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The Affordable Care Act: A Study of the Modern United States Health Insurance System

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The Affordable Care Act:

A Study of the Modern United States Health Insurance System

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Abstract

In this paper I examine the outcome of the Affordable Care Act as it pertains to increases in insurance coverage. As part of this, I use prior projections provided before the law took effect by the nonpartisan Congressional Budget Office as a benchmark to determine whether the law met expected growth in insurance rates. The ACA was enacted to make many changes to the U.S. healthcare structure, including the adoption of insurance marketplaces and a cost-sharing system, the expansion of Medicaid, imposing both employer and individual mandates, and consumer protective rules. After examining data gathered by multiple nonpartisan studies, I find that the ACA did not meet expected increases in insurance rates by a range of six to 1.45 percent, and 11.066 million to 12.4 million, respectively. I argue that political polarization as a result of political upset over the law, technical difficulties when opening the Federal exchange, the delay of the individual mandate due to objection over existing policies and related issues, and the delay of the employer mandate resulting from confusion over this portion of the law's complexity were all contributing factors that affected the law's inability to provide the increase in coverage that was expected. Additionally, I examine the proposed changes to the healthcare system provided by both Hillary Clinton and Donald Trump, and find that both policies are faced with issues of their own. I conclude that the ACA has provided a valuable model whose strengths and weaknesses may be used to better shape the healthcare structure in coming years.

Key words: Affordable Care Act, Obamacare, healthcare reform, United States health insurance

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Introduction

The 111th U.S. Senate's writing of the Patient Protection and Affordable Care Act resulted from the culmination of a myriad of growing issues in the current healthcare system, including its unaffordability, inadequate levels of healthcare, and growing number of uninsured Americans. President Barack Obama signed Public Law 111-148 on March 23, 2010 (Legal Content, Inc., n.d.). The Affordable Care Act (henceforth referred to as the ACA in this text) was not an entirely new health insurance system. It is a compilation of programs, regulations, subsidies, and mandates that attempted to complete the insurance system and solve any issues within it (Oberlander, 2012). The goal of the ACA was to provide uninsured Americans with affordable, comprehensive options, transform the healthcare economy, and improve the effectiveness of health care. The ACA was estimated by the Congressional Budget Office (subsequently referred to as the CBO), a nonpartisan federal agency that provides budget and economic information to Congress, to lead to a thirty-two million increase in citizens insured, as of 2016. The law was further projected by CBO analysts to be the reason that ninety-five percent of Americans would be insured within six years (Elmendorf, 2011).

In this paper, I will examine the outcome of the ACA, focusing on increases in insurance rates, with CBO analysts' projections as a benchmark. I will provide information pertaining to why the law did not meet the projections that I chose to use. I will first provide a background on the American healthcare system to elucidate the motivation behind the ACA's enactment. I will then provide an overview of the law, which will be followed by the analysis of its outcome as it pertains to increases in insurance rates. After I will scrutinize reasons why the law did not meet expected increased in insured rates. I will thereafter provide an explanation of ways that both 2016 presidential nominees proposed to improve the law, and an outlook on the probable

consequences of the 2016 election as it relates to the ACA. Finally, I will provide concluding remarks.

A Background

The ACA was an attempt at restructuring the American healthcare system which was on track to become detrimental to Americans' financial health; low insurance rates were leading to significant losses in the healthcare sector and higher taxes for citizens. Further, the government spent increasing amounts of money on the healthcare system, yet it was plagued by inadequate levels of care. I will discuss the issues that were arising from inadequate insurance rates in this section, along with a few of the other issues that were causing a need for reform. Although there are provisions in the ACA that attempt to fix these issues that I will briefly discuss, the outcome of those will not be discussed in this paper; the focus of this text is primarily on insurance coverage rates.

Prior to healthcare reform, insurance rates were alarmingly low. As of June 2009, forty-six million Americans lacked coverage, and without reform that number was projected to rise to seventy-two million by 2040 (United States Council of Economic Advisors, 2009). Low rates of insurance are concerning for several reasons. Citizens incur medical costs regardless of whether they are insured or not. When someone fails to pay a medical bill due to being uninsured and thus unable to afford it, the unpaid bills develop into a significant burden for the rest of society. "Many hospitals perform services that they are never compensated for." For example, in 1989 Georgia incurred an estimated three hundred million dollars in unpaid medical services. The government compensated some of these costs, yet the net loss still amounted to 175 million dollars, an amount equivalent to six percent of the hospital's gross patient revenues for the year (Cicconi & Strug, 1999).

The U.S. government spent approximately 42.9 billion dollars to reimburse healthcare providers for uncompensated costs. The costs that the government cover are paid for by tax dollars; the average citizen pays for medical bills of the uninsured through increased tax burdens. The tax burden on an average family of four in 2008 was 627 dollars; in the absence of reform, this amount was projected to rise to 1,652 dollars by 2030 in 2008 dollars (United States Council of Economic Advisors). Further, the uninsured receive virtually no preventative care; as a result, when the uninsured do receive medical treatment, their conditions are more difficult to treat and more expensive (Cicconi & Strug).

The U.S. spent more money on its healthcare system as a percentage of the gross domestic product in 2008 than any other country (Rak, et al., 2013). In 2011, spending on healthcare was almost one-fourth of the gross domestic product (World Health Organization, 2013). Further, Americans were not receiving proper preventive care. Preventive care deficits were found to contribute to the number of preventable deaths. “These deficits, which pose serious threats to the health and well-being of the U.S. public, persist despite initiatives by both the federal government and private health care delivery systems to improve care” (Adams, et al., 2003). To illustrate the futility of the U.S. healthcare system, a comparison may be made with the Canadian healthcare structure. Canada spends less on its healthcare system, yet the country provides universal healthcare; there are no co-payments, premiums, or deductibles. Canada spent only 10.4 percent of its GDP on healthcare in 2005, compared to sixteen percent that the U.S. spent. As of 2007, the U.S. spent twice as much as Canada on health expenditures per capita (O’Neill & O’Neill, 2007). For these reasons, it becomes clear that healthcare reform was merited. In the following section, I will provide a summary of the alterations the law made to the U.S. healthcare system in an attempt to solve the aforementioned problems.

An Overview of the Affordable Care Act

Insurance Marketplaces and a Cost-Sharing System

To make insurance accessible to everyone, insurance marketplaces were made available through the ACA in October 2013. These exchanges were set up individually by state, or if the state opted not to, the government created one for them. Individuals fill out an application either by phone, mail, or online, and the application assesses what insurance plans they are eligible for and the cost of available plans. The plans work on a four level set up, from bronze to platinum. Bronze has the highest deductibles and lowest monthly rates, while platinum has the lowest deductibles and the highest monthly rates (Hidalgo, 2013). Every plan on the exchange is required to meet health care criteria deemed essential by the Secretary of Health and Human Services (42 U.S.C. § 18071(c)(IV)).

