The Impact of the Affordable Care Act on the Low-Income Population

HN-300-C: Honors Capstone

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Introduction

The debate on whether affordable or free healthcare has been around for over a century. Many individuals believe that it is unnecessary or unfeasible to have affordable healthcare. This is due to the fact that it can significantly increase taxes and might affect quality of healthcare among several other reasons. However, it is unacceptable to compromise the health of low-income individuals and families for the sake of a small cost saved. Low-income individuals are forced to sacrifice their overall health because they can't afford basic doctor's visits, check ups, screenings, and medication. Many families are put in the position of choosing between their next meal or affording basic living expenses and their medication. Though the public may not want an increase in taxes, many fail to realize the privilege of being able to do simple, overlooked things such as going to yearly physicals. Healthcare is a basic human right, and it should be treated as such.

This paper will provide a detailed analysis on the reasons why affordable healthcare should be provided without question and the benefits that it has brought over the past few years. I have used a combination of case studies and scholarly articles to analyze the changes in healthcare access after the implementation of healthcare policies, specifically the Affordable Care Act (ACA), as well as the hardships and negative consequences that low-income individuals face as a result of difficult accessibility. This paper will begin by introducing the ACA and the evolution of the United States healthcare reform. After this, I will explain the views of the opposing side, which will dive into both the financial and implementation concerns of affordable healthcare. Once I have thoroughly explained the rebuttal, I will go into detail throughout the remainder of the paper about difficulties that were faced before the ACA was established, as well as the abundance of improvements the ACA has brought to the health of the

low-income population. The analysis of this information will explain how legal reform and implementation of healthcare policies is worth the expenditure to assist individuals in low-income areas.

A Brief History of Health Care Reform

Health care reform discusses changes that have been made to major health policies, which can either be governmental or private (Manchikanti et. al, 2017). The goal of reform is to ensure that a larger amount of the population has access to health care coverage, as well as increases in the amount of healthcare providers available, a higher chance of accessing healthcare, improving quality of care, and decreasing the cost (2017). Though establishing policies to implement affordable healthcare and reform have been attempted many times, there have been multiple failures. In 1854, the Bill for the Benefit of Indigent Insane was vetoed by Franklin Pierce. He argued that it wasn't the government's job to be involved in healthcare and social welfare (2017). After the Civil war, the South established national medical care, which led to the construction of 40 hospitals and the employment of more than 120 physicians (2017). However, this did not last long before its eventual failure.

In the early 1900s, Theodore Roosevelt initiated the support of universal healthcare coverage, which mirrored the actions of European countries at the time. Following this, Franklin D. Roosevelt pushed for both publicly funded healthcare programs and additions to Social Security (2017). Towards the mid 1900s, several private insurers such as Blue Cross emerged. Additionally, President Harry S. Truman proposed universal health care, but it wasn't passed (2017). Throughout the 1900s and forward, universal healthcare was met with ample criticism and rejection. During President Bill Clinton's term, Clinton wanted to reform the healthcare system. On September 22, 1993, he argued that the healthcare system was broken, and that it

needed to be fixed (Patel, 2003). He explained how despite the fact that millions of healthcare professionals constantly worked hard to make it the best it could be, the system was too uncertain, expensive, bureaucratic, and wasteful, and that it was full of fraud and greed. (2003). Clinton wanted an improvement in security, simplicity, savings, choice, quality, and responsibility. He wanted to provide coverage to those who didn't have it, and he wanted the system to be a lot less complex for both patients and health care professionals. This included less bureaucratic paperwork and complicated rules (2003). This idea became known as the Health Security Act of 1993. However, Clinton was unable to explain the key elements of his plan in ways that Americans could relate to or understand, and it ultimately led to the failure of this act. In 1962, Senator Edward Kennedy was elected into the senate. Kennedy was a part of the Senate Health Committee and was a strong advocate of affordable health (Raimondi, 2010). He sponsored legislation that created the national community health center program. This was the start of a national program that includes more than 1,200 health centers nationally serving more than 20 million low-income patients (2010). In 2010, President Barack Obama passed Obamacare, which was viewed by some as a tribute to all of Kennedy's efforts towards affordable care.

