Assessing the New Health Care Law

Will it improve care and reduce spending?

In June, the Supreme Court upheld most of the Obama administration’s 2010 health care law, allowing the government to fine people who decline to buy medical insurance. But the court barred cutting off Medicaid funds for states that refuse to participate in a new program expanding health care for the poor. Some Republican governors have balked at the expanded coverage, undermining the administration’s goal of adding 30 million people to the health insurance rolls. Meanwhile, GOP presidential nominee Mitt Romney, along with many congressional Republicans, vows to repeal the entire Affordable Care Act, arguing it is too costly and abridges individual freedoms. The law’s supporters, however, say its benefits already are evident, as children with pre-existing illnesses can no longer lose coverage and young adults can enroll in their parents’ health plans.

THE NEXT STEP ..............811
OUTLOOK .....................806
BIBLIOGRAPHY ................810
CURRENT SITUATION ..........803
CHRONOLOGY .................799
BACKGROUND ................798
THE ISSUES ....................791

An opponent of President Obama’s health care plan — derisively known as Obamacare — protests at the Supreme Court on June 28, 2012, the day the court largely upheld the controversial law aimed at reducing health care expenses and expanding coverage to some 30 million Americans without insurance.
ASSESSING THE NEW HEALTH CARE LAW

THE ISSUES

791 • Should the health care law be repealed?
• Will Americans be better off because of the law?
• Will the law cost too much?

BACKGROUND

798 The Mandate
The new law’s “individual mandate” requires most Americans to obtain insurance or pay a penalty.

798 The Poor
The law can’t penalize states that don’t expand Medicaid.

798 The Court
The individual mandate was narrowly upheld, but the justices compromised on Medicaid expansion.

CURRENT SITUATION

803 Uncertain Future
Most of the new law’s provisions are a year or more from implementation.

804 Court Fallout
Numerous state officials say they won’t expand Medicaid, but many analysts predict they will eventually.

806 Only a Beginning
The states and the federal government are not meeting the law’s implementation schedule.

OUTLOOK

806 Voting on Health
Voters worry more about jobs than the new law.

SIDEBARS AND GRAPHICS

792 Biggest States Have High Rates of Uninsured
California, Texas and Florida have some of the largest percentages of uninsured residents.

794 Medical Expenses Worry Younger Adults
One in three under age 65 has delayed health care because of financial concerns.

796 Coverage of Young Adults Rises
Those under 26 can now obtain health coverage through parents’ policies.

799 Chronology
Key events since 2006.

796 At Issue
Should the Affordable Care Act be repealed?

FOR FURTHER RESEARCH

809 For More Information
Organizations to contact.

810 Bibliography
Selected sources used.

810 The Next Step
Additional articles.

811 Citing CQ Researcher
Sample bibliography formats.

Cover: Getty Images/Mark Wilson
The Issues

Caleb Medley, a 23-year-old aspiring stand-up comic, was at a midnight showing of “The Dark Knight Rises” in Aurora, Colo., on July 20, when a gunman entered the theater and shot 70 people, killing 12. Shot in the eye, Medley remained in a medically induced coma for more than a month. He has endured multiple brain surgeries, but is slowly improving, according to his family. On Sept. 12, Medley was transferred from the hospital to a long-term-care facility. Meanwhile, his wife, Katie, gave birth to the couple’s first child a few days after the shootings.

The Medleys have no health insurance. To help with what doctors said could amount to $2 million in medical bills, Michael West, a longtime family friend, is soliciting donations through a website he set up. “Caleb . . . needs to get better because he needs to be a dad,” said West.

Stories of uninsured people who unexpectedly incur high medical bills have figured heavily in debates over the Obama administration’s controversial health care law, the 2010 Patient Protection and Affordable Care Act (ACA). Ideological arguments over the legislation came into sharp focus June 28, when the U.S. Supreme Court upheld most of the ACA, whose main provisions take effect in 2014, but said states could opt out of a key provision aimed at expanding Medicaid coverage for the poor.

The court rendered its decision in two parts:

- In a 5-4 ruling dominated by court liberals, with Chief Justice John G. Roberts unexpectedly providing the swing vote, the justices upheld the ACA’s requirement that uninsured people buy medical insurance or pay a penalty — a stipulation in the law known as an “individual mandate.” Conservative justices objected that it is unfair to force healthy young people to buy insurance they may not need.
- In a 7-2 vote dominated by court conservatives, plus two liberal justices, the court greatly narrowed the ACA’s requirement that states either accept new federal grants to pay for expanded Medicaid coverage or risk losing all the money they receive from Washington for their Medicaid programs. The court said states can refuse the expansion grants without giving up their existing Medicaid funding.

The Supreme Court’s philosophical and legal differences over the health care law reflected a broad national divide over the measure since its enactment in March 2010. In their dissenting opinion, the court’s four conservative justices, who voted to strike down the entire law, asserted that Congress exceeded its constitutional authority by requiring every American to purchase health insurance or pay a penalty. Moreover, they wrote that healthy young people “may decide that purchasing health insurance is not an economically sound decision” — especially, they said, because the ACA allows them to purchase it in later years at the same cost, even if they have developed a pre-existing medical condition by then.

But Justice Ruth Bader Ginsburg, a liberal who voted to uphold the ACA in its entirety, argued that getting everyone — even healthy young people — to buy insurance is the only way to ensure that there is enough money to pay for every American’s care. “A victim of an accident or unforeseen illness will consume extensive medical care immediately, though scarcely expecting to do so,” Ginsburg wrote. If that person hasn’t bought coverage, others have to pick up the tab, she argued.

Ultimately, the ACA’s impact on health care costs and insurance coverage remains unclear. With implementation of the law’s major provisions more than a year away, much of the debate is still driven by theories rather than data. But the ACA’s
supporters and detractors have long given voice to the issues raised by the Supreme Court. President Obama said the court’s affirmation of the law is a boon for average Americans. “Insurance companies no longer have unchecked power to cancel your policy, deny you coverage or charge women more than men,” he said. Furthermore, “soon, no American will ever again be denied care or charged more due to a pre-existing condition, like cancer or even asthma.”

But GOP presidential nominee Mitt Romney, who derides the new law as “Obamacare,” has vowed to repeal it if he is elected president in November. He has said he would replace it with another plan that relies more on the private sector to deal with many of the same problems the ACA addresses. “Obamacare puts the federal government between you and your doctor,” potentially limiting a physician’s options for treating patients, Romney has said. As governor of Massachusetts in 2006, Romney worked with Democrats to enact a plan similar to the ACA, but he has since said health care should be left to the states.

Supporters say the ACA is structured in a way that will make the American health care system more effective and efficient and eventually save hundreds of millions of dollars annually in unnecessary or misdirected care. To keep insurance premiums for older, sicker people from becoming unaffordable, the ACA will subsidize them by raising premiums somewhat for young, healthy people.

And in an attempt to ensure that health coverage is worth its costs, the law also will require that all insurance plans cover a basic but comprehensive slate of benefits, essentially eliminating some bare-bones, low-cost plans available today. Beginning in 2014, four tiers of coverage will be available to individual purchasers, ranging from low-cost plans providing only basic benefits to comprehensive coverage, but at higher premiums.

The ACA represents “tremendous progress towards reshaping our health system into one that saves the lives of at least 44,000 people who die annually simply because they do not have health insurance that could keep them healthy,” said Georges Benjamin, executive director of the American Public Health Association.

But many ACA opponents argue that it forces people to buy insurance they don’t want and may not need. “Never before has the federal government coerced its citizens to purchase a personal commodity for private use,” said Brooks Wicker, a Kentucky Republican running for a U.S. House seat. “I’ll work to repeal the mandate through legislation and to return [to] the American people the full measure of freedom taken from them.”

Meanwhile, some young adults complain that they are being required to buy a minimum level of coverage and, in their view, overpay for it to help hold down premiums for older, sicker people.

The law is biased against young people, who will be forced “to shoulder the burden of the entire health system,” complained Ryan Fazio, a columnist for Northwestern University’s Daily Northwestern, in Evanston, Ill. Richard Cooper, a 26-year-old lawyer in Miami, said requiring all health plans to include basic coverage for such services as mental health

---

### Biggest States Have High Rates of Uninsured

The Affordable Care Act and any other attempt to overhaul the health care system to increase insurance coverage will face daunting challenges. Not least is the fact that three of the nation’s four most populous states — California, Texas and Florida — have among the highest rates of uninsured residents. Texas leads the pack with one in four residents uninsured.

