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New Youth for Health Care: The Affordable Care Act Story

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Prof. Osborn

New Youth for Health Care: The Affordable Care Act Story.

The dust has settled. The final cards have been played. The last punch has been thrown, and through the haze a lone figure stands. He is beaten and bruised, but still he stands. Around him lay the remains of a great battle. Rubble and mortar are strewn across the ground, flung haphazardly by a titanic force of wills. Blood is intermixed amongst the fallen stones, some of it belongs to the champion standing in the center of it all, some of it doesn't. Who is this man, this champion in the haze? It is none other than the Patient Protection and Affordable Care Act. This might be a little over dramatic, but discussions on the drawn out political and economic free-for-all that is American health care reform can become a bit dull. It can be easy to forget that in the finagling within and around dense legal code, a thousand pages worth of it, people's lives are on the line. This paper is a front row seat to the 50 year long slug fest that ended with the ratification of the Affordable Care Act, and its surviving not one, but two Supreme Court cases brought against it. These pages will also ask if it was worth all the trouble and address how a person can use it to get health insurance. Before that however, it is imperative to start where healthcare began in the United States and the fee-for-service model.

Where we once were:

Health insurance is a fairly new concept, which isn't surprising since modern medicine is just as young. Treatment from a hospital or doctor used to be (and sometimes still is) paid out of pocket according to services provided. This "fee – for – service" method was much like paying for a car tune up. A person would see the doctor, the doctor would bill him, and then go about their merry way. Well, in theory. The critical issue that makes fact more difficult than theory is medical care has become more expensive, the burden on the sick to pay is greater and greater, and it is very difficult to pay for medical care when working isn't an option. The issue is worse when a person with no income needs medical care, like the elderly. Fee – for – service hits medical providers where it hurts as well because people will attempt to avoid using their services. Many people will just choose to go without to save money. Yearly checkups and dental visits aren't necessarily a high priority without symptoms, and auxiliary care, like physical therapy, is neglected as well because of the time consuming and expensive nature of multiple visits for results that don't begin to show for weeks or months. Finally, all of this compounds upon the fact that hospitals cannot deny care to those who need it. To use the car comparison again, if a person's car breaks down the shop can refuse service or threaten suit if she doesn't pay. Hospitals just have to bite the bullet (or get the bullet out depending on who they are treating). In order to offset this, they raise prices, which lead to more people being unable to pay. In light of this, the medical industry can't be treated like other industries because it's too important, but it is still an industry and those who run medical care facilities still need to make a profit. Expecting doctors to live selfless hard working lives might be noble, but it's also unrealistic. This creates a question that American legislators have asked for the last 50 years:

“How should America pay for health care.” The Patient Protection and Affordable Care Act is only the latest attempt to answer that question.

The first strategy that Congress tried was adding a few additions to the Social Security act in 1965 specifically to help with health care costs. These additions are affectionately called Medicare and Medicaid. These are almost interchangeable, and named thusly, but they are not quite the same. The primary difference between the two is eligibility. Medicare is provided to those above 65, the permanently disabled, and those with end stage renal disease, while Medicaid is provided to people based on their income. These groups are the most vulnerable to the fee – for – service model because many lack any source of income or lack enough income to pay for expensive medical care. By splitting the way care is given this way, many people can get assistance from both Medicare and Medicaid. A disabled war veteran living below the poverty line would be able to received benefits from both programs, totally covering his medical care without the need to pay anything out of pocket. This can lead to confusion that if somebody is able to get one they will automatically get the other. Financial prosperous people over 70 can still receive Medicare – much like they could still receive social security – but would not be eligible for Medicaid. On the other hand, an unemployed single mother who is thirty five could qualify for Medicaid by not for Medicare. There are a few other small differences between them as well. When Medicaid is used alongside Medicare it is used second. This allows those individuals that need long term care to receive it as long as they need it. Also, of the two, Medicare is slightly bigger in terms of the amount of care provided, but together they account for more than thirty percent of total medical care expenditures in the United States. However,

it is not the difference between them, but what they have in common that make Medicare and Medicaid so special.

