

Grace Lee

Poverty & Human Capability Capstone

Professor Beckley

### The Affordable Care Act: What's Passed is Prologue

The Patient Protection and Affordable Care Act (PPACA or ACA), passed on March 23, 2010, is the most comprehensive U.S. healthcare reform legislature enacted since the passage of Medicaid and Medicare in 1965. The overarching design of the ACA hinges on three main goals: Reform the non-group insurance market, create an individual mandate, and make insurance affordable to lower income citizens (Grueber, 2011). In doing so, the law aims to expand coverage, control health care costs, and improve the health care delivery system. The ACA is not limited to providing and requiring health insurance; provisions to improve the quality of the health care system are integral to its methods. This comprehensive reform attempts to reduce many discrepancies within the healthcare system, but evaluating its potential to succeed involves understanding the underlying determinants and caveats of poor health, particularly among the uninsured impoverished.

#### **Justice and Healthcare Policy**

Much of the controversy over the Affordable Care Act is rooted in its premise that there is a governmental and societal obligation to provide healthcare. Within the U.S. health care system, there have been social policies about medical insurance such as Medicaid, Medicare and tax deductions, but much of healthcare coverage remained in the market. The overall policy approach prior to the ACA was inconsistent in its justifications. If healthcare is a universal right, it should be treated as such. There was no requirement for healthcare, indicating that it was seen

as a commodity. Contradictorily, there has been federal law mandating treatment for people without regard to ability to pay in emergency rooms. In order to achieve a consistent philosophical framework for healthcare policy, the central question asks if health is essential in providing fair and equal opportunity. Under a Rawlsian perspective of justice, members of a society are accountable to each other and therefore retain an obligation to aid those in need. John Rawls writes, “The basic structure of society must be designed so that social and economic inequalities are attached to offices and positions open to all under conditions of fair equality of opportunity” (Rawls p. 54). Underlying this theory is a view of justice that is based on the social contract, the inherent philosophy behind government in which citizens give up certain autonomy in order to benefit from political order. In order to achieve justice within the society, there is a collective obligation to foster capability among all members. Otherwise, the premise of justice by political order falls apart.

Accepting that it is the responsibility of the state to improve the conditions of its indigent citizens, the results of public policy should be in line with just aims. Rawls provides further guidance with his second principle of justice, stating that policies “are to be of the greatest benefit to the least-advantaged members of society,” (Rawls 1971). Though it is realistically impossible to implement this theory of justice into all policies, Rawls’ theory of justice is useful in providing a philosophical backbone for policy decisions regarding those in poverty. Rawls would consider a policy just if it succeeds in improving the lack of equality of opportunity among the impoverished. Amartya Sen broadens this concept of equality of opportunity to encompass fostering equal capability, a term that refers to the ability for individuals “to choose among the life plans they can reasonably pursue, given their talents and skills,” (Daniels 77).

In *Just Health*, Norman Daniels extends Sen's analysis and Rawls's principle of fair equality of opportunity to health and healthcare with regards to the social determinants of health. Daniels elaborates that health is largely a result of the life-long accumulation of social conditions and therefore represents issues outside of the realm of medicine and medical insurance (Daniels p.26). Health inequity is heavily connected to social injustice, which necessitates an examination of broader social constructs. He identifies specific social determinants of health to include income, wealth, education, political participation, the distribution of goods, and opportunity (Daniels p. 4). Daniels contends that holding justice as fairness logically dictates a just distribution of all social determinants of health. He distinguishes between injustice and inequality by specifying that inequalities are unjust when they are avoidable, unnecessary, and unfair (Daniels 82). Contrarily, the mere presence of excessive income inequality may significantly impact injustice in health. Studies within the United States imply a correlation between the extent of income inequality and the gradient of health inequality (Daniels 87). This would indicate that health differences are at least partially determined by relative deprivation of social determinants such as education instead of absolute deprivation of goods necessary to survival. Capabilities such as the social basis of self-respect and societal participation are linked to relative deprivation, which supports this extension of Sen's interpretation of opportunity to Rawls' principles of justice.

Moreover, Daniels contends that health precedes other realms of functioning, giving it special moral importance. Health is integral in providing fair equality of opportunity, and it is society's responsibility to reduce health injustices. Therefore, the equal opportunity principle requires society to provide extensive health services to promote normal functions, including but not limited to universal comprehensive health care (Daniels 96). In order to accept and

implement policy that reflects the understanding of health as a social determinant, healthcare must first and foremost be universally distributed. The implementation of a universal healthcare policy begins to address the societal responsibility to decrease inequality in healthcare across the country. Improving access to healthcare, improving the quality of care provided, and reducing healthcare costs are the three general strategies the ACA implements in its attempt to ameliorate the health of American citizens. Defining policies of the ACA work to impact each of these areas in different ways and the outcomes for low-income communities will be determined by how effectively the policies are carried out. In order to successfully increase the equality of opportunity for indigent citizens, these policies should be approached holistically to target the social determinants of health and to work around the impact of these social determinants.

