

# Introduction to the U.S. Health Care System

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One of the key topics of political discussion in the U.S. these days is its healthcare system. Most recently, “repeal and replace” has been the pivotal issue of political debate. The urge to reform the Affordable Care Act comes not from its many accomplishments, such as reducing the uninsured rate, but from what still needs improving: healthcare costs and spending. In this context, the “Triple Aim” approach is the center of focus within the healthcare system and will be portrayed in this essay after giving a short overview of the U.S. healthcare system itself. The framework of the “Triple Aim” consists of goals aiming to improve the experience of care and health of the population at a lower per capita cost. Providers of the U.S. healthcare organizations are being paid by a hybrid structure with different insurance forms existing parallel to each other, resulting in an inefficient and extremely fragmented healthcare system. Like most other countries, there are both private and public insurers in the U.S., with payments coming from two main sources which will be explained in this essay. Political efforts play a big role in the American healthcare system. Health insurance marketplaces initiated by the Affordable Care Act come short of achieving managed competition where choice drives efficiency. High administrative costs also contribute to the current inefficiency of the American healthcare system, making it difficult to reach the Triple Aim. The goal of the Trump Administration to change regulations of the Affordable Care Act could not be reached either, letting the final structure and outcome of the U.S. healthcare system be unknown.

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## **1 Introduction**

Political debate over the U.S. healthcare system is a constant throughout the public space, media commentary, and the legislative bodies themselves. Most recently, “repeal and replace” has been the major topic of discussion, reignited by the transfer of governmental power from one party to another. The urge to reform the Affordable Care Act (ACA) comes not from its many accomplishments, such as reducing the uninsured rate, but from what still needs improving: healthcare cost and spending. The U.S. spent 17% of its gross domestic product (GDP) on healthcare in 2013, which correlates to twice the average of all Organization for Economic Cooperation and Development (OECD) countries (OECD, 2015). From 2015 to 2025, healthcare spending growth is projected to be an average of 5.8% or 1.3% faster than the growth in GDP, suggesting that by 2025 the U.S. will spend 20.1% of its GDP on healthcare (Keehan et al., 2016, p. 1,522). Despite the rising costs, the U.S. population faces poorer health outcomes than other high-income countries such as Germany or the UK. When it comes to infant mortality, the U.S. leads the ranking with 6 deaths per 1,000 live births, whereas in Germany (or the UK) 3.2 (or 3.9) infant deaths occur per 1,000 live births. In terms of life expectancy at age 60, the U.S. ranks last with 23.6 years compared to 24.1 years in the UK (Schneider et al., 2017, pp. 4-24). The aim of this essay is to give a short overview of the U.S. healthcare system, especially recent developments and new health insurance markets, to understand the reasons for the exorbitant cost Americans pay for inefficient healthcare and to argue whether the Triple Aim approach is observed in action.

## **2 Overview of the U.S. health care system**

Compared to many of the other OECD countries, U.S. healthcare has no uniform, nationwide system. The U.S. hosts a hybrid payment structure with different insurance forms existing parallel to each other, resulting in an inefficient and extremely fragmented healthcare system (Schmid and Himmler, 2015, p.11). Additionally, no universal healthcare coverage is given in the U.S. As with most other countries, there are both private and public insurers in the U.S. healthcare system, with payments coming from two main sources:

- Public: Centers for Medicare and Medicaid Services (CMS)
- Private: State-Specific Nonprofit Blue Cross Blue Shield and Private Commercial Insurers

Insurance choice is influenced by a number of factors, including age, income, geography, employment status, and disability (Doonan and Katz, 2015, p. 747). Both private and public health insurance programs differ in regard to the benefits covered, financial sources, and payments to healthcare providers (De Lew et al., 1992, p. 151). Persons

without any health insurance can seek care from safety-net health systems that deliver essential services through inpatient, emergency, and ambulatory care. Core safety-net providers offer access to care regardless of a patient's ability to pay and have a patient population consisting mostly of uninsured or Medicaid patients in addition to patients who are ineligible for coverage under public programs. These individuals depend on subsidies and charity to bear the rising healthcare costs, which results in low operating margins at safety-net facilities (Chokshi et al., 2016, p. 1,790).