**Percentage of Population Without Health Insurance (2009-2010)**


unaffordable, the ACA will subsidize them by raising premiums somewhat for young, healthy people.

And in an attempt to ensure that health coverage is worth its costs, the law also will require that all insurance plans cover a basic but comprehensive slate of benefits, essentially eliminating some bare-bones, low-cost plans available today. Beginning in 2014, four tiers of coverage will be available to individual purchasers, ranging from low-cost plans providing only basic benefits to comprehensive coverage, but at higher premiums.

The ACA represents “tremendous progress towards reshaping our health system into one that saves the lives of at least 44,000 people who die annually simply because they do not have health insurance that could keep them healthy,” said Georges Benjamin, executive director of the American Public Health Association.

But many ACA opponents argue that it forces people to buy insurance they don’t want and may not need. “Never before has the federal government coerced its citizens to purchase a personal commodity for private use,” said Brooks Wicker, a Kentucky Republican running for a U.S. House seat. “I’ll work to repeal the mandate through legislation and to return [to] the American people the full measure of freedom taken from them.”

Meanwhile, some young adults complain that they are being required to buy a minimum level of coverage and, in their view, overpay for it to help hold down premiums for older, sicker people.

The law is biased against young people, who will be forced “to shoulder the burden of the entire health system,” complained Ryan Fazio, a columnist for Northwestern University’s Daily Northwestern, in Evanston, Ill. Richard Cooper, a 26-year-old lawyer in Miami, said requiring all health plans to include basic coverage for such services as mental health
treatment and maternity care is “one of the things I’m sort of leery about. I’m going to be paying for things I don’t need.”  

But both young and old will get far more comprehensive coverage from even the cheapest plans than many people find in the insurance they can buy today, said Paul Ginsburg, president of the Center for Studying Health System Change, a nonpartisan research group in Washington. “That’s worth something.”  

While much of the controversy over the ACA has centered on the individual mandate, the law’s Medicaid provision has been equally contentious. Medicaid is a program financed jointly by the states and the federal government that covers health care, including nursing home care, for some groups of poor people — children, their custodial parents, pregnant women and the blind, disabled and elderly. The ACA expansion provision was designed to broaden coverage to include some 17 million poor, able-bodied, childless adults.  

States leery about expanding their Medicaid rolls worry that doing so will bust their budgets, despite the fact that under the law most costs will be covered by federal grants.  

But Stan Dorn, a senior fellow at the Urban Institute, a nonpartisan think tank in Washington that studies poverty and health care, says the ACA’s Medicaid provision would help states save money and improve health care efficiency. Today states reimburse hospitals for care they provide to uninsured people and for mental-health care provided to low-income adults. The federally funded Medicaid expansion would pay for that care up front, at least as efficiently as today’s fragmented programs do, he says. “It’s mind-boggling to see the opposition,” given the way the law is structured, says Dorn. “There are lots of ways that states can actually save money on the expansion.”  

As lawmakers, health care providers and the public ponder the ACA’s impact, here are some of the questions being asked:  

Should the health care law be repealed?  

The ACA’s opponents in Washington argue that nothing short of repeal will stop the law from damaging free-market economics and the American health care system. Central to their criticism is the law’s individual-mandate provision requiring every American to buy health insurance or pay a financial penalty.  

But the law’s supporters argue that it is that very mandate that holds the key to the law’s success. By requiring universal coverage, they contend, the law prevents insured people from having to shoulder the cost of treating the uninsured, often through costly emergency room visits.  

Sen. Minority Leader Mitch McConnell, R-Ken., has said that if Republicans gain control of the Senate in November, he will schedule a vote to erase the ACA from the books. Ultimately, that may not work, he acknowledges, unless Republicans also win the White House and control of the House. Still, McConnell says most Americans agree with him that the law should go. “I’m confident they’re going to give us the votes to repeal it,” he said.  

Michael D. Tanner, director of health and welfare studies at the Cato Institute, a think tank in Washington that promotes a philosophy of individual liberty and limited government, said the “individual mandate crosses an important line” because it enshrines in law the principle “that it is the government’s responsibility to ensure that every American has health insurance. It opens the door to widespread regulation of the health care industry and political interference in personal health care decisions. The result will be a slow but steady spiral downward toward a government-run national health care system.”  

Others argue that the ACA usurps responsibilities that rightly belong to the states.

---

**Medical Expenses Worry Younger Adults**

*The inability to pay medical bills or afford necessary health care services is of greatest concern to adults under age 65, when Medicare eligibility begins. About one in three adults 18-64 has delayed a medical procedure or doctor’s visit because of financial concerns.*

<table>
<thead>
<tr>
<th>Health Care Problems and Worries by Age, 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Problem or worry</strong></td>
</tr>
<tr>
<td>Problems with paying medical bills in past 12 months</td>
</tr>
<tr>
<td>Put off or postponed necessary health care</td>
</tr>
<tr>
<td>Worried about not being able to afford health care services you think you need</td>
</tr>
</tbody>
</table>

"States shouldn’t be forced by the federal government to adopt a one-size-fits-all health care plan,” said Sen. Scott Brown, R-Mass., whose home state, under Romney, adopted a health care system similar to the ACA in 2006. “Each state’s health care needs are different.”

Thomas Miller, a resident fellow at the American Enterprise Institute (AEI), a conservative think tank in Washington that opposes the health care law, instead wants legislation that facilitates development of a nationwide market offering a wide variety of private medical plans for purchase.

Miller says the ACA will undermine the development of free-market dynamics in the health insurance field and force states to accede to federal dictates. At first, he says, states may be able to shape their own insurance exchanges through which people purchase health coverage. But that is simply because Washington made certain “concessions” to the states to induce them to back the law, he says. Once the new health regime is deeply rooted, he predicts, “the long-term dynamics will very much have Washington in control rather than having open markets.”

But ACA supporters say the individual mandate — and the fact that the law is national, not limited to some states — ensure that health care will be available to as many people as possible. Furthermore, they say, states will have flexibility to shape their own insurance markets under the law.

Most states aren’t willing or able to resolve the problem of the uninsured on their own because states rightly fear bankrupting themselves if they offer universal coverage and other states don’t, Justice Ginsburg wrote. She quoted an earlier court ruling that described a universal state coverage program as a potential “bait to the needy and dependent elsewhere, encouraging them to migrate and seek a haven of repose.” States that took the lead in offering universal coverage would be
“placing themselves in a position of economic disadvantage as compared with neighbors or competitors,” she wrote. 23

The ACA does not create the one-size-fits-all nightmare for states that critics fear, says the Urban Institute’s Dorn. The Obama administration’s implementation rules for the law permit “a huge amount” of flexibility in the kind of insurance exchanges — markets — states may set up, thus accommodating “hugely different visions,” both liberal and conservative, of how the health care market should operate.

“You can have a tightly managed exchange and allow only three health plans to come in and sell only a particular set of benefits” or “simply say that any company can come in’ and give consumers a wide choice of health plans, Dorn says.

The ACA’s supporters also say that the new law will relieve some of the pressure on workers’ compensation and other parts of the health care system that have been strained in recent decades by the lack of universal insurance coverage.

Workers’ compensation insurance — mostly state-based programs that pay for injuries workers suffer on the job — will function better under the law, according to Joseph Paduda, a Connecticut-based consultant on managed care and workers’ compensation insurance. Because so many people lack regular health insurance, workers’ comp often ends up paying for care that has nothing to do with on-the-job injuries, he wrote.

In states such as Texas and Florida with high percentages of residents without insurance (see map, p. 792), a person who tears a rotator cuff on the job, for example, may also need treatment for unrelated maladies, such as diabetes or high blood pressure, before having rotator cuff surgery. The ACA’s widespread insurance coverage will cut costs and red tape for the workers’ comp system, he said. 24

Meanwhile, supporters tout an ACA provision requiring insurers to spend a minimum percentage of premium payments on patient care or refund the money to employers and consumers. But many conservatives say this so-called Medical Loss Ratio rule will run insurance companies out of business. Sen. Charles Grassley, R-Iowa, said one insurer, the American Enterprise Group, left the business in Iowa and Nebraska last year, dropping thousands from its rolls and laying off 110 employees, and the “culprit is the new Medical Loss Ratio regulation.” 26

Will Americans be better off because of the health care law?