Many Americans lacked healthcare coverage due to the inability to afford it. The ACA integrated cost sharing in an attempt to solve this issue. Out-of-pocket expenses are reduced for those who are above one hundred percent of the federal poverty level but below four hundred percent, and are enrolled in a silver level of insurance: The out-of-pocket spending limit is reduced by two-thirds for those who are over one hundred percent of the federal poverty level and under two hundred percent. It is reduced by one-half for those above two hundred percent of the federal poverty level but under three hundred percent. Out-of-pocket spending is reduced by one-third for those over three hundred percent of the federal poverty level but under four hundred percent. Health insurance providers report to the Secretary of Health those who are eligible for cost sharing benefits, and the Secretary reimburses the provider for the amount not paid by consumers (42 U.S.C. § 18071(c)(IV)).

Medicaid Expansion

Medicaid expansion is a large part of the ACA's attempt at covering more Americans. All adults – including those without children (Iglehart, 2010) - who have an income of below 133 percent of the federal poverty level are eligible for Medicaid. This part of the law was projected by the CBO to provide coverage for sixteen million citizens (Sommers, & Epstein, 2010). Although Medicaid expansion is free to the states (it is fully funded by the government), some states chose not to expand their coverage; it is believed by some that the government funding of Medicaid expansion steps on the state's control of the program (Iglehart).

Individual Mandate

To support the healthcare system and decrease the amount of government spending it required, the ACA mandated that all Americans obtain health insurance coverage no later than March 31, 2014 or pay a tax penalty (Pear, 2013). Prior to healthcare reform, people with health insurance paid increased insurance rates to contribute to the healthcare costs of uninsured Americans incapable of paying their medical bills. Requiring health insurance coverage ensures everyone who can afford it take responsibility for their health care costs. The tax penalty was one percent of the uninsured individual's income, or ninety-five dollars, whichever is higher. The fee for children in 2014 was 47.50 dollars per child. The fee increases steadily every year. In addition to the fee, people without insurance also have to pay all of their medical bills with no assistance. People too poor to afford insurance, however, are exempt from the fee. Members of a federally recognized Indian tribe as well as those belonging to religious sects of which health insurance goes against beliefs will also be exempt from the mandate (United States Government, n.d.b).

Employer Mandate

In addition to an individual mandate, the ACA also contains an employer mandate. This mandate applies to what the legislation considers large employers, or those who have more than fifty full-time/full-time equivalent employees. Part-time employees (those working less than thirty hours a week) are combined to figure full-time equivalents, and these equivalents are used to determine whether an employer meets the fifty full-time employee threshold.

Employers must offer coverage of minimum value to at least ninety-five percent of their full-time employees and their dependents up to age twenty-six. If they do not, the employer is subject to a penalty of two thousand dollars per full-time employee if said employee qualifies for a tax credit to purchase health insurance through the exchange. Because employees qualify for tax credits if they are within four hundred percent of the federal poverty level, chances are likely that a large employer is subject to the penalty if they do not offer at least minimum insurance coverage to the ninety-five percent. Large employers who offer plans that do not adhere to new guidelines for what is considered minimum coverage will have to update their plans, or possibly pay the penalty (Salazar, 2015).

Ninety-five percent of privately insured Americans obtain coverage through their employer, and most are satisfied with the coverage they pay for. The employer mandate dissuades employers from dropping employees into a market where coverage is more expensive and less comprehensive. Furthermore, low and moderate income employees would be eligible for tax credits through the exchange if they had to purchase coverage through the exchange, and this would increase government spending (Jost, 2015).

Consumer Protective Rules

There are a few consumer protective rules written into the ACA. For instance, health insurers can no longer take away an enrollee's coverage because they become sick. Omission or

incidental errors in an individual's insurance application is not grounds for coverage rescission. The Secretary of Health works to determine whether an insurance provider has discouraged an individual from maintaining their policy because of illness. Individuals are able to take advantage of an appeals process that protects against "waste, fraud, and abuse." An investigation determines whether their coverage has been rescinded for any other reason than that of fraud, intentional lying about material facts, or not paying their premiums. Likewise, if an individual has a preexisting condition, insurers are prohibited from denying coverage to that person. In 2010, a high risk insurance pool was created for citizens of the U.S. or individuals lawfully present in the country that were not covered under a creditable plan within six months of applying, to provide immediate insurance to those previously unable to obtain coverage (42 U.S.C. § 18001(c)(IV)) due to rescission or denial because of preexisting conditions.

Children are now able to stay on their parents' health insurance plans until age twenty-six, so college students are not faced with the burden of paying for health insurance while they are in school. Even if individuals are married, not living with parents, not financially dependent on parents, and eligible to enroll in their parents' plan themselves, they are still allowed to stay covered under their parents (United States Government, n.d.c).

To address the shortage of healthcare personnel in the country, the law created incentives for medical students in college. 150,000 dollar grants are given out annually to state workforce boards if they have/are "at least one representative from health care employer, labor organization, a public 2 or 4 - year institution of higher education, the recognized State federation of labor, the State public secondary education agency, the State P – 16 or P – 20 Council if such a council exists, and a philanthropic organization." There are loan repayment

options available for healthcare personnel working in medically underserved areas (Association of University Centers on Disabilities, 2010).

The United States spent twice the amount of money on health insurance administrative costs as they did on heart disease, and three times the amount spent on cancer in 2012. In an attempt to improve the quality of care for U.S. citizens, the ACA does not allow healthcare providers to spend excessive amounts of consumer money on administrative costs. This is to ensure that consumer money is spent directly on health care. Providers may save up to eleven billion dollars a year if they comply with the standards required through the Act (Cutler, et al.). A medical loss ratio of 80/20 was implemented, meaning that providers must spend at least eighty percent of consumer money on healthcare and only twenty percent on administrative costs. Healthcare providers that violate this ratio are forced to return the extra money spent to customers through rebate checks (Lee, 2013).

America's healthcare spending could decrease if citizens took advantage of preventive services available to them. "Seventy-five percent of all health care costs in our country are spent on the treatment of chronic diseases, many of which could be easily prevented" (Trust for America's Health, 2013). To help increase the country's health and thus reduce money spent on preventable diseases, preventive health care services are available to Americans at no additional costs. "We will require insurance companies to cover routine checkups and preventive care, like mammograms, colonoscopies, or eye and foot exams for diabetics, so we can avoid chronic illnesses that cost too many lives and too much money." These services theoretically increase the health of Americans and lead to less money being spent on healthcare (Office of the Press Secretary, 2009).