Medicare and Medicaid are federally run programs that use taxes to pay for people's health care needs. This is unlike almost every other insurance company in America because it follows a "single payer system". Everyone pays a single party, in this case the government, and care is given out appropriately. Most people who pay for Medicare/Medicaid do not benefit from it directly, they benefit indirectly. Hospitals don't have to worry about the cost, to an extent, of certain individuals because they don't have an income. The medical providers avoid treating people for free, so they don't have to raise other patients' cost to compensate. This helps to keep medical costs lower. Plus, there is the added bonus of treating the downtrodden with respect and dignity, rather than leaving them to their own devices. Medicare and Medicaid essentially spread the nobility of helping a neighbor in need to everyone, not just medical professionals. It would be nice to end right there, and say the programs have been shining examples of effective legislation, but it would be remiss to forget about the flaws the Medicare and Medicaid have. The most glaring of which is that costs haven't really been controlled very well and many people don't have a chance at receiving aid from the programs even though they might desperately need it. One step across the poverty line is not much easier a life than one step behind it. Something needed to be done to get more people a chance at Health insurance. A different strategy was about to step up to bat.

While Medicare and Medicaid gave insurance and security to those above 65, the disabled, and the extremely impoverished, the rest of America still had the pay-per-use version

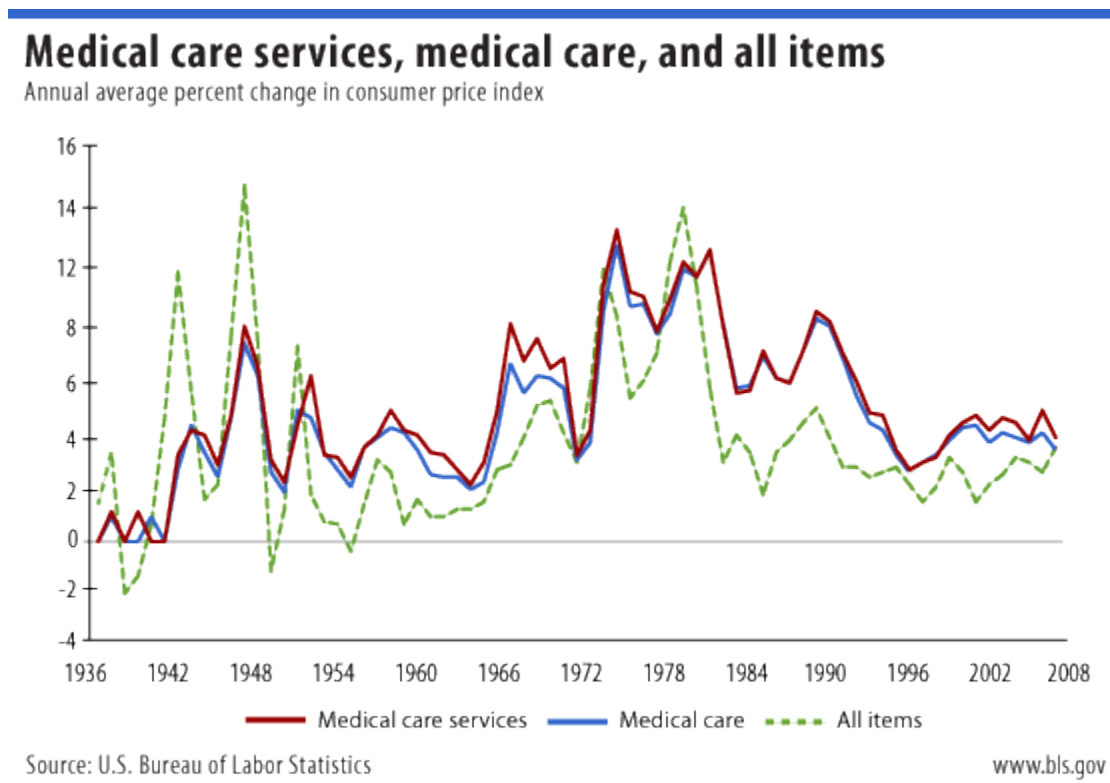
of health care. People still chose to go without and medical care costs were still rising. Change had to happen, and it came in the form of Health Maintenance Organizations Act of 1973. HMO's are "legal entities providing a prescribed range of health services, known as basic health services, to an enrolled population in return for a pre-paid payment (Uyehara, 1973)." Basically, HMO is just a different way to say health insurance Company that also provides the care themselves or contracts with a separate medical care group to do it for them. HMOs also follow a pre-pay plan. Those who are part of an HMO pay a certain amount every year, and are then entitled to a certain amount of services regardless if they are sick or not. Doctor Check-ups, physical therapy, Dentist visits, and even vision care could be covered by HMOs. This method promotes the use of these auxiliary care options, which will help a person stay healthy so they don't need basic services like hospital care as often. Meanwhile, doctors do not have to worry where their paycheck is coming because the HMO pays them for services rendered. By giving an incentive to patients to use the modern treatments and preventative care available to them, and guaranteeing physicians they were going to get paid, there were high hopes that HMOs would provide a solid framework for the rest of the health care system. The lofty aims of cost control and improved care seemed a reality. Unfortunately there were some major flaws in the regulation of HMO's that didn't work so well.