If we follow Daniels on social determinants of health, providing insurance is not sufficient to improve health or provide the health basis for equal opportunity. There are social determinants, including behavioral patterns, which restrict the ability of healthcare to make an impact; these barriers must be acknowledged. One of the most prevalent health issues in America is diabetes – a disease that is fairly manageable with diet and exercise. Unfortunately, in urban impoverished areas, there is often a lack of available fresh foods. Even in areas without food deserts, people in poverty tend to be dependent on fast food and long lasting shelf items. Further, a parent working multiple part time jobs has little time to prepare fresh meals, even with the means, and personal fitness is too often at the bottom of the priority list. In order to adequately address the health issues plaguing impoverished communities, the intertwined factors of living need to be considered.

Considering the scope of health, the ACA is not intended to be the cure-all of the deficiencies in health across the nation. There are vast limitations to the extent of which the

Affordable Care Act can impact health. Factors such as income, housing, and education are all correlated with the ability and behavioral patterns necessary to effectively manage health. These factors span across different realms of social policy and cannot be adequately addressed by health policy. Patterns of low health correlating with low socioeconomic status persist even in countries with firmly established universal healthcare access (Daniels 80). However, limitations are no reason to reject the policy on ethical grounds. There are widespread mechanisms through which policy, organizations, and individuals can positively affect health. The ACA has significant potential to positively impact health through its specific avenues of health insurance, healthcare facilities, and quality improvement. By acknowledging the inefficiencies of the current healthcare system and promoting a more holistic perspective on healthcare, the ACA even has the capacity to address some of the social determinants of health, such as the lifestyle habits of the patients.

### **Access to Health Insurance**

In improving access to healthcare, the ACA largely relies on the creation of the individual mandate, exchanges, community health centers, and primary care models, as well as the expansion of health coverage. The individual mandate, highly contested but eventually upheld by the Supreme Court, requires U.S. citizens and residents to have a certain extent of health insurance. The penalty for neglecting to obtain health insurance is a tax that gradually increases from 2014-2016 (Sec. 1004). The mandate exempts those with financial hardship, religious objection, undocumented immigrants, incarcerated individuals, and American Indians. The economic theory behind this individual mandate is adverse selection. Adverse selection assumes people with worse health are more likely to buy insurance than healthy people.

The ACA also imposes rate restrictions to limit the premium costs that an insurance company can charge based on personal factors. There are two types of rate restrictions, rate bands that prohibit variation in premium cost above a certain level and community rating, which sets premiums based on the risk spread evenly across a community (Kaiser 2012). In addition, guaranteed issue prevents insurance companies from refusing to insure someone with preexisting conditions. The ACA implements community rating and guaranteed issue on a national level. These prohibitions prevent insurers from determining prices based on patient information. The economic consequences of guaranteed issue and community rating in a laissez-faire market would lead to destabilization because healthy individuals would drop coverage, pushing premiums for enrolled clients higher due to both a smaller and sicker pool of people insured (Sasso 2011). If insurance companies cannot adjust their premiums to account for higher risk, the average healthcare costs of the insurance plans are higher (Chandra p.294). Since insurance companies must cover patients who pose a significant financial risk without charging them for this risk, they must compensate for the future loss of revenue by increasing the premiums for all patients. Since the market will not ensure the availability of insurance in adverse selection, government intervention in the form of this individual mandate intends to improve the well-being of the society as a whole (Friedman & Becker, 2012).

On the other hand, citizens should not be legally obligated to pay for insurance that is too costly to afford. Consequently, the ACA includes American Health Benefit Exchanges and subsidies, the main mechanism through which the mandate can be enforced. These Exchanges provide coverage with premium subsidies and cost-sharing credits for those whose income is between 100-400% of the federal poverty line (Sec. 1311). The Affordable Care Act also provides a new type of tax credit, premium tax credits, that can help pay for the monthly

premium costs. This is a subsidy that can be paid in advance directly to the health insurance exchange, or that can be included in the family's federal income tax refund. The amount received in tax credits is determined on income tax returns, with a limited amount of required repayments to the federal government (Fernandez 2013). The ACA also provides cost-sharing assistance to those with incomes below 250% of the poverty line. These cost-sharing subsidies cover part of the remaining cost of services in a health insurance plan that the beneficiaries are expected to pay. This subsidy coupled with policy regulations results in lower deductibles, copayments, and out-of-pocket costs for those with lower incomes (CBPP April 2013). For example, a family of four living in Virginia with a combined income at 200% of the poverty line would have to pay a maximum of 6.3% of its income for the premium. They could receive a government tax credit to cover the remaining 65% of the health insurance premium, and the family's total out-of-pocket costs is limited to 9.5% of its income (Kaiser Subsidy Calculator). These calculations are based on a silver plan; a gold plan would be a higher level of coverage while a bronze plan would be less comprehensive. There are also Exchanges catering to small businesses to purchase coverage to be exempt from tax credit penalties (Sec. 1411).

