CHAPTER 2

Benchmark Developments in U.S. Health Care

This chapter describes the important legislative, political, economic, organizational, and professional influences that transformed health care in the United States from a relatively simple professional service to a huge, complex, corporation-dominated industry. The effects of medical education, scientific advances, rising costs, changing population demographics, and American values and assumptions regarding health care are discussed. This chapter concludes with a brief discussion of judicial challenges to the Patient Protection and Affordable Care Act (ACA) and a review of the ACA provisions that address basic, cost, quality, and access issues of U.S. health care system.

From its earliest history, health care, or, more accurately, medical care, was dominated by physicians and their hospitals. In the 19th and early 20th centuries, participation in U.S. medicine was generally limited to two parties—patients and physicians. Diagnosis, treatment, and fees for services were considered confidential between patients and physicians. Medical practice was relatively simple and usually involved long-standing relationships among physicians, patients, and their families. Physicians set and often adjusted their charges to their estimates of patients' ability to pay and collected their own bills. This was the intimate physician–patient relationship that the profession held sacred.

Free from outside scrutiny or interference, individual physicians had complete control over where, when, what, and how they practiced. In 1934, the American Medical Association (AMA) published this statement: "No third party must be permitted to come between the patient and his physician in any medical matter."[1] The AMA was concerned about such issues as non-physician-controlled voluntary health insurance, compulsory health insurance, and the few prepaid contracts for medical services negotiated by remote lumber or mining companies and a few workers' guilds. For decades, organized medicine repeatedly battled against these and other outside influences that altered "the old relations of perfect freedom between physicians and patients, with separate compensation for each separate service."[1]

As early as the 19th century, some Americans carried insurance against sickness through an employer, fraternal order, guild, trade union, or commercial insurance company. Most of the plans, however, were simply designed to make up for lost income during sickness or injury by providing a fixed cash payment.[1] Sickness insurance, as it was originally called, was the beginning of social insurance programs against the risks of income interruption by accident, sickness, or disability. Initially, it was provided only to wage earners. Later, it was extended to workers' dependents and other people.[2]

Around 1915, the drive for compulsory health insurance began to build in the United States, after most European countries had initiated either compulsory programs or subsidies for voluntary programs. The underlying concern was to protect workers against a loss of income resulting from industrial accidents that were common at the time. Families with only one wage earner, often already at the edge of poverty, could be devastated by loss of income caused by sickness or injury, even without the additional costs of medical care.

At the time, life insurance companies sold "industrial" policies that provided lump-sum payments at death, which amounted to $50 or $100 to pay for final medical expenses and funerals. Both Metropolitan Life and Prudential Insurance Company rose to the top of the insurance industry by successfully marketing industrial policies that required premium payments of 10–25 cents per week.[2]

In 1917, World War I interrupted the campaign for compulsory health insurance in the United States. In 1919, the AMA House of Delegates

officially condemned compulsory health insurance with the following resolution[3]:

> The American Medical Association declares its opposition to the institution of any plan embodying the system of compulsory contributory insurance against illness or any other plan of compulsory insurance which provides for medical service to be rendered contributors or their dependents, provided, controlled, or regulated by any state or the federal government.

Most of physician opposition to compulsory health insurance was attributed to an unfounded concern that insurance would decrease, rather than increase, physician incomes and to their negative experience with accident insurance that paid physicians according to arbitrary fee schedules.[1]

The Great Depression and the Birth of Blue Cross

As the Depression of 1929 shook the nation, it also threatened the financial security of both physicians and hospitals. Physician incomes and hospital admission rates dropped precipitously as individuals were unable to pay out of pocket for medical care, and hospitals began experimenting with insurance plans. The Baylor University Hospital plan was not the first, but it became the most influential of those insurance experiments. By enrolling 1,250 public school teachers at 50 cents a month for a guaranteed 21 days of hospital care, Baylor created the model for and is credited with the genesis of Blue Cross hospital insurance. Baylor started a trend that developed into multihospital plans that included all hospitals in a given area. By 1937, there were 26 plans with more than 600,000 members, and the American Hospital Association began approving the plans. Physicians were pleased with the increased availability of hospital care and the cooperative manner in which their bills were paid. The AMA, however, was characteristically hostile and called the plans "economically unsound, unethical, and inimical to the public interest."[4]

The AMA contended that urging people "to save for sickness" could solve the problem of financing health care.[2] Organized medicine's consistently antagonistic reaction to the concept of health insurance, whether compulsory or voluntary, is well illustrated by medicine's response to the 1932 report of the Committee on the Costs of Medical Care. The committee's establishment represented a shift from concern about lost wages

to concern about medical expenses. Chaired by a former president of the AMA and financed by several philanthropic organizations, a group of prominent Americans from the medical, public health, and social science fields worked for 5 years to address the problem of financing medical care. After an exhaustive study, a moderate majority recommended adoption of group practice and voluntary health insurance as the best way of solving the nation's health care problems. However, even this relatively modest recommendation was rejected by some commission members who in a minority report denounced voluntary health insurance as more objectionable than compulsory insurance. Health insurance, predicted the minority, would lead to "destructive competition among professional groups, inferior medical service, loss of personal relationship of patient and physician, and demoralization of the profession."[5] In 1933, the AMA's House of Delegates again reiterated its long-standing opposition to health insurance of any kind by declaring that the minority report represented "the collective opinion of the medical profession."[6] The dissenting physicians did, however, favor government intervention to alleviate physicians' financial burden, resulting from their obligation to provide free care to low-income populations.

From the turn of the 20th century to the present, there have been many efforts to enact various forms of compulsory health insurance. It was only when the proponents of government-sponsored insurance limited their efforts to older adults and low-income populations; that they were able to succeed in passing Medicaid and Medicare legislation in 1965. Voluntary insurance against hospital care costs became the predominant health insurance in the United States during those decades. The advocates of government-sponsored health insurance had little success in improving patient access to medical care, but the Blue Cross plans effectively improved hospitals' access to patients.

Following World War II, the federal government gave a huge boost to the private health insurance industry by excluding health insurance benefits from wage and price controls and by excluding workers' contributions to health insurance from taxable income. The effect was to enable employees to take wage increases in the form of health insurance fringe benefits rather than cash. Also following World War II, the federal government began heavily subsidizing the health care industry's expansion through hospital construction and medical research, with physician resources as an overriding policy objective.

Because insurance companies simply raised their premiums rather than exerting pressure on physicians and hospitals to contain costs,

the post–World War II private health insurance system pumped an ever-increasing proportion of the national income into health care. There was little regard for cost growth, and attention was focused on avoiding any infringement on physicians' or hospitals' prerogatives to set prices and control costs. Medicare and Medicaid followed the same pattern. In fact, the preamble to those original legislative proposals specifically prohibited any interpretation of the legislation that would change the way health care was practiced.