With the ACA still in early stages of implementation, researchers have been unable to collect much data that either prove or refute claims of the law’s success. Supporters point to millions of additional Americans who will gain insurance coverage. Opponents argue that new taxes and regulations will cripple innovation by medical firms such as health insurers and pharmaceutical companies.

Regardless of the ACA’s merits, the changes it brings will cause some problems in the early going, even the law’s supporters acknowledge. For example, expanded coverage and the emphasis on preventive care mean “there will (very) likely be an access problem over the near term as primary care providers are inundated with new patients, and over the medium term for specialists as folks who’ve long avoided care because they could not afford it now get those problems resolved — knee replacements, etc.,” wrote insurance consultant Paduda. 25

That’s because selling health insurance to individuals and very small businesses is an economically tricky enterprise that works much differently than selling insurance to large-employer groups, Grassley said. The medical needs of an individual or employees at a small business are much harder for insurers to estimate than those of workers at a large employer, where the group’s health status tends to mirror that of the general population. As a result, individual and small-group insurers must set each year’s premiums high enough to ensure coverage of hard-to-predict costs, said Grassley. The Medical Loss Ratio rule, which
penalizes insurers in any year the government deems their premiums are too high compared to spending on patient care, simply makes the risks of the insurance business “too great,” he said. 27

Opponents of the ACA point to what they see as other ill effects of the law. To help pay for expanded coverage, the ACA imposes new taxes that threaten research-and-development budgets and medical innovation, said Sally Pipes, president of the San Francisco-based Pacific Research Institute, a think tank that promotes a limited-government philosophy. “Excise taxes on drug-company sales are already in effect,” Pipes wrote. “In 2013, there will be a new 2.3 percent excise tax on medical-device companies.” As a result, she said, some firms have announced workforce cuts. “These industries are job creators and will no longer be unless the Affordable Care Act is repealed and replaced.” 28

John Goodman, a conservative analyst who heads the National Center for Policy Analysis, in Dallas, has found particular fault with efforts to expand Medicaid, the ACA’s main means of insuring the poor. Medicaid, he argued, provides such low-quality care that “the Supreme Court has done a lot of families a big favor” by ruling that states can’t be penalized for failing to expand coverage. As an example of what he sees as Medicaid’s failings, he said 16 states cap the number of prescriptions Medicaid patients can get, with Mississippi limiting patients to two brand-name drugs and Arkansas limiting adult enrollees to six medications a month. 29

Supporters of the law are just as vocal as opponents in their views about the ACA’s impact on consumers. Ron Pollack, founding executive director of the national consumer-advocacy group Families USA, says many people will be better off under the law and that some already are. “Right now, a significant but still minor share of the benefits are already in effect,” he says, and “we’re hearing from people who’ve already gotten significant help.”

Among those who have benefited are enrollees in Medicare, which provides health insurance for people age 65 and older, Pollack says. Under the ACA, they now receive additional government help with prescription-drug expenses, he says. Young adults also have benefited, Pollack notes. They now can remain on their parents’ insurance plans until age 26.

And Pollack cites a host of other benefits: When insurers spend too little premium revenue on health care, they must provide rebates; children with pre-existing illnesses must be offered health coverage; preventive services such as diabetes and cervical-cancer screening are available without deductibles or copayments; and small businesses receive tax credits for providing worker coverage.

A study published in July in the New England Journal of Medicine concludes that previous Medicaid expansions similar to what the ACA calls for have resulted in decreased death rates. Researchers from the Harvard School of Public Health examined mortality data from three states — New York, Maine and Arizona — that added low-income, nondisabled adults with no children to their Medicaid programs in the past decade and found that the death rate for people age 20 to 64 decreased in the five years following the expansion. 30

While the study included all deaths in the states, not just those among low-income people, the mortality rate dropped most for nonwhites and people living in poor counties, suggesting a Medicaid connection. Meanwhile, death rates rose in four neighboring states that didn’t expand Medicaid. The coverage expansions are associated with a 6.1 percent decrease in death rates, or about 2,840 fewer deaths per year for each additional 500,000 adults insured. 31

Some analysts say the ACA will provide economic as well as health benefits. “If basic insurance is made universally available on the individual market,” the country could see a substantial drop in so-called job-lock — “people staying in jobs that might not be the best for them” simply because those jobs are the only potential source of health insurance, said

---

Coverage of Young Adults Rises

A provision of the Affordable Care Act that took effect in 2010 allows adult children under age 26 to obtain health care coverage through their parents’ policies. Experts credit the provision with increasing the share of young adults covered by medical insurance in 2011.

**Percentage of Adults Ages 19 Through 25 With Private Insurance Coverage, 2010-2011**

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>51%</td>
</tr>
<tr>
<td>2011</td>
<td>56.2%</td>
</tr>
</tbody>
</table>

Jonathan Kolstad, a professor of health care management at the University of Pennsylvania’s Wharton School, job-lock not only keeps workers from advancing in their careers but also hurts the economy by inhibiting innovation and productivity, he said.  

Will the health care law cost too much?

ACA opponents say both the government and individuals will pay too much for health care under the new law. Supporters say expanded insurance coverage is worth its costs and that provisions aimed at creating a more efficient, prevention-focused system will eventually help to tame soaring medical expenses.

The ACA “virtually ignored the health care cost crisis facing this country and instead imposes billions of dollars in new mandates” — such as requiring insurers to devote a minimum amount of premium dollars to patient care — “and taxes that will increase the costs of coverage,” said Robert Zirkelbach, a vice president of America’s Health Insurance Plans, the main association representing health insurers in Washington.

“Even accepting the law’s assumptions about how the health care system should be reformed, actually putting all the pieces in place is exceptionally expensive,” said Joseph Antos, who studies health and retirement policy at the free-market-oriented American Enterprise Institute in Washington. Furthermore, “the Supreme Court decision on Medicaid will . . . drive up federal spending” even more because in states that decline to participate “the alternative is expanded enrollment in subsidized [private] insurance through the [state insurance] exchanges,” and private insurance costs more than Medicaid, Antos said.

Meanwhile, liberal ACA critics argue that by relying on private insurance companies, rather than making the government the single payer for all insured people, the law forgoes most cost savings it might have achieved. Insurance companies “only add cost and complexity” to the system without improving care, said Bill Mahan, a political activist and retiree in Lexington, Ky., who advocates a switch to a single-payer system.

But ACA supporters point to analysis by the Congressional Budget Office, Congress’ nonpartisan budget-analysis agency, which has repeatedly found that the law will actually lower government health care spending and pare federal deficits because cost-saving provisions will offset the price of expanded coverage. In 2011, the CBO estimated that the law’s coverage expansion would cost the federal government $1.1 trillion between 2012 and 2021, but that the law as a whole would end up saving the government money. That’s because the cost of the coverage expansion will be offset by ACA provisions aimed at trimming unnecessary and wasteful health-care spending. As a result, the ACA will lower federal deficits by about $210 billion in that period, CBO said.

The fact that the law saves taxpayers some cash means that a Republican repeal of the ACA “would cause a net increase in federal budget deficits of $109 billion over the 2013-2022 period” — that is, repealing the law would cost money, not save it, as repeal supporters had hoped, the CBO wrote to House Speaker John Boehner, R-Ohio, in July.

The law also invests heavily in studies designed to establish definitively which treatments are most successful. Many analysts believe that, eventually, the federal investment in such “comparative-effectiveness” research will discourage doctors from prescribing costly treatments that don’t work. That’s “good news indeed for [workers’] comp payers,” for example, who are “saddled with back surgeries” that many experts now believe don’t help but whose ineffectiveness hasn’t yet been established by research, said insurance consultant Paduda.

Few promise that cost savings will come easily, however. Besides comparative-effectiveness research, the law also will launch experiments on potential cost-control measures such as paying health care providers based on whether they keep people from getting sick rather than for rendering individual services. But because neither public nor private health care entities have yet seriously explored such techniques, “it will be at
least 10 years” before it’s known whether they work, says Robert Laszewski, an Alexandria, Va.-based insurance industry consultant.

