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Commentary

Affordable Care Act: Implications for Recent Legal Permanent Residents

Shibikom A*
Assistant Professor, Worden School of Social Service, Our Lady of the Lake University, USA

Abstract

Affordable Care Act (ACA) enacted in March 2010 to provide comprehensive health care reform in the United States. It aims to improve quality of health care, decrease health care and expand access to health care in the United States. The Affordable Care Act makes many changes to strengthen Medicare and provide stronger benefits to low-income families, while slowing cost growth. This article analyzes the theoretical premises, goals, discusses how and to whom benefits are provided, how the benefits are funded. The article also analyzes the bases of eligibility to determine whether a policy is adequate, equitable, and efficient, in addressing the social problem in question. This evaluation of Affordable Care Act with particular emphasis to recent legal permanent residents and their children will reveal strengths and limitations of the policy and suggest steps for the future to be considered by policy makers. Recommendation for policy reform include change in eligibility criteria for recent legal recent permanent resident to restore Medicaid coverage by waving the five year waiting period or to include recent this population in insurance subsidies; and provision of competitive reimbursement for physicians in order to reduce health care access problems experienced by people with government funded insurance.

Introduction

A central aim of the Affordable Care Act (ACA) is to provide comprehensive health care reform that reduces health care disparities in the United States. The act has three fundamental goals; (1) Improve the quality of health care; (2) Decrease the cost of health care; and (3) Expand access to health care in the United States. The primary underlying assumption for this regulatory action is that the number of uninsured Americans is rising due to lack of affordable insurance, barriers to insurance for people with pre-existing conditions, and high prices due to limited competition and market failures [1]. In addition, health care costs are rising since millions of people without health insurance use health care services for which they do not pay, shifting the uncompensated cost of their care to health care providers who pass it along resulting in higher premiums paid by the insured, or by State and local governments.

It is important to recognize the goals of the policy, and to understand the underlying theoretical premise of those goals in an effort to identify whether those goals are reasonable and attainable. It is also important to consider service delivery and financing, as well as the bases of eligibility, to determine whether they reasonably meet the expected outcomes of the policy and determine whether a policy is adequate, equitable, and efficient, in addressing the social problem in question. Moreover, it is imperative to analyze the outcomes and consider alternative strategies for reform. This evaluation of Affordable Care Act with particular emphasis to recent legal permanent residents and their children will reveal strengths and limitations of the policy and suggest steps for the future.

Health insurance is one of the best known and most common means used to obtain access to health care [2]. Increasingly, the evidence points to harmful health and economic consequences related to being uninsured. A robust body of literature provides compelling findings about the harms of being uninsured and the benefits of gaining health insurance for both children and adults. Despite the availability of some safety net services, there is a chasm between the health care needs of people without health insurance and acccess to health care services. This gap may result in needless illness, suffering, and even death.

In response, various health care reforms took place in order to address the issue and provide solutions for health care crisis in the United States. Despite this, 49.9 million Americans had no health insurance in 2010 [3]. Healthcare is a major economic sector in the Unites States, which provides job opportunities for millions of Americans, with trillions of dollars in yearly spending. However, over 20 million Americans didn't have access to health insurance before the enactment of ACA in 2010. In addition, health care costs and insurance premiums have been constantly increasing over the past decade, which resulted in creating access problems for low-income Americans.

Cognizant of this, President Obama's health care (ACA) overhaul enacted to address certain fundamental problems with the nation's health care system, including the growing numbers of people who lack health insurance coverage, rapidly rising health care costs, and health care quality. ACA has won the last stamp of approval from the U.S. Supreme court in 2010 and extended health care coverage to some 30 million uninsured Americans along with an expansion of Medicaid services [4].

Policy Overview

The Patient Protection and Affordable Care Act, enacted in March 2010, aimed at both decreasing cost and improving accessibility and it requires every American to have health insurance. The logic is that, if every person has health insurance; (1) The aggregate cost of health care will decline in the long run because the likelihood of providing care for the uninsured reduce; and (2) Health care will be more accessible because individuals will no longer be denied care based on their inability to pay.

The two main goals of ACA, as indicated above, are universal coverage and bending the cost curve down. On universal coverage, it is expected that more than 30 million out of the 49.9 million Americans who were uninsured in 2011 according to the latest U.S. Census Bureau figures [3] will become insured starting in 2014.