Dominant Influence of Government

Although the health insurance industry contributed significantly to the spiraling costs of health care in the decades after World War II, it was only one of several influences. The federal government's coverage of health care for special populations played a prominent role. Over the years, U.S. government developed, revised, and otherwise adjusted a host of categorical or disease-specific programs designed to address needs not otherwise met by state or local administrations or the private sector. Federally sponsored programs account for about 40% of this country's personal health care expenditures.[7] In much smaller amounts, the federal government also provides funds for research and development and public health activities.[7]

In the evolution of U.S. health care delivery system, the policy implications of certain federal initiatives cannot be overemphasized. By establishing the principle of federal aid to the states for public health and welfare assistance, maternal and child health, and children with disabilities services, the Social Security Act of 1935 was the most significant social initiative ever passed by any Congress. It was the legislative basis for a number of significant health and welfare programs, including the Medicare and Medicaid programs.

The government increased its support of biomedical research through the National Institutes of Health, which was established in 1930, and the categorical programs that addressed heart disease, cancer, stroke, mental illness, mental retardation, maternal and infant care, and many other conditions. Programs such as direct aid to schools of medicine, dentistry, pharmacy, nursing, and other professions and their students and support of health planning, health care regulation, and consumer protections,

which were incorporated in the various 1962 amendments to the Food, Drug, and Cosmetic Act of 1938, were all part of the Kennedy–Johnson presidential policy era called Creative Federalism. The aggregate annual investment in those programs made U.S. government the major player and payer in field health care.

Grants-in-aid programs alone, excluding Social Security and Medicare, grew from $7 billion at the start of the Kennedy administration in 1961 to $24 billion in 1968 under President Johnson's administration. Several other programs beside Medicare and Medicaid were initiated during the Johnson administration to address mental illness and to support health care professionals' role. The Health Professions Educational Assistance Act of 1963 provided direct federal aid to medical, dental, nursing, pharmacy, and other professional schools, as well as to their students. The Nurse Training Act supported special federal efforts for training professional nursing personnel, and during the same period, the Maternal and Child Health and Mental Retardation Planning Amendments initiated comprehensive maternal and child health projects and centers to serve people with mental retardation. The Economic Opportunity Act supported the development of neighborhood health centers to serve low-income populations.[8]

In 1970, in a direction labeled New Federalism, President Nixon expressed his intent to rescind the federal government's direct administration of several health care programs and shift revenues to state and local governments through block grants. In spite of his efforts, federal grants-in-aid programs grew to almost $83 billion by 1980. Congress had resisted block grants and allowed only limited revenue sharing to take place.[8]

In the meantime, with no effective controls over expenditures, federal and state governments underwrote skyrocketing costs of Medicare and Medicaid. The planners of the Medicare legislation had made several misjudgments. They underestimated the growing number of older adults in the United States, the scope and burgeoning costs of the technologic revolution, and the public's rising expectations for use of advanced, diagnostic, and treatment modalities.

The Medicare and Medicaid programs provided access to many desperately needed health care services for older Americans, people with disabilities, and low-income populations. Because rising Medicare reimbursement rates set the standards for most insurance companies, however, their inflationary effect was momentous. In the mid-1960s, when Medicare and

Medicaid were passed, the United States was spending about $42 billion on health care, or approximately 8.4% of the gross domestic product. The costs of U.S. health care now exceed $2.7 trillion and consume over 17% of the gross domestic product.[7, 9]

Three Major Health Care Concerns

The three major health care concerns of cost, quality, and access have comprised a generations-long conundrum of U.S. health care delivery system. Virtually, all attempts to control one or two of these concerns have exacerbated the one or two remaining. The federal government's improvements in access to care by measures such as the post–World War II hospital expansion and the Medicare and Medicaid legislation, which extended government health insurance to millions of older and low-income Americans, were accompanied by skyrocketing expenditures and quality issues. These measures resulted in the health care system's excess capacity, and while virtually unchecked funding improved access to competent and appropriate medical care for many, it also resulted in untold numbers of clinical interventions of questionable necessity. Almost all the federal health legislation since the passage of Medicare and Medicaid and the Balanced Budget Act of 1997 were targeted at reducing costs but with little focus on the reciprocal effects of reducing both the access and the quality of health care.

Efforts at Planning and Quality Control

The federal government did not ignore the issues of cost and quality, but efforts to address those concerns were doomed to be ineffectual by their designs. Powerful medical and hospital lobbies exerted great influence over any legislation that might alter the existing constellation of health care services or that would scrutinize the quality of clinical practice. Any legislation had to be "provider friendly," allowing physicians, hospital administrators, and other health professionals to maintain control over how the legislation was interpreted and enforced.

Two legislative initiatives of the 1960s typify the circumstances surrounding federal legislative efforts to address the cost, quality, and access

concerns of the health care delivery system. In 1965, the Public Health Service Act was amended to establish the Regional Medical Program initiative, a nationwide network of medical programs in designated geographic areas to address the leading causes of death: heart disease, cancer, and stroke. Throughout the nation, groups of physicians, nurses, and other health professionals met to deliberate innovative ways to bring the latest in clinical services to the bedside of patients. Representatives of each constituency advocated for funding in their respective disciplines. As a consequence, the regional medical programs improved the educational and clinical resources of their regions but did not materially improve prevention or cost reductions in the treatment of the target conditions.

A parallel program, the Comprehensive Health Planning Act, was passed in 1966 to promote comprehensive planning for rational systems of health care personnel and facilities in designated regions. The legislation required federal, state, and local partnerships. It also required that there be a majority of consumers on every decision-making body.[10]

Almost all the Regional Medical Programs and Comprehensive Health Planning Act programs across the country soon were dominated by medical–hospital leaders in their regions. Many productive outcomes resulted from the two programs, but conflicts of interest regarding the allocation of research and development funds were common, and there was general agreement that the programs were ineffective in achieving their goals.

The Johnson-era programs of 1966–1969, especially Medicare and Medicaid, entrenched the federal government in the business of financing health care. President Johnson's ambitious creative federalism enriched the country's health care system and improved the access of many impoverished citizens, but it also fueled the inflationary spiral of health care costs that has persisted until today.

The National Health Planning and Resources Development Act of 1974 ultimately combined the Regional Medical Health Program and Comprehensive Health Planning Act programs with political rather than objective assessments. The Congress apparently assumed that combining two ineffective programs would result in one successful program. Nevertheless, the legislation established a new organization, the Health Systems Agency (HSA), which required broad representation of health care providers and consumers on governing boards and committees to

deliberate and recommend health care resource allocations to their respective federal and state governing bodies.

HSAs were largely ineffective for many of the same reasons as their predecessor organizations had failed to provide meaningful strategies to address cost, quality, and access concerns. The general ineffectiveness of HSAs in their regions was acknowledged by the federal administration, and support ultimately was withdrawn.[11,12]

Managed Care Organizations

In 1973, the Health Maintenance Organization Act supported the development of health maintenance organizations (HMOs) through grants for federal demonstration projects. An HMO is an organization responsible for the financing and delivery of comprehensive health services to an enrolled population for a prepaid, fixed fee. HMOs were expected to hold down costs by changing the profit incentive from fee for service to promoting health and preventing illness.