Outcome of the Affordable Care Act

In the preceding section, I put forth the components of the ACA and the issues they set out to address. In this section, I will use a number of nonpartisan data sources to determine whether one particular improvement, the expected increase in citizens insured, was realized. I use the CBO's estimates of an increase of thirty-two million people insured by 2015 and an insurance rate of ninety-five percent within six years of the Act passing as a benchmark. I first researched data aggregated by the U.S. Census Bureau regarding health insurance coverage in the U.S. from 2010 to 2015. The data was gathered through the Current Population Survey and the Annual Social and Economic Supplement. The Current Population Survey uses a probability selected sample of approximately sixty thousand households that are located across all fifty states and the federal district. They administer a questionnaire through personal and telephone interviews (United States Census Bureau, n.d.).

The data retrieved from the 2010 and 2015 Current Population Survey Annual Social and Economic Supplement and the Current Population Survey indicated a decrease in citizens uninsured from 49.9 million uninsured in 2010 to 28.966 million uninsured in 2015. Thus, the data indicated a 20.934 million increase in citizens insured. This falls short of the CBO's expectation to have an increase in thirty-two million citizens insured by 2015. The percentage of citizens covered by any health plan in 2014 was 89.6 percent. The insured percentages for 2013 and 2015 were 86.7 percent and 90.9 percent, respectively. With a 2.9 percent increase from 2013 to 2014 and a 1.3 percent increase from 2014 to 2015, it stands to reason that averaging these two rates of change to roughly estimate an increase in citizens insured by 2.1 percent in 2016 is plausible, with a resulting ninety-three percent of Americans insured. This falls short of the ninety-five percent projection of citizens insured within six years of the Act's passing, but it does indicate that reaching this percentage within the next few years is a realistic assumption.

Direct purchase insurance plans (4.9 percent) and Medicaid (two percent) experienced the largest increase in consumer coverage from 2013 to 2015. It is also worth noting that uninsured rates from 2009 to 2010 were not statistically different – and this minor change was an increase in the uninsured: forty-nine million in 2009 and 49.9 million in 2010 (Barnett & Vornovitsky; DeNavas-Walt et al., 2011). Significant changes in uninsured rates were seen after the implementation of the Act, which is indicative of its effectiveness in getting the population insured.

I then accessed the Centers for Disease Control and Prevention to evaluate the data gathered from the National Health Interview Survey for 2010 through 2015. 2015 statistics in this report are only for the first quarter. The survey is conducted through face-to-face personal interviews and spans forty-two thousand households per year (National Center for Health Statistics, 2016). The data reported an increase in the number of people insured from 2010 to 2015 of 19.6 million (48.6 million uninsured in 2010 and twenty-nine million in 2015.) Again, the data provides that the expected estimate was not met. The data reported an increase in citizens insured from 2013 to 2015 of approximately 19.6 million Americans. The percentage of citizens covered by any health plan was 90.9 percent in 2015, 88.5 percent in 2014, and 85.6 percent in 2013. Averaging the rates of change over the previous three years results in an estimated increase of insured persons by 2.65 percent, with a resulting estimate of 93.55 percent citizens insured in 2016. This too falls short of the CBO's rate estimate, but provides reassurance as to the feasibility of reaching the expected thirty-two million insured increase and ninety-five percent rate of coverage in the near future.

Other notable statistics include a decrease in persons who failed to obtain medical care due to cost to 4.5 percent in 2015, which is promising, after the same percentage had increased

from 4.3 percent in 1999 to 6.9 percent in 2010 (Ward, et al., 2016). This could indicate that initiatives to decrease medical costs in the ACA have been effective.

I accessed Gallup, Inc. in an attempt to obtain statistics reported by a non-governmental entity. This data relates to statistics relevant during the second quarter of every year. The data was obtained through telephone interviews conducted between April 1, 2016 and June 30, 2016 and consisted of a random sample of 46,060 adults. The results obtained through Gallup indicated a slightly smaller increase in insurance rates since the ACA's implementation, although it does report that the uninsured rate is at a historical low. The percent uninsured in the second quarter of 2010 was approximately 16.5 percent; this number decreased to a record eleven percent in the second quarter of 2016 (Marken, 2016). Unlike my other statistical sources that only have data for 2015 (their 2016 data is not available at this time), Gallup has actual evidence regarding health insurance coverage in the 2016 year-to-date, and a more solid affirmation regarding the failure to reach a ninety-five percent insurance rate within six years of 2010 is realized. Significant change in the uninsured rate is unlikely to occur, because the most recent open enrollment period ended on January 31, 2016. I was unable to access the raw data pertaining to these statistics, so testing whether an increase in insured citizens by thirty-two million occurred cannot be commented upon.

Worth noting is the overall increase in uninsured rates that occurred between 2010 and 2013, when it reached its record high in the last eight years at 17.1 percent before declining sharply after the marketplace went into effect. A 2.7 percent increase in Medicaid coverage was seen from 2013 to 2016. Plans fully paid for by self or family member increased by 4.2 percent between 2013 and 2016, while plans through current or former employers decreased by 0.7 percent (Marken).

The data retrieved from the 2010 and 2015 Current Population Survey Annual Social and Economic Supplement, the Current Population Survey and Centers for Disease Control and Prevention as well as the National Health Interview Survey for 2010 through 2015 indicates that Congress failed to achieve the CBO's projection of a thirty-two million increase in insured citizens by 2016 by a range of 11.066 million (DeNavas-Walt, et al.) to 12.4 million (Ward, et al.). It is important to note that these figures are comparing 2015 data; a significant change in these figures is unlikely to have occurred in the last year, so it is safe to assume that the expected estimate was not met. Percentages pertaining to coverage vary by source, but at the minimum eighty-nine percent (Marken) of Americans are insured as of 2016, and an estimated maximum (calculated by averaging rates of change from data gathered from the National Health Interview Survey for the years 2013 through 2015) does not exceed 93.55 percent.

Based on the previously reported evidence, I conclude that the ACA has not increased the number of Americans insured by thirty-two million as of 2016, and that although the ACA has made progress toward the CBO analysts' expectation of insuring ninety-five percent of Americans within six years, this goal will not be realized within the time frame expected. There is a plethora of possible justifications as to the aforescribed stunting in growth of insured rates. I will describe these in the following section.