With the implementation of the ACA, the U.S. population was introduced to a new option for getting access to health insurance. However, this system is currently targeted to be repealed and replaced under the Trump Administration (Graves and Nikpay, 2017, pp. 297-304). The ACA health insurance marketplaces in place are accessible via websites and toll-free numbers enable insurance coverage independent of pre-existing conditions. The system provides consumers with choices, increasing competition between insurers which theoretically reduces cost, maximizes quality, and increases the number of insured persons (Doonan and Katz, 2015, pp. 749-752). Insurers can combine the small individual insurance market with the also small group insurance market into one risk pool, reducing payer risk and increasing the number of consumer choices (Doonan and Katz, 2015, pp. 749). For further analyzing of these marketplaces, see section 5 in this essay.

A new healthcare delivery concept initiated by the ACA is an Accountable Care Organization (ACO), a clinical care enterprise that influences provider financial risk by incentivizing improvements (Rosenbaum, 2011, pp. 875-876). An ACO can be defined as a healthcare delivery system with either a Medicare or private payer payment model as well as a network of providers responsible for the cost and quality of care for a defined groups of patients (Rosenbaum, 2011, p. 875). Inspired by private-sector examples of integrated health delivery system, such as Kaiser Permanente and Geisinger Health System, the goal of an ACO is to provide financial incentives for coordinated, deliberate use of adequate high quality care (Frakt and Mayes, 2012, p. 1,954). Section 4 in this volume provides a more detailed insight into this health care delivery form.

### **3 Triple Aim**

When talking about goals in the healthcare system, a widespread term in the U.S. is the Triple Aim. The Triple Aim is a term originated by the Institute for Health Improvement (IHI) that it defines as, "A framework for optimizing health system performance," aiming to (1) improve the experience of care, (2) enhance the health of the population, and (3) reduce the per capita costs of healthcare. As independent goals, movement towards achieving one goal can affect the other two positively or negatively, making it essential that all three components are balanced in order to optimize the healthcare system. Pre-

conditions for reaching the three goals include the enrollment of an identified population, a commitment to universality for its members, and the existence of an organization (an integrator) that assumes responsibility for all three aims for that population.

In the U.S., the pursuit of the Triple Aim is facing a variety of obstacles which need to be overcome: supply-driven demand, physician-centric care, many new technologies that show limited impact on outcomes, little or no foreign competition to spur domestic change, and little appreciation of system knowledge among clinicians and organizations (leading them to sub-optimize the components of the system with which they are most familiar at the expense of the whole) (Berwick et al., 2008, p. 760). Similarly, the pursuit of the Triple Aim is also a question of political barriers since the effects of its vision includes disruption of the status quo in institutions, forms, habits, and income streams (Berwick et al., 2008, p. 768). Also absent, but necessary, is a focus on primary care and public health which must be developed (as a building block for high quality care) (Rice et al., 2014, p. 894).

One of the founders of the Triple Aim is Dr. Donald Berwick, who was recruited by former President Barack Obama in July 2010 to serve as the Administrator of the CMS. Berwick and his colleagues derived the Triple Aim strategy from IHI's leadership in measuring and improving the quality of care after having worked at IHI for decades. After Berwick left the Agency in 2011 (because of Senate Republicans refusing to confirm his nomination), the Triple Aim still remained a priority for CMS and the U.S. healthcare system (Fox and Grogan, 2017, pp. 32-33).

## **4 Providers in the U.S. Health Care System**

### **4.1 Hospitals**

Regarding providers of healthcare in the U.S., one can distinguish between primary providers (organizations providing health services) and secondary providers (organizations providing financial, educational or technological resources) (Janus, 2003, p. 120). This section will focus on the primary providers of the American healthcare system.

