

Supplement to **U.S.**
Jonas' Introduction to the
Health Care
System

EIGHTH EDITION

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FRAMEWORK FOR ANALYZING HEALTH CARE POLICY

It is the summer of 2017. The U.S. health care system is under intense scrutiny, and there is much uncertainty about its future form. Passage of the Affordable Care Act (ACA) in 2010 under the Obama administration brought about comprehensive change that addressed many of the system's problems, but not to the satisfaction of all. In fact, repealing the ACA (or Obamacare) was a major platform of the Republican Party during the 2016 elections. Now the newly elected Trump administration has provided ACA's opponents the opportunity to challenge the ACA and change the health care system once again. The purpose of this supplement is to help readers understand the current turbulence in the U.S. health care system, how and why the proposals that have been considered by the Trump administration so far differ from the ACA, and their current status.

What do we need to know in order to understand specific health care policy proposals?

The key questions that need to be answered about health care policy proposals are:

- What are the perceived problems with the status quo that motivate the desire for change?
 - What are the system performance goals of the proposed change?
- How does the new policy propose to achieve these system performance goals?
 - How would one or more of the building blocks of the health care system be changed?
 - What are the likely indirect impacts on other building blocks from the proposed changes?
- What stakeholders of the health care system are affected by the proposed changes?
 - Are the changes negative or positive for each affected stakeholder?
- What are the factors affecting support or opposition to the new policy?
 - How does self-interest affect support for policy changes?
 - How does ideology affect support?
 - How do political ties affect support?
- For policies that are implemented, what have been the results?
 - What worked as planned?
 - What did not work?

What is the context of health care policy debates?

As we wrote in Chapter 1, each nation has a health care system that is organized to provide the diagnosis and treatment of individuals' health problems and consists of health care providers, practice settings, providers of therapeutics that are ancillary to diagnosis and treatment, workforce training institutions, organizations providing system policy and oversight, and health care payers. These are the common building blocks of a health care system.

Assessment of a health care system's performance drives change and the desire for change. Is the system generally seen as performing well or poorly? This assessment is based on performance criteria, and performance of all health care systems can be evaluated on three criteria: equity, efficiency, and quality (or effectiveness) of health care (Aday et al., Chapter 6). These criteria can be measured at the organizational level and the population level—communities and societies. When we are dealing with national health policy, our measures are mostly at the societal (population) level. Efficiency, for instance, concerns what combination of inputs produces the greatest health improvements in a

population, given the available resources (Aday et al., 1999). Quality concerns whether the system's treatments are effective in achieving improvements in population health.

However, just because health care systems are evaluated on the same criteria does not mean that they organize, manage, and finance their system's building blocks in the same way. Quite the opposite. Different health care systems throughout the world attempt to achieve equity, efficiency, and quality in different ways. Thus, the organization and interaction among the common building blocks of a health care system can vary tremendously. In addition, health care systems can place different emphases on the three criteria. For example, some countries emphasize quality over efficiency; others prioritize equity.

What factors affect how a health care system is organized to achieve equity, efficiency, and quality?

Factors that affect how a health care system is organized include resources, history, and the amount and kind of population health needs. Another crucial factor is value. In this regard, a crucial distinction between health care systems is the amount and kind of involvement of the public and private sectors. There is a range of involvement extending from almost completely public to almost completely private. A country's preference for a private or public health care system has a huge impact on how the system is organized, managed, and financed to achieve equity, efficiency, and quality.

How does preference for private or public involvement impact the U.S. health care system?

Along the continuum of private to public involvement, the U.S. health care system lies between the two extremes. It is a complex mix of public and private activities that reflects America's continuing debate over the appropriate roles for private enterprise and the public sector. This debate has led to our complex health care system, in which both private and public sectors play important roles. Indeed, throughout our history, the public versus private debate has been adjudicated by policymakers whenever they considered whether and how to change the health care system—as discussed in Chapters 7, 8, and 9. Thus, regardless of the stated goals of U.S. health care system change—reduced cost, increased access to health care, better-quality health care—policy options have varied according to their proponents' beliefs about public and private action. Furthermore, changes often reflect pendulum swings between public and private policy solutions when a convincing case can be made that we have gone too far in one direction or the other.

How do economic principles apply to health care economics in the United States?

In economics, the three fundamental questions that need to be answered are:

- What to produce?
- How to produce?
- For whom to produce?

A fourth economics question comes up—perhaps unique to health care economics—which is, Who bears the cost?

In a pure market economy, these questions would be determined by market forces—health care products and services would be produced to meet the demand of those who had money to afford them, and producers would determine the most efficient organizations and processes to do this efficiently.

Challenges for achieving efficiency in a health care system with market solutions:

- Efficient markets depend on rational individuals who are the best judge of their own welfare, have sufficient information to make good choices, and can accurately predict the results of their consumption decisions.
 - Aside from challenges with the increasing complexity of medicine, where much remains unknown and even what is known remains unevenly distributed among doctors, most individuals don't have the knowledge or expertise to make rational decisions about health care.

- This becomes a form of the agency problem (e.g., patients often do not know what they are buying and at what price and they pay what doctors bill).
- More complicated are those individuals who are decidedly not rational—those with mental and behavioral health problems, as well as those unconscious or similarly incompetent.
- Market efficiency may be limited when firms have market power and/or there are barriers to firms entering a market.
 - The vast majority of health care utilization in the United States is local—from routine visits to a physician to emergency care—and great health care at great prices 500 miles away is unlikely to divert people from local options except in the case of planned and significant procedures (e.g., total hip replacement surgery) or needs that local providers cannot meet.
 - Some markets simply do not have the scale to support multiple competing providers with the scale to offer efficiency with present standards of care.
 - Outside of major cities, the market for acute care is likely a monopoly or oligopoly, and with the need for vertical integration, coordination of care, and even cooperation for admitting privileges, even ambulatory care, may more closely resemble an oligopoly if not a monopoly.
- In the case of infectious diseases, those who can afford health care may still be at risk from those who cannot afford it.
 - Providing health care outside the market to ensure the surveillance and other public health activities may be justified, similar to government activities for the common defense.
- In extreme cases, health care services can have infinite value to the consumer.
 - In traditional microeconomics, goods and services have a high but finite decreasing value relative to quantity consumed.
 - When the next-best alternative to not accessing health care is death, the market clearing price for services can be unbounded—arguably patients would be better off paying all the money they have or could get if it meant living rather than dying.
 - Since death is irreversible, warranties and similar types of guarantees used in other markets are less likely to mitigate these issues.
- Last, a market economy does not distribute goods and services evenly or even according to objective need, but many people are challenged to see their fellow citizens dying or suffering for lack of access to health care.

The last issue is perhaps what motivated the passage of the Emergency Medical Treatment and Active Labor Act (EMTALA) in 1986 as part of the Omnibus Reconciliation Act that was signed by President Ronald Reagan. It followed after 20 states passed similar laws based on a Texas law passed under the leadership of Ron Anderson, M.D., who was the medical director of the emergency department at Parkland Memorial Hospital. As he described the situation at the time, “I would see patients transferred with knives still in their backs, or women giving birth at the door of the hospital, simply because they were uninsured.” In order pass the law, one of his fellow advocates showed legislators a photo of a woman who had lost her baby while she was being transferred during active labor.

