begun forming their own version of health care legislation before a House bill has even been brought to the floor (Cannan, 2013). The ultimate goal of using two separate entities was for both the committees to each produce a form of legislation that could be merged together into a single bill (Cannan, 2013). The use of separate committees was similar to the method the House utilized, but the Senate actually ended up taking the lead in shaping the future of the ACA. In fact, House bill 3962 was never even referred to a Senate committee at all. The Committee on Health, Education, Labor and Pensions was the first of the Senate committees to complete a health care bill. It is important to note that in the Senate "...bills are numbered as they are introduced. Bills that originate in committee have not yet been introduced in the technical sense and, as a result, are not numbered until after they are reported out of committee" (Cannan, 2013, p.144). When the draft bill was released from the HELP committee on June 9, 2009, it had

no number to label it. Every revision of the bill remained unnumbered as well. This, unfortunately, can make tracking the history of a bill somewhat complicated (Cannan, 2013).

Over the course of a few months, several amendments were made to the legislation draft and on October 13, the bill was finally given a number, 1796. Senate bill 1796, titled the America's Healthy Future Act, was voted to report out along with a committee report (Cannan, 2013). However, there was still much debate regarding health care legislation, especially between Republicans and Democrats. The well-known "checks and balances" method that the United States' government uses to ensure shared power among different branches of the government, although necessary, can make the process of creating and implementing legislation an extremely lengthy process. Senate Majority Leader Harry Reid began the effort towards combining bills in order to speed up the legislative process. Reid was the leading voice in the effort by prominent Democratic senators and the White House to merge the HELP and Finance Committee bills into one health care legislation. His proposal was unveiled on November 18, 2009. "The Reid proposal did not become a new piece of legislation but rather was inserted as an amendment to an existing one. With this decision, the legislative history of health care merged with that of the Service Members Home Ownership Tax Act of 2009" (Cannon, 2013, p.150).

While Senator Reid was preparing the blended health care bill, the Senate had access to review and amend some of the House bills. These "..bills [were] available to use for an amendment between the houses on the Senate Calendar of Business, including House bill 3962, the House's health care bill, and House bill 3590, the Service Members Home Ownership Tax Act of 2009"(Cannon, 2013, p.152). Senator Reid used this opportunity to implement his proposal of the blended bill within one of the House bills. The wording of House bill 3590 was

altered using the Reid health care proposal, Senate amendment 2786 (Cannon, 2013). After much debate and countless amendments, some of which were not significant to the legislation itself, "Senate amendment 3276 passed on December 22; Senate amendment 2786 passed on December 23; and House bill 3590 finally passed on December 24" (Cannan, 2013, p.158). The last action of the bill was for it to be renamed the Patient Protection and Affordable Care Act (Cannan, 2013).

Fast forward several years later and the history of health care legislation is still being shaped. The Department of Health and Human Services was appointed to formulate a list of essential health benefits. The HHS asked the Institute of Medicine (IOM) for assistance in establishing these essential benefits plan. "The IOM tackled its assignment with dispatch, quickly convening an expert panel to write a report recommending methods for determining and updating essential benefits" (Bagley & Levy, 2014). In December of 2011, the HHS released its essential benefit list. However, it was ultimately left up to the individual states to define their own essential benefit plan. Each state was required to have health insurance exchange operating within two years, in order for people to sign up for health insurance and determine the individual's cost. At the same time, employer-sponsored coverage was determined. However, this coverage also lacked the detail of benefits covered by the state covered benefit list. Eventually, the IOM released a report that issued a recommended method of determining what constitutes an essential benefit. "Because of the way premium subsidies and tax-sharing credits are calculated, recipients of subsidized coverage in states with generous benefits will receive modestly more federal support than those in less generous states" (Bagley & Levy, 2014). The result was a variety of issues with determining what the federal government was liable to financially cover. This ultimately left the individual states responsible for the payment of what

that particular state considered to be an essential benefit. According to the HHS, the essential health benefits must, at a minimum, include:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventative and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

Then in January of 2014, twenty-four states, along with the District of Columbia, expanded Medicaid. All of the residents in these twenty-four states now had access to subsidized premiums. “Twenty-six states chose not to expand Medicaid at the time, though nonpoor residents of these states gained access to subsidized coverage on the exchanges” (Griffith et al., 2017, p.1503). The expansion of Medicaid through the Affordable Care Act is one of the most significant elements of the new health care legislation.

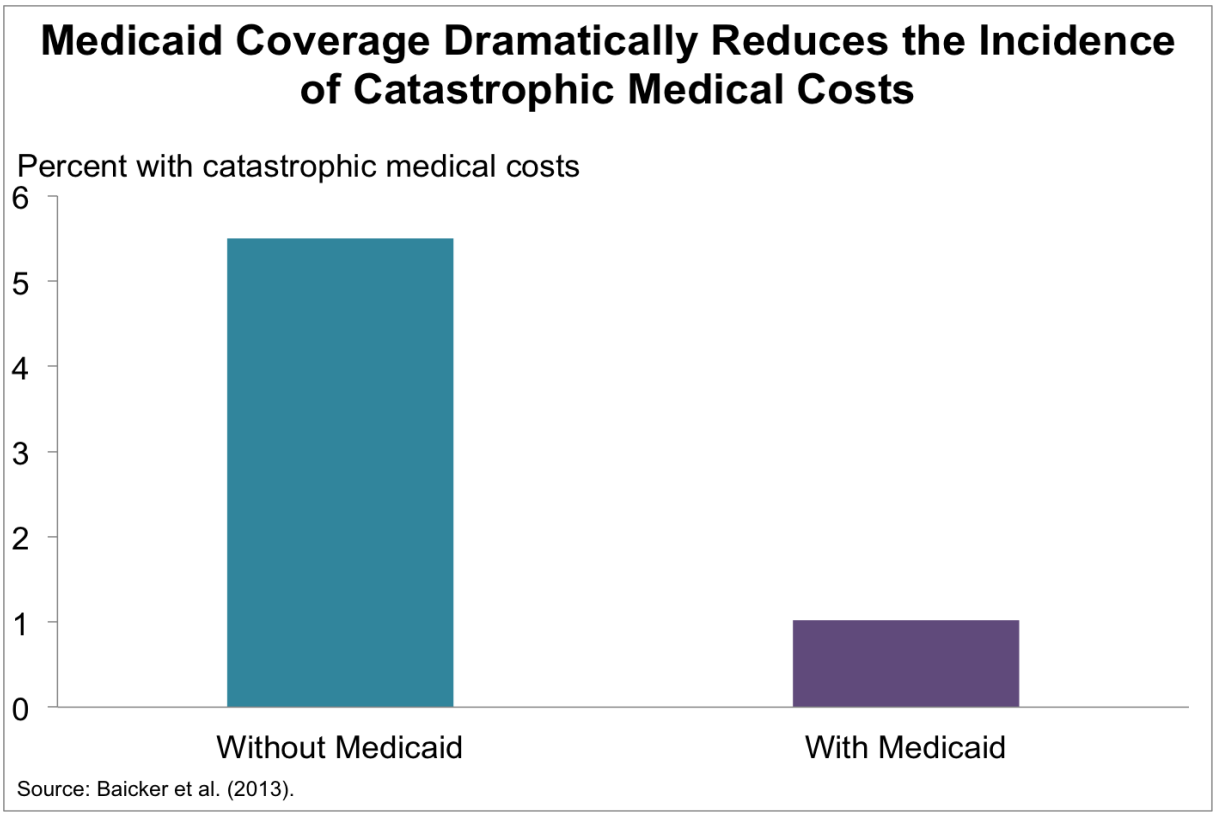
Since the ultimate goal of this new legislation was to provide access to quality health care to every U.S. citizen, federal law needed to be restructured to create four different methods to access health care coverage. These four include employer coverage, individual market coverage,

Medicaid, and Medicare. Employer coverage is the primary method used by the working-age population to obtain health care. Individual market coverage is "...coverage purchased in a fundamentally reconfigured individual market, with premium tax credit subsidies and cost-sharing assistance for low and moderate income people who buy their coverage through a health insurance Exchange, also known as the Marketplace" (Rosenbaum & Thorpe, 2016, p.534). Health care coverage access through Medicaid is limited to the lowest income households in the United States, with family incomes at or below the federal poverty level. Lastly, Medicare is utilized for elderly Americans and individuals with severe disabilities that prevent them from working (Rosenbaum & Thorpe, 2016). "After 2015, the Children's Health Insurance Program (CHIP), Medicaid's small companion established in 1997 and reauthorized in 2009, would effectively be folded into/replaced by the Exchange system for families needing affordable coverage for themselves or just their children. States would operate health insurance Exchanges (now referred to as Marketplaces), with federal backup in the event of a state refusal or failure" (Rosenbaum & Thorpe, 2016, p.534).