In 2017, more than 5,500 hospitals with about 900,000 beds were registered throughout the country (AHA, 2017a). Most of these are non-profit hospitals (Phelps, 2013, p. 214). With a total of 4,862, the majority of the hospitals are community hospitals, followed by 401 registered nonfederal psychiatric hospitals, 212 federal government hospitals, 79 nonfederal long-term care hospitals, and about 10 hospital units within institutions (such as prison hospitals) (AHA, 2017a). The community hospitals are nonfederal and provide mainly acute, short-term care. Often, they also function as academic medical centers where medical staff is trained (Folland et al., 2007, p. 294). Currently, 59% of the community hospitals are owned by non-government, non-profit institutions, 21% are owned

by profit seeking companies, and 20% are owned by state and local governments (AHA, 2017b).

Two classifications of medical treatment in hospitals can be distinguished: (1) inpatient care and (2) outpatient care. The first represents the more traditional case where patients stay in the hospital for more than one day, whereas the second represents a patient's intra-day treatment with no overnight stay included (Phelps, 2013, p. 233). In the past 30 years, the core function of hospitals has changed dramatically. Hospital utilization, lengths of stay, and surgeries have decreased considerably. Instead of the traditional inpatient treatment path, the number of outpatient medical procedures has increased (including outpatient clinics, emergency departments, outpatient surgeries, and other examples). Since 1975 outpatient visits have risen from 254,814 to 637,689 in 2005, which amounts to an inflation of about 165% (Phelps, 2013, p. 233).

## **4.2 Physicians**

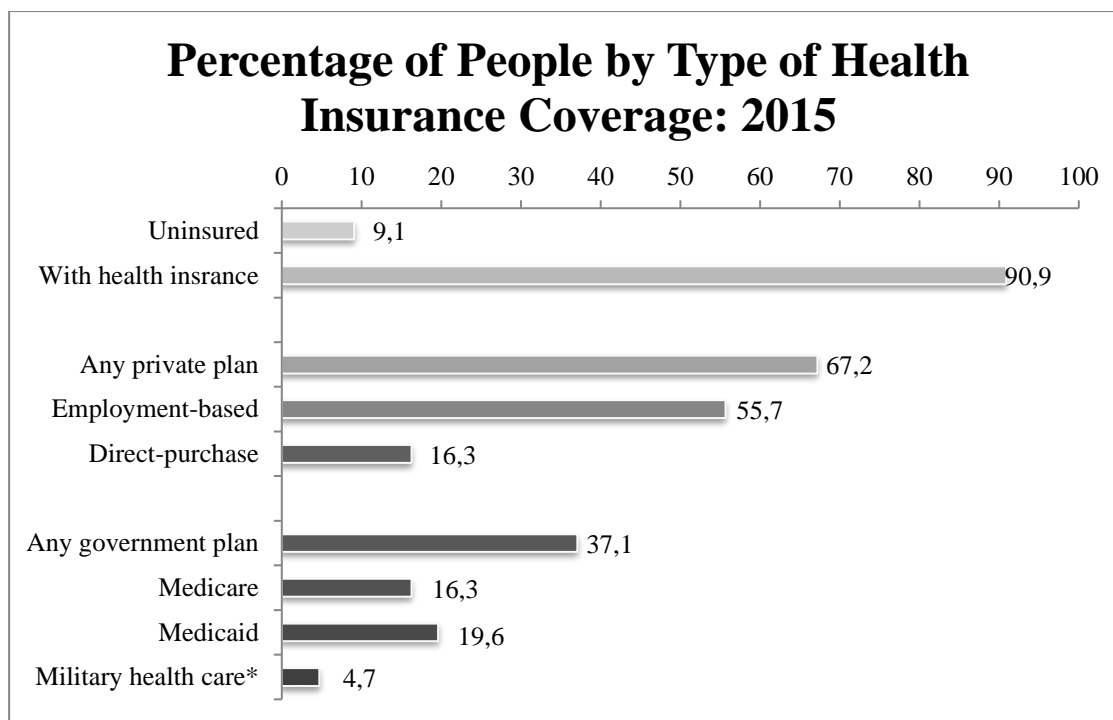
Several decades ago, the vast majority of physicians were in private practice and paid on a fee-for-service (FFS) basis. They could provide care to their patients in their offices and admit them to hospitals where they could personally serve them further (De Lew et al., 1992, p. 151). Nowadays, most physicians have negotiated third-party contracts with insurers and hospitals (Getzen, 2010, pp. 135-136). In 2010, the number of new doctors who started to work in hospitals exceeded the number of those who chose the work in a physician-firm for the first time in U.S. history (Ärztezeitung, 2012). In 2015, an AMA study found that nearly 57% of physicians worked in physician-firms (descending trend) and, in contrast, about 33% of the physicians worked directly for a hospital (ascending trend) (AMA, 2015).