### **Constitutionality of the ACA**

In July of 2012, the Supreme Court evaluated the constitutionality of the Affordable Care Act in the *National Federation of Independent Business v. Sebelius*. The Court upheld the individual mandate that required citizens to maintain a minimum level of health insurance under the jurisdiction of Congress to exercise a power to tax. This decision relied on the facts that the penalty for failing to satisfy the individual mandate is a tax that costs much less than insurance and the ACA prohibits punitive prosecution from the IRS (Kaiser July 2012).

The second major decision the Supreme Court made about the ACA regarded the Medicaid Expansion. State and federal governments jointly fund the Medicaid program, established to provide health insurance to low income citizens. The federal funds are based on the state's Medicaid costs and average per capita income. In order to receive matching federal funds, states must comply by federal Medicaid rules. The Health and Human Services secretary retains the right to withhold part or all of the state's federal funds for Medicaid if the state does not abide by the federal regulations (Kaiser August 2012). The previous Medicaid laws included coverage for pregnant women and children under 6 years old with family incomes below 133% of the federal poverty line and children ages 6-18 with family incomes below 100% FPL (Ibid). It also covered caretakers who met financial eligibility requirements, and elderly people and people with disabilities who qualified for Supplemental Security Income (Ibid).

The original version of the ACA expanded eligibility for Medicaid on a national scale by requiring coverage to include those at or below 133% of the federal poverty line. This policy change would now include the non-disabled, non-pregnant adults without dependent children in Medicaid coverage. The federal government pledges to cover the entire cost of the expansion for the first two years of enactment, and then at decreasing intervals to 90% coverage in a decade. This expansion was intended to impact an estimated 17million low-income Americans who would otherwise remain uninsured (Ibid). The ACA stated that if the states did not carry out this expansion, the federal government could withhold all existing Medicaid funding. The Supreme Court decision on this provision found that expansion was unconstitutionally coercive (Ibid). In order to reconcile the lack of adequate notice for the states to voluntarily consent to the expansion, the Court decided that the law could not make the state's previous Medicaid funding contingent upon compliance with the ACA Medicaid expansion (Roberts). However, this



decision does not affect other ACA provisions involving Medicaid, nor the ability of the Health and Human Services Secretary to withhold Medicaid funds based on existing federal regulations.

States have not widely taken this initiative largely because of the claim that expansion exposes state budgets to future higher costs. The legitimacy of this argument can be called into question because the federal government still continues to commit to 90% of the costs after the transition period. Given that most individuals under 100% of the federal poverty line are ineligible for subsidies to purchase coverage in exchanges, there is a gap in coverage options available to those in states that do not comply with the Medicaid expansion (Ibid). The costs of healthcare for this population would need to be absorbed elsewhere. After the Supreme Court decision, the Congressional Budget Office estimated the expansion would cover 11 million people instead of its original assessment of 17 million people (CBO July 2012). Thus far, the limited expansion has resulted in over 7million people enrolling in Medicaid. The greatest financial incentive for Medicaid expansion is in the potential for savings in state budgets due to increased coverage for uninsured residents who rely upon uncompensated care such as emergency room visits (CBPP 2013). The only type healthcare available for uninsured residents is emergency care due to federal law mandating treatment regardless of status or ability to pay. The overuse of this form of healthcare generates significant healthcare costs that are often unnecessary but inherent in the protocol system of emergency room visits with high-cost technology for simple complaints.

### **Community-based Care**

The Affordable Care Act goes above and beyond providing universal health coverage; the remainder of the act does more to address quality, public health, and the social determinants of

health. Another method of the ACA to increase access to healthcare, especially for impoverished communities, involves \$11 billion of funding for community health centers and \$1.5 billion for school-based health centers and nurse-managed health clinics (Sec. 1322). Community health centers are community-based, patient-directed medical organizations that serve a high need community, are governed by a community board, provide comprehensive primary care, provide care regardless of patient information or ability to pay, and meet federally defined performance and accountability requirements (HRSA). Community health centers provide medical, dental, and behavioral health care to approximately 20 million patients nationwide (Kaiser 2013). The healthcare providers at community health centers are ideally participating in a multi-disciplinary clinical workforce designed for holistic, culturally competent, and accessible care (HRSA). School based health centers operate within K-12 schools to provide age-appropriate primary medical care, health education, and counseling to students. Nurse-managed health clinics are healthcare sites that are operated by nurse practitioners qualified to provide primary care, health promotion, and disease prevention to individuals with limited access to care. The aim of these clinics is to improve access and provider training specifically in medically underserved areas. There is also an expansion of Medicare services that creates the Independence at Home program to provide high-need Medicare beneficiaries with in-home primary care to prevent hospitalizations due to a lack of transportation or other means to manage regular primary care appointments (Sec. 3024). By investing in these various different models of healthcare, the ACA makes an impact that surpasses insurance availability.