Benefits

With an abundance of negative messages targeted at the Affordable Care Act, it is hard for the American population to embrace the positive implications associated with the policy. When considering the act as a whole, one must observe the reduction in overall health care costs due to the availability of free preventive care, the improved coverage of behavioral health among a variety of other insurance coverage expansions, and the vast majority of citizens in the United States that now have access to quality health insurance coverage.

American citizens end up spending significantly more money when he or she delays treatment and is forced to undergo emergency health care than what it would cost to prevent the medical emergency in the first place. The ACA ensures that preventative care is accessible to all citizens, therefore helping reduce the overall cost of health care. Another area of the ACA that has transformed the financial burden of medical care is the expansion of Medicaid. Research was conducted in the state of Oregon which confirmed that the expansion of Medicaid coverage ensured that financial turmoil did not occur when getting sick. See below chart (Furman, 2014).



Research conducted at the University of Tennessee at Knoxville assessed the state Medicaid expansion under the Affordable Care Act and how it impacted insurance status and access to health care among low-income mid-life individuals in 2014 (Choi, 2017). The research analyzed the 2012 and 2014 Behavioral Risk Factor Surveillance System data and compared the pre-Medicaid time period with the post-Medicaid data (Choi, 2017). The results demonstrated a major improvement in the number of individuals that have access to health care. "Regardless of income status, U.S. mid-life adults' access to healthcare improved from 2012 to 2014. ...the insured rate increased from 66.5% (2012) to 80.4% in 2014 (20.9% increase) among low-income mid-life residents in Medicaid expansion states, while it increased from 61.3% to 70.0% (14.2% increase) among their counterparts in nonexpansion states" (Choi, p.1088, 2017). The rate of improvement was even greater among low-income residents living in the states that participated in Medicaid expansion.

The Affordable Care Act did not simply provide coverage for individuals that did not have access to health care in the United States, it actually improved the coverage for individuals who already had health insurance. Since the implementation of the ACA, it is now mandatory for insurance companies to include certain benefits in all health care policies, for example, mental health services and addiction treatment are now required to be financially covered by health care insurance companies. Another area of the ACA helped improve was coverage for individuals with pre-existing conditions. Individuals can no longer be denied or terminated from health care coverage for pre-existing conditions, no matter the severity of the condition or the length of time one has had the condition. Pre-existing conditions are medical conditions that began prior to a person's health benefits going into effect. What this means for American citizens is that if an individual changes insurance companies or policies or obtains insurance for the first time, the

new health coverage must continue to provide coverage of the condition. These pre-existing health conditions include asthma, diabetes, or even cancer. The significance of this element of the policy is the number of citizens that are affected by these conditions. Millions of Americans take the risk of being denied health care or are burdened with higher policy rates because of medical conditions out of his or her control. After 2014, this fear was removed from individuals with pre-existing conditions.

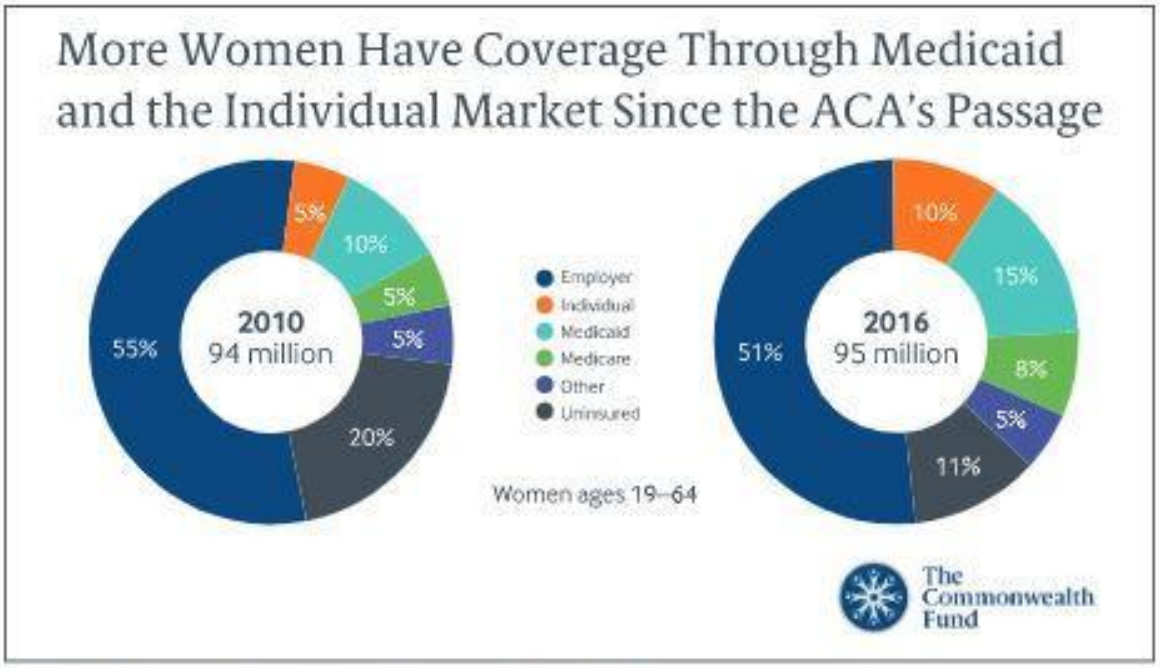
Another change that went into effect after the implementation of the ACA is the lifetime and annual limits of health insurance. Prior to the ACA, health plans could and often times did, set these restrictive and unfair limitations on coverage. A lifetime limit was a dollar amount limit on what the insurance company would spend on an individual during the time of enrollment. After the limit had been reached either for the year or for the lifetime, any medical cost became the insured's financial responsibility. These annual and lifetime limits were often reached by many insured who accumulated costly treatments for diseases such as cancer or traumatic brain injuries. These conditions would financially cripple even the most insured families because of the frequency and intensity of the treatments. That is, until these limitations were removed. If an individual is paying for insurance, they should receive the benefits of the coverage despite the expense of the treatment. That is the whole point of an individual having health insurance.

The Affordable Care Act has increased coverage for the group of Americans that were severely lacking access to health care, including low-income women, adolescents, pregnant women and their newborns.

According to an article in the American Journal of Nursing, the Commonwealth Fund Biennial Health Insurance conducted a survey in 2016 that demonstrated that the Affordable

Care Act has provided low-income women in the United States the greatest gain in coverage. (Potera, 2019). However, this increase of coverage did not just benefit low-income women. Women from every socioeconomic, ethnic, and age groups have seen an improvement in health care coverage since the launch of the ACA policies. The percentage of uninsured women has decreased and the access to care has increased drastically. Women that are now covered under the ACA are seeking preventative care services including screenings and vaccinations. The chart below depicts the changes in women's health care since the implementation of the ACA. Women covered by Medicaid increased by 5 % from 2010 to 2016. Women covered by the individual market also doubled from 5% in 2010 to 10% in 2016. The percentage of uninsured in 2010 compared to those in 2016 was nearly cut in half from 20% to 11% (Potera, 2019).

Prior to the ACA, women were forced to pay higher premiums than their male counterparts or they were denied coverage altogether " ..inequities in coverage deterred about a third of women from buying insurance in the individual market. These included having to pay higher premiums than men; being denied coverage for pre-existing conditions, including pregnancy; and lack of coverage for maternity care and contraceptives" (Potera, p.15, 2019).



