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Repeal, Replace, Reform – Current Issues in U.S. Health Politics

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With the election of Donald Trump as President of the United States, the start of a new chapter of uncertainty in health policy has begun. The Trump administration aimed to repeal the Affordable Care Act (ACA) and replace it with the American Health Care Act (AHCA). In March 2017, the AHCA was withdrawn before being voted on. However, it was passed by the House of Representatives with changes in May 2017. Based on this development, this essay analyzes and reviews the ACA and the AHCA on (1) access, (2) affordability, (3) quality of care and individual health, as well as (4) costs giving an overview about the ACA, the AHCA and their effects. This paper shows the ACA increased insurance coverage by 20 million Americans. However, Americans still face issues in affording healthcare due to high deductible plans while the American healthcare system is confronted with rising costs in the future. The AHCA would be cutting costs in the federal budget by an estimated $935 billion, but approximately 24 million Americans would lose their health insurance. Under the AHCA, costs for individual plans for Americans above the age of 50 as well as the actual out-of-pocket expenses for Americans would increase. Instead of improving shortcomings of the ACA, the AHCA would exacerbate these by increasing the uninsured rate and out-of-pocket expenses. Although being passed by the house, the bill was not passed by the Senate. At this point, it remains unclear how future political reforms will look like.

Contents

1 Introduction

On November 8, 2016, the Republican candidate Donald Trump won the presidential election and the Republican party retained the majority in the House of Representatives and the Senate (Wilensky, 2017, p. 21). As the presidential leadership of the United States of America (US) changes, health policy is likely to change as well (Obama, 2017, p. 297). With the triumph of Donald Trump and the Republicans, the start of a new chapter of uncertainty in health policy in the US has begun (Oberlander, 2017a, p. 1). During the election campaign Donald Trump repeatedly pledged to "repeal and replace" the Affordable Care Act (ACA), a healthcare policy enacted by his predecessor Barack Obama (Butler, 2017, p. 244). On March 6, the first proposal to replace the ACA, the American Health Care Act (AHCA), was released by the Trump administration drawing much criticism, even from Republicans (Steinhauer, 2017). Less than three weeks later, the bill was withdrawn from consideration before it was even voted on in the House of Representatives (Oberlander, 2017c, p. 1,497). After this, the bill was slightly changed by the GOP leadership and the administration, leading to its passing by the House on May 4 (Flegenheimer, 2017). However, the bill failed a Senate vote afterwards (Parlapiano et al., 2017).

Based on these current developments in American health policy, this essay will provide a broad overview and analyze the ACA and the AHCA on the basis of (1) access, (2) affordability, (3) quality of care and individual health, as well as (4) costs. Key elements and the effects of the ACA and AHCA will be discussed in the following sections. Based on the results of the analysis, a conclusion will be drawn from the most important findings.

2 Methods and Areas of the Analysis

Figure 1: The areas of the analysis

Source: Own representation.

In previous analyses of the ACA, criteria including access, affordability, quality of care/health, and costs were applied (Geyman, 2015, p. 209). Within the category of access, the effects of the ACA and AHCA in terms of insurance coverage is reviewed. The affordability category assesses the ability of people being able to pay for healthcare services under the bill. Within the quality of care and individual health section incremental quality and health improvements under the reform are reviewed. In the category of costs, budgetary effects of the bills are considered.
Within this paper, both bills, the ACA and the AHCA, their performance, and their effects will be assessed and hypothetically forecasted in the mentioned categories. For the AHCA, it can be stated, that an assessment of the quality of care or the influence on the overall health of individuals or the population cannot be evaluated at this time. For the other areas, a review of the literature was performed in the databases and search engines Web of Science, Science direct, J-Stor and Google Scholar. Abstracts of relevant articles were screened and then selected for the analysis.