Failure to Meet Expectations: An Analysis of Possible Drivers

A contributing factor to the ACA falling short of its goals is due in part to the hurdles the law was faced with. The ACA was passed in 2010, taking advantage of a rare opportunity: A Democratic House and Senate. The ACA passed without a single Republican vote. "Within minutes of the President's signing the bill, a group of state attorneys general challenged the law's constitutionality in a federal district court in Florida" (Dietrich & Dolgin, 2011). Eventually

more than a dozen states would challenge the law's constitutionality. Immediately following the Act's passage, fears arose regarding the government's control becoming too far-reaching (Dietrich & Dolgin). Republicans gained the majority in the House of Representatives through using the platform of reducing the role of government, taxes, and the deficit. Their strategy to accomplish this was to fight the implementation of the ACA – in essence, to protect individual freedom and decrease the role of the government. “Since the beginning of 2011, Republicans have spent no less than fifteen percent of their time on the House floor trying to repeal ObamaCare” (Levin, 2013).

Within a year of the Act's passing, twenty-eight states were involved in suits challenging the law, and five courts had reached decisions: two upheld the individual mandate, and two invalidated the mandate. Other judges stopped challenges to the law based on various procedural grounds. In November 2010, Republican Representative Ted Poe of Texas claimed that the law was an oppressive force on Americans, that it coerced Americans without their consent, and that the Constitution does not provide language permitting the use of governmental force to encourage the purchase of insurance. Several days later, the Republic majority in the House, as well as two Democrats, voted to repeal the ACA. Repeal was, of course, virtually impossible due to the Democratic Senate majority (Dietrich & Dolgin).

Because conservatives could not replace the Act unless they had the necessary Republican majority in the Senate, Republicans in the House instead took the stand of refusing to fund the ACA. Chad Mulvany, technical director of the Healthcare Financial Management Association, foretold the government dilemma that would be created around the ACA's implementation. He discussed the process that entails all the funds for the law having to pass through separate annual congressional appropriation bills, and how this would enable

Republicans to withhold funding for the implementation of the ACA. Republicans could also write rules into appropriations bills to prohibit federal employees from spending time on any activity related to the law, and the Senate probably would not pass that bill, nor would the president sign it. He foresaw a government shutdown resulting from the sparring parties (Mulvany, 2010). A government shutdown was indeed the outcome of the Republican battle against the ACA. Both parties failed to come up with an agreement for funding the government through the September 20, 2013. Republicans refused to further fund the government unless the healthcare law was defunded, and the Democrats refused to pass a spending bill that would include any overhauls to the ACA (Montgomery, Helderman, & Branigin, 2013).

In October 2013, the Supreme Court ruled in a landmark decision on the constitutionality in the *National Federation of Independent Business, et al. v. Sebelius, Secretary of Health and Human Services* case. The individual mandate was upheld:

... The individual mandate may be upheld as within Congress's power under the Taxing Clause. ... The payment is not so high that there is really no choice but to buy health insurance; the payment is not limited to willful violations, as penalties for unlawful acts often are; and the payment is collected solely by the IRS through the normal means of taxation.

After repealing the law failed, Republicans then wanted to delay the ACA's implementation for a year, which the Democrats once again refused (Memoli, 2013). Their last effort was that of a measure that would force members of Congress to have insurance through the exchanges (rather than employer-based insurance) and ridding the ACA of a tax on medical devices that helps fund the law. This too failed. With the government one day away from defaulting and the House of Representatives suffering from increasingly low public opinion, the sixteen-day government

shutdown came to an end on October 16, 2013. The House of Representatives achieved one small victory as a result of the shutdown: The “strengthening [of] safeguards against fraud among recipients of federal health-insurance subsidies.” They agreed to temporarily fund the government with no defunding of the ACA (Montgomery, Helderman, & Branigin).

This political upset may have resulted in less people eventually obtaining insurance as a result of the law for the following reason: the political battle served to exacerbate polarization among the public; Americans who may not have had much actual knowledge regarding the law became starkly against it because the Republican party was. Citizens who have less predispositions related to pertinent values and principles can be influenced by affiliated party opinions. These individuals let their party provide cues that guide them on how to feel on various public policies. “It is widely believed that what political parties say and do in policy debates has a marked influence on citizens’ policy views” (Leeper & Slothuus, 2013). This belief may have contributed to decreasing public approval rates of the Act during the Republican crusade to dismantle the law; in December 2012, Gallup polls indicated that approval was at forty-eight percent, disapproval was at forty-five percent, and seven percent of the population had no opinion. But in June 2013, approval had dropped: fifty-two percent disapproved of the law, forty-four percent approved, and only four percent had no opinion (Newport, 2013). The implications of the public’s polarization may be seen through the objections that were raised against the Act and the ensuing extensions that were made to accommodate a disapproving public.

Significant delays in the implementation of the law may be a contributing factor to the ACA not expanding coverage as broadly as planned. The first delay was experienced by the Federal insurance exchange, which resulted in a smaller number of citizens signing up for health

insurance than expected. The Federal online marketplace launched on October 1, 2013 for U.S. citizens who lived in states that had opted out of their own marketplace. The website immediately experienced malfunctions as 250,000 users concurrently accessed the website. Of all the attempts at enrollment, only six applicants were able to select an insurance plan the first day. Undeniably disastrous, the website outages created new ground for opponents of the Act to speak against. So widely reported were the issues regarding the website, programmers working to fix the site initially checked progress on coding through CNN, as the news outlet was continuously reporting on the condition of the marketplace (Levinson, 2016). Then-U.S. Chief Technology Officer Todd Park reported that the government was expecting a mere sixty thousand simultaneous users; malfunctions were a result of poor capacity planning. The capacity was based on Medicare.gov's all-time high use of thirty thousand simultaneous users. Critics pointed out that anyone with any knowledge of the public's interest in the exchange would have known to build for excess capacity (Mullaney, 2013).

Correcting the website's issues became difficult when, the day of the launch, the government shut down. Marketplace staff was reduced to one-third its normal levels for the duration of the sixteen-day shutdown. Outside contractors were hired to fix the bugs plaguing the site. By the end of November, functional capacity was at ninety percent. In 2014, preparation for the next open enrollment period at the end of that year went under way. Programmers worked to improve the navigation within the site to reach a wider range of eligible citizens. Staff also worked to improve communication regarding the importance of updating and providing more accurate estimates of income; an estimated half of consumers underreported their income in the first year of enrollment which made them eligible for tax credits, but when taxes came due, they owed income tax because they had taken credits when they were not eligible. Frustration

regarding the website's malfunctioning and annoyance that people may have felt when they were faced with paying more income taxes than they expected might have contributed to less people signing up for or remaining enrolled in health insurance coverage through the exchange. In fact, the website reported success in June 2015 when it was found that 9.9 million consumers had signed up for health insurance through the marketplace, but this statistic fell short of the CBO's estimate of thirteen million enrollees (Levinson).

In addition to issues with the exchange, Americans began receiving notifications of current policy cancellations. These notices were numerous; in Pennsylvania, an estimated 215,000 to 250,000 people were notified that their health insurance was being cancelled in 2013 because it did not meet new coverage requirements included in the law. Forced to turn to the exchange, they were faced with plans that were much more expensive than their current policies (Iorfino, 2013).

