ObamaCare: A Retrospective. Can It Sustain Itself?

Historical Paper

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Introduction

The Affordable Care Act (H.R. 3962) is the federal health care reform bill that was signed into law in March 2010 by President Barack Obama. Often times referred to as “Obamacare,” this health care reform bill is one of the largest pieces of legislation to be passed in the United States in a generation. The document that contains the bill is more than 1,000 pages long and is quite complicated. This bill affects every American (Health reform & you, 2014).

The objective of this paper is to provide background information about how the Affordable Care Act (ACA) came into existence spanning a period of seventy-five years. Discussion will continue on with regard to the Affordable Care Act’s current state more than five years into health care reform. Following this will be dialogue about future state scenarios and predictions that will provide information supportive of and in contradiction to the sustainability of the Affordable Care Act. This information will be provided through the use of internet articles and documents, personal insight and opinions, and interviews with health care professionals.

Background

On most counts, Democrats consider President Obama’s health care reform to be a historic achievement. It is thought by many to be one of the most important pieces of social policy legislation in recent American history. Many would deem it to be as notable and significant as the Social Security Act of 1935 and the Civil Rights Act of 1964. The passing of the Affordable Care Act was seventy-five years in the making. The first attempt at national health care began with President Franklin D. Roosevelt in 1943. President Roosevelt took his concept for national health care to the people to gain approval. As World War II was coming to an end, he considered making national health insurance his next great political crusade. A plan was formulated and prepared for consideration, but the President died just before the end of the war. Until the Affordable Care Act was signed into law, the only major health care programs that had been enacted were put into place by President Lyndon B. Johnson and are known as Medicare and Medicaid (Morone, 2010).
It would be nearly fifty years following President Roosevelt’s death before President Clinton made the next attempt at implementing national health care. Five days after his inauguration in 1993, President Clinton named his wife, Hillary Clinton, to chair a newly established President's Task Force on National Health Care Reform. Once organized, the public had the impression that the task force was responsible for coming up with the Administration's health care reform plan. However, by the time the task force was established, President Clinton’s methodology on the topic was already well-advanced into reform that would ultimately be of his own design. During his campaign he had settled on a plan for universal coverage that was based upon consumer choice among competing health plans that would operate under capitation on total spending. This approach was known as “managed competition within a budget.” In the end the task force proved to be ineffective and a new direction was adopted. President Clinton never really gave up control of the process and the work was ultimately performed by a small team of advisors under his direction (Starr, 2007).

President Clinton wanted to put the responsibility on employers to provide insurance for their employees. His proposed plan faced an untold number of road blocks. In part this was due to concerns that the plan as outlined was far too complex. This was coupled with the fact that people were cynical about government and its intentions toward them in general. Reform was of interest but the Administration misinterpreted what the people wanted, according to Bob Blendon, a public opinion scholar at the Harvard School of Public Health. Americans desired health care reform, but wanted something that was easy to understand and not as threatening as the Clinton plan seemed to be (Clymer, Pear, Toner, 1994).

Lobbyists swarmed the capital, huge advertising campaigns were launched, and newspaper and television did little to educate people about health care reform according to Kathleen Hall Jamieson, dean of the Annenberg School at the University of Pennsylvania. The press seemed to embrace and foster cynicism. They were not as supportive as they could have been in promoting health care reform. This lack of information left the public feeling that there
was no agreement about what the problem even was, let alone how to resolve it (Clymer et al, 1994).

There were arguably many mistakes and misjudgments made in an effort to achieve universal health care on the part of President Clinton’s Administration. It showed a continuing uncertainty about how to deal with the Republican point of view throughout the planning process. From a political standpoint the Administration also seemed to be overly combative as they worked toward the formulation of what national health care should look like. It even assumed that the kind of change that the public desired was the kind of change that the policy analysts wanted. This could not have been further from the truth. There did seem to be agreement on both sides of the political spectrum on one point, however. It was agreed by both Democrats and Republicans that the critical, fundamental error for the Clinton Administration in its effort to achieve national health care was delay (Clymer et al, 1994). Given all of the obstacles to achieving Clinton’s proposed national health care plan, coupled with a huge divide between what President Clinton proposed and what Republican Senators were willing to accept, the Clinton plan for national health care reform failed.

The next attempt at national health care reform came with the election of Barack Obama as President in 2008. As President Obama’s health reform bill grew closer to becoming a reality, there were several key events that occurred during the process. In July 2009 Speaker of the House, Nancy Pelosi, along with Democrats from the House of Representatives revealed their plan for overhauling the American health care system. At that time, it was called the “Affordable Health Care for America Act.” Shortly thereafter Massachusetts Senator Ted Kennedy passed away which placed the Senate Democrats’ 60-seat super majority required to pass a piece of legislation at risk. The super majority was quickly restored in September 2009 when an interim senator was appointed to replace Senator Kennedy (History and Timeline of the Affordable Care Act, 2014).
When it came time for the House of Representatives to vote on the health care bill in November and December 2009 there were 219 Democrats and one Republican vote in support of the Affordable Health Care for America Act. Thirty-nine Democrats and 176 Republicans voted against the bill. This vote ensured the passing of the health care bill within the House of Representatives. Likewise, the Senate’s version of the bill, named “American’s Healthy Future Act” passed with sixty Democrats voting in favor of the bill. Thirty-nine Republicans voted against it (History and Timeline of the Affordable Care Act, 2014).