**BACKGROUND**

**The Mandate**

In their bid to expand coverage to 30 million of the approximately 50 million uninsured Americans, the drafters of the Affordable Care Act (ACA) proposed two strategies:

- Medicaid would be expanded, through a federal-state effort, to cover everyone in households earning less than 138 percent of the federal poverty level (FPL), or $26,344 for a family of three.
- The law would require everyone whose earnings exceed that threshold either to carry employer-sponsored insurance or to buy it from a new, federally subsidized government-regulated insurance market or else pay a financial penalty for not doing so.

Both provisions are controversial. Opponents — largely Republicans — argue that states opting into the Medicaid expansion would be unreasonably burdened financially and that the individual mandate violates Americans’ freedom by forcing them to buy a product — insurance — they may not want. Because the U.S. Supreme Court significantly altered the Medicaid provision, the CBO projects that about 3 million fewer people will be covered by the ACA than originally estimated.

The individual mandate is a practical necessity to create a working insurance system, its defenders say. At any given time, only relatively few have high medical costs, and different people experience high costs in different years, wrote David Cole, a professor at Georgetown University Law Center in Washington. Because predicting when and whom serious accident or illness will strike is virtually impossible, it’s crucial to bring everyone into the insurance pool so that premiums paid by the currently healthiest can subsidize care for the currently sick and injured, said Cole.

State experience proves that without a mandate, efforts to provide affordable coverage for all will collapse, Cole wrote. In 1994, for example, Kentucky enacted a law similar to the ACA, requiring insurers to cover people with pre-existing health conditions at affordable prices, “but without an individual mandate.” Quickly, “costs rose so steeply that they became untenable,” insurers left the market and Kentucky had to repeal its law, Cole said.

Ironically, many conservatives have proposed health-system overhauls over the past quarter-century that included a mandate.

“In our scheme, every person would be required to obtain basic coverage, through either an individual or a family insurance plan,” Mark Pauly, a professor of health care management at the University of Pennsylvania’s Wharton School, wrote in 1991. Pauly, along with other conservative scholars, devised a plan they hoped President George H. W. Bush could use to expand coverage.

“It is reasonable” to impose “a requirement on individuals to enroll themselves and their dependents in at least a basic health plan — one that at a minimum should protect the rest of society from large and unexpected medical costs incurred by the family,” Stuart Butler, director of the Center for Policy Innovation at the conservative Heritage Foundation, told a congressional panel in 2003.

In 2004, Senate Majority Leader Bill Frist, R-Tenn., a transplant surgeon and heir to the founders of the large for-profit hospital chain Hospital Corp. of America, said “higher-income Americans today have a societal and a personal responsibility to cover in some way themselves and their children.”

Recently, though, most conservatives have turned against the mandate, arguing that requiring healthy people to buy insurance to subsidize the sick is an attack on individual freedom.

“The mandate’s proponents call it an ‘individual responsibility’ requirement. But its real aim is to force young people to cover up for irresponsible government policies” — mainly gov-
2006-2018
Congress enacts legislation to expand health insurance coverage; controversies dog the law.

2006
Massachusetts, under Republican Gov. Mitt Romney, enacts mandatory, universal health coverage with bipartisan support, requiring residents to buy insurance in a state-regulated market.

2007
As of July 1, all Massachusetts residents must purchase health insurance.

2009
To control costs, Massachusetts officials consider paying doctors and hospitals flat, up-front fees to provide care. In December, U.S. Senate passes the Affordable Care Act (ACA) 60-39, but with no Republicans voting in favor; House scheduled to take up the bill in spring 2010.

2010
House passes Affordable Care Act (ACA) 219-212, with no Republican support. President Obama signs the law March 23; it aims to expand coverage to 30 million people and trim costs while maintaining quality. States and private groups challenge the ACA's constitutionality in court. Federal government opens “high-risk” health plan, in which people with pre-existing health conditions can get affordable coverage; sign-up is slow because premiums remain costly. Adults under 26 become eligible for coverage on their parents’ health plans. Health insurers must cover children with pre-existing illnesses.

2011
Some Medicare enrollees get ACA rebates for prescription drug expenses. Very small businesses become eligible for tax credits for insuring workers. Newly elected House Republican majority repeatedly votes to repeal or defund the ACA, but Democrat-controlled Senate declines to consider the bills. Federal appeals courts consider challenges to the ACA, upholding some but rejecting others; matter heads to the Supreme Court, which agrees to examine the ACA's "individual mandate" provision requiring people to buy insurance coverage or pay a penalty and the law’s Medicaid-expansion provision. Primary-care doctors treating Medicare patients get payment boost. Copayments waived for some preventive-health services under Medicare. High-income Medicare beneficiaries pay higher premiums. States get grants to improve Medicaid care for chronic-disease patients. Payments cut for private “Medicare Advantage” health plans. Medicare Independent Payment Advisory Board (IPAB) established. Beginning in 2015, Medicare must implement cost-control measures recommended by IPAB, absent a two-thirds “no” vote by Congress.

2012
Supreme Court declares ACA’s individual mandate constitutional but makes Medicaid expansion optional for states. Republican governors and state legislatures say they might not expand Medicaid to cover poor adults. Health plans that spend too little on medical care must give cash rebates to enrollees. With bipartisan support, Massachusetts clamps down on health care cost growth and adopts incentives to pay doctors and hospitals for “bundles” of high-quality care, rather than “fees for service.”

2013
Primary-care doctors get Medicaid payment boost. Taxpayers who itemize medical expenses must meet a higher threshold to claim a deduction. Federal sales tax imposed on some medical devices. Payroll tax on Medicare Part A, which pays for hospital services, rises. With the ACA set to extend coverage to more uninsured people, special hospital reimbursements for providing free care to the uninsured are phased out.

2014
ACA’s Medicaid expansion and individual mandate slated to begin. Individuals may buy federally subsidized insurance in state- or federally managed markets, called exchanges. Insurers banned from imposing annual dollar limits on individuals’ health spending. Fees imposed on large employers who do not offer health coverage. Insurers must sell coverage to people with pre-existing health conditions. New fees imposed on health insurers.

2018
Tax imposed on insurers offering employer-sponsored coverage costing more than $10,200 for individuals or $27,500 for families.
Caring for the Poorest and Sickest

Expanding Medicaid challenges would-be reformers.

Regardless of what happens to the Affordable Care Act (ACA) — whether it rolls out as planned over the next several years or is repealed under a new Republican administration — American health care still will face perhaps its biggest challenge: caring for the sickest and the poorest. Analysts from across the ideological spectrum agree on the urgency of the challenge, but solutions remain elusive.

Today, Medicaid, which is funded jointly by states and the federal government, provides care for poor families with children as well as many people with severe disabilities; it also provides long-term-care, mostly in nursing homes, for the low-income elderly. But as the costs of care have risen far faster than incomes, more Americans who fall outside these coverage categories continue to lose access to care. In 2010, 49.1 million Americans were uninsured. 1 (As of June 2011, 52.6 million people were covered by Medicaid. 2)

“You can be penniless” and yet receive no assistance in getting health coverage, says Ron Pollack, founding executive director of the national consumer-advocacy group Families USA. “We have 42 states that don’t do anything for adults without children,” making the Medicaid safety net “more holes than webbing,” he says. But the ACA aims to remedy the problem by expanding Medicaid to low-income childless adults.

Some liberals have long predicted that such an expansion would not only provide much-needed access to care but also save money. The savings would come from poor people getting preventive health care rather than ending up seeking expensive emergency room treatment after long-unreated medical conditions worsened. Some conservative commentators, on the other hand, scoff at the ACA expansion, arguing that Medicaid is such a skimpy program and pays doctors and hospitals so little that the new Medicaid enrollees will gain almost nothing of value.

“There’s a lot of rhetoric on both sides” of the Medicaid-expansion question, says Katherine Baicker, a professor of health policy at the Harvard School of Public Health. She says new data she and other scholars collected show clearly that the most extreme claims of both proponents and detractors miss the mark.

