Lessons Learned From Teaching the Affordable Care Act of 2010

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ABSTRACT
This is a reflection on the evolution of our market-based focus to teaching students about the Patient Protection and Affordable Care Act of 2010 (ACA). Since March 2010, we have presented 12–15 hours of in-class training for students in public policy and administration or in public health, medicine, social work, gerontology, and psychology. We find that teaching the change associated with the ACA is simpler with a focus on pre- and post-enactment market financing. By dividing insurance into public and private markets, we emphasize the financing sources and requirements of each market. Students find it simpler to identify components of policy as it applies to markets. Each class focuses on the fact of change—not arguing about its utility. We use a case-based approach to illustrate specific policies pre- and post-ACA. Based on our classroom experience, a market-based focus on ACA-related reforms is an effective approach to teaching this complex topic.

KEYWORDS
health care policy, case-study approach, Affordable Care Act, policy implementation

For professors teaching the public administration of health care, the Patient Protection and Affordable Care Act of 2012 (ACA) is a challenge. The ACA contains sweeping reforms of both private and public health insurance markets, and its implementation requires a workforce with additional knowledge and an ability to adapt to the changes in the fundamental structure of health insurance policy and administration. Since the enactment of the ACA, the U.S. Department of Labor has estimated that employment in the health care field will create about 25% of the new jobs between 2010 and 2020 (Bureau of Labor Statistics, 2013). Some schools of public affairs and administration already offer health policy courses that examine problems with the health care system in general. The coming enactments of major reforms deserve extra attention in light of the ways in which they dramatically restructure financing of the American health care system.

Wading through the political rhetoric is a daunting task. The larger society is focused on health care consumer issues. This conversation is useful for the body politic, but it does not help teachers of health care policy. Our primary job has not changed. We train professionals to work in the legal and public affairs environment created by law. Course content must adapt when the legal environment changes. For the past three years, we have worked to adapt the content of our courses to reflect the changing landscape of health care policy and law.
The ACA raises crucial questions for the education and training of public administration students. What do our students need to know about this law? What do these reforms require health insurance professionals to do? What knowledge, skills, and strategies do they need to do it effectively? How do we transform curriculum to align with the skill sets required? What does faculty need to know to educate and train students?

Keeping the ACA requirements in mind, our paper addresses these questions and offers recommendations and innovations in pedagogy and knowledge acquisition. The article reflects the philosophical and pedagogical adaptations we bring to the challenge of teaching the details of ACA implementation. The content is based on our classroom experiences. The paper ends with a discussion of how implementation of the law, its provisions, and its legal framework strengthens the capacity of instruction in all aspects of public administration, including public finance, management, human resources, technology, and innovation.

**SPEAKING THE LANGUAGE OF HEALTH CARE INSURANCE**

The new health care law is complex. Its text is more than 2,000 pages of legislative language. Early in our pedagogical journey, we elected to use the National Association of Insurance Commissioners (NAIC) vocabulary of ACA to create a framework. The NAIC is a professional organization of state-based insurance regulation that focuses on standard setting and regulatory support. The chief insurance regulators from the 50 states, the District of Columbia, and the five U.S. territories govern the NAIC. Through the NAIC, state insurance regulators establish standards and best practices. NAIC members are elected or appointed state government officials (National Association of Insurance Commissioners, 2012). Our use of its glossary, which defines new terms associated with the ACA, made it easier to separate policy fact and political hyperbole.

Research shows that students need to encounter a new word at least 10 to 16 times to effectively learn its use (Nation, 1990). “Policy bingo” is a tool we use in class to facilitate understanding of the vocabulary of the ACA. This exercise fits squarely into a core course where students examine the role of different levels and branches of government in the implementation of health and public policy. In policy bingo, each student is provided with a game card containing 25 squares in a five-by-five arrangement. Each square contains a term that will be used during the presentation. Each term is used by the president, Congress, the courts, bureaucracy, and nongovernmental actors, such as the Health Insurance Association of America, in the policy-making process. As the two-hour lecture proceeds, students mark a square when they hear the term. Marking continues until a vertical, horizontal, or diagonal line on the bingo card emerges. The line reflects combinations of ACA-related terms. A student who achieves a certain pattern then calls out “ACA bingo.” Immediately, the class stops and terms are read aloud. If we all agree, then the student is rewarded with a small treat; candies are well received by our students.