In the U.S. healthcare system, a doctor in a hospital is not an employee, nor the owner of the hospital, since physicians function as independent economic entities (Janus, 2003, p. 123). Nevertheless, physicians in the U.S. often apply to the institutions in order to get access to hospital staff privileges and receive assignments for special procedures being practiced almost exclusively within hospitals. Yet physicians do not pay hospitals for the privilege of working there, rather the hospital functions as the doctor's "rent-free workshop" where the physicians get access to important resources (Folland et al., 2007, p. 296). It is another type of competition compared to other countries such as in Great Britain or Germany because in the U.S. the hospital does not hire physician, rather, it has to attract them. Evidently, without the service of a doctor, no hospital can provide medical treatment. However, because the two players do not directly exchange money, hospitals have to offer doctors other advantages to attract them, for example, by providing a high-tech environment, excellent nursing staff, and particular operating rooms and equipment. Hospitals aim to make themselves more attractive and ease the strain of medical practice while increasing profit (Phelps, 2013, pp. 239-240).

## 5 Health Insurance in the U.S.

In America, 28.5 million people remain uninsured, representing nearly 9% of the total population. For comparison, two thirds of the insured population is covered by private health insurance with the remainder covered under public insurance (Table 1) (Kaiser Commission on Medicaid and the Uninsured, 2016, p. 1).

Table 1: Percentage of People by Type of Health Insurance Coverage: 2015



Source: United States Census Bureau, 2016a.

A citizen has private coverage either through employment or direct purchase of coverage from a private company. Public insurance uses Tricare to cover those in military service and the Department of Veterans Affairs to cover military veterans<sup>1</sup>. The two pillars of public insurance are Medicare (primarily serving the elderly) and Medicaid (primarily serving poor persons). Medicare and Medicaid were both developed with the Social Security Act of 1965 and represent more than a third of national health spending today (Béland et al., 2016a, p. 92).

### 5.1 Public Health Insurance

Medicare is the predominant public insurance of the U.S. This national insurance program provides health insurance for people 65 years of age or older as well as for persons

<sup>1</sup> The medical supply of the veterans, the military and their relatives is beyond the scope of this study. For more information look at Barnett and Vornovitsky, 2015, p. 1.

with disabilities, end-stage renal disease, and amyotrophic lateral sclerosis (CMS, 2014). With the original Social Security Act in 1965, Medicare consisted of two parts: Hospital Insurance (HI, which covers inpatient care, hospice care, and home health care) and supplementary medical insurance (SMI, which covers physician services, hospital outpatient care, and other services) (Jonas, 1998, p. 93).

2015 marked the 50<sup>th</sup> anniversary of signing the Medicare program into law. After 50 years of growth and development, 52 million Americans are covered by Medicare under one or many parts, most predominantly Parts A through D. All Medicare recipients have access to HI, also known as Part A, with all other parts coming at additional cost. Part B is for SMI, Part C is for Medicare Advantage plans, and Part D is for drug coverage. On average, Medicare Part A covers half of all expectant costs, forcing patients to cover remaining costs with supplemental Medicare insurance, separate insurance, or out-of-pocket spending (Cohzven et al., 2015, p. 15).

Medicaid is a welfare-based program that provides coverage for some health services to qualifying low-income people and those with disabilities (Cohen et al., 2015, p. 12). In 2014, 66 million people were covered by Medicaid, with applicants judged and placed in categories. Compared to Medicare, Medicaid covers a range of services that other government programs do not, including dental and long-term care coverage, but the program reimburses provider at a lower rate, thereby incentivizing providers to avoid Medicaid patients (Cohen et al., 2015, p. 14).