Reprinted from Gunja MZ, et al. *How the Affordable Care Act has helped women gain insurance and improved their ability to get health care: findings from the Commonwealth Fund Biennial Health Insurance Survey, 2016.* The Commonwealth Fund, Aug 17.

Another group that has witnessed a positive change in health care coverage as a result of the ACA, is adolescents. "Historically, the age group most likely to lack health insurance coverage in the United States has been young adults, too old to qualify for insurance available nearly universally to minors and too young to have high rates of employment at large employers that provide employer-based insurance" (Breslau et al., p.132, 2018).

Kathleen Tebb, Erica Sedlander, Sara Bausch, and Claire Brindis completed two phases of research evaluating the impact of the Affordable Care Act on adolescent health care (2015). Both phases of the research conducted were done through in-depth semi-structured telephone

interviews with health care administrators, health policy researchers, and adolescent medicine specialists (Tebb et el., 2015). The participants in the interviews were asked open ended-questions that were recorded, then analyzed by a panel. These questions included topics such as, "...opportunities under the ACA to promote adolescent health, the extent to which implementation efforts were taking into account the special health needs of adolescents; the enrollment process and strategies to maximize enrollment; how confidentiality for young people is being addressed in light of the ACA expansions; and the challenges that need to be addressed to meet the needs of adolescents" (Tebb et el., p.2090, 2015). The researchers used the results from the interviews along with extensive literature review to determine if the ACA has expanded and improved coverage for adolescents and where the policy can further develop. The results of the research demonstrated that the ACA did, in fact, expand health insurance access for adolescents; however, some inequities in coverage and barriers to access remain. "Prior to the ACA, nearly 10% of children and adolescents were uninsured and after initial implementation efforts, this proportion decreased to 5.5 % in 2012" (Tebb et el., p.2090, 2015). Tebb and the rest of the research team concluded that the reason for this decrease is due to two major policy changes from the ACA (2015). The first of these being the removal of pre-existing condition limitations, as mentioned earlier. Health insurance companies can no longer deny or limit coverage to individuals with pre-existing conditions, therefore allowing more adolescents to gain coverage. Since a large portion of adolescents have special health care needs, this element of the policy open access to health care for many young Americans. The second policy under the ACA that has contributed to greater health care access for adolescents is Medicaid expansion. Medicaid covers children in families below the Federal Poverty Line, which are typically the population under age 18 that need coverage the most.

Preventative health care is a major factor in avoiding illnesses and deaths of the youth. A child needs proper health care in order to avoid illness, injury, death or simply health issues later in life. “Preventive services include immunizations, behavioral assessments for adolescents, obesity screening, FDA-approved contraception and patient education counseling, and sexually transmitted infection (STI) counseling and screening” (Tebb et el., p.2091, 2015). This is uniquely important for adolescents because they are at a critical time in their development where behavioral patterns become established into lifetime habits. Adolescents are also going through drastic changes in hormones, making them susceptible to mental health issues and increased interest in sexual activity. Proper education and access to preventative care is extremely important to the well-being of this age group. This is another reason the ACA can continue to positively impact adolescents.

The next group that has been impacted drastically by the Affordable Care Act overlaps with both women and adolescents, pregnant women. Since a majority of mothers needing health care assistance are typically still adolescent age, this area connects with both low-income women and adolescents. However, this category needs to be separate because of the distinct health care needs for pregnant women. “Before the ACA was enacted in 2010, only 11 states required coverage of maternity benefits in individual health plans” (Srinivas, 2019). Many women all over the United States either faced crippling maternity cost or remained uninsured during the length of their pregnancies. The financial burden of a child is not limited to after a child is born. The routine checkups, the supplements, the classes needed, all add up before the child has even entered the world. The costs for normal delivery can reach around an astonishing $20,000. If the pregnancy is high risk, the costs associated with the prenatal care can exceed that amount dramatically. The ACA covers a great majority of the hefty prenatal, labor and delivery costs.

Along with this, the ACA also covers postpartum and newborn care. The benefits of this are limitless. Not only does it ensure the health of the mother and child, but it also ensures that the mother will be financially able to support the child that has now entered the world.

The new health care legislation benefits do not stop there. The ACA now covers contraception services with no out-of-pocket expenses for the patient. This greatly reduces the overall costs of prenatal and postpartum care for providers. It also allows for individuals that cannot afford contraception the ability to avoid pregnancy. Preventative services that must be covered without copayment include the following:

- Grade A or B recommendations of the US Preventive Services Task Force (USPSTF)
- Preventive services for women identified by the Health Resources and Services Administration (HRSA) and the Institute of Medicine
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
- Preventive care and screenings for infants, children, and adolescents supported by HRSA
- Preventive care and screenings for women added under the Women's Health Amendment of the ACA

These advancements have improved the quality of life for both expecting mothers and newborns, along with reducing the number of unwanted pregnancies. In addition to those listed above, the ACA provides access to several more important preventative services such as, well-women visit, screenings for human papillomavirus, and counseling services. "A study on the effects of the Medicaid expansion in the United States for cohorts of individuals born between 1979 and 1993 examined whether increased eligibility for prenatal Medicaid coverage influenced

subsequent health outcomes when they became adults" (Srinivas, 2019). The studies found that the children whose mothers experienced prenatal care had better overall health throughout life and were less reliant on public assistance into adulthood. There was a reduction in the cost of health care for Medicaid recipients because the individuals sought preventative care rather than going to the doctor for treatment of illness and diseases. To fully understand the impact of the ACA, one must think of what would happen if the benefits for the ACA were removed. If maternity and newborn care were to be dismissed from being an essential health benefit, it would trigger a domino effect causing multiple problems for the system. There would be an increase of individuals dropping their insurance coverage causing the price of insurance for others to increase. If the ACA was not in place, contraception would no longer be required to be covered by insurance companies. Since approximately 45% of all pregnancies in the United States are unintentional or unplanned, the cost of care for those uninsured would put a financial burden on the already strained Medicaid budget (Srinivas, 2019). The Affordable Care Act was implemented, in order to alleviate the strain and massive burden of the cost of health insurance.

Before the Affordable Care Act, medical insurance was a completely separate insurance plan from dental and vision. Many employers did not offer paid or discounted dental and/or vision coverage for employees. Under the current health care legislation, dental coverage is considered an essential health benefit for children 18 and under. Unfortunately, dental coverage is not considered an essential health benefit for adults. Therefore, insurers are not required to offer adult coverage for dental services. This same condition also applies to vision coverage. Children under 18 are covered for services like eye exams and glasses. However, only some marketplace plans include vision coverage for adults. If an adult needs vision coverage, they may have to purchase a stand-alone vision plan. Although the ACA has made tremendous strides in

getting Americans access to quality health care, there are some areas that the United States still falls short.

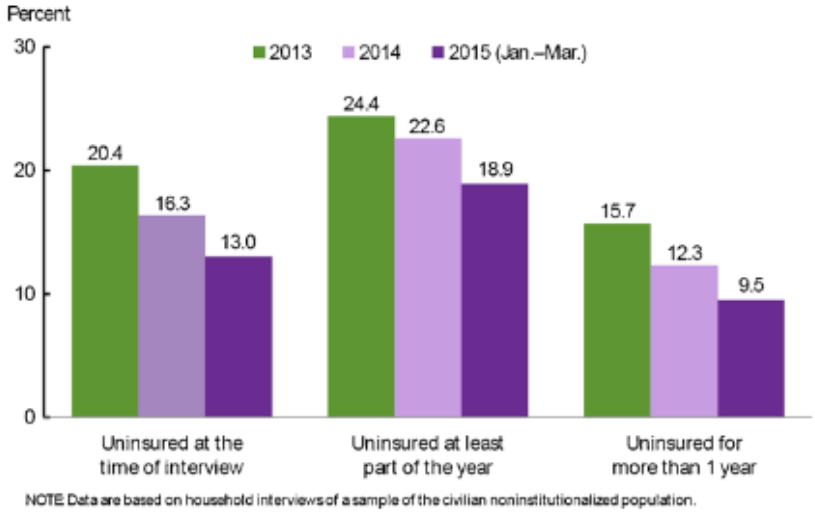
Kevin H. Nguyen, MS and Benjamin D. Sommers, MD, PhD conducted a survey of low-income citizens 19 to 64 years of age in Arkansas, Kentucky, and Texas. The survey measured access and quality of care for Medicaid, private insurance, Medicare and uninsured individuals. The results showed that insured individuals reported better health care access and quality than uninsured. The uninsured were the only group that reported as fair or poor rate of care. Nguyen stated "Our results suggest that, although some tradeoffs in specialty access and affordability may exist between Medicaid and private insurance, coverage expansions to low-income adults will likely lead to substantial gains in overall access to quality health care, regardless of whether that coverage is private or public insurance" (Nguyen & Sommers, 2016). The goal of the Affordable Care Act is for every citizen in the United States to have equal access to proper health care, whether through Medicaid or private insurance.

