



# **The SAGE Encyclopedia of Pharmacology and Society**

## **Patient Protection and Affordable Care Act (Obamacare)**

Contributors: Joyce Addo-Atuah

Edited by: Sarah E. Boslaugh

Book Title: The SAGE Encyclopedia of Pharmacology and Society

Chapter Title: "Patient Protection and Affordable Care Act (Obamacare)"

Pub. Date: 2016

Access Date: March 30, 2016

Publishing Company: SAGE Publications, Inc.

City: Thousand Oaks,

Print ISBN: 9781483350004

Online ISBN: 9781483349985

DOI: <http://dx.doi.org/10.4135/9781483349985.n297>

Print pages: 1038-1044

©2016 SAGE Publications, Inc.. All Rights Reserved.

This PDF has been generated from SAGE Knowledge. Please note that the pagination of the online version will vary from the pagination of the print book.

The Patient Protection and Affordable Care Act (PPACA), commonly called the Affordable Care Act (ACA) or otherwise known as Obamacare or health care reform, is a U.S. federal statute that was signed into law on March 23, 2010, by President Barack Obama, the 44th president of the United States. Over the past century, almost every U.S. president had proposed health care reform to fix the broken American health care system without success. Signed along with the Health Care and Education Reconciliation Act, the passage of the ACA is important to the American people because it represents the most significant overhaul of the U.S. health care system since the establishment of the Medicare and Medicaid programs under the Social Security Act (SSA) Title XVIII and XIX, respectively, in 1965.

The ACA creates a health insurance marketplace for people without coverage to shop and purchase federally regulated and subsidized private health insurance. This, along with other interventions, are toward the achievement of the goals of the ACA—expanding access to affordable health insurance coverage, improving health care quality and controlling costs, and protecting consumers from insurance industry abuses. Realizing these goals will not only bring health and well-being to the U.S. population but will also address the high rate (over 60 percent) of medical-related bankruptcies in the country, 75 percent of which are filed by people with health insurance.

The U.S. Census Bureau reported in 2010 that 16.3 percent (49.8 million) of the U.S. population was uninsured. However, even among those with health insurance coverage, the various abuses by the insurance industry before the passage of the ACA were common knowledge. These included excluding people with preexisting conditions from coverage, charging higher premiums for women, arbitrarily increasing premiums and other costs, retroactively canceling enrollees' coverage when they became sick, setting annual and lifetime limits on health coverage, and usually not covering preventive health services.

These were confirmed by an international survey of adults in 11 industrialized countries including the United States in 2013. In this survey, the United States was found to be an outlier with respect to health care costs, access to health care, and affordability, compared to the other 10 countries studied. The United States spent an average of \$8,508 on health care cost per person per year in 2013; this was found to be \$3,000 more than that of Norway, the industrialized country with the next-highest health care spending per person. Thirty-seven percent of the U.S. study participants reported going without recommended care, or could not see a doctor when sick or failed to fill needed prescription because of cost. Only 4 to 6 percent of adults in the United Kingdom and Sweden reported facing similar challenges. The same study found that 23 percent of the U.S. respondents either had severe problems paying medical bills or were unable to pay them, compared to less than 13 percent of those in France, and up to 6 percent of those surveyed in the United Kingdom, Sweden, and Norway. Furthermore, 32 percent of U.S. adults reported spending a lot of time dealing with insurance paperwork or disputes in the form of insurance claim denials or receiving less payment than expected. Other countries with insurance structures like that of the United States reported fewer problems (25 percent in Switzerland, 19 percent in the Netherlands, and 17 percent in Germany). The study concluded that high deductibles and cost sharing, and lack of limits to out-of-pocket costs could explain why even those with health insurance coverage in the United States reported struggling to afford needed health care. It was no wonder then that 75 percent of the adults polled in the United States

agreed that the U.S. health care system needed fundamental changes or should be completely rebuilt.

Consisting of 1,990 pages and 10 Titles or main sections, the ACA is a very extensive document, but it has three broad goals: (1) expanding access to affordable health insurance coverage, (2) improving health care quality and controlling health care cost, and (3) protecting consumers from the long-standing abuses and high costs of the insurance industry through legislation.