Medicaid functions as both federal and state-run initiative. The federal government creates general guidelines and mandates, while each state defines its own precise policy rules. The program is financed through federal, state, and municipal taxes with the federal government paying 50-80% of the total expenses for every state based on an agreed-upon-federal-state matching system. As a result, the financial health and stability of the program differs between states since Medicaid investments depend on the amount of federal funding received (Cohen et al., 2015, p. 14).

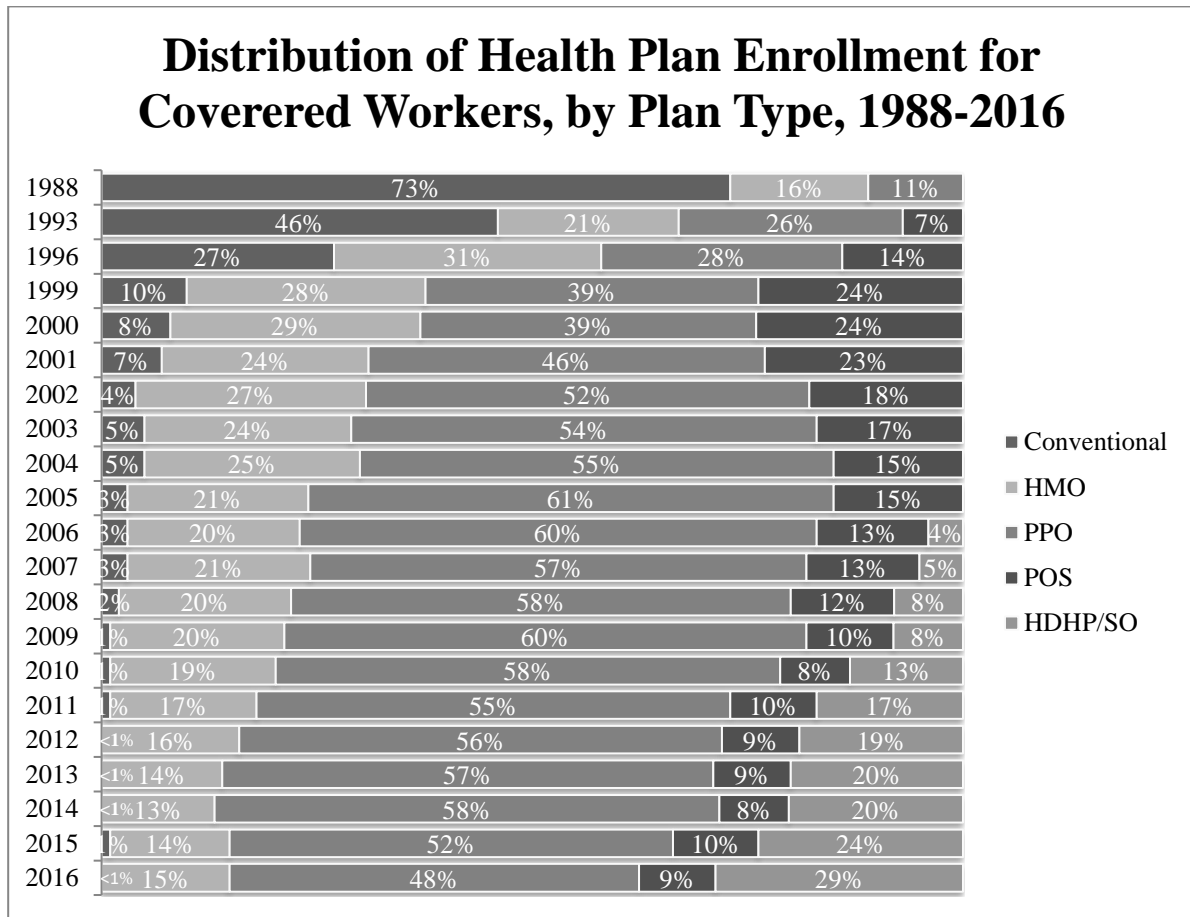
## **5.2 Private Health Insurance**

In 2015, 67.2% of the American population had some kind of private health insurance coverage, with 55.7% of the population insured through employer-sponsored plans and the other 16.3% insured through direct purchase exchanges (Barnett and Vornovitsky, 2015, p. 1). The two biggest players in this sector are the 36 regional non-profit Blue Cross/Blue Shield organizations and large commercial for-profit companies (Blue Cross Blue Shield, 2017).