Impact on Health Coverage

After the first year the Affordable Care Act was implemented, the Public Policy and Advocacy Committee of the Society for Surgery of the Alimentary Tract (SSAT) held a conference discussion to evaluate the impact of the ACA with a panel of policy experts. One discussion held by the SSAT focused on the associated positive outcomes and negative outcomes of the ACA's effect on public care and surgical care. The ultimate goal of the ACA has been to improve the quality and access of health care for individuals and decrease costs of care. The manuscript for the panel hosted by the SSAT provides some valuable statistics regarding

uninsured individuals before and after the implementation of the ACA. The numbers are extremely straight forward, demonstrating the vast number of uninsured Americans obtaining health coverage after the implementation of the ACA. This can be contributed to a variety of reasons. The primary reason being the removal of insurance obstacles. Difficulties to obtain health care coverage have decreased for Americans, making it more accessible to the general public. The article also reflects on the change of the insurance industry. “The positive effects of the ACA can be divided into three broad categories as follows: (1) insurance industry reform, (2) expansion of coverage, and (3) the ‘triple aim’ of the improved outcomes, and reduced costs of care, the last of which will take the most time to evolve” (Rudnicki et al., p.353). The chart below depicts the percentage of individuals between ages 18 and 64 without insurance over the course of a two-year period. It is extremely promising for the future of the ACA. This positive increase in insured individuals is a reflection of the expansion of health legislation as it takes effect throughout the United States. Fewer and fewer Americans go without health insurance as each year passes.

Fig. 1 Percentage of adults 18–64 without health insurance using three measures of uninsurance: USA 2013–March 2015



Coverage expansion has shown to be extremely significant for individuals with chronic medical conditions, since the cost of care and amount of care is higher than the average person. "In 2012, more than 29 million Americans were living with diagnosed diabetes. The serious health challenges facing people with diabetes include heart disease, stroke, hypertension, kidney disease, neuropathy, and blindness" (Brown & McBride, 2015). In just that year, the estimated economic cost of care for individuals with diagnosed diabetes reached a staggering $245 billion. The financial burden of having a chronic condition like diabetes could potentially cripple a family, especially if that individual is uninsured or under-insured. "Although private and public health insurance programs provide important access to health care for some people with diabetes, millions of working-age adults with diabetes lack health insurance" (Brown & McBride, 2015). This suggests that a significant number of the U.S population with diabetes are confronted with barriers to health care. These barriers to coverage could lead to suboptimal care, increased likelihood of long-term complications, and overall greater health care expenditures (Brown & McBride, 2015).

A study was conducted by Derek Brown, PhD and Timothy McBride, PhD to evaluate the impact of the Affordable Care Act on improving the care of Americans with diabetes. Their goal was to determine if diabetes care for these individuals has improved through increased access to health care. The study was published in 2015 in the Centers for Disease Control and Prevention publication regarding Preventing Chronic Disease. The study compares the outcomes of insured and uninsured individuals with diabetes.

The study "examined demographics, access to care, health care use, and health care expenditures of adults aged 19 to 64 years with diabetes by using the 2011 and 2012 Medical Expenditure Panel Survey" (Brown & McBride, 2015). Diabetes is a serious health disease that effects millions of Americans. The disease causes serious health related complications such as stroke, hypertension, and blindness, just to name a few. The economic burden is in the billions. Many Americans diagnosed with diabetes do not have health insurance coverage because they cannot afford it. They put themselves at high risk by not seeking management from a health care professional to control the disease and the many complications. "As of September 2014, ACA had reduced the number of uninsured by more than 9 million..." (Brown & McBride, 2015). High out-of-pocket cost was a barrier for many to seek health care. The ACA provides subsidies and tax credits to assist individuals in obtaining health care plans through their state's health insurance marketplace.

The Medical Expenditure Panel Survey provides data from surveyed respondents on questions such as health care use, insurance, expenditures, access to care, preventive care services, and chronic diseases. The questions are asked multiple times throughout one calendar year. For this study, data from the years 2011 and 2012 were used. Individuals with diabetes are

asked about their health outcomes. The individuals covered in the reported data had incomes above and below 138% of the federal poverty level.

The results of the study estimated that "more than 13 million adults in the United States aged 19 to 64 years were living with diagnosed diabetes, and nearly 2 million of them lacked health insurance." The absence of health insurance is a hurdle for individuals to seek medical care, which increases their risk of diabetes complications. The uninsured individuals sought emergency department services or inpatient hospital stays more than those insured individuals. This results in a higher cost of health care expenses. The insured participants showed a greater use of prescription medications than those uninsured. There was a lack of consistent care for those uninsured. Therefore, the study showed that access to health care was a recognizable barrier. The population with undiagnosed diabetes is substantial. However, there will be newly diagnosed individuals with the improved health care access under the ACA.

Improved Coverage of Behavioral Health

The Affordable Care Act was created to bridge a large gap that existed in the U.S. population's overall health and well-being. One of these areas that was neglected prior to the implementation of the ACA was behavioral health. The ACA was predicted to improve behavioral health in three different ways. "First, private health insurance exchanges with premium subsidies were established to make in- surance more accessible to individuals and families who do not have employer-based coverage. Second, Medicaid expansion was designed to increase enrollment by raising the income threshold and eliminating other qualifications not related to income. Third, the ACA extended provisions of the Paul Wellstone and Pete Domenici

Mental Health Parity and Addiction Equity Act of 2008, mandating parity between behavioral health and general medical insur- ance benefits across most sources of insurance coverage" (Creedon & Lê Cook, 2016). A study conducted by Timothy B. Creedon and Benjamin Lê Cook in 2014 gathered and analyzed data from the National Survey on Drug Use and Health, "a nationally representative annual survey of drug and alcohol use behaviors, mental health status, and behavioral health treatment among the civilian noninstitutionalized US population age twelve or older" (Creedon & Lê Cook, 2016) in order to determine the impact of the ACA on behavioral health. Creedon and Cook assessed four outcomes of the survey over the course of a year; inpatient, outpatient, and pharmacy mental health treatments among those with serious psychological distress, treatment for those with a diagnosed substance use disorder, treatment barriers for respondents that could not access but self-identified a need for care, and lastly, insurance coverage among individuals diagnosed with serious psychological distress or a substance use disorder (Creedon & Lê Cook, 2016). Although the authors indicate that 2014 alone was likely to have not been a long enough period to fully evaluate the impact of the Affordable Care Act on behavioral health, there were some promising results from the survey. Creedon and Lê Cook specifically state that "there might have been a lagged effect, with many newly insured individuals requiring additional time to identify a need for care, find a provider, and determine what their new insurance covered" (2016). An additional survey, having given the program more time to fulfill its purpose, may provide a better idea of the true effect of the ACA on behavioral health. Despite the disparities in the survey, the results demonstrated a positive impact on individuals needing mental health treatment. In 2014, survey respondents with serious psychological distress or substance use disorders had an estimated insurance coverage of about 81.5 percent, which is a drastic difference from years prior where insurance coverage was

significantly lacking. “Among those meeting criteria for serious psychological distress in the past year, survey respondents in 2014 were significantly more likely ($p < 0:05$) to receive mental health treatment than respondents in any of the pre-2014 comparison periods” (Creedon & Lê Cook, 2016). It can be concluded that in 2014, when ACA-driven Medicaid expansion and private insurance exchanges were initiated, mental health treatment rates increased significantly (Creedon & Lê Cook, 2016). The results did show little effect on individuals with substance use disorders. Despite the increase in insurance coverage and the individuals having newly gained access to care, many did not seek help. These results allow for revision and improvements in areas the ACA might not yet be reaching. The authors note that “this finding indicates that substance use disorder treatment continues to be somewhat of an outlier, responding against expectations and differently than mental health treatment” (Creedon & Lê Cook, 2016).