Introduction to the Affordable Care Act

The election of President Barack Obama led to the passing of the ACA, otherwise known as Obamacare, which was signed into law in March 2010. He had three goals in mind: increasing the number of Americans insured, improving quality of care, and lowering the cost of care (Manchikanti et. al, 2017). The ACA covers several health benefits, including ambulatory services, emergency services, hospitalization, laboratory services, maternity and newborn care, mental health and substance abuse services, pediatric services, prevention, wellness and chronic

disease management, prescription drugs, and rehabilitative and habilitative services and devices (Plaxe 2014). Obama planned to finance the ACA in the following ways: annual fees on pharmaceutical manufacturers (around $2.8 billion), annual fees on health insurance sector ($8 billion), indexed to premium growth, excise tax on the sale of taxable medical devices, limiting deductions of executive and employee compensation for health insurance providers, taxing 10% on cost of indoor tanning, and excluding unprocessed fuel from bio-fuel credit (2014).

Obama stood firm on his beliefs that every American deserves the right to healthcare access. In a press conference in November 2014, Obama defended his stance and verbalized why he believed the ACA is worth fighting for. He stated that "Efforts that would take away healthcare from the 10 million people who now have it and the millions more who are eligible to get it, we're not going to support…the law works. You've got millions of people who have health insurance who didn't have it before. You've got states that have expanded Medicaid to folks who did not have it before, including Republican governors who've concluded this is a good idea for their state" (McCarthy, 2014). Though not everyone agrees with the law, Obama emphasized the importance of maintaining it. The public often looks for the perfect solution to ongoing problems, which is unreasonable to expect out of any legislation. Obama showed that the law may not be perfect, but it brings health insurance to many more Americans that suffered greatly without it. Without affordable healthcare, there will be millions of Americans who will have no way of accessing it, thereby not having access to services as simple as casual doctor's appointments or purchasing prescriptions.

The Opposition

Though it might seem reasonable that there should be no opposition to the idea of Americans having the right to healthcare access, there are many reasons why people disagree

with the existence of the ACA. One of the main issues with the ACA was that there many uninsured individuals were uninformed of the act and their eligibility. According to a poll conducted on March 31, 2014, 26% of people knew nothing about the ACA, and an additional 37% only knew a little about it (Plaxe & Nagle 2014). Because the ACA has such an extensive benefit package, many insurance policies are not under compliance, which cause them to be canceled (Manchikanti et. al, 2017). This benefit package also led to an increase in premiums, thereby reducing affordability. For anyone with incomes above 400% of the federal poverty level, they were only able to purchase insurance that was unsubsidized with hefty premiums and out-of-pocket expenses, thereby making it pointless in the eyes of many (2017).

Additionally, it has been stated that the number of insured Americans is mainly due to Medicaid's expansions. According to Laxmaiah Manchikanti et. al (2017), people have nicknamed the ACA the "Medicaid Expansion Act". Though the nation showed a significant decrease in the number of insured individuals, the source of this decrease was different than expected. While Medicaid covered about 17 million more individuals than expected, the ACA unexpectedly covered 10 million fewer individuals than originally projected (Manchikanti et. al, 2017). When looking at worker benefits, coverage from employers decreased from 62% in 1999 to 55% in 2016, even though part of the benefit package listed in the ACA stated that large employers must offer ACA-compliant policies to their employees (2017). In 2015, more than one-third of fully insured adults reported having a difficult time receiving access to care, including dental care, drug prescriptions, finding providers who were taking in patients, and scheduling appointments with existing providers (2017). These statistics show that though health coverage has increased, it has not made certain aspects of healthcare easier for many. It has made access to care challenging at times, and cost of care has increased. Though these are valid

arguments to show why the ACA might not be fully effective, it is important to weigh the negatives with the positives and investigate the benefits that have come with easier access to insurance.

