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WORKING PAPER SERIES

NO. 011/2022

Paper Title: Does Affordable Care Act Promote Preventive Care Services?

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Does Affordable Care Act Promote Preventive Care Services?

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Abstract

This paper investigates whether the Affordable Care Act of 2010 adequately provides for preventive care services, which is a major element for the provision of universal healthcare for the American people. The paper relies on a historical review of the provisions of the Act and empirical evidence from literature to conclude that the Affordable Care Act has adequate provisions for preventive care services. The paper therefore suggests that policy makers should expand the enrollment period to accommodate individuals who may not be able to register within the enrolment period but may stand in need of a comprehensive periodic care, especially pregnant women who need prenatal care during the term of their pregnancy. The paper also recommends that those states yet to establish exchanges should set aside political differences, to enable the citizens take appropriate steps to benefit from the preventive care services provided by the healthcare program. The paper then concludes that the universality of the Affordable Care Act implies a good implementation of preventive care services.

Key Words: Affordable Care Act, Preventive Care, Healthcare Services, United States

Introduction

This paper investigates the Affordable Care Act (ACA) of 2010 in a bid to ascertain its universality in the provision of adequate healthcare and promoting preventive care services in the United States. There is evidence of less than optimal utilization of preventive healthcare services (Hong, Jo and Mainous 2017). This paper draws on existing literature on the issues of preventive care services from the ACA in order to find the impact of public policy formulation and implementation on the political decision-making process. Blumenthal and Collins (2014) finds that evidence-based policy formulation and adoption should be a condition for policy implementation. The Affordable Care Act (ACA) mandates that private health insurance plans cover evidence-based preventive services. But, in the course of implementing the ACA, policy makers have found inadequacies in the up-to-date of several preventive care services. To improve public health, better preventive care service needs to be the goal of health care system. Because the benefits of receiving preventive health services are well-documented, it reduces the overall cost of healthcare and promotes wellness. The issue raised by this paper is whether the Affordable Care Act has enough provisions for preventive care services, which is an essential ingredient of a universal coverage in healthcare delivery. To answer this question, this paper draws on the literature of the origin and methods of implementation of the Act.

To promote the utilization of preventive services, ACA mandated that private health insurance plan cover evidence-based preventive services, in particular those recommended by the US Preventive Services Task Force (USPSTF) and the Advisory Committee on Immunization Practice (ACIP) without additional out-of-pocket costs to eligible individuals. Early diagnosis of chronic diseases could significantly reduce the prevalence of such, and at the same time lead to healthier lifestyle and better management of associated diseases (Wherry and Miller 2016). Several studies have examined the relationship in the implementation of the ACA and the rates of preventive screenings, but these studies have shown mixed results (Hong

et. al 2017, Wherry and Miller 2016)). This paper intends to fill the existing gap in the literature of the role of ACA in fulfilling its mandate of providing the basis for preventive care services.

There is no doubt that the Patient Protection and Affordable Care Act otherwise known as Obamacare has been one of the most comprehensive, complicated and controversial piece of healthcare legislation in the history of the United States. The fundamental goal is to make an efficient and effective healthcare delivery service accessible to the American people. Responses to the Affordable Care Act have ranged from support of the many who feel coverage expansion for Americans is a tremendous positive to vehement opposition resulting in a federal government shutdown in an effort to delay or repeal the Affordable Care Act (Bourne 2019). The implementation of the ACA has been very challenging, the initial roll-out was somewhat faulty. Despite all the anomalies, the Obama administration and their supporters in congress did a poor job in communicating to the American public about why they should support the health care reform. These factors with strong Republican opposition caused a negative public reaction and created impediments to its various provisions. The aim of this paper is to analyze the universality of the Affordable Care Act and argue in favor of its role in the provision of preventive care services (Weimer and Vining 2017, Barbach and Patashnik 2020). Many have argued on the inadequacy of the Act to safeguard the health of the American people, but one may not lose sight of the importance of preventive care services in our healthcare system. This paper will be structured in five sections; the next will be on the background of the Affordable Care Act, the third will feature a review of related literature of the issue under discourse, the fourth will be a discussion of possible solutions towards improving preventive care services in healthcare delivery system. The paper concludes in the fifth section with recommendations and policy implications.

Background of the Affordable Care Act

Before the Affordable Care Act was passed by Congress and signed into law by the President, more than 47 million Americans were uninsured, and 29 million others were considered underinsured (Gee, Levy & Reyes 2014). More than 30% of the plans on the individual market did not cover pregnancy care, which poses a significant threat to almost half of the pregnancies in the United States. The unintended consequences of childbirth and pregnancy related conditions are costly and account for nearly one-fourth of hospital stays. Before the ACA it was estimated that women on average spent 25-50% more than men for identical insurance coverage. In the past insurance companies were able to exclude coverage for preexisting conditions, charge different premiums based on gender, and underwrite premiums based on other medical risk factors, leaving individuals exposed to fluctuations in premium prices and possible cancellation of policies in the event of a serious medical condition such as breast cancer.