Affordable Care Act provides financial assistance for low-income families who do not have access to public health or private health insurance. Approximately 18 million will be added to the 50 million currently enrolled in Medicaid, the federal-state funded program for low income Americans who earn under 133% of the Federal Poverty Level (FPL). A further 16 million will receive subsidies from the government on a sliding scale up to 400% of the FPL. On cost reduction, the Affordable Care Act levels the playing field by gradually eliminating most of this excess in payments to Medicare Advantage plans and also cut the cost curve down by reducing administrative costs and fraud. The provisions of ACA are expected to save nearly $8 billion within the next two years and approximately $418 billion by 2019 [5].

Theoretical Premise

There are three dominant theories of health insurance and each has a different vision of which types of risks should be collectively mitigated through the mechanism of insurance. Each theory of health insurance prioritizes mitigating a different type of risk. The first theory posits that the primary goal of health insurance is to mitigate the risk of harms to health; insurance design prioritizes funding care, both preventive and remedial, to maintain or promote health. This is called the "Health Promotion" theory of health insurance. The second theory posits that the primary goal of health insurance is to mitigate harms to wealth; that is, insurance should be designed in a way that medical costs are covered when they threaten financial security. This is called the "Financial Security" theory of health insurance. The third theory posits that health insurance should prioritize coverage of medical costs that result from unavoidable harms, which are more the result of bad brute luck than of individual behavior. Accordingly, this theory is called the "Brute Luck" theory of health insurance [6].

By far the most frequently cited theoretical framework discussed in health care reform literature is the Health Promotion Theory. This theory involves two core ideas. First, health insurance should primarily function to foster health by distributing the costs of indemnifying against harms to health among all insured. It can do so by using insurance dollars to prevent the onset of illness or injury or to limit the impact of illness or injury that occur. Second, health insurance should prioritize spending on the most valuable interventions for promoting health. In other words, insurance spending should be cost-effective or high value, with value defined as health benefit gained per dollar spent [6]. These core ideas, when translated into practice, will often mean allocation of spending on more basic interventions and treatment for more people, rather than for intensive treatment for fewer people. Under this theory, insurance is thus first and foremost mechanism to pool and redistribute the costs of promoting a healthy population.

Policy Benefits

The Affordable Care Act includes two primary instruments for helping people afford health coverage. First, low income families that meet the income eligibility criteria get access to health insurance through Medicaid. Second, individuals who are buying their own coverage receive tax credits from the federal government in order to fund the cost of insurance [7]. The Affordable Care Act makes numerous changes to strengthen Medicare and provide stronger benefits to low-income families, while slowing cost growth. Studies [8] indicated that the following benefits have already been received as a result of Affordable care act. ACA has provided the following benefits: millions of young adults get access to health insurance; millions of older adults saved in prescription drugs; insurance companies no longer deny access to health insurance because of pre-existing health conditions.

One group of Americans who can look forward to the law being upheld is young adults and their parents. Historically, young Americans beginning their careers have struggled to afford health coverage, often putting off their dreams in order to take a job with health benefits. To help these young people, the law allows many Americans under age 26 to stay on their parents' health plans. Today, more than 2.5 million young people have already taken advantage of this benefit [8].

Another group of Americans who are counting on the law are the tens of millions of people now getting preventive care at no additional cost. In the past, far too many Americans went without critical cancer screenings and vaccinations because of unaffordable co-pays and deductibles, often at great risk to their health. Now, many recommended preventive services are free for those with Medicare and private coverage. The number of people with Medicaid coverage increased by over 20 million and people with private coverage get access to free preventive services, which is a great step forward in building an affordable system in the United States.

Cost and funding

Congressional Budget Office (CBO) estimated that insurance coverage expansion will result in costs of 1.3 trillion over 10 years from the date of the enactment of the policy. Costs include the exchange subsidies and related spending, increased spending on Medicaid, and tax credits for some employers. It is further estimated that those costs will be partially offset by penalties paid by uninsured individuals and

employers, an excise tax on high-premium insurance plans, and net savings from other effects that coverage expansion is expected to have on tax revenues and outlays (CBO, 2012). The office projected that insurance coverage provisions will result in net costs of 1 trillion in 10 year's period.