Although subsidies make obtaining health insurance coverage attractive for low-income Americans, many members of the middle class felt they were being forced to pay for others' medical expenses because, without subsidies, many plans on the exchanges are significantly more expensive than their previous plans. Kelli Kennedy interviewed Dean Griffin regarding his policy cancellation and the cost for a replacement plan in her article "Affordable Care Act Sign-Up: Sticker Shock Often Follows Insurance Cancellation" (2013). The Philadelphian family's previous plan was 770 dollars a month with a 2,500 dollar deductible; on the exchange, they were faced with a bronze tier plan with a monthly premium of over a thousand dollars and a 12,700 dollar deductible.

Unaffordability of replacement plans and the influx of policy cancellations required action on behalf of the government; on December 19, 2013, individuals whose policies were

cancelled because of noncompliance with minimum coverage guidelines were deemed qualifiers for the hardship exemption of the law if they found other options to be more expensive and were able to purchase catastrophic coverage (Cohen, 2014). It was also expanded to those whose state opted out of Medicaid expansion, thus making them ineligible (United States Government, n.d.a). This exemption was valid through October 1, 2016 (Cohen). The hardship exemption was initially applicable for a myriad of issues that would result in Americans experiencing hardship, including being homeless, coming evicted or facing eviction or foreclosure, receiving a shut-off notice from the utility company, domestic violence was experienced, there was a death in the family, there was a fire, flood, or other natural or human-caused disaster, and more (United States Government, n.d.a). It stands to reason that allowing Americans to claim hardship exemptions for reasons other than previously mentioned affected the number of people who have purchased health insurance, and is a factor in why the ACA did not meet insurance rate expectations as of 2016 – after all, the expansion on the hardship exemption does not end until the fourth quarter of 2016.

In addition to the extension of the individual mandate that was discussed above, the employer mandate was also extended. The complexity of this portion of the law confused employers – for instance, seasonal employees are usually not considered in determining the employee threshold, and affiliated employers may be treated as a single employer for determining employee numbers. Further, determining the status of salaried employees and those whose hours fluctuate greatly is also difficult. The Act attempted to decrease the burden of figuring full-time employee numbers by allowing employers to track hours over a period of time, but they only increased employers' record-keeping burden because of its complexity (Jost, 2015). These complexities, combined with backlash regarding the forcing of employers to

provide insurance to their employees, raised fears that massive layoffs would be seen in the workforce. This served to be a great source of misinformation about the law; backlash was so large and confusion so great that the government extended the employer mandate's deadline.

The employer mandate was supposed to go into effect on January 1, 2014 (Swanton, 2016). The mandate was extended and a gradual phase-in approach was adopted. Larger firms (more than one hundred employees) had to comply by 2015, and employers with fifty or more employees had to comply by 2016. Employers had to offer coverage to seventy percent of full-time employees in 2015 and ninety-five percent in 2016, to give employers that, for example, may offer coverage to employees working more than forty hours but not yet offering coverage to those who work more than thirty, time to comply. Employers with plan years that do not start on January 1 are able to begin compliance at the start of their plan year, instead of January 1. The retrospective method of determining the employee threshold remains effective, but there is also an alternative monthly method and additional clarifications to assist employers. The Treasury and Internal Revenue Service issued final regulations to simplify and streamline the reporting requirements (U.S. Treasury Department, 2015).

Like the individual mandate, extensions provided to employers likely decreased the number of citizens that would have otherwise gained health insurance by 2016. Ninety-five percent of privately insured Americans obtain their coverage through an employer (Jost), and “more than half of the U.S. population (55.1 percent) had employment-based health insurance coverage in 2011, and among the employed population aged eighteen to sixty-four, over two-thirds (68.2 percent) had health insurance through their own employer or another person's employer” (Janicki, 2013). Now that I have provided an understanding of the drivers behind the ACA's falling short of meeting expectations per increases in insured rates, I will delve into

proposed ways to reshape the existing law or enact a different healthcare structure to obtain the increase in insured rates that the current legislation failed to.

Future Reforms to the Healthcare System

There is a multitude of suggested ways that the ACA could be improved upon or abolished to establish a more successful policy. Improving or abolishing the law would serve to accommodate disapprovers and possibly entice those still uninsured to obtain health insurance, thus aiding the healthcare system in achieving the projections that the ACA has failed to. In this section I will discuss proposed changes to the law by the 2016 Democratic Presidential nominee Hillary Clinton and Republican President elect Donald Trump, to provide an understanding of what will happen to the ACA and the U.S. healthcare system going forward. Comparing Democratic and Republican viewpoints provides an insightful contrast in healthcare ideology; further, it has been shown that candidates do not always follow through on promises made on the campaign, so there is some uncertainty about what will actually happen under the Trump Administration. Because of this, and the fact that 43.36 percent of Congress is comprised of Democrats, I include Clinton's proposed policy; I assume that this Democratic minority shares her views, and will attempt to bring them to fruition.

Hillary Clinton believes that the ACA was a "critically important step" (Hillary for America, n.d.) toward obtaining health insurance coverage for every American. She promised to increase the functionality of the ACA markets by offering additional subsidies, tougher cost controls, continued delivery system reform, and inciting an aggressive outreach program to increase enrollment (Meyer, 2016).

According to "Hillary Clinton's Commitment: Universal, Quality, Affordable Health Care for Everyone in America", there are a few changes Clinton wishes to implement to improve

upon the ACA. Clinton puts forward that incentives should be given to encourage states to expand Medicaid so that its access is not dependent on where a person lives. If this had been successful, approximately three million Americans would have been able to enroll in coverage under Medicaid (Hillary for America). She maintains that immigrants should be able to purchase health insurance coverage regardless of their immigration status. Additionally, she planned on expanding Medicare to permit the enrollment of those older than fifty-five. Clinton asserts that expanding Federally Qualified Health Centers through doubling their funding for primary care services would aid in establishing universal healthcare, as twenty-five million Americans currently receive their care from these centers. Community health centers save the healthcare system approximately forty-nine billion dollars annually, and she believes that expanding Federally Qualified Health Centers would provide a substantial return on investment through increased savings for the healthcare system. Clinton further believes that healthcare costs need to be contained; to achieve this, she planned on giving the Secretary of Health and Human Services the authority to block or modify unjust premium increases. She recognizes the increasing out-of-pocket and prescription drug costs, so she had comprehensive plans to cap drug costs and limit out-of-pocket costs for families. She acknowledged the issue pertaining to stifling drug revenues and the decline in research and innovation that would likely occur, and planned on placating drug companies throughout the process of making these drugs more affordable (Hillary for America). The fate of these proposed changes, should Clinton's presidency have been realized, were questionable at best: Douglas Holtz-Eakin, former director of the CBO, noted that Clinton's agenda would be "dead on arrival" because there is no money to fund it and Republicans strongly oppose it (Meyer).