The ACA further provides state grants to train and recruit providers in rural areas and medically underserved areas (Sec 1201). Within this provision is the specified promotion of a diverse workforce, cultural competence, and a public health focus (Sec. 5307-5404). Due to the

extensive correlation of socioeconomic status and health, the question of personal responsibility in healthcare becomes difficult. Since social determinants play a large role in determining an individual's health status and personal habits, no bright line for patient responsibility exists. In low-income communities, primary care providers often regret that their patients' chronic diseases are consistently exacerbated by lifestyle choices. These choices may seem careless to those outside of the situation, but there are infinite factors, both physical and mental, that play into personal care. In order to promote patient cooperation, the level of understanding and patience of providers must be exceptional. Targeting medical needs with community-based providers and personal comprehensive primary care not only creates more facilities, but also increases the patients' capability to manage their health. The empirical evidence of improved health when patients are treated from a holistic perspective demonstrates how strongly social determinants impact health.

A successful example of community-based care is the Camden Coalition of Healthcare Providers (CCHP). Camden, NJ is one of the poorest and most dangerous cities in the country with a history of governmental corruption. Working with this organization in the summer of 2012 provided me with a first-hand view of the failures and gaps in the previous health care system and how they impact an impoverished community. The processes involved in necessary treatment - such as paperwork, secure transportation to clinics, applying for government assistance benefits, and overall coordination of care, for chronic conditions and preventable diseases are geared largely toward socially and economically stable citizens. The CCHP operates on a model that targets the highest need patients who are suffering from multiple chronic and social issues and works with them intimately. This program leads to better health of the patients and significantly lower healthcare costs because of reduced use of the ER and hospital for

uncompensated care. High quality of care and low cost of care are not mutually exclusive; they can go hand in hand. The initial support provided is essential for the patients because focused, attentive care leads to obviously necessary changes in habits, environment, or lifestyle. There was one patient whose diabetes was not under control, although he claimed to take insulin injections regularly. His doctors and nurses did not understand why the insulin was not helping, so a nurse from the Coalition went on a home visit to ensure he was injecting the insulin correctly. The nurse immediately realized the patient had terrible vision and was not actually filling the syringe with any insulin - then, with a pair of glasses, his health improved.

Several barriers prevent these patients from becoming healthier. They face more than the obvious difficult environments and situations. During a group therapy session, patients shared about their chaotic lives. They struggled with deeply rooted self-loathing, psychological and physical exhaustion, and lack of preventative knowledge, leading to a mindset of surrender to their conditions. These are the people who believe that a diabetes diagnosis is a death sentence because they have witnessed family members die from it. The goal of the Coalition is to provide individualized support and educate patients on how to navigate the healthcare system and manage their diseases. The clearest lesson from working with these patients is that they benefit the most from their relationships with their healthcare providers. The key, as one nurse said, is the relationship. When the teams take the time to make home visits, call on a weekly basis, follow up on appointments, help them schedule, and find transportation, the patients learn to trust these providers with their health. This holistic care is an integral part of equal opportunity for all through provisions of the ACA.

Moreover, the ACA promotes a focus on primary care and preventative care. Approaches to primary care are recently evolving to cater to patient needs. A popular example is the medical

home that revolves around individual attention and care for the personal needs of every patient. This involves a primary care team that oversees patient care and works with the patient to coordinate tests, procedures, and regular care (Abrams). To be eligible for a medical home, a patient must have two chronic conditions or be at risk for a second chronic condition. Though this seems limiting, conditions such as obesity, substance abuse, mental health disorders, and heart disease are specified (McClanahan). Therefore, the vast majority of adults in the US are eligible for enhanced primary care in the form of a medical home. By creating a support base centered on medical needs, models such as medical homes work to counteract social determinants that act as barriers to receiving healthcare.

The American Health Association created an Accountability-Based Primary Care Workforce Model in light of the ACA's increased funding for effective primary care practices. In this model, the physician diagnoses and oversees a plan of care for complex patients, the physician assistance does the same for patients under supervision, and the advanced practice nurse diagnoses and provides the plan of care (AHA 2011). The registered nurse triages patients, provides education and management, and the medical assistant provides direct patient care. The pharmacist manages and educates about prescriptions, and the psychiatrist provides behavioral health support. A clinical social worker provides case management and community connections, a nutritionist oversees diet, a dentist addresses oral health, and a health coach acts as a liaison among the patient, community, and primary care providers (AHA 2011).