The most glaring were copayments, which are still everywhere today. The HMOs could charge their constituents up to, no joking, 50% of services rendered as long as the total copayments never amounted to more than 20% of total care. On top of this there was no limit or regulation on copayments for supplemental health services like the dentist visits mentioned earlier. This allowed huge copayments to eat up the potential benefits that supplementary care

would have for physicians and constituents alike. People still tended to avoid receiving care without critical symptoms to treat and doctors were still paid for services rendered. Services that were not rising according to the amount of money it takes to run HMO and pay doctors. This was not the worst problem though.

One of the main goals of HMOs was to get health insurance to more people, but the HMOs wanted to avoid anyone refusing to buy insurance until they fell ill. The 1973 Law allowed the HMOs to refuse service to people. This means an HMO could deny sick or disabled people insurance. They also had open enrollment periods, where HMO had to except anyone who applied until a certain number had joined, but these were only thirty days long. A month isn't too short a time, but they had the option to cancel open enrollment if they could show it would be detrimental to the economic integrity of the HMO. This gave HMOs freedom to do as they wanted. They could deny care to the very people that needed it. The people who needed health insurance the most, the injured, sick, or otherwise compromised peoples not eligible for Medicare or Medicaid, still did not have health insurance. This means they still went to the emergency room and the hospitals still had to help them. The price of health care skyrocketed. Figure 1. is a graph from the Bureau of Labor Statistics that shows the percent increase in the cost of medical care compared to the increase of all items (All other services and goods). 1973 and 1974 had the highest increase in the cost of medical care since the 30's. Since then, HMO has almost become a dirty word. Insurance companies use terms like Managed Care Organization instead, but they are essentially the same thing.

Figure 1



HMOs along with other privately owned insurance companies still provide health insurance to the majority of Americans and through the 80s, 90s, and 2000s there was no major comprehensive legislation that changed how HMOs could go about their business. They could still deny coverage and have high copayments. This changed slowly state by state and there was a small change to Medicare that allowed the coverage of prescription drugs, but this didn't necessarily help matters. As the new millennium began, more and more states were requiring insurance companies to accept people regardless of the state of their health, but this lead to

the exact problem denying coverage was meant to prevent. People would avoid paying for health care until they needed it, so insurance had to raise premiums, which lead to less people having health care, which lead to a greater burden on the hospitals, which lead to increased cost of care, which lead to increase premiums, and so on and so forth. An economic “death spiral” began to take hold of the medical industry, and the Insurers were not spared. Many insurance companies failed during this time. The average percentage increase in medical cost remained higher than the average increase for other industries every year from 1981 to 2007. Health care was not getting more affordable, and many people still didn’t have it. Again, something drastic was needed. Something that would attempt to face all the issue health systems could dish out, and that something was called the Patient Protection and Affordable Care Act (PPACA or just ACA).

