So Now What?

While the Affordable Care Act (ACA; Pub L No. 111–148) is the most significant health-related legislation in recent years, in my opinion it "ain't what it's cracked up to be." It is not the greatest social health policy of the century, second only to the passage of Medicare and Medicaid in 1965, as portrayed by Democrat enthusiasts, nor is it a federal government takeover of health care in the United States, the beginning of socialized medicine, as portrayed by Republicans who have often demonized this legislation as an unconstitutional overreach of government. These polarized portrayals are shameful and have been used for political purposes, but are misleading to the public. Notwithstanding the "politicization" of health care policy in our country, the ACA is substantive and significant legislation. The following are what I consider the good aspects of this law, some problems or deficiencies, and some opportunities to address pressing problems with future health reforms in the United States.

The primary purpose of the ACA was to increase the number of Americans with health insurance, and clearly this is related to "public health" with evidence that having such coverage is an important factor related to health status. However, there is much more to the ACA than expanding access to health insurance—through Medicaid expansion, subsidized purchase of insurance on the Federal Exchange or "Marketplace," and reform of insurance regulations.

A positive aspect of the ACA is the increase in the number of Americans who have health insurance coverage. More than 20 million individuals have coverage because of Medicaid expansion, Health Insurance Marketplace coverage (the federal "exchange"), and changes in private insurance such as allowing young adults to stay on their parent's health insurance plans until 26 years of age and requiring plans to cover people with preexisting health conditions. Recent Census Bureau data (September 16, 2006) show that only 9.1% of Americans do not have coverage, the lowest level ever recorded by the agency.[1] In my home state of Utah, 164 415 persons have obtained health insurance through the federal exchange, reducing our rate of the uninsured to 10.5%, a 16% decrease. Of those Utahans who enrolled on the federal exchange, 85% received a premium subsidy. (However, there are significant differences among various population groups [e.g., Utah ranks lowest in the nation of the number of insured Hispanic children, with 16.8% being uninsured].[2])

The negatives of the ACA include a disruption of the health insurance market with consolidation leading to fewer consumer choices and less competition among plans offering coverage on the federal exchange; the increased cost of insurance premiums and patient expenses (higher copayments and deductibles), as well as the complexity of regulations adding to administrative overhead and costs of compliance; and the failure of most of the authorized "Co-op Health Plans," not-for-profit health insurance companies that were intended to demonstrate that quality care could be provided at a lower cost than commercial plans.

SO NOW WHAT?

The stage is set for change, regardless of who wins the Presidential election. The ACA will not be repealed, but it will be amended to address significant concerns (e.g., the need for administrative simplification, costs, and stabilizing the commercial insurance market). Beyond this law, what can we do to move forward and achieve a more robust public health system? At the recent annual meeting of the Association of State and Territorial Health Officials, I heard that *all* public health policies must be based on: *science*, considered in the context of *current politics*, and *financial feasibility*. As Jewel Mullen, MD (currently Deputy Assistant Secretary of Health, US Department of Health and Human Services, formerly the State Health Official for Connecticut) told me at this meeting, "No matter who wins the White House, we have important and essential work to do and will continue to do it, to the extent we can with the budget provided, and as directed by our elected officials." This is exactly what all public health professionals should do.

This is also a time to "think big," to consider major reforms to improve governmental public health, to collaborate with our colleagues throughout our complex health care system and communities, to improve the health status of all. For the sake of stimulating discussion about next steps, I have a few suggestions that relate to an alternative to Medicaid, as we know it, that could potentially improve the public's health:

1. Federalize "acute care" Medicaid—repeal the federal–state collaboration and enroll those now entitled to Medicaid in Medicare (while a bold proposal, it is likely more feasible than "Medicare for All" which is a proposal favored by many to achieve a more fair and affordable health care system). This would need to be supplemented by a provision to cover the social and support services customarily provided Medicaid patients that Medicare does not cover (e.g., transportation, translation services). The additional costs to the federal government could be offset the savings to states from their considerable costs of administering their Medicaid programs.
2. Block Grant Long-Term Services and Support—this is not a new idea, was proposed early on in the Regan Administration, and given the demographics on aging in our country, this proposal should be revisited. There is great variation among states in the proportion of elderly, and their care should be culturally appropriate and tailored to different needs, which can likely be best achieved at the local level. We also need to consider more creative options for cost savings and improved quality of life that can be

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achieved by caring for more of the elderly and disabled in community-based and home care settings.