The concept was accepted widely, and between 1992 and 1999, HMOs and other types of managed care organizations experienced phenomenal growth, accounting for the majority of all privately insured persons.[13] Subsequently, the fortunes of managed care organizations changed as both health care costs and consumer complaints increased.

Beginning in 2001, a derivative of managed care organizations, preferred provider organizations (PPOs), gained in popularity. Although PPOs encompass important managed care characteristics, they were organized by physicians and hospitals to meet the needs of private, third-party, and self-insured firms. By 2002, PPOs had captured 52% of covered employees.[14] Although most Americans are now receiving their health care through some sort of prepaid managed care arrangement, the evidence that significant savings will be realized is fragmentary. Stiff increases in HMO premium rates suggest that the widespread application of HMO concepts will not provide the long-sought containment of runaway health care costs. In addition, both consumers and providers are suggesting that the HMO controls on costs are compromising the quality of care. Consumer concerns about restrictions on choice of providers, limits on availability of services, and quality of health care evoked a managed care backlash and generated support for government regulation of managed care organizations.[15]

The Reagan Administration

Beginning with the Reagan administration in 1981, attempts continued to shrink federally supported programs begun in the 1960s and 1970s. Unlike Nixon and Ford, Reagan succeeded in implementing New Federalism policies that were all but stymied in previous administrations. A significant reduction in government expenditures for social programs occurred. Decentralization of program responsibility to the states was achieved primarily through block grants. Although his attempts at deregulation to stimulate competition had little success, Reagan's implementation of Medicare prospective payment to hospitals based on diagnosis-related groups, rather than retrospective payment based on hospital charges, signaled the new effort to contain health care costs that were widely adopted as standard by the health insurance industry.[16]

The conversion of categorical and disease-specific programs to block grants, the withdrawal of federal support for professional education, and the creation of a Medicare resource-based relative value scale to adjust and contain physicians' fees are but a few other examples of presidential or congressional efforts to reduce the federal government's financial commitment to health care.

Biomedical Advances: Evolution of High-Technology Medicine

Health care in the United States dramatically improved during the 20th century. In the first half of the century, the greatest advances led to the prevention or cure of many infectious diseases. The development of vaccines to prevent a wide range of communicable diseases, from yellow fever to measles, and the discovery of antibiotics saved vast numbers of Americans from early death or disability.

In the second half of the 20th century, however, technologic advances that characterize today's health care were developed and the pace of technologic development accelerated rapidly. The following are a few of the seminal medical advances that took place during the 1960s:

- The Sabin and Salk vaccines ended annual epidemics of poliomyelitis.
- The tranquilizers Librium and Valium were introduced and widely prescribed, leading Americans to turn to medicine to cure their emotional as well as physical ills.

- The birth control pill was first prescribed and became the most widely used and effective contraceptive method.
- The heart-lung machine and major improvements in the efficacy and safety of general anesthesia techniques made possible the first successful heart bypass operation in 1964. Three years later, the first human heart transplant took place.

In 1972, computed tomography was invented. Computed tomography, which unlike x-rays can distinguish one soft tissue from another, is installed widely in U.S. hospitals and ambulatory centers. This valuable and profitable diagnostic imaging device started an extravagant competition among hospitals to develop lucrative patient services by making major capital investments in high-technology equipment. Later, noting the convenience and profit associated with diagnostic devices such as computed tomography and magnetic resonance imaging, medical groups purchased the devices and placed them in their own facilities. This practice represents one example of how hospitals, physicians, and other health service providers came to act as isolated economic entities rather than as members of a community of health care resources established to serve population needs. The profit-driven competition and resulting redundant capacity continued to drive up utilization and costs for hospitals, insurers, and the public.[17]

New technology, new drugs, and new and creative surgical procedures have made possible a wide variety of life-enhancing and life-extending medical accomplishments. Operations that once were complex and hazardous, requiring hospitalization and intense follow-up care, have become relatively common ambulatory surgical procedures. For example, the use of intraocular lens implants after the removal of cataracts has become one of the most popular surgical procedures. Previously requiring hospitalization, these implants are performed in outpatient settings on over 3 million Americans annually,[18] with the procedure taking less than 1 hour.

Technical Advances Bring New Problems

Almost every medical or technologic advance seems to be accompanied by new and vexing financial and ethical dilemmas. The increased ability to extend life raises questions about the quality of life and the right to die. New capabilities to use costly and limited resources to improve the quality of life for some and not others create other ethical problems.

Whatever its benefits, the increased use of new technology has contributed to higher health care costs. Some believe, however, that if

the new technology were used properly and not overused for the sake of defensive medicine or to take advantage of its profit potential, it would actually lower health care costs.[19]

Both the AMA and the federal government developed programs to explore these issues and to provide needed information for decision makers. The AMA established three programs to assess the ramifications of medical advancements: the Diagnostic and Therapeutic Technology Assessment Program, the Council on Scientific Affairs, and the AMA Drug Evaluations.[20]

In the Technology Assessment Act of 1972, Congress recognized that "it is essential that, to the fullest extent possible, the consequences of technologic applications be anticipated, understood, and considered in determination of public policy on existing and emerging national problems."[21] To address this goal, the Office of Technology Assessment (OTA), a nonpartisan support agency that worked directly with and for congressional committees, was created. The OTA relied on the technical and professional resources of the private sector, including universities, research organizations, industry, and public interest groups, to produce their assessments and provide congressional committees with analyses of highly technical issues. Established by a democratically controlled Congress because of distrust of the Nixon administration, it was intended to help officials sort out increasingly complex scientific information without advocating particular policies or actions. The OTA was shut down in 1995 as a result of political controversies adverse to the then Republican-controlled Congress.[22]

The Agency for Health Care Policy and Research, created by Congress in 1989 and now called the Agency for Healthcare Policy and Quality, is intended to support research to understand better the outcomes of health care at both clinical and systems levels. It has a particularly challenging mission as technologic and scientific advances make it ever more difficult to sort out the complexities of health care and determine what works, for whom, when, and at what cost.

Roles of Medical Education and Specialization

Medical schools and teaching hospitals in the United States are the essential components of all academic health centers and are the principal architects of the medical care system. In addition to their research

contributions to advancements in health care and their roles as major providers of health services, they are the principal places where physicians and other professional personnel are educated and trained.