At the end of the exercise, the glossary of terms and health concepts are reviewed and incorporated into future readings and assignments. At the end of the session, students complete an evaluation form. What three new ideas did you learn from the lecture today? What did you find most useful? What, if anything, could be improved in learning about the ACA? According to the responses to this evaluation, students find this sort of experiential learning exercise enjoyable and informative because they learn new terminology. As one student put it:

> Another important element [of the ACA] I learned today was understanding the differences in the private and public aspects of health insurance. Often people assume insurance falls under the public sector and they will increasingly have to pay, but in reality, for many Americans things will not change.

Many students thought that the exercise is particularly useful because it improves under-
standing of key concepts. Several students commented along these lines: “[ACA bingo is a] good vocabulary lesson to better understand the issue and it keeps my attention.” Students also thought they learned the “true” meaning of colloquial terms used by policy makers, such as Teddy Bear Plan, bundled payment, silver sneakers, reconciliation in a title of an act, and adjusted community rating, all of which helps to bracket the issue in what is already covered by state law.

Each of Us Lives in a Single Insurance Market for Most of Our Lives
To teach ACA, each of us had to clarify our own place in the health insurance market. Throughout our adult lives, each of us has had jobs that came with employer-sponsored health insurance. In effect, our personal experience is defined by private market plans available to companies with a large workforce. Our students, however, made us aware that there are other market-based experiences. Some of these young adults worked for small companies that offered plans with limited benefits. Other students were unemployed and had experience with Medicaid. We also reflected on our own experience with aged and disabled family members. We brought the collective experience of our students, colleagues, and families to the problem of teaching. Once we understood that each student brings his or her experience into the classroom, the need for case-based illustrations became apparent.

With the NAIC language in hand, we begin our sessions with a comparison of public and private models of health insurance. This pedagogy is crucial for framing two separate pieces of the ACA: the Health Insurance Exchanges and the Expansion of Medicaid. The exchanges are a financing strategy to increase the capital pool in private insurance markets. Their logic is simple. An increased number of persons paying premiums increases the total pool of dollars available to pay for care in the private market (Haeder & Weimer, 2013). This is one source for stabilizing the capital used by pharmacies, hospitals, and physicians. The individual mandate is designed to ensure that the premium pool is large enough. The other source of capital is the expansion. Like the exchange, it is a financing strategy to increase the capital pool. Unlike the exchange, its dollars are directed toward public health insurance markets. These dollars stabilize health care infrastructure in areas where there is limited private capital. These dollars also stabilize health care education and the physician training pipeline. The expansion is designed to ensure that the capital pool is large enough.

Together, the exchanges and the expansion attempt to correct structural flaws in the current capital building framework (Rosenbaum, 2011). Before the ACA, the framework was based on an environment where a large segment of the population had employer-sponsored insurance (private market capital) and the number of older adults with Medicare was relatively small (public market capital). Demographic trends are changing the sources of capital available to sustain health care infrastructure. The number of persons with employer-sponsored plans is declining. The number with Medicare is rising. Our fundamental strategy remains the same—increase the size of pooled dollars for sustaining health care infrastructure. What is changing is the structure we use as a society to create capital pools.

We decided to focus on the challenge of teaching the U.S. health care insurance structure. For teaching purposes, it is useful to frame health insurance as a financial strategy to pool dollars, and almost every detail in the ACA serves this larger purpose. Pooled dollars become capital that can be used to create or sustain health care infrastructure. It is also the source of profit in the delivery of health care. Currently, we have two sources of capital: private and public insurance markets. The history of health insurance begins with the process of creating pooled capital in the private markets (Richmond & Fein, 2005). At a fundamental level, pooling capital gave birth to Blue Cross Blue Shield (Starr, 1982). The public markets emerged when the infrastructure created by private dollars proved to be too small to accommodate population needs. Before
Medicare, physicians had to stabilize their business and household economies with strategies that included trading service for goods or labor or dividing work time between medical and nonmedical tasks. Simply put, doctors had to do something else while waiting for episodes of acute illness. Public market dollars stabilized professional income and allowed full-time attention to health care delivery.