The scholars, who also include Amy Finkelstein, a Massachusetts Institute of Technology economics professor, conducted the first-ever research on insurance coverage using the most rigorous standards of scientific evidence, says Baicker. In the study, nearly 90,000 very low-income Oregonians, ages 19 to 64, signed up for a lottery that randomly assigned them either to the Oregon Health Plan or left them uninsured. 3 The research, which is ongoing, ultimately will examine and compare the health care usage, health status and financial situations of both the group covered under the state health plan and those in the uninsured control group.

The data show that, after one year, those who gained Medicaid coverage gave their health status better marks than did their uninsured peers, and they also faced far fewer struggles with medical bills, says Baicker. The newly insured were more

The Poor

The ACA’s other proposed coverage mechanism — Medicaid — also stirs controversy, mainly because many states worry about the program’s rising costs and federal rules imposed on it. Enacted in 1965, Medicaid replaced two federal grant programs that helped states provide medical care to the poor elderly and to people on welfare. Eventually, Medicaid used combined state and federal funds to provide health coverage for very poor families with children, long-term care and other services for low-income elderly and disabled people and, as a state option, coverage for other groups such as poor, childless adults.

States can choose whether or not to participate in Medicaid, and indeed not all states jumped on the Medicaid bandwagon at first. Arizona didn’t start a Medicaid program until the 1980s, for example. Today, every state provides Medicaid, although eligibility rules vary widely. 49 In Alabama and Louisiana, for example, parents with dependent children who make more than 11 percent of the federal poverty level — about $2,100 a year for a family of three — are ineligible for Medicaid, while in Minnesota the same family could earn more than $41,000 and receive benefits. 50

Before the Supreme Court altered the ACA’s Medicaid provision, the law essentially required states to help the federal government expand Medicaid coverage or risk losing the federal Medicaid funds they already received, a penalty intended to ensure that all states would participate. 51
likely to describe their health as good and improving and themselves as happier than did the uninsured, she says.

In addition, the newly insured were 25 percent less likely to have had an unpaid medical bill sent to a collection agency and 40 percent less likely to have had to borrow money or leave other bills unpaid to pay their medical bills.

These findings prove that “expanding Medicaid has real benefits,” not just for health but for people’s financial status as well, says Baicker. The findings should effectively end speculation by Medicaid’s critics that the program would be of no help to people if it were expanded, she says.

The data don’t “tell you whether it’s a good idea to expand Medicaid, but they do give you information about what the effects are,” on individuals and on government budgets, Baicker says.

Nevertheless, the same data also dampens expectations by Medicaid-expansion supporters that hospital use might decline, along with expenses, if more people receive Medicaid coverage, says Baicker. Instead, she says, “we found a substantial increase [in hospital use], at least in the first year,” she says. Still, she says, the increase in scheduled hospital care such as non-emergency surgeries, not in pricey emergency-room visits that sometimes result from neglected preventive care.

Meanwhile, conservative economists who hope to see the ACA repealed and replaced with a less-regulated, more market-oriented system also acknowledge the importance — and trickiness — of serving the poorest and sickest people while allowing a free market to flourish in health care for the rest of the population.

“Sometimes there’s a tendency to think only in dollar terms, but that’s not the be-all and end-all,” says Thomas Miller, a resident fellow at the free-market-oriented American Enterprise Institute. Miller says “you need a health care system that works for people” — both the poorest and sickest, who need more assistance than others, and the rest of the population, who are best served by having a health care market that offers them choices.

“You need first to acknowledge that the very poor or the very sick must get more” help to meet costs, Miller says. But at the same time, he adds, “you want to allow a wider variety of choices” for others so that savvy consumers can drive the market toward better quality and lower cost. Subsidies are required for the poor under any system, but the ACA’s subsidies are too rich and reach people who earn too much, thereby undercutting the incentives for wiser spending, he says.

— Marcia Clemmitt


States provide a hefty share of the funding for traditional Medicaid. In fiscal 2010, for example, they spent a total of $126 billion, supplemented by $263 billion in federal funds. The federal contribution to the ACA’s Medicaid expansion is much bigger, with the government picking up 100 percent of costs from 2014 through 2016, then gradually shifting more costs to states until the federal share drops to 90 percent in 2020 and thereafter.

About half of the people who were expected to gain coverage under the ACA were expected to gain it through the Medicaid program, said Alan Weil, executive director of the National Academy for State Health Policy, which helps states improve their health systems. “This is not a small change to Medicaid, and it’s also not a small part of the Affordable Care Act.”

The Court

As soon as the law was enacted, both the individual mandate and Medicaid-expansion mechanisms came under legal challenge. Twenty-six states eventually joined an anti-ACA lawsuit filed in Florida on March 23, 2010, the same day President Obama signed the act into law. In this and other suits, states and private groups charged that Congress had overstepped its constitutional authority by requiring individuals to buy health insurance or pay a penalty and by requiring states to expand Medicaid or lose federal Medicaid funding altogether.

Some of the first cases reached the U.S. Supreme Court in its 2011-2012 session, and the Court agreed to examine both the mandate and the Medicaid issues.

On June 28, the Court issued a mixed ruling that pleased ACA’s defenders and left the law’s critics with little to do but vow to try to repeal it.

The ACA’s supporters and even some conservative legal commentators have argued that Congress has the power to require individuals to buy health insurance because the Constitution’s Commerce Clause gives federal lawmakers the right to impose rules on business dealings that cross state boundaries. “The health industry is of course an interstate business; there is a continuous flow of health insurance payments, health insurance
Assessing the New Health Care Law

Trying to Trim the Waste From Health Care

Conservatives and liberals both take “big picture” approach.

In this campaign season of extreme political bickering, Democrats and Republicans agree on one thing: the pressing need to slow ever-rising health care costs. In 2010, U.S. spending, public and private, on health care totaled nearly $2.6 trillion, more than 10 times the cost in 1980.

Moreover, conservative and liberal economists take essentially the same big-picture cost-cutting approach — setting annual budgets and giving them teeth by forcing an entity such as an insurance company or hospital-and-physician group to pick up the tab for cost overruns, says Michael Chernew, a professor of health care policy at Harvard Medical School.

In conservatives’ preferred model — sometimes called a “voucher” or a “premium-support” system — the annual budget comes in the form of a capped payment that insurers receive in exchange for keeping an individual healthy for a year, says Chernew. (GOP vice presidential candidate Paul Ryan proposes such a plan as a new model for Medicare, for example.)

Under this kind of capped-payment plan, the government — or an employer — calculates what it deems fair for a year’s worth of health care and hands each person a check to shop for an insurance plan at that price. Individuals must choose wisely, and insurers must provide adequate care at the set price, since extra spending won’t be reimbursed, Chernew explains.

Chernew says left-leaning analysts favor a similar fixed-price approach, but with health-care providers, such as integrated hospital-physician practice groups, rather than insurers getting the cash. The Affordable Care Act (ACA) dubs such groups Accountable Care Organizations (ACOs). In this model, a group of providers, rather than an insurer, gets a “bundled” payment to provide all needed health services. The providers must provide adequate care at that price or else pick up the tab for additional services patients need.

Both models are intended to “change the nature of the good that’s being bought” in the health care market from “specific services that are sold at certain fees” to “care overall” — a total package of care to keep people healthy, Chernew says.

The current system of buying one health service at a time encourages consumers to purchase unneeded, or even harmful, medical services, since health-care organizations profit by selling as many services as possible, says Robert Laszewski, an insurance consultant in Alexandria, Va. Both proposed capped-payment systems have promise and pitfalls, though, and which one a policymaker opts for is still largely a matter of ideology, since little evidence exists about either plan’s effectiveness.

Chernew says he believes the conservative plan of offering insurers capped payments would encourage competition in the insurance industry. But many questions remain. For example, it is unclear how effective it would be to shape the health care system around consumers’ ability to “shop around,” Chernew says. Among other issues, such an approach makes it crucial for the government to prevent any insurers from gaining monopoly power, because only with a wide range of buying options can consumers run an overpriced or low-quality health plan out of business.

On the ACO side, too, “we know enough to be somewhat optimistic, but not enough to be sure,” Chernew says.