A new bill, the Affordable Care Act, would then be considered by both the House and the Senate. By March 2010 Senate Democrats were lacking the sixtieth vote that they needed to pass the bill. They decided to use another tactic called budget reconciliation in an attempt to get one bill approved by both the House and the Senate. This method provides for a lower threshold of favorable votes required to pass a bill. Budget reconciliation requires that fifty-one Senators vote in favor of a bill versus the normal requirement of sixty votes. If attained the bill can then be presented to the President for signature. As a result, the Senate’s version of the bill was approved and passed. The House of Representatives also approved the bill by a vote of 219 in favor and 212 against. All of the House Republicans and thirty-four Democrats voted against the plan. President Obama signed the act into law on March 23, 2010 (History and Timeline of the Affordable Care Act, 2014).

**Consumer Education**

Insurance companies had to begin educating the public to increase understanding about what this new national health care legislation really meant to them on a personal level. Blue Cross Blue Shield of Michigan’s position on reform is provided on their website. It summarizes the expectations of insurance companies, in layman’s terms, as they relate to the Affordable Care Act. Their position serves as an example of how other insurance companies may have formulated their positions on health care reform in an attempt to educate the public and is stated here.
Passage of the Patient Protection and Affordable Care Act on March 23, 2010, marked an historic occasion for our country with implications for nearly every American. This monumental legislation is fundamentally changing how health care is financed, delivered and regulated for years to come.

Blue Cross Blue Shield of Michigan is well prepared to act in the best interest of its customers, members and the State of Michigan, as we already act much as Congress now requires other insurers to act.

- We take anyone, regardless of health status.
- We community rate our health coverage for individuals, which means we ask for the same premium regardless of the individual's health condition.
- As a nonprofit insurer, we do not make money on health care, averaging just one-tenth of one percent margin over the last 20 years.
- We work cooperatively with doctors and hospitals to reduce cost and improve quality of care, and these partnerships have saved hundreds of millions of dollars and many lives in the process.

These are endeavors we've long embraced and we will continue to do so. It's simply the right thing to do, regardless of legislation from Washington, D.C.

Passage of legislation didn't mark the end of the process to reform health care. It was just the beginning. As Americans will be required to obtain coverage, we will experience tremendous growth in the individual insurance market. Expansion of coverage also comes with challenges that will require innovative approaches and an unending pursuit of continuous improvement to stave off increased costs. The Michigan Blues have been pursuing these efforts for many years, and our continued efforts in a post-reform world will no doubt prove valuable.

There is much work to be done in the next few months and years as reforms phase in over time. We welcome the opportunity to compete on a more level playing field
where other insurers will no longer be able to cherry pick the young and healthy. We welcome the opportunity to advance new products that put more focus and value on personal accountability by incentivizing members to better manage and improve their health.

As reform takes further shape, rest assured that Blue Cross Blue Shield of Michigan is, and always has been, committed to providing high-quality, affordable health care coverage to Michigan. This is the long-standing mission we embrace (Our Position on Reform, n.d.).

**Required Services**

As a result of the Affordable Care Act, insurance companies were required to begin providing services that previous to its initiation were not necessarily covered services. Prior to the ACA, insurance companies were permitted to cover services at their own discretion. They were also allowed to deny coverage to patients with morbidities that they deemed to be associated with high costs. Many companies were not willing to risk the expense associated with insuring patients with certain conditions. This created an enormous disadvantage for patients who needed the coverage. If they were able to find an insurance company that was willing to insure them, the premiums were potentially so high that they were unable to afford the care they so desperately needed (Medicaid expansion & what it means for you, n.d.).

The Affordable Care Act required insurance companies to cover specific services and it also required them to provide coverage to all patient populations. Insurance companies were also required to make these offerings available for purchase within a federally-guided venue termed the “Marketplace”. They were no longer able to discriminate against people with serious illnesses. As a result, there is now a proliferation of Medicaid policies in effect in many states. Insurance companies had to scramble to prepare their Marketplace insurance policies. They had to consider their risk to cost ratio when insuring extremely ill people, price the policies
appropriately, and make them available to the public in a relatively short period of time
(Medicaid expansion & what it means for you, n.d.).