Private insurance coverage models have shifted over the last 30 years starting with the traditional FFS system chronologically trending towards the managed care or health maintenance organization (HMO) system, the preferred provider organization (PPO)

system, the points of service (POS) system, and the high deductible health plans (HDHPs, which are currently generating the most interest) (Table 2).

Table 1: Distribution of Health Plan Enrollment for Covered Workers, by Plan Type, 1988-2016



Source: Kaiser Family Foundation, 2016.

FFS is the easiest system to implement as it reimburses providers for every unit of care they offer, ensuring that they are fully compensated for their efforts. However, the system incentivizes providers to carry out the maximum volume of care without regard to its value, leading to high costs for the entire system while presenting limited value to its consumers.

In response, progressive provider organizations began the “Managed Care Movement” represented by the HMOs which became increasingly prevalent, even into today. The Managed Care Movement started in 1973 with the primary purpose of managing cost, quality, and access to health care. Additionally, it represents a spectrum of systems, which includes the previously mentioned private health insurance manifestations (HMOs, PPOs and POS plans) (Haubrock, 2000, p. 22).



To satisfy the movement toward managed care, the HMO Act was signed into law in 1973. Consequently managed care entities started participating in Medicare and Medicaid directly, controlling costs and clinically integrating healthcare delivery as early as the 1990s (Rosenbaum, 2011, pp. 875-876). Insurers began to influence healthcare delivery as many provider organizations created their own insurance platforms in order to reduce costs and maintain operating margins. However, a managed care backlash occurred in the late 1990s as operators of the HMOs deprived essential medical services to patients in order to maintain margins, inspiring distrust from patients (Schmid and Himmler, 2015, p.11). As a result, new forms of insurance coverage exist today that focus on the preferably full integration of coverage and care. The system pays providers less for the volume of treatment that they deliver compared to FFS, but offers providers the ability to recover those lost revenues through enhanced health promotion and care delivery for their patients. The system is capitated, meaning that the providers receive a fixed, covered budget through which all medical expenses must be paid. The advantage of this model is that the providers have the incentive to cost-effectively treat patients and save money by avoiding overtreatment in efforts to recover the unused part of the budget (Folland et al., 2007, pp. 242-243).

HMOs, on the other hand, restrict patient provider choice, requiring patients to stay within their network in an ambitious attempt to improve the value of care. Compared to the HMO model, the PPO model consists of groups of healthcare providers who have agreed with an insurance company or a third party administrator to provide care at a reduced rate to the insurer's or administrator's beneficiaries (Getzen, 2010, pp. 124-125). PPOs provide the most patient choice and have the highest beneficiary satisfaction rates in all categories besides cost, as such expansive selection often results in higher treatment costs. These organizations, due to their popularity among patients, currently represent 48% of all privately covered lives, the largest portion by far.

An attempt at an optimal system, the POS system, includes the positive aspects of HMO and PPO systems, such as the diminished costs, but inevitably carries some of the negative aspects as well, most significantly a diminished choice of providers for patients. Enrollees in a POS plan are requested to choose a primary care physician from within the plan's network, who acts as the patient's point of service. For care provided out of network, the insurer reduces provider compensation and raises patient out-of-pocket costs, encouraging both parties to stay within the network. In addition, the insurer performs all paperwork on behalf of the beneficiary for care provided in-network, whereas the patient handles those duties and the additional non-covered costs for care provided out-of-network (Health Coverage Guide, 2016).

In 2007, HDHPs with Savings Options were established on the private insurance marketplace. HDHPs are the only plans that allow an enrollee to contribute to health savings accounts into which they can deposit tax-exempt income to spend on future care tax-

free. These accounts are needed due to the plan's excessively high deductibles, which are more than \$6,000 for an individual and \$12,000 for a family. HDHPs only cover preventive care before the deductible is reached, meaning that the enrollee must pay for all not-preventive medical care out of pocket until the deductible is reached, after which point all care is covered based on the beneficiary's coinsurance rate. Fortunately, many HDHPs have complete coverage after the deductible, thereby covering catastrophes. These relatively new plans currently represent 29% of all privately insured patients, the second greatest portion of the sector (Health Insurance Resource Center, 2017).

