**Questions on the State of Universal Coverage in the US Healthcare**

**Describe the four parts of Medicare as they are today—who is eligible, what is covered, and what coverage gaps remain.**

Medicare, the federal health insurance program for people who are aged over 64 and those with specific disabilities or those diagnosed with End-Stage Renal Disease, comprises four parts, which are Parts A, B, C, and D. Understanding the different parts will help you make important choices. Part A, referred to as hospital insurance covers the cost of hospital care, hospice, skilled nursing facility care, and health services delivered at home. Most people become eligible for Part A owing to the taxes they paid during active employment. Part B is known as medical insurance and covers supplies and services that are medically necessary, and which meet the standards of medical practice, and which are required to treat or diagnose a medical condition (Neuman, & Rother, 2015). Part B of Medicare also covers preventive care services, including screenings, vaccination and annual wellness visits. Part C, on the other hand, is referred to as Medicare Advantage Plan, and is a coverage provided by private companies that enter into contracts with Medicare to offer part A and B benefits. The last component is Part D, or prescription drug coverage. Since prescriptions are neither covered under Part A or Part B, Part D is critical in relieving the burden associated with the cost of prescribed medication.

**Trace the history of Medicare and highlight times when Medicare took an assertive role in healthcare transformation and times when it purposefully avoided such a role.**

Medicare, which was developed in 1965 as part of amendments to the Social Security Act, established the very first public health insurance program catering for the elderly. The initial statute focused primarily on the acute care needs of older adults, restricting home care benefits. In 1972, President Nixon signed a law making the first adjustment to Medicare, a legislation that would expand the range of coverage to include persons aged under 65 who had long term disabilities, as well as those with end-stage renal disease (ERSD) (Blumenthal et al., 2015). In 1980, the US congress passed the Omnibus Reconciliation Act, which brought Medicare under federal oversight. In 1982, Medicare was further expanded to include hospice services among its benefits. In the 2000s persons under the age of 65, who have been diagnosed with ALS were allowed to enroll into Medicare. In the year 2003, President G. W. Bush signed an act into law, which created the prescription drug benefit, also referred to as Part D. Until then, there had not existed a prescription drug plan in Medicare coverage.

**What are Medicare’s biggest challenges today? How is Medicare tackling these challenges, and which vulnerabilities remain insufficiently addressed?**

Some of the biggest challenges facing Medicare include financing, affordability**,** managing chronic disease, and delivery-system reform (Neuman, & Rother, 2015). In terms of financing, although spending growth on Medicare has slowed significantly over the recent past, and is expected to slow further in the coming years, the rise of the baby boomer generation is increasing the number of people eligible for Medicare. There exist several proposals to curb federal expenditure on Medicare, including raising the eligibility age, cost sharing and restructuring benefits. However, these proposals are yet to accurately address the problem of financing.

**Even though many envisioned the enactment of Medicare as a stepping stone to universal health care, why did it take 45 years for the enactment of the ACA?**

Universal health care, also referred to as universal health coverage, implies provision of quality health services to all the citizens of a particular country. Although the Patient Protection and Affordable Care Act of 2010 currently stands as the capstone of long-overdue efforts to reform the US healthcare system, the Act, which was enacted in 2014, started with a more modest objective of helping uninsured individual access insurance. The reason why it has taken more than 45 years for the act to be enacted can be partly attributed party politics and challenges in financing such an undertaking. In terms of party politics for instance, political naivete, particularly on the part of reformers in failing to handle the interest group opposition, historical experiences, and ideology, as well as the overall political context played a major role in the delay.  In fact, as noted by Glied et al. (2017), the ACA was an outcome of a narrowly partisan process. The process narrowly survived political wrangles and barely made it past a 2012 Supreme Court challenge.

**In what ways do financing mechanisms for the care of vulnerable populations contribute to a two-class care system?**

The access to and quality of care in the financing mechanisms of vulnerable populations are far from optimal. Evidence from previous research shows that Medicaid and Medicare beneficiaries, for instance, face financial and other barriers to care from private care providers and have had to depend on emergency departments and publicly funded care facilities (Kimmel et al., 2016). Many of the mechanisms’ features, including their potential to strengthen services and the coordination of care, improved case management and clearly indefinable providers will improve access to care for the vulnerable populations.

However, there remains a tendency for the healthcare system to discriminate against patients under such systems, who are seen as costly or difficult. Managed care plans that are paid on a risk and capitated basis offer incentives for limiting the beneficiary use of covered services seen to be unneeded or as being inappropriate. In addition, since the beneficiaries have little or no capacity to pick among care organizations, their ability to express their dissatisfaction by disenrolling from plans that they see as arbitrarily denying them access to needed covered services (Neuman, & Rother, 2015). In addition, incentives aimed at economizing on care also pose serious problems for beneficiaries of such aid, who are mostly economically disadvantaged groups without the financial resources needed to directly purchase care.

**How will the ACA help eliminate some of the variation that currently exists among states in terms of the access, quality, and cost of care?**

The key features of the Affordable Care Act (ACA) include universal access to health care through improved coverage, enhanced quality and efficiency, as well as consumer protection (Glied et al., 2017). These features will play an important role in eliminating disparities in the access, quality, and cost of care, thus moving the country closer towards universal coverage. In addition, affordable care payment reforms are also transforming the focus from a volume-driven approach to care, to a more value-driven approach based on reimbursement according to measurement of meaningful outcomes. In this way, the ACA incentivizes high quality as well as efficient, safe, and cost-effective care. Another notable contribution of the ACA is the fundamental change from a delivery system based on care management and infrastructure to one that is more integrated and collaborative.

**Which group or groups of people still have inadequate insurance coverage?**

While commendable strides have been made towards universal healthcare coverage, certain groups still remain largely uninsured. Research shows that insurance status largely correlates with employment status, income level, and educational attainment (Kimmel et al., 2016). In terms of work status for example, members of families without wage earners remain largely uninsured. Those from poor economic backgrounds also tend to be uninsured. Another inadequately insured group is the immigrant population.

**References**

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