**Medicaid Expansion**

While there was no requirement to expand Medicaid programs, many states expanded
their programs to cover individuals living in households with incomes below a certain monetary
threshold. In states that expanded Medicaid coverage, a person can qualify for health care
benefits based on income alone. Specifically, household incomes that fall below 138% of the
federal poverty level are eligible (Medicaid expansion & what it means for you, n.d.). This
means that both an individual making less than $16,243 or a household of four making less than
$33,465 qualifies for Medicaid. If an individual or household qualifies for Medicaid but the state
that they reside in elected not to participate in the expansion of Medicaid coverage, they then
become exempt from meeting the requirement of obtaining health insurance. As a result, the
individual or household cannot be held responsible for paying fines associated with not having
health insurance (ObamaCare Medicaid Expansion, n.d.).

**Patient’s Bill of Rights**

On June 22, 2010, President Obama announced new interim final regulations. These new
regulations are called the Patient’s Bill of Rights. They include a set of protections that apply to
health coverage commencing on or after September 23, 2010, six months after the enactment of
the Affordable Care Act. The Department of Health and Human Services, the Department of
Labor, and the Department of the Treasury collaborated on the Patient’s Bill of Rights. This list
of patient rights will help children, and eventually all Americans with pre-existing conditions gain
coverage and keep it. It will also protect all Americans’ choice of doctors. If patients are
required to choose a primary care provider, they have the right to choose who that provider will
be, assuming the provider is accepting new patients. This ability will allow patients to play an
active role in obtaining quality health care appropriate to their specific needs, rather than the
needs of a particular insurance company. The Patient’s Bill of Rights will also end lifetime limits
on the care consumers may receive. These new protections created an important foundation of patients’ rights in the private health insurance market by putting Americans in charge of their own health care choices at a level never seen before. Specifically, extremely ill patients and children who had no health care coverage prior to Obamacare were given new opportunities to seek and receive the appropriate treatments they required (Patient's Bill of Rights, n.d.).

**Preventive Services**

Another aim of health care reform includes providing greater access for preventive care to improve our nation’s health and reduce overall health care spending. This goal can be achieved by finding and treating diseases more quickly. What is preventive care? Preventive care is service that, if taken advantage of, can potentially prevent people from getting sick. It can also aid in earlier detection of diseases or conditions before they become serious health problems with associated escalating costs. Preventive care can range from vaccinations and blood pressure screenings to smoking cessation assistance (What Is Covered Under Preventive Care, n.d.).

Preventive care was categorized into specific groups of people. The categories were adults, women (including pregnant women), and children. There were fifteen required services for adults. Several of the new preventive coverage requirements include colorectal cancer screening, immunizations, obesity screening, and tobacco screening. There were twenty-two required preventive services for women eight of which required no cost sharing. These include services such as contraception education and counseling, screening and education for gestational diabetes, HIV testing for sexually active individuals, and screening and education for sexually transmitted infections. For children, there were twenty-six required preventive services. Examples of required coverage under the new health care system for this group include lead screening, hearing screenings for newborns, fluoride chemoprevention for children without fluoride in their primary water source, and autism screening for children 18-24 months (Preventive Care, 2015).
Pre-Existing Conditions

Obamacare eliminated the ability of insurance companies to deny coverage to patients with pre-existing conditions in 2014. This was of great benefit to patients because insurance companies could no longer deny health care coverage, charge more for the same services that others received, or deny treatment because of one’s health status. Statistics indicate that one in two Americans has a health condition that qualifies them as having a pre-existing condition. According to the Centers for Disease Control, 75% of all health care expenditures are as a result of chronic diseases. They also state that many of these chronic conditions are preventable. It is estimated that 133 million Americans, nearly one in two adults, lives with at least one chronic health-related condition. Obamacare strives to focus on achieving and maintaining health and wellness in an effort to improve the quality of health care outcomes. It also seeks to drive down health care costs across the spectrum for all (ObamaCare Pre-existing Conditions., n.d.).

Value vs. Volume

With the inception of the Affordable Care Act in 2010, the initial focus was placed upon providing consumer protections, improving the quality of care provided, lowering costs, and increasing access to affordable care. From 2011 through 2013 the emphasis remained on improving quality and lowering costs. In 2014 there were additional consumer protections added with a continued concentration on improving quality and lowering costs. In 2015 there was a shift in focus toward paying physicians based on the value of the health care delivered rather than the number of patients being treated. This change provided for a direct correlation between the quality of the care delivered and the payments received by medical providers. This was an extreme change in thinking. While medical professionals were always concerned about delivering quality care, their attention would now have to shift. They would be required to begin providing evidence of giving higher quality care in order to receive maximum reimbursement for services rendered (Features of the Affordable Care Act by Year, 2015).
Why this move to payment for value versus volume? There are those that would suggest that one leading reason for this change is that the payment systems that we have become so familiar with have serious flaws associated with them. Another major cause is that current payment systems encourage volume-driven care rather than value-driven care. Over time, the health care system as a whole has appreciated gains in revenues and profits by delivering more services to more people. With the shift to value-based payment systems, providers are held to a high standard of care. This is accomplished through the use of quality measures used to maximize the positive impact on patient care. In this new model, health care professionals are measured and subsequently reimbursed based upon meeting these quality standard benchmarks. This modification also gives providers greater responsibility and influence over health care expenditures than ever before. When services are covered under the same “episode of care” there is greater incentive for providers to coordinate their services with other providers. This coordination of care in turn helps to reduce redundancies in care and decrease the costs associated with that care (Volume to Value: Better Ways to Pay for Health Care, n.d.).