Finally, while a market economy produces and consumes goods and services according to the aggregate across all the individuals in the market, some determination of total health care expenditures is needed—or at least the amount to be paid through shared means—if it will not be solely left to the market to determine. In 2015, National Health Expenditures (NHE) in the United States were about \$10K per person, while the median household income was about \$55K. In other words, if the typical American family of four had to cover the average cost of health care, it would be more than 70% of their gross income. In practice, the \$55K does not cover the employer contribution to health care in gross income, while it does include the higher-than-average health care costs of Medicare patients, whose health care is already paid through a progressive federal tax system.

While efficiency, quality, and equity are the common criteria that we use to evaluate a health care system, the high-level inputs to its design include answers to the following questions:

- For whom and at what cost are different health care products and services available?
- How are these health care products and services produced?
- How much will be spent on each of the building blocks?
- Who bears the cost of these expenditures?

Additional critical design inputs include how are funds allocated, how do they flow through the system, and what are the drivers of payment?

As discussed in Chapter 5, the drivers determine what will be rewarded and how the system will respond, and a mismatch between how those wanting to pay and those wanting to be paid requires an intermediary. Additionally, to the extent we want to share expenditures as a society and base those contributions on income or similar criterion, it is likely that a government entity will be required.

The ACA, brought about under the Obama administration, and its contrast to the proposals currently being considered under the Trump administration, provide a case in point, as we shall see. Both respond to rising costs and other acknowledged problems in the health care system, but the ACA increases the role of government, while the plans considered under President Trump attempt to restrict government involvement through limits on government funding and regulation.

HEALTH CARE REFORM UNDER THE OBAMA ADMINISTRATION

What were the problems that motivated the desire for change?

When President Obama took office in January 2009, he and his administration faced an intricate tapestry of public and private health care payers, as well as a sizeable, but differentiated, population of uninsured persons:

- Insured population's health care payers
 - Employer-sponsored insurance (ESI)
 - Private health insurance not related to employment
 - Medicare
 - Medicaid
 - Children's Health Insurance Program (CHIP)
 - Military and veterans health insurance
- Uninsured population's makeup
 - Unemployed, who cannot afford insurance on the individual market
 - Employed with no ESI and who cannot afford the individual market
 - Employed, especially the young, who did not take ESI that was available to them

This existing system of public and private payers was the springboard from which any new policies would have to emerge, and it was widely considered a problem. At the societal level, costs were escalating, and health care expenditures were accounting for a greater and greater portion of the gross domestic product (GDP). Health expenditures as percent of GDP had steadily increased from 13.3% in 2000 to 17.3% in 2009. Per capita expenditures for health care had gone from \$4,857 in 2000 to \$8,141 in 2009. See Table 1: Trends in Health Care Costs, 1960–2015. Meanwhile, other developed countries were paying much less for their health care systems. For example, see Figure 1: At 17.4% of GDP in 2009, U.S. health spending was one and a half times more than the next most expensive health care in the Netherlands, and 1.8% higher than the OECD average. In addition, per capita costs were higher in the United States than in any other OECD country. See Figure 2: Total Health Expenditure Per Capita, Public and Private, 2009. Also, administrative costs were very high compared to systems

in other industrialized countries, particularly single-payer systems. For example, administrative costs were 1.2% of GDP in the U.S. in 2009 compared to .7% of GDP in France, the country with the next highest administrative costs (OECD, 2009). Finally, the U.S. health care system had poorer health outcomes compared to other countries, particularly when life expectancy and healthy life expectancy were compared. In 2007, the United States had a life expectancy of 78 and a health-adjusted life expectancy (HALE) of 70. The maximum life expectancy in that year was 83 and the maximum HALE was 76 (WHO, 2010). Most of our peer industrialized countries do better. Within the

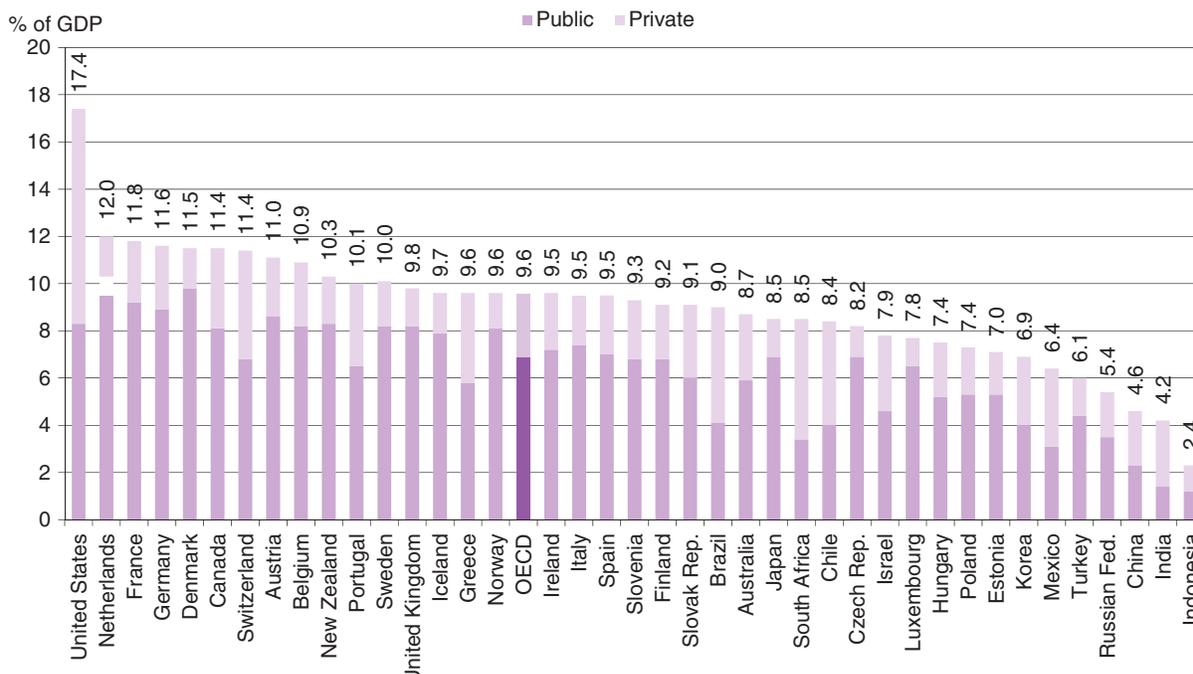


FIGURE 1 Total health expenditure as a share of GDP, 2009 (or nearest year)
 Source: OECD Health Data 2011; WHO Global Health Expenditure Database.