Overall, the Affordable Care Act's attempt to increase access to healthcare on a national scale has enormous potential. In particular, the recruitment of providers to underserved areas and the financial support for community-based healthcare policies are unfairly overlooked (Sec 2303). The individual mandate and the government intervention necessary to implement it are

given attention for expanding healthcare coverage, but in the holistic perspective of health, medical coverage is simply insufficient to improve health without society-based support systems targeting the social determinants of poor health. The availability of insurance is crucial in enabling the further mechanisms in healthcare, which the ACA attempts to support. In order to effectively utilize the ACA's potential to expand access to healthcare, there must be extensive and deliberative planning on a case-by-case basis for different communities. State governments need to cooperate with local nonprofits and the federal government in order to efficiently promote access to holistic healthcare. On the federal level, initiatives such as the Nonprofit Sector and Community Solutions Act of 2010 would provide government support by producing reports and recommendations, creating agency coordination, and compile data to be made available to the nonprofit sector (Library of Congress, Bill H.R.5533). The cooperation between local governments and community-based organizations could be advantageous in regards to sharing of resources and accountability. The community-based organizations are better suited to fostering action among citizens and the local government can facilitate these actions with allocation of responsibilities and funds for institutional mechanisms.

There is also an obvious need for individual medical providers to be willing and able to work in underserved areas with the increased healthcare difficulties that are inherent in impoverished communities. The provisions of the ACA that financially incentivize training and working in these underserved areas is a step in the right direction, but much more could be done. For one, there is a general lack of awareness of medically underserved populations and their specific needs. Medical professionals are not necessarily trained to handle difficulties such as a lack of equipment or transportation, nor are they always encouraged to work in lower income areas. There is a cultural stigma about the lack of responsibility on the part of patients in

impoverished communities that should be addressed on a national scale in all fields. Healthcare providers must address their patients with a perspective that includes an understanding of the social determinants of health behavior, such as community values and family upbringing.

### **Quality Improvement Efforts**

Beyond access and support for holistic care, the ACA also attempts to provide quality improvement initiatives. Outside of the broad promotion for a more effective approach to healthcare, the ACA funds specific treatments and strategies that demonstrate the best patient results. Provisions within the ACA employ two broader strategies of supporting research and focusing on preventative care (Title III). Comparative effectiveness research is the effort made through the Affordable Care Act to determine which treatments, diagnostic tests, public health strategies, and other healthcare services are the most effective and efficient. This initiative is essential because there is historically very little scientific basis for the decision between treatment options in the U.S (Benner p. 1768). The Patient-Centered Outcomes Research Institute (PCORI) is one way that the ACA funds patient-centered outcomes. This organization receives income from the general fund of the Treasury and a fee assessed on Medicare, private, and self-insured plans. To date, PCORI has approved 279 awards to fund patient-centered comparative clinical effectiveness research projects nation-wide (“Patient-Centered Outcomes Research”). For 2014, PCORI has announced high-impact topics to prioritize including integration of mental and behavioral health services into primary care and populations at risk for disparities in care and outcomes, and the effectiveness of specific features of health insurance on access, use, and outcomes of care (Knopf).

On the local front, the ACA requires that nonprofit hospitals must conduct a community needs health assessment at least every three years (Section 9007). This process must involve representatives from the community served by the facility, and it must be widely available to the public. The penalty for not completing an assessment is \$50,000 fine to the facility. These efforts represent an understanding of the holistic nature of health and works to support a system that goes beyond insurance to target more behavioral and social determinants of health. These work in conjunction with the community care based approach to ensure that the actual delivery process of healthcare is effective.

The ACA also supports higher quality in primary care by increasing payments to primary care providers, giving patients incentives to obtain preventative care, promoting new models of care such as medical homes, funding testing for these models, and containing initiatives to strengthen the primary care provider workforce (Abrams). For the physicians, there will be an increase in pay for seeing Medicaid patients. For the patients, annual wellness visits and most preventative care services will be covered for Medicare beneficiaries at no cost. If implemented as the law intends, this will result in increased primary care for patients, a higher standard for quality of care, and better patient outcomes.

The ACA also creates a Value-based Purchasing program throughout the US. These involve rewarding providers with payment incentives for demonstrating patient safety and effective care (Sec. 3007). This pay-for performance program weighs patient experiences for both incentives and penalties. The quality of hospital performance is based on an approved set of measures and dimensions that apply to each fiscal year (Sec. 3014). A provision on readmissions for patients in hospitals imposes financial penalties, as does a provision based on the instances of inpatient hospital-acquired conditions (Sec. 3008). However, potential issues of these provisions



that provide financial penalties for low patient outcomes include establishing a disincentive for hospitals to admit patients with complex, chronic conditions. This disincentive further applies to providers in medically underserved areas. If the income of the provider is linked directly to the health of his or her patients, it is less likely for providers to be willing to work in areas that are plagued by exceptional health issues. Healthcare centers could be penalized for serving a population that resides in the midst of unsanitary and polluted living conditions. These communities are more often than not consisting of low-income, impoverished families who struggle with multiple health issues due to their social, economic, and cultural backgrounds. Therefore, there is some potential tension between quality of care and access to care in impoverished communities. Hopefully, the community-care based models will work in conjunction with the quality improvement initiatives to resolve the disincentive, but healthcare providers need to be aware of the issues surrounding disadvantaged populations.