One way to understand the investments of health care insurance dollars is to imagine the segments that would disappear if pooled dollars were not available. The stand-alone pharmacy is possible because a large capital pool stabilizes the dollars available for this business model. Pharmacies purchase and stockpile medications, medical devices, and over-the-counter drugs. Without insurance dollars, those midnight runs for medicine could not happen. Before the growth of capital pools, health care access in the United States was highly fragmented. Its delivery was concentrated in the cities with medical schools. Medical schools mostly provide in-class training, which transforms under-graduates into graduates with a didactic medical education. It does not contain much hands-on experience. Pooled dollars stabilized undergraduate medical education. Before insurance dollars, the number of medical schools nationwide was limited and the training offered was not standardized (Starr, 1982). Increased numbers of schools, their dispersion across the United States, and standardization of training emerged with the advent of public insurance dollars. Postgraduate or residency training is an important component of experiential training. Medicare supports the U.S. system of postgraduate physician education by providing salaries to doctors as they learn the details of specialty care. Before Medicare, there were fewer physicians and almost no specialists.

The insurance capital pool also stabilizes financing of health care delivery systems. In large areas of the United States, the presence of well-educated physicians was not enough to improve the health of an area or ensure a supply line for knowledge and technology. A dedicated capital pool was required for true growth. Combining private and public dollars stabilizes our national network of hospitals. In particular, rural communities benefit from support of critical access hospitals. These 25-bed facilities bring health care to geographic areas without sufficient local capital.

To teach the ACA and its changes to the health care environment, we emphasize the primary role of insurance in the creation of capital pools. When viewed through this prism, the old forms of both private and public plans have an organized logic. Title I and II of the ACA are built upon this foundation. Changes to health care financing are designed to promote the U.S. capital pool development philosophy. Before focusing on the explicit details of insurance and teaching in public policy, we present a few examples that illustrate the connection between capital development and ACA law.

**History Is an Important Part of Teaching**

National medical care systems can be understood only in terms of the larger society in which they operate (Quadagno, 2004). History shapes a nation’s health care delivery (Litman, 1997). Political culture drives its approach to financing, and a formal curriculum needs to position health insurance policy within a sequence of events. ACA policy is rooted in the history of political and legislative events that led to health care financing reforms (Patel & Rushefsky, 2006). Knowing this history helps trainees. Specific policies for individuals, employers, and the public seem less arbitrary when viewed in a larger context. Consider the history of Medicare. Before the enactment of Medicare and Medicaid, the population without access to health care included the elderly who were retired, children in low-income families, and pregnant women. President Johnson framed barriers to health care as a civil rights issue. He made the nation aware of how these specific groups in the United States had unequal access to health care. Congress amended the Social Security Act to create Medicare and Medicaid, using the taxing authority of the U.S. Treasury to finance them (Moon, 2006). These public dollars of Medicare
also served to end racial segregation in U.S. hospitals. Universities across the country strive to help their students understand the roots of health care disparities. Enactment of health care policy has the potential to diminish barriers to care. Medicare and Medicaid are examples in the United States. This potential to address civil rights is one feature that distinguishes health care insurance from property or casualty insurance. Property insurance does not need to pay for the production and sale of new goods. Its premiums do not need to support infrastructure needed for repairs. In health care, the entire cost of replacement or repair is not the sole driver of premiums. Health care insurance, particularly public plans, have the added task of supporting infrastructure between episodes of care.