From post–World War II to the mid-1970s, there were numerous projections of an impending shortage of physicians. The response at federal and state levels was to double the capacity of medical schools and to encourage the entry of foreign-trained physicians.[23]

The explosion of scientific knowledge in medicine and the technologic advances in diagnostic and treatment modalities encouraged specialization. In addition, the enhanced prestige and income of specialty practice attracted most medical school graduates to specialty residencies. It soon became evident that specialists were being produced in numbers that would lead to an oversupply. Also, they needed to be close to their referring doctors and to associate with major hospitals, which caused graduates to concentrate in urban areas. At the same time, the shortage of primary care physicians among rural and inner-city populations grew.

In response, medical schools and hospitals developed a more acceptable physician workforce policy to maintain or increase their training capacities. Schools erroneously assumed that producing an oversupply of physicians would force more physicians into primary care in underserved rural and inner-city areas. Unfortunately, this trickle-down workforce policy did little to change supply distribution problems and only added to the swelling ranks of specialists. Hospitals added to the problem by developing residencies that met their own service needs without regard for oversupply. Supplemental Medicare payments for teaching hospitals and indirect medical education adjustments for hospital-based residents were and still are strong incentives for hospitals to add residents.[24]

The rapid growth of managed care plans in the 1990s with their emphasis on prevention and primary care was expected to produce profound changes in the use of the physician workforce and cause a significant oversupply of specialists by the year 2000. To stave off the surplus, many medical schools and their teaching hospitals endeavored to produce equal numbers of primary care and specialist physicians instead of the one-third-to-two-third ratio that had existed for years.

As soon as the effort produced a sizable increase in the number of primary care physicians, new medical workforce projections refuted the prior predictions and forecasted a shortage, rather than a surplus, of specialists. Clearly, estimating a future physician shortage or surplus is a tenuous endeavor.

The forces of reform are exerting increasing pressures on schools of medicine and other major health professions to change their curricula in keeping with the new emphasis on population-based thinking, prevention, and cost effectiveness. The inflexibility of traditional departmental organization and the relatively narrow areas of expertise required of faculty, however, present formidable obstacles to needed educational reforms.

Influence of Interest Groups

Many problems associated with U.S. health care result from a system shared among federal and state governments and the private health care industry. The development of fully or partially tax-funded health service proposals initiated waves of lobbying efforts by interest groups for or against the initiatives. Federal and state executives and legislators receive intense pressure from supporters and opponents of health care system changes.[25] Lobbying efforts from special interest groups have become increasingly sophisticated and well financed. Since the 1970s, former congressional staffers appear on the payrolls of private interest groups, and former lobbyists assume positions on Capitol Hill. This strong connection between politicians and lobbyists is evidenced by the record number of dollars spent to defeat the Clinton Health Security Act of 1993 and both "for" and "against" President Obama's health care reform plans.

Five major groups have played key roles in debates on tax-funded health services: providers, insurers, consumers, business, and labor. Historically, physicians, the group most directly affected by reforms, developed the most powerful lobbies. Although the physician lobby is still among the best financed and most effective, it is recognized as not representing the values of large numbers of physicians detached from the AMA. In fact, several different medical lobbies exist as a result of political differences among physicians.

The American Medical Association

The AMA, founded in 1847, is the largest medical lobby, with a membership of 217,000 individuals, yet it represents only 17% of medical professionals and medical students.[26] The AMA was at the height of its power

from the 1940s to the 1970s, opposing government-provided insurance plans by every president from Truman through Carter. Compromises gained in the final Medicare bill still affect today's program. In the 1980s, however, the AMA steadfastly opposed cuts in Medicare proposed by the Reagan–Bush administration.

In 1989, the AMA changed its relationship with Congress. Initially locked out of White House discussions on the Clinton plan, the AMA was later included and supported, at least publicly, by the Obama plan for expanding health care access to all Americans. Nevertheless, cost containment, malpractice reform, and physician autonomy still remain as areas of contention.[27]

Insurance Companies

Even more than physicians, nurses, or hospitals, insurers' political efforts have been viewed as completely self-serving. The efforts of insurance companies to eliminate high-risk consumers from the insurance pools and their frequent premium rate hikes contributed significantly to the focus on cost containment and the plight of the uninsured and underinsured in the debate on health care reform. Nevertheless, the Health Insurance Association of America, founded in 1956 and representing some 300 small companies, was responsible for a robust onslaught of television commercials featuring middle-class people worrying about the limited choice of physicians and other potential dangers of cost containment in the Clinton plan.

The insurance companies played an even stronger but more deceptive role in the debates about President Obama's health care reform effort by appearing to support the general idea while vigorously opposing the idea of a public option that would severely limit their profits. The amount of dollars spent in lobbying efforts by insurers and others with vested interests in the status quo and in misinforming the public to raise unwarranted fears about the proposed health care reform legislation hit a new high in deception and a new low in political machinations.[28]

Consumer Groups

Although provider groups have been most effective in influencing health care legislation, the historically weak consumer movement has gained strength. Much of the impetus for health care reform on the national

scene was linked to pressure on politicians from consumers concerned about rising costs and lack of security in health care coverage. Despite widespread disagreement among groups about the extent to which government involvement was needed, all were concerned about the questions of cost, access, and quality in the current health care system.

Better educated and more assertive citizens have become more cynical about the motives of leaders in both the political and the health arenas and are much more effective in influencing legislative decisions. A prominent example is the American Association of Retired Persons (AARP). Founded in 1958, the AARP is one of the most influential consumer groups in the health care reform movement. Because of its size and research capability, it wields considerable clout among legislators who are very aware that the AARP's 40 million older citizens are among the most determined voters.

Although a single consumer group may have some influence in shaping a legislative proposal, consumer group coalitions that rally around specific issues are much more effective in generating political pressure. For example, a political battle over revamping the U.S. Food and Drug Administration (FDA) was initiated in 1995 when conservative think tanks and drug company officials urged a receptive Congress to make major changes in the agency's operations. These changes were intended to weaken the agency's investigative powers and reduce the time required for drug companies to introduce new drugs to the consumer market. The proposed changes would require the FDA to meet deadlines for investigating and approving new drugs and allow pharmaceutical companies to submit one, rather than two, well-controlled studies as proof of effectiveness.