The ACA employs different strategies, including legislation, in an effort to achieve the three goals outlined. With respect to the goal of expanding access to affordable health insurance coverage, the main strategies include the following:

- a. Optional expansion by states of their Medicaid program to cover low-income adults without dependent children and adults with incomes up to 133 percent of the federal poverty level (FPL), at no cost to the states.
- b. Expansion of coverage for young adults by allowing them to stay on their parents' plans until 26 years of age.
- c. Establishment of state-specific insurance exchanges, commonly called the Health Insurance Marketplace, which allows individuals and families to search for, compare, and enroll in health plans that meet their specific needs.
- d. Establishment of the Small Business Options Program (SHOP Exchanges) on the marketplace and providing federal tax credits for small businesses with fewer than 50 full-time employees to buy coverage for their employees.
- e. Assisting states, through the federal Exchange Establishment Grants, to establish their health insurance exchanges.
- f. Providing federal subsidies in the form of cost-sharing reductions and Advance Premium Tax Credits for people with incomes up to 250 percent and 400 percent, respectively, thus making insurance coverage more affordable.
- g. Setting up of temporary preexisting conditions health plans for those uninsured because of preexisting conditions.
- h. Instituting the Individual Mandate, which requires all Americans (with the exception of American Indians, incarcerated people, those in extreme financial hardship, religious objections, and undocumented immigrants) to maintain a "minimal essential" health insurance coverage or make "a Shared Responsibility Payment" to the federal government in the form of a surtax made to the IRS during the filing of annual tax returns.
- i. Institution of the Employer Mandate requiring employers with 50 to 99 employees to provide health insurance to their full-time workers starting from 2016 or pay per month per employee "Employer Shared Responsibility" payment on their federal tax returns. For employers with 100 or more full-time employees, the deadline is 2015.

Toward the second goal of improving health care quality and controlling health care costs, strategies employed by the ACA include the following:

- a. Promoting new models of care (e.g., accountable care organizations and medical homes), which promote coordination and integration of care among multidisciplinary health care teams to deliver quality care with better outcomes for patients with chronic diseases.
- b. Investing in electronic health record systems to provide comprehensive patient information to providers so as to promote quality of care.

Contact SAGE Publications at <http://www.sagepub.com>. [Page iv]

- c. Supporting community initiatives and the development of public health infrastructure to help prevent disease and illness.
- d. Reimbursing providers, plus other incentives, for providing quality care based on their performance when compared to physician-validated patient outcome measures.
- e. CMS negotiating with drug manufacturers to provide discounts for Medicare enrollees in the “donut hole” coverage gap in the Part D program. The “donut hole” is a point in drug coverage in some Medicare drug plans where the individual covered is required to pay a higher percentage of the cost of their drugs. The ultimate goal is to close the donut hole completely with time and thus ensure that seniors do not go without needed medications.
- f. Rectifying the excessive payments that were being made to Medicare Advantage Plans to make their services more cost-effective.
- g. Aggressively reducing Medicare expenditure by fighting fraudulent claims and abuses in the program.

With the third goal of protecting consumers from insurance industry abuses and arbitrary price increases, the ACA adopts various measures, including the following:

- a. Instituting the 80/20 rule that requires the health insurance industry to use not less than 80 percent of premium payments to provide health care for their enrollees.
- b. Mandating full transparency on the part of the industry with respect to the reason for premium increases, which would have to be approved by the state and publicized on the state health insurance marketplace.
- c. Requiring all health insurance plans to provide 10 essential health benefits. These are ambulatory patient services; emergency services; hospitalization; maternal and newborn care; mental health services and addiction treatment; prescription drugs; rehabilitative services and devices; laboratory services; preventive services, wellness services and chronic disease treatment; and pediatric services.
- d. Requiring insurance plans to cover four broad categories of preventive health services without any out-of-pocket payments by enrollees (i.e., evidence-based screenings and counseling; routine immunizations; preventive services for children and youth; preventive services for women, which involve women’s general and reproductive health-related services.
- e. Dictating premium levels only by plan type (bronze, silver, gold, or platinum), family size, geographic location, age, and smoking status, and no longer by gender, preexisting condition, health status, or claims history.
- f. Issuing the Patient’s Bill of Rights.