### **5.3 The Problem of Uninsurance in the U.S.**

In 2016, 29 million Americans, just under 10% of the population, had no health insurance for the entire calendar year. Although a significant number, it is a decrease of 13 million people since 2013 when the ACA took effect. The decrease is primarily the result of Medicaid expansion and private insurance enrollment through the exchanges. Being uninsured, especially in the U.S., is a major problem because it comes with many consequences: poorer health status, less healthcare access, less preventive care, delayed treatment for serious disease, poorer control of chronic diseases, and lower life expectancy (Kaiser Family Foundation, 2002). The majority of the uninsured are low-income adults and families that are either without access to or could not afford employer-sponsored coverage (Folland et al., 2007, p. 217). Additionally, some fall in the window between being too poor to afford private insurance but too rich to qualify for Medicaid, resulting in no coverage at all in the end. Illegal immigrants and those who do not legally qualify for insurance of any type in the country make up a small, but still significant, portion of the total uninsured population. Lastly, the prohibitively high cost of insurance causes some to risk paying out-of-pocket costs as opposed to risk-abating insurance, looking at it as a financial gain to go uninsured (Kaiser Commission on Medicaid and the Uninsured, 2016, p. 1).

## **6 Politics**

### **6.1 Situation before the implementation of the ACA**

Political measurements can lay the foundations for counteracting high rates of uninsurance. When President Barack Obama signed the ACA into law in March 2010, he fundamentally affected the future of healthcare in the U.S. Before the ACA, it was legal for insurance companies to practice Risk Rating in combination with Medical Underwriting. If insurers predicted higher costs for a person, they could look out for their own interests by lowering the number of these high-risk people they insured e.g. by denying them coverage (Doonan and Katz, 2015, p. 747). These tactics led to 47 million U.S. residents lacking insurance coverage before the ACA was implemented (Neuss, 2015,

p. 203). The uninsured had poor access to the services of private physicians, so these patients previously received care from safety-net providers such as federally qualified health centers, emergency rooms, and charity care. Although patients could buy insurance directly from insurers or through a state's high-risk pools, the high costs of both insurance and care itself made patient much more likely to skip seeking care altogether (Doonan and Katz, 2015, p. 747).

## **6.2 ACA**

A major aim Barack Obama had during his presidency was to reform the fragmented U.S. healthcare system and move toward universal health insurance (Béland et al., 2016b, p. 42). In March 2010, he signed the ACA into law as the most significant health legislation since Medicare and Medicaid were established in 1965. Although it initiated much change, it had four main aspects which will be described in the following paragraphs.

First, the individual mandate requires all U.S. citizens and legal residents to either have insurance coverage that meets federally defined essential benefit standards or face a tax penalty. By requiring everyone to be covered, the pool of insured persons would be large enough for the cheaper, healthy individuals to cover the expenses for more costly, sick individuals (Béland et al. 2016b, p. 51).

Second, the employer mandate requires employers with more than 50 employees to either provide health benefits to full-time employees or face a steep financial penalty. By forcing employers to provide insurance to their employees, the number of insured persons increases (Kaiser Family Foundation, 2016b).

Third, the act expanded Medicaid coverage. As of now, 31 states have expanded Medicaid coverage in one way or another and received 90-100% of additional needed capital from the federal government (Béland et al., 2016a, p. 92). Not all states have chosen to expand coverage due to the Supreme Court decision *National Federation of Independent Business v. Sebelius* that ruled Medicaid expansion was a state right and therefore could not be forced upon states by a federal declaration.

Lastly, at a high, general level adolescents can stay on their parents' health insurance policies until age 26, caps on total insurance benefits and denial of coverage due to preexisting conditions have been eliminated, and the individual insurance marketplace exchanges have been established. The ACA also subsidizes insurance costs for low-income beneficiaries and requires all insurers to offer 10 essential health benefits, including maternity care and preventive services (Obamacare Facts, 2017).