Where we are now:

Obamacare, also known as the Affordable Care Act, seems to attract a lot of polarity between people, much like politics in general. As far as sweeping legislation goes, it is the biggest overhaul of the United States Health Care System since the establishment of Medicare and Medicaid. The bill in total is over 900 pages long and addresses everything from more regulation of private insurance companies to expanding the benefits of Medicare and Medicaid. However, the goal of the bill is simple: Lower health care cost and get more people health care. How does the ACA go about this? It learns from the past. There needed to be accountability on providers to provide care for anyone that applied, but there needed to be a system in place to prevent the abuse of this privilege by consumers. In order for health insurance, or any

insurance for that matter, to be sustainable there needs to be a displacement of risk. A large group of people pool their money and their risk into one giant pot of security providing goodness. It is like life is a huge casino floor full of games for people to play. Games like: how high can I climb that tree, I wonder how sharp I can turn my seadoo, cigarettes won't hurt me, and boring games like genetic predisposition for cervical cancer. People play these games all their life and a loss at one of them can be unfixable, but fortunately there is also the insurance game. The insurance game is the reverse of gambling, in that the losers win the pot. You lose the insurance game by losing any of the other games on the floor, so if someone loses "texting while driving" and needs money to pay for "spinal surgery" and "rehab" in order to move on with their life, they can get it because they were part of the pot in the insurance game. Unfortunately, if a bunch of people decide they are just going to take their money and risk losing all of it instead of playing the insurance game, the pot can no longer support everyone gambling around it. Everyone becomes a loser who stays in, so the pot can't cover Jason's 16 month long session at the rehab slot machine. Also, some of those risk takers will statistically lose as well, leaving the hospitals to cover the difference by raising the cost of medical care, which raises the premiums of insur... you get the idea.

The Affordable care act tackles this issue of risk and accountability in three ways. First, it protects consumers. In the ACA it explicitly says an insurer cannot deny coverage based on the health of an individual, and insurers cannot raise premiums for those individuals. This allows for the possibility that everyone could have insurance. Next, in order to make sure everyone actually gets insurance, the act requires everyone to have insurance or else they have to pay a fee to the IRS. This is called the "Individual Mandate". The penalty isn't too extreme, only 2.5%

of a household's income, but it takes away the incentive to go without insurance. This will prevent the death spiral from starting, but there is one other issue. There are many people on the edge of qualifying for Medicare/Medicaid that can't afford health care or the 2.5% penalty. That is where the third major part of the ACA comes in. The government will provide tax credits to households with annual incomes between 100% and 400% of the Federal Poverty Level. This is probably the most inspired, if a bit back-handed, part of the ACA. It is essentially a way of sneaking a sort of single payer system into the bill without actually creating one. The people who are most likely to avoid paying for health care, people with incomes just above the poverty line and don't receive Medicaid, are given an ultimatum: either get health care, and get a tax break so it is financially feasible, or pay a fine and get nothing. This was one of the things people took issue with immediately. Before going more in depth it is important to mention couple things about the nature of the Affordable Care Act.

There is no actual single payer program in the Affordable Care Act. It does attempt to increase the reach of Medicaid by setting a higher income for eligibility, but no new single payer programs are included. Instead, there is an online marketplace of many private insurers that is organized state by state. A state can option not to make a market place, but it then becomes the Federal government's job to create and then hand over to the State to run. These market places have dozens, or even hundreds, of insurance plans to choose from. This allows competition between them to help drive the price of insurance down, if a person puts in the work. These programs are all like HMOs to some extent. They are all pre-paid programs with month/yearly premiums and copays just like normal HMOs, but the government has greater

control to set limits on them along with provide assistance to those who need assistance to pay them.

These are the main points of the Affordable Care Act, but there are dozens and dozens of smaller additions that add up to 900 pages. There are several parts that deal with worker compensation and health insurance provided by employers. One such clause gives assistance to small business with under 25 employees for health insurance, another requires businesses with over 200 employees to automatically offer insurance. There is a clause that lets States choose whether or not insurance plans cover abortions. There is different one that lets children stay on their parents plans until they are 26 (as a 22 year old, I feel this is the best part of the ACA). A clause that specifically promotes preventative care. A clause for disaster relief. A clause to assist American Indians with health care. The list goes on and on. The bill is as far reaching as they come, so it is unsurprising that there are a few people that were unhappy about it passing. The bill gives more control to the Federal government over the States, and the fallout from it passing was quick indeed.