The results from the survey not only demonstrate positive results for mental health treatment but show a promising future for the nation’s behavioral health overall.

Challenges

The Affordable Care Act has an extensive variety of benefits that extend from providing the most low-income households with the health care they need, all the way to improving the quality of care a newborn receives. However, the legislation is not perfect, there are many issues that are both public and logistic with the ACA. Income taxes have been increased for some Americans, drug companies will also see a hike in taxes that could be passed on to the consumer and will take many Americans time to adjust to all the changes implemented by the act.

Joshua P. Cohen, PhD, describes the challenges still faced with the roll out of the Affordable Care Act in his 2015 article. While a majority of Americans that were previously lacking coverage are now insured under the ACA, there are still millions of individuals living without insurance or limited coverage. The ACA is set up to be launched into operation in stages which has streamlined the process but makes evaluating the ACA somewhat difficult. Financially speaking, the rising cost of health care has slowed down since the inception of the ACA. Depending on a Supreme Court ruling, the entire system could collapse. Due to the high cost of health insurance for some young healthy individuals, they opt not to pay the cost and therefore not elect to be insured. This affects the system's ability of functioning as originally planned. The predicted advantages are supposed to range from affordable premiums and deductibles to a better quality of health care. Cohen summarizes that "legal issues aside, major hurdles remain, namely, to: (1) get more uninsured people to sign up through employer and individual mandates; (2) ensure quality, affordable access; and (3) make the overall health care system more efficient and better coordinated" (Cohen, p.718, 2015).

The regulation changes that were a result of the Affordable Care Act has had a great impact on small businesses. Depending on whether small businesses maintain grandfathered insurance plans or self-insure, the impact could cause insurance plans sold through the insurance exchange to have unaffordable premiums. "The goal of these regulations is to spread the financial risk associated with insuring unusually sick or high-cost enrollees across a wide pool of employers. This type of risk spreading tends to reduce premiums for firms with sicker and higher-cost enrollees, while increasing premiums for firms with healthier and lower-cost enrollees." as stated in the article "Small Firms Actions in Two Areas, And Exchange Premium and Enrollment Impact."

With the progress that has been made over the past seven years, the ACA faces a threat of being repealed by the new President. Louis Jacobson focused on the thread of repeal asking the question, “What would the impact be if the Affordable Care Act is repealed?” One of the changes that has been addressed, is the loss of federal subsidies which helps provide funds to those individuals unable to pay insurance premiums on their own, but do not qualify for Medicaid coverage. Another change would be, to roll back the Medicaid expansion, which is another blow to those individuals who cannot pay for insurance premiums on their own due to their poverty level. The Affordable Care Act had also included a specification that forced the insurance companies to provide insurance to those individuals being denied coverage for pre-existing conditions. “The Kaiser Family Foundation projected that if the pre-existing conditions provision is repealed, 52 million Americans could be at risk of being denied coverage in the future” (Jacobson, p. 4). That means about 30% of insured individuals would no longer be eligible for health care. This is a step backwards. The implications for those on Medicaid would also be devastating if the repeal takes place. The reason healthy individuals need to be required to pay for health insurance, is to help offset the cost of covering those who require more health care benefits because of their health conditions.

Hospitals will also be distressed by a repeal of the Affordable Care Act. In a press release from the American Hospital Association, it states that a report finds that “hospitals would face a net negative impact of $165.8 billion from 2018-2026” (AHA). This is a major negative affect of the repeal of the Affordable Care Act and funding that it provides for the operations of the hospitals to provide care to Medicaid and Medicare patients. This impact would have a trickle effect on the community it serves. Patient care would diminish with budget cuts that would result in job losses.

Another issue that the current health care legislation fails to combat is the fluctuating coverage for low-income households. Since low-income individuals and families typically change jobs frequently, they often experience change in health coverage. These changes mean that the low-income households could potentially experience changes in health insurance programs, with presumably different providers in the approved provider network. “Estimates indicate that approximately half of low-income adults, who are not receiving employer sponsored insurance, will experience a change in income or family circumstances that will change their eligibility for coverage in a given year affecting a significant proportion of adolescents. Such disruptions in their health care coverage can lead to delays in care, an unmet medical need, and/or lack of preventive health care services” (Tebb et al., p.2090, 2015). These disruptions in coverage are known as “churning”. This issue of churning is not unique to the ACA legislation. In accordance with history, other publicly funded insurance programs experienced this same issue and actually have developed strategies to help avoid churning. “The ACA does require all state insurance Market places to have some type of assistance programs to help consumers understand the various insurance options and to help them enroll. However, navigators and other enrollment assistance counselors have faced considerable challenges such as: inequities in the distribution of assistance programs, variations in the training and experience of navigators and limited capacity to address the vast post-enrollment help needed” (Tebb et al., p.2090, 2015). So, although the current health care legislation is attempting to alleviate the issue of churning, the efforts are falling short and individuals are left without coverage. The biggest issue with churning is that it often impacts the individuals that need extended care the most. Disruptions in coverage can equal disruptions and delays in health care. This severely impacts individuals with chronic illnesses, disabilities, or youth that need regular routine care. Many low-

income adolescents are left without health care when a parent loses work. While the ACA tries to fill this gap, adolescents are at a delicate time of their lives and the efforts to provide for them cannot fall short. “Adolescents comprise a special population that is not receiving sufficient attention, particularly related to enrollment and full access to health care services” (Tebb et al., p.2092, 2015). The primary care needs that ACA fails to recognize when it comes to adolescents include; access to health care insurance, continuity of care, access to and utilization of preventive health care services, and confidentiality. It is vital that a greater emphasis be placed on improving and sustaining healthy behaviors for adolescents. As previously mentioned, this age group is going through a unique and critical time in their development. Lifetime behavioral patterns are developing, heightened hormones make them susceptible to mental health issues and increased interest in sexual activity, and they typically have the lowest income, if any. The Affordable Care Act has improved the quality of care for many adolescents, but there are still areas that can be improved. Some ideas to promote better care include incentive payments for doctors. Physicians could be offered incentive payments for spending greater amount of time counseling youth on preventative care and addressing mental health issues. “For example, one study found that after over 3 years of the ACA, 43% did not know that the ACA eliminated out-of-pocket expenses for preventive services” (Tebb et al. p.2091, 2015). Adolescents need to be guided to seek a physician routinely. Habits these adolescents form now will be carried into their adulthood, impacting their health choices for a lifetime.

Impact on Well-Being

One of the goals of the Affordable Care Act is to improve the quality of care an individual receives. The idea is that individuals that are receiving a higher standard of medical care will not only stay healthier but will have a higher quality of life. The American Journal of Public Health published research on the impact the ACA had on an individual's quality of life. The researchers analyzed the well-being, or life satisfaction, in order to evaluate the ACA in a different area than typical indicators for health policy evaluation. There has been an increased interest in human well-being as a metric of social welfare (Kobayashi et. al., 2019). "Broadly defined, subjective well-being is a multidimensional concept that refers to people's evaluative judgments about their quality of life, referred to as "life satisfaction," and emotional or affective states such as happiness, anger, or sadness. Life satisfaction and emotional states are sensitive to external events" (Kobayashi et. al., 2019). The researchers hypothesized that the Medicaid expansion from the ACA would increase access to health care, which would result in less health risks and less financial burden. From this, the researchers believed the expansion of the ACA Medicaid would result in an improved well-being for the individuals in participating states. (Kobayashi et. al., 2019) "...it is important to note that the ACA was politically unpopular when the Medicaid expansion component went into effect in January 2014. At this time, 50% of persons in the United States had an unfavorable view of the ACA, compared with just 34% who reported a favorable opinion of the ACA" (Kobayashi et. al., 2019). This is significant to note because despite the societal welfare benefits introduced by the ACA Medicaid expansion, the unpopularity of the ACA could also result in having negative effects on well-being in the general population. The study utilized the GallupSharecare Well-Being Index from 2010 to 2016, a telephone survey that conducts over 500 interviews each day with adults 18 years and older.