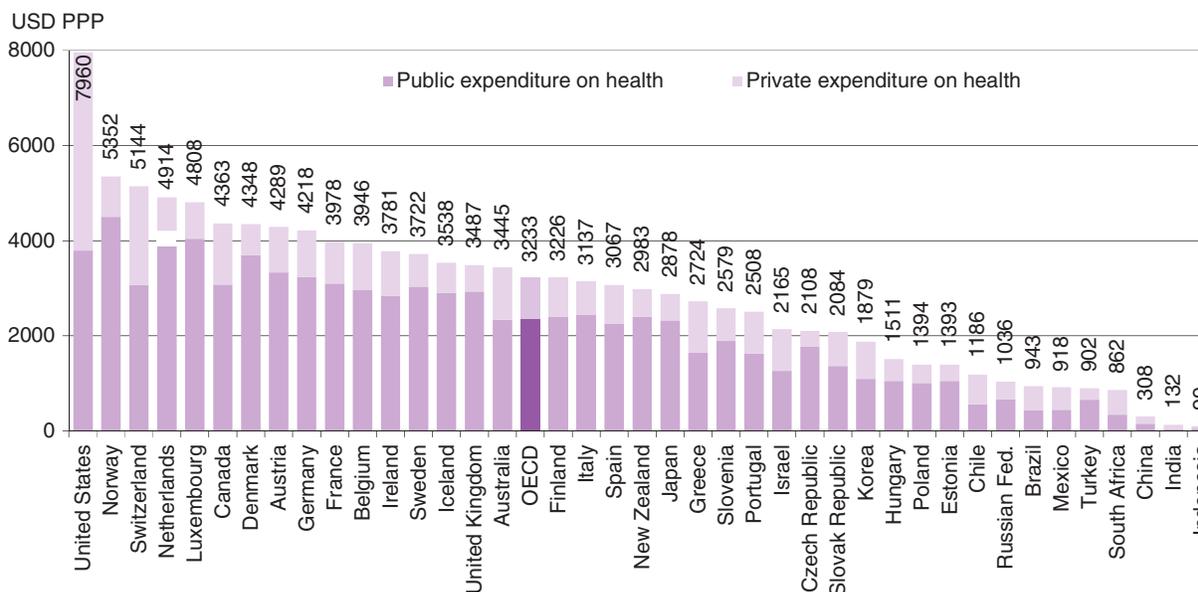


FIGURE 2 Total health expenditure per capita, public and private, 2009 (or nearest year)
 Source: OECD Health Data 2011; WHO Global Health Expenditure Database.

TABLE 1 Trends in Health Care Costs, 1960–2009

	1960	1970	1975	1980	1990	2000	2009	2014	2015
% National Health Expenditures of GDP	5.0	6.9	7.9	8.9	12.1	13.3	17.3	17.4	17.8
Per Capita Health Expenditures (in \$)	146	355	605	1,108	2,843	4,857	8,141	9,515	9,990
% of Health Consumption Expenditures Spent on Administrative Costs	3.9	3.5	3.7	4.7	5.4	5.9	6.7	7.8	7.9

National Center for Health Statistics, 2017. Health, United States, 2016. Hyattsville, MD.

Data abstracted from Table 93. Gross domestic product, national health expenditures, per capita amounts, percent distribution, and average annual percent change: United States, selected years 1960–2015

United States, there were disparities in these health outcomes, particularly by socioeconomic status and race and ethnicity, with life expectancies lower than 78 and HALEs lower than 70.

Equity was a huge problem, as well, both in terms of having health insurance and the quality of that insurance. “The percentage of adults aged 18–64 who were uninsured increased from 11.9% in 1978 to over 18% by the mid 1990s before climbing to more than 20% in the early years of the 2010 decade” (Martinez, Zammitti, & Cohen, 2017). Inequity in access to health care was also indicated by the wide variation in covered benefits, “junk coverage,” lack of coverage for preexisting conditions, and other characteristics of health insurance policies that affected health care coverage inequitably. Private- and employer-sponsored health plans could and did offer inexpensive plans, but at a price. Poor health insurance policies were characterized by highly restricted benefits and high out-of-pocket expenses for deductibles, premiums, and copayments, as well as lifetime and annual caps on payments.

The number of uninsured and poorly insured patients had serious cost implications for the health care system. Uninsured and poorly insured persons increased the amount of uncompensated care for providers, distorting pricing as providers shifted these costs to patients with better health insurance. In addition, the uninsured and poorly insured had a greater tendency to postpone health care until their condition required emergency room or hospital treatment. Deferred health care exacerbates health problems and makes them more costly to treat.

From the perspective of the individual, the health care system was also a problem:

- People with health insurance feared losing it, especially those with preexisting conditions. For Medicaid recipients, eligibility could be lost as a result of a small increase in income. Persons with employer-sponsored insurance (ESI) might lose health insurance through job loss or job change. Children lost coverage on their parent’s health insurance, often before they were able to afford their own or obtain a job with ESI. The tendency of insurance companies not to cover people with preexisting conditions exacerbated these fears.
- Out-of-pocket costs were increasing, including, deductibles, co-insurance, and premiums (Schoen, Lippa, Collins, & Radley, 2012).
- Fewer and fewer employers were offering ESI. Adults under age 65 had to purchase usually more expensive health insurance on their own or go without (Planalp, Sonier, and Fried, 2015).
- Even though an individual had health insurance, a health condition might not be covered or covered sufficiently to afford care. A major health problem—for example, serious injury, cancer, or stroke—could result in health care bills that exceeded an individual’s ability to pay for care.

The perception of policymakers and the public that we needed to respond to these health care system problems in a significant way propelled President Obama and the Democratic-controlled Congress to focus their attention on health care reform as a signature achievement of the administration. The Obama administration's goals were comprehensive: to bend the cost curve downward, achieve greater equity in insurance coverage, and improve the quality of health care.

How did the ACA try to achieve its goals?

It was apparent early on that reform eliminating any of the existing payers in the U.S. health care system—Medicare, Medicaid, SCHIP, ESI, private health insurance, veterans and military health insurance—would not have sufficient support for passage. Each had its own set of stakeholders with vested interests in continuing their role in the health care system. This fact precluded a popular, but not sufficiently popular, option, the single-payer plan.

Thus, the Obama administration and its supporters in Congress decided that the reform would have to maintain our patchwork system of public and private payers. To address the cost, equity, and quality problems of the health care system, myriad policy changes were needed to “fix” many of the major system problems that were leading to high costs, uninsurance, and disparities in health care quality, while maintaining the existing payers in the system.

An underlying assumption was that cost, quality, and equity are linked as a system, and access to health care is a prerequisite for assuring equity and controlling cost (efficiency). Thus, insuring most, if not all people, was imperative. Access to health care for all, or most, would:

- Reduce the use of expensive care (hospital, emergency room, and urgent care) that results from delaying needed care because of cost.
- Reduce costly exacerbation of health conditions that result when patients delay seeking needed care because of cost.
- Reduce uncertainty and uncompensated care for providers.

To do this within the complex system of private and public payers and the mixed ability of patients to pay for health insurance, existing government health insurance plans were relatively unchanged, with the exception of the expansion of Medicaid:

- Medicare and health insurance for veterans and the military were retained.
- Traditional Medicaid was retained and could be expanded to 138% of the federal poverty level as a state option.
- SCHIP was extended.

It was changes to the private health insurance market that were at the heart of the ACA, and these were aimed at insurance coverage (equity). The ACA did the following:

- Mandated that private health insurance plans meet minimum standards. There are ten essential health benefits that must be included, as well as no-cost preventive benefits with limited cost-sharing.
- Mandated that plans cannot discriminate against people with preexisting conditions (*guaranteed issue*), cannot impose lifetime and annual limits on coverage, and must extend dependent coverage to age 26.
- Created state-based health insurance exchanges for individuals and small businesses to compare plans, apply for financial assistance, and purchase coverage.
- Created the Small Business Health Options Program (SHOP) to help firms with 50 or fewer employees cover their workers.
- Mandated that most citizens and legal residents have health insurance—the *individual mandate*. The private health insurance market is intended to cover everyone not already insured—those

without ESI or government insurance and the uninsured. By mandating that everyone have health insurance, the ACA distributes health care costs over people in poor health and good health (*community rating*), not according to individuals' risk of using health care. Historically, insurance companies controlled their costs by tailoring health insurance policies and pricing to the health care risk of the individual or the risk of the population covered (e.g., employment populations). Under the ACA, the risk of utilizing health care is determined on a larger, healthier mix of people because of *the individual mandate*.