Struggles of the Low-Income Population

Without access to healthcare, low-income individuals are put in a position that many cannot fathom. If families are unable to follow health regulations and interventions, there is a much higher chance of outbreaks and spread of illness amongst the population. During the COVID-19 pandemic specifically, the CDC enforced several guidelines such as social distancing, quarantines, and work from home. In a study done by Nina Fefferman et. al (2021) regarding the COVID-19 pandemic, data showed that low-income households experienced both an increase in poverty and difficulty finding access to healthcare services. Because of the overflow in hospitals, it became harder for individuals to access healthcare. Additionally, because of the distancing guidelines and closures of establishments, it became a challenge for low-income families to go out and earn money as easily, thereby resulting in the lack of adherence to public health guidelines (Fefferman et. al, 2021). In the interest of public health, taking away the already minimal health coverage that low-income families receive would result in the worsening of these types of situations. When households are below the poverty line and cannot afford to access healthcare, it can cause an adverse effect on the health of an individual and families, resulting in both a worsening in physical health issues and mental health issues such as anxiety, stress, and depression (2021). The results of this study showed that socioeconomic status can affect the course of an outbreak, and that economic constraints and limits to healthcare access due to expenditure could affect a country's ability to enact prevention policies (2021). Without health coverage such as the ACA, the struggle to find healthcare

amongst the low-income population would not only negatively affect the group directly, but the country as a whole in certain instances.

Some may wonder whether there is a significant enough problem in access to healthcare to be wasting money on the ACA. In a study done by Jingchuan Guo et. al (2022), a geographical information systems analysis was completed to determine whether there was a significant issue with access to health care infrastructure. A sample of 2,982,544 United States residents was used. 32.4% were categorized as low-income, and 14.8% of these individuals lived in non-metropolitan counties (Guo et. al, 2022). Among 207 metropolitan counties, residents had a significantly higher chance of having to drive over one mile to the closest facility. In comparison, among 1967 non-metropolitan counties, 747 of them had a higher chance of its closest facility being over a driving distance of 10 miles (2022). These 954 counties represent over 14% of the population. The analysis of these results showed that within this representative population, low-income residents have poorer access to healthcare facilities. There is a high prevalence of structural disparities in health care throughout the entire country, which affect the health care outcomes of the low-income population (2022). Additionally, there are geographical barriers that can prevent a person from being able to access healthcare. Low-income individuals have a much lower chance of owning cars, and they are most likely to reside in areas where public transport is sparse (2022). This study showed that investing in healthcare access in the U.S. should be a priority. As previously stated, two of the benefits that the ACA provides are ambulatory and emergency services. With low access to transportation for many, it is clear that these benefits cannot be taken lightly.

Low socioeconomic status can also lead to a higher mortality rate in individuals. In a report by the Institute of Medicine prior to the passing of the ACA, many surveys found that

low-income individuals bear a higher burden of death, disease, and disability than their middle-class counterparts (Becker & Newsom, 2003). Healthcare resources were gradually diminishing at this point, which raised concern. However, no action was being taken. In 2003, those who were from low socioeconomic backgrounds were less likely to be insured and were most often on Medicaid. They had very poor quality healthcare, and they only seeked healthcare in cases of emergency. Those with a low socioeconomic status, predominantly in the African American population, reported that they had a chronic or serious illness and did not have an ambulatory visit (2003). They are less likely to be covered by private insurance carriers or have insurance in general. 1 in 4 individuals reported having problems paying for medical bills, which included physicians, hospitals, and prescriptions (2003). Middle-income individuals received healthcare through private practice and had few to no complaints about their health care. In contrast, low-income individuals had high levels of dissatisfaction with health care. They reported fighting to receive basic health care and confusion with the complicated nature of trying to access the healthcare system in case of emergency. One woman with asthma and heart disease reported that if she arrived late to an appointment, they would make her either wait in line for a new one or postpone it to several weeks later. She reported that unless someone was dying, they would not be seen (2003). Though this report was taken in 2003, this data shows that removing the ACA would be detrimental. Prior to the ACA, access to healthcare was already extremely difficult for low-income populations. Becker and Newsom emphasized the idea that affordable healthcare has been something that individuals have strived for, but had no solution to. The ACA is not perfect, but it has brought millions access to services such as transportation, prescriptions, and physician care, which is a significant improvement.