### **Cost Control**

The focus on preventative and primary care has an economic foundation of cost-effective health care practices. As evidenced by its initiatives to increase quality of care, the ACA includes many new funding programs in specific categories within healthcare. The ACA financially invests in programs that center around community-based prevention, Federally Qualified Health Centers (FQHCs), primary care workforce, long-term care, market reform, maternal health, Medicaid, CHIP, and Medicare (CHRT 2012). Federal spending can be categorized as discretionary or mandatory. Discretionary funding requires Congressional approval and must go through an annual appropriations process, whereas mandatory funding is not dependent on annual appropriations bills (APHA 2010). The Affordable Care Act allocates \$101.25 billion in

mandatory spending for the decade following its enactment in programs that center around healthcare improvement efforts. (CHRT 2012).

Obviously, the money has to come from somewhere. Though these initiatives were created with the intention that financial investment in reform will eventually decrease healthcare costs, the transition period must be funded. One way that the ACA does this is through a new range of fees and taxes on health insurance issuers and sponsors of group health plans. Though the agent paying these fees and taxes may vary, the costs affect premium insurance costs for all individuals.

In particular, a regressive tax expenditure in the ACA mandates that taxpayers with income over \$200,000 for single filers and over \$250,000 for joint filers will have to pay a surtax of 3.8% of their investment income, including capital gains and dividends. 91% of the effect of this surtax will fall on the top 1% of income earners (“The Tax Breakdown” 2013). The rest will affect the 96<sup>th</sup> through 99<sup>th</sup> percentiles. The surtax is expected to raise revenues by \$17 billion in 2013. Since this tax is only imposed on a small minority of top income earners, it should not prevent investment from the majority of taxpayers.

There are six other main fees and taxes, largely based on programs previously discussed (Coventry 2013). The Patient-Centered Outcomes Research Institute is partially funded by its own fee charged to employers and health plans, but it has an expiration date of 2019. Further, evident of community-based care promotion, the Annual Health Insurance Industry Fee is a permanent and contributes to premium-subsidies and cost-sharing reductions for individuals on the exchanges. This fee is geared towards the citizens who cannot afford expensive of health insurance to ensure that cost does not deter them from receiving care. The remaining fees and

taxes are permanent and targeted towards stabilization of the market and premium costs. In spite of the newly imposed fees, the financial burden of comprehensive reform is justified by the benefits of efficient uses of resources.

The ACA has built in protection to prevent market collapse with practices that redistribute funds from the lower risk insurers to the higher risk insurers (Kaiser, January 2014). This protects against adverse selection by spreading financial risk among the market. To further stabilize the market in the midst of comprehensive reform, the ACA works on the side of insurance companies by programs that protect against premium increases by providing payment to plans that enroll higher-risk individuals (Ibid). The initial years of reform are predictably complicated, with data from recent months finding that less people from 18-24 years of age are purchasing insurance than expected. The Congressional Budget Office reports that about 40% of the market should be young, low-risk buyers in order to make the exchange plans actuarially sound.

To determine the best use of resources, cost-effective analysis involves practices such as comparative effectiveness research, accountable care payments, and needs assessments. Cost-effective health care would also pay attention to opportunities to provide better care at lower cost in regards to technologies, drugs, and treatments. The value of a treatment or plan of care may be subjective, but the focus on efficiency in medicine is necessary. According to the World Health Organization, three times per person income per quality-adjusted life year gained is a cost-effective intervention (Weinstein 2010). This may not be a perfect standard, but it provides a general guideline to challenge healthcare providers to use resources effectively.

The ACA attempts to couple a higher quality of care with a lower cost. Within the previous US healthcare system, there are various examples of poor quality with high cost. One of the most dramatic in terms of financial loss is the empirical overuse of the Emergency Department. According to federal law, Emergency Departments are required to treat everyone regardless of personal factors such as ability to pay. Surprisingly, the lack of health insurance does not seem to be a major determinant in this behavior, since Medicaid recipients on average used ERs twice as much as people who were uninsured and three times as much as those with private insurance (Falik 2001). This indicates that there are certain conditions that contribute to emergency department overuse, more often associated with disadvantaged patients who qualified for Medicaid. The effect of social determinant on patients is evident in the behavioral data of Medicaid patients.