Among other things, the Patient’s Bill of Rights banned the health insurance industry from (i) excluding preexisting conditions from coverage, (ii) imposing annual and lifetime limits on coverage, and (iii) arbitrarily canceling anyone’s coverage except on the grounds of fraud or intentional misrepresentation of facts. The Bill of Rights also provided consumers the right to both internal and external appeal with respect to decisions of their insurance plans. Another important tool provided by the ACA is the empowerment of consumers with objective information through the official website of the health insurance marketplace, [www.HealthCare.gov](http://www.HealthCare.gov), to assist them to make informed choices concerning health care coverage for themselves and families. A federal government toll-free, 24-hour hotline (1-800-318-2596) is also available to answer consumers’ questions.

Two key provisions of the ACA, the Individual Mandate and the Medicaid Expansion by States, have faced the most severe opposition by critics and opponents of health care reform. Medicaid is a public health insurance program which, since 1965, has been covering low-income families, pregnant women, children, and people with disabilities, among others. Although the program is run by states under federal government guidelines, the federal government supports the states to finance the program by shouldering 50 to 83 percent of the costs, depending on each state's per capita income compared to the national average. The ACA initially required all states to expand the Medicaid program to cover people who have previously not been eligible for the program (adults without dependent children and people with incomes up to 133 percent of FPL), with the federal government fully financing the expansion initially. The contention of the critics was that the ACA mandated states to expand their Medicaid programs or face losing all federal funding for the program in their states. Complete federal funding cut for the Medicaid program for the states would have meant a big financial burden for those states who refused to comply with the mandated Medicaid expansion. Consequently, 26 states, several individuals, and the National Federation of Independent Business brought a legal suit in October 2011 challenging the constitutionality of the Medicaid Expansion and the Individual Mandate. On June 28, 2012, the Supreme Court upheld the constitutionality of the Individual Mandate, citing congressional authority to "lay and collect taxes" (known as the Taxing and Spending Power of Congress) as the legal basis. With respect to the mandated Medicaid Expansion, the Supreme Court ruled it unconstitutional and gave the states the option to expand the program without losing any federal funding for their current program. As of May 2015, 30 states have opted to expand their Medicaid programs, three had Medicaid expansion under discussion, and 18 had chosen to not expand their Medicaid programs.

The ACA implementation is intended to roll out from 2010 through 2022 with different timelines of implementation for different aspects of the law, with respect to the provisions, protections, mandates, and taxes. The year 2014 can be defined as the pivotal year for the ACA's implementation because some of the biggest changes in the law came into effect in 2014. Perhaps the biggest is the health insurance coverage of people in the Health Insurance Exchange or Marketplace, which became effective on January 1, 2014. This insurance marketplace is a state-specific online platform, accessed through the official website ([www.HealthCare.gov](http://www.HealthCare.gov)), where individuals and small businesses can shop for health insurance plans using side-by-side comparisons of costs and benefits to choose the plans that best meet their needs. People can also apply for coverage in the marketplace by calling the toll-free, 24/7 marketplace hotline (1-800-318-2596), in person at designated locations (LocalHelp.HealthCare.gov), or by mailing in a paper application (<https://www.healthcare.gov/apply-and-enroll/how-to-apply>). Some state-specific exchanges are built and run by the states themselves with federal funding; these usually have unique or specific names such as "Covered California," and "NYStateofHealth." Other states partner with one or more other states or with the federal government to run their state marketplace. A third group of about 26 states that chose not to run the marketplace themselves have theirs being run by the federal government. Four tiers of "qualifying health plans" or "metal plans" are available in the health insurance marketplace, starting from the lowest-cost "Bronze" plans, through the midrange "Silver" plans, to the "Gold" plans, and finally the "Platinum" plans. The differences in these plans lie in their costs, benefit coverage, and network coverage of providers; however, they all provide the 10 Essential Health Benefits package mandated by the ACA. The marketplace's first open-enrollment period started

Contact SAGE Publications at <http://www.sagepub.com>. [Page iv]

on October 1, 2013, and ended on March 31, 2014. The next open-enrollment period began on November 15, 2014. The Individual Mandate also took effect on January 1, 2014, but since the ACA allows each person to go without coverage for three consecutive months (coverage gap exemption) without penalty, this means that people without health insurance had up to April 1, 2014, to obtain coverage through the marketplace without paying the "Shared Responsibility Fee." For coverage to start on April 1, enrollment should have been completed not later than March 15. However, those who had started the enrollment process before the end of the first open-enrollment period on March 31 were given an extension of the coverage gap exemption to complete the process without attracting the penalty. The penalty/fee/tax for not having coverage is a per-month fee that is collected by the IRS when filing the federal tax returns.