On the other hand, Donald Trump plans to ask Congress to fully repeal the ACA “on day one of the Trump Administration.” Trump claims that no person should be required to buy insurance unless they wish to, and eliminating the individual mandate is a priority. He plans on implementing a series of reforms that will give freedom to the economy through aligning reforms with free market principles (The Trump Organization, n.d.).

It appears that Trump will hand health policy issues over to House Speaker Paul Ryan. Premium subsidies may be reduced and restructured, and possibly eliminated altogether as the elimination of the ACA would also abolish the revenue it is earning; as veteran Republican health policy expert John Goodman notes, there would be no way to fund subsidies. Conservative House members have proposed taxing employer health benefits to provide funding for subsidies (Meyer).

He plans on modifying existing legislation that inhibits the sale of health insurance across state lines; by encouraging full market competition, insurance costs would presumably decrease. He believes that individuals should be permitted to use Health Savings Accounts, the contributions to which would be tax-free and permitted to accumulate. These would be allowed to be inherited by heirs upon the contributor’s death, could be used by family members, and might prove to be attractive to young citizens who are healthy and can afford high deductible health plans. Trump states that “we must review basic options for Medicaid and work with states to ensure that those who want healthcare coverage can have it” (The Trump Organization); however, he goes on to claim that because most states already offer benefits beyond the required Medicaid structure, states should receive block grants to decrease the federal bureaucracy states are subject to. Further, to reduce the individuals that need access to Medicaid, he asserts that programs need to be installed that would bring jobs back to America (The Trump Organization).

The CMS Innovation Center and the Medicare Independent Payment Advisory Board would be eliminated, and Holtz-Eaken suggested that the Trump Administration might try to move Medicare into a premium support program wherein the privatized Medicare Advantage Program would adopt a competitive bidding structure that would eventually jettison CMS price fixing entirely (Meyer).

Trump believes that increases in the transparency of the reporting on prices charged for medical procedures is critical to allow citizens to find the best prices for procedures. He also believes that Congress disregarding special interests and removing entry barriers in the free markets for drug providers, along with allowing consumers to access imported overseas drugs, will bring more options to consumers for obtaining affordable pharmaceuticals. To further increase the affordability of health insurance, Trump proposes allowing individuals to deduct health insurance premiums from their tax returns, because according to him, businesses are allowed to do so under the existing legislation (The Trump Organization). It is worth noting that this statement is false; the tax benefit of employment-based health insurance coverage goes to employees, not the employer. Employees that pay a portion of the cost of health insurance for workers do not have that portion of pay included in their taxable income (Custer, 2016). Trump states that enforcing immigration laws and restricting the issue of visas would relieve healthcare cost pressures on governments by saving a reported eleven billion dollars annually (The Trump Organization).

The policies that the nominees vouched for throughout their campaigns are both faced with substantial obstacles. Where the monetary sources to make Hillary Clinton's proposed policies would have come from remains undetermined. According to the Congressional Budget Office's January 2015 *Updated Estimates of the Insurance Coverage Provisions of the*

Affordable Care Act, gross costs for subsidies issued for insurance purchased through the exchange will amount to 1,993 billion dollars for the 2016-2025 period. However, only 643 billion dollars will be available from penalty payments, excise taxes on high-premium plans, effects of payroll and income tax revenues, and outlays arising from changes in coverage offered through employers to offset this expense (Congressional Budget Office, 2015).

According to the study, *An Analysis of Hillary Clinton's Tax Proposals* (2016), Clinton planned on addressing these discrepancies in funding with increased taxation of the rich, modifying taxation of multinational corporations, repealing fossil fuel tax incentives, and increasing gift and estate taxes. More specifically, a four percent surcharge on adjusted gross income above five million dollars, a thirty percent effective tax rate on those with an adjusted gross income above one million dollars, and limiting the tax value on certain exemptions and deductions to twenty-eight percent would have increased the tax burdens on America's top one percent of the income distribution with a resulting decrease in after-tax income of five percent. The bottom ninety-five percent of the income distribution would see little change in their after-tax income. These tax policy changes, in combination with other alterations mentioned previously, would have, according to the non-partisan Tax Policy Center, resulted in an increase in federal revenue by 1.1 trillion dollars, and an additional 2.1 trillion dollars over the subsequent ten years (Auxier, Burman, Nunns, & Rohaly, 2016).

Donald Trump's proposed healthcare policy has issues as well. Permitting tax deductions for health insurance premium payments would do little to entice those who already pay little or no federal income taxes into purchasing insurance on the individual market (Haberman & Pear, 2016). Paul Ryan claims that coverage will be offered to all Americans regardless of their health status (Litvan, 2016); however, the entire basis of the individual mandate under the ACA is that

the contributions of the healthy covers the expenses of the sickly. This is the only feasible way to allow lawmakers to prohibit health insurers from rescinding or denying coverage, because otherwise, health insurers do not earn enough in premiums to pay for the sickly (Glied, 2008). He explains that proposed tax cuts will give Americans the ability to afford health insurance (Ryan, 2016a; Ryan 2016b), but without a mandate, costs for those who do purchase health insurance will have to increase to cover the costs for the sickly, because there will be a smaller pool of healthy people paying into the health insurance market (Glied). It is implausible that families already paying minimal taxes would save enough through tax cuts to pay into the increasingly expensive health insurance system. Consequently, a large issue facing Trump's changes to the healthcare system is the question of how the millions of Americans who obtained health insurance under the ACA will remain covered after the legislation is abolished (Haberman & Pear).

According to Gial R. Wilensky, Medicare and Medicaid administrator under George Bush from 1990 to 1992, there is nothing in Trump's plan that would cover more than a couple million people. Thus, millions of low-income Americans may be without health insurance as a result of Trump's health policy, especially because he will attempt to slow Medicaid's growth with the block-grants. The future of Medicaid is unknown if Trump delivers on his promise to turn the program into a block-grant-funded system. States would, in theory, be entitled to shape Medicaid however they see fit (Haberman & Pear). This could lead to decreased coverage for those currently covered under Medicaid. Ultimately, roughly twenty-one million Americans would lose health insurance coverage under the changes that Trump wishes to make, and middle and low income Americans would be hurt the most by his policies (Sullivan, 2016).