Consumer groups entered the debate on both sides of the issue. The biggest and best organized was the Patients' Coalition, which is made up of more than 50 national nonprofit health groups. It includes such dissimilar organizations as the American Cancer Society, National Hemophilia Foundation, Arthritis Foundation, and several AIDS organizations such as the AIDS Action Council and Gay Men's Health Crisis. The coalition rushed to the FDA's defense and urged Congress to reject the proposals that could hurt consumers. Other consumer groups support the positions of the Pharmaceutical Research and Manufacturers Association, the main industry trade group that claims that FDA reforms could be accomplished without risking safety and effectiveness.[29]

The battle continues, however, between those who believe that keeping new drugs from the market while safety and effectiveness are carefully

tested is denying help to those patients who might benefit from them and those who presume that drug manufacturers would take advantage of less rigorous testing to foist unproven or dangerous drugs on the market for profit. Although the two sides continue to debate, administrative changes have taken place that shortened the assessment time for cancer-treating drugs in an effort to prolong life for dying patients.[30]

Business and Labor

The National Federation of Independent Businesses, founded in 1943, has 350,000 individual members and is the largest representative of small firms.[31] The National Association of Manufacturers founded in 1895 represents the interests of large employers and has a current membership of 11,000.[32] The U.S. Chamber of Commerce was founded in 1912 and represents 3 million businesses of all sizes.[33] The Chamber and the National Association of Manufacturers have similar views on reform; they both generally welcome the equalizing effect of an employer mandate but are wary of intense government regulation and, particularly, of more government-run health care.[32,33]

Whenever business groups are involved in an issue, and especially one of the magnitudes of health reform, labor unions will have a strong presence to represent their members' interests. The American Federation of Labor and Congress of Industrial Organization (AFL-CIO), once over 14 million individuals strong,[34] has had a tremendous influence on national health policy. Although job losses during the current economic downturn have reduced membership by over a million members, the influence of organized labor is significant. Intimately connected with the AFL-CIO is the Service Employees International Union, founded in 1921. It is the largest union representing health care workers, with a membership of 2.1 million individuals, 1.1 million of whom are in the health professions.[34] During the mid-1940s, labor unions demanded and received health care benefits as an alternative to wage increases prohibited by postwar wage and price controls. The two major national unions, the AFL and the CIO, consolidated their power by merging in 1955. During the late 1960s, they were able to address the issues of occupational safety and health and achieved passage of the Occupational Safety and Health Act of 1970. Today, occupational safety and health hold prominent places on the national agenda.

Pharmaceutical Industry

In recent years, the profit-laden pharmaceutical industry increased its spending on lobbying tactics and campaign contributions to unprecedented levels. With prescription drug prices and pharmaceutical company profits at record highs, the industry correctly anticipated public and congressional pressure to legislate controls on drug prices and drug coverage for older adults on Medicare.

In 2003, as lawmakers moved to add a prescription drug benefit to Medicare that would include price controls, the pharmaceutical industry deployed more than 1,000 lobbyists.[35] The pharmaceutical industry was given a large role in crafting the 2003 Medicare Part D prescription drug benefit plan. As a result, the final plan prohibited Medicare and the federal government from using its enormous purchasing power to negotiate prices with drug companies.[35]

One of the most contentious elements in the Medicare Part D drug plan was the so-called "doughnut hole." Beginning in 2006, the legislation required ending federal payment for a person's drug purchases after an annual spending limit was reached. Federal support resumed only after the beneficiary spent $3,600 out of pocket for prescription drugs. The "doughnut hole" directly affected the middle-class and disabled retirees who do not qualify for special poverty assistance yet still lived on limited incomes.

Public Health Focus on Prevention

Although the groups discussed in the previous section are primarily concerned with the diagnostic and treatment services that constitute over 95% of U.S. health care system, there is an important public health lobby that speaks for health promotion and disease prevention. Often overlooked because of this country's historical emphasis on curative medicine, public health organizations have had to overcome several negative perceptions. Many health providers, politicians, and others associate public health with governmental bureaucracy or link the care of low-income populations with socialism. Nevertheless, the American Public Health Association, founded in 1872 and having an aggregate membership of approximately 30,000, has substantial influence on the national scene, and in 2012 in its advocacy role, reported over 150 individual meetings with congressional members.[36]

Economic Influences of Rising Costs

The single most important impetus for health care reform throughout recent history has been rising health care costs and insurance premiums. Since the introduction of Medicare and Medicaid in 1965, almost all federal health law has been aimed at cost containment but without success. Growth in health spending has been advancing much faster than the rest of U.S. economy.[7,9]

The number of Americans without adequate or any health insurance was estimated at 37 million during the health care reform debates of 1994. As noted above, census bureau estimates now put the number of uninsured at 49 million Americans or 17% of the total population.[9] Of most importance, when considering the magnitude of this problem, is that the composition of that uninsured population is constantly changing. When those on Medicaid or other unemployed persons find jobs that provide group health insurance, those individuals leave the ranks of the uninsured. They are replaced, however, by those who become unemployed or lose Medicaid coverage.

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act, or HIPAA, signed into law in 1996, was intended to address the problem of the growing number of uninsured. The legislation permits individuals to continue insurance coverage after a loss or change of employment by mandating the renewal of insurance coverage except for specific reasons, such as the nonpayment of premiums. The Act also regulates the circumstances in which an insurance plan may limit benefits because of preexisting conditions. It also mandates special enrollment periods for individuals who have experienced certain changes in family composition or employment status.

More sweeping in its effects is the part of the law called "Administrative Simplification." It required medical records to be computerized by October 2003. Although yet to be achieved, it is intended to reduce the costs and administrative burden of health care by standardizing the electronic transmission of many administrative and financial transactions. The standardization must also maintain the privacy of health information. Subsequent

major support for health information technology development occurred with President Bush's executive order of 2004 establishing the Office of the National Coordinator for Health Information Technology.[37] In 2009, President Obama signed the American Recovery and Reinvestment Act that designated $20.8 billion to incentivize physicians and health care organizations to adopt electronic health records.[38] As a result, virtually, the entire health care industry is involved in a high-technology upgrade of complex medical care delivery information.

Aging of America

The elimination or control of many infectious diseases through immunization and antibiotics; the implementation of basic public health measures that contribute to the safety of food, water, and living and working conditions; a far more nutritious food supply; and constantly improving medical care have all combined to extend the life expectancy of people in the United States. Although AIDS, accidents, and violence are causing an increasing number of deaths among young people, the vast majority of Americans live to advanced ages. U.S. Census Bureau projects that nearly one in five residents will be aged 65 or older by 2030 and that by 2050 the number of Americans aged 65 and older will be 88.5 million, more than double its projected population in 2010.[39] Between 2010 and 2050, U.S. Census Bureau projects that the proportion of U.S. population comprised by persons over 85 years old will increase from 14% to 21%.[39]

Although the medical model of curing illness, maximizing function, and preventing premature death has been beneficial to many older Americans, it has offered little to the growing number of older citizens who are not acutely or morbidly ill but who have irreversible physical or mental limitations that require diligent care by others.

Of increasing importance to the future health care system are mechanisms to support caregivers as older person care becomes the responsibility of more and more Americans. Changes in U.S. social structures have increased the stress on today's adults because they are required to provide financial, functional, or emotional support to aging family members. More women working outside the home, a high divorce rate, the geographic dispersion of family members, an increase in the number of

adults simultaneously caring for both children and aging relatives beg for additional respite services, adult day care, and other strategies to reduce stress and caregiver burnout.