The health insurance marketplace under the ACA combines the benefit of pooling together the buying power of millions of individuals and small businesses with marketplace competition among insurance companies and plans to bring down coverage prices for all shoppers. However, since the ACA provides that no American should spend more than 9.5 percent (3 to 9.5 percent) of their income on health care, health plan shoppers in the marketplace can use the available price calculator to see if they qualify for health insurance cost subsidies, which are income dependent. The ACA provides three types of cost-assistance subsidies in the marketplace. Individuals/families with incomes below 138 percent of FPL will be eligible for Medicaid or the Children's Health Insurance Program (CHIP), provided their states have opted for the Medicaid expansion. People having incomes below 250 percent of FPL will receive assistance with their out-of-pocket costs (deductibles, copays/coinsurance); this type of assistance is known as cost-sharing reductions. The third type of subsidy, known as the Advance Premium Tax Credit, is available for people with incomes below 400 percent of FPL. This tax credit is available immediately to lower the purchasers' premiums; on the other hand, if they choose to pay the full premiums themselves, they will receive these as tax credits when they are filing their federal tax returns. It is important to note that the cost-sharing reductions and the tax credits are not mutually exclusive; people can therefore qualify for both subsidies depending on their incomes. The Congressional Budget Office (CBO) estimates that an average subsidy would be in the region of \$5,290 per person in 2014, cutting coverage cost by an estimated 60 percent, which may translate into premium costs of a Silver plan falling below \$100 per month.

An important provision of the ACA that needs stressing is the requirement by all health plans to cover preventive health services without any cost sharing by enrollees. Access to preventive services is expected to cut down health care spending in significant ways due to early diagnosis and treatment of disease, as well as disease avoidance in the first place. The preventive services to be covered are in four categories:

1. Evidenced-Based Screenings and Counseling for breast, cervical, and colorectal cancers, and for chronic conditions such as hypertension, diabetes, obesity, lipid disorders, depression, and osteoporosis.
2. Routine Immunizations, including influenza (the flu); hepatitis A and B; haemophilus influenza; human papillomavirus vaccine (HPV) for women; meningococcal vaccines; measles, mumps, and rubella (MMR) vaccine; and pneumococcal vaccine.
3. Preventive Services for Children & Youth (birth to 18 years), including all routine immunizations for children plus developmental screening and assessment of

Contact SAGE Publications at <http://www.sagepub.com>. [Page iv]

vision and hearing, blood pressure, autism, behavioral assessment, and HIV/STI screening for adolescents.

4. Preventive Services for Women combine general women and reproductive health-related services. They cover annual well-women checks, human immunodeficiency virus/sexually transmitted infection (HIV/STI) counseling and screening, prenatal visits, contraceptives, alcohol and tobacco abuse screening and counseling, and smoking cessation intervention. Breastfeeding support and counseling following childbirth is another service required for women under the provisions of the ACA. This is a huge step in the right direction, especially for women's health and well-being considering the fact that before ACA, women's premiums were usually higher than those of men and these services now required under ACA were not routinely covered by health insurance plans.

Despite the rocky start of the opening of the health insurance marketplace on October 1, 2013, the technical glitches have been fixed, enabling 8 million people to sign up for health coverage by the middle of April 2014. There had been some apprehension that young people without insurance coverage may not be motivated to enroll in the marketplace, thus resulting in adverse selection of mainly older and sicker people. If this had happened, it would have resulted in relatively high premiums. However, reports indicate that 35 percent of the 8 million currently having coverage through the marketplace are below 35 years; this represents a more balanced demographic population in the marketplace. In March 2015, the CBO announced that projected costs for the ACA over the next 10 years were \$142 billion, 11 percent less than original projections, due in part to lower premium costs and fewer employers dropping coverage than expected. Additionally, 4 million young people have received coverage through their parents' plans as provided for under the ACA. According to a 2015 analysis by Matthew Buettgens and colleagues, if the 21 states that had not expanded Medicaid eligibility as of April 2015 were to expand eligibility, 4.3 million fewer Americans would be uninsured, and almost 7 million additional nonelderly people would be enrolled in Medicaid.