- Provided subsidies for low-income enrollees between 100% and 250% of the federal poverty level (FPL) to reduce patient cost-sharing (e.g., deductibles and copays). The federal government then makes payments to insurance companies directly to cover these reductions (*cost-sharing reduction or CSR payments*).
- Provided refundable premium tax credits, based on income and cost of coverage, for individuals and families with income between 100% and 400% of the FPL.

The *individual mandate* was critical to the success of the ACA as its purpose was to stabilize the private health care marketplace:

“Insurers use the term ‘death spiral’ to refer to a phenomenon wherein a greater number of individuals with high health care costs enroll in a particular health plan, which drives up costs. These higher costs incentivize healthier individuals to drop their coverage and switch to a lower cost (and potentially lower coverage) plan, thus leaving behind an overall sicker pool of people. The sicker individuals are, the more health care goods and services they tend to use, which drives up their health care costs. As a result, premiums for the plan they chose go up the next year as well. Higher premiums mean even fewer people enroll, thus continuing the cycle until the market collapses.

Drafters of the ACA designed the law to avoid a death spiral. They knew that by keeping healthier individuals in the markets, risk of a costly medical event spreads among a broader pool, which can help keep premiums down for the group and prevent a death spiral. To do so, the architects of the ACA created the individual mandate, a requirement that most Americans have health insurance. The individual mandate also had accompanying enforcement (a stick) and assistance (a carrot). The enforcement largely comes through tax reporting, and corresponding penalties for noncompliance with the mandate. Assistance comes in the form of subsidies and tax credits to help people afford the insurance the ACA requires them to obtain. These intersecting components of the ACA, taken together, were designed to increase coverage for individuals, while preventing a death spiral in the insurance markets” (Health Reform Tracker, 2017a).

In addition, the ACA put in place three organizations intended to lower health care costs and improve quality over the long term:

- *Independent Payment Advisory Board*

The Independent Payment Advisory Board, as described by the White House in 2011, as follows: “...outlined a framework for reducing our deficits and debt that is based on the values of shared responsibility and shared prosperity. We know we can’t reduce our deficit without reducing the growth of health care spending. But we also cannot bring down health care cost growth by simply raising costs for seniors and States and ending Medicare as we know it. That’s why the President opposes any plan that would simply place the burden of deficit reduction on seniors and undermine Medicare.

“The President’s framework instead builds on the improvements made by the Affordable Care Act. It tackles Medicare fraud and excessive payments for prescription drugs, proposes a

stronger Federal-State partnership in Medicaid, and includes a series of health care reforms that would save \$340 billion by 2021, \$480 billion by 2023 and at least an additional \$1 trillion in the following decade” (DeParle, 2011).

- *Center for Medicare and Medicaid Innovation*
The Center for Medicare and Medicaid Innovation was established to develop cost savings through health services research, which evaluates the effectiveness and efficiency of health care treatments. “The CMS Innovation Center has a growing portfolio testing various payment and service delivery models that aim to achieve better care for patients, better health for our communities, and lower costs through improvement for our health care system” (Centers for Medicare and Medicaid Services, 2017).
- *Prevention and Public Health Fund*
Preventing health problems is another way to decrease demand for health care, and thus its costs. If fewer people had, for example, diabetes, the cost of care to the health care system would be lower. This is the aim of the Prevention and Public Health Fund. “The Affordable Care Act established the Prevention and Public Health Fund to provide expanded and sustained national investments in prevention and public health, to improve health outcomes, and to enhance health care quality. To date, the Fund has invested in a broad range of evidence-based activities including community and clinical prevention initiatives; research, surveillance and tracking; public health infrastructure; immunizations and screenings; tobacco prevention; and public health workforce and training” (U.S. Department of Health and Human Services, 2017).

How was the ACA financed?

A report by the Congressional Budget Office (CBO) in 2012 identified how the ACA was expected to obtain the money needed for implementation. There are two sources: cutting government spending and raising revenue (Congressional Budget Office, 2012). Cuts to government spending were estimated at \$741 billion, mostly in government changes to payments to doctors and hospitals that provide care to Medicaid and Medicare patients. See Figure 3: ACA Spending Cuts.

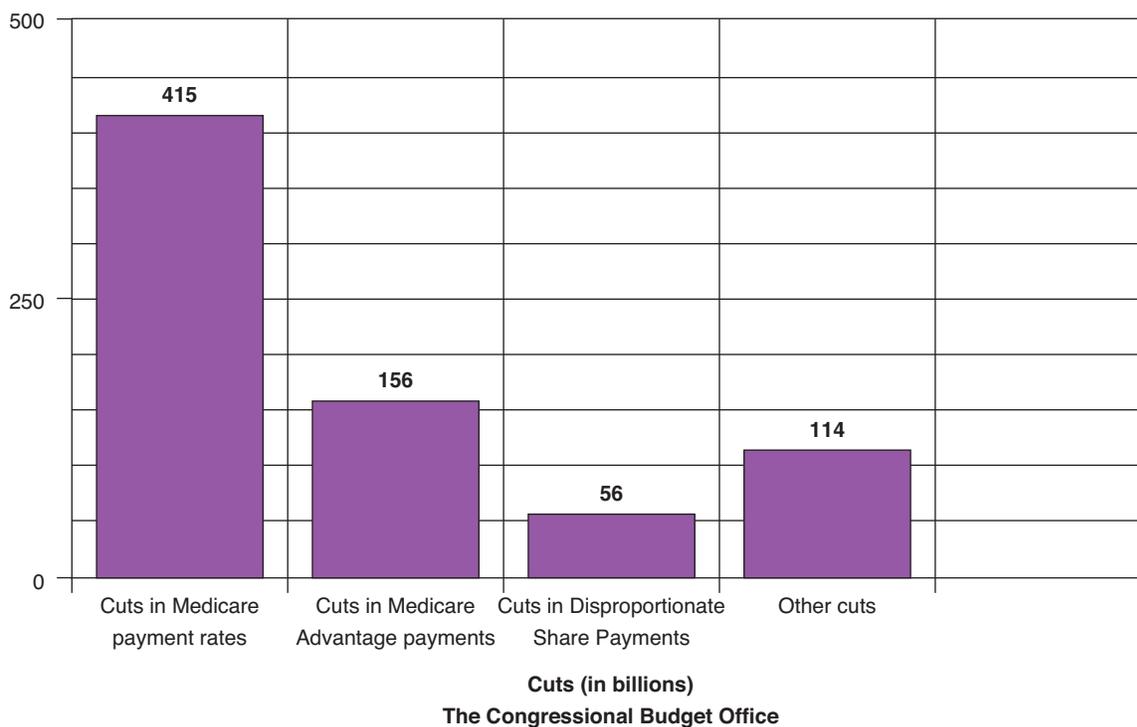


FIGURE 3 Affordable Care Act Spending Cuts, 2013–2022

In addition, new revenue is brought in through various provisions of the ACA. These include a tax penalty for those who do not purchase coverage, which would generate \$55 billion over a decade. A tax on the most expensive, so-called “Cadillac” insurance plans results in \$111 billion. The CBO expected \$216 billion to be saved from the positive side effects of expanding insurance, like reduction in uncompensated care. Another \$318 billion was expected to be generated by having those who earn a gross income over \$200,000 pay 3.8 percent of investment income toward Medicare’s hospital insurance. There are also taxes on drug and medical device makers and insurance companies based on their market share and others. See Figure 4: ACA Revenue Increases:

What was the status of the ACA at the end of the Obama administration?