Oregon Death with Dignity Act

November 8, 1994 was a pivotal date in U.S. social legislation. Oregon voters approved Ballot Measure 16, the Oregon Death with Dignity Act, also known as the Oregon Physician-Assisted Suicide Act. The Act legalized physician-assisted suicide by allowing "an adult resident of Oregon, who is terminally ill to voluntarily request a prescription for medication to take his or her life."[40] The person must have "an incurable and irreversible disease that will, within reasonable medical judgment, produce death within six months." The Death with Dignity Act was a response to the growing concern among medical professionals and the public about the extended, painful, and demeaning nature of terminal medical care for patients with certain conditions. An additional consideration for some voters was the worry that the extraordinary costs associated with lengthy and futile medical care would exhaust their estates and leave their families with substantial debts.

A survey of Oregon physicians showed that two-thirds of those responding believe that physician-assisted suicide is ethical in appropriate cases. Also, almost half of the responding physicians (46%) said that they might assist in a suicide if the patient met the criteria outlined in the act.[41]

The issue of euthanasia and physician-assisted suicide has been debated for years in other countries. Although among Westernized countries only Northern Australia has legalized physician-assisted suicide, the Netherlands has a long history of allowing euthanasia within the medical community.[42]

Physicians must meet multiple requirements before they can write a prescription for a lethal combination of medications. The physician must ensure that the patient is fully informed about the diagnosis, the prognosis, the risks, likely result of the medications and alternatives, including comfort care, pain control, and hospice care. A consulting physician must then confirm that the patient's judgment is not impaired and that the decision is fully informed and voluntary. The patient is then asked to notify next of kin, although family notification is not mandatory. After

a 15-day waiting period, the patient must again repeat the request. If the patient does so, the physician is then permitted to write the fatal prescription. Although it varies from year to year, not all patients requesting physician prescriptions opt to use them.[43]

In November 2008, the State of Washington initiated its own Death with Dignity Act along the same lines as that of Oregon.[44] On the last day of 2009, the Supreme Court of the State of Montana ruled to maintain the state law that protects doctors from prosecution for helping terminally patients die.[45] With issues of the burgeoning aged U.S. population and this population group's increasing political strength in numbers, consumer pressure for more states to enact "right to die" legislation will be a subject of increasing interest in the years to come.

Internet and Health Care

Data collection and information transfer are critical elements of the health care system, and thus it is not surprising that the Internet has become a major influence in U.S. health care. A 2012 Pew Foundation survey report noted that "one in three U.S. adults have gone online to diagnose a condition and about half consulted a medical professional about what they found."[46] The Internet provides consumers with access to vast resources of health and wellness information, the ability to communicate with others sharing similar health problems, and the ability to gain valuable data about medical institutions and providers that permit well-informed choices about services and procedures. Internet users are becoming more educated and participatory in clinical decision making, challenging physicians and other providers to participate with a more knowledgeable and involved patient population.

Physicians and other health care providers also are entering the online world of health care communication. After a slow start, provider-sponsored websites are proliferating at a rapid pace. In addition to information for consumers about the provider's training, competencies, and experience, many providers encourage email exchanges that invite queries and provide opportunities to respond to consumer informational needs.

A wide variety of other web-based entrepreneurial ventures have also begun to take advantage of the huge and growing market of Smartphone

users with "apps," that "give consumers access to health information wherever and whenever they need it."[46] Both professionally reliable and questionable entrepreneurs are offering consumers opportunities to cybershop for pharmaceuticals, insurance plans, medical supplies and equipment, physician services, and other health-related commodities, making the public well advised in exercising caution.

Landmark Legislation: The Patient Protection and ACA of 2010

"The first promise Obama made as a presidential candidate was to enact a universal health care plan by the end of his first term."[47] Many months prior to his inauguration, senate Democrats led by Senators Max Baucus, chair of the powerful Senate Finance Committee, and Senator Edward Kennedy were collaborating with a diverse group of stakeholders to craft a plan.[47] Only days after President Obama's 2008 election, Senator Max Baucus, released a white paper on November 12, 2008, "A Call to Action: Health Reform 2009," in which he outlined goals to improve access to quality, affordable health care, and to control costs in the U.S. Health Care system.[48] Some in the new administration opposed advancing the cause of universal coverage at a time when the President also had to advance his pledges for economic stimulus package, education reform, and bailouts for banks and the auto industry.[49] Nevertheless, believing "that rising medical costs were crippling average families, cutting into corporate profits, and consuming more and more of the federal budget,"[49] President Obama moved the health care agenda forward through a tortuous and often rancorous maze of political machinations and public reactions.[50] Decades-long analyses and assessments by the most prestigious academic research and industry experts overwhelming noted that U.S. health care system focused on providing excellent care for the individuals with acute conditions, although virtually ignoring the more basic health service needs of larger populations who could benefit enormously from primary preventive care. The system continued to reward providers for the volume of services delivered with piecemeal reimbursement rather than with financial incentives to maintain or improve health status among populations of service recipients.

Given that a succession of federal administrations beginning in 1945 with President Harry Truman had proposed and failed at enacting some form of universal health care coverage,[51] the ACA was an achievement of historic proportion. The groundbreaking nature of the ACA resides in its addressing what have been historically intractable system problems of cost, quality, and access.

Through a variety of measures, the ACA intends to reverse incentives that drive up costs, to enact requirements that increase both accountability for and transparency of quality, and by 2019, to increase access by expanding health insurance coverage to an additional 32 million Americans.[52,53] The ACA also adds important new consumer protections and enhances access to needed services for the nation's most vulnerable populations.[54]

Judicial Challenges

On the day the ACA was signed into law, the state of Florida filed a federal district court lawsuit challenging the constitutionality of the law's requirement for individual coverage and its expansion of the Medicaid program. Twenty-five additional states, the National Federation of Independent Businesses, and other plaintiffs also filed suit in Florida.[55] The Virginia state attorney general also filed a separate lawsuit challenging the federal requirement to purchase health insurance.[56]

The primary issues of contention were whether Congress had the authority to impose the individual coverage mandate with personal financial penalties for noncompliance under either its authority to regulate interstate commerce or its taxing power; and whether Congress had the authority to make all of a state's existing Medicaid funding contingent on compliance with the ACA's Medicaid expansion provisions.[55] The U.S. Supreme Court agreed to decide the two issues and heard oral arguments from proponents and detractors of the ACA provisions during the spring of 2012. On June 28, 2012, in a 5-4 decision, the court upheld the constitutionality of the individual mandate with Chief Justice Roberts writing, "The mandate is not a legal command to buy insurance. Rather it just makes going without insurance just another thing the government taxes."[57] The court determined that the Medicaid expansion as described in the ACA was unconstitutionally coercive of states but remedied this violation of states' rights by prohibiting the federal government from making states' existing Medicaid funding contingent on participation in

the expansion. The court's decisions made no changes to the preexisting Medicaid law and the federal government's authority to require states' compliance with existing Medicaid program rules.[55]

The ACA Implementation Provisions

The ACA is over 900 pages in length written under 10 titles[58] and is organized under 4 broad headings that highlight its major goals:

- Providing new consumer protections
- Improving quality and lowering costs
- Increasing access to affordable care
- Holding insurance companies accountable

The following outline of the ACA provisions is provided as an overview with a suggestion to interested readers to use this chapter's references and their Internet links to obtain further information and detail.