The issue is that an emergency room visit can cost up to seven times the amount a primary care visit would cost due to extensive use of specialized equipment (NCSL 2011). These visits are excessively expensive when the patients are not in need of emergency-level care. Studies from years 2008-2010 found that 17-27% of Emergency Department visits were for non-urgent conditions, such as chronic pain. These add up to unnecessary billions of dollars in annual healthcare costs. While in Camden, NJ, I conducted a survey at Cooper University Hospital based on Medicaid patients who were triaged as those with least urgent conditions. In my results, I found that 14% of the patients declared that they believed their condition required emergency care. The remaining 86% were in the Emergency Department for reasons of convenience or preference. This evidence strongly supports the need and potential benefits for primary care reform. Prevention at the level of primary care would save on costs due to less severe conditions, and quality care in a personal setting would prevent patients from behaviors such as emergency

department overuse. Further, fostering medical education would support the effective use of services.

In light of the incentives provided by the ACA, hospitals and providers are attempting cost reductions. The major ways that healthcare providers can maximize efficiency in the changing health care system include managing capacity in terms of space, departmentalizing, strategic planning, and effective distribution of labor (Parrott 2013). Addressing clinical utilization by creating agreed-upon guidelines for care and treatment would also lead to accountability within the health care organization. Further, a widespread understanding and focus on a patient-centered model of care would benefit patients by enabling them to make more informed decisions about their healthcare, therefore creating an environment that reduces excessive and costly services.

The ACA also involves a provision based on more effective payment approaches for providers. Through a mandatory National Pilot Program on Payment Bundling in Medicare for episodes of hospitalization, the bill tests a promising method of paying for healthcare services. An episode of hospital care is considered to be from three days prior to admission to thirty days after discharge. The services included in episode bundling are acute inpatient hospitalization, physician service, outpatient services, emergency room services, post-acute services and care coordination (Komisar 2011). Episode bundling could be beneficial because combining the payment encourages the providers to choose specific services appropriate to the situation and work as a group to manage care. Coordination among various health care workers could reduce unnecessary services, risk of complications, and inefficient use of resources. By moving towards a more coordinated system in healthcare and decreasing fragmentation among providers, the bundled payment system may result in more effective care with lower costs. An increase in

efficiency of care would benefit the patients who are uninformed about the intricacies of provider networks. Particularly in impoverished communities, there are very few individuals who are comfortable and equipped to manage the combinations of providers, specialties, tests, and treatments. Creating systems that promote more of this accountability and responsibility on the part of the providers would benefit the patients who need the most support.

In order for the changes that the ACA makes in the health insurance market to be financially sustainable, there must be success in slowing the growth of healthcare costs nationwide. The main issue is a lack of current evidence of how to most effectively reduce costs – hopefully ameliorated by the research focus of some provisions in the ACA. In 2012, the Congressional Budget Office estimated that the coverage expansions of the Affordable Care Act would decrease overall federal healthcare costs by \$84 billion. However, there are critical factors that will strongly influence the impact of the ACA, especially on the state level. Since expansion of Medicaid is under state jurisdiction, the necessary prerequisite to many aspects of the healthcare system, health insurance, may not be expanded as intended. Factors such as provider capacity, infrastructure, and fiscal conditions vary from state to state and lead to differing decisions.

## **Conclusion**

Though the impacts of the Affordable Care Act are yet to be fully realized, this legislature introduced tremendous potential for improvement within the U.S. healthcare system. The various facets of the ACA work together in order to promote an increased access to healthcare through expanded coverage, more effective care, and increased quality of care. The most significant barriers to the aims of the ACA are currently the hesitation of state expansion of

Medicaid and lack of access to insurance exchanges for the target populations. However, there is reason to be optimistic about the changes to come from the reformed healthcare system, especially in the realms of community-based care and hospital accountability for health outcomes. The ACA provides opportunities for healthcare providers and policy makers to focus on augmenting the range of opportunity for people who have previously been neglected by our healthcare system and society as a whole. It is more than access to traditional care, as important as that is, because it also promotes higher quality, more holistic care that addresses social determinants of health behavior. The provisions within the ACA recognize the necessity of improving the method of delivery and availability of healthcare on a nation-wide scale by moving towards a patient-centered model of care. A united front of medical providers, policy makers, and administrators could lead a movement for better health and healthcare practices in the midst of this healthcare reform.