They took this data of over 1.6 million US adults aged 18 to 64 years and used difference-in-differences analysis to compare pre- to post-ACA Medicaid expansion. The subjective well-being indicators used included "..the policy-eligible low-income population who newly gained access to health insurance, and the general adult population as a spillover effect of this policy change" (Kobayashi et. al., 2019). The researchers categorized the thirty-two U.S states that participated in the Medicaid expansion into three different categories, full, substantial, and mild. This categorization helped alleviate the variation in results based on the significance of the expansion of that particular state. They then measured life satisfaction using a system called Cantril's Self-Anchoring Striving Scale. In this method, "...the respondent is asked to rate his or her life on a ladder scale in which 1 represents "the worst possible life for you" and 10 represents "the best possible life for you." Two versions of the scale were administered in the study interview: 1 for current life satisfaction and 1 for the expectation of life satisfaction in 5 years" (Kobayashi et. al., 2019)

The research team first analyzed if the individuals residing in the states that expanded Medicaid reported any change in their health care, including changes in insurance coverage rates, accessibility to doctors, or difficulty affording health care (Kobayashi et. al., 2019). They then examined the subjective well-being relative to non-expansion states. Lastly, they "...visually compared differential pre- and post-Medicaid expansion time trends in the outcomes between expansion and nonexpansion states to confirm that the outcomes followed parallel trends over time before Medicaid expansion in both groups" (Kobayashi et. al., 2019).

The results of this study were not exactly what the researchers expected. Although there were apparent increases in the rates of health insurance coverage, increased access to a doctor,

and less reports of difficulty affording medical care, there was no significant difference in the reported well-being of individuals living in participating states. “In both the policy-eligible and the general adult populations, we observed no meaningful changes in mean reported life satisfaction in the expansion states versus nonexpansion states following Medicaid expansion” (Kobayashi et. al., 2019). However, there was a small observed effect on expected life satisfaction in 5 years in the general population. Which simply means that the individuals reporting increased access to medical care predict their lives will be satisfactory in the next 5 years. Ultimately, the ACA has succeeded in providing more health care coverage, however, it does not seem to have a significant impact on emotional states or life satisfaction of the US adult population. It appears that the expansion of medical coverage does not directly mean the life satisfaction of the population will be improved.

Measuring Success

In order to evaluate the Affordable Care Act impartial, without the bias lens of political opinion, research must examine the policy in three areas: adequacy of access to care, cost of care, and the quality of care experienced (Blumenthal, Abrams, & Nuzum, 2015). As noted previously, many of the benefits of the ACA are associated with preventative care, such as allowing more doctors' visits or covering vaccinations and screenings. This fact, partnered with the policy being relatively new, makes analysis of the direct benefits somewhat arbitrary and difficult to fully evaluate at this point in time. The New England Journal of Medicine published a Health Policy Report reviewing the Affordable Care Act after its implementation five years prior. The report evaluates the ACA by looking at the proportion of Americans with access to needed health care, the rate of increase in individual and national health care spending and

national measures of quality, such as those reported in the Agency for Healthcare Research and Quality (Blumenthal et al., 2015).

A study conducted just three years after the implementation of the Affordable Care Act measured the disparities across different categories of health coverage, including income, race, marital status, age, gender, and residence (Courtemanche et al., 2018). The study found that the "..ACA reduced the coverage disparity by income by 43% and that this was entirely driven by the Medicaid expansion.. the ACA contributed to the 23%, 46%, and 36% reductions in coverage disparities by race, marital status, and age.." (Courtemanche et al., 2018). One of the primary goals of the ACA was to make medical care more accessible for citizens that previously did not have the means to access necessary health care. The data collected from the study, although conducted only three years after implementation, demonstrates a broadened access to health coverage. Despite the variation in the exact parameters of adequate access to health care, anecdotal reports and analysis of coverage indicates the ACA has been successful in this aspect.

The next area of success measurement is cost reduction, looking at both individual cost reduction and federal reduction. The New England Journal of Medicine reports a significant decrease in federal expenditures per capita for health care from 2010 through 2013 (Blumenthal et al., 2015). "Within the Medicare program, which most directly affects federal health spending and deficits, per-beneficiary expenditures have actually decreased in real terms. These trends have caused the Congressional Budget Office to reduce projected Medicare spending dramatically: its current estimate of Medicare spending in 2020 is more than $200 billion (20%) lower than it was immediately before the enactment of the ACA .." (Blumenthal et al., 2015).

The last area to measure success within is the quality of care that is reported by the American population. Quality of care is not only difficult to determine on a mass-scale, but with the program only being nine years old, it is difficult to accurately measure the success of the ACA in this area. There is also a great deal of subjectivity when measuring the quality of care. Particular standards can be placed on hospitals, physicians, and other health care providers to determine the level of quality, however there will always be variation and bias in this area. It is mentioned that, "reductions in hospital-acquired conditions and Medicare re-admissions since the enactment of the ACA are unprecedented and encouraging, but here again the causes of these favorable trends are uncertain" (Blumenthal et al., 2015).

The three parameters a health care system is typically evaluated on; access, cost, and quality, are used to measure if the ACA can be considered successful. The idea is to achieve higher quality health care for everyone, while reducing the cost. "System behavior suggests that only two of the three can be fulfilled at any one time, e.g., increasing the access to, and quality of, health care leads to increasing costs, while reducing costs leads to reduced access or quality" (Rudnicki et. al., p.356, 2015). The goal of the Affordable Care Act was to find a method in which all three of these goals can be accomplished.

Access to Health Care

Overall, the Affordable Care Act has grossly expanded access to health care for U.S citizens in every socioeconomic, ethnic, and age demographic. Most individuals either have access to Medicaid or have now qualified for insurance they did not have access to before. The newly gained access to insurance coverage is associated with better access to health care.

"National studies of the full non-elderly population have detected improvements in trends for coverage, satisfaction with insurance, and access to care. Research specifically comparing Medicaid expansion versus non-expansion states have shown important clinical changes including increased primary care visits, improved blood pressure control and Pap testing rates, and suggestive evidence of improved self-reported health" (Sommers et. al., p. 3, 2017). Although this data alone is promising, published analyses have been limited to 2014 or 2015. Due to the gradual nature of insurance expansion, more recent data could be even more significant in determining if the ACA is covering this group of Americans adequately and appropriately.

The group of Americans that has been the most significantly impacted by the coverage expansion are the individuals living with chronic medical conditions. Since this group has such a high cost of care, there has been increased interest to understand how the ACA has impacted the care they receive. It is apparent that they have received more insurance coverage, but the question still remains on whether the quality of coverage has improved. A significant portion of the population has gained insurance coverage due to the implementation of the ACA, however, this does not demonstrate whether those individuals are receiving care.

Charles Courtemanche PhD, James Marton PhD, Benjamin Ukert PhD, Aaron Yelowitz PhD, Daniela Zapata PhD, and Ishtiaque Fazlul conducted research on the effect of the Affordable Care Act has had on the disparities in insurance coverage among different demographics. Although the research is a few years old, it is a strong indicator of whether the ACA played a role in providing better access to care for a range of Americans. The researchers used the 2011-2016 waves of the American Community Survey, ensuring that the sample was

restricted to only non-elderly adults (Courtemanche et al., 2018). To accurately assess the disparities among this group, the researchers separated the sample into categories by income, race/ethnicity, marital status, age, gender, and geography (Courtemanche et al., 2018). "We estimate a difference-in-difference-in-differences model to separately identify the effects of the nationwide and Medicaid expansion portions of the ACA using the methodology developed in the recent ACA literature" (Courtemanche et al., 2018). The differences noted include; time, state Medicaid expansion status, and local area pre-ACA uninsured rates. The researchers found that the new health care legislation reduced the coverage disparity from income by 43% in just three years (Courtemanche et al., 2018). The ACA also reduced disparities by race, marital status, and age. This means that in just the short amount of time evaluated by this research team, the ACA made a monumental impact on access to health care.