3 The Affordable Care Act

3.1 General Approach

After a controversial political debate, the Affordable Care Act (ACA) was signed into law by President Barack Obama on March 23, 2010 (French et al., 2016, p. 1,735). The ACA has struck out as the most significant change to the US healthcare system since the enactment of Medicare and Medicaid in 1965. The intention of the bill was to address the three main challenges in US healthcare: access to healthcare, costs of healthcare and the delivery of healthcare services (Blumenthal, Abrams and Nuzum, 2015, p. 2,451). In 2010 elements of the law went into effect immediately but the major part of the law became effective in 2014. The following bullet points show the overall approach of the ACA to improve healthcare in the US (Kaiser Family Foundation, 2017a):

- Most US citizens and legal residents are required to have health insurance
    - People without coverage usually must pay a tax penalty
    - A tax penalty is imposed on employers with 50 or more employees that do not offer health insurance meeting government standards is imposed
    - Young adults are eligible to stay on parent's plan until the age of 26
    - Insurance companies are not allowed to neither neglect patients nor charge them higher premiums due to pre-existing conditions
- Implementation of state based health insurance exchanges
- Provision of refundable premium tax credits
- New insurance market regulations

- Insurance coverage for ten essential health benefits and no-cost preventive benefits
- Expansion of Medicaid eligibility to 138 percent of the federal poverty level as an option for states
- Extension of the funding for the Children's Health Insurance Program to 2015
- Enhancement of preventive benefits in Medicare and closing of the doughnut holeReduction of Medicare spending
- Establishment of an independent Payment Advisory Board and the Center for Medicare and Medicaid Innovation

3.2 Access

The ACA has succeeded in increasing insurance coverage. Since the enactment of the ACA in 2010, 20 million Americans obtained health insurance coverage by February 2016 (Uberoi, Finegold and Gee, 2016, p. 1). This has been the largest decline of the uninsured rate since the introduction of Medicare and Medicaid in 1965 (Obama, 2016, p. 527). The largest reductions were recorded in the uninsured rate among low-income individuals, people of color, as well as young adults (Kaiser Family Foundation, 2016, p. 6). Coverage has mainly increased by the expansion of Medicaid and operation of health insurance exchanges. Americans with annual incomes between 138 and 400 percent of the federal poverty became eligible for federal subsidies to be able to afford insurance coverage (Geymann, 2015, p. 210). Further, consumer protection became more important with the introduction of the ACA. Insurers are not allowed to deny patients with pre-existing conditions anymore (Blumenthal and Collins, 2014, p. 276). Furthermore, 7.8 million young adults aged 19 to 26 gained coverage by enrolling in the parents' plan. Most of them would not have been eligible without the enactment of the ACA (Blumenthal and Collins, 2014, p. 275).

However, even if the ACA was not repealed by the current Trump administration, 27 million Americans would remain uninsured in 2025. Within this uninsured group, less than one third would be undocumented immigrants and approximately 56 percent would be people who opted out. The remaining 10 percent would be people suffering from poverty in states that did not expand Medicaid (Hellander, 2015, p. 707). The US Supreme Court ruled in 2012 that states may choose to expand or not expand Medicaid. Although the federal government would pay 100 percent of the expansion initially, gradually phasing down to 90 percent in 2020, only 26 states decided to expand Medicaid. This caused 4.8 million people still being uninsured and is known as the Medicaid gap (Geymann, 2015, p. 211). In terms of access, it can be concluded that overall insurance coverage in the United States increased by 20 million. However, the healthcare system is still not close to achieving universal coverage for the US population as 27 million citizens still remain uninsured.

3.3 Affordability

As the previous part shows, the ACA increased the number of Americans with insurance coverage. But the affordability of healthcare also relies on factors like costs, prices, the value of insurance coverage, the household's income levels and other living expenses (Geymann, 2015, p. 213). An eleven-country survey published in 2016 found Americans are far more likely to go without healthcare because of high cost than in other countries (Osborn et al., 2016, p. 2,327). According to the survey, US adults were the most likely to report financial barriers to healthcare services. In 2016, 33 percent of Americans went without the recommended care, did not see a doctor when they were sick or failed to pick up a prescription because they could not afford it (Osborn et al., 2016, p. 2,328). The percentage decreased from 37 percent in 2013 by 4 percent over 3 years. However, in countries like Germany or Great Britain only 7 percent of the population experienced such problems (Osborn et al., 2016, p. 2,329). Furthermore, in October 2014 an Associated Press poll found stated one quarter of insured Americans feel insecure about their ability to pay for healthcare bills (Geymann, 2015, p. 213).