Health care insurance is an area of public policy reflecting a balance between social contract and capital markets. Medicaid, in particular, is a public insurance plan. A partnership that combines matched state and federal dollars finances Medicaid. Most states contract with private companies to manage Medicaid care. These for-profit companies are specialty managers of insurance benefits for public plans. Medicaid is the nation’s primary source of financing for long-term care, which is a mandatory benefit in Medicaid. States cannot obtain federal dollars without providing this coverage. Medicaid is just one example of public plans. The Veterans Health Administration and the Indian Health Service are two others. During our class, we discuss the place of these two systems within the context of health care delivery and the ACA.

Case-Based Illustrations Are an Effective Part of Instructional Sessions

Our teaching experience of the ACA began with presentations to local professional and public groups. Early on, we found it effective to develop examples that capture the experience of an individual seeking health care. For each case, we present the pre-ACA environment surrounding health insurance coverage for the condition and the changes legislated in the ACA. The presentation shows commonly experienced barriers to health care and includes a list of specific sections in the law designed to address those barriers. Case one illustrates the health insurance issues surrounding access to maternity care pre- and post-ACA. For a detailed discussion of young adults and their experience with health care access, see Health Reform and Disparities (Miles, 2012, pp. 155–169). Case two illustrates the health insurance issues surrounding access to mental health care for young men with psychiatric illness as they transition into adulthood. Each case emerged from questions asked in these early presentations.

**Case One: Access to Maternity Care.** One student commented, “I was unaware of how common it was for private insurance to not cover maternity care and that that was not always the case (and that the Act now requires maternity care coverage).”

Health insurance coverage for maternity care is a little-discussed aspect of care in the United States. In 2010, this issue emerged during an ACA presentation to a student group. Their question was simple: “What’s in it for us?” The student group was the University of Louisville Mom’s Club. This organization was formed to address the challenges faced by young women attempting to obtain a college education while raising a family. It was a mixture of single and married women. Most members of the baby boomer cohort completed their child bearing during the 1980s. During that period, almost all jobs with large companies offered maternity care as a standard part of employer-sponsored health insurance. The coverage included scheduled office visits, in-hospital care for normal and complicated delivery, and aftercare for both mother and infant. The Mom’s Club students’ questions about the ACA and its impact on maternity care led to the following insurance market analysis of maternity care:

- **Concept 1.** Maternity care is a very small part of the health insurance market with a low profit margin. Chronic disease is a significantly larger portion with potential for profit. Small numbers and low profitability have led to restricted benefit over the past 20 years.
Concept 2. Any differential market analysis limits access to maternity care.

Concept 3. Pre-ACA, most deliveries were supported by Medicaid.

Concept 4. Pre-ACA, pregnant women who were ineligible for Medicaid purchased maternity plans that were expensive and reduced length of stay and other benefits enjoyed by a previous generation of women.

Concept 5. By making maternity care an essential benefit in private plans, Title I of the ACA restores comprehensive maternity care for women in private markets. The ACA (Title II) increases access to maternity care for women working in low-wage jobs without health insurance through the public markets.

During the presentation, the class viewed a video clip on YouTube of a discussion of this issue between Senator Jon Kyl (R-AZ) and Senator Debbie Stabenow (D-MI). Senator Kyl presents the market perspective: “Why should I pay for maternity that I do not need in my health insurance?” Senator Stabenow replies, “Your mother needed it.” In addition to showing this specific discussion, we present pre-ACA price quotations from single maternity benefit plans and examples of state regulations defining the populations and the content of maternity coverage. For many students in class, the discussion of the maternity benefit is an “aha!” moment. The following comment captures the insight: “Young adults are the least insured group: they have the most difficulty gaining access to health care; 56% of babies born in Texas with Medicaid. …Pregnancy used to be classified as a pre-existing condition—crazy!”

