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**HEALTH CARE REFORM IMPLEMENTATION**

**Analytical Essay**

**1. Health care reform**

According to Garrett and Gangopadhyaya, (2016)

*“Ohio was one of 31 states that had expanded Medicaid as of September 2017. Even if a state did not expand Medicaid, it could have seen an increase in enrollment in the program due to the ACA's requirement to acquire health insurance. In the fiscal year 2015, annual Medicaid enrollment in Ohio increased by 17 percent, compared to 5.4 percent in 2014 and 7.5 percent in 2013. In Ohio, monthly Medicaid enrollment amounted to 2.8 million in May 2017. Before the Affordable Care Act, the average monthly enrollment in Ohio amounted to 2.2 million, according to the Kaiser Family Foundation. This represented a difference of 29.6 percent”.*

In Ohio, there are changes in the health care delivery method as the state increases the Medicaid program, marks the uninsured to the central healthiness indemnity market, optimizes healthiness care and social services plans, and initiates new health care expense systems. This information presents an outline of community physical condition, health care exposure, and Ohio health care systems in the era of physical condition care improvement (Obama, 2016).

**2. Impacts**

The delivery of the Medicaid program is delegated to the federated states, which jointly fund it with the federal government. In a whirlwind of red tape, it is up to the program candidate to prove that he is a resident in Ohio. Some states have chosen to rename the Medicaid program, making it difficult to understand the various programs for those who are not familiar with them. Access to the Medicaid program is open to all US citizens. On the other hand, the eligibility criteria are strict. In compliance with the minimum conditions imposed by Congress, they vary from one state to another according to the income threshold. This heterogeneity is de facto limiting the mobility of the poor in Ohio.

Applying for the Medicaid program involves a cumbersome, as well as participation in certain meetings. The form of application and the conditions of acceptance constitute a barrier to access to the program for patients whose social conditions would allow them to be accepted. This was one of the points raised in 2008 by Barack Obama in his plea for the social security excluded. He pointed out, particularly in the particular case of social insurance for children, that a significant portion of the beneficiaries was excluded by the difficulty of accessing the program, although it falls within the criteria of acceptance.

The organization and eligibility policy of the Medicaid program, as well as the conditions for financial support, vary greatly from one State to another. Two patients admitted to the Medicaid program in different states will have very different coverage conditions (services received, amount of care, amount of reimbursement, duration of compensation, etc.). Similarly, a citizen may be eligible for Medicaid in one state while he or she will be excluded in another. On the other hand, the eligibility criteria are strict. In compliance with the minimum conditions imposed by Congress, they vary from one state to another according to the income threshold. This heterogeneity is de facto limiting the mobility of the poor in Ohio (Obama, B. (2016).

The reform of the hospital card, the objectives of financial profitability set by government institutions lead to a reconsideration of the medical function. Henceforth, the public hospital faces new constraints oscillating between the fundamental principle of equity and equal freedom of access to care (J. Rawls, 1971) and the other, a financial dimension becoming ubiquitous and indispensable in order to ensure the sustainability of the system in place.

**3. Effects of economics in health care**

While maintaining patient freedom of choice, the objective of the law is to allow each beneficiary of this program to save an average of $ 4,200 over the next ten years. To finance part of the progress, Medicare Part A contribution rates are going from 1.45% to 2.35% for wages over $ 200,000, and a new 3.8% tax is introduced on the highest non-wage incomes. By changes to the rules on the reimbursement of medicines, people who previously reached what is called the donut hole, that is to say the amount beyond which the drugs become fully dependent on the patient, will save an amount of 16,000 USD on average (Dumanovsky *et al.,* 2016).

In Ohio, The first stage of the reform came into force in 2010. It consisted in allocating to the 4 million people concerned an amount of USD 250 to help them cover their costs. In 2011, these same people receive a 50% discount on the price of their original drugs when they reach the donut hole.

Another aspect relates to prevention. In Ohio, Medicare beneficiaries are now entitled to some free preventive care, including an annual check-up and screening tests for diabetes, colorectal cancer, cardiovascular disease, depression, etc. This care also covers a series of vaccinations (against the flu, hepatitis, etc.), support for smoking cessation and alcohol or for the fight against drug addiction, an annual consultation related to the well-being of the patient, etc (Peterson, A. B. 2016).

**References**

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