ACA's provisions are intended to be funded by a variety of taxes and offsets. Major sources of new revenue include a much-broadened Medicare tax on incomes over $200,000 and $250,000, for individual and joint filers respectively, an annual fee on insurance providers, and a 40% excise tax on "Cadillac" insurance policies [5]. There are also taxes on pharmaceuticals, high-cost diagnostic equipment, and a 10% federal sales tax on indoor tanning services. Offsets are from intended cost savings such as changes in the Medicare advantage program relative to traditional Medicare.

Eligibility

This final rule implements several provisions of the Affordable Care Act related to Medicaid eligibility, enrollment and coordination with the Affordable Insurance Exchanges (Exchanges), the Children's Health Insurance Program (CHIP), and other insurance affordability programs. It also simplifies the current eligibility rules and systems in the Medicaid and CHIP programs. This final rule: (1) Reflects the statutory minimum Medicaid income eligibility level of 133% of the Federal Poverty Level (FPL) across the country for most non-disabled adults under age 65; (2) eliminates obsolete eligibility categories and collapses other categories into four primary groups: children, pregnant women, parents, and the new adult group; (3) modernizes eligibility verification rules to rely primarily on electronic data sources; and (4) codifies the streamlining of income-based rules and systems for processing Medicaid and CHIP applications and renewals for most individuals [9].

Illegal immigrants will be ineligible for any of the benefits; however, the act does not identify the legal status of non-citizens. To account for this, it is assumed that over one-third of permanent residents who would otherwise be eligible for assistance would be ineligible due to their immigration status. Legal permanent residents who lived less than five years in the United States are not eligible for expanded Medicaid coverage and for subsidized coverage in exchanges [10].

Naturalized citizens and lawfully residing immigrants and their children who have been in the US for more than five years will have the same opportunities to obtain more affordable health insurance coverage as native-born citizens under the ACA. Thus, the ACA is expected to lead to substantial reductions in uninsured rates among these immigrant groups. However, lawfully residing immigrants who have been in the US for five years or less will not be eligible for Medicaid/CHIP, thus, some may continue to face affordability barriers even after the ACA is fully implemented.

Who is left out?

Although the demographic characteristics and population diversity is considered by the provisions of ACA, still disparity in provision of services due to eligibility criteria. There are roughly 12 million Lawful Permanent Residents (LPRs) in the United States; 4.2 million are uninsured. These LPRs have to stay for five years after obtaining a green card to be eligible to ACA or Medicaid or CHIP. There are also estimated 10.8 million unauthorized immigrants in the United States. They are ineligible for Medicaid and other means-tested federal benefits. Immigrants already take the largest share of the uninsured in the United States and may continue to be the most vulnerable segments of the population. In 2007, Legal permanent residents (LPRs) were more than twice as likely as born citizens to be uninsured. A quarter of LPR children were uninsured, versus just 10% of US born citizens. In the same year, 55% of unauthorized children and 59% unauthorized adults were uninsured [11].

One in every five American children is a member of an immigrant family. Despite their substantial numbers, these children are much less likely to have health insurance and ready access to health care than children in native-born citizen families [12]. Family immigration status is, in fact, one of the most important risk factors for the lack of health care coverage among children in the United States. About one-third of the nation's low-income, uninsured children live in immigrant families [13]. Almost all of these children meet the income requirements for eligibility for Medicaid or the State Children's Health Insurance Program (SCHIP) and ACA, but for various reasons they are not enrolled. For example, some of these children are ineligible for Medicaid and SCHIP because of immigrant eligibility restrictions.

Strength and Limitations

The Affordable Care Act seeks to expand coverage immediately and over the long term. It establishes a temporary, national high-risk pool to provide coverage for individuals denied insurance in the individual market. It creates incentives for the formation of non-profit Consumer Operated and Oriented Plans (CO–OPs) to compete with existing insurers as early as 2012. By 2014, the states will create health insurance exchanges that guarantee coverage for all individuals and small businesses, and Medicaid eligibility will be extended to all Americans with income below 133% of the federal poverty level (FPL). With few exceptions, all individuals will be required to have coverage that qualifies as "an essential health benefits package."

The new law acknowledges that health insurance leads to better outcomes when it makes health care affordable and helps consumers use care appropriately. In addition, preventive and wellness services, chronic disease management, and mental health and drug benefits are included in the essential benefit package that will constitute minimum required coverage in 2014.

While it is true that ACA expected to play significant role in reducing health care disparities in the United States by helping people to afford health coverage, still health care disparities in health care access may continue even after ACA is fully implemented.