Case Two: Access to Mental Health Care for Young Men Leaving Home. Fifteen percent of all young adults have some form of disability or chronic medical condition. Chronic mental illness usually appears in young adulthood. The first episode of manic depression costs an average of one-half million dollars. These dollars go beyond health care to include legal fees, housing issues, and other expenses related to the sudden onset of manic behavior. Unfortunately, males are more likely than females to develop manic depression. Before the ACA, young men with chronic illness faced access barriers to Medicaid. Medicaid eligibility criteria generally excluded young men until their illness was unstable. Private insurance policies also created a barrier to mental illness care in two ways. First, there was no parity between physical illness care and mental illness care. Anyone with a mental illness or a substance abuse problem was subjected to limited numbers of visits and higher co-pays in private insurance market plans. Two health insurance reform laws—the Paul Wellstone & Pete Domenici Act of 2008 and the ACA—created parity. With the implementation of these two laws, both public and private insurance plans were required to treat mental and physical illnesses equally. Student response to this component of the presentation can be captured in the following comments:

I have thought some about young single men being a group lacking coverage, but the part about men with bipolar disorder or other mental illnesses was very powerful, especially given the recent shootings in the U.S.

And this comment is about actual knowledge gained:

Details regarding Wellstone-Domenici (W-D) versus Affordable Care Act—similarities and difference. How both the W-D and ACA apply directly to mental health and substance abuse. How both the W-D and ACA apply directly to maternity care. Had no idea maternity care costs were so low compared to other health costs. Specific details on the W-D and ACA, populations that are affected and how, [and] how the act will logistically WORK.

SUMMARY AND CONCLUSION
Teaching the changes associated with the ACA will be simpler with a specific focus on pre- and post-enactment insurance market structure. Divide the market into public and private
plans. Emphasize the demography of each market group. They are not the same people. They do not have the same problems. Resist the urge to argue about the utility of a specific policy. Save that discussion for a special topic. By following this strategy, the classroom environment is enjoyable, engaging, and civil.

In the current classroom discussion of health care policy, we did not discuss the issue of ethics. Other students, however, have raised the need for ethics analysis of health care policy (Adams & Miles, 2013). Attention to ethical issues is a routine part of medical research. Health policy education, like research training, should include a formal review of these issues. Ethical knowledge is, of course, a critical component of epistemology and is inherent in development of laws and principles of justice. However, we cannot assume that new policies are subject to a formal ethics review. The Belmont Report of 1978 provides a platform for this process. The Belmont Report highlights three general principles: respect for persons, beneficence, and justice. By restructuring payment, the ACA has laid a foundation for formal training in the review of the ethics of health care delivery policy. Can this process be the foundation for ethics training of students in health care policy?

Health care policy is one of the most challenging subjects in professional programs of public affairs, administration, and policy. Not only is it an area with significant personal implications for all of us—students and teachers alike—but it is also in a period of rapid and fundamental change. For example, some have called for delay of the individual mandate for one year. This delay creates opportunity to train students in the procedures leading up to “open season” for health insurance. Open season is a traditional contract period allowing individuals to change their coverage. Premium levels offered during open season are based on anticipated numbers of insured persons. A delay in the individual mandate would invalidate insurer premium rates that have already been approved for 2014, creating disruption and uncertainty for insurers, consumers, and government. The delay creates a teachable moment and the potential to develop exercises illustrating the process of premium rate setting. Before the ACA, premium pricing was not an interesting and dynamic process. Now it is.

In conclusion, the Affordable Care Act provides a historic moment for the Network of Schools of Public Affairs and Administration member schools to enhance the learning environment through innovative teaching tactics. Toward that end, this essay describes a plan that provides ACA instruction in an innovative case-study format. The course content is contemporary and lends itself to modifications as health care reforms unfold over the next few years. Furthermore, the pedagogical approach extends the instructional format beyond topical seminars in health care and public health to foundation courses, such as policy development, management and leadership, public financial management, advanced quantitative analysis, and policy evaluation, among others. This approach will enrich the learning process for students and help prepare them to navigate the public policy environment of the future as policy professionals and public administrators.

REFERENCES


Haeder, S. F., & Weimer, D. J. (2013). You can’t make me do it: State implementation of insurance exchanges under the Affordable Care Act. Public Administration Review, 73, S34–S47.


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