Generosity in Healthcare Policy Under the Obama Administration:
Reflecting Various Dimensions Focused on the ACA

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INTRODUCTION

The goal of the Patient Protection and Affordable Care Act (ACA) was to achieve nearly universal health insurance coverage in the United States through a combination of policies largely implemented in 2014 (Obama, 2016). Several recent studies, including Frean, Gruber, and Sommers (2017) and Courtemanche et al. (2017), have shown that the ACA led to gains in insurance coverage.In fact,Patient Protection and Affordable Care Act (ACA) ofMarch 2010 was to achieve nearly universal health insurance coverage in the United States through a combination of insurance market reforms, mandates, subsidies, health insurance exchanges, and Medicaid expansions (Gruber, 2011). These major components of the ACA all took effect in 2014, with the Medicaid expansion being optional for states after a Supreme Court decision.Nowadays, the Affordable Care Act (ACA) constitutes an effective public policy alternative that remedies some of the previous problems that existed in America's healthcare system(Gholipour and Rouzbehani,2016;Rouzbehani,2017). The ACA seeks to accomplish several fundamental objectives namely reforming the private insurance market,expanding Medicaid to the working poor, and changing the way medical decisions are made in end-of-life situations. All these objectives are rooted in private choices and expectations of rational decision making and incentives (Silvers, 2013). The objectives of the ACA, when examined from the perspective laid out above, in terms of the maximization of net value achievement, could be perceived in the context of the rational resource allocation policy model (Dye, 1981; Birkland, 2005).

BACKGROUND

The Affordable Care Act (ACA) expanded Medicaid eligibility to persons earning up to 138% of the federal poverty level, as part of the largest expansion of coverage to nonelderly adults since the 1960s. Although the expansion was originally intended to be enacted nationally, a 2012 U.S. Supreme Court decision made it optional for states. A total of 24 states decided not to expand in 2014, which affected 6.7 million uninsured low-income adults who otherwise would have gained eligibility. Since 2014, an additional 5 states have implemented expansions, although 19 states still have not adopted the expansion as of January 2017.

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FOCUS OF THE ARTICLE

In this article, the author will discuss reports reflecting empirical studies of various dimensions focused on the ACA. As readers will note, these studies ranged from investigations of the apparent gender differences in support for the policy (Lizottle, 2015), the impact of the policy on dependent coverage mandate on insurance premiums (Depen and Bailey, 2015), and the implications of the ACA expansion to young adults in terms of inpatient hospitalizations (Antwi, Moriya and Simon, 2015).

Some of the findings presented in these empirical studies confirmed the proposition that the ACA has led to improvement and thus exercised a positive impact on the healthcare system in the United States. However, other findings (see for example, Garson, 2000) also point to the fact that there are still greater tasks ahead in producing a healthcare system that is both affordable and that ensures quality of care for all population groups in the United States.

Research Hypothesis

The central hypothesis of this research is that the ACA led to major improvements on the previous healthcare policy of the United States. This hypothesis is predicated on the fact that the previous system was inadequate. Thus, in the previous system there were many problems with the private insurance market. There was also a need to expand Medicaid to the working poor and change medical decisions during end-of-life situations. Further, the need existed in the previous system to close the insurance gaps for young adults. This need arose out of the fact that in the United States the transition from adolescence to young adulthood was associated with the collapse of one's insurance coverage (Antwan, Moriya and Simon, 2014).Overall, the previous healthcare policy did not meet the affordability test and could not ensure quality of care for all segments of the population regardless of socio-economic status, gender, race, or creed. To buttress the hypothesis that the previous system did not meet the affordability test, Herzlinger (2010) noted that public healthcare spending in the United States threatened the economic welfare of the country because it was a poor value proposition in relation to its cost. Garson (2000) for his part, acknowledged the fact that to make the system more viable there was a need for more savings. The author proposed a variety of tools that would help accomplish this task (pp. 1048-52).

These are just a few of the many challenges that the previous healthcare policy could not meet.On the heels of these problems,hence,a new policy framework was set in motion with the passage of the ACA. In this paper, the efficacy of the ACA using the rational resource allocation model as a conceptual framework is assessed. Other theoretical approaches are also used to provide clarity on how political and institutional variables impinge upon policy development in the healthcare field(Gholipour and Rouzbehani,2016).

Methodological Framework

Alternative approaches to policy formation are often governed by various policy models (Dye, 1981; Arnold, 1990; Mann, 1991; Birkland, 2005; Anderson, 2003, Kingdom, 2003). This researcher argues that sometimes even if government decides not to do anything in relation to a perceived policy problem, such decision may also be governed by a policy model (Birkland, 2005). Thus, policy models enable us to clarify our thinking about government, politics, and the policy process (Dye, 1981; Kingdom, 2003). They also allow us to make sense of the motivations of policy actors and consequences of policy alternatives (Dye,1981,p.17). For purposes of this discussion, I adopt the rational resource allocation policy