According to the Commonwealth Fund's measure of underinsurance, people are underinsured if the deductible is 5 percent or more of the total household income (Collins et al., 2014, p. 2). The share of employer-sponsored health plans having a deductible increased from 55 percent in 2006 to 80 percent in 2014. The average deductible of $1,217 more than doubled compared to the deductible of $584 in 2006 (Collins et al., 2014, p.1). A survey of the Commonwealth Fund in 2014 found that 13 percent of privately insured adults have a deductible which is 5 percent or more of their household's income (Collins et al., 2014, p. 3). In this survey, 43 percent of privately insured adults with a deductible plan claimed that their deductible caused them financial troubles or it was impossible to afford (Collins et al., 2014, p. 4). About 20 percent of the ACA enrollees are covered by Bronze plans, with an actuarial value of 60 percent. Enrollees in bronze plans face an average deductible of $5,331 for an individual per year. Some of these plans even require that the full amount of the deductible must be paid before any drugs get covered by the insurance (Hellander, 2015, p. 708). The assessment of affordability reveals that although more people gained insurance coverage by the ACA, the affordability of healthcare is still relatively low compared to other industrial countries.

3.4 Quality of Care and Health of Individuals

The intention of the ACA was to increase the access to care, enable the provision of preventive services without cost sharing, make payment changes attempting to encourage quality of care, establish accountable care organizations (ACOs), and expand the use of electronic-health records (EHR) and establish the Patient Centered Outcomes Research Institute (PCORI) (Geymann, 2015, p. 214). After the enactment of the ACA, the

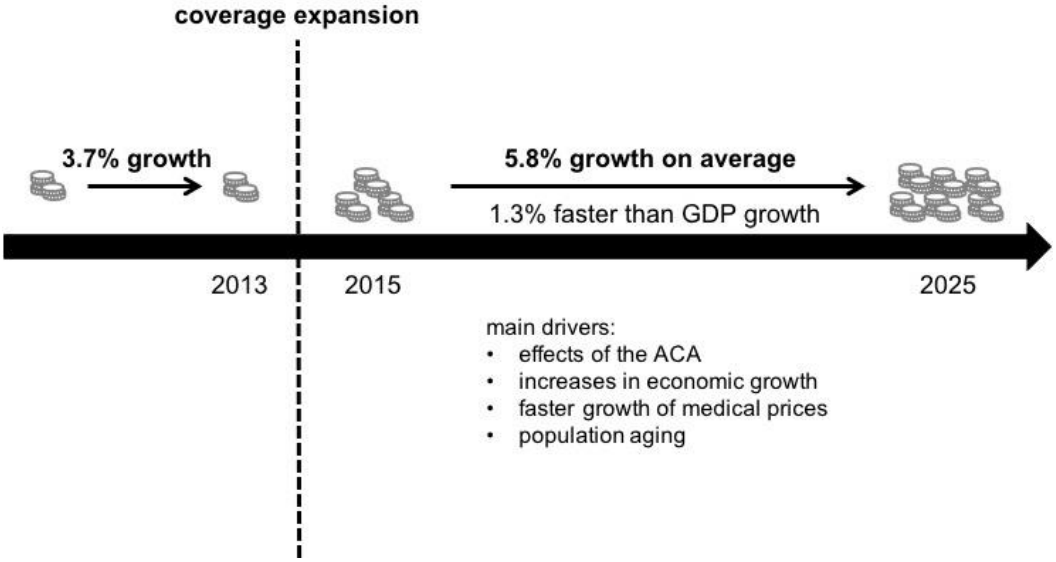
USA had some improvements in quality of care (Obama, 2016, p. 528). The rate of hospital acquired infections decreased by 17 percent from 145 per 1,000 discharges in 2010 to 121 per 1,000 discharges in 2014 (Agency for Healthcare Research and Quality, 2015, p. 1). Considering research on the relationship between hospital-acquired illnesses and mortality, the Agency for Healthcare Research and Quality estimated that the decline of hospital acquired conditions led to a prevention of cumulative 87,000 deaths over four years (Agency for Healthcare Research and Quality, 2015, p. 4). However, the policies initiated by the ACA might not be the only reason for this decline (Agency for Healthcare Research and Quality, 2015, p. 6). In addition to lower rates of hospital acquired infections, the readmission rate within 30 days after discharge of Medicare patients declined from 19.1 percent in 2010 to 17.8 percent during 2015 as well (Obama, 2016, pp. 528-529).