The Final Battle:

The ACA passed congress and was signed into law in March of 2010. Immediately opponents of the bill picked up their swords and prepared to take on the new law in the arena of the judicial system, and try to get the bill deemed unconstitutional by the Supreme Court. Twenty- six states, starting with Florida, along with the Nation Federation of Independent Business brought suit to court questioning the constitutionality of the law in “National Federation of Independent Business V. Sebelius”. They chose two areas of attack. Their main

assault was against the Individual mandate clause. This was a key component of the bill without which the bill would fall apart. They argued that the government did not have the right to punish citizens for not buying something just because an industry would fail. If the milk industry was failing, the government couldn't punish people who didn't buy milk in order to save it. This was a viable argument. The bill was essentially forcing people to purchase something they might not want to purchase, which could be used as a precedent in future cases to give congress the right to decide what people had to buy. This was far beyond any control that the constitution gave congress. The opponents' second point of attack was on the clause dealing with Medicaid expansion. They had no problem with the Federal government requiring states to extend it to people up to 133% of the Federal Poverty Line, but they did have a problem with the way the government could enforce it. According to the Affordable Care Act, if States refused to increase Medicaid the Government could withdraw all federal Medicaid funding from the state. This would make it impossible for States to pay for Medicaid, thus forcing them to expand it.

The Court case was decided on June 28, 2012 after much debate. The court found that it was indeed unconstitutional for the government to punish citizens for not purchasing something. This stepped beyond the power Congress had to regulate commerce. However, it did not go beyond the power of Congress to tax. Since punishments for not buying health insurance were lenient, only a small fine equaling 2.5 percent of annual income or a minimum of \$625, the Supreme Court labeled it as a tax on not buying health insurance. The punishment on the bill was viewed just like a tax on gas or on cigarettes, except instead of taxing the purchase of something, congress was taxing the lack of purchasing something. There was no

chance of incarceration so the punishment wasn't really a punishment. Multiple offenses didn't mean an increase in the fees a person had to pay, it just meant the same fees. They weren't really breaking a law, just choosing not to partake in the program. The fees were necessary to prevent the "death spiral" from increasing medical care cost exactly like taxes for Medicare did. The individual mandate was still constitutional and the Affordable Care Act survived.

The expansion of Medicaid did not fare so well. States had been able to set their own cut off point for Medicaid, so this cross the board increase to 133% of the FPL would be a huge increase in cost for many States. Even with Federal subsidies, the burden of the states would increase dramatically. Even worse was the harshness of the punishment for not complying. Without Federal assistance for Medicaid, States could lose up to 10% of their budget. That would be ruinous. States would have no choice but to comply. The Government countered this argument by saying it was just a modification to another bill that the States agreed the Government had the right to modify. However, the Supreme Court ruled that the change was too great. This was more than a mere modification, but a complete overhaul that the States had not agreed to allow. The Supreme Court viewed the punishment on States for not expanding Medicaid as unconstitutional.

From here the opponents of the ACA tried to get the whole bill called unconstitutional. They argued that if one part of a bill was, then the whole thing was. The Supreme Court didn't agree. They argued their purpose wasn't to try to cancel a bill, but to keep the legislation as intact as possible. Much like a person is innocent until proven guilty, a bill is viable unless

proven otherwise. It was Congress's job to strike down laws according to their whims, not the Supreme Court's. The Medicaid expansion clause of the law remained partially intact, but there was now no way for the Government to enforce it. States could just ignore it if they wanted to. The only downside was they lost out on increased funding from the Government, which most likely wouldn't cover all the needs of the new members of Medicaid.

The Affordable Care Act made it through its first judiciary battle relatively unscathed. The three main premises of the Law remained unchanged and Medicaid expansion remained an option, if an unenforceable option. However, it was a close thing. The Supreme Court passed it in a 5-4 decision, any more dissent would have spoken doom for the ACA. The bill opponents knew this, so it was only a matter of time till they tried again.