By and large, people insured under Medicare, Medicaid, SCHIP, large employer ESI, or veterans and military insurance saw little change in their coverage and costs under the ACA. And many people benefited from the specific ACA policies aimed at reducing the number of uninsured and addressing the instability of health care coverage faced by people prior to the ACA’s passage. For example, the provisions of the ACA including mandated coverage for preexisting conditions, mandated minimum benefit plans, and subsidies for low- and moderate-income individuals were helpful to many. For example, the *guaranteed issue* policy helped people in transition: “The Affordable Care Act has enabled many of those workers to get transitional coverage that provides a bridge to the next phase of their lives—a stopgap to get health insurance if they leave a job, are laid off, start a business or retire early” (Abelson, 2017).

And although there still remains an uninsured population, the ACA led to decreased numbers of persons without health insurance. A recent report by Cohen, Martinez, and Zammitti (2017) confirms:

- “In the first 9 months of 2016, 28.2 million (8.8%) persons of all ages were uninsured at the time of interview—20.4 million fewer persons than in 2010 and 0.4 million fewer persons than in 2015 (a nonsignificant difference).

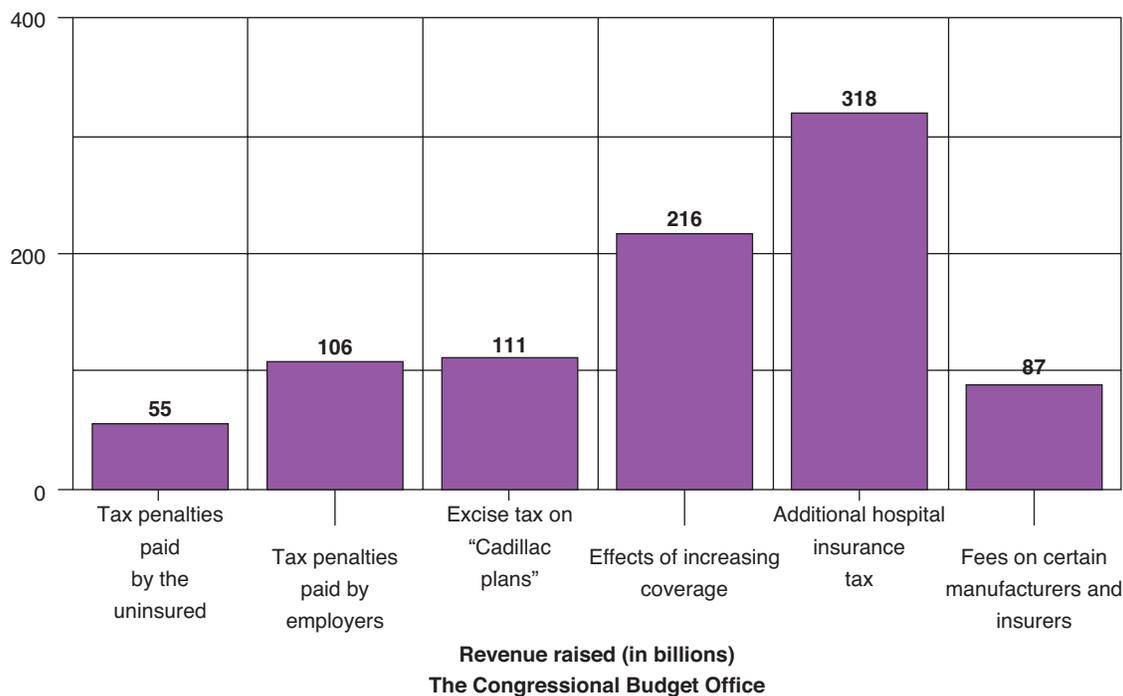


FIGURE 4 Affordable Care Act Revenue Increases, 2013–2022

- In the first 9 months of 2016, among adults aged 18–64, 12.3% were uninsured at the time of interview, 20.3% had public coverage, and 69.0% had private health insurance coverage.
- In the first 9 months of 2016, among children aged 0–17 years, 5.0% were uninsured, 43.4% had public coverage, and 53.5% had private coverage.
- The rates of uninsurance at the time of interview remained relatively stable from 2010 through 2013 for all age groups except adults aged 18–24. Among adults aged 18–24, the percentage of those uninsured decreased, from 31.5% in 2010 to 25.9% in 2011, and then remained stable through 2013” (Martinez, Zammitti, & Cohen, 2017).

The ACA also had a positive impact on uncompensated care, which the ACA counted on to reduce overall health care costs and stabilize provider costs. Using Medicare Hospital Cost Reports from 2011 to 2015, The Commonwealth Fund (2017) found economically meaningful declines in uncompensated care associated with the Medicaid expansion:

Uncompensated care burdens fell sharply in expansion states between 2013 and 2015, from 3.9 percent to 2.3 percent of operating costs. Estimated savings across all hospitals in Medicaid expansion states totaled \$6.2 billion. The largest reductions in uncompensated care were found for hospitals in expansion states that care for the highest proportion of low-income and uninsured patients. Legislation that scales back or eliminates Medicaid expansion is likely to expose these safety-net hospitals to large cost increases. Conversely, if the 19 states that chose not to expand Medicaid were to adopt expansion, their uncompensated care costs also would decrease by an estimated \$6.2 billion. (Commonwealth Fund, 2017)

However, Obamacare was never overwhelmingly supported by the public during the Obama administration. This lack of support was due mainly to problems within the private health insurance market, which is how the ACA intended to provide health insurance for those who did not have Medicare, Medicaid, SCHIP, veterans and military insurance, or ESI. Historically, persons served by the private health insurance market have been the self-employed, small business owners, employed persons whose employers do not offer ESI, or unemployed persons with the means to purchase their own health insurance coverage. Under Obamacare, many people who were already in the private health insurance market faced higher costs because the law eliminated lower-quality, cheaper health insurance plans. Therefore, an often-heard complaint about the ACA was that people could not keep their old insurance policy, as had been promised. To address this problem during implementation, short-term waivers were given for those who wanted to keep policies that did not meet the ACA’s minimum standards.

In addition, people who moved into private insurance markets and did not qualify for subsidies or tax credits under the ACA because they exceeded the qualifying FPL were particularly affected by the cost of health insurance. Recall that subsidies are provided up to 250% of the FPL, which for a family of four is \$61,500 annual income—a moderate, not opulent amount. Subsidies end for individuals earning more than \$30,150 annually. Tax credits then are provided to individuals and families over 250% FPL up to 400% FPL, which end for individuals at \$48,240 and for families of four at \$98,400. See Table 2: Federal Poverty Guidelines, 2017.