Benefits of the Affordable Care Act

The ACA has brought several benefits, both with access and improvements in health conditions. One of the biggest successes of the legislation was the reforms designed to improve accessibility, affordability, and quality (Manchikanti et. al, 2017). The ACA dramatically increased insurance coverage, with the rate of uninsured individuals declining by 46%. The uninsured population dropped from 49 million people in 2010 to 27 million people in 2016. (2017). Obama also stated that this expanded coverage has helped improve access to treatment, financial security, and health. Non-elderly adults experienced a 3.5% increase in being able to find a physician, a 2.5% increase in access to medication, a 5.5% decrease in inability to afford care, and a 3.4% decrease in reports of poor health. (2017). Apart from the direct medical benefits, the ACA did not decrease the chances of finding jobs, as many had predicted. Instead, it was shown that private sector employment increased every month since the establishment of the ACA (2017).

The ACA has also increased the survival of those with chronic disease by providing them access to screening and more consistent treatment. A study done by Michael Roth et. al (2022) described how the ACA has benefitted the lives of cancer patients. Prior to the ACA, young adults with cancer were more likely to develop advanced disease and have poor prognosis (Roth et. al, 2022). Once they turned 18 years old, they were removed from their parent's insurance plan, leading to a third of young adults in their 20s losing their health insurance. When the ACA was established, the Dependent Care Expansion (DCE) clause was added. This allowed for young adults to stay on their parents' health insurance plan until the age of 26, which eased the issue of not being able to afford individual healthcare immediately after reaching adulthood. Through this expansion, 2.5 million young adults received health insurance through their parents' plans, which caused the rate of uninsured individuals in this population to drop

dramatically. Today, less than 18% of young adults in their early 20s are uninsured (2022). With an increase in access to healthcare insurance came more screenings, which caused a rise in the number of patients who were diagnosed with stage I cancer in relation to a lower number of older patients.

Increase in health coverage had a positive impact on long-term survival of cancer patients. The ACA and the implementation of the DCE resulted in the decrease of insurance interruptions, which resulted in shorter wait times for diagnoses and continuity of care (2022). With aggressive forms of cancer such as sarcoma and acute myeloid leukemia (AML), any slight delay in treatment can cause a significant reduction in survival rate compared to those who receive timely treatment. With Hodgkin lymphoma patients, delays in diagnosis could result in an advancement in the disease, resulting in the need for harsher treatments such as radiation treatment. This can cause a higher chance of adverse effects from treatment and higher mortality rate. Additionally, the ACA has helped women receive access to mammograms and other preventative measures for breast cancer. Breast cancer is the most common non-skin cancer for women, affecting 1 in 8 women in the United States (Toyoda et. al, 2020). Mammography screening has been shown to reduce breast cancer mortality by 15% for women between the ages of 39-49 and is one of the main ways physicians detect cancer. Though there are several factors that could cause a challenge in receiving cancer care such as structural barriers and influencing physician recommendations, Toyoda et. al came to the conclusion that financial barriers are the biggest obstacle that stands in the way of equal access to care (2020). Breast cancer screening is essential for women in the effort to detect cancer as early as possible. This study focused on comparing states that expanded Medicaid under the ACA to the states that did not expand. The ACA mandated that individuals must purchase insurance by creating state-based subsidies, and it

expanded Medicaid to cover adults anywhere at or below 138% of the federal poverty level (2020). Results showed that in expansion states, mammogram screening rates for women who make less than $15,000 a year went from 62.6% in 2010 to 73.8% in 2018, whereas screening rates in non-expansion states only went from 68.2% to 69.3% (2020). When given the opportunity, low-income individuals will take advantage of available insurance. Expanded availability and eligibility can benefit this population, as access to care will not be as challenging. With easier access to health insurance and earlier diagnoses, quality of life has improved for patients and has resulted in a lower financial burden of healthcare. Nobody should have to choose between saving their own life or affording basic living costs, which is what many low-income individuals unfortunately experience.