Medical Practice Insights

The Affordable Care Act was initially overwhelming and confusing for many physicians and medical practices that were uncertain about what to expect or how to proceed. The effect of the changes brought about by the Marketplace and how reimbursement might change in the office setting required innovative ideas. Prior to the Affordable Care Act, staff verified benefits simply by checking websites or calling insurance companies.

Due to changes in the health care system associated with the ACA, patients who purchased insurance through the Marketplace were covered by their insurance on a conditional basis. The condition of insurance coverage was based upon whether or not patients maintained timely payment of their insurance premiums. Insurance companies were scrambling to come up with ways to identify the patients who had not paid their premiums. This was done in an attempt to provide solutions that would assist providers in understanding what monies were to be
collected from patients at the time of service. If patients failed to pay their insurance premiums they were initially covered for a grace period within which insurance companies were paying claims. Once delinquent premiums reached a particular threshold, patients fell outside of grace periods. Patients became uninsured for all intents and purposes back to the first day that the premiums had not been paid. Insurance companies would then begin recouping claim payments from those who had been paid for providing services.

As a result of this potential re-payment concern, medical practices were on high alert about what financial impact the Marketplace might have on cash flow and ultimately the bottom line. Would they be paying back a substantially higher percentage of money to insurance companies than ever before? How would they keep track of every single patient and every single insurance coverage available in an attempt to maintain some sense of order in their collection process?

This new way of looking at health insurance from a billing perspective was initially significant. Offices had to consider how they might need to change processes and procedures. They could not assume that patients were covered by insurance. This seemed to change the focus from providing patient care to patient collections. As patients moved into higher deductible health care plans, the amount they owed directly to the practice had the potential of being substantial. In a sense, practices could hold patients financially captive. They could require them to pay their portion of financial responsibility in advance of allowing them to receive medical care. Front line staff had to be trained in a new approach on how to discuss Marketplace insurance coverage with their patients.

**Medical Billing Interview**

An interview with Innovative Practice Concepts (IPC), a professional billing company, found that while IPC is not directly involved with confirming benefits, they discovered that many of the high-deductible plans needed to be treated differently. Patients had to be considered as if they were self-paying customers. Their financial responsibility had to be collected prior to
services being rendered. If medical practices were not doing a good job of collecting up front, then it became much more difficult for them to collect monies that were owed after the fact. Innovative Practice Concepts indicated that many patients applied for insurance through the Marketplace to avoid the tax penalties associated with being uninsured. As a result, patients often times chose the highest deductible plans to keep their costs as low as possible. These patients also tended to be those who could not afford to pay the out-of-pocket insurance deductibles for medical care. So while one could say that they were insured, for a large majority of those individuals, they were often times unable to use their coverage in an effective way.

Another problem that Innovative Practice Concepts recognized was the fact that many patients do not understand their insurance coverage. For example, partnerships were formed between insurance companies and health care provider groups that were considered to be a “closed network” type of coverage. These partnerships required the insured patients to be seen at a limited number of facilities in order to have their health care covered by the insurance company. Many patients did not understand this. When they were seen at non-partnered providers they were surprised when they were held accountable for the entire bill for services rendered. Also, it was possible that a specialist could perform a procedure only to find out that ninety days later the patient failed to pay insurance premiums. They had no coverage for the time period in which the procedure was performed. As a result, specialists had a higher probability of ending up without payment while the patients would potentially end up in collections, in worst case scenarios.

IPC indicated that as it looks back at the last five years, they feel that more patients have been able to obtain coverage than ever before. This coverage has been primarily through Medicaid. Many practices are treating higher percentages of Medicaid patients. As a result, there has been a negative impact on the bottom line for many health care providers. The proliferation of high deductible plans has resulted in medical practices being required to become pre-service collection experts. Unfortunately, this need to consider how a practice will be paid may be perceived by patients and providers alike as shifting the focus from patient care to money care.
Medical Practice Interviews

Several medical practice managers were interviewed relative to how the Affordable Care Act has affected their practices. All participants agreed that they planned ahead to increase their insurance verification processes with specific emphasis on insurance not provided by an employer. They were also more aggressive in their initial financial discussions with their patients. There was general agreement about the fact that there were, and will continue to be, workflow adjustments as health care seems to be in a fluid state of change. Of interest, one participant indicated that her practice felt that the increase in insurance verification was not really required because it did not provide any increased protection from the inevitable need to collect money directly from patients. Interview participants believe that it is extremely difficult to get comprehensive and reliable insurance information. Without it, it is more difficult to make solid business decisions on how to proceed in each patient’s case.