These problems have continued into 2017. Health care costs have been rising since the ACA was fully implemented, and individuals and families who exceeded the FPL for subsidies or tax credit have faced higher premiums in the private market:

Health insurance premiums on the Affordable Care Act’s marketplaces (also called exchanges) are expected to increase faster in 2017 than in previous years due to a combination of factors, including substantial losses experienced by many insurers in this market and the phasing out of the ACA’s reinsurance program. (Dox et al., 2016)

TABLE 2 Federal Poverty Guidelines, 2017

Household Size	100% FPL*	133% FPL	150% FPL	200% FPL	250% FPL	300% FPL	400% FPL
1	\$12,060	\$16,040	\$18,090	\$24,120	\$30,150	\$36,180	\$48,240
2	16,240	21,599	24,360	32,480	40,600	48,720	64,960
3	20,420	27,159	30,630	40,840	51,050	61,260	81,680
4	24,600	32,718	36,900	49,200	61,500	73,800	98,400
5	28,780	38,277	43,170	57,560	71,950	86,340	115,120
6	32,960	43,837	49,440	65,920	82,400	98,880	131,840
7	37,140	49,396	55,710	74,280	92,850	111,420	148,560
8	41,320	54,956	61,980	82,640	103,300	123,960	165,280

Note: FPL = Federal Poverty Level

The increases between 2016 and 2017 for people who do not qualify for subsidies or tax credits will range from 9% or lower in 18 states: Arkansas, California, Indiana, Iowa, Kentucky, Massachusetts, Michigan, Missouri, Nevada, New Hampshire, New Jersey, North Dakota, Ohio, Rhode Island, Vermont, Virginia, Washington, and Wyoming. Other states, however, will see larger increases, with five states over 50%: Alabama, Arizona, Minnesota, Oklahoma, Pennsylvania. Each state is different, but the reader should refer to Table 1 in the Kaiser Family Foundation publication (Dox et al., 2016) for the monthly premium costs for 2016 and 2017, in each state, before and after tax credits.

Furthermore, the reader is directed to the website: <https://www.health care.gov>. The costs of various health care plans and eligibility for subsidies and tax credits are provided for each state.

By the end of the Obama administration, even supporters of the ACA acknowledged that the private health insurance market needed attention and revision. The variation in health policy premiums by state and their increasing costs has been a concern about the ACA. There has been a growing consensus that the private market needs to be stabilized and premium costs need to be affordable for all. In addition, some ACA supporters have gone so far as to say that the ACA tweaking of our mixed private/public health care system was not enough and that a single-payer system, based on Medicare, would be preferable. This is the context in which the Trump administration and the Congressional Republican majority began their health care deliberations.

HEALTH CARE REFORM AT THE BEGINNING OF THE TRUMP ADMINISTRATION

What are the Trump administration objections to the ACA?

The 2016 election brought a Republican president and Republican-majority Congress, in both the House of Representatives and the Senate. Republicans in the House had been voting to repeal the ACA since they gained a majority in 2010 mid-term elections, although they knew that President Obama would veto any bill that reached him, and with a Democratic-controlled Senate, no bill to repeal the

ACA would be passed. However, the election of 2016 altered that situation. The Republicans now had the opportunity to bring about change in the health care system by repealing and/or replacing the ACA.

The Republican opposition to the ACA is motivated by a central belief that the problems of cost, quality, and equity in the health care system could be solved more effectively by the private sector—a case of the goals being similar, but the means different. Competition in the private market would lead to greater efficiency and quality and eventually equity, according to the Republicans. They also believe that government regulations hamper the private sector's ability to achieve these goals. As a result, Republican opposition to the ACA has focused on aspects of the law that increased government's involvement in both spending and oversight. Related to spending, these are the Medicaid expansion and federal government subsidies for low-income individuals and families. Related to oversight, the regulatory mandates on the private health insurance market and the *individual mandate* to purchase health insurance are opposed. And the three organizations intended to lower health care costs and improve quality over the long term are opposed on both fronts: Independent Payment Advisory Board, Center for Medicare and Medicaid Innovation, and the Prevention and Public Health Fund. Indeed, a view expressed by many Republican opponents is that the ACA is a springboard to a single-payer system—a total government system—a plan they dislike even more than the ACA.

Funding of the ACA is another point of contention. Many Republicans view the tax sources of new revenue as unfair transfers of wealth from the rich to the poor, the young to the old, and the healthy to the unhealthy.

How is the Trump administration trying to achieve its goals?

Some opponents would like to repeal the ACA and start over with a law that conforms to market principles. Michael Tanner at the Cato Institute expressed this view in April 2017 in the *National Review*:

Republicans would be well advised to stop trying to win a popularity contest and simply do what's right. They need to repeal Obamacare down to the last comma and semicolon, then replace it with true market-based reforms. Those plans are out there. All it would take is for them to face up to a few hard truths. (Tanner, 2017)

However, a replacement, whether immediate or later, would be extremely difficult since it would need to meet certain federal requirements. As Eibner wrote for The Commonwealth Fund:

The Congressional Budget Office is required to produce a 'score,' or budget estimate, for most bills approved by a full committee in both the House of Representatives and the Senate. Each score represents the CBO's best estimate of the 10-year impact of legislation on the federal deficit. Bills scored as deficit-increasing may be difficult to pass given certain statutory and procedural rules intended to prevent new legislation from increasing the federal deficit. (Eibner, 2017)

Furthermore, the ACA is very popular among many people, particularly those in the 30 states that expanded Medicaid under the ACA. Even in the Republican-majority states that expanded Medicaid, such as Nevada, Ohio, Arkansas, Arizona, Iowa, and Louisiana, the public generally supports the ACA, and these governors are reluctant to lose the Medicaid expansion. See the states that adopted the Medicaid expansion and the percent of state population receiving Medicaid in Table 3: State

TABLE 3 State Characteristics Affecting Support for the AHCA and BRCA

	Statistically Significant Increase in Overdose Death Rate, 2014 to 2015 ¹	Adopted Medicaid Expansion by 2017 (n=31) ²	Medicaid & SCHIP Enrollment, April 2017 ³	Total Population Estimate, July 2016 ⁴	Medicaid & SCHIP % of Population	Republican Governor, 2017 (n=33) ⁵	Number of Republican Senators, 2017 (n=52) ⁶
Alabama			622,948	4,863,300	12.8	X	2
Alaska		X	87,553	741,894	11.8	-	2
Arizona		X	-	6,931,071	-	X	2
Arkansas		X	426,133	2,988,248	14.3	X	2
California		X	5,179,413	39,250,017	13.2		
Colorado		X	632,879	5,540,545	11.4		1
Connecticut		X	311,561	3,576,452	8.7		
Delaware		X	104,604	952,065	11.0		
Florida	X		2,604,622	20,612,439	12.6	X	1
Georgia			1,214,895	10,310,371	11.8	X	2
Hawaii			145,025	1,428,557	10.2		
Idaho			213,540	1,683,140	12.7	X	2
Illinois	X	X	1,428,118	12,801,539	11.2	X	
Indiana		X	791,659	6,633,053	11.9	X	1
Iowa		X	307,016	3,134,693	9.8	X	2
Kansas			267,860	2,907,289	9.2	X	2
Kentucky	X	X	568,157	4,436,974	12.8	X	2
Louisiana	X	X	757,013	4,681,666	16.2		2
Maine	X		111,650	1,331,479	8.4	X	1
Maryland		X	604,761	6,016,447	10.1	X	
Massachusetts	X	X	661,050	6,811,779	9.7	X	
Michigan	X	X	944,328	9,928,301	9.5	X	