Largely excerpted and edited from a federal government Website managed by the Department of Health and Human Services, the overview describes key features of the ACA by year of scheduled implementation. In the dynamic process of implementation, schedules are updated and amended; current information is available from the federal Websites. The "time-line" format provides a sequenced view of the ACA provisions as scheduled to take effect by 2019.

2010

New Consumer Protections

- Putting Information for Consumers Online: establishes a website on which consumers can compare health insurance coverage options and choose their preference.
- Prohibiting Denying Coverage of Children Based on Preexisting Conditions: new rules to prevent insurance companies from denying coverage to children under the age of 19 because of a preexisting condition.
- Prohibiting Insurance Companies from Rescinding Coverage: new rules that make it illegal for insurance companies to deny payments

for a subscriber's illness because of technical or other errors discovered in a subscriber's original insurance application. In the past, insurance companies could search for an error or other technical mistake on a customer's application and use this error to deny payment for services when the subscriber experienced an illness.

- Eliminating Lifetime Limits on Insurance Coverage: prohibits insurance companies from imposing lifetime dollar limits on essential benefits, such as hospital stays.
- Regulating Annual Limits on Insurance Coverage: prohibits insurance companies' use of annual dollar limits on the amount of insurance coverage a patient may receive under new plans in the individual market and all group plans. In 2014, the use of annual dollar limits on essential benefits like hospital stays will be banned for new plans in the individual market and all group plans.
- Appealing Insurance Company Decisions: provides consumers with a way to appeal coverage determinations or claims to their insurance company and establishes an external review process.
- Establishing Consumer Assistance Programs in the States: provides federal grants to states that apply to help set up or expand independent offices to help consumers navigate the private health insurance system. These programs help consumers file complaints and appeals; enroll in health coverage; and get educated about their rights and responsibilities in group health plans or individual health insurance policies.

Improving Quality and Lowering Costs

- Providing Small Business Health Insurance Tax Credits: up to 4 million small businesses are eligible for tax credits to help them provide insurance benefits to their workers. The first phase of this provision provides a credit worth up to 35% of the employer's contribution to the employees' health insurance. Small nonprofit organizations may receive up to a 25% credit.
- Offering Relief for 4 Million Seniors Who Hit the Medicare Prescription Drug Reimbursement Gap: provides a one-time, tax-free $250 rebate check for uncovered prescription drug costs.
- Providing Free Preventive Care: all new plans must cover certain preventive services such as mammograms and colonoscopies without charging a deductible, co-pay or coinsurance.

- Preventing Disease and Illness: a new $15 billion Prevention and Public Health Fund will invest in proven prevention and public health programs that can help keep Americans healthy—from smoking cessation to combating obesity.
- Reducing Health Care Fraud and Abuse: invests new resources and requires new screening procedures for health care providers to boost federal antifraud and waste initiatives in Medicare, Medicaid, and Child Health Insurance Program.

Increasing Access to Affordable Care

- Providing Access to Insurance for Uninsured Americans with Preexisting Conditions: the Preexisting Condition Insurance Plan provides new coverage options to individuals who have been uninsured for at least 6 months because of a preexisting condition. States may operate these programs or opt for the Department of Health and Human Services to do so in that state.
- Extending Coverage for Young Adults: young adults will be allowed to stay on their parents' plan until they turn 26 years old.
- Expanding Coverage for Early Retirees: creates a $5 billion program to provide needed financial help for employment-based plans to continue providing health insurance coverage to people who retire between the ages of 55 and 65, as well as their spouses and dependents.
- Rebuilding the Primary Care Workforce: provides new incentives to expand the number of primary care doctors, nurses, and physician assistants through funding for scholarships and loan repayments for primary care doctors and nurses working in underserved areas.
- Holding Insurance Companies Accountable for Unreasonable Rate Increases: provides eligibility for $250 million in new grants to states that have or will implement measures requiring insurance companies to justify premium increases; also may bar insurance companies with excessive or unjustified premium levels from participation in the new health insurance exchanges.
- Allowing States to Cover More People on Medicaid: provides federal matching funds for states covering some additional low-income individuals and families under Medicaid for whom federal funds were not previously available.

- Increasing Payments for Rural Health care Providers: provides increased payments to rural health care providers to help them attract and retain providers.
- Strengthening Community Health Centers: provides new funding to support the construction of and expand services at community health centers, allowing these centers to serve some 20 million new patients across the country.

2011

Improving Quality and Lowering Costs

- Offering Prescription Drug Discounts: provides Medicare recipients who reach the prescription drug coverage gap with a 50% discount when buying Medicare Part D covered brand-name prescription drugs; for the next 10 years, seniors will receive additional savings on brand-name and generic drugs until the coverage gap is closed in 2020.
- Providing Free Preventive Care for Seniors: provides certain free preventive services, such as annual wellness visits and personalized prevention plans for seniors on Medicare.
- Improving Health care Quality and Efficiency: establishes a new Center for Medicare & Medicaid Innovation to test new ways of delivering care to patients to improve the quality of care, and reduce the rate of growth in costs for Medicare, Medicaid, and the Children's Health Insurance Program (CHIP); DHHS will also submit a national strategy for quality improvement in health care, including these programs.
- Improving Care for Seniors after Hospitalization: establishes The Community Care Transitions Program to help high-risk Medicare beneficiaries avoid unnecessary readmissions by coordinating care and connecting patients to services in their communities.
- Introducing New Innovations to Reduce Costs: establishes a new Independent Payment Advisory Board to develop and submit proposals to Congress and the President aimed at extending the life of the Medicare Trust Fund by focusing on ways to target waste in the system, recommend ways to reduce costs, improve health outcomes for patients, and expand access to high-quality care.

Increasing Access to Affordable Care

- Increasing Access to Services at Home and in the Community: allows states to offer home and community-based services to disabled individuals through Medicaid rather than institutional care in nursing homes through the Community First Choice Option.

Holding Insurance Companies Accountable

- Reducing Health care Premiums: ensures that premium dollars are spent primarily on health care, by generally requiring that at least 85% of all premium dollars collected by insurance companies for large employer plans are spent on health care services and health care quality improvement; for plans sold to individuals and small employers, at least 80% of the premium must be spent on benefits and quality improvement. Failing to meet these goals, insurance companies must provide rebates to subscribers.
- Addressing Overpayments to Big Insurance Companies and Strengthening Medicare Advantage: eliminates additional Medicare costs from Medicare managed care plans (Medicare Advantage) and provides bonus payments to Medicare Advantage plans that provide high-quality care.