The ACA allows young adults between the ages of 19-25 to remain on their parent's coverage, which somehow expanded the scope of coverage to reduce the number of uninsured. The insurance market place under ACA mandates coverage of a standard package of benefits called "essential health benefits." This kind of coverage was intended to curb hospital visits, but promote disease prevention and wellness, which will otherwise reduce underinsurance. In addition to required essential health benefits the Act requires that some covered services be provided without any patient copayments or out of pocket cost. Services that are covered without out of pocket costs include; all U.S. Preventive Services Task Force A or B recommendations, all vaccinations recommended by The Advisory Committee on Immunization Practices, the Bright Futures recommendations from the American Academy of Pediatrics, and The Clinical Preventive Services for Women recommendations from the Institute of Medicine.

The Affordable Care Act sets minimum standard of essential Health Benefits to include the following: Maternity and newborn care, prescription drugs during hospitalization, ambulatory patient services, preventive and wellness services for chronic disease management, emergency services, laboratory services, rehabilitative and habilitative services and devices, mental health and substance use disorder services, including behavioral health treatment, pediatric services including oral and vision care. Nonetheless, coverage for preventive services is dynamic and evolving. New policy recommendation trigger changes in preventive care services. As new recommendations are reviewed by the U.S. Preventive Services Task Force, those with A or B recommendations are required to be covered at no cost-sharing for the patient. Before the Affordable Care Act, most plans covered some preventive services but required member cost-sharing. The absence of copayments has been shown to increase use of preventive health services; however, many health care providers are concerned about the lack of collecting copayments in the office and whether insurance payments will offset this loss of revenue (Gee, Levy & Reyes 2014,).

The Affordable Care Act creates new exchanges for an online market where consumers and small businesses can shop for health insurance, compare the available plans and purchase insurance online. The plans in the exchanges are grouped in four tiers of bronze, silver, gold and platinum. However, all plans do cover essential health benefits, the tiers vary by the amount of cost-sharing required of the individual. The federal government established exchanges in states that refused to develop their own especially in Republican controlled states, whose goal was to repeal and replace the Act. States like Massachusetts with an existing and similar health services platform created their own exchanges or have a hybrid partnered exchange with the federal government. In the original design of the Act the architects have envisaged that some states would set up their own exchange marketplace rather than relying on a federally

administered exchange. As at 2014, only 14 states and the District of Columbia have created their own exchanges, leaving a large number of Americans depending on the federal exchange.

Although the early implementation of the exchanges was a public relations failure and colossal loss to the federal government. In order to make the exchanges an affordable option for low-income Americans, the Affordable Care Act provided financial incentives to purchase insurance on the exchanges in the form of tax credits and subsidies for individuals who qualify based on income levels. Despite all the challenges the Congressional Budget Office had estimated that in the rolling period of October 2013 to March 2014, over seven million people will find a health plan through the exchanges. Unfortunately, because of term limitations of enrolment within the time period allotted many were excluded from coverage. For instance, women must sign up for insurance on the exchanges during the enrolment period. Women who become pregnant and have not signed up for coverage during the enrolment period will not be eligible for coverage during the term as a result of pregnancy and may not get the much-needed prenatal care they desire.

The Affordable Care Act expanded Medicaid by providing greater federal subsidies for new populations enrolled into Medicaid. Prior to the Affordable Care Act, in most states being poor or incomes falling within the poverty threshold or belonging to one of the following groups of individuals within the population: children, parents, pregnant women, people with severe disability, or seniors. Single adults were excluded from Medicaid unless a state had applied to the federal government for permission to cover them. Before the Affordable Care Act Medicaid coverage was limited in 17 states to parents earning less than 50% of the federal poverty level.

Medicaid is a program in which states pay a portion of the health care costs and the federal government pays the rest with the proportion based on the wealth of the state. With the Affordable Care Act, for the first 3 years, the federal government pays for the full cost of

Medicaid expansion for most low-income adults to 138% of the federal poverty level, which is \$15,856 for an individual or \$26,951 for a family of three. Federal subsidies to states decrease to a nadir of 90% of the costs for caring for the expansion population with the state paying for 10% of the Medicaid payments for this expansion group by 2020. Initially, the law was designed to penalize states that declined to expand enrollment by withholding federal matching funds for the population of patients that states were currently covering. In June 2012, the U.S. Supreme Court in *National Federation of Independent Business v. Sebelius* struck down this provision, in effect making Medicaid expansion optional for the states. Nevertheless, not all states are accepting expansion subsidy in the states that do expand, millions of women will have coverage before during and after pregnancy rather than simply during the pregnancy. This change would pose a dramatic increase in the amount of money spent for prenatal care for ensuring optimal health for women going into pregnancy.