One of the goals of ACA is to expand health care access in the United States. Indeed, ACA makes many changes to strengthen Medicare and provide stronger benefits to low-

income families expanding access to young adults, seniors and people with disabilities, children and adults in poor households. Despite this, there is still a tremendous inequality of access to health care for children with government-funded insurance when compared with those with commercial insurance. Physicians indicate that this disparity is related to excessive administrative burdens and low monetary reimbursement. Physicians do not want to treat Medicaid patients because the government reimbursement rates are so low. It is projected by HHS that Medicaid payments are between 58% and 66% of private health insurance payments, a 34% to 42% underpayment.

The other health care access problem is created due to eligibility criteria of ACA that left poor immigrant families and children. Indeed, naturalized citizens and lawfully residing immigrants and their children who have been in the US for more than five years will have the same opportunities to obtain more affordable health insurance coverage as native-born citizens under the ACA. However, recent legal permanent residents who lived less than five years in the United States are not eligible for expanded Medicaid coverage and for subsidized coverage in exchanges. Generally, being uninsured have a lot of adverse health related outcomes, especially for children. Uninsured children generally receive much less care, either preventive or for acute and chronic conditions, than insured children. Uninsured children are less likely than insured children to receive medical care for common childhood conditions, such as sore throat, or for emergencies, such as a ruptured appendix.

This health access problem may not only affect the uninsured immigrant children, but the effect may be felt by everyone in the country. Undiagnosed and untreated illnesses and conditions can result in costs to both individuals and society. Exclusion of recent LPRs from health insurance reform would leave large population still dependent on emergency rooms, community health centers and other public health facilities and would discourage early detection and treatment of transmitting diseases. It may have serious impact on the overall public health of American citizens as well. In addition, ultimately taxpayers and health care consumers would have to pay for uncompensated care for uninsured immigrants as well as higher health care costs in the future. Moreover, because recent LPRs are relatively young and healthy, including them in health insurance risk pools could help contain costs. Moreover, untreated health conditions cause uninsured children to lose opportunities for normal development. Their educational achievement suffers because they miss more days of school. In addition, poorer health, greater disability, and premature death among uninsured immigrant adult workers have economic consequences for their families, employers, and the overall economy. The economic cost of lost productivity is substantial, especially when added to the costs of avoidable health care.

Recommendations

Based on the previous review and analysis of the policy, one recommendation for policy reform is to address eligibility criteria for recent LPRs. Lawmakers may be reluctant to restore Medicaid coverage by waving the five year waiting period or to include recent LPRs in insurance subsidies because these policy changes would raise the short term costs of health care reform. These short term costs overstate the costs of including LPRs in Medicaid and insurance subsidies because recent immigrants are younger and healthier than native born citizens, with lower disability and chronic disease rate. Partly for this reasons, immigrants are less likely that natives to visit health care services. Recent studies have found that immigrants spend 14% to 20% less on health care than natives, and that noncitizens spend less than half as much as citizens on health care overall. Recent LPRs, therefore, cost less to insure than other Americans and could lower insurance premiums for US citizens if included in the exchange in large numbers.

In addition, any apparent savings from excluding recent immigrants from Medicaid or insurance subsidies would be partly offset by cost shifts in two areas. First, recent immigrants and their children without health insurance would continue to use the health care system. Low income LPRs who cannot afford to visit a doctor often seek non-urgent care at emergency rooms, where they must be treated regardless of their immigration status and ability to pay. And providing non-urgent care this way is inefficient because the same service cost eight to ten times as much in an emergency room as in more basic health setting. Thus, some of the short term cost savings form excluding recent legal permanent residents from the healthcare reform would be lost through cost shifting to state and local providers.

Second, excluding recent LPRs and from Medicaid or insurance subsidies also shift some health costs into the future because uninsured LPRs would be less likely to obtain preventive care and early detection of chronic conditions, resulting in more expensive future treatment. Projecting these types of treatment is difficult because the savings from preventive care will emerge over decades. It is indicated earlier that, these immigrants are ineligible only because they have to wait for five years and they will be eligible in the future. Therefore, the long term cost of health care for this group of people may increase which will then be covered by Medicaid or exchanges when they become eligible after five years of stay.