Cost Reduction

The cost of health care in the United States is an undeniable epidemic. A vast majority of individuals go without treatment because they simply cannot afford insurance or the associated fees for their insurance. Health care costs are not limited to the individual, the burden of health care costs weighs on the federal budget as well. The goal of health care reform was to not only reduce the cost of health care for the individual, but to also reduce the overall cost of health care for the government as well. "From 2010 through 2013, per capita U.S. health care expenditures increased at the historically low rate of 3.2% annually, as compared with 5.6% annually over the previous 10 years" (Blumenthal, Abrams, & Nuzum, 2015). Meaning that, although the cost of care is still increasing, it has drastically slowed down since the implementation of the ACA.

Health care spending has seemed to somewhat stabilize as a percentage of gross domestic product. As mentioned earlier, the Congressional Budget Office has recognized the drastic reduction of federal health spending and deficits within the Medicare program. They have now reduced the projected Medicare spending by a large margin. It is predicted that Medicare spending will be reduced by 20% in 2020 as a result of the ACA (Blumenthal, Abrams, & Nuzum, 2015). This huge cost reduction is demonstrated in the figure below.

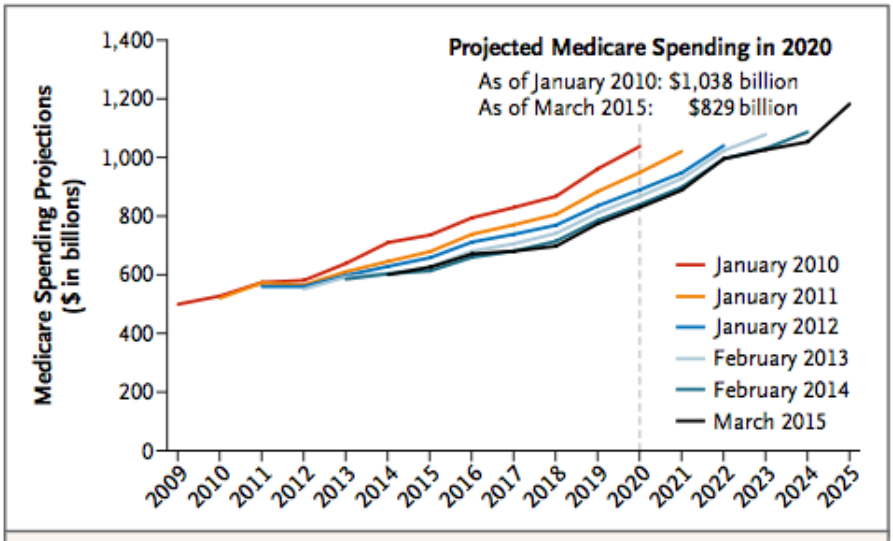


Figure 4. Ten-Year Medicare Spending Projections, January 2010 through March 2015.
Adapted from the Congressional Budget Office.[26,27]

Joshua Breslau, Bradley D. Stein, Bing Han, Shoshanna Shelton, and Hao Yu did a research study on the impact of the Affordable Care Act's dependent coverage expansion on the health care and health status of young adults. They primarily used literature review to evaluate the effects of the ACA. "We searched bibliographic databases and reference lists of relevant papers for peer- reviewed empirical studies of the impact of the ACA's DCE on insurance

coverage, health care access, utilization, health status (including health behaviors), and labor market activity" (Breslau et. al., p.133, 2018). The research team used data from September 2010 through January of 2016. The literature gathered by the team primarily used difference-in-differences (DD) method for estimating the impact of the ACA. In fact, 24 of the 25 manuscripts in the review use the DD method for evaluation (Breslau et. al., 2018). Of the papers reviewed, four of them examine the impact of the DCE on out-of-pocket (OOP) expenditures on health care, all using the Medical Expenditures Panel Survey (Breslau et. al., 2018). Three of these four different research papers report significant reductions in out-of-pocket expenses that can be credited to the DCE. "One study found that the DCE reduced the probability of having more than $1,500 of OOP expenditures in a year by over 50% (Busch, Golberstein, & Meara, 2014)" (Breslau et. al., p.136, 2018). The other two studies reviewed demonstrate that the DCE reduced the average out-of-pocket expenses by 18% and decreased the expenses paid by individuals with behavioral health conditions (Breslau et. al., p.136, 2018).

In Gwendolyn Roberts Majette article "Controlling Health Care Costs under the ACA — Chaos, Uncertainty, and Transition with CMMI and IPAB", Majette evaluates two components of the NGA that help to reform the delivery of health care. The specific components of the NGA that are discussed are in place in order to help control the costs of the health care system. Majette refers to the regulatory structure in which the Affordable Care Act was established and executed as the "new governing architecture" or NGA. The NGA is how the ACA is able to complete its primary objectives; expanding health care coverage, reforming the health care delivery system, and shifting the system to focus on wellness and prevention (Majette, p.857, 2018). "There are nine components of the NGA: (a) the National Strategy for Quality Improvement in Health Care, (b) the National Prevention, Health Promotion and Public Health Council and Advisory Council,

(c) the National Prevention, Health Promotion, Public Health, and Integrative Health Care Strategy, (d) the Independent Payment Advisory Board, (e) the Center for Medicare and Medicaid Innovation, (f) the CMS — Federal Coordinated Healthcare Office, (g) the CMS — Center for Consumer Information and Insurance Oversight, (h) the Health Care Workforce Commission, and (i) the Commission on Key National Indicators" (Majette, p.857, 2018).

The Center for Medicare and Medicaid Innovation (CMMI) and the Independent Payment Advisory Board (IPAB) were the two components of the NGA Majette addressed in the article. The "CMMI was created in 2010 to test new payment and delivery models that reduce health care costs and improve the quality of care provided in Medicare, Medicaid, and the Children's Health Insurance Program" (Majette, p.858, 2018). Since the results of the 2016 election, there has been some threats to the systems that help maintain the cost of health care. President Donald Trump did not provide a detailed health care policy agenda, resulting in the health care industry and individual states having to interpret the meaning of a campaign promise to "repeal Obamacare" (Majette, 2018). Instead of systematically redesigning the health care policy, the current political environment supports a catastrophic dismantling of health care legislation. "The republican-controlled federal government has partially disassembled these two components, threatening the effectiveness of federal delivery system reform and cost control initiatives" (Majette, p.857, 2018). So, despite the cost reductions witnessed, these mechanisms that help reduce health care costs may be threatened.

Quality of Care

The advocates of the Affordable Care Act did not simply want to expand coverage and reduce costs, the goal of the legislation was to also improve the quality of care individuals receive. Executing all three of these objectives seems impossible, but the ACA developed ways in which quality could be a focus while cost effectively expanding coverage. One way in which quality assurance is implemented is through incentive programs. "The ACA creates Medicare payment incentives for hospitals and physicians to improve their performance on a variety of quality and cost metrics other than hospital-acquired conditions and re-admissions" (Blumenthal, Abrams, & Nuzum, 2015). The incentive program went into effect for hospitals in 2013. That year, 1% of Medicare payments were redistributed to the facilities that performed well on a variety of cost and quality measures. By 2017, the number of redistributions increased to 2% for hospitals. "On the physician side, the incentive program began in 2015 with large group practices on a voluntary basis and is progressing to a mandatory program that will include smaller and solo practices by 2017. Year 1 results show a modest financial effect on physicians. Payment adjustments range from a 1% decrease to a nearly 5% increase" (Blumenthal, Abrams, & Nuzum, 2015). Although these results are extremely promising for quality of care improvement, the Blumenthal notes that the results are too preliminary to draw any definitive conclusions about the effect of the program (2015).