(continued)

TABLE 3 State Characteristics Affecting Support for the AHCA and BRCA (continued)

	Statistically Significant Increase in Overdose Death Rate, 2014 to 2015 ¹	Adopted Medicaid Expansion by 2017 (n=31) ²	Medicaid & SCHIP Enrollment, April 2017 ³	Total Population Estimate, July 2016 ⁴	Medicaid & SCHIP % of Population	Republican Governor, 2017 (n=33) ⁵	Number of Republican Senators, 2017 (n=52) ⁶
Minnesota		X	511,922	5,519,952	9.3		
Mississippi			456,466	2,988,726	15.3	X	2
Missouri			634,305	6,093,000	10.4	X	1
Montana		X	125,279	1,042,520	12.0		1
Nebraska			158,625	1,907,116	8.3	X	2
Nevada		X	300,527	2,940,058	10.2	X	1
New Hampshire	X	X	92,350	1,334,795	6.9	X	
New Jersey		X	839,032	8,944,469	9.4	X	
New Mexico		X	360,311	2,081,015	17.3	X	
New York	X	X	2,468,569	19,745,289	12.5		
North Carolina	X		1,412,835	10,146,788	13.9		2
North Dakota		X	43,868	757,952	5.8	X	1
Ohio	X	X	1,155,805	11,646,273	9.9	X	1
Oklahoma			535,756	3,923,561	13.7	X	2
Oregon		X	420,614	4,093,465	10.3		
Pennsylvania	X	X	1,380,369	12,784,227	10.8		1
Rhode Island		X	120,239	1,056,426	11.4		
South Carolina			636,826	4,961,119	12.8	X	2
South Dakota			82,107	865,454	9.5	X	2
Tennessee	X		-	6,651,194	-	X	2
Texas			3,494,601	27,862,596	12.5	X	2
Utah			216,091	3,051,217	7.1	X	2
Vermont		X	64,400	624,594	10.3	X	

(continued)

TABLE 3 State Characteristics Affecting Support for the AHCA and BRCA (continued)

	Statistically Significant Increase in Overdose Death Rate, 2014 to 2015 ¹	Adopted Medicaid Expansion by 2017 (n=31) ²	Medicaid & SCHIP Enrollment, April 2017 ³	Total Population Estimate, July 2016 ⁴	Medicaid & SCHIP % of Population	Republican Governor, 2017 (n=33) ⁵	Number of Republican Senators, 2017 (n=52) ⁶
Virginia			658,256	8,411,808	7.8		
Washington		X	842,054	7,288,000	11.6		
West Virginia	X	X	225,382	1,831,102	12.3		1
Wisconsin			490,743	5,778,708	8.5	X	1
Wyoming			38,218	585,501	6.5	X	2

*Sources:*¹Rudd, Seth, David, and Scholl, 2016.²Kaiser Family Foundation, 2017b.³Kaiser Family Foundation, 2017c.⁴U.S. Census Bureau, 2017.⁵Republican Governors Association, 2017.⁶U.S. Senate, 2017.

Characteristics Affecting Support for the AHCA and BRCA. And Democratic-led states concur. The number of Medicaid enrollees alone tells why:

74,531,002 individuals were enrolled in Medicaid and CHIP in the 51 states reporting April 2017 data. 68,884,085 individuals were enrolled in Medicaid and 5,646,917 individuals were enrolled in CHIP. Compared to the period prior to the start of the first ACA open enrollment period (July - Sept. 2013), over 16.7 million additional individuals were enrolled in Medicaid and CHIP in April 2017 in the 49 states that reported relevant data for both periods, representing over 29 percent increase over the baseline period. (Connecticut and Maine aren't included because they did not report data for both periods). (Medicaid.gov, 2017)

Finally, Republicans in Congress and in general are not identical in their views toward the ACA (Silver, 2017). Some are more concerned about the political and social costs of repealing a law that has helped so many people. They are willing to accept modification of the law that would bend toward less government involvement in the private market while keeping other parts of the ACA intact. Others are strongly opposed to the ACA ideologically.

The House of Representatives Bill

The variation in views among those in Congress who are opposed to the ACA is reflected in the House bill, which passed in May 2017. The American Health Care Act (AHCA) proposed a complicated mix of changes to the ACA, not a repeal and replace bill. The AHCA left Medicare, VA and military insurance, and ESI relatively intact. The biggest changes would have occurred in the private insurance market and to Medicaid and CHIP. The AHCA:

- Repealed the *individual mandate* (in 2016).
- Repealed premium and cost sharing subsidies for the private market plans (in 2020).

These totals encompass the 50 states as well as the District of Columbia

- Retained the private market rules for policies sold on the exchanges (e.g., no preexisting condition exclusions), but increased the ability of private insurers to sell policies outside of the exchanges, which do not have to meet the minimum benefit mandates.
- Modified the ACA tax credits so that younger people get more credit and older people get less credit.
- Retained health insurance market places and enrollment periods.
- Encouraged use of Health Savings Accounts.
- Maintained the Medicaid expansion for those states that had adopted it, but phased it out by 2020.
- Converted Medicaid funding to a per capita allotment and limited growth in 2020. This would end Medicaid as an entitlement program.
- Created the Patient and State Stability Fund to provide money to states for multiple purposes such as high-risk pools and cost-sharing subsidies.
- Added a state option to require work as a condition of eligibility for able Medicaid adults.
- Repealed the Medicare high income tax increase and other ACA revenue provisions.
- Defunded the Prevention and Public Health Fund (Kaiser Family Foundation, 2017a).
- Defunded Planned Parenthood.

The Patient and State Stability Fund was intended to influence the private health care market, but in a non-uniform way. States would have the discretion to use the funding as they determined best. As the bill's authors state:

Our plan provides a solution to help repair the insurance market damaged by Obamacare and provide more affordable coverage options to consumers: The Patient and State Stability Fund. This new and groundbreaking fund can help states lower the cost of care for some of their most vulnerable patients.

The \$138 billion fund will help repair state markets damaged by Obamacare. States can use the funds to cut out-of-pocket costs, like premiums and deductibles, or to promote access to preventive services, like getting an annual checkup, or dental and vision care. States could use these resources to promote participation in private health insurance or to increase the number of options available through the market. Even more, they have the option to arrange partnerships with health care providers to support their efforts to provide care. (Energy and Commerce Committee, 2017)

The AHCA would have shifted more cost to individuals purchasing insurance in the private market by eliminating subsidies and reducing federal payments to states for Medicaid by converting the program in 2020 to a per capita allotment. Once Medicaid was funded per capita, growth could be controlled through changes in per capita payments to the states. Low- and moderate-income individuals and families who would be covered in the private market or by Medicaid would be most adversely affected. Despite its negative effects on coverage, the AHCA was viewed positively by its supporters because it was a step toward reducing federal government involvement—funding and regulation—in health care.