It is interesting to note that although the United States is not yet a party to the International Covenant on Economic, Social and Cultural Rights (ICESCR), and hence not obligated to fulfill the Right to Health provision under the ICESCR, the ACA has taken important steps forward to eliminate all forms of discrimination (preexisting conditions, health status, claims history, gender, duration of coverage, etc.) that prevented the realization of the Right to Health as a human right.

**See Also:** [Disease Management](#); [Healthcare Cost and Utilization Project \(HCUP\)](#); [Medicaid and Medicare Systems](#); [Medicare Prescription Drug, Improvement, and Modernization Act \(2003\)](#); [Organisation for Economic Co-operation and Development](#); [Patient Rights](#).

Joyce Addo-Atuah Touro College of Pharmacy  
<http://dx.doi.org/10.4135/9781483349985.n297>  
10.4135/9781483349985.n297

#### **Further Readings**

Buettgens, Matthew, John Holahan, and Hannah Recht. "Medicaid Expansion, Health Coverage, and Spending: An Update for the 21 States That Have Not Expanded Eligibility." Henry J. Kaiser Family Foundation Issue Brief (April 29, 2015). <http://kff.org/medicaid/issue-brief/medicaid-expansion-health-coverage-and-spending->



Contact SAGE Publications at <http://www.sagepub.com>. [Page iv]

[an-update-for-the-21-states-that-have-not-expanded-eligibility/](http://www.sagepub.com) (Accessed June 1, 2015).

Gabel, J. R., H. Whitmore, J. Pickreign, J. L. Satorius, and S. Stromberg. "Small Employer Perspectives on the Affordable Care Acts Premiums, SHOP Exchanges, and Self Insurance." *Health Affairs*, v.32/11 (2013).

[HealthCare.gov](http://www.healthcare.gov). "Health Insurance Marketplace." <https://www.healthcare.gov> (Accessed April 17, 2014).

Kaiser Family Foundation. "Preventive Services Covered Under the Affordable Care Act." <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8219.pdf> (Accessed April 15, 2014).

Kaiser Family Foundation. "Status of State Action on the Medicaid Expansion Decisions" (May 26, 2015). <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/> (Accessed June 1, 2015).

ObamaCare Facts. "Health Care Reform Timeline." <http://obamacarefacts.com/health-care-reform-timeline.php> (Accessed April 15, 2014).

ObamaCare Facts. "Obamacare Essential Health Benefits." <http://obamacarefacts.com/essential-health-benefits.php> (Accessed April 15, 2014).

ObamaCare Facts. "Obamacare Subsidies on Your State Health Insurance Market Place." <http://obamacarefacts.com/obamacare-subsidies.php> (Accessed April 15, 2014).

Sochoen, C., R. Osborn, D. Squires, and M. M. Doty. "Access, Affordability and Insurance Complexities Are Often Worse in the United States, Compared to 10 Other Countries." *Health Affairs*. Web First, November 14, 2013.

<http://content.healthaffairs.org/cgi/content/full/hlthaff.2013.0879?ijkey=7LvT9RmkGiN8A&keytype=ref&siteid=healthaff> (Accessed April 15, 2014).

United Nations Human Rights, Office of the High Commissioner for Human Rights. "International Covenant on Economic, Social and Cultural Rights." <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx> (Accessed September 11, 2015).

U.S. Census Bureau. "Health Insurance Highlights 2010." <http://www.census.gov/hhes/www/hlthins/data/incpovhlth/2010/highlights.html> (Accessed April 15, 2014).

U.S. Department of Health and Human Services. "Insurance Marketplace." <http://www.hhs.gov/healthcare/insurance/index.html> (Accessed April 15, 2014).

U.S. Department of Health and Human Services. "Key Features of the Affordable Care Act." <http://www.hhs.gov/healthcare/facts/timeline/index.html> (Accessed April 15, 2014).