Massachusetts, which enacted a universal health-coverage program similar to the ACA in 2006, has been experimenting
with a version of ACOs — called Alternative Quality Contracts (AQC). In an AQC, a hospital or physicians’ group negotiates a set price from an insurer to cover the entire cost of care for all the insurer’s patients whom the health care providers serve. If the provider group goes over budget, it must pay the difference. That gives it a financial stake in avoiding problems such as untreated chronic conditions that worsen until costly emergency care is needed. ²

So far, evidence is mixed on AQC. One study last year found no savings while another reported “modest” savings. ³ A 2012 study, however, concluded that the average AQC spent 1.9 percent less than control groups in the first year of operation and 3.3 percent less in the second year, while providing better chronic-disease and preventive-health care. ⁴

Liberal proposals generally set strict rules to prevent an organization receiving a capped payment from skimping on care, while conservatives believe that a robust market will perform that function, says Laszewski. That difference gets to the heart of the debate over the competing models, says Laszewski. “Some people fear big business and prefer to be protected from it by the government, and others fear the government” and its potential to strangle choice and innovation with rules.

Whatever plan economists or lawmakers may propose to slow the growth in medical costs, consumers or the health care industry can undermine the effort. Consumers may balk at cost-cutting, fearing it deprives them of care. And providers, from medical-device manufacturers to individual physicians, have routinely pushed back against such efforts to avoid losing income. In Massachusetts, that dynamic is playing out with AQC.

A seven-member court majority, led by Roberts, issued a split decision, allowing the Medicaid coverage proposal to stand, but only as a voluntary program that states could take or leave without penalty. Roberts concluded that the proposal was outside established Medicaid rules, meaning states’ pledges to go along with all legislated changes in the program don’t apply.

Medicaid “was designed to cover medical services for . . . particular categories of the needy: the disabled, the blind, the elderly, and needy families with dependent children,” and previous Medicaid amendments “merely altered and expanded . . . these categories,” Roberts wrote. The coverage expansion, by contrast, is not “a program to care for the neediest among us, but . . . an element of a comprehensive national plan to provide universal health insurance coverage.” ⁵⁹

CURRENT SITUATION

Uncertain Future

The Supreme Court’s June ruling has not ended the legal controversy surrounding the ACA. Church-run institutions are claiming in new lawsuits that a requirement in the ACA that health plans provide contraception coverage violates the Constitution’s guarantee of religious freedom.

The main ACA story of 2012, though, is uncertainty, as most of the law’s provisions are a year or more from implementation and the Supreme Court ruling has made Medicaid expansion voluntary for states.

This year, several groups, including colleges run by the Roman Catholic Church and some conservative Protestant churches, as well as at least seven states and some for-profit businesses whose owners strongly oppose contraception out of religious conviction, have filed lawsuits seeking to exempt employers from the contraception mandate. ⁶⁰ (Churches, but

— Marcia Clemmitt

³ Ibid.
not employers such as church-run hospitals and schools, already are exempt.)

“We’re very clear on the sanctity of life, and this insurance mandate goes against our conscience,” said Philip Graham Ryken, president of Wheaton College, an evangelical Protestant institution in Wheaton, Ill. 61

The Obama administration announced a compromise plan last February. Women who work at nonprofit, church-affiliated entities can go directly to the insurance companies that administer their employer-based health plans and get contraceptive coverage — free — so that employers can avoid acting as go-betweens. Under the ACA, insurers face stricter government rules than in the past on what coverage they offer and what they charge for it. In this case, the administration argues that insurers may not demand that women pay a higher premium to get contraceptive coverage because contraceptives are a preventive-health measure that reduces overall health spending. 62

But opponents contend that the compromise still implicates employers in immoral activity.

“We have a president who, for the first time in American history, is directly assaulting the First Amendment and freedom of religion,” said former Sen. Rick Santorum, R-Pa., in a campaign speech on behalf of Romney. President Obama, he said, is “forcing business people right now to do things that are against their conscience.” 63

Since the Supreme Court rendered its decision, numerous Republican governors and state lawmakers have expressed doubt about whether their states will undertake a Medicaid expansion. Officials in states including Mississippi, Nebraska, Missouri, Idaho, Texas, Wisconsin, Florida, Indiana, South Carolina, Iowa, Louisiana and Kansas have suggested they might reject the expansion funds, thus reducing by millions the number of people covered under the law. 64 About 1.8 million uninsured people who were expected to gain Medicaid coverage live in Texas alone, and nearly 1 million reside in Florida. 65

Some officials have flatly announced that the expansion is a no-go. “I don’t see any chance” of Missouri participating, said Ryan Silvey, a budget committee chairman in that state’s Republican-dominated legislature. 66

Opposition, by and large, is not about money, and that’s why it will stick, argued Andrew Koppelman, a professor of law and political science at Northwestern University. Because the state funding share is so low — the federal government will pick up 100 percent of costs through 2016, gradually dropping to 90 percent in 2020 — the objections amount to “states refusing to spend federal money to help people that they do not want to help,” he contends. “The temptation to trash Obamacare will be irresistible.” 67

However, many analysts expect states eventually to back away from their hardline resistance and adopt the program.

“I’m really excited about the ruling” because by freeing states to turn down the program altogether, it gives them leverage to bargain with the federal government for looser rules about how they structure it, says insurance consultant Laszewski. “I believe that states will implement the law; but [Louisiana’s Republican Gov.] Bobby Jindal will do it

Continued on p. 806
Should the Affordable Care Act be repealed?

THOMAS MILLER
RESIDENT FELLOW, AMERICAN ENTERPRISE INSTITUTE
WRITTEN FOR CQ RESEARCHER, SEPTEMBER 2012

The Affordable Care Act (ACA) — also known as “Obamacare” — was unpopular, unwise and unsustainable when enacted in March 2010. Another two years of stumbling implementation and real-world analysis, amid fierce battles in the courts, on Capitol Hill and throughout the states, provided further evidence of the health law’s flaws. The law is too costly to finance, too difficult to administer, too burdensome on health care practitioners and too disruptive of health care arrangements that many Americans prefer.

The ACA is not just too misguided to succeed. It’s too dangerous to maintain and far too flawed to fix on a piecemeal basis. The law will jeopardize future economic growth, distort health care delivery and limit access to quality care. It doubles down on our already unsustainable entitlement spending for health care, transferring dedicated funds from one overcommitted program (Medicare) to expand another (Medicaid) and establish a new one — the subsidies the ACA provides consumers to buy insurance in government-run exchanges.

The ACA will further erode meaningful limits on the powers of the federal government. Its maze of current and future mandates, regulatory edicts and arbitrary bureaucracy undermines political accountability and the rule of law.

Obamacare was built on faulty premises, then disguised with accounting fictions and narrowly approved through cynical deal-making. Repealing it in whole is necessary to clear the way for the lasting reforms of health care we so desperately need.

The long overdue journey to health policy that drives sustainable health care improvement must be centered on better incentives, information, choices, competition, personal responsibilities and trust in the decisions of individuals and their families. It should not be guided by top-down mandates, arbitrary budgetary formulas and bureaucratic buck-passing. We won’t improve our health until we move personal health care decisions out of politics and back into the hands of patients and physicians.

Repeal of the ACA is not enough by itself. But it opens the door to a more decentralized and market-based alternative that will work and improve the lives of Americans. The country needs a more competitive health care marketplace that encourages more entry and less command-and-control regulation, while retargeting our tax-funded resources on protecting the most vulnerable individuals and their families.

Rebalancing our resources, our values, our hopes and our fears is too important, complex and personal to leave in the hands of the many politicians, experts and entrenched interests that have failed us in the past.

RON POLLACK
FOUNDING EXECUTIVE DIRECTOR, FAMILIES USA
WRITTEN FOR CQ RESEARCHER, SEPTEMBER 2012

In June, the Supreme Court upheld the constitutionality of the Affordable Care Act. Just last week, however, its theatrical opponents in the House of Representatives staged their 34th loud, divisive and utterly futile vote to repeal it. Afterward, nothing changed; it remains the law of our land. The benefits and protections it grants consumers are real, and many are already in place. Soon, even strident opponents will put aside their showmanship and recognize the positive impact and value of the law.

The law makes sure that insurance companies treat people fairly. Under the law, it will be illegal for insurers to discriminate against women by charging higher premiums simply because of their gender. Nobody — male or female — will be denied coverage or charged higher premiums because of a pre-existing condition, such as asthma or diabetes. No one will live in fear of their insurance being cancelled. People will no longer be subject to arbitrary lifetime or annual caps in what insurers pay out, thereby denying coverage when it is needed the most.