The expansion of insurance coverage may have positively influenced the health of Americans at some point as well. Given the results of the 2008 Oregon Health Insurance Experiment, a randomized controlled trial of Medicaid expansion, Medicaid expansion and insurance coverage is valuable for an improvement in health status but may not be as valuable as hoped due to a fragmented and inefficient system (Skinner and Chandra, 2016, p. 497) Newly insured individuals used more primary and hospital care than individuals without insurance and even received more preventive services as well. Furthermore, individuals had a better self-reported physically and mental health in addition to being less likely to suffer from medical debts and bankruptcy (Finkelstein et al., 2012, p. 1,057). However, there are limitations of increasing insurance coverage to improve population health, as hypertension and diabetes control did not change in comparison to the control group (Taubman et al. 2014, p. 263).

A true improvement in the health of individuals cannot be concluded at this point. There is no high-quality data, which demonstrates clearly a substantial improvement in health outcomes directly related to the ACA. The health outcomes above, hospital acquired infections and readmission rate more likely reflect process measures of care. Improving the health of an individual or an entire population takes much more time than the period since the ACA was enacted. Thus, the effects of the ACA on individual or population health cannot be quantified at this point (Bauchner, 2016, p. 492). Furthermore, social determinants of health, as a much more influencing factor for health than healthcare itself, must be considered here as well (Lantz, Lichtenstein and Pollack, 2007, p. 1,253).

3.5 Costs

Figure 2: Growth of costs



Source: own representation.

The implementation of the ACA has been less expensive than expected. This has helped lower federal deficits. The Congressional Budget Office estimates that in terms of overall costs of the ACA, the insurance coverage provisions from 2015 to 2019 have decreased 29 percent from 2010 estimate of $716 billion to $506 billion estimate in 2015. This decrease is caused by favorable factors like a low healthcare inflation but also factors like the Medicaid expansion in some states and the low number of enrollments in the exchanges (Emanuel, 2016, p. 1,331).

Overall, the healthcare system of the United States is the most expensive healthcare system in the world. In 2014 healthcare spending composed 17.1 percent of the US GDP compared to 12.3 percent for the OECD average (World Bank, 2017). From 2015 to 2025 health spending is estimated to grow by 5.8 percent on average. This rate would be 1.3 percent faster than the growth of the gross domestic product (GDP) and would represent 25 percent of the US total economy by 2025. The main drivers of the national health spending are expected to be the effects of the ACA (healthcare spending and insurance coverage beginning in 2014), increases in economic growth, faster growth of medical costs and population aging (Keehan et al., 2016, p. 1,522).

However, before 2014 and in the first years after the ACA was passed, the bill was supposed to help keep healthcare inflation modest. An analysis conducted by the Robert Wood Johnson Foundation-Urban Institute found that national health expenditures are expected to be $2.6 trillion (11 percent) lower from 2014 through 2019 than projected before the ACA was enacted (McMorrow and Holahan, 2016, p. 10). The five years between 2009 and 2013 had historically low growth of healthcare cost of 3.7 percent

(Martin et al., 2016, p. 150). Unfortunately, the expansion of high deductible health plans, which discourage the use of healthcare services, might be attributable to the low level of inflation as well (Emanuel, 2016, p. 1,331). Besides that, some analysts attribute this low healthcare inflation to a slow economic growth due to the economic recession (Blumenthal, Stremikis and Cutler, 2013, p. 2,551). A significant share of cost savings also derived from ACA measures slowing down the growth of reimbursement rates in Medicare (Center for Healthcare Research & Transformation, 2014, p. 2). A list of selected payment reform policies and initiatives of the ACA is shown below (Table 2.1).