Allowing insurers to sell insurance across state lines is a traditional Republican healthcare stance, and is one of the largest facets of Trump's proposed reform. There is a reason that this has never been enacted, however. Selling health insurance across state lines would actually be fairly difficult to do. Insurers would have to establish networks of doctors and hospitals in other states to commence the selling of insurance in that state, and that could be a long and arduous process. Further, disallowing the selling of insurance across state lines serves a critical purpose: it gives state officials the power to regulate insurers and protect consumers. Legalizing insurance sales across state lines would undermine this power and make protecting consumers increasingly difficult (Haberman & Pear). There is a wide variation among states regarding insurance laws. Insurers would be able to choose the state whose laws benefit them best, operate out of this state, and effectively ignore other states' laws. This could cause discrepancies in premium costs, and the National Association of Insurance Commissioners has argued that this policy could actually make coverage less affordable (Custer). Finally, according to Merrill Matthews, a resident scholar at the Institute for Policy Innovation, "just because a good affordable policy is available in another state doesn't mean that I would be able to get the network of physicians and the good prices that are available in that other state" (Merline, 2015).

Alas, promises made during a political campaign and the policies that result while in office are arguably disconnected. Political campaigns are a simple competition over whose avenues to providing citizens with the best lifestyle possible is deemed the most attractive to voters. Campaigns are a tool to develop an image relayed to the public that will entice voters to put them in office. Politicians are acutely aware of public opinion and may alter their behavior to cater to the public's opinions on key issues. "Many studies of campaigns assume that rational candidates avoid taking divisive issue positions and instead assume ambiguous positions to

project more appealing images” (Marschall & McKee, 2002). The Trump Administration asserts its goals when it comes to healthcare policy, but an examination of previous promises broken by presidents throughout history indicate that the actions they claim will be made may vary from what will actually occur in office.

Take, for instance, the promises made during George W. Bush’s campaign and what actually occurred when he was elected. In response to the state of the country’s healthcare, he announced that he would reverse the trend of the four million increase in citizens uninsured (thirty-nine million to forty-three million) that occurred during the previous administration through making health insurance affordable for “hard-working, low-income families”. Indeed, the exact opposite occurred during his time in office; in the first two years of his presidency, the number of uninsured Americans increased by almost four million. Premiums rose by an average of 12.5 percent per year (Center for American Progress Action Fund, 2004). After examining the discrepancies that exist between political campaigns and subsequent policies, it may be plausible to assume that it is much too early to determine what the outcome of the ACA will be in the upcoming years. From the previous discussion, it is easily concluded that healthcare policy is a multi-faceted issue in which shaping legislation that benefits the entire population is incredibly arduous; to be sure, this is exactly the problem that the ACA faced.

Conclusion

The necessity for healthcare reform in the U.S. when Barack Obama took office is undeniable. The ACA made sweeping changes to the U.S. healthcare system, in an arguably vain attempt at fixing the problems that it was faced with. An examination of the achievements and failures of the ACA provides us with a higher level of knowledge that will aid policymakers in determining how to shape the healthcare system for a successful system going forward. It failed

to achieve the increase in Americans insured that was expected by CBO analysts, as was the focus of this text: it failed to insure thirty-two million people by approximately eleven to thirteen million, and did not meet the expectation of insuring ninety-five percent by roughly six to an estimated four percent. But substantial increases were still seen; because of this, it will be interesting to observe the methods the Trump Administration uses to maintain insurance rates while fixing the myriad of issues that the healthcare system remains plagued with; issues that have been examined in other texts – indeed, there are a multitude of teething troubles that arose from the ACA, which are the bases for President Elect Trump’s determination in repealing and replacing the Act. An analysis of his proposed improvements, however, indicate that the state of the American healthcare system may likely remain as unhealthy as it currently is. Ultimately, the ACA served as a stepping stone along the path to correcting the issues that are plaguing the U.S. healthcare system. If nothing else, it has contributed knowledge of what does and does not work for Americans in an insurance system. Although the ACA did not meet CBO analysts’ expectations for increases in coverage, it still increased coverage substantially, which was a gaping problem with the previous system. Hopefully, moving forward, policymakers will keep in mind the successes and failures of the ACA and create a new system that builds on those attainments and corrects those problems.

References

42 U.S.C. § 18001(c)(IV).

42 U.S.C. § 18071(c)(IV).

Adams, J., Asch, S.M., DeCristofaro, A., Hicks, J., Keeseey, J., Kerr, E.A., and McGlynn, E.A.

(2003). The Quality of Health Care Delivered to Adults in the United States. *New England Journal of Medicine*, 348(26). 2635-2645. doi:10.1056/NEJMsa022615

Association of University Centers on Disabilities. (2010, May 28). Title V of the Patient Protection and Affordable Care Act Health Care Workforce Provisions. Aucd.org.

Auxier, R., Burman, L., Nunns, J., and Rohaly, J. (2016, March 3). An Analysis of Hillary Clinton's Tax Proposals. Tax Policy Center. Urban Institute & Brookings Institution. 1.

Barnett, J.C., and Vornovitsky, M.S. (2016). Health Insurance Coverage in the United States: 2015. U.S. Current Population Reports. U.S. Government Printing Office. Washington, DC. 60-257.

Center for American Progress Action Fund. (2004, Aug 9). The Broken Promises of George W. Bush. Online.

Cicconi, L., and Strug, K. (1999, May 25). Universal Health Care in the US. *Ethics of Development in a Global Environment*. Stanford University.

Cohen, G. (2014, March 5). Insurance Standards Bulletin Series – Extension of Transitional Policy though October 1, 2016. *Center for Consumer Information & Insurance Oversight*.

Congressional Budget Office. (2015, January). Updated Estimates of the Insurance Coverage Provisions of the Affordable Care Act. The Budget and Economic Outlook: 2015 to 2025. Appendix B.

- Custer, B. (2016, July 21). Trump's Healthcare Plan Not Truly on Point. *United Press International*.
- Cutler, D., Wikler, E., and Basch, P. (2012). Reducing Administrative Costs and Improving the Health Care System. *The New England Journal of Medicine*, 367(20), 1875-8.
- DeNavas-Walt, C., Proctor, B.D., and Smith, J.C. (2011). Income, Poverty, and Health Insurance Coverage in the United States: 2010. U.S. Government Printing Office. Washington, DC. 60-239.
- Dietrich, J., and Dolgin, J. (2011). Social & Legal Debate about the Affordable Care Act. Hofstra University School of Law. *Legal Studies Research Paper Series No. 11-20*, 45-70.
- Elmendorf, D.W. (2011). CBO's Analysis of the Major Health Care Legislation Enacted in March 2010. *Congressional Budget Office*.
- Glied, S.A. (2008). Universal Coverage One Head at a Time -- the Risks and Benefits of Individual Health Insurance Mandates. *The New England Journal of Medicine*, 358(15), 1540-2. doi:<http://dx.doi.org/10.1056/NEJMp0802027>
- Haberman, M., and Pear, R. (2016, April 8). Donald Trump's Health Care Ideas Bewilder Republican Experts. *The New York Times*. Online.
- Hidalgo, J. (2013). What You Need to Know: Answers about the Health Insurance Plans Available in Nevada. *Reno Gazette-Journal*. Online.
- Hillary for America. (n.d.). Hillary Clinton's Commitment: Universal, Quality, Affordable Health Care for Everyone in America. *Factsheets*.
- Iglehart, J.K. (2010). The End of the Beginning: Enactment of Health Reform. *Health Affairs*, 29(5), 758-759. doi:10.1377/hlthaff.2010.0411