The act also comes with much-needed direct help for middle-class families. They will receive substantial subsidies to make health insurance premiums affordable. Seniors will no longer fall into the huge prescription drug coverage gap in Medicare euphemistically named the “doughnut hole.” Comprehensive preventive care will be available at no cost for women, including mammograms and contraception.

A significant number of these benefits, and many others, already are being provided in whole or in part, such as the millions of young adults (under age 26) who are staying on their parents’ policies. As more and more people feel the direct protections and benefits of the new law, repealing the Affordable Care Act will increasingly be considered an absurdity.

At its heart, the ACA is about keeping people healthy and giving Americans the peace of mind that health care will always be there when they need it. Irrespective of changes in any person’s life circumstances — the desire to switch jobs or start a business, being laid off from work, changes in marital status or the sudden loss of income — the Affordable Care Act ensures the availability of quality, affordable health care.

Instead of playing politics with the act, it’s time to fully implement it across the country. In fact, Democrats and Republicans should come together to build on the ACA so that additional steps can be taken to moderate health care costs for America’s families and businesses.
ASSESSING THE NEW HEALTH CARE LAW

Continued from p. 804

in a different way than in New York” under Democratic Gov. Andrew Cuomo.

The result will be a variety of natural experiments carried out around the country that will test how different coverage models work, from single-payer systems to the most loosely regulated private markets, he says. Conducting such experiments has always been a good idea, “but the problem is that you need gobs of federal money” for states to do them, which the ACA now offers, he says.

“Virtually every state” will implement the expansion “after the rhetorical season” of the November election is over, says Pollack of Families USA. Some “very influential” health care sectors, such as hospitals, already are urging states to take the funding to help eliminate the unpaid medical bills they struggle with, he says.

“ACA provided a carrot and a stick” for the expansion, and “although the stick is gone, the very big carrot remains,” he says.

Only a Beginning

Because many aspects of health care are state responsibilities, such as setting and enforcing rules for health insurance sold to individuals and small businesses, the ACA puts additional burdens on state governments. However, the law allows the federal government to step in if states don’t fulfill these responsibilities effectively and on time.

“A few states — including Massachusetts, California and Maryland — appear to be well along in their implementation activities” for the insurance exchanges through which individuals will buy health coverage using ACA subsidies, said Antos of the American Enterprise Institute. Nationwide, however, given the present rate of progress, both the states and the federal government are doomed to fall behind the aggressive schedule the law requires, he said.

For example, 37 states have not yet enacted enabling legislation or issued an executive order to establish an insurance exchange through which citizens can buy coverage, Antos noted. Citizens of those states risk becoming liable for the ACA’s mandate-related tax penalty in January 2014 — before their states have managed to set up the exchanges through which affordable coverage is supposed to be available, he wrote. What’s more, it’s “doubtful that the federal government . . . will be capable of stepping in” to help states get their insurance exchanges up and running, he said. “The task is too large, the time is too short.” 68

But ACA supporter Pollack says the law’s opponents are secretly rooting for the law to stumble hard out of the gate. He calls their predictions that lagging ACA implementation will harm citizens “wishful thinking.” Even “a lot of governors who actually oppose the law and joined the lawsuit [against it] are still working quietly with folks to get ready” to implement it, he says. That’s partly because many Republican governors hope to shape the exchanges according to their own ideas — not the Obama administration’s — about how the insurance market should work he says. “It would put a conservative governor in an ironic situation — letting the federal government decide what goes on in the state.”

Besides expanding insurance coverage, the ACA also is intended to reshape the way health care is delivered and paid for, with the goal to hold down cost increases while maintaining quality. The law includes a wide range of possible cost-control measures, such as establishment of an independent board empowered to make cost-saving changes to Medicare. It also offers financial incentives to induce physicians and hospitals to provide preventive care. But all these measures “have to be built” before it becomes clear whether they actually work, says insurance consultant Laszewski.

Furthermore, much more must be attempted on the cost-control front, Laszewski says. “This law didn’t take a really serious shot at it” — not surprising, given the controversy that surrounds any attempt to reduce medical costs, he says. Massachusetts, which enacted a close-to-universal coverage system similar to the ACA in 2006, “just passed their cost-control bill this year,” a full six years into the program’s operation, Laszewski says.

OUTLOOK

Voting on Health

Parts of the ACA, if not the law as a whole, undoubtedly will have some impact in the November elections. The ACA provisions intended to trim some wasteful Medicare spending, for example, could undermine President Obama’s popularity among older voters. Meanwhile, many congressional Republicans continue to say they’ll cut implementation funding for the law and repeal it in January if they have the power.

On July 18, 127 members of the House GOP caucus — more than half its members — wrote House Speaker Boehner and House Majority Leader Eric Cantor, R-Va., expressing “outrage” over the Supreme Court’s upholding of the health care law. They pledged to “continue efforts to repeal the law in its entirety this year, next year, and until we are successful.” 69 Romney has repeatedly made the same vow in his campaign for the White House.

Still, says Robert Blendon, a professor of health policy and political analysis at the Harvard School of Public Health, the ACA may not be foremost on voters’ minds this fall. “The
polling is pretty clear,” he says. “The economy and jobs are the main issues for voters, but if the election is within three or four points, then other issues matter.” Health care counts high among those other issues, but in that category it is mainly Medicare that has voters concerned, Blendon says.

Ryan, the GOP vice presidential nominee, wants to provide future Medicare recipients with a fixed government payment and let them choose among private Medicare plans, Blendon notes. But the idea “has not done well in any poll,” he says.

That doesn’t mean the Medicare issue is friendly to Obama, however, Blendon says. The Romney campaign “is trying to do something quite politically sophisticated” by taking Medicare and reframing it in campaign ads, speeches and interviews to depict Obama as Medicare’s chief foe, he says. Romney charged in an August TV ad and in an interview that in the ACA, Obama “cuts Medicare by $716 billion, takes that money out of the Medicare trust fund and uses it to pay for Obamacare.” 70

But the ACA’s defenders argue that the cuts don’t trim Medicare benefits but shift the payments in ways aimed at reducing wasteful spending. For example, the law trims payments to so-called Medicare Advantage private health plans that cost more than traditional Medicare. It also lowers payments to hospitals that discharge too many patients too quickly, only to readmit them to treat conditions that could have been prevented with better patient management. If those changes save money, as many expect they will, the savings will fund new Medicare benefits — such as free preventive care — as well as other ACA provisions, PoliFact Florida, a fact-checking website run by the Tampa Bay Times, reported. 71

Nevertheless, Republican ads and speeches condemning the cuts are successfully harming Obama’s standing with senior voters, at least for now, says Blendon. “Just the one big number” — $716 billion — is enough “to make people very nervous,” while details that could make the number sound less frightening “are awfully complex to explain to people.” In states such as Florida and Ohio, where the presidential vote will be close, the Medicare ads could win the day for Republicans, he says.

In polls, most voters continue to say they dislike the ACA, despite expressing support for some of its provisions, such as its guarantee that people with pre-existing illnesses can buy insurance at a relatively affordable price. Public opposition stems in large part from people’s lack of knowledge about what the law does, some analysts argue.

The Urban Institute’s Dorn describes a conversation he had with a small-business owner who doesn’t provide health insurance for his mainly low-wage workers and buys his personal coverage in the private market. “I said, ‘Your own premiums will come down a lot’ once the ACA kicks in in 2014, “and your low-wage workers will get subsidies” from the government to help them buy coverage, too. The man responded that he hadn’t heard of these ACA features and wasn’t sure he believed they existed, Dorn says.

Nevertheless, the ACA has set in motion some changes that will go forward, whatever the election results, says Dorn. For example, states are using ACA funds to automate and streamline their Medicaid administrative procedures, which may trim costs and make it easier for poor people to get access to all the state services they need. And some hospitals and doctors are shifting their focus to preventive care, in anticipation of ACA payment changes that will reward prevention.

“Even if Republicans sweep the table” in November, says Dorn, “they can’t take all of those things away.”