Table 1: Selected payment reform initiatives

Policy/Initiative	Description	Project Cost Savings Over Ten Years
Disproportionate Share Hospital Payments	Reduction of Medicare & Medicaid disproportionate share hospital (DSH) funding as more patients gain insurance coverage	$36 billion
Hospital-Acquired Conditions	Reduction of Medicare payments by 1 percent for hospitals with relatively high rates of hospital-acquired conditions	$1.5 billion
Hospital Readmission Reduction Program	Issues penalties of up to 3 percent of payment to hospitals with relatively high preventable hospital readmissions among patients with defined conditions	$7 billion
Market Basket Updates	Reduction of rate of reimbursement growth through changes to providers' annual market basket updates and inclusion of productivity adjustments into such updates	$160 billion
Medicare Durable Medical Equipment	Expands competitive bidding for durable medical equipment from 70 to 91 areas; requires that all payment rates are subject to competitive bidding or that rates are adjusted using the competitively bid rates	$1 billion
Prescription Drug Rebates	Increases minimum Medicaid drug rebate amount and expands scope of drugs covered by the rebate requirement; expands rebate requirement to drugs provided through Medicaid managed care organizations	$38 billion

Source: Own representation based on Center for Healthcare Research & Transformation, 2014, p. 2.

4 The American Health Care Act

4.1 General Approach

The AHCA is the plan of the current Trump administration and the Republicans to repeal and replace Obamacare. Less than three weeks after the first introduction of the bill, it was withdrawn from consideration by GOP leadership and the Trump administration before it was voted on in the House of Representatives. Although Republicans hold a majority in the House of Representatives, it was very unlikely that this version of the bill would have been passed by the House (Oberlander, 2017c, p. 1,497). The Republican party was divided over the bill. For very conservative Republicans, such as the House Freedom Caucus, the bill was too much like the ACA and did not go far enough in deregulating healthcare markets and decreasing government spending. On the other hand, less conservative Republicans felt that the bill would go too far in eroding health insurance coverage (Andrews, Bloch and Park, 2017). Republican leadership finally changed some provisions of the AHCA to get the votes of the House Freedom Caucus. The bill was passed by the house on May 4 (Flegenheimer, 2017).

Although the AHCA aimed to originally repeal and replace the ACA, it actually proposes to retain important elements of it. Therefore, it would keep the ACA mostly intact (Oberlander, 2017b, p. 2). This similarity to the ACA is not surprising. A lot of Obamacare elements are quite popular in the American population. According to a Kaiser Family Foundation analysis, 90 percent of Democrats and 82 percent of Republicans have a favorable opinion of the provision allowing young adults on the parent's plan until the age of 26 (Kirzinger, Hamel and Rousseau, 2017). Furthermore, the ACA is a conservative reform model with ideas previously supported by Republicans. By fully repealing this bill, Republicans would have certainly renounced their own ideas in healthcare (Oberlander, 2017b, p. 2). According to the AHCA proposal, insurers are still not allowed to neglect patients with pre-existing conditions. However, a loophole for insurance companies is created within this bill. If a person does not continually have insurance for two months, insurers can charge an additional 30 percent premium surcharge when the individual seeks insurance. In the reworked bill of the AHCA, which has passed the house in May, more state options to waive provisions were enacted. States could waive retained essential health benefit requirements as well as the prohibition on health status rating for individual market applicants, who have not maintained continuous coverage (Kaiser Family Foundation, 2017b). Besides those alterations, young adults until the age of 26 are still allowed to stay under their parents' coverage (Stark, 2017, p.1). The overall approach of the AHCA including the amendments as of March 20, 2017 includes the following major elements (Kaiser Family Foundation, 2017b; Stark, 2017, pp. 2-3):