## Works Cited

- Abrams, Melinda. "How the Affordable Care Act Will Strengthen Primary Care and Benefit Patients, Providers, and Payers." *The Commonwealth Fund*. N.p., Jan. 2011. Web.
- Abrams M, Nuzum R, Mika S, Lawlor G. Health reform and primary care: Implications for patients, providers, and payers. New York: The Commonwealth Fund; 2011.
- "The Affordable Care Act: A Summary of Fees and Taxes." *Coventry Health Care*. N.p., 2013. Web.
- "Affordable Care Act Funding: An Analysis of Grant Programs under Health Care Reform." » *Center for Healthcare Research & Transformation*. N.p., Sept. 2012. Web.
- "Affordable Care Act Provisions Affecting the Rural Elderly." *Rural Health and Human Services*. N.p., Dec. 2011. Web.
- "Back To The Future For ACA Cost And Policy Analyses." *Health Affairs Blog Back To The Future For ACA Cost And Policy Analyses Comments*. N.p., July 2012. Web.
- Benner, Joshua S., Marisa R. Morrison, Erin K. Karnes, S. Lawrence Kocot, and Mark B. McClellan, "An Evaluation of Recent Federal Spending on Comparative Effectiveness Research: Priorities, Gaps, and Next Steps," *Health Affairs*, 29, no. 10 (2010): 1768-76.
- "Can Cost-effective Health Care = Better Health Care?" *HSPH News*. N.p., 2012. Web.
- "Center on Budget and Policy Priorities." *Files/status-of-the-ACA-medicaid-expansion-after-supreme-court-ruling* —. N.p., n.d. Web.
- "Center on Budget and Policy Priorities." *Making Health Care More Affordable: The New Premium and Cost-Sharing Assistance* —. N.p., 2013. Web.
- Chandra, Ambita. "The Importance of the Individual Mandate - Evidence from Massachusetts — NEJM." *The Importance of the Individual Mandate - Evidence from Massachusetts — NEJM*. New England Journal of Medicine, Jan. 2011. Web.



"Community-Based Long-Term Services & Supports | Medicaid.gov." *Community-Based Long-Term Services & Supports / Medicaid.gov*. Medicaid, n.d. Web. Apr. 2014.

Congressional Budget Office, Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision (July 2012)

"Diverting Costly Emergency Room Visits to Health Centers." *Diverting Costly Emergency Room Visits to Health Centers*. N.p., n.d. Web.

Falik, M. et al. "Ambulatory Care Sensitive Hospitalizations and Emergency Visits: Experiences of Medicaid Patients" *Medical Care* 39(6) 551-556 (June 2001)

"The Federal Budget and Appropriations Process." *American Public Health Association*.

"The Federal Budget and Appropriations Process." (n.d.): n. pag.

Fernandez, Bernadette. "Health Insurance Premium Credits in the Patient Protection and Affordable Care Act." *Congressional Research Service*. N.p., Mar. 2014.

Galewitz, Phil. "Hospitals Seek More ER Patients Even as Medicaid Tries to Lessen Demand." *Washington Post*. The Washington Post, 22 Aug. 2011.

"A Guide to the Supreme Court's Affordable Care Act Decision." *Kaiser Family Foundation*. July 2012.

"Health Cost Containment: State Initiatives & Federal Health Reform." *Health Cost Containment: State Initiatives & Federal Health Reform*. National Conference of State Legislatures, Sept. 2013.

"Health Costs." *Kaiser Family Foundation*. N.p., 2014. Web. Apr. 2014.

"Health Insurance Market Reforms: Rate Restrictions." *Kaiser Family Foundation*. N.p., June 2012. Web.

Knopf, Alison. "ACA-funded "comparative Effectiveness" Research Group Invites Behavioral Health Grant Applications." *ACA-funded "comparative Effectiveness" Research Group Invites Behavioral Health Grant Applications*. Behavioral Healthcare, Feb. 2014.

Komisar, Harriet. "'Bundling' Payment for Episodes of Hospital Care." *American Progress*. N.p., July 2011. Web.

Krishna, Anirudh. "Partnerships Between Local Governments and Community-Based Organizations: Exploring the Scope for Synergy." *Public Administration and Development* 23.4 (2003): 361-371.

McClanahan, Carolyn. "Secrets of the ACA: What Is a Medical Care Home?" *Forbes*. Forbes Magazine, 05 Jan. 2012.

"Patient-Centered Outcomes Research." *PatientCentered Outcomes Research Institute*.

"Planning for ACA: Effective Cost Reduction." *Healthcare Finance News*. N.p., 23 Sept. 2013.

"Read the Law." *United States Department of Health and Human Services*.

Roberts, C.J., Slip Opin. at 50.

Sasso, Jonathon. "Community Rating and Guaranteed Issue in the Individual Health Insurance Market." *National Institute of Healthcare Management*. N.p., Jan. 2011. Web.

"Site-wide Navigation." *Cost and Coverage Implications of the Affordable Care Act*. N.p., 2012.

"Subsidy Calculator." *Kaiser Family Foundation*. N.p., n.d. Web. Mar. 2014.

"The Tax Break-Down: Preferential Rates on Capital Gains" *The Committee For A Responsible Federal Budget*. 2013.

"What Is a Health Center?" *What Is a Health Center?* Health Resources and Services Administration, n.d. Web. Mar. 2014.