Because there were no exchanges for the sale of health insurance before the Affordable Care Act, it was very difficult to develop the system to expand enrolment as quickly as possible. Besides the political impediments were enormous. Most Republican controlled states refused to align with the federal government by subscribing to demand of the exchanges. Such states were rather poised to frustrate the system and hence see the failure of the Affordable Care Act than to see it succeed. Albeit, the piece of legislation became a complex policy framework fraught with a lot of spatial and temporal inconsistencies. One of the major issues for concern is ensuring the provision of preventive care services, which would make any health policy plan more comprehensive and therefore universal in application.

Literature Review on Affordable Care Act and Preventive Care Services

The issue of the universality of the Affordable Care Act in the area of preventive care has been very controversial. While the health plans may cover some prenatal care services, some

underlining health checks for cancer and some debilitating diseases might not be covered since there is an open enrolment period. Many individuals who are unable to register under the exchange during the open enrolment period find themselves in a dilemma of sort. Even though no one can predict when he will be afflicted with a disease or ill-health, it becomes very difficult to align the open enrolment period with times of medical need. This anomaly threw many people out of the insurance market, unable to get the insurance they so desire to sustain a healthy living.

According to Gee et. al (2014) the Affordable Care Act did not expand as envisaged by policymakers. It was thought that with the passage of the bill, nearly all the 47 million uninsured Americans would benefit from the scheme and have access to an affordable health care. However, that was not the case, the main issue was attributable to the lack of states accepting Medicaid expansion, this number will be much lower than expected. Nonetheless, beginning in 2014, tax penalties were imposed for those who did not buy health insurance for 3 or more consecutive months. However, these penalties are much less than the cost of buying insurance. Unfortunately, if young, healthy, low-risk people fail to enroll in the exchanges, the risk pool will not expand as expected and result in overall premium increases to cover the cost of covering the sicker individuals who have been enrolled.

As a result of the Affordable Care Act, millions more American women will have access to comprehensive and affordable care. Challenges remain in implementing the contraceptive coverage provisions and in providing access to the full range of reproductive health services. Although the Affordable Care Act requires all health plans to provide the full range of U.S. Food and Drug Administration – approved contraceptive methods, there are exemptions for religious institutions. The coverage expansion of the Affordable Care Act gives millions of Americans unprecedented access to health care services, lowers out-of-pocket costs for preventive services, and secures benefit packages that include coverage for areas of critical

importance to women such as pregnancy care. However, the Affordable Care Act is not a fundamental redesign of health care but rather an attempt at near universal coverage. True reform must mean that not every American gets what they want but the essential services they most need. As a nation we must tackle the sustainability of this system by achieving the triple aim of “lower costs, better population health outcomes, and better individual care.”

Hong, Jo & Mainous (2017) opines that the provisions of the Affordable Care Act have resulted in very trivial or minimal increases in being up-to-date on selected preventive care services. The study went further to list the measures taken up-to-date on preventive care services under the Affordable Care Act. They include the receipt of an annual routine check-up and six preventive care services, which includes flu vaccination, blood pressure check, cholesterol check, pap smear test, mammography, and CRC screening were the main outcome. Prevalence of diagnosed conditions that were estimated by the study included being diagnosed with hypertension, high cholesterol, diabetes, cardiovascular disease. The study by Hong et. al (2017) found no significant changes in the diagnosis of health conditions, given that most of the preventive care services except certain cancer screening, for example colonoscopy and mammography, were likely covered by some private plans at no or low out-of-pocket costs before the Affordable Care Act went into action. It seems the overall impact of the ACA on the likelihood of being diagnosed among those with private insurance has been diminished. Another possible explanation is that the ACA’s provision for preventive service was not well-targeted to detect undiagnosed conditions.

One of the reasons for the recommendation of screenings under the ACA is to make people feel that preventive care services are highly effective at improving individual health outcomes, which ultimately leads to improved population health and slowdown in national health care spending. On the basis of the findings from Hong et. al (2017), it appears that the ACA’s elimination of cost-sharing may not be enough to increase use of preventive care

services among those with private insurance. The full implementation and the provision of dependent coverage had no impact on the results, as the use of sensitivity analyses show.