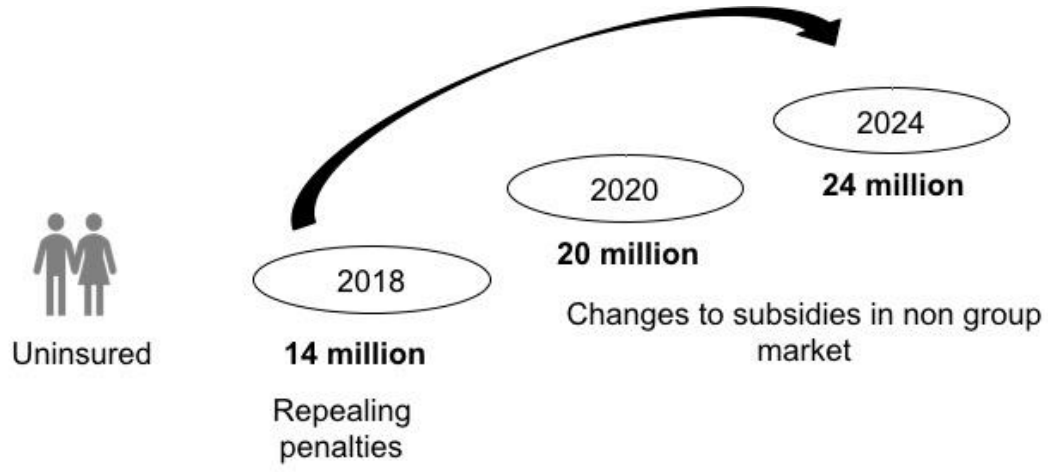
Table 2: Major elements of the AHCA

Major elements of the AHCA
Individual and employer insurance
- Repeal of individual and employer mandate immediately, standards for health plan actuarial values in 2020 and premium and cost sharing subsidies in 2020 - Retain health insurance marketplaces and annual enrollment periods - Modification of community rating from 3:1 to 5:1 - Impose late enrollment penalty for people who do not have continuous coverage - Modification of ACA premium tax credits based on age instead of income o Credit starts at $2,000 for 18-year-olds and gradually increases to $4,000 as people age. $14,000 is the maximum for a family o People, who purchase catastrophic health insurances without the current ACA benefits mandates, can receive tax credits o Expansion of health savings accounts (HSA) by increasing tax free contributions ▪ to $6,550 per year for individuals ▪ to $13,000 per year for families
Medicaid
- Conversion of federal Medicaid funding to a per capita allocation - Limit growth beginning in 2020 by using 2016 as a base year - State option to receive block grant for non-expansion adults and children or non-expansion adults only - Implement state option requiring employment/work as a condition of eligibility for nondisabled, nonelderly, non-pregnant Medicaid adults
Funding of States
- Establishment of State Innovation Grants o Over the next nine years, states would receive $130 billion federal funding and additional funding of $8 billion over 5 years for states that elect community rating waivers o States could use the money for financial help to high-risk individuals, promote access to preventive services, provide cost-sharing subsidies and other purposes (in states that do not successfully apply for grants, money is used for reinsurance) - Repeal of funding for Prevention and Public Health o Cancelation of any unobligated funds at the end of fiscal year 2018 o Provision of supplemental funding for community health centers of $422 million for fiscal year 2017
Other
- Repeal of Medicare high income tax increase and other ACA revenue provisions - Prohibition of federal Medicaid funding for Planned Parenthood clinics

Source: Own representation based on Kaiser Family Foundation, 2017 and Stark, 2017.

4.2 Access

Figure 3: Estimated development of uninsured population



Source: Own representation based on CBO, 2017, p. 2.

The CBO and the Joint Committee on Taxation (JCT) estimate that the number of uninsured would increase under the AHCA by 14 million in 2018. Repealing the penalties associated with the individual mandates would be the main reason for this increase, because many people chose to be enrolled just to avoid the penalty under the ACA. In 2020, the number of uninsured people would be expected to rise further to 21 million and in 2026 to 24 million. This increase in the number of uninsured people would be caused by changes to subsidies for insurance purchased in the non-group market and changes to the Medicaid program within the AHCA (CBO, 2017, p. 2).

Another important factor for access to insurance and healthcare is also the premium. Coverage will presumably drop, if insurance premiums increase (Chernew, Cutler and Seliger Keenan, 2005, p. 1,021). According to estimations of the CBO and JCT, premiums for single policy holders in the non-group market would increase by 15 to 20 percent in 2018 and 2019 under the AHCA because of the elimination of the mandate penalties. Because of the elimination, fewer healthy Americans would sign up for health insurance plans. Therefore, insurance companies would have higher risk pools and premiums would likely rise (CBO, 2017, p. 3). In 2020, premiums would be decreasing due to several factors, such as grants to states from the Patient and State Stability Fund, the elimination of a minimum actuarial value (see Affordability) and a younger mix of enrollees. In 2026, the average premium would be approximately 10 percent lower than under the ACA. In the long term, the AHCA would reduce average premiums. However, premiums would differ among different age groups, because insurers would be allowed to charge five times more for older enrollees than for younger under the new bill (CBO, 2017, p. 3).