However, as a partisan act, the ACA has received much criticism from the political right-wing supporters across the country. In 2013, during an episode of the NBC News, a Republican Representative stamped the ACA as, "The single worst piece of legislation that's been passed in modern times in this country." Nearly a year later, and for the

fiftieth time, the Republican-controlled House of Representatives voted to repeal or alter the ACA (Béland et al., 2016b, pp. 40-41).

### **6.3 Plans under the Trump Administration**

On May 3, 2017, the House of Representatives passed the American Health Care Act (AHCA), which had the main purpose of repealing and replacing large fragments of the ACA. The bill was sent to the Senate for deliberation (Young, 2017). As explained above, the ACA requires individuals to gain health insurance and companies to offer it to their employees. The Republican bill was expected to repeal mandates that encouraged broader insurance coverage by imposing penalties. Such a step may have incited healthy people to stay uninsured, raising the prices for those who are older or sick. In order to limit unaffordability for those who need insurance, the Republican plan proposed a “continuous coverage incentive”, charging residents in the individual market a 30% penalty for lapses in health insurance coverage (Park and Sanger-Katz, 2017). Federal funding animating Medicaid expansion (especially to cover low-income adults) would be reduced by capping it based on how much the state enrollees were living in was spending. After 2020, states that expanded Medicaid would receive less federal support, and those that did not undergo Medicaid expansion would be prohibited from doing so (Lee, 2017). Under the ACA, subsidies are tied to income and premiums, whereas the Republican bill would have provided U.S. residents with refundable tax credits to purchase health insurance, allotted mainly based on the age of the recipient. Some protections for those with pre-existing conditions would also be repealed: states could apply for waivers to allow insurers to offer slimmer policies, enabling them to charge higher premiums to those with chronic medical issues. Those states would then have to establish programs, such as high-risk pools, in order to protect insurers from patients causing high costs. Funds worth more than \$130 billion would have been set up to finance and support high-risk pools and patients with pre-existing conditions (Lee, 2017). The provision in the ACA which lets children stay on their parents’ insurance plans until the age of 26 would be one of the few pieces to not be repealed and replaced. However, this bill supported by the Trump Administration would have left 24 million fewer people insured by 2026 than under Obamacare (Lee, 2017).

On June 22, 2017, 13 Republican Senators drafted the Senate’s substitute version of the AHCA, releasing the first discussion draft for an amendment to the bill (Ku et al., 2017, p. 2). However, this alternative was returned to the calendar on July 28, 2017 after the Senate rejected a third Republican amendment to repeal the ACA (Parlapiano et al., 2017). Since Donald Trump signed an executive order to change ACA regulations in the beginning of his time as President, it is presumable that the efforts to do so will continue in the future despite the fail of the AHCA (Amadeo, 2017).

## **7 Conclusion**

All in all, the U.S. healthcare system is a fragmented complex that remains unclear in structure. Since the new AHCA has failed, it is unsure if future efforts will help to achieve the Triple Aim, but the U.S. healthcare system will likely face more problems if Congress is successful in repealing the major enhancements of the current system. Even after the passage of the ACA, the American healthcare system did not show any progress in terms of reduced costs. Expanded choice of insurance plans did not optimize quality of care at a lower cost. Large and small U.S. companies provided more insurance options for high deductible plans that have lower premiums, but higher out-of-pocket costs. As evidence indicates, these plans are more attractive to younger, healthier consumers, pushing older and sicker employees into conventional plans which raise their rates. High administrative costs also contribute to the inefficient healthcare system, making it difficult to reach the Triple Aim (Lave et al., 2011, pp. 139-144). To counteract higher costs, innovation centers were founded under the Medicare and Medicaid program as a result of the ACA. These centers are meant to establish measurable and lasting improvements in payment systems providers utilize. Ideally, payment should be linked to patient outcomes instead of merely services provided. However, the interests of the providers and those of patients differ strongly (Neuss, 2015, p. 2013). While the final structure and outcome of the U.S. healthcare system is unknown, these disagreements between providers, patients, insurers, and political parties will be instrumental in shaping the healthcare provided to Americans.

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