The Senate Bill

The last Senate bill developed before Congress recessed in July—the Better Care Reconciliation Act of 2017 (BCRA)—was another complicated mix of changes to the ACA, not a repeal and replace. There were a number of revisions to the Senate bill, but the BCRA never received the 50 votes from Republican senators needed to pass. No Democrats were asked to participate in the process of developing the bill and none voted for it. The June 26, 2017 version of the bill provides insight, however, into the kinds of

changes considered by the Senate. There is actually little difference between the AHCA and the BCRA in their fundamental components:

- Repeal the *individual mandate* (in 2016).
- Repeal premium and cost-sharing subsidies (in 2020).
- Modify tax credits to benefit younger people.
- Encourage Health Savings Accounts.
- Retain the private market rules for policies sold on the exchanges (e.g., no preexisting condition exclusions).
- Maintain the Medicaid expansion for those states that had adopted it, but phase it out by 2024.
- Convert Medicaid to a per capita allotment.
- Create a fund to provide money to states for multiple purposes such as high-risk pools and cost-sharing subsidies—State Stability and Innovation Program.
- Add a state option to require work as a condition of eligibility for able Medicaid adults.
- Repeal the Medicare high income tax increase and other ACA revenue provisions.
- Defund Planned Parenthood.
- Defund the Prevention and Public Health Fund (Kaiser Family Foundation, 2017a).

The differences between the AHCA and the BCRA are in their details such as dates when traditional Medicaid is ended, different federal poverty eligibility levels for subsidies and tax credits, and funding amounts allocated for different components. For example, the State Stability and Innovation Program in the BCRA was allocated \$112 billion in federal dollars over 9 years, while the AHCA's Patient and State Stability Fund was allocated \$115 billion in federal dollars over 9 years. An excellent account of the detailed differences between the ACA, AHCA, and BCRA is given by Levey and Kim (2017) in the *Los Angeles Times*.

One component of the BCRA that is not in the AHCA is the addition of a \$2 billion appropriation for 2018 for grants to states to support substance-abuse treatment and recovery services. The substance abuse inclusion in the BCRA was intended to gain the support of Republican senators in states where the opioid problem is particularly acute, including Florida, Ohio, Kentucky, Louisiana, Maine, North Carolina, Tennessee, and West Virginia. All of these states have experienced a significant increase in overdose deaths since 2015 and have at least one Republican senator (see Table 3: State Characteristics Affecting Support for the AHCA and BRCA).

Both the AHCA and BCRA proposals sought less federal government funding and regulation by converting Medicaid to a per capita allotment and ending the program as an entitlement, eliminating the Medicaid expansion, ending the *individual mandate*, weakening regulation of the private health insurance market through waivers and other means to allow insurers to offer products that are less regulated, and giving money to states that they could spend on their own priorities including high-risk pools and cost-sharing subsidies.

What are the stakeholder positions toward the AHCA and BCRA?

A report by Health Reform Tracker (2017b) summarizes many stakeholder views on the AHCA and the BCRA—advocacy groups, provider organizations, and insurance companies. Advocacy groups including AARP and the American Public Health Association oppose them on the basis of equity issues. Health care provider associations that also oppose them include the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Congress of Obstetricians and Gynecologists, America's Essential Hospitals, American Health Care Association/National Center for Assisted Living, American Hospital Association, American Medical Association, and others. Insurance companies and industry trade groups are generally critical, but

with some insurance company exceptions. The chief executive of America's Health Insurance Plans, Marilyn Tavenner, has criticized the AHCA but did not directly oppose it:

Tavenner explained that the insurance trade group intends to stop the immediate threat of eliminating subsidies for plans sold to low-income people. She also pointed out that insurers do not wish to return to a time before the law was passed when people with preexisting conditions were denied coverage in the individual market. Furthermore, she said that insurers are hesitant to include the creation of high-risk pools because those programs have not been adequately funded in the past. However, insurers in the trade group have also emphasized the need for an alternative since the ACA's penalty is not large enough to persuade enough people to enroll. (Health Reform Tracker, 2017b)

The ACA, AHCA, and BCRA considered

At the start of the Obama administration, virtually all policymakers were concerned about the cost of health care. The trends in spending and percent of GDP for health care were not in dispute. Thus, the authors of each plan put forward since then—ACA, AHCA, and BCRA—viewed rising costs as a big problem for individuals, families, and the country. However, one way to view the difference between the ACA and the Trump administration proposals is that the ACA started with insurance coverage (equity), believing that quality and cost control would follow once the majority of people were insured. After that, the three organizations—Independent Advisory Board, Center for Medicare and Medicaid Innovation, and the Prevention and Public Health Fund—would drive cost and quality improvements over the long term. Quality would be measured, for example, by population life expectancy and healthy life expectancy (HALE), as well as indicators such as decline in ambulatory-care sensitive hospitalizations and hospital readmissions.

The AHCA and BCRA began with the assumption that costs needed to be controlled directly and immediately, and quality and equity would follow later by removing regulations and subsidies for the private market. The AHCA and BCRA achieve cost controls largely through caps on Medicaid spending (per capita funding) and elimination of subsidies and tax credits for low- and moderate-income individuals and families. Therefore, it is not unexpected—since cost control was one of the main objectives of the AHCA and BCRA—that substantial federal deficit reduction was projected by 2026 under these plans, \$118.7 billion under the AHCA and \$321 billion under the BCRA. Most of the savings were produced by cutting Medicaid and reducing subsidies to help people pay for health insurance (Levey and Kim, 2017). It is also not unexpected that the CBO projected a rise in uninsured individuals under the AHCA of 23 million and a rise of 22 million under the current BCRA compared to the ACA, since access (equity) was not the immediate objective of the two proposals but rather an expected long-term outcome.

The AHCA and the BCRA also targeted tax increases on higher-income persons and eliminated these. The idea was that these taxes unfairly took from the wealthy to subsidize the poor and working-class families. This contrasted with the ACA, which assumed that the wealthy could afford to pay more and these taxes were less burdensome for them than for lower-income individuals and families.

What is not addressed by the ACA, AHCA, or BCRA?

It should be noted that none of the plans—ACA, AHCA, and BCRA—tackled a certain set of problems that have enormous influence on cost and access to health care. These include drug and medical device pricing and the maldistribution of health care providers, which leaves many rural and urban areas underserved. The factors affecting where health care providers are located, which determine how much access even people with health insurance have, are complex and difficult to address.

What is the status of the BCRA?

Two other proposals were put forward in the Senate in late July: the Obamacare Repeal and Reconciliation Act, a partial repeal amendment, and the Health Care Freedom Act, a “skinny” repeal amendment. Both bills failed to gain the 50 votes needed in the Senate, which would have allowed Vice President Pence to cast the deciding 51st vote. The Health Care Freedom Act, which would have repealed the individual mandate and the mandate that large employers provide insurance for their employees, narrowly and dramatically failed on the votes of three Republican Senators: Susan Collins of Maine, Lisa Murkowski of Alaska, and John McCain of Arizona. Senators Collins and Murkowski had voted against all previous repeal and replace bills. However, Senator McCain’s “no” vote was quite unexpected and occurred on his return to the Senate just a week after his surgery for brain cancer.

With the defeat of the “skinny” repeal, the ACA remains in place. There are no overt plans to repeal and replace it, although there may be attempts to weaken it by reducing funds for the subsidies that make health insurance affordable for individuals and insurers.

STUDY QUESTIONS:

- What were the cost-saving policies in each bill?
- What were policies that addressed the equity problems in each bill?
- What were the policies that addressed the quality problems in each bill?

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