- Iorfino, M. (2013, Nov 18). Cancellation Notices at Center of Affordable Care Act Controversy. *McClatchy - Tribune Business News*. Online.
- Janicki, H. (2013, February). Employment-Based Health Insurance: 2010. *United States Census Bureau Household Economic Studies*, 1.
- Jost, T. (2015). It's Time to Rethink the Employer Mandate. *HR Magazine*, 60(2), 22-23. Web.
- Kennedy, K. (2013, Nov 3). Affordable Care Act Sign-Up. *Sunday Gazette – Mail*. Web.
- Lee, Emily Oshima. (2013). Only 3 Years Old, the Affordable Care Act Is Already Having a Big Impact. Center for American Progress.
- Leeper, T.J., and Slothuus, R. (2013, Sep 20). Political Parties, Motivated Reasoning, and Public Opinion Formation. Aarhus University Department of Political Science, 8-9.
- Legal Content, Inc. (n.d.). Explanatory Note. Health Care Reform. Law Compilation Series, V. Print.
- Levin, Sandy. (2013, May 2016). Levin Statement in Opposition of The 37th Affordable Care Act Repeal Vote. Floor Statements.
- Levinson, Daniel R. (2016, February). CMS Management of the Federal Marketplace: A Case Study. U.S. Department of Health and Human Services, Office of Inspector General.
- Litvan, Laura. (2016, June 21). Ryan Seeks to End Obamacare While Keeping Most Popular Parts. *Bloomberg Politics*. Bloomberg.com.
- Marken, Stephanie. (2016, July). U.S. Uninsured Rate Remains at Historical Low of 11.0%. Gallup.com.
- Marschall, M., and McKee, R. (2002, January and March). From Campaign Promises to Presidential Policy: Education Reform in the 2000 Election. *Educational Policy*, 16(1), 97-98.

- McCaughey, B. (2016, Jan 21). McCaughey: Hillary's Healthcare Lies. *The Ledger*. Online.
- Memoli, M.A. (2013, Sep 28). Republican-led House Votes to Delay Obamacare. *The Los Angeles Times*. Online.
- Merline, J. (2015, Oct 6). Donald Trump's One Health Care Reform Idea Might Be Bogus. The Institute for Policy Innovation. *Investor's Business Daily*. Online.
- Meyer, H. (2016, July 25). What Will Happen with Healthcare Policy under President Trump ... or ... Clinton? *Modern Healthcare*, 46(29), 12.
- Montgomery, L., Helderman, R.S., and Branigin, W. (2013, Oct 17). Government Reopens after Congress Passes Budget Deal, Raises Debt Limit. *Washington Post*, Washington, D.C. 1-4.
- Mullaney, T. (2013, Oct 6). Obama Adviser: Demand Overwhelmed HealthCare.gov. *USA Today*. Online.
- Mulvany, C. (2010, December). Gridlock on the Beltway, More Gridlock in Congress: Some Provisions in the Affordable Care Act Will Likely Face a Stiff Headwind After Republicans Gain Seats in Both the House and the Senate. *Healthcare Financial Management Association*, 64(12), 32-34.
- National Center for Health Statistics. (2015). Summary of Current Surveys and Data Collection Systems. Centers for Disease Control and Prevention.
- National Federation of Independent Business, et al. v. Sebelius, Secretary of Health and Human Services. (2012). 567 U.S., 3-5.
- Newport, F. (2013, Oct 23). Approval of Affordable Care Act Inches Up. Gallup.com.
- Oberlander, J. (2012). The Future of Obamacare. *The New England Journal of Medicine*, 367(23), 2165-7.

Office of the Press Secretary. (2009, Aug 8). Weekly Address: President Obama Calls Health Insurance Reform Key to Stronger Economy and Improvement on Status Quo.

Whitehouse.gov.

O'Neill, J.E., and O'Neill, D.M. (2007). Health Status, Health Care and Inequality: Canada vs. the U.S. *NBER Working Paper Series 13429*, 1-42.

Pear, R. (2013, Oct 23). White House to Tweak Tax-Penalty Deadline. *New York Times*. Online.

Rak, S., and Coffin, J. (2013). Affordable Care Act. *The Journal of Medical Practice Management*, 28(5), 317-319.

Ryan, Paul. (2016, June 22). Health Care. Speaker.gov.

Ryan, Paul. (2016, June 24). Tax. Speaker.gov.

Salazar, L. (2015, March-April). How to Insure Employees under the Affordable Care Act. *GP Solo*, 32(2), 40.

Sommers, B.D., and Epstein, A.M. (2010). Medicaid Expansion -- the Soft Underbelly of Health Care Reform? *The New England Journal of Medicine*, 363(22), 2085-2087.

Sullivan, P. (2016, July 8). Trump's Healthcare Plans Trouble GOP. *The Hill*.

Swanton, M. (2012, November). Pay or play: employers face a difficult choice under the Affordable Care Act. *InsideCounsel*, 53.

The Trump Organization. (n.d.). Healthcare Reform to Make America Great Again. Donald J Trump for President. *Positions*.

Trust for America's Health. (2013, May). The Prevention and Public Health Fund at Work in Wyoming. Healthyamericans.org.

United States Census Bureau. (n.d.) Current Population Survey (CPS): Methodology. Census.gov.

United States Council of Economic Advisors (2009, June). The Economic Case for Health Care Reform. Whitehouse.gov.

United States Government. (n.d.). Hardship Exemptions, Forms, & How to Apply. Healthcare.gov.

United States Government. (n.d.). Health Coverage Exemptions, Forms, & How to Apply. Healthcare.gov.

United States Government. (n.d.). How to Get or Stay on a Parent's Plan. Healthcare.gov.

U.S. Treasury Department. (2015). Fact Sheet: Final Regulations Implementing Employer Shared Responsibility Under the Affordable Care Act (ACA) for 2015. 1-3.

Ward, B.W., Clarke, T.C., Nugent, C.N., Schiller, J.S. (2016, May). Early Release of Selected Estimates Based on Data from the 2015 National Health Interview Survey. National Center for Health Statistics.

World Health Organization. (2013). Table of Key Indicators, Sources and Methods by Country and Indicators. Who.int.