4.3 Affordability

In general, the AHCA proposal is distinguishing itself from the current ACA legislation by giving more money to wealthier people through tax cuts and decreasing government support for the low-income population to afford health insurance (Oberlander, 2017b, p. 2). The tax credit under the AHCA for a 21-year-old with an income at 175 percent of the federal poverty level in 2026 would be $950 less than under the ACA (CBO, 2017, p. 16). In terms of affordability, that will result in a growing group of people not being able to afford health insurance and healthcare. In addition to that, the AHCA would make changes to the actuarial value requirements. An actuarial value is the percentage of total cost for covered benefits that the insurance plan pays (Kaiser Family Foundation, 2011). Under the current ACA legislation, the non-group and small group markets must have actuarial values of at least 60 percent. In 2020, the AHCA would allow plans to have an actuarial value below 60 percent. Although these plans would still be required to cover the ten categories of essential health benefits, the underinsurance would grow with the repeal of this requirement (CBO, 2017, p. 14). People would tend to buy plans with low premiums and therefore, they would only have limited financial coverage of benefits along with high deductibles. When they need healthcare it might be less affordable than it used to be under the ACA.

4.4 Costs

According to estimations of the CBO and the JCT, the enactment of the AHCA would reduce federal deficits by $935 billion over the 2017 - 2026 period (see Table 2.3). However, other provisions, mostly reduced tax revenues, would increase the deficits by $599 billion resulting overall in a reduction of approximately $337 billion (CBO, 2017, p. 6). Within these reductions, reductions from outlays in Medicaid and the elimination of the ACA's subsidies for the non-group health insurance would account for the largest savings (CBO, 2017, p. 1). However, by cutting the Medicaid expansion, the number of uninsured Americans will increase. Because Medicare makes an additional payment to facilities giving care to uninsured patients, Medicare spending would be expected to increase by $43 billion over the 2018-2026 period (CBO, 2017, p. 19). The estimated budgetary effects are displayed in the table below.

Table 3: Cost reducing and offsetting elements

Cost reducing elements		Offsetting cost elements	
Reduction in federal outlay for Medicaid	$880 billion	Costs for the new tax credit	$361 billion
Savings mostly from the elimination of ACA's subsidies for nongroup health insurance	$673 billion	Reduction in revenues from eliminating the penalties for uninsured	$210 billion
Savings mostly associated with shifts in the mix of taxable and nontaxable compensation	$70 billion	New Patient and State Stability Fund grant program	$80 billion
Savings from repeal of tax credit for certain small employers providing health insurance to their employees	$6 billion	Increased Medicare spending for uninsured patients	$43 billion
$1,629 billion		$694 billion	
= $935 billion deficit reduction			
- $599 billion increase from other provisions			
= $337 billion deficit reduction overall			

Source: Own representation based on CBO, 2017, pp. 6-7.

Another analysis of the Robert Wood foundation estimated the reduction in federal Medicaid spending to be $841 billion. This estimate is lower than the estimate by the CBO, which assumed that many states would cut Medicaid enrollment (Holahan et al., 2017, p. 2). However, concluding the budgetary point of view, the AHCA would certainly reduce the federal deficit and cut governmental costs in healthcare.

5 Discussion

After analyzing both bills in terms of performance and projections in the areas access, affordability, quality of care/individual health and costs, the differences and the effects caused by the ACA and AHCA become more obvious.