The next case brought against the Affordable Care Act reached the Supreme Court in 2015. *King v Burwell* attacked a different key clause of the ACA, the tax credit clause. This time four Virginia individuals argued that they shouldn't have to pay for insurance because paying for it would be more than 8% of their income. The IRS claimed that they were eligible for tax credits that would put paying for their health care below 8% under the ACA. The petitioners disagreed. The issue was over the wording of a certain part of the law. They argued that the only insurance plans available for tax credits were part of insurance Exchanges that were "established by the state." Virginia had neglected to make its own marketplace for health insurance, so the Federal government established one, so technically the Exchange had not been established by the states. The opponents of the ACA argued that the wording of the law was too ambiguous and didn't allow for accurate interpretation. They wanted the tax credit

part of the law struck down which would kill it. Without the tax credits many of those with an income of 133%-400% of the FPL would no longer have their insurance premiums be under 8% of their income the law required that they should be.

The Supreme Court's answer to this was simple. They fought fire with fire. The wording in another portion of the law said the Federal Government would make "such an Exchange" if the State could not. The word "such" in this case was referring to State established Exchanges, so the Supreme Court ruled that the wording wasn't ambiguous. Basically, the petitioners said the law said one thing, the Supreme Court disagreed, so the law remained constitutional. All three key clauses were kept intact once again and the Affordable Care Act was more securely justified than at any point in its history. However, it is important to point out that due to the length of the legislation, the wording can get a bit confusing or contradictory. The four Virginians did have a point, but the ACA is probably not the only law that can have confusing wording at times. The English language has many words with multiple meanings that the reader must choose which version is appropriate due to the context around it. The ACA obviously didn't mean to neglect states that didn't create their own marketplace / exchange, so the Supreme Court chose to read the Law that way.

Since the Affordable care act has now defeated two cases against it, it is unlikely to go anywhere anytime soon. Any cases brought against it would have to question the constitutionality of the third key component of the bill that prevents insurance companies from denying coverage to individuals because of pre-existing conditions. Of the big three, this would be the hardest to argue as unconstitutional since many states already did that in the 90's.

That's beside the fact that it protects consumers more than any other part of the law. The only way that opponents of the law can change it now would be to pass new legislation to. This is also unlikely because the law is so young and a counter health care reform bill would need to reform the problems that the ACA causes. It has only been 5 years since it was enacted, and many of the law's clauses are still adjusting to their intended places, so it is still unclear what the laws flaws actually are. There hasn't been a major jump in health care cost like after the 1973 HMO act and the amount of people who have insurance has risen slightly. So far there isn't a reason to amend the Affordable Care Act. For now it stands. It's battered and bruised, but it has withstood all attempts to topple it.

Flirting with single payer:

Now that the story behind the ACA is out of the way, it is time to ask if it is a good thing. Certainly the fact that the law passed was astounding, but it has had surprisingly little effect on anything. There's no reason to amend the ACA yet, but that is because not much has changed. Sure, there hasn't been a huge rise health care cost, but there hasn't been a substantial drop either. The price of health care costs have increased steadily since it passed in 2010. The raise in costs has been below 4%, but there hasn't been any indication that this increase would have been any more if the ACA hadn't been passed. Piled on top of this is the fact that millions people in America – citizens and non-documented workers alike – do not have health care still. Those that do have health care face the cost of premiums and copays which have lead them to avoid using physicians services, which means physicians raise their prices to compensate for lower business, which means insurance premiums and copays start to rise... and the death

spiral begins again. The tax credits that provided people incentive to purchase health care do not incentivize them to use the insurance and pay copayments along with their premiums. The ACA hasn't really accomplished its goal of lowering health care cost and still has a long way to go before guaranteeing health care for everyone.