3. Establish a National Initiative to Reduce Infant Mortality—take coverage for maternity care out of Medicaid, Title XIX of the Social Security Act, and merge it with Title V, the Maternal and Child Health Services Block Grant. The United States ranked 26th in the world in infant mortality, according to a 2014 Centers for Disease Control and Prevention Vital Statistics report. This should be cause for national embarrassment, and calls for a new bipartisan initiative to address this shameful situation.[3] Medicaid now covers half of all deliveries in the United States, and the focus should not just be on paying for maternity services, but on birth outcomes. I think this could better be achieved through a major public health initiative that couples insurance coverage with proven public health practices that improve birth outcomes and maternal health.

In summary, we are experiencing an historic and disconcerting time in American politics. The nation is divided on what the role of government should be. But those of us working to improving the health of our nation need to remain committed to public health principles and practice, to be a reliable resource to whomever are chosen as our leaders, and to make the case for new policies that will improve health of all. AJPH

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A Women's Health Legacy of the Obama Administration

The Obama administration has made progress on US women's health, with both groundbreaking and incremental actions that have impacts now and in the future.

BIG STEPS: ACA, PREVENTION, AND CONTRACEPTION

The Affordable Care Act (ACA; Pub L No. 111–148) introduced many opportunities to expand access to health care and improve quality of care. For women, new insurance reforms that prohibit gender rating and exclusions because of preexisting conditions, as well as required coverage of maternity care and preventive services, allowed more women to access insurance coverage that better addresses their health needs. The rate of uninsured women between ages 18 and 64 years was cut nearly in half, dropping to 10.8% in 2015.[1] Women gained coverage through the new marketplaces and through Medicaid expansion, and we are starting to see improvements in measures such as delayed access to health care.

A groundbreaking aspect of the ACA is its focus on prevention. The requirement to cover preventive services without cost sharing was contrary to traditional insurance principles, yet has the potential to significantly increase the use of preventive services. For women, making sure that critical women's preventive health services were on the list of covered services was both a challenge and an opportunity. The ACA included the Mikulski Women's Health Amendment, which directed the US Department of Health and Human Services (HHS) to develop a list of women's health preventive services to fill the gaps in the list from the US Preventive Services Task Force. HHS asked the Institute of Medicine to identify missing women's preventive services, and then quickly added the eight services to the list for coverage (http://bit.ly/2f01p7q). These services included coverage of at least one well woman visit per year; screening services for HIV, human papillomavirus, and other sexually transmitted diseases; lactation support and gestational diabetes screening for pregnant women; and screening and counseling for interpersonal and domestic violence. It also includes coverage for all US Food and Drug Administration (FDA)–approved contraceptive methods and counseling.

This required coverage of contraception led to many legal challenges, vigorously defended by the Obama Administration and culminating in US Supreme Court rulings that allow for some employers to object to providing coverage. However, millions of women have benefited from new insurance coverage of contraception, and we are seeing the impact through reduced out-of-pocket costs for women.[2] Expanded coverage for over-the-counter contraceptives, including emergency contraception, and vasectomy for men is being considered at both the federal (http://bit.ly/2eV41VQ) and state levels. Increasing quality of care for women also is fundamental to ensuring women and couples have the broad range of choices on planning whether and when to have children. The guidelines issued jointly by the Centers for Disease Control and Prevention and the HHS Office of Population Affairs on Quality Family Planning in 2014

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