Access

In terms of access it becomes clear, that the two bills follow a completely opposite approach. Since the ACA's aim is to reduce the uninsured population by having an individual mandate and expanding Medicaid, the AHCA would emphasize the aspect of freedom of choice as well as reducing costs and premiums. Therefore, the AHCA would repeal the mandate and change the Medicaid funding into a block grant leading to individuals being unable to enroll in Medicaid if the block grant is used up. As shown in the previous section of the AHCA the projected increase of 26 million uninsured people by

2026 would more than repeal the efforts the ACA made in providing more Americans insurance coverage. However, it is questionable if the AHCA is actually proposing real freedom of choice to the American population. The vulnerable and poor population, due to their financial situation, is very limited in their freedom of choice and therefore the proposition of freedom is irrelevant here. Furthermore, individual choices are often limited due to restrictions of employers, insurers, doctors or pharmaceutical companies (Partanen, 2017).

Affordability

The analysis in terms of affordability of the ACA showed that although Americans have health insurance coverage, they are still facing challenges to afford healthcare due to high deductible plans under the ACA. By allowing insurance to have actuarial values below 60 percent (CBO, 2017, p. 14), the AHCA would decrease insurance premiums. However, insurance benefits would decrease and out-of-pocket costs for individuals would increase at the same time. Furthermore, the AHCA would have substantially raised costs of individual plans for older Americans (Oberlander, 2017c, p. 1,498). Another analysis from the Kaiser Family Foundation showed that 6.3 million people with pre-existing conditions would be at risk for higher premiums under the AHCA because they had a gap in insurance coverage of 63 days or more (Kaiser Family Foundation, 2017c). While proposing deep cuts in financial help for low-income Americans for buying health insurance, the AHCA is giving higher-income Americans and the healthcare industry large tax cuts (Oberlander, 2017c, p. 1,498). In terms of affordability, the AHCA is therefore not improving conditions for lower-income people at all and health insurance in the US can rather be considered as a protection against catastrophic circumstances for them.

Quality of Care/ Indivdiual Health

After the ACA was enacted, improvements in the rate of readmission of Medicare patients as well as the hospital-acquired diseases could be demonstrated. In terms of individual health there is no reliable data suggesting an improvement at this time. However, given the study about the Medicaid expansion experiment mentioned in section 0, it is likely that somehow population health has improved by expanding Medicaid coverage. Looking at the AHCA, possible effects cannot be stated at this point. However, according to the results of the study, the AHCA which would increase the number of uninsured, potentially worsening population health.

Costs

The most popular part of the ACA, which brings the US closer to universal coverage is the most expensive, too (Herzlinger, Richman, and Boxer, 2017, E1). With the major

insurance expansion in 2014, the growth in healthcare spending accelerated and is expected to be faster than the GDP growth by 1.3 percent (Keehan et al., 2016, p. 1,522). Costs are found to be one of the major challenges for US healthcare in the future. The AHCA is addressing this issue and is estimated to reduce the federal deficit by $935 million (CBO, 2017, p. 6). However, this reduction would be mainly achieved by cutting costs in the Medicaid program and eliminating the ACA subsidies. This comes at a high price to lower-income Americans and is throwing the US back to pre-ACA times in terms of coverage and access to care.

6 Conclusion

This paper aimed to compare the ACA and the AHCA and review their effects in the areas of access, affordability, quality of care and health of individuals as well as costs and to give the reader a broad overview and a comparison of these two health care bills. As the analysis showed, the ACA increased insurance coverage by 20 million Americans and therefore it represents a historic step in making health insurance a right in the US. However, the analysis also showed that Americans still face issues in affording healthcare due to high deductible plans while the American healthcare system is confronted with rising costs in the future.

The effort of the Republican party to repeal and replace the ACA was a failure at first. Only a few weeks after the AHCA was introduced, the bill was withdrawn from consideration by the Trump administration and the House GOP leadership without holding a vote in the House of Representatives. However, after the bill was changed in favor to the Freedom Caucus movement, it was passed by the House of Representatives in May 2017. The review showed that while the AHCA would be cutting costs in the federal budget by an estimated $935 billion, approximately 24 million Americans would be likely to lose their health insurance. Under the AHCA costs for individual plans for Americans above the age of 50 as well as the actual out-of-pocket expenses for Americans would increase. It becomes obvious that the AHCA would not improve the shortcomings of the ACA, instead it would worsen these.

Since the AHCA did not pass the Senate, the direction of future legislation is unclear, the results on American healthcare will be profound and either take the US healthcare system back into pre-ACA times or align with a movement towards universal health insurance coverage and healthcare.

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