Notes

12 For background, see “Plan Levels/Standardization of Coverage,” American Cancer Society, www.acscan.org/pdf/healthcare/imple
mentation/background/PlanLevelsStandardizationOfCoverage.pdf.
17 Quoted in ibid.
25 Ibid.
27 Ibid.
31 Belluck, op. cit.
38 Padula, op. cit.
43 Ibid.
FOR MORE INFORMATION


Alliance for Health Reform, 1444 Eye St., N.W., Suite 910, Washington, DC 20055; 202-789-2300; www.allh.org. Nonpartisan group that calls on health care experts representing a wide range of opinions to provide information about the ACA and other issues.


Center on Budget and Policy Priorities, 820 First St., N.E., Suite 510, Washington, DC 20002; 202-408-1088; www.cbpp.org. Liberal think tank that analyzes how economic policies, including the ACA, affect individuals and state and federal budgets.

Families USA, 1201 New York Ave., N.W., Suite 1100, Washington, DC 20005; 202-628-3030; www.familiesusa.org. Liberal consumer-advocacy group that is tracking the progress and effects of the ACA’s rollout.

Health Affairs Blog, http://healthaffairs.org/blog. Blog run by an academic journal covering health policy that presents a range of opinion on the ACA.


**Books**


A Harvard professor of public health who supports the 2010 Affordable Care Act explains its background and why he believes it will improve American health.


A Princeton professor of sociology and public affairs chronicles legislative attempts to overhaul the U.S. health-care system over the past three decades and the vested interests of health-care practitioners, insurers and the public that have made those attempts so difficult.


Analysts from the free-market-oriented think tanks Galen Institute (Turner) and American Enterprise Institute argue that the Affordable Care Act (ACA) relies on government regulation rather than market competition to address health-system problems and say alternative approaches would allow consumer choice to determine how the health-care market develops.

**Articles**


The director of South Carolina’s Medicaid program argues that eliminating waste in the medical system and changing how health care providers are reimbursed can help his state provide care to more poor people than by accepting federal funds under the ACA to expand Medicaid.


As ACA provisions aimed at trimming ineffective health-care spending and improving care quality take effect, more than 2,000 hospitals will lose some Medicare payments because too many of their elderly patients were readmitted for conditions that could have been prevented during their hospital stay. ACA supporters argue that such penalties prevent hospitals from profiting from readmissions and protect patients from ineffective care. But hospitals that serve low-income neighborhoods contend they’re being unfairly penalized because their patient populations tend to need more care than do wealthier people.


A Princeton University professor of economics describes the differences between what he calls the European “social-solidarity” approach to health care and the American “libertarian” approach and why he considers the European view more practical.

**Reports and Studies**


A nonpartisan group that provides information to and about state governments offers a plain-language summary of the 2010 health-care law.


Analysts from Congress‘ nonpartisan research office explain the workings of the ACA’s highly controversial expert board that will develop payment and care-delivery changes to trim Medicare costs.


Lawyers at Congress’ nonpartisan research arm explain the Supreme Court’s ruling upholding the 2010 Affordable Care Act’s requirement that individuals buy health insurance.


Experts on improving health care quality say 30 cents of every dollar in health-care spending is wasted on useless services. To stem soaring medical costs, the United States should pay medical practitioners based on health outcomes rather than “per service rendered,” they contend. Quick adoption of information technology also would help keep doctors up to date on which treatments are supported by science and on patients’ medical histories, they also say.
Cost


The Affordable Care Act (ACA) reduces health care costs by providing better care and promoting better health, says a former administrator of the Centers for Medicare and Medicaid Services.


If the ACA is repealed, $716 billion in potential Medicare savings would be lost and elderly Americans would pay more for health care, according to analysts at the American Institutes for Research.


President Obama's health care law was supposed to reduce health insurance costs, but it imposes six taxes on Americans who are already insured, says the president of Americans for Tax Reform.

Medicaid


Republican critics of Medicaid hope to shrink the program if their party wins the presidential election.


Gov. Mike Beebe, D-Ark., says he favors expanding Medicaid under the federal Affordable Care Act and will seek legislative support.


Gov. Rick Scott, R-Fla., says his state will not expand its Medicaid program because doing so would cost an additional $1.9 billion annually.

Supreme Court


The Supreme Court ruling in favor of Obama's health care law puts the United States on a positive path toward universal coverage, says a Johns Hopkins professor of surgery.


The Supreme Court's decision to uphold health care reform gives Republicans another opportunity to call for its repeal leading up to the November elections.

Kersten, Katherine, “Obamacare Is a Disaster, So, No, the Fight Isn't Over,” Star Tribune (Minneapolis), July 1, 2012, p. OP3.

Flaws in Obama's health care law ensure that battles over medical care will continue well past the Supreme Court decision, says a fellow at the Center of the American Experiment, a conservative think tank in Minneapolis.


Americans are divided over the Supreme Court's ruling on health care reform, as they have been since the law was enacted in 2010.

CITING CQ RESEARCHER

Sample formats for citing these reports in a bibliography include the ones listed below. Preferred styles and formats vary, so please check with your instructor or professor.

MLA STYLE


APA STYLE


CHICAGO STYLE

For more than 80 years, students have turned to *CQ Researcher* for in-depth reporting on issues in the news. Reports on a full range of political and social issues are now available. Following is a selection of recent reports:

### Civil Liberties
- Solitary Confinement, 9/12
- Re-examining the Constitution, 9/12
- Voter Rights, 5/12
- Remembering 9/11, 9/11
- Government Secrecy, 2/11

### Crime/Law
- Debt Collectors, 7/12
- Criminal Records, 4/12
- Police Misconduct, 4/12
- Immigration Conflict, 3/12
- Financial Misconduct, 1/12

### Education
- Arts Education, 3/12
- Youth Volunteerism, 1/12
- Digital Education, 12/11
- Student Debt, 10/11

### Environment/Society
- Genetically Modified Food, 8/12
- Smart Cities, 7/12
- Whale Hunting, 6/12
- U.S. Oil Dependence, 6/12
- Gambling in America, 6/12
- Sexual Harassment, 4/12

### Health/Safety
- Farm Policy, 8/12
- Treating ADHD, 8/12
- Alcohol Abuse, 6/12
- Traumatic Brain Injury, 6/12
- Distracted Driving, 5/12
- Teen Drug Use, 6/11

### Politics/Economy
- Privatizing the Military, 7/12
- U.S.-Europe Relations, 3/12
- Attracting Jobs, 3/12
- Presidential Election, 2/12

### Upcoming Reports
- Supreme Court, 9/28/12
- European Debt Crisis, 10/5/12
- Politics and Social Media, 10/12/12

**ACCESS**

*CQ Researcher* is available in print and online. For access, visit your library or www.cqresearcher.com.

**STAY CURRENT**

For notice of upcoming *CQ Researcher* reports or to learn more about *CQ Researcher* products, subscribe to the free e-mail newsletters, *CQ Researcher Alert!* and *CQ Researcher News*; http://cqpress.com/newsletters.

**PURCHASE**

To purchase a *CQ Researcher* report in print or electronic format (PDF), visit www.cqpress.com or call 866-427-7737. Single reports start at $15. Bulk purchase discounts and electronic-rights licensing are also available.

**SUBSCRIBE**

Annual full-service *CQ Researcher* subscriptions—including 44 reports a year, monthly index updates, and a bound volume—start at $1,054. Add $25 for domestic postage.

*CQ Researcher Online* offers a backfile from 1991 and a number of tools to simplify research. For pricing information, call 800-834-9020, or e-mail librarymarketing@cqpress.com.

---

**CQ RESEARCHER PLUS ARCHIVE**

Get online access to vital issues from 1923 to the present

CQ Researcher Plus Archive delivers fast, online access to every *CQ Researcher* report from 1991 to the present, PLUS lets you explore the complete archive of *Editorial Research Reports* from 1923-1990. Search and browse more than 3,600 in-depth reports.

Loaded with handy online features, *CQ Researcher Plus Archive* provides the trustworthy reporting and the advanced online functionality today’s researchers demand. The new "Issue Tracker" feature provides quick links to past and present reports on the specific topics you need.

For a free trial, visit http://library.cqpress.com/trials.

For pricing information, call 1-800-834-9020, ext. 1906 or e-mail librarymarketing@cqpress.com.

*Editorial Research Reports, the predecessor to *CQ Researcher*, provides the same expert, nonpartisan reporting on the vital issues that have shaped our society.

CQ Press • 2360 N Street, NW, Suite 800 • Washington, DC 20037