As mentioned before, the ACA has helped states expand their Medicaid programs. In an article by Paula M. Lantz and Sara Rosenbaum (2020), it states that the "ACA provides significant incentives to states to expand their medical programs to nearly all low-income adults up to 138% of the federal poverty level. States that underwent expansion experienced increases in access to healthcare and healthcare coverage. There has been about a 12% increase of health insurance coverage due to expansion in comparison to the non-expansion states solely due to title 1 provisions (Lantz & Rosenbaum, 2022). This article incorporated hundreds of studies, with their most prominent finding being that Medicaid expansion under the ACA has led to significant increases in health care insurance for vulnerable populations, such as low-income adults, LGBTQ adults, those with substance abuse disorders, veterans, and HIV/AIDS patients (2022). Medicaid expansion also reduced racial/ethnic disparities, as it allowed individuals to have a consistent source of healthcare without having to give it up due to financial concerns. Increases in frequency of treatment, earlier diagnoses, and overall broader healthcare access have led to an

improvement in diseases and health outcomes, such as better self-reports of general health, cardiovascular disease, and birth outcomes (2022). Health centers have been able to receive larger numbers of patients, and they are able to treat more patients for conditions such as behavioral health-related problems, opioid addiction, and social service (2022). With ACA's expansion of Medicaid, these health centers are now properly financed, and they are able to provide services to a larger extent. Because of this, many who were not prioritized for care prior to the establishment of the ACA are now receiving the healthcare they deserve without having to stress about affordability and potential discrimination.

Conclusion

The Affordable Care Act has done more than simply providing Americans insurance. Over the course of this paper, I examined both the concerns that some have with the ACA, as well as the benefits to show why they outweigh the negatives. Affordable care had been attempted several times from the mid 1800s forward, but was met with many failures until Barack Obama's presidency. When Obama established the ACA, his goal was to provide as many Americans with health coverage as possible. He succeeded in this effort, with more than 20 million Americans receiving health insurance. The law was met with a lot of opposition. It was argued that those who qualified barely knew about their eligibility, and because of the extensive benefits, many insurance companies were canceled due to failure of compliance. Additionally, low-income individuals had a hard time finding providers, receiving access to care, and scheduling appointments due to high demand. However, the ACA brought much improvement to the health of this population.

Without access to healthcare, low-income individuals are unable to do things as simple as follow health guidelines, thereby putting themselves at risk as well as raising the risk of public

outbreak and exacerbating their financial struggles. Apart from this, they often have no convenient way of accessing healthcare nearby. Because many live in poorly developed metropolitan areas with little to no access to public transportation, it became a challenge to find a way to get to a medical facility. These facilities can also be more than ten miles away, which can be nearly impossible to reach due to sparse transportation. Additionally, those who came from low socioeconomic backgrounds were unable to receive timely, convenient healthcare and were often only seen if they were dying. They would rarely receive emergency healthcare, even with chronic or serious illness, as it was too expensive.

The ACA improved accessibility, affordability, and quality. It increased the survival rate of those with chronic illness, as it helped them stay on insurance. With this came more consistent physician visits, access to medication, and screening. Individuals are now able to detect conditions ahead of time, and more patients are receiving diagnoses at earlier stages, allowing for less harsh treatment and lower mortality rates. Without the ACA, millions of Americans would remain uninsured and unable to receive basic care. Through this research process, it became apparent how quick some people are in forgetting their privilege. It can be so easy for many of us to be able to call our doctors to schedule appointments for minor inconveniences or buy any prescription we need, while low-income individuals can barely afford healthcare services even in critical condition. Though affordable healthcare is expensive and might not seem necessary to some, it has brought ease into the lives of millions. In order to make sure this act is best utilized, it is important to advertise it effectively. Out of those who qualify, a large percentage are uninformed about the benefits they can receive. Whether it is through legal representation, guidance, or other methods of informing, low-income individuals need to be brought aware of these benefits so that the ACA can have the biggest possible impact.

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