In another dimension the utilization and policy implementation of the Affordable Care Act could be measured by improvements of the coverage in Medicaid expansion (Wherry & Miller 2016). This study concludes that the ACA Medicaid expansions were associated with higher rates of insurance coverage, improved quality of coverage, increased utilization of some type of health care, and higher rates of diagnosis of chronic health conditions for low-income adults. The outcome measures of the study by Wherry & Miller were based on self-reported information in the NHIS. The first set of outcomes was related to insurance coverage and health care utilization. Three binary coverage variables indicated no health insurance coverage, which is defined as coverage between through Medicare, Medicaid, a private insurer, the military or other government programs. At the time of the survey (interview) for this study, respondents indicated that their health insurance or health care coverage was better than it had been 1 year before.

Solutions for Improving Preventive Care under the Affordable Care Act

Koh & Sebellius (2010) stated that the Affordable care Act of 2010 responds to the need for the prevention of diseases in the nation's health system. Many of the ten major titles in the law emphasize the prevention of chronic diseases and improving public health. The law covers a range of recommended preventive services with no cost sharing by the beneficiary. These services include those rated "A" (strongly recommended) or "B" (recommended) by the U.S. Preventive Services Task Force (USPSTF), vaccinations recommended by the Advisory Committee on Immunization Practices (ACIP), and preventive care and screening included both in existing health guidelines for children and adolescents and in future guidelines to be developed for women through the U.S. Health Resources and Services Administration (HRSA). Examples of covered services include screening for breast cancer, cervical cancer and

colorectal cancer screening for human immune-deficiency virus (HIV) for persons at high risk; alcohol-misuse counselling; depression screening. The prevention theme according to Koh & Sebellius (2010) also affects individuals covered by public insurance programs. In addition, the paper stated that Medicare will cover without cost sharing, an annual wellness check from January 1, 2011.

Koh & Sebellius (2010) emphasizes that to prevent disease and promote health and wellness, the Affordable Care Act breaks new ground, reaffirming the belief in the principle “the health of the individual is almost inseparable from the health of the larger community, and that the health of each community and territory determines the overall health status of the nation.” Moving prevention to the mainstream of healthcare delivery was the cardinal objective of the Affordable Care Act, and one of the most lasting legacies of this health policy.

From all indications we have seen that the policy process is a process of balancing different solutions that address the different aspects of a cluster of problems (Flavin 2013, Kusek and Rist 2004). The problem of ensuring that preventive care services are adequately covered under the Affordable Care Act is rife, but the distinctive nature of healthcare policy makes it very possible to direct focus on early care instead of cure. In addition to protecting the population through preventive care there is also the need to provide healthcare advisory to individuals. The healthcare policy of the United States has gone through several reforms under every administration (Ruderman 1997, Starke 2014). Knowing that healthcare is the live wire of economic growth and development, every administration strives to ensure that the society is enriched by its healthcare policy. The Affordable Care Act of 2010 was the signature legislation of the Obama administration aimed at providing a universal care for all Americans irrespective of age, gender and station in life.

Another proper solution for guaranteeing the success of the Affordable Care Act with a view to creating a universal healthcare policy is considering the conditions for policy change.

Some state governments were very reluctant in administering the exchanges based on partisan politics. In a fragmented situation as this, DeLeo and Donnelly (2017) argues that when a policymaking system is marked by competition between various subsystems or constellations of policy participants, each focusing on one particular issue it could be a condition of “punctuated equilibrium.” Often subsystems are marked by internal conflict and different coalitions of actors will advocate for their preferred policy outcomes. The punctuated equilibrium model seeks to capture periods of abrupt policy change (punctuation) and relative stasis (equilibrium). To this end, we see that periods of change like the one introduced by the Affordable Care Act signify acute deviations from the status quo that upend and, eventually, replace existing policy monopolies – coalitions that effectively control the way an issue is framed and discussed.

Conclusion

This paper has reviewed the Affordable Care Act in broad terms with a view to ascertaining its universality based on the premise of providing a comprehensive preventive care service. As we have seen there is empirical evidence to show that preventive care services reduce the overall cost of healthcare provisions in the system. The paper argues that the Affordable Care Act has been very successful in making provisions for preventive care services in the United States. The outcome of this measure is that the cost of healthcare is reduced and there are adequate provisions for preliminary health care services as opposed to the curative measures that is often put in place as a measure of last resort.

The study recommends that those states, who for political reasons have refused to abide with the provisions of the Affordable Care Act by establishing the required exchanges for enrolment should do so in order to provide the citizens of the state the opportunity to benefit from the preventive care services that this healthcare policy provides. In the same vein, the open enrollment period should be expanded to ensure that more people are captured within the

enrolment time frame. Many people are deprived of the benefit of preventive care services because they were unable to enroll within the short time allotted for the exercise.

However, the universality of healthcare implies reaching out to all, and ensuring that there are no restrictions to any American to receive adequate healthcare irrespective of the circumstances surrounding their station in life. Healthcare should be considered a human right and not a privilege. Every citizen should be entitled to an adequate measure of protection under the law including the guarantee of a decent and healthy living.

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