IN THE NEWS
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Update on Obamacare

Introduction

The Patient Protection and Affordable Care Act (also known as the PPACA, the Affordable Care Act , the ACA, and Obamacare) has been demonized by politicians and pundits on the right as massive government "overreach"[1] and by some advocates of single-payer health care on the left as just plain "awful."[2] While such characterizations can be disputed, the ACA is undeniably the largest expansion of the U.S. health-care system since the creation and implementation of Medicare and Medicaid in 1965.

Though media coverage often focuses on issues of individual health insurance related to the federal and state market exchanges and Medicaid expansion, the ACA also attempts to affect public health more broadly by improving the efficiency of the health-care system, preventing chronic disease, and improving the supply and education of a qualified health-care workforce. This study will highlight aspects of the system that are working and those that are not by examining the federal and state health insurance marketplaces, Medicaid (and CHIP) expansion, and community health promotion.

Private Insurance Enrollment Statistics

To say that the beginning of the open enrollment period for Obamacare at healthcare.gov was rocky is an understatement. However, after getting the technical assistance of experts from Google, Red Hat, and Oracle, issues were gradually overcome. By April 19, 2014, more than eight million people had signed up for private insurance through healthcare.gov and fourteen state exchanges. About 2.2 million people, or 28 percent, of the people who enrolled in the ACA are between the ages of eighteen and thirty-four. Nearly 3.8 million, or 47.5 percent, of those who enrolled did so in March, the last month of the enrollment period.[3]

Medicaid and CHIP Enrollment

By the end of the open enrollment period, more than three million people had enrolled in Medicaid and the Children's Health Insurance Program (CHIP) through their state agencies.[4] The Affordable Care Act was originally designed to expand Medicaid and CHIP nationwide by including not just individuals and families who are at 100 percent of the poverty level but also those at up to 138 percent of the poverty level. However, the Supreme Court decision of 2012 made expanding Medicaid optional for states. Currently twenty-six states and the District of Columbia have expanded Medicaid and CHIP coverage. The remaining states either have decided against expansion or are debating the issue.

States that are still debating the issue include Indiana, Pennsylvania, Missouri, Utah, and Virginia. Newly elected Democratic Virginia Governor Terry McAuliffe wants to implement Medicaid expansion. However, he has to contend with a Republican majority in his state legislature that vehemently opposes it.[5] In February 2014 the Missouri legislature voted to not expand Medicaid and CHIP coverage. One Republican lawmaker, Kit Bond, is advocating for expansion because he is afraid that if Missouri does not expand Medicaid, many of the rural hospitals in the state will not survive.[6] Pennsylvania is awaiting a decision from the U.S. Centers for Medicare and Medicaid Services (CMS) about whether their request to attach a work requirement to Medicaid benefits will be honored.[7] Similarly, Utah is negotiating with CMS to craft their Medicaid and CHIP expansion to include cost sharing, a work requirement, and the three-year block grant to cover 110,000 low-income people with private insurance.[8] Indiana governor Mike Pence is seeking ways to integrate Medicaid and CHIP expansion with existing Indiana programs to help the poor.[9]

The twenty-four states that are currently not expanding Medicaid and CHIP are allowing 4.8 million poor people to fall into a coverage gap: they make too much money to qualify for Medicaid but not enough to qualify for marketplace subsidies.[10]

Though there has been a reduction in the overall number of people who are uninsured, racial minorities are still disproportionately uninsured.

Drop in the Rate of the Uninsured

A Gallup poll released in May 2014 found that the uninsured rate dropped to 13.4 percent, which is the lowest monthly uninsured rate recorded since Gallup began tracking it in January 2008. Though there has been a reduction in the overall number of people who are uninsured, racial minorities are still disproportionately uninsured. The rate of Hispanics without insurance is an alarming 33.2 percent, though this number is down 5.5 points since the end of 2013. The rate of African Americans without insurance fell more than for any other racial group, from 20.9 percent to 13.8 percent. Gallup research shows that the uninsured rates have fallen more in states that have chosen to expand Medicaid and run their own health-care exchanges.[11]

The Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) estimate that because of the insurance coverage provisions of the ACA, 12 million more nonelderly people will have health insurance in 2014 than would have without the ACA. They project that 19 million more nonelderly will be insured in 2015, 25 million more in 2016, and 26 million more will be insured each year from 2017 through 2024.[12]

Though the number of people with health insurance will continue to grow in the coming years, in 2024, 31 million will still be without health insurance. Of those, 30 percent are expected to be unauthorized immigrants, making them ineligible for subsidies or Medicaid, and 5 percent will be ineligible for Medicaid because they live in a state that has chosen not to expand coverage. About 20 percent will be eligible for Medicaid but will choose not to enroll. The remaining 45 percent of the uninsured will simply choose not to purchase insurance through an employer, through an exchange, or from an insurer.[13]

Workplace Options

In February 2014 the CBO reported that because of Obamacare, there will be a decline in total number of hours worked by the U.S. workforce

that will equate to 2 million full-time workers in 2017. In 2024, the decline will be equivalent to 2.5 million workers. Some news outlets reported that Obamacare was going to cost 2 million jobs.[14] The report actually contended that rather than costing workers 2 million jobs, the ACA offers workers more options. Before the ACA, some workers had to work a set number of hours to gain access to health insurance offered through their employers.