2012

Improving Quality and Lowering Costs

- Linking Payment to Quality Outcomes: establishes a hospital Value-Based Purchasing program in Traditional Medicare, offering financial incentives to hospitals to improve the quality of care; requires hospitals to publicly report performance for certain diagnoses and patients' perceptions of care.
- Encouraging Integrated Health Systems: provides incentives for physicians, hospitals to join together to form "Accountable Care Organizations" to better coordinate Medicare beneficiary patient care and improve the quality, help prevent disease and illness and reduce unnecessary hospital admissions.
- Reducing Paperwork and Administrative Costs: institutes a series of changes to standardize billing and requires health plans to begin

adopting and implementing rules for the secure, confidential, electronic exchange of health information.
- Understanding and Reducing Health Disparities: requires any ongoing or new federal health program to collect and report racial, ethnic, and language data to help identify and reduce disparities.

Increasing Access to Affordable Care

- Providing New, Voluntary Options for Long-Term Care Insurance: intended to create voluntary long-term care insurance program, "Community Living Assistance Services and Supports Act (CLASS)," to provide cash benefits to adults who become disabled. CLASS was officially abandoned by the DHHS in October, 2011 and will not be implemented.

2013

Improving Quality and Lowering Costs

- Improving Preventive Health Coverage: provides new funding to state Medicaid programs that choose to cover preventive services for patients at little or no cost to expand the number of Americans receiving preventive care.
- Expanding Authority to Bundle Payments: establishes a national pilot program, Bundled Payments for Care Improvement (BPCI), to encourage hospitals, doctors, and other providers to work together to improve the coordination and quality of patient care by paying a flat rate for a total episode of care rather than billing Medicare for individual services. The BPCI aligns the incentives of those delivering care, with any savings shared between providers and the Medicare program.

Increasing Access to Affordable Care

- Increasing Medicaid Payments for Primary Care Doctors: requires states to pay primary care physicians no less than 100% of Medicare payment rates in 2013 and 2014 for primary care services, with full federal funding of the increase; the requirement anticipates an influx of new Medicaid enrollees into the system.

- Providing Additional Funding for the CHIP: provides states with two additional years of funding to continue coverage for children not eligible for Medicaid.

2014

New Consumer Protections

- Prohibiting Discrimination Due to Preexisting Conditions or Gender: prohibits insurance companies from refusing to sell coverage or renew policies because of an individual's preexisting conditions and in the individual and small group insurance market, prohibits insurance companies from charging higher rates because of gender or health status.
- Eliminating Annual Limits on Insurance Coverage: prohibits new plans and existing group plans from imposing annual dollar limits on the amount of coverage an individual may receive.
- Ensuring Coverage for Individuals Participating in Clinical Trials: prohibits insurers from dropping or limiting coverage because an individual chooses to participate in a clinical trial; applies to all clinical trials that treat cancer or other life-threatening diseases.
- Improving Quality and Lowering Costs
- Making Care More Affordable: makes tax credits available for middle-class individuals with incomes between 100% and 400% of the federal poverty level who are not eligible for other affordable coverage to make insurance coverage more affordable.
- Establishing the Health Insurance Marketplace: enables individuals to purchase health insurance directly in the Health Insurance Marketplace if their employers do not offer health insurance; individuals and small businesses can buy affordable and qualified health benefit plans in this new transparent and competitive insurance marketplace, offering a choice of plans that meet certain benefits and cost standards.
- Increasing the Small Business Tax Credit: implements the second phase of the small business tax credit for qualified small businesses and small nonprofit organizations; in this phase, the credit is up to 50% of the employer's contribution to provide health insurance for employees; there is also up to a 35% credit for small nonprofit organizations.

Increasing Access to Affordable Care

- Increasing Access to Medicaid: enables Americans who earn less than 133% of the federal poverty level eligible to enroll in Medicaid; provides states with 100% federal funding for the first 3 years to support this expanded coverage, phasing to 90% federal funding in subsequent years.
- Promoting Individual Responsibility: requires most individuals who can afford it, to obtain basic health insurance coverage or pay a fee to help offset the costs of caring for uninsured Americans; if affordable coverage is not available to an individual, he or she will be eligible for an exemption.

2015

Improving Quality and Lowering Costs

- Paying Physicians Based on Value Not Volume: a new provision ties physician payments to the quality of care provided. Physicians will see their payments modified so that those who provide higher value care will receive higher payments than those who provide lower quality care.[59]

Increasing Access to Affordable Care

- Increasing Federal Match for CHIP: provide states with a 23% increase in their CHIP matching rate up to 100%; CHIP eligible children excluded from the program because of enrollment caps are eligible for tax credits in the state health insurance exchanges.[53]

2016

Increasing Access to Affordable Care

- Increasing Competition and Choices: creates Health Care Choice Compacts that allow selling health insurance across state lines to increase competition among plans and consumer choices; Compacts provide consumer protections to ensure that policies will be subject to the laws and regulations of the state in which the policy was issued and must offer the same benefits required by the consumer's state of residence.[60]

2018

Improving Quality and Lowering Costs

- Imposing an Excise Tax on High-cost Insurance Plans: creates incentives to limit the costs of health insurance plans to a tax-free amount with the intent to generate revenue to help pay for covering the uninsured and to make the most expensive plans less attractive.[61]

The Congressional Budget Office (CBO) 2012–2021 estimate of the net cost of the PPACA for insurance coverage provisions for 32 million newly insured individuals is just under $1.1 trillion, with deficit reductions derived from new taxes, penalties, and other revenues of $510 billion.[62]

ACA implementation is proceeding in a variety of ways that include new agency programs, grants, demonstration projects, guidance documents, and regulations. The ACA contains over 40 provisions that require or permit agencies to issue rules with some allowing agencies to "prescribe such regulations as may be necessary."[56] It is anticipated that the ACA will generate scores of rules over the years of its implementation that must be published to allow public comments before issuance of a final rule and, as such, are subject to change.[56] In making financial estimates, the CBO notes that "projections of the budgetary impact and other impacts of health care legislation are quite uncertain because assessing the effects of making broad changes in the nation's health care and health insurance systems—or of reversing scheduled change—requires assumptions about a broad array of technical, behavioral, and economic factors."[63] It is certain that financial projections will continue to evolve as the ACA is implemented over succeeding years.

It remains very early to speculate on the ACA's success in achieving its intended changes in the organization, delivery, efficiency, and effectiveness of a monstrously complex industry that encompasses over 17% of the nation's economy. As implementation rules are published and challenges are navigated in the courts, outcomes will be determined over the next several years. Regulatory and legal changes enacted by the ACA are indeed only two components of the equation. A multitude of other factors as far-ranging as the nation's economy, the political environment, and provider and consumer reactions and behaviors to name only a few, will determine the outcomes of this landmark legislation.

Key Terms for Review

Block Grants
Health Maintenance Organization Act of 1973
Health Systems Agencies
Medicaid
Medicare
Oregon Death with Dignity Act of 1994
Social Security Act of 1935
The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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