The other recommendation is about the access problem for those who are currently enrolled in Medicaid and exchanges. It is indicated earlier that there is still a tremendous inequality of access to health care for children with government-funded insurance when compared with those with commercial insurance because the government reimbursement rates are so low. Therefore, it is important to design and implement competitive reimbursement for physicians in order to reduce health care access problems experienced by people with government funded insurance. In addition, in implementing the new law, federal and state policymakers should consider lessons learned about continuous coverage and affordable care. For example, cost sharing, especially for mental health and drug benefits, can create financial barriers that jeopardize the appropriate and efficient use of care. Policymakers might consider ways to make it easier for populations enrolled in public programs and coverage through the exchanges, particularly populations with serious conditions or special needs.

Conclusion

Affordable Care Act aims to provide comprehensive health care reform that reduces health care disparities in the United States. The primary underlying assumption for this regulatory action is that the number of uninsured Americans is rising due to lack of affordable insurance, barriers to insurance for people with pre-existing conditions, and high prices due to limited competition and market failures. The new law acknowledges that health insurance leads to better outcomes when it makes health care affordable and helps consumers use care appropriately. Although ACA expected to play significant role in reducing health care disparities in the United States by helping people to afford health coverage, still health care disparities in health care access may continue even after ACA is fully implemented. There is still a tremendous inequality of access to health care for LPR children with government-funded insurance when compared with those with commercial insurance because of low monetary reimbursement. In addition, although the demographic characteristics and population diversity is considered by the provisions of ACA, still disparity in provision of services due to eligibility criteria. There are roughly 12 million Lawful Permanent Residents (LPRs) in the United States. These LPRs have to stay for five years after obtaining a green card to be eligible to ACA or Medicaid or CHIP. Family immigration status is, in fact, one of the most important risk factors for the lack of health care coverage among LPRs and their children in the United States. Maintaining this eligibility criterion may result in increased risks for major long-term disabilities associated with such outcomes and their subsequent costs for immigrant children and their families. In addition, denying legal immigrants access to basic health care would significantly deprive them of basic needs and core services that are imperative to the wellbeing of LPRs and their children. This health access problem may not only affect the uninsured immigrant children, but the effect may be felt by everyone in the country in the long run.

References

1. Manchikanti L, Hirsch J (2010) Obama health care for all Americans: Practical implications. Pain Physician 12(2): 289-304.
2. Kenney G, Cook A, Dubay L (2009) Progress enrolling children in Medicaid/CHIP: Who is left and what are the prospects for covering more children? Urban Institute, Washington, DC.
3. Denavas-Walt C, Proctor D, Smith J (2011) Income, poverty & health insurance coverage in the United States. Current Population Report, Washington D.C.
4. Hudson J (2009) Families with mixed eligibility for public coverage: Navigating Medicaid, CHIP and uninsurance. Health Affairs 28(4): 697-709.
5. Congressional Budget Office (2012) Updated estimates for the insurance coverage provisions of the Affordable Care Act.
6. Mayer M, Skinner A, Slifkin R (2004) Unmet need for routine and specialty care: Data from the national survey of children with special health care needs. Pediatrics 113(2): 109-115.
7. DHHS (2011) Patient Protection and Affordable Care Act: exchange functions in the individual market; eligibility determinations; exchange standards for employers. Federal Register, 76(159): 51202–51237.
8. Elmendorf D (2010) CBO's Analysis of the Major Health Care Legislation Enacted in March 2010. Congressional Budget Office, Washington, DC.
9. Chapin R (2011) Social policy for effective practice: A strengths approach. Routledge, London, UK.
10. Pauly M, Herring B, Song D (2010) Tax credits, the distribution of subsidized health insurance premiums, and the uninsured. Forum for Health Economics and Policy 5(5): 28-37.
11. Goldman D, Smith J, Sood N (2009) Immigrants and the cost of medical care. Health Affairs 25(6): 1700-1711.
12. Ku L, Matani S (2001) Left out: Immigrants' access to health care and insurance. Health Affairs 20(1): 247-256.
13. Huang Z, Yu S, Ledsky R (2006) Health status and health service access and use among children in US immigrant families. Am J Public Health 96(4): 634-640.

***Corresponding author:** Alegnta Shibikom, Ph.D., MSW, Assistant Professor, Worden School of Social Service, Our Lady *of the* Lake University, Office- Worden #15, USA; Tel: (210) 431-3911, e-mail: afshibikom@ollusa.edu

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