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However, thanks to the ACA, subsidies enable these workers to afford health insurance while working fewer hours or not working at all. As a result, workers may work fewer hours in general.

The CBO also contended that some disabled workers who would ordinarily not qualify for private insurance because of preexisting conditions and who would, therefore, leave the workplace in order to qualify for Disability Insurance or Supplemental Security Insurance can now continue to work. They too are eligible for subsidies in state exchanges and will not have insurance denied because of preexisting conditions.[15]

While the CBO had some good news for workers, they also had some bad news. Some employers will choose to reduce the number of full-time workers to avoid paying the penalty assessed to employers who have fifty or more full-time workers.[16]

State-Run Health-Care Exchanges

Fourteen states decided to set up their own exchanges and received millions of dollars from the federal government to do so.[17] Successful exchanges include Connecticut, California, Kentucky, Rhode Island, and Washington. The governors of both Connecticut and Kentucky hired website developers to begin work on their sites in 2012. The Connecticut exchange, Access Health CT, worked smoothly from the first day of enrollment. By the end of the open-enrollment period, two hundred thousand people had signed up for coverage, which was more than twice the number the Centers for Medicaid and Medicare Services had forecast. Similarly, Kynect, the exchange site for Kentucky, also worked well from day one.[18] There was a significant amount of testing put into the Kynect website, and by the end of the enrollment period, 82,795 Kentuckians had enrolled in private insurance plans and 330,615 had enrolled in Medicaid.[19]

While some exchanges have worked well, others have been plagued with bugs and missing features that have yet to be resolved. Maryland Health Connection had one of the worst private plan sign-up rates in the country. The exchange was projected to enroll 150,000 people. However, only 67,757 signed up for private insurance.[20] Cover Oregon was such a disaster that not one person was able to enroll in private health-care plans online. The more than seventy thousand people who have signed up for private health care were enrolled by paper after the state hired four hundred additional workers. Oregon officials will be voting soon on whether they should discard the current site and switch to the federal system after spending $248 million on the site. The time and $78 million that it will take to make the site effective is more than the people of Oregon can afford.[21] Other states that have experienced technical issues with their sites are Minnesota, Nevada, Vermont, and Massachusetts.

Community Health Grants

Another goal of the ACA is to improve community health. To accomplish this goal, the federal government entrusted the Centers for Disease Control and Prevention (CDC) with the responsibility to award funding to local and state entities that facilitate tobacco-free living, engender active living and healthy eating, and provide clinical and community services to prevent and control high blood pressure and high cholesterol. In 2011 the CDC awarded $103 million to sixty-one state and local government agencies, native tribes, territories, and nonprofit organizations in thirty-six states. In addition, the CDC awarded nearly $4 million to six national networks of community-based organizations. These projects can help improve the quality of life of more than 120 million people.[22] Though the full impact of each of the funded projects will not be fully known for years to come, by 2016 there should be measurable outcomes for millions of people around the country.

Summary

In a *New York Times* article, film producer Michael Moore, a staunch advocate of single-payer health care, deemed Obamacare to be "awful." However, in the same article he wrote that Obamacare was a godsend. He lamented that the ACA is a pro-insurance-industry plan and that millions of people are still without health insurance while acknowledging that millions more have coverage now than ever before. Moore's points are well taken. The ACA is good news in many ways: more people have insurance coverage than ever before, the rate of uninsured has fallen to its lowest point in six years, workers now have a choice of working more or less (or not at all) while still being able to afford medical coverage, some state exchanges are working very well, and the impact of community health grants will positively impact the general health of millions. Simultaneously, the rate of uninsured remains disproportionately high for African American and Hispanics, millions will remain uninsured well into the future, some workers may not have the option for full-time work, and some state exchanges hinder enrollment rather than enable it.

In a recent speech at the White House, President Obama acknowledged that the ACA was not perfect, admitting work must be done to achieve coverage for the many who still do not have insurance.[23] Since he has only two years left in office, it seems that the best hope for insurance for all lies with the electorate.

Endnotes

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Questions for Reflection

1. In the Gospels, healing was an important aspect of Jesus' earthly ministry. What is our personal or individual Christian responsibility as it relates to health care? For example, do we have a responsibility to take care of our own bodies? Do we have a responsibility to help take care of others?

2. From a Christian perspective, is health care a right or a privilege?

3. In 2024, more than 9 million unauthorized immigrants will be without health care. In the Hebrew Bible, God instructed the Israelites about how to treat immigrants and why they should be treated in a particular way:

   When an alien resides with you in your land, you shall not oppress the alien. The alien who resides with you shall be to you as the citizen among you; you shall love the alien as yourself, for you were aliens in the land of Egypt: I am the Lord *your God.* (Lev. 19:33–34, emphasis added)

   Do we have a Christian responsibility toward immigrants (legal/authorized and/or unauthorized)? If so, why? If not, why not?

4. Racial minorities are still disproportionately uninsured. Are there systemic causes for the gap in the rates of uninsured African Americans, Hispanics, and Caucasians? If so, what are they? If not, what are the reasons for the disparities?

5. Some critics have derided the fact that private insurance companies make large profits in the current system while millions go without health care because they can't afford it. Is for-profit health care inherently sinful? Is there a way to reconcile the tenets of capitalism with the need every human being has for health care?