As mentioned before the ACA is not a single payer system. It has several parts that almost act like single payer, but all the insurance companies in the online marketplaces are privately owned. Each one has their pool of money and can afford to take on only so much risk. Each one of these companies also needs the employees, organization, and overhead costs of a business that is trying to make a profit. Many people see the easiest way to save cost on medical care would be to get rid of all these insurers entirely. There would be no need to pay the CEOs, no need to worry about profits; the money would just be used to pay physicians for care. The problem that all these different insurance companies create is other similar to other examples of lack of government oversight, like the ones unregulated railroad gages or electronics charges create. If each railroad company builds rails that could only be used for their trains, any attempt to cross rails would be an extremely arduous process. Likewise, If there was no universal phone chargers, companies would have to create a different charger for every phone, drastically raising cost. There was a time when that was the case, and it created a huge amount of e-waste before standards were set by the government allowing use of other companies technology (except Apple of course, Apple does what it wants). Private health care is much the same. Each one has to develop its own business and take care of its own cost while providing care. Proponents of pre-paid and private insurance plans argue that competition will keep costs

down, but it is impossible for all the cost saving measures in the world to compete with simply not having to pay as much and completely eliminating the need for profits.

Single Payer seems to make a lot of sense, but does it make sense for America? The answer is maybe, maybe not. The amount of money needed to insure everyone would be staggering. America is the third most populated country in the world, and a system that works for smaller European countries or Canada might not work for America. The problems that can cause rising prices for health care in America are more similar to the problems Russia and China have than to the issues Denmark or Germany face. More people over a larger area mean more hospitals that service less people. Larger populations of poor people, such as undocumented workers, cause greater strain on the single payer system. Finally taxes would be a huge issue. Taxes would have to be raised for every group of people. Lower, middle, and upper classes would all have to sacrifice for a single payer system, and no one would be happy about it. Many lower income families can avoid paying what these taxes would cover by just going without, and rich people don't need health care, they can pay for it out of pocket. Saying single payer would be nice to have without thinking about taxes increase is irrational. You can't have one without the other.

It is also important to point out that making an entire industry non-existent overnight might have far reaching economic consequences. Many people are invested in the success of insurance companies, so shifting to a single payer system would require payments to be made to these companies to offset the cost of losing their business. Otherwise another economic collapse wouldn't be far off.

The argument of expanding Medicare and Medicaid to everyone has been tossed around since 1965 and there isn't a clear cut answer if this would work. The United States has flirted with the idea of a single payer for a while now, and the ACA comes closer than most other legislation to actually commit to it, but it is not a true commitment yet. This is ok though. It would be much worse for the United States if they adopted a single payer system and it failed completely, breaking under a weight it was not prepared to bare. Hopefully the ACA is a preparation phase that is brings the United States closer to a successful single payer program, and not an indefinite state of affairs. It would be unfair to call it either a huge success or a giant failure. The Affordable Care act was the next logical step to take in bringing people access to health care. It's not perfect, but it is a step in the right direction.

The Marketplace:

Now it's time to look at some practical application of this step in the right direction and ask: "How do I get health care using the affordable care act?" The process is both very simple and complex. Every State has an online market place that includes all the possible health care providers. A quick google search of "Affordable Care Act plans" will bring up plenty of good sites, but www.healthcaremarketplace.com is a good option to go with. These sites require a person to list general information about themselves including their annual income. This is used to decide if a person were to receive any tax credits on their health insurance. After this information is given, the next step is to receive a quote from an insurance agency. This tells how much premiums and copayments will be. Then, if the applicant wants, they can apply for that insurance. It is illegal for insurance companies to deny anyone without coverage, so all that

is left is to fill out is the paper work. However, this doesn't take advantage of the competitive nature of the online marketplace.

It is best to get more than one quote and ask questions about the services the insurances covers. Questions like: Does it cover yearly check-ups? Are prescription drugs included and what is the copay for them? How many physical therapy sessions are covered if I need rehabilitative care? This way the applicant can make counter offers to the different companies to save money and get better care.

This is only a brief summary, but that is because there is no one right way to go about the process of applying for health care. It is a time consuming process that depends upon how much work a person wants to put into it. It can take a day or a week, the people who put more time into it get more out of it.

The United States has come a long way from its fee-for-service days. The Affordable Care Act shows promise that it has changed health care for the better. It may not be perfect, and it may be just a step in the right direction, but it is a strong step. The sweeping changes it brings sets a new precedent in the direction America is headed. There are still many battles ahead to reach total universal health care for all, but for the first time in a while America finally has a victory.

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