Interview participants had initial concerns about how to formulate and implement having financial conversations with patients in a way that they had never had to before. They also had concerns about the additional time constraints required to verify patient benefits and how this might affect the bottom line for their practices. Some worried about whether they would essentially end up seeing more Medicaid patients, further decreasing reimbursement. As time went on and they were able to settle into this new reality, they found that they were seeing the same percentage of Medicaid patients but from many more managed care plans than ever before. The increase in Medicaid plans simply added to the frustration involved in dealing with so many different insurance companies.

One of the biggest issues identified by interview participants is the patient who has a procedure “authorized” by the insurance company based upon the coverage in place prior to receiving the procedure. When the patient fails to pay their insurance premiums, it is the practice that takes on the burden of the financial loss, not the insurance company. It is impossible to anticipate whether or not a patient will pay their insurance premiums and this can cause a large
fluctuation in accounts receivable. Secondarily, with a large number of managed Medicaid plans in the Marketplace, it can be confusing and difficult to stay current with every health plan’s specific requirements. Also, high deductible plans might not be clearly understood by patients. As a result, additional time and training is required of practice staff in order to provide explanations about coverage that would have been previously managed by a patient’s employer or their insurance agent.

One interview participant mentioned the fact that the Affordable Care Act has also made it more difficult to manage their practice’s own employee health benefits. All of the regulations seem to limit employer options in providing health care coverage to employees without experiencing enormous insurance premium increases. They are unable to provide good health care coverage to their employees without increasing the practice’s cost to insure. As a result, the burden of any potential increases in cost often times shift to the employees.

Overall, there was a general sense of neutrality about the effect that the Affordable Care Act has had on medical practices from a work flow standpoint. While the ACA has required changes in work flows, it has not increased the amount of work to be completed. Staff training in process changes has been critically important. The staff need to have the ability to lead patients in a new way through educational components required of medical practices. Patients need to be educated about available community resources, health conditions requiring visits to the emergency department, how to best use patient portals, and how to increase patient understanding about what it means to be a part of a patient-centered medical home to name a few.

Practices quickly learned that although a person has insurance, they may not have adequate coverage to meet their health care needs, nor does it mean that they have more readily available health care. It would seem logical that many of the individuals who did comply with the regulation to purchase health insurance might seek the minimum coverage required, which is most likely the least expensive coverage possible. Unfortunately, this could leave many patients faced with an unexpected health crisis with inadequate coverage and significant financial liability.
Alternatively, there was one benefit that was recognized by the participants. When patients purchase a minimum coverage/high deductible insurance plan, they are provided with the potential of a lower fee schedule based on provider participation with an insurance company. This could be beneficial when paying their personal responsibility portion of the bill to the practice.

**Social Barriers**

There are multiple concerns about possible barriers that are facing the future success of the Affordable Care Act. There are questions about whether consumers initially signed up and then cycled out of the system because they failed to pay their insurance premiums. Additionally, there is a percentage of Americans who fell through the “policy gap” when the federal government did not require all states to provide expanded Medicaid coverage. Some patients requiring health care may be difficult to reach or find due to barriers such as mental illness and language differences. Additional obstacles are high deductible plans or plans that cover too few doctors, thus causing consumers to have fewer health care options when they need them (Sanger-Katz, 2014).

**Insurance Company Volatility – United Health Care**

United Health Care is an example of an insurance company that has made a stand against the Obamacare exchanges. The company has suggested that it will lose nearly $1 billion due to Obamacare policies. United Health Care reported losses of $475 million in 2015 and they expect losses of more than $500 million in 2016 relative to the Obamacare exchanges. They reported that at the end of 2015 they had approximately 500,000 enrollees, and are expecting this to increase to almost 800,000 enrollees during the 2016 open enrollment period (Luhby, 2016).

United Health Care is not looking to grow its exchange business. Instead, it has increased prices, eliminated marketing and commissions of its exchange products, and withdrawn its top-tier products in an effort to stem its exchange losses. It is also working more closely with providers and enrollees to manage illnesses and the care being provided to them. The company
warned in November 2015 that it might pull out of the Obamacare exchanges altogether in 2017, indicating higher than expected claims. Specifically, United Health Care places blame on the large number of members signing up outside of the open enrollment period. These enrollees are using an increased number of medical services (Luhby, 2016).

Some insurers argue that Americans are waiting until they get sick to sign up for health insurance and then finding ways to qualify during the so-called special enrollment period. This special enrollment period is generally intended for those who change jobs, get married, divorce, or have a baby. President Obama’s Administration has since said that it will tighten the rules for joining Obamacare during this special enrollment period (Luhby, 2016).

United Health Care is the nation’s largest health insurer, although it is not the largest in the individual insurance market that the exchanges serve. If United Health Care’s final decision is to dramatically decrease its involvement in the exchanges, it would severely limit competition in parts or all of approximately ten states. That could mean higher premiums in states and counties being left with one or two insurers. This would only change if other insurance companies were to enter those markets. For example, Oklahoma and Kansas would be left with one insurer should United Health Care withdraw from those markets (Galewitz, 2016).

In April 2016 United Health Care confirmed that it will drop out of most of the Affordable Care Act state exchanges. It will continue to operate in a handful of exchanges in 2017 compared to the 34 state exchanges it participated in during 2016. United Health Care states escalating losses in the Obamacare insurance plans as its primary reason for this decision. This decision may severely limit competition. This lack of competition amongst insurers could cause insurance premiums to increase for those seeking affordable health care in the affected states (Galewitz, 2016).

Despite the concerns, a spokesman from the U.S. Department of Health and Human Services has said, “We have full confidence, based on data, that the marketplaces will continue to thrive for years ahead. The marketplace should be judged by the choices it offers consumers, not
the decisions of one insurer.” United Health Care officials have said that they are unwilling to continue losing money and that they cannot broadly serve the smaller insurance markets in an effective and sustainable way (Galewitz, 2016).

As reported in The Wall Street Journal, troubles complying with the Affordable Care Act are not unique to United Health Care. Many believe that other large insurance companies such as Aetna and Anthem could also face challenges in the near future. The challenges would be due to the increasingly large number of chronically ill people joining the exchanges. Because the Affordable Care Act does not allow insurance companies to charge different rates or deny coverage due to pre-existing conditions, Americans are joining and taking advantage of subsidies offered through the Marketplace. This may be putting insurance companies in precarious financial positions (Haskins, 2015).

Financial Constraints

Under Obamacare, many physicians and medical practices have experienced increasing strain on their bottom line. This strain is a result of costly new regulations, intricate payment “reforms” that tie their Medicare reimbursement to complex federal reporting requirements, and mandates that they install and make “meaningful” use of electronic health records. These initiatives alone are extremely costly. Adding to that burden is the increasing proportion of patients that are transitioning from commercial health plans to Medicaid plans. This transition from commercial health plans to Medicaid plans results in physicians receiving significantly lower reimbursement when compared to the reimbursement that they received from private health insurers. Required increases in costs and decreases in reimbursement are both factors that can have a potentially devastating effect on medical practices as a whole (Gottlieb, 2015).

Obamacare health plans are paying close to Medicaid rates for many ambulatory procedures. There is evidence that many people who are now insured under Obamacare were previously insured in the individual or group market and had their previous commercial coverage terminated. As a result, they were required to seek coverage through the Marketplace. This fact
alone is a strong indicator that provider revenues will continue to decrease while medical practice costs will continue to escalate (Gottlieb, 2015).

For the end consumer, health care costs continue to escalate. Often, consumers do not know what health plan to choose, let alone which one will most closely suit their health care requirements. Obamacare’s attempts to reduce health care premiums have led to a rising number of Americans becoming underinsured. Underinsured is defined as an insured individual whose out-of-pocket costs (excluding premiums) equals 10% or more of their household income or whose deductible equals 5% or more of their household income. It is estimated that 23% of insured people between 19 and 64 are now underinsured which is twice the percentage that it was in 2003 (Eisenberg, 2015).

Another limitation is that many consumers, specifically young people, are choosing to pay the required fines rather than paying insurance premiums. This is due in part to a sluggish economy. There is also the potential that many individuals will not meet the required financial threshold to obtain an exemption from paying the Obamacare fines. The current maximum fine in 2016 for an individual not insured by a qualified plan for a 12-month period is $695 or 2.5% of taxable income, whichever is greater. While $695 may seem to be a significant amount of money, it is still much less than the cost to purchase health insurance on an annual basis. As a result, the penalty may not be high enough to incentivize people to purchase health insurance. However, increasing the penalty at this point would likely have negative political repercussions and be highly unpopular with the American public. Without strong enough financial enticement to sign up for health insurance, healthy Americans are choosing to go without insurance or to purchase non-qualifying policies that cover only the most expensive health circumstances (Haskins, 2015).

**ACA – Death Spiral or Survival?**

The future of Obamacare is uncertain. How it will perform over time remains to be seen. There are clearly two sides in this continuing saga and the economic battle has just begun. Can
the Affordable Care Act survive in today’s ever changing economic market? Although the outlook remains uncertain, some indications suggest that the answer is no. The Affordable Care Act will not be able to succeed by simply securing first-time enrollments in its exchanges (Epstein, 2015).

The Affordable Care Act was intended to reduce the number of Americans who were without health insurance. Measuring against this goal, there has been progress made. Private sector surveys suggest that in 2014 the number of Americans without health insurance was reduced by 25%, or between 8 and 11 million people. It appears that about half of these people signed up for Medicaid. This was especially true in states that instituted a more robust Medicaid program for lower income residents (Sanger-Katz, 2014).

It remains unclear as to whether insurance companies have collected sufficient premiums to cover their expenditures. No one knows for certain how the new coverages required by the Affordable Care Act should be priced. For companies working on a cash flow deficit, new ideas will have to be considered. They will have to become ever more prudent about pricing their insurance strategically to better reflect the corresponding value of services provided. Customers of the various insurance companies could potentially begin to think that they are paying too much for benefits that they would rather not have. This perception would hold a stronger argument with those who are healthy and/or young (Epstein, 2015).

Difficulties in the exchanges can be traced back to the original design of Obamacare. The concept was based upon the idea that a federal program could allow for the delivery of higher quality care at lower costs than could be obtained through conventional private insurance companies. The Marketplace seems to work under the assumption that the private insurance plans are inefficient and expensive (Epstein, 2015).

In theory, the burden on insurance companies could become more manageable over time as they learn how to adjust to government program requirements. If the government continues to remain rigid, this is less likely to occur. President Obama’s response to concerns about high
premiums suggests that if insurance commissioners are doing their jobs, premiums will come
down significantly over time. In fact, it is the risk of insufficient rate hikes that could potentially
undermine the stable health care environment required for the markets to be effective. If
insurance carriers are unable to cover their expenses through the collection of appropriate
premiums, they will be unable to remain in the exchanges. This inability to compete will cause
health care to become more volatile and unpredictable. Partial deregulation of the Affordable
Care Act would potentially decrease the financial pressures being put on insurance companies
(Epstein, 2015).

By the end of Obamacare’s 2015 open enrollment, the industry was hopeful to have had a
better understanding about the way that the program would look. However, there remain a
number of unanswered questions relative to the intended outcomes and future of this reform
effort. There have been 7.8 million confirmed enrollments or renewals to qualified health plans.
Most insurers are entering many markets, but some have already reported financial difficulties.
Data on the uninsured is not readily available, but Gallup numbers indicate that about 4% of the
population has become insured since the commencement of the Affordable Care Act. This
equates to between 10 and 12 million people (McArdle, 2015).

Much about the Affordable Care Act remains ambiguous. What will prices look like on
the exchanges given the fact that the Administration continues to funnel subsidies to insurance
carriers who are reporting financial losses through various risk-sharing programs? Also there are
various startup insurance companies who may be underestimating their eventual costs. These
factors would suggest that there is the possibility that prices will begin to rise steeply in 2016 and
2017 (McArdle, 2015).

How strong is the individual mandate? The real test will come as Marketplace consumers
start to experience significant tax ramifications due to subsidies they received being too large,
thus requiring repayment. For those choosing to remain uninsured, it remains to be seen as to
whether consumers understand the individual mandate penalty. Consumers may be
overwhelmingly surprised when they eventually realize the costs they will incur due to penalties for non-participation in the health care programs. As a result, consumers may end up putting a lot of pressure on Democrats to weaken the financial requirements associated with non-participation (McArdle, 2015).

What will the courts do? Lawsuits have been filed challenging the right of the federal government to subsidize federally run exchanges (King v. Burwell). If the plaintiffs win, subsidies will disappear in a majority of states. This will set in motion the very expensive process of setting up state run exchanges. Also, Medicaid providers are seeking the right to challenge payment rates if they are too low (Armstrong v. Exceptional Child Center). Should the providers win the case, the cost of Medicaid expansion will increase. Consequently, states that have not expanded their Medicaid programs may find expansion an even less attractive proposition (McArdle, 2015).

What will Republicans do? They have seemed to be interested in minimizing and/or eliminating the employer mandate and many other provisions of the Affordable Care Act. Until President Obama leaves office, there is not much that can be done. It is likely that the President would veto any proposed changes with regard to health care reform. Republicans will arguably hope for a Republican to be elected into office, or that Democrats succumb under increased public pressure to override a veto by the President (McArdle, 2015).

These factors all add up to uncertainty. The health care industry has an idea about what the Affordable Care Act looks like right now. However, it is impossible to predict the future of the program. In the next few years, Congress may experience overwhelming political pressure to make modifications. Elements of the current plan, such as mandates and increasing costs, may cause consumers to become increasingly discontent as they gain a better understanding about how the system works. This may cause an uprising that demands change (McArdle, 2015).

President Obama stated six years ago, when the health care bill was signed, that, “Every single good idea to bend the cost curve and start actually reducing health care costs [is] in this
bill.” It was projected by the Obama Administration that their version of health care reform, which was full of investments in health information technology, health care delivery, and payment reform, would translate into significant cost reductions for every person, family, and business. President Obama suggested that every family would see $2,500 in savings annually (Moffit, 2016).

With lower than anticipated enrollment in health insurance exchanges, and the refusal of twenty-one states to participate in Medicaid expansion, health care costs are continuing to increase. This is fueled by sharp increases in both public and private health care spending. The Centers for Medicare and Medicaid Services data indicates that per capita health insurance spending will rise from $7,786 in 2016 to $11,681 in 2024. The Congressional Budget Office projects that job-based premiums are poised to increase by 60 percent between now and 2025 (Moffit, 2016).

Under Obamacare, public spending has increased at a quicker pace than private spending. For 2015 the Congressional Budget Office reported that the $936 billion spent on health programs is a 13% increase over 2014. This increase included Medicare, Medicaid, and the Affordable Care Act with Medicaid being the fastest growing sector realizing a 32% increase in spending alone (Moffit, 2016).

Many Affordable Care Act advocates are pleased with the increasing role that the government is playing in American health care. In this regard, the reform is seen as positive progression. However, this increased governmental role has not bent the cost curve in a downward trajectory as it was initially suggested by the Obama Administration. It also does not guarantee that there is value given to those using Obamacare for the dollars being spent to support its initiatives (Moffit, 2016).

Health care delivery and payment reforms such as value-based purchasing, pay for performance, and accountable care organizations are several strategies that were enacted by the Affordable Care Act. The goal was to decrease overall expenditures. The Congressional Budget
Office, through a detailed evaluation, found that these strategies have had limited success. It was found that the “value-based” initiatives are largely unimpressive as a way to appreciate health care savings (Moffit, 2016).

These attempts to reduce costs call for sustained payment cuts to the popular Medicare Advantage program. The Affordable Care Act has also scheduled some big Medicare payment reductions that will affect hospitals, nursing homes, home health agencies, and hospice care programs. Attempts to reduce costs have the biggest effect on senior citizens or those using Medicare to pay for their health care. Should these reductions take place, most of these entities will be operating with a financial loss in the next few decades. This will jeopardize access and quality of care for the older population of Americans (Moffit, 2016).

Payment reductions and price controls may not be the right solution for the rising cost of health care in America. Congress and the next Administration may need to consider focusing on the continuing problem of health care costs. Decisive steps may need to be taken to level the playing field and take advantage of real market competition among health insurance plans and providers to control costs. They may also need to consider providing genuine consumer choice to achieve real value for health care dollars spent. Big bureaucracy does not seem to be working and lawmakers will need to produce a better strategy in an effort to achieve a solution that works (Moffit, 2016).

Conclusion

Long before the Affordable Care Act was signed into law, it had its supporters and its critics. It took many decades and many attempts for this nation to finally appreciate national health care. Prior to the ACA being passed by the Senate and the House of Representatives, there were many good ideas brought to the table about how to formulate our national health care system throughout the years. In theory, many of those ideas on how to create a national health care system made sense. Since being signed into law in 2010 there is no doubt that the concepts of national health care were borne of good intention. When put into practice it would appear that
the overall program is in significant need of continued change. The goals of this change will need to focus on improving the quality of care given to all patients while at the same time reducing the cost of care as originally outlined six years ago. Data indicates that not only have cost reductions not been realized by the average American, but in actuality, costs have increased and are projected to continue to increase over time.

The effects of the ever changing Affordable Care Act should be managed without consideration for political affiliation. Legislators need to step to the center of the aisle, putting aside political differences in order to provide a program that truly works for all Americans, regardless of income or health condition. The consequences of the Affordable Care Act’s attempts at providing quality health care at lower costs are placed on those who need health care the most urgently, the critically ill patient. Citizens are paying more for their health care than ever before with no guarantee of being given the quality care that they deserve.

If Americans are not paying more for health care, it is often times because they are choosing not to seek treatment for their medical conditions. This is largely due in part to the fact that they require health care that they cannot afford or access. Patients in lower income brackets that do not qualify for Medicaid are at high risk of not seeking proper medical care. This lack of care has the potential to increase negative medical outcomes. This may further reduce the Affordable Care Act’s ability to proclaim its success toward increasing positive patient outcomes and decreasing health care costs.

The Affordable Care Act will remain the law under which our national health care system will belong into the foreseeable future. The decision in King v. Burwell assured that tax credits would continue to assist qualifying persons in obtaining health insurance whether through their state established exchanges or those established by the Department of Health and Human Services (Leonard, 2015). As time passes, the system will continue to improve in its ability to become more patient centric. Being centered around patients and meeting their health care needs was the original intent of this initiative when President Obama signed it into law.
There is much anticipation about the prospect that many of the arguments and concerns surrounding the current state of our national health care system will cease to exist. As our legislators begin to work together for the common purpose of providing all patients with affordable, quality health care, the American public will reap the benefits. Just as it was initially envisioned at its conception some seventy-five years ago by President Franklin D. Roosevelt, Americans can be cautiously optimistic. There is real potential that the health care system that was conceptualized and implemented will continue to evolve and improve well into the future. The vision being that it will become a health care system that can be appreciated for its all-encompassing focus on meeting the needs of America’s patients.


History and Timeline of the Affordable Care Act (ACA). (2014, October 22). In