Conclusion

The controversy surrounding the Affordable Care Act is comparable to the years of issues that surrounded the Social Security Act. In 1935, after the devastation of the Great Depression, President Franklin D. Roosevelt called for legislation to provide financial assistance to U.S citizens with inadequate or no income (Social Security Act). Although there was a great deal of debate over the bill in both the Senate and the House, President Roosevelt signed the Social Security Act into law on August 15, 1935. From its conception, the Social Security Act has raised controversy despite the obvious benefits of the legislation. The Social Security Act has also been altered many times and is still under much debate today. The Affordable Care Act seems to be taking on a similar path as the Social Security Act. The ACA will more than likely be at the center of political debates for decades to come. Health care legislation has a long way to go before it will be ideal for the needs of the United States. It will need to continually grow in order to keep up with changing technologies and the evolving culture. However, it does not need to be forgotten in this current political environment.

Typically, the controversy surrounding the ACA is a result of misconceptions and an overall lack of understanding of the entire policy. The benefits of the Affordable Care Act are apparent, however, so are the challenges associated with the legislation. With the current administration, the steps that need to be taken in order to improve the ACA will not only be neglected, but the entirety of health care legislation could be threatened. Research demonstrates the immense impact the ACA has had on a wide range of citizens. Low-income individuals have gained access to insurance by the ACA's expansion of Medicaid, adolescents are receiving preventative care, patients with chronic conditions are not burdened with crippling premiums or

denied coverage, all pregnant women and their newborns have access to health care, and individuals with behavioral and mental health conditions are receiving the treatment they need to be functioning members of society. U.S. citizens are receiving health care they otherwise could not afford or access prior to the implementation of the ACA. The ACA has also reduced the cost of health care not only for individual U.S. citizens, but is demonstrating a reduction in cost for the U.S. government. A positive element that even anti-health care legislation politicians cannot deny. While there is still work to be done to improve health care legislation, there is a great deal of potential with the Affordable Care Act.

The Affordable Care Act is still somewhat premature for researchers to draw definite conclusions on its success. The collected research thus far is a strong indicator of the outcome of the current health care legislation and can serve as a model for where the legislation can improve. Further research should be conducted in the future in order to evaluate the Affordable Care Act more effectively. For now, it can be assumed that the ACA will continue to be successful if given the proper funding and support needed from the public and the government.

References

AHA www.aha.org/presscenter/pressrel/2016/160612-pr-aca.shtml. Accessed 17 April 2017.

Bagley, N., & Levy, H. (2014). Essential health benefits and the Affordable Care Act: Law and process. *Journal of health politics, policy and law, 39*(2), 441-465.

Breslau, J., Stein, B., Han, B., Shelton, S., & Yu, H. (2018). Impact of the Affordable Care Act's Dependent Coverage Expansion on the Health Care and Health Status of Young Adults: What Do We Know So Far? Medical Care Research and Review, 75(2), 131-152.

Brown, D.S., & McBride, T.D. Impact of the Affordable Care Act on Access to Care for US Adults with Diabetes, 2011–2012. Prev Chronic Dis 2015; 12:140431. DOI: http://dx.doi.org/10.5888/pcd12.140431 .

Blumenthal, D., Abrams, M., & Nuzum, R. (2015). The Affordable Care Act at Five Years. The New England Journal of Medicine. doi: 10.15868/socialsector.25102

Cannan, J. (2013). legislative history of the affordable care act: How legislative procedure shapes legislative history. Law Library Journal, 105(2), 131-174.

Choi, S. (2017). THE AFFORDABLE CARE ACT'S MEDICAID EXPANSION: THE EFFECTS ON LOW-INCOME MID-LIFE ADULTS, Innovation in Aging, Volume 1, Issue suppl_1, July 2017, Pages 1088-1089, doi.org/10.1093/geroni/ign004.3993

Creedon, T. B., & Cook, B. L. (2016). Access To Mental Health Care Increased But Not For Substance Use, While Disparities Remain. Health Affairs, 35(6), 1017–1021. doi: 10.1377/hlthaff.2016.0098

Cohen, Joshua P. Implementing the Affordable Care Act: Remaining Hurdles. *Clinical therapeutics* 37.4 (2015): 717-9. *ProQuest*, doi: http://dx.doi.org/10.1016/j.clinthera.2015.02.026. Web. Accessed 23 Mar. 2017.

Courtemanche, C., Marton, J., Ukert, B., Yelowitz, A., Zapata, D., & Fazlul, I. (2019, February). The three-year impact of the Affordable Care Act on disparities in insurance coverage. Health Services Research, 54(1), 307+. Retrieved from https://link-gale-com.ezproxy.waterfield.murraystate.edu/apps/doc/A574566635/HWRC?u=murr79496&sid=HWRC&xid=7a3d0113

Fitzgerald, M. P., Bias, T. K., & Gurley, C. T. (2017). The Affordable Care Act and Consumer Well-Being: Knowns and Unknowns. Journal of Consumer Affairs, 51(1), 27–53. https://doi-org.ezproxy.waterfield.murraystate.edu/10.1111/joca.12059

Furman, J. (2014, February 6). Six Economic Benefits of the Affordable Care Act. Retrieved from https://obamawhitehouse.archives.gov/blog/2014/02/06/six-economic-benefits-affordable-care-act.

Furman, J. (2014, February 6). Six Economic Benefits of the Affordable Care Act. Retrieved from https://obamawhitehouse.archives.gov/blog/2014/02/06/six-economic-benefits-affordable-care-act.

Griffith, K., Evans, L., & Bor, J. (2017). The Affordable Care Act Reduced Socioeconomic Disparities In Health Care Access. Health Affairs, 36(8), 1503–1510. doi: 10.1377/hlthaff.2017.0083

HealthCare.gov Retrieved from https://www.healthcare.gov/glossary/affordable-care-act/

Jacobson, Louis. "What would the impact be if the Affordable Care Act is repealed?" 5 Jan. 2016. www.politifact.com Accessed 17 April 2017.

Kobayashi, L. C., Altindag, O., Truskinovsky, Y., & Berkman, L. F. (2019). Effects of the Affordable Care Act Medicaid Expansion on Subjective Well-Being in the US Adult Population, 2010-2016. *American Journal of Public Health, 109*(9), 1236-1242. doi: 10.2105/ajph.2019.305164

Nguyen, Kevin H., and Benjamin D. Sommers. "Access and Quality of Care by Insurance Type for Low-Income Adults before the Affordable Care Act." *American Journal of Public Health* 106.8 (2016): 1409-15. *ProQuest,* doi: 10.2105/AJPH.2016.303156. Web. Accessed 19 Mar. 2017.

Potera, C. (2019). Women Benefit from the Affordable Care Act. *AJN American Journal of Nursing, 119*(7), 15. doi: 10.1097/01.naj.0000569400.28552.c8

Rosenbaum, S., & Hyatt Thorpe, J. (2016). The Affordable Care Act at Six: Reaching for a New Normal. Journal of Law, Medicine & Ethics, 44(4), 533–537. https://doi-org.ezproxy.waterfield.murraystate.edu/10.1177/1073110516684781

Rudnicki, Marek, et al. "Expected and Unexpected Consequences of the Affordable Care Act: The Impact on Patients and Surgeons-Pro and Con Arguments." *Journal of Gastrointestinal Surgery* 20.2 (2016): 351-60. *ProQuest,* doi: 10.1007/s11605-015-3032-8. Web. Accessed 20 Mar. 2017.

Social Security Act (1935). (n.d.). Retrieved from https://www.ourdocuments.gov/doc.php?flash=false&doc=68.

Sommers, Benjamin D., Bethany Maylone, Robert J. Blendon, E. John Orav, and Arnold M. Epstein. 2017. "Three-Year Impacts of the Affordable Care Act: Improved Medical Care And Health Among Low-Income Adults." Health Affairs 36(6) (May 17): 1119-1128. Doi: 10.1377/hlthaff.2017.0293.

Srinivas, S. K. (2019). SMFM Special Statement: The Affordable Care Act's foundation of coverage: Essential health benefits are essential. *American Journal of Obstetrics & Gynecology, 221*(2), B13–B17. https://doi-org.ezproxy.waterfield.murraystate.edu/10.1016/j.ajog.2019.05.007

Tebb, Kathleen P., et al. "Opportunities and Challenges for Adolescent Health Under the Affordable Care Act." *Maternal and child health journal* 19.10 (2015): 2089-93. *ProQuest,* doi: 10.1007/s10995-015-1737-7. Web. Accessed 20 Mar. 2017.