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Health Care Reform—A Historic Moment in US Social Policy

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IN A HISTORIC CEREMONY ON MARCH 23, 2010, PRESIDENT Obama signed into law the first US comprehensive health care reform bill, the Patient Protection and Affordable Care Act (PPACA). For almost a century, presidents have tried and failed to pass national health insurance—ranging from President Franklin Roosevelt's exclusion of national insurance from the Social Security Act to the failure of President Nixon's and President Clinton's health care plans.¹ Previously, health care reform passed incrementally with a uniquely US blend of public and private coverage. The War Labor Board's exclusion of employer-based health insurance from wage and price controls significantly increased coverage. By 1954, Congress exempted employee benefits from income tax, creating powerful incentives. The enactment of Medicaid and Medicare in 1965 expanded public coverage, followed by President Clinton's State Children's Health Insurance Program and President Bush's Medicare Part D Prescription Drug coverage.¹

Expanded Coverage

The current public/private system has resulted in major coverage gaps, with an estimated 46.3 million US individuals uninsured in 2008 (15.4% of the population)² and an additional 25 million underinsured.³ Premiums have far surpassed the inflation rate, with many insured individuals paying disproportionate out-of-pocket costs relative to their income. The United States currently spends approximately twice as much per capita for health care as other industrialized countries, but ranks low on health outcomes and preventable mortality. The PPACA is expected to expand health insurance coverage to 32 million individuals by 2019 through a variety of measures.

Individual Purchase Mandate. By 2014, the PPACA requires most individuals to have health insurance. With certain exceptions (eg, income level and religious objections), individuals without qualifying coverage will pay an annual tax penalty reaching the greater of \$695 (\$2085 per family maximum) or 2.5% of household income.⁴ To make insurance more affordable, the act offers sliding-scale subsidies and caps out-of-pocket spending. The mandate expands the pool of insured individuals, spreading the health risk and

thereby decreasing premiums. However, if the penalty proves to be too low or is not adequately enforced, individuals might not purchase insurance, thereby defeating the central purpose of the mandate.⁵

Medicaid. The PPACA will expand Medicaid to individuals with incomes up to 133% of the federal poverty level (FPL), adding 16 million to 20 million individuals to the Medicaid roster. This includes a critical group of low-income adults without children who were previously ineligible for Medicaid coverage. The reform standardizes Medicaid benefits by guaranteeing a minimum package of essential services. However, even with expanded eligibility, access to essential services may be limited due to a lack of clinicians. Medicaid reimbursement rates are low and although the PPACA raises rates temporarily in 2013 and 2014, it is uncertain whether this will truly expand access.

Health Insurance Exchanges. By 2014, states are required to establish American Health Benefit Exchanges and Small Business Health Operations Program (SHOP) Exchanges—marketplaces in which consumers will shop for health insurance at competitive rates. Exchanges will offer an array of private health insurance choices, centralizing enrollment and providing information.⁶ Exchanges will also provide consumers greater purchasing power by allowing individuals or small businesses to join together to purchase insurance. The same market regulations apply in and out of exchanges, and exchanges will have to sell at least one "qualified health plan" with minimum benefits.

The PPACA helps low-income US citizens (up to 400% of the FPL) who are not Medicaid-eligible to purchase insurance through exchanges by giving credits and subsidies for premiums and other out-of-pocket costs. It also gives small businesses with fewer than 100 employees tax credits for offering insurance.⁷

Eliminating Coverage Barriers. The PPACA reverses common industry practices that created barriers to coverage. It immediately prohibits insurers from denying coverage to children with preexisting medical conditions and allows young adults to remain on their parents' plans up to age 26 years. In 2014, insurers will have to accept all applicants, irre-

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spective of health status or preexisting condition, and renew coverage. Furthermore, the legislation proscribes rescission (canceling coverage), eliminates the lifetime amount insurance will pay for certain conditions, and restricts annual limits. Until Medicaid expansion and state exchanges begin in 2014, the act creates federally subsidized state high-risk pools for those with preexisting conditions.

The PPACA closes the Medicare Part D coverage gap or “donut hole.” Currently, after Medicare beneficiaries surpass the prescription drug coverage limit, they are financially responsible for the entire cost of prescription drugs until the expense reaches the catastrophic coverage threshold. The act provides a \$250 rebate to Medicare Part D enrollees, with industry required to decrease the cost of prescription drugs by 50% in 2011. For Medicare recipients, the act eliminates cost sharing for preventive care and limits the amount of out-of-pocket costs consumers must pay each year.

Cost to the Nation

At a cost of \$938 billion over 10 years, the PPACA is projected to reduce the deficit by \$143 billion in the first decade and \$1.2 trillion in the second.⁸ However, despite the guarantee of coverage for 95% of US individuals and a deficit neutral projection, concerns that the expansion costs will offset the savings are beginning to emerge. Recent estimates report a potential increase in costs of 0.9% over 10 years.⁹ Additional savings over the initial estimates are difficult to predict and might not be realized until well after implementation.

Promises and Challenges of Health Care Reform

National health care reform promises to dramatically expand access to care, increase consumer choice, and ban insurance discrimination for individuals with preexisting medical conditions—representing a historic moment in US social policy. The PPACA also contains vital resources for prevention, public health, and community care. Similarly, it expands medical and nursing education and training, creating incentives for much-needed primary care and for human resources in underserved communities.

The United States, however, missed a unique opportunity to significantly reduce medical costs and improve quality. The government-run public option—omitted from the final bill—was designed to curtail administrative costs and increase competition in the private market. Additional proposals for comparative effectiveness research, independent review panels, and physician incentives (paying for quality rather than quantity of health care) similarly proved politically untenable with public fears of “rationing” and even “death panels.”

State attorneys general have launched constitutional challenges, claiming the federal government lacks the power to

impose tax penalties against individuals who choose not to purchase insurance. This argument is likely to fail because the federal government has a broad power to regulate commerce. Health care has a substantial national economic impact and is not restricted to intrastate business. Furthermore, because the mandate is enforced through a tax penalty, the federal government can also rely on its taxing power.

State attorneys general similarly argue that the federal government cannot compel states to create insurance exchanges. The act, however, does not create a requirement for states to establish exchanges. Instead, states can either create an exchange or opt for the Secretary of Health and Human Services to set up and operate the exchange. This conforms to Supreme Court precedent. The Supremacy Clause, moreover, holds that federal law supersedes state law—if state and federal law conflict, federal requirements prevail.

Like Medicare and Social Security, which were highly contested before enactment, national health insurance reform hopefully will, in time, become part of accepted social structures. Affording everyone the right to medical care irrespective of income or health status should become a widely shared social norm, as it is in most other countries. Future debate probably will center on the difficult choices needed to curtail increasing costs, improve quality, and change physician and hospital incentive structures. Those are crucial aspects of reform that will have powerful effects on the economy and the population’s health